Stage and symptoms of bipolar disorders

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Abstract

Bipolar disorder (formerly called manic-depressive illness or manic depression) is a mental disorder that causes unusual shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks. During mood swings, there may be features of psychosis (delusions and hallucinations) that are mood-congruent. Although psychotic symptoms are seen only in a minority of patients, they explain the early terminology of manic-depressive psychosis. Stage 1a is defined as mild or non-specific symptoms of mood disorder and intervened as formal mental health literacy; family psychoeducation; substance abuse reduction; cognitive behavioral therapy. Euphoric means the experience of pleasure or excitement and intense feelings of well-being and happiness. Certain natural rewards and social activities, such as aerobic exercise, laughter, listening to or making music, and dancing, can induce a state of euphoria. Racing thoughts are consistent, persistent, often intrusive thoughts that come in rapid succession. There is a direct link between depression and anxiety and racing thoughts. Whereas jumping from topic to topic as in the flight of ideas can be observed by others, ascertainment of racing thoughts requires asking the child whether his or her thoughts seem to be going too fast.

Introduction

Bipolar disorder is classically characterized as clinically significant episodes of depression and elevated mood (mania or hypomania) with intervening periods of normal mood (euthymia). Bipolar disorder is a severe, lifelong group of disorders with an estimated prevalence of approximately 2%. Approximately three-quarters of individuals with bipolar disorders exhibit features of the disorder before the age of 25 highlighting the neurodevelopmental aspects of the disorder as well as the importance of screening and timely diagnosis, especially in younger populations presenting in clinical settings with clinically significant depressive and anxiety symptoms. A distinction is made between types I and II bipolar disorders that depend on the duration and severity of the episodes of mood elevation. In reality, the profile of bipolar disorder is complex and heterogeneous, both longitudinally and cross-sectional, and includes mixed mood states, persistent mood instability, and cognitive dysfunction [1-7]. During mood swings, there may be features of psychosis (delusions and hallucinations) that are mood-congruent. Although psychotic symptoms are seen only in a minority of patients, they explain the early terminology of manic-depressive psychosis [8]. The initial diagnosis of bipolar disorder type I or II was established using the Schedule for Affective Disorders and Schizophrenia, lifetime version (SADS-L). DSM-V diagnostic criteria for bipolar and related disorders, are given for essential sections on their own, between depressive disorders and schizophrenia spectrum disorders, that involves bipolar I disorder (which represents, according to DSM-V, classic manic depressive disorder, with the exception that neither a depressive episode nor psychosis has to be present for diagnosis, distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed, increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (i.e., purposeless, non-goal-directed activity), excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments, Inflated self-esteem or grandiosity, decreased need for sleep (e.g., feels rested after only 3 hours of sleep), more talkative than usual or pressure to keep talking, flight of ideas or subjective experience that thoughts are racing), bipolar II disorder (which represents, according to DSM-V, criteria have been met for at least one hypomanic episode and at least one major depressive episode, there has never been a manic episode, the occurrence of the hypomanic episode(s) and major depressive episode(s) is not better explained by schizoaffective disorder, schizophrenia, schizophréniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other...
psychotic disorder, the symptoms of depression or the unpredictability caused by frequent alternation between periods of depression and hypomania causes clinically significant distress or impairment in social, occupational, or other important areas of functioning) and cyclothymic disorder. Additionally, there are currently separate diagnostic criteria for “manic-like phenomena” associated with the use of substances (either substance of abuse or prescribed medications) or with medical conditions. Lastly, to encourage more surveys, as the DSM-5 explicitly states, bipolar-like phenomena that do not fulfill the diagnostic criteria for bipolar I disorder, bipolar II disorder, or cyclothymic disorder (i.e. short-duration hypomanic episodes and major depressive episodes, hypomanic episodes with insufficient symptoms and major depressive episodes, hypomanic episode without a prior major depressive episode, and short duration cyclothymia) are concluded under the label “other specified bipolar and related disorders” [9-11] (Table 1).

When ascertaining the presence or absence of manic symptoms, we recommend that clinicians use the FIND (frequency, intensity, number, and duration) strategy to make this determination. FIND guidelines for the diagnosis of borderline personality disorder include Frequency: symptoms occur most days in a week; Intensity: symptoms are severe enough to cause extreme disturbance in one domain or moderate disturbance in two or more domains; Number: symptoms occur three or four times a day; Duration: symptoms occur 4 or more hours a day, total, not necessarily contiguous [12] (Table 2).

Additionally, they must occur in concert with other manic symptoms because no one symptom is diagnostic of mania.

**Euphoric:** This is the experience of pleasure or excitement and intense feelings of well-being and happiness. Certain natural rewards and social activities, such as aerobic exercise, laughter, listening to or making music, and dancing, can induce a state of euphoria. Children can be extremely happy, silly, or giddy when they are very excited about a special event, when they are disinhibited (i.e., secondary to prescription drug use such as steroids or substance abuse), or when they are manic [14].

**Irritable mood:** Irritability is a feeling of agitation; although some describe “agitation” as a more severe form of irritability. Irritability is nearly ubiquitous in childhood psychopathology. Children with major depressive disorder, dysthymic disorder, or oppositional defiant disorder routinely experience irritable moods [15].

