

A Case in the Bipolar Spectrum

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ABSTRACT

It has been reported that the correct diagnosis and treatment are delayed when subsyndromal bipolar mood disorder symptoms are overlooked. Patients in this spectrum are reported to have a diminished level of functioning, and these patients fail to accept their diagnosis; therefore, there is a low level of treatment adherence. This

case report focuses on the diagnosis and treatment of a patient in the bipolar spectrum.

Keywords: Misdiagnosis, bipolar disorder, diagnosis

INTRODUCTION

Mania is defined as a distinct mood episode in which the patient's level of functioning is diminished compared with the premorbid level, and where a high or irritable mood is accompanied by three or four classical mania symptoms and findings (1). Acute mania may further be grouped into classical/pure, psychotic features, and mixed state subtypes. Although major depression and bipolar disorder are defined as distinct clinical entities, in recent years it has been proposed that bipolar disorder may be viewed as part of the spectrum (2). On the other hand, these different clinical presentations cause difficulty in correctly diagnosing and treating bipolar disorder. One possible explanation could be that in clinical follow-up bipolar disorder, patients who do not meet the full diagnostic criteria for hypomania or depression are frequently encountered. In this report, a case whose symptoms first appeared during adolescence, with social phobia symptoms, and who met diagnostic criteria for atypical or major depressive episodes, but failed to meet the full diagnostic criteria for hypomania will be presented in line with the bipolar spectrum definition. The case consented that her history and mental status examination findings may be used solely for scientific purposes and under the terms that her personal information will be confidential.

CASE

A 25-year old university graduate female patient presented to our outpatient clinic with symptoms of not completely remitting despite a 5-year-long psychiatric treatment. She complained of not being able to express herself and being incapable of social interaction with others, and she cried during the psychiatric interview.

The patient had been administered different medication regimens for the last 3 years and lamotrigine 100 mg/day and moclobemide 600 mg/day for the last 1.5 years. Despite being adherent to her drugs, her symptoms of depression, lack of volition, thoughts of worthlessness, and anorexia persisted. She felt irritable and tense for no apparent reason from time to time, could not concentrate, felt an urge to move around restlessly, did not want to go to her house, and despite her family's objections, left the house to walk around at midnight. She said that during these periods she had higher levels of self-confidence; got more sociable with strangers; was more talkative; felt more irritable, tense, and behaved aggressively; and burst into laughter, which was quite unusual for her.

The patient reported that her symptoms first appeared during sixth grade after she began wearing glasses and was afraid of disgracing herself, felt unhappy, could not feel well even when something good happened, but her appetite and sleep were normal. Her symptoms increased when she left for college, and she only had a limited relationship with others. She felt more distressed in crowded places such as the classroom, dining hall, or library. She felt that she was worthless, had no motivation, and lacked energy, did not feel like leaving the bed all day long. Furthermore, she ate too much and felt the urge to move around restlessly. During this period she presented to a psychiatrist and was diagnosed with depression and prescribed fluoxetine 20 mg/day and trifluoperazine 1 mg/day. She did not completely adhere to her drugs. After 1 year, because her symptoms persisted, she presented to the psychiatry outpatient clinic of a university clinic; she was diagnosed with bipolar disorder type II and prescribed valproic acid 1000 mg/d and sertraline 50 mg/day. She was receiving these drugs for 1 year; however, she suffered from a dampening of her feelings and stopped her drugs because she thought that she did not need them anymore. At this time,



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Received: 07.10.2014 **Accepted:** 18.11.2014

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another psychiatrist claimed that she was not suffering from bipolar disorder, and that diagnosing this disorder was not easy, and if she was diagnosed with that the disorder, it would not be a good decision to change her treatment. Therefore, she was confused, and decided not to take any more drugs. After a short period, she was taken to the psychiatrist by her family members because she could not stop crying. The psychiatrist offered her lithium after he was told that she had been previously diagnosed with bipolar disorder. Further, because of the nausea that she experienced, she stopped lithium. Yet, after 5 months, she presented to another psychiatrist with symptoms of frequent crying, thoughts of worthlessness, depression, and anhedonia. She was prescribed lamotrigine and moclobemide, but she did not completely adhere to her treatment regimen and her symptoms did not remit.

The psychiatric evaluation of the patient revealed the following findings: She appeared to be of her biological age, was casually dressed and her hair was disheveled, was overly restrained and shy, and could not easily express herself. She was alert and oriented, but did not have any issues with attention, memory, or perception. Her affect was depressed and she had thoughts of worthlessness. No psychotic features were observed, and she had partial insight into her symptoms. No suicidal ideation was observed. All her routine laboratory investigation, including thyroid functions, was within normal limits. Computerized brain tomography did not reveal any significant findings. On her psychometric evaluations, she received the following scores: Hamilton Depression Rating Scale: 23/51, Young Mania Rating Scale: 2/60, Liebowitz Social Phobia-Anxiety Rating: 76/96, Avoidance Rating: 62/96. Her Minnesota Multiphasic Personality Inventory results were interpreted as "social withdrawal, low activity level, shy, and incompetent during interaction with others."

