The bipolar disorder over-diagnosis trend – in brief

O nadrozpoznawalności zaburzenia afektywnego dwubiegunowego – rzecz krótka

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Abstract

Recently, the discussion about the over-diagnosis of the bipolar disorder and other conditions with psychotic features has been taking place among the psychiatrists. Because the mood stabilizers to treat mental conditions with the broad spectrum of the affective component are prescribed more and more nowadays, the tendency to over-diagnose a bipolar disorder seems to be present. The existing problem with the coverage provided by the National Health Insurance Agency also contributes to the picture.

The authors remind us about the presently valid diagnostic criteria for this condition, discuss the possible reasons for the over-diagnosis phenomenon and present the opposite scientific approaches, views and opinions. At the end, they come to the conclusion that the near future might bring some revisions to the bipolar disorder definition and diagnostic criteria. The inclusion of the biomarkers as well as "the dimension concept" in the diagnostic system will alter it even further.

Keywords: manic-depressive disorder/bipolar disorder, over-diagnosis

Streszczenie

W ostatnim okresie w środowisku psychiatrycznym toczy się dyskusja na temat nadrozpoznawalności zaburzeń psychotycznych, w tym zaburzenia dwubiegunowego. Ponieważ leki stabilizujące nastrój uzyskują coraz szersze zastosowanie w leczeniu zaburzeń psychicznych z szeroko rozumianego spektrum zaburzenia afektywnego, a ponadto istnieje problem refundacji leków, pojawiają się tendencje do częstego rozpoznawania zaburzenia dwubiegunowego. Autorzy przypominają obowiązujące aktualnie kryteria diagnostyczne, dyskutują na temat ewentualnych przyczyn nadrozpoznawalności tego zaburzenia, przytaczają stanowiska przeciwne. Najbliższe lata prawdopodobnie doprowadzą do redefinicji tego zaburzenia z wprowadzeniem tzw. pojęcia wymiaru i markerów biologicznych do systemu diagnostycznego.

Słowa kluczowe: zaburzenie afektywne dwubiegunowe, nadrozpoznawalność

Let us start with the short presentation of the bipolar disorder diagnostic criteria [1].

According to ICD-10, a bipolar disorder can have a shape and form of:

- Hypomania
- Mania
- Depression
- Mixed state
- Remission state

Hypomanic state:

In order to diagnose a hypomanic state the following criteria have to be met:

(1) the present hypomanic episode,

(2) the occurrence of at least one more of hypomanic, manic, depressive or mixed episodes in the past history.

Manic state:

(1) The criteria for mania are at least four days of psychomotor hyperactivity and increased arousal as a state uncharacteristic for a given individual.

(2) At least three out of the following list of symptoms constituting disruptive factors in one's every day functioning, need to be present: increased activity, talk ability, short attention span, concentrating difficulty, insomnia or reduced sleep, sexual overindulgence, overspending and other patterns of irresponsible behavior, as well as, increased approachability and the lack of boundaries.

Depression:

(1) Depressive state in a manic – depressive disorder comes in the mild, medium and severe forms. The severe state of depression might be sometimes complicated by psychosis.

Mixed state:

(1) It is characterized by quick, sometimes taking place within the same day, succession of hypomanic, manic or depressive mood changes (rapid cycling).

(2) These mood changes need to be present for the minimum duration of two weeks.

Remission state:

(1) This state is characterized by the absence of any symptoms of the above mentioned mood disturbances. It also usually follows the treatment period.

Summing up, what the manic depression diagnosis requires, is the well documented episode of hypomanic, manic or depression state, as well as at least one more affective episode.

The presently existing body of ICD-10 criteria and commentary emphasizes that the most common indication for referring to diagnosing the bipolar disorder is the substance abuse, including the alcohol dependency, on the part of the patient.

While it is true that some people, men especially, might show an increased tendency towards alcohol abuse while suffering a hypomanic or a manic episode, it is also true that the resulting group of symptoms would have a broader symptomatic scope. Nevertheless, the substance abuse, including alcohol abuse would definitely result in mood disturbances.

The ICD-10 looks upon the substance abuse as a separate entity. The criteria for its recognition are the following:

(1) The existence of a number of damages, both somatic and psychological in nature, caused by the impaired sense of judgment on the part of the individual that in many instances results in poor relationships with other people.

(2) The pattern of substance abuse that had lasted for at least one month or had shown a repetitive nature of occurrence for one year.

