*Psychiatria Danubina, 2010; Vol. 22, Suppl. 1, pp 15–17* *Conference paper*


# THE TEMPERAMENTS AND THEIR ROLE IN EARLY DIAGNOSIS OF BIPOLAR SPECTRUM DISORDERS

**Tavormina Giuseppe**

*"Centro Studi Psichiatrici" ("Psychiatric Studies Centre" - Cen.Stu.Psi.),*
*Piazza Portici, 11 - 25050 Provaglio d'Iseo (BS) – Italy*

***SUMMARY***

***Background:*** *There is a public health issue regarding the correct diagnosis of BSD: these diseases are often underreferred, underdiagnosed and undertreated/mistreated. To fail to treat BSD may result in serious complications (loss of work, relationship crisis, substance-abuse, suicide, rapes, etc).*

*In order to correctly diagnose Bipolar Spectrum Mood Disorders, it is important to know the patient's premorbid personality and past history: it is essential to know the longitudinal history and the full family history.*

***Methods:*** *423 patients, who were recruited and assessed over six years have been reassessed to demonstrate their temperaments, as these emerge from their personal anamnesis.*

***Results:*** *More patients within the series appear to have a soft bipolar illness than a major unipolar depression; the depressive episodes are now considered as only one phase of the bipolar spectrum. Furthermore, every patient with bipolar spectrum disorder already presented in their personal history of the illness a sub-clinical evidence of one of the temperaments (hyperthymic temper.: 35%; cyclothymic temper.: 49%; depressive temper.: 16%).*

***Discussion:*** *The different temperaments are described, and their significance elucidated.*

***Conclusions:*** *The subthreshold presence of the temperaments in the history of the patients with bipolar spectrum disorders leads us to consider this to be an important method of early diagnosis of bipolar spectrum mood disorders.*

***Key words:*** *bipolar spectrum – temperaments - depression*

* * * * *

## Background

Bipolar disease can be considered a real chrono-pathology, in which there is a recurrent switch/shift of mood balance (Akiskal et al. 1996).

Depression and Mania are not only successive conditions, depression and mania are both successive and simultaneous conditions (Rhimer et al. 2009).

Bipolar Spectrum Disorders (BSD), including sub-threshold forms, are much more common then previously thought (Agius et al. 2007).

There is a public health issue regarding the correct diagnosis of BSD: these diseases are often under-referred, underdiagnosed and undertreated/mistreated. To fail to treat BSD may result in serious complications (loss of work, relationship crisis, substance-abuse, suicide, rapes, etc).

In order to correctly diagnose Bipolar Spectrum Mood Disorders, it is important to know the patient's premorbid personality and past history: it is essential to know the longitudinal history and the full family history.

An observational study of the diagnosis of 300 consecutive new patients over a period of four years led to the main observation of a high percentage of bipolar spectrum diagnosis (Tavormina 2007). This has suggested a new classification of "the bipolar spectrum" (ten sub-types of bipolar spectrum mood disorders).

These sub-types also include the temperaments, even if they are only sub-clinical aspects of the bipolar spectrum. The temperaments are continuous presentations of the character's mood-peculiarities, and also are subthreshold (sub-clinical) forms of the Bipolar Spectrum (Fig. 1, Fig 2).

## Methods

The present author had previously published a study of 300 consecutive patients who attended my practice (Tavormina 2007). Using the same method (the diagnostic method was based, by clinical interviews, on an analysis of: premorbid personality, personal and familiar history of the illness) and with the same aims, the author has added to this sample another 123 consecutive new patients who were recruited and assessed over the subsequent two years; then, all the 423 patients, who were recruited and assessed over six years, have been reassessed in order to demonstrate their temperaments, as these emerge from the patients' personal anamnesis.

## Results

It appears clear that significantly more patients within the series appear to have a soft bipolar illness than a major unipolar depression; the depressive episodes are now considered as only one phase of the bipolar spectrum. Furthermore, every patient with bipolar spectrum disorder had already presented in their personal history of the illness a sub-clinical evidence of one temperament (hyperthymic temper.: 35%; cyclo-thymic temper.: 49%; depressive temper.: 16%) (Fig 3).