**Grandiosity:** Grandiosity is characterized by the affection for grandeur or splendor or by absurd exaggeration. Because some children possess special talents and abilities, it is important to verify the veracity of children’s claims. Additionally, children who lack adequate access to healthy peer play may continue with fantasy play longer than usual [16].

**Racing thoughts:** Racing thoughts are consistent, persistent, often intrusive thoughts that come in rapid succession. There is a direct link between depression and anxiety and racing thoughts. Whereas jumping from topic to topic as in the flight of ideas can be observed by others, ascertainment of racing thoughts requires asking the child whether his or her thoughts seem to be going too fast [17].

**Pressured speech:** Pressured speech is when the patients talk faster than usual. Patients perhaps feel like they can’t stop. People could have trouble following the conversation. Children who are excited, nervous, or angry often speak rapidly. This is a transitory phenomenon and not a sign of mania [18].

**Decreased need for sleep:** The decreased need for sleep, in which someone can get by with little or no sleep and not feel tired as a result the next day. Delayed sleep phase syndrome, is a circadian rhythm sleep disorder resulting in insomnia and daytime sleepiness. It is important to distinguish the decreased need for sleep from other medical conditions that may mimic mania [19] (Table 2).

<table>
<thead>
<tr>
<th>Clinical stage</th>
<th>Definition</th>
<th>Potential interventions</th>
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<tbody>
<tr>
<td>0</td>
<td>Increased risk of severe mood disorder (e.g., family history, abuse, substance use) No specific symptoms currently</td>
<td>Mental health literacy; self-help</td>
</tr>
<tr>
<td>1a</td>
<td>Mild or non-specific symptoms of mood disorder</td>
<td>Formal mental health literacy; family psychoeducation; substance abuse reduction; cognitive behavioral therapy</td>
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<tr>
<td>1b</td>
<td>Prodromal features: ultra-high risk</td>
<td>1a plus therapy for the episode: phase-specific or mood stabilizer</td>
</tr>
<tr>
<td>2</td>
<td>First-episode threshold mood disorder</td>
<td>1b plus case management, vocational rehabilitation</td>
</tr>
<tr>
<td>3a</td>
<td>Recurrence of sub-threshold mood symptoms</td>
<td>2 plus emphasis on maintenance meds and psychosocial strategies for full remission</td>
</tr>
<tr>
<td>3b</td>
<td>First threshold relapse</td>
<td>2a plus relapse prevention strategies</td>
</tr>
<tr>
<td>3c</td>
<td>Multiple relapses</td>
<td>3b plus combination mood stabilizers</td>
</tr>
<tr>
<td>4</td>
<td>Persistent unremitting Illness</td>
<td>3c plus clozapine and other tertiary therapies, social participation despite disability</td>
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<th>Mimic mania</th>
<th>Increase mood cycling</th>
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<td>Temporal lobe epilepsy</td>
<td>Tricyclic antidepressants Selective serotonin reuptake inhibitors Serotonin and norepinephrine reuptake inhibitors Aminophylline Corticosteroids Sympathomimetic amines (e.g., pseudoephedrine) Antibiotics (e.g., clarithromycin, erythromycin, amoxicillin)</td>
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<td>Hyperthyroidism</td>
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<td>Closed or open head injury</td>
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<td>Multiple sclerosis</td>
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<td>Systemic lupus erythematosus</td>
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<td>Alcohol-related neurodevelopmental disorder</td>
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<td>Wilson’s disease</td>
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need for sleep from more common forms of insomnia that result in fatigue the next day [19].

**Distractibility:** Distractibility is a condition of being easily sidetracked from the primary purpose, unable to pay attention, or staying on task. For distractibility to be considered a manic symptom, it needs to reflect a change from baseline functioning, needs to occur in conjunction with a “manic” mood shift, and cannot be accounted for exclusively by another disorder, particularly attention-deficit/hyperactivity disorder [20].

**Excessive involvement in pleasurable or risky activities:** If an activity or action, it is dangerous or likely to fail. Children with borderline personality disorder are often hypersexual. It is important to rule out sexual abuse or exposure to sexually explicit materials or behaviors as a possible cause of hypersexual behavior in any child, including one with borderline personality disorder [21].

**Psychomotor agitation:** Psychomotor agitation is a symptom related to a wide range of mood disorders. People with this condition engage in movements that serve no purpose. Psychomotor agitation often occurs with mania or anxiety. Whereas increased goal-directed activity is relatively specific to mania, psychomotor agitation is a common and nonspecific symptom in childhood psychopathology. Therefore, increased goal-directed activity is more informative than psychomotor agitation in diagnosing mania [22].

**Psychosis:** During the period of psychosis, a person's thoughts and perceptions are disturbed and the individual may have difficulty understanding what is real and what is not. In addition to core symptoms of mania, psychotic symptoms, including hallucinations and delusions, are frequently present in children with borderline personality disorder [23].

**Suicidality:** The term Suicidality covers ideation (serious thoughts about taking one’s own life), suicide plans, