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HOW UNDERSTANDING THE TEMPERAMENTS CAN HELP CLINICIANS TO MAKE A CORRECT DIAGNOSIS OF BIPOLAR MOOD DISORDERS: 10 CASE REPORTS

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SUMMARY

The temperament is a key factor when assessing a patient within the bipolar spectrum. The temperaments are conditions in their own right within the bipolar spectrum, since they are 'soft' forms of bipolar condition within the spectrum: they can develop over time into a more clear bipolar condition, and hence are important in early diagnosis. Bipolar disorders are very often diagnosed late (approximately 25 year late, on average, from the beginning of the illness), in part because the temperaments of the patients have not been identified early.

Key words: *bipolar spectrum – temperaments - early diagnosis – mixed states – mixity - mixed state rating scale*

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BACKGROUND

Disorders of the bipolar spectrum (including sub-threshold forms) are very common: more common than is usually believed, especially when we include the sub-threshold forms. These conditions are often underestimated epidemiologically, under-diagnosed, and ineffectively treated or untreated (Agius 2007, Tavormina 2007). Inadequate diagnosis and consequent inadequate treatment of these illnesses can lead to various public health issues, with serious consequences, including abuse of substances, employment difficulties, suicidal risk and problematic or criminal behaviour (Akiskal-Rihmer 2009, Tavormina 2010).

Evaluating the characteristic of temperament of the patient at the beginning of his history of mood disorder is essential in making a correct diagnosis and providing the correct therapy. Rihmer and Akiskal (2009) have commented: "The sub-threshold types of temperament have an important role in the evolution of clinical episodes of mood disorder in that they indicate the direction of the polarity and the formation of symptoms of acute mood episodes… They also significantly affect the course and development of these pathologies, thus influencing the suicidal risk and other forms of self-destructive behaviours such as substance abuse and eating disorders".

Every patient with BSD has already presented in their personal history of illness subclinical evidence of one of the temperaments: depressive temperament, hyperthymic temperament and cyclothymic-irritable temperament; inside the cyclothymic temperament we can find the so called "softly-unstable temperament" (a "soft cyclothymic temperament) (Tavormina 2012).

The patient with the "Depressive Temperament" shows the following aspects: he is gloomy, humourless and incapable of fun, tending to worry, with frequent pessimistic cognitions, introverted, passive and lethargic, tending habitually to sleep long hours or suffering from intermittent insomnia, constantly preoccupied with inadequacy, failure, or negative events, tending to be sceptical, self-critical, over-critical.

The patient with the "Hyperthymic Temperament" shows instead the following aspects: he is cheerful, tending to overoptimism and exuberance, demonstrating mental overactivity, tending to be overtalkative, extrovert, people seeking, overconfident, a habitually short sleeper, having a high energy level, tending to be full of plans and improvident activities, tending to be overinvolved, uninhibited, stimulus seeking, or promiscuous.

Finally, the patient with the "Cyclothymic-irritable Temperament" shows the following aspects: he presents a biphasic dysregulation of mood characterised by slight endoreactive shifts from one phase to the other, each phase lasting for a few days at a time, with infrequent euthymia; mental overactivity, insomnia or bad quality of sleep, and somatization.

The "Softly- unstable Temperament" is a "soft cyclothymic temperament", characterised by: vague and fluctuating uneasiness, mood instability of low grade, anxiety traits, and trait-state overlap.

All the temperaments may develop over time into a more clear bipolar picture.

Whereas the other three temperaments had been described by Akiskal (1989), the softly unstable temperament has been first described by our group, based on our clinical observations.

When this temperament develops to threshold forms of bipolar disorder, it presents a better prognosis than cyclothymic temperament development (Tavormina 2009).

Table 1. Patients ages: diagnosis, years without correct diagnosis

Patients	Sex	Age	Beginning age of symptoms	Years lost without diagnosis	Diagnosis	Temperament	GT-MSRS, initial
1	F	31	28	3	Agitated depression	Cyclothymic	6 (L)
2	F	44	14	30	Bipolar II	Hyperthymic	11 (M)
3	F	50	20	30	Agitated depression	Hyperthymic	11 (M)
4	M	32	28	4	Dysphoric depression	Cyclothymic	8 (M)
5	M	40	30	10	Agitated depression	Hyperthymic	9 (M)
6	F	47	20	27	Cyclothymia	Cyclothymic	10 (M)
7	F	47	15	32	Cyclothymia	Hyperthymic	10 (M)
8	F	76	40	36	Agitated depression	Cyclothymic	8 (M)
9	M	52	25	27	Agitated depression-GAD	Softly-unstable	8 (M)
10	M	45	15	30	Cyclothymia	Cyclothymic	8 (M)

OBJECTIVE AND METHOD

Ten consecutive new out-patients with the diagnosis of mood disorders, visited in my office in the first two months of the year 2018, have been included in this observational study, with the aim to show how the correct evaluation of the temperament of the patients with mood disorders enables the psychiatrist to make an early diagnosis of bipolar disorder and at the same time, consequent to this, to prescribe appropriate treatment (mood-stabilisers, with eventual antidepressant) to these patients.