There is a is quite substantial deal of literature on the interrelations between alcohol and mood disturbances. Among the works of the older generation of researchers, Hrynkiewicz's works on the mood swings among those who are alcohol dependent stand out [2]. The Melibrudy's body of research papers about the concept of the polarized "me" and the efforts on the part of some individuals who try to regulate their mood response in terms of increased alcohol consumption, falls into the same category of works [3]. There also exists the" depressive type III" which in terms of Lesch's typology of alcohol dependence does not necessarily result, especially in its initial stages, in heavy biological consequences.

In most cases the patients abuse alcohol in order to improve their mood contents as well as to take advantage of its sleep inducing properties. However, excessive alcohol consumption results in bad chronobiology and also all sorts of emotional disturbances including but not limited to emotional instability and irritability. The alcohol itself may act as the depression and anxiety inducer and according to Lesch some individuals may end up experiencing some real mood disorders. Therefore, the patients themselves should become aware of their own attempts to use the alcohol as a safety vent in their overactive and stressful life or as an antidepressant and a sleep inducer.

In the most recent years, many experts have been pointing out to the fact that the bipolar disorder, a serious mental disorder with personal and social consequences has been over-diagnosed [4,5,6]. This situation might also be the case of the pendulum swinging back in the opposite direction.

According to Zimmerman, in the past when CHAD was under-diagnosed, the treatment regimen of the depressive component alone oftentimes had resulted in acute, rapid cycling form of the disease [7]. The Zimmerman's research papers also indicated that as much as fifty percent out of his 700 bipolar patients, whose diagnostic criteria were comprised of SCID, inquiry sheets and family interviews, did not fulfill the bipolar disorder requirements. Needless to say, that we are facing both medical, as we have to be mindful of the potential for the various side effects of medication, as well as financial burdens on the system. Also Goldberg (2008), points out that the main group of patients with the bipolar over-diagnosis are the ones with the mood swings that could be contributed to their substance abuse [8]. His body of research indicates that only thirty percent of the double diagnosis CHAD and SUD patients according to DSM IV would fulfill the bipolar diagnostic criteria type I and II.

In the same line of thinking, Brim (1998) wrote about the serious mental disorders over-diagnosis phenomenon among both substance abusers and those with personality disorders [6]. In 2009 Wilens also researched the co-existence of substance abuse and bipolar disorder, this time focusing on young patients exclusively. He came to the same conclusion as his predecessors [9]. Angst (2008) calls for more intensive research on the subject while Hutto (2000) points out that the reason for over-diagnosis might be the tendency to include groups of patients with various types of personality disorders [10,4]. This has also been Prof. Kasper's opinion that he expressed during the debate at the VX Symposium "The Update in Psychiatry" that took place in Vienna. During that meeting the participants debated the issue of paradoxical influence that the pharmaceutical industry and its educational sessions for doctors might have on the CHAD over-diagnostic trend [11].

On the other hand there is a group of authors, who share the opinion that the spectrum of the affective mood disorders is much broader in scope than it has been commonly believed. They notice that many mental conditions with the remitting/flaring up patterns respond to the mood stabilizing treatment, therefore, there is a strong possibility that the affective mood disorders might have more types and subtypes than it is currently diagnostically available [12,13]. Moreover, chances are that even the one -dimensional depressive disorder of the

remitting/flaring up type might benefit from being looked upon as one belonging to the bipolar spectrum disorders.

Another set of issues stemming from the bipolar disorder diagnosis that has been approached in a hastily manner are legal issues. The patients with personality disorders, who are substance abusers and happen to fall within the realms of civil or criminal proceedings, constitute a serious problem for the psychiatrists performing the expert functions at the court hearings. The same goes true for the judges who rule in insanity and the free will declaration hearings. One has also to remember that the psychiatric diagnosis itself is not an automatic indication for the insanity defense as well as does not constitute the basis for the exclusion from the right to make decisions bearing legal consequences in civil court matters. It oftentimes happens that a person with the bipolar diagnosis is still capable of functioning in his/her daily life.

There is lots of hope that the above mentioned dilemma will be addressed in the newly comprised DSM V and ICD II classification systems. The older, DSM IV and ICD –IO system will be replaced by so called "dimensional approach". Because there exists a vast body of research pointing out to the genetic component of the mental disorders, bipolar disorder included, the new diagnostic systems will definitely incorporate this new data into their testing methods [14,15]. Except genetics, among other biomarkers which might have the future classification bearings, there are the neuroimaging technology results which point out directly to the changes that take place in the bipolar patients' brains [16,17]. The neurocognitive testing and other diagnostic criteria will also find its way into the system [18,19,20,21].

Having all the above in mind, one might expect that the updates and revisions in the mental disorders classification system would have a self-limiting impact on the bipolar disorder over- diagnosis in the future.

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