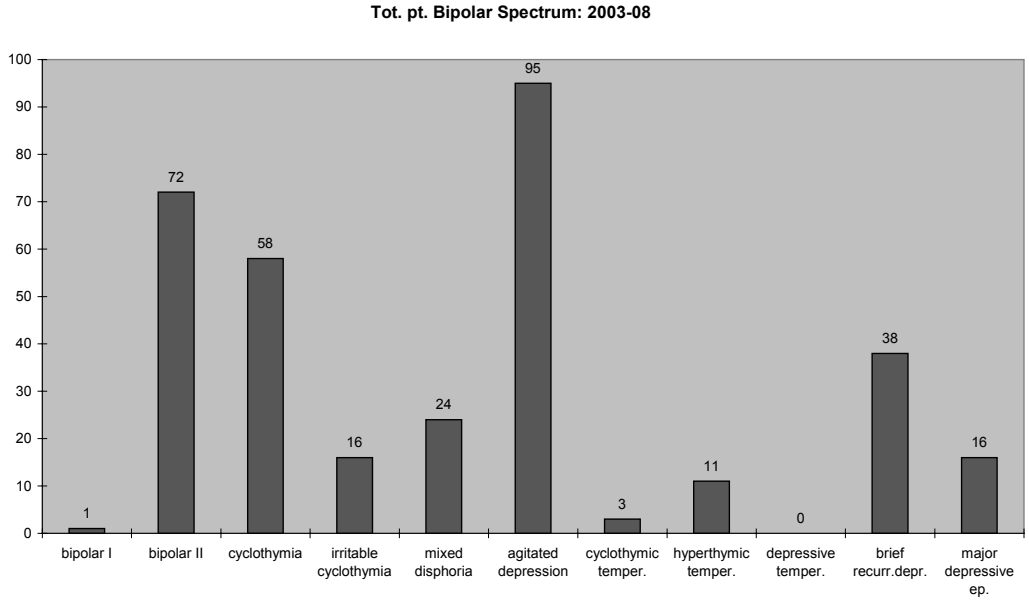


**Figure 1.** Patients in the bipolar spectrum out of 423 consecutive patients

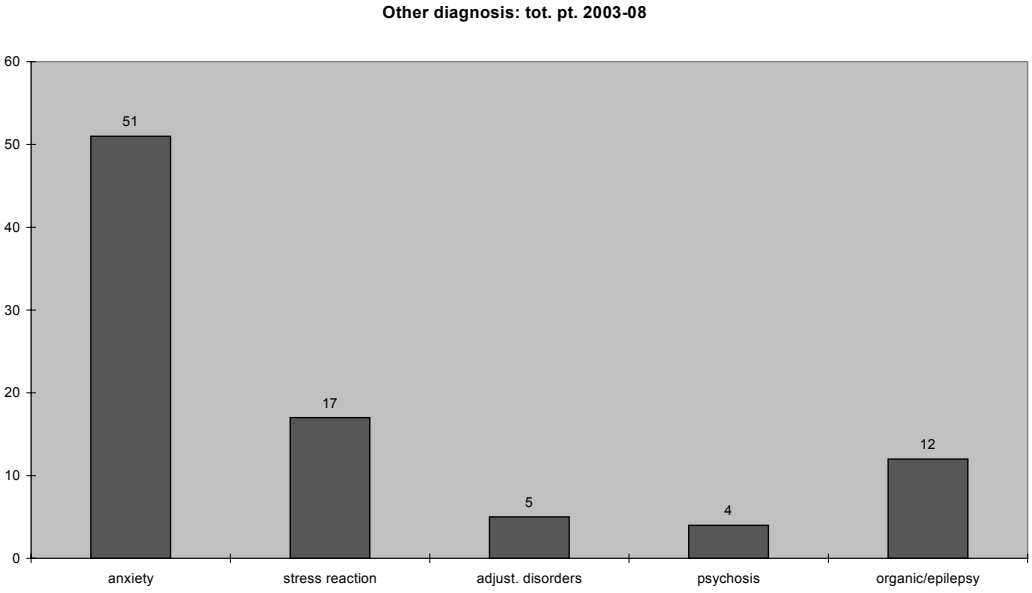


**Figure 2.** Patients not in the bipolar spectrum out of 423 consecutive patients

## Discussion

Following this classification, we can find:

***Depressive Temperament*** (with these main symptoms: gloomy, humorless, or incapable of fun, given to worry, or pessimistic cognitions, introverted, passive, or lethargic, habitually long sleeper (> 9 hours of sleep) or suffering intermittent insomnia, preoccupied with inadequacy, failure, and negative events, skeptical, self-critical, overcritical, complaining and guilt-prone);

***Hyperthymic Temperament*** (with these main symptoms: cheerful, overoptimistic or exuberant, mental overactivity and overtalkative, warm, people seeking, extroverted, overconfident, self-assured, boastful or grandiose, habitual short sleeper (< 6 hours of sleep), including weekends, high energy level, full of plans and improvident activities, overinvolved, uninhibited, stimulus seeking, or promiscuous);

***Cyclothymic - irritable Temperament*** (with these main symptoms: byphasic dysregulation characterised by slight endoreactive shifts from one phase to the other, each phase fasting for a few days at a time, with infrequent euthymia; mental overactivity, insomnia or bad quality of sleep, somatizations);

***Softly- instable Temperament*** (this is a "soft cyclothymic temperament", characterised by: vague and fluctuating uneasiness, mood instability but of low grade, anxious traits, trait-state overlap). When this temperament develops to threshold forms of bipolar disorder, this temperament presents a better prognosis then cyclothymic temperament development (Tavormina 2009).

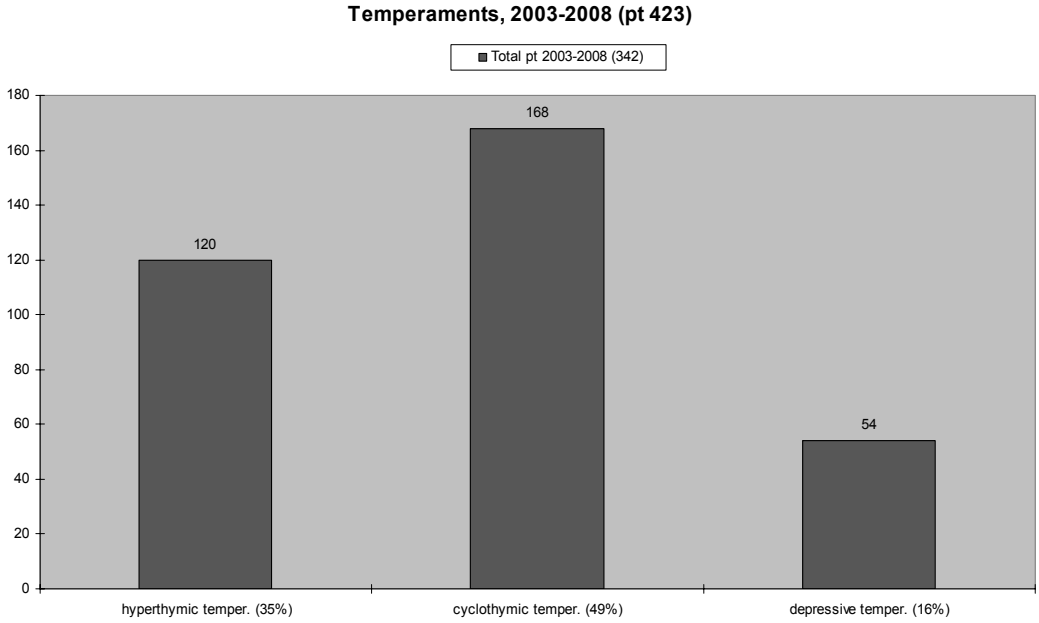


**Figure 3.** The percentages of the tempertaments of 423 consecutive patients

## Conclusions

The subthreshold presence of the temperaments in the history of the patients with bipolar spectrum disorders allow us to consider this to be a crucial method for early diagnosis of bipolar spectrum mood disorders. In order to achieve this, it is very important to focus on the temperaments during the clinical interview, to be effective in the early diagnosis of mood instability, and to identify affective instability between episodes, the high frequency of somatizations, the stormy object relations, and the complicated biographies which these patients describe.

## References

1. *Akiskal HS. The prevalent clinical spectrum of bipolar disorders: beyond DSM-IV. J Clin Psychopharmacol 1996; 16 (suppl 1): 4-14.*
2. *Agius M, Tavormina G, Murphy CL, Win A, Zaman R. Need to improve diagnosis and treatment for bipolar disorder. Br J Psych Electronic Letters 2007; 9th March.*
3. *Tavormina G, Agius M. The high prevalence of the bipolar spectrum in private practice. J Bipolar Dis: Rev & Comm 2007; 6; 3: 19.*
4. *Tavormina G, Agius M. A study of the incidence of bipolar spectrum disorders in a private psychiatric practice. Psychiatria Danubina 2007; 19: 370-74.*
5. *Rihmer Z, Akiskal HS, et al. Current research on affective temperaments. Current Opinion in Psychiatry 2009; 22:000-000.*
6. *Tavormina G. The bipolar spectrum diagnosis: the role of the temperaments. Psychiatria Danubina 2009; 21: S2: S160-S161.*

*Correspondence:*
*Tavormina Giuseppe, M.D.*
*"Centro Studi Psichiatrici" ("Psychiatric Studies Centre" - Cen.Stu.Psi.)*
*Piazza Portici, 11 - 25050 Provaglio d'Iseo (BS), Italy*
*E-mail: dr.tavormina.g@libero.it*