As the table 1 shows, the patients include males (4 patients) and females (6 patients), with a range of age between 40 and 52 years old (except: only one patient aged 76 years, and two patients under 40 years old). The history of the illness of the patients, crucial to identify the correct development of the symptoms of the mood disorders (Tavormina 2007), shows how early (sometimes very early) the mood disorder has begun in the life of the patients, much before the day of the "first visit" in my office.

The "G.T. Mixed States Rating Scales" was administered on the day of the "first visit" of the patient, on easier making a diagnosis of mixed states (and focusing on the symptoms of "mixity"; Tavormina et al. 2017); the level of uneasiness of the patients has been assessed by administering the GAS scale on the day of their "first visit", and also after four months to evaluate the level of the improvement of the quality of mood (Figure 1); the "Tavormina bipolar disorders scheme" (Tavormina 2007, Tavormina 2012) has been followed for the diagnostic modalities.

RESULTS

Interesting results have been obtained with this observational study: the diagnostic approach of identifying the temperaments of the patients alongside their history of illness enabled an early diagnosis of bipolarity and the prescription of a correct treatment with a mood regulator; the utilization of the rating scale "GT-MSRS", administered to the patients on the day of the "first visit", helped and speeded this up. Table 1 also shows for how many years the patients had not received a correct diagnosis (data carefully assessed from their history of illness) before the visit in my office (all the patients told they were taking some inappropriate drugs, because they were feeling ill). The prescription of a correct treatment with a mood regulator allowed the patients to quickly reach a good level of quality of mood (figure 1 shows the average level of the improvement of the quality of mood obtained by GAS).

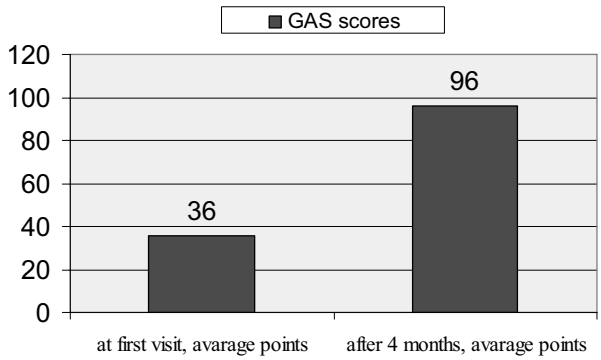

Figure 1. Level of quality of mood

Clinical evaluations

It is crucial for the clinician to carefully assess the patient by taking a careful history of the illness and also the family history, identifying the temperaments so as to make a correct diagnosis of mood disorders: my motto is "a correct treatment follows to a correct diagnosis".

Very often the patients with bipolar disorders received a correct diagnosis after several years: my present and also past papers (McCombs et al. 2007, McCraw et al. 2014) have confirmed that bipolar patients receive a correct diagnosis 25 year late, on average, from the beginning of the ilness. The clinicians meet great difficulties in making a correct diagnosis of mood disorders which they are assessing, above all when mixed

states are present: this is because the patients mainly focus their own symptoms on depressive uneasiness (inducing the clinicians to frequently prescribe antidepressants drugs alone or together with benzodiazepines), inducing them to prescribe these inadequate treatments and not take note of the real problem of increasing dysphoria caused by these treatments.

The "mixity" of depressive phases (that are the most insidious symptoms of overlapped depression-restlessness-irritability) can cause increased risk of suicidality (Akiskal 2007).

CONCLUSIONS

The bipolar disorders are pathologies which are often underestimated or, worse, not diagnosed or mistreated (Agius 2007, Tavormina 2007). The subthreshold presence of the temperaments in the history of the patients with BSD allows us to consider this to be a crucial method for early diagnosis of bipolar spectrum mood disorders. It is very important to focus on the temperaments during the clinical interview, in order to be effective in the early diagnosis of mood instability.

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