During her psychiatric evaluation she interestingly stated the following: *"There were times when I laughed, laughed without any reason, but I suppose that was not very healthy. It felt like some cream on spinach. The cream was fine, but it felt awkward because it was on spinach."*

She was diagnosed with "bipolar mood disorder, unspecified type" according to DSM 5 criteria because of her symptom onset during adolescence, atypical features of her depressive episodes, chronicity of symptoms, psychomotor agitation, and her hypomania like symptoms, which do not completely meet the diagnostic criteria. Furthermore, she was diagnosed with social anxiety disorder because of her anxiety symptoms she experiences in social situations or around people she does not know well and her avoidance of such situations (3). Her mood swings, low self-worth, frequent change of psychiatrists, distrust in relationships, and low adherence to treatment suggested a diagnosis of personality disorder; however, she did not meet the criteria for a specific personality disorder. She was further evaluated for dysthymia; however, because her comorbidity with social phobia and antidepressant induced hypomanic episodes could not be totally ruled out, a diagnosis within the bipolar spectrum was deemed clinically appropriate.

The patient was provided detailed information regarding her condition and advised to take her lamotrigine and moclobemide regularly. During follow-up, because she had previously responded, valproic acid was titrated up to 1000 mg/day, and her lamotrigine dosage was halved. Furthermore, she received regular individual psychotherapy sessions, and her depressive symptoms partially resolved. She began private tutoring high school students, which reflected a significant increase in her level of functioning; she stated that her communication issues with others decreased.

DISCUSSION

The terms "soft bipolar" or "bipolar spectrum" were first proposed by Akiskal and Mallya (4) to describe psychopathological states that could not be easily diagnosed. It has been reported that soft bipolar cases may be prevalent up to 5.1%–23.7% (5). Cyclothymia and unspecified type of bipolar disorder are suggested to be present on the extreme end of this spectrum.

Diagnosing hypomania may be difficult for the practicing clinician because the distinction between mania and hypomania is not clearly defined in DSM or other classification systems. Hypomania is defined as a less severe form of mania without any specific criteria. This may result in the clinicians to overlook a diagnosis of bipolar disorder type 2 or misdiagnosing bipolar disorder type 1 as type 2. Some researchers have proposed that the 4-day-criterion of DSM to diagnose hypomania is not empirically validated, that this time criterion may be unnecessarily long, and that the time threshold should be 2 days instead of 4 days, with a modal time of 1–3 days (6,7). Furthermore, it is suggested that an increase in the level of activity in social and occupational contexts and psychomotor symptoms may be more relevant in the diagnosis of hypomania rather than the mood elevation criteria (8). Angst has grouped hypomania into two clusters referred to as hard and soft criteria in his Zurich study (7). According to the hard criteria, euphoria, irritability, or overactivity in addition to at least the three criteria listed in DSM is present to meet a hypomania diagnosis. The time criterion requests that a 1-day period is sufficient. According to the soft criteria, euphoria, irritability, or overactivity and at least two DSM criteria are necessary for a hypomania diagnosis. No episode length is defined in the soft criteria. The Zurich study has shown that 90% of all major mood disorder diagnoses correspond to major depressive disorder, and that minor bipolar mood disorders and mild depression are overlooked. It has been proposed that the hard and soft Zurich criteria are more sensitive to diagnose hypomania and that it may detect minor bipolar mood disorders and mild depression (49.5% and 25.7%, respectively). The soft Zurich criteria suggest that almost half of all major depressive disorder diagnoses may actually be reclassified as bipolar disorder type 2 (9). On the other hand, a bipolar mood disorder diagnosis depends on the patient's ability to recall hypomanic episodes and the report of significant others, irrespective of diagnostic criteria. In this particular case, the "cream on spinach" metaphor may reflect the elevated mood as a creamy taste, whereas its inappropriateness with the patient's present context or other people's reactions to it may be reflected by its being on spinach. Patients frequently fail to describe their hypomanic episodes as a part of their disorders, but they experience such episodes as joyful. Therefore, a correct diagnosis requires the collaboration of the patient's significant others, and a thorough retrospective anamnesis of the patient's mood episodes. In the present case, the role of a comprehensive history taking and the importance of a reliable therapeutic relationship are emphasized.

Bipolar spectrum disorders are recurrent and result in significant disruptions in interpersonal relationships and social contexts. Twenty percent of these patients who do not receive an adequate treatment act on their suicidal thoughts (10). Therefore, a comprehensive assessment of these patients' symptoms is essential to prevent any negative consequences, including suicide. The incomplete history of the patient's hypomania has caused confusion among the treating psychiatrists. The discrepancy between the diagnosing the disorder and conveying this to the patient appears to have impaired the doctor–patient relationship, which in turn may have led the patient to frequently change psychiatrists. This case aimed to highlight the difficulties of the patients' acceptance of their bipolar spectrum diagnosis when they are not clearly informed, particularly if the case lies on the soft end of the bipolar spectrum.

Acknowledgements: We would like to thank Professor E. Timuçin Oral, MD for his guidance and feedback during the review of this case report.

Conflict of Interest: No conflict of interest was declared by the authors.

Financial Disclosure: The authors declared that this study has received no financial support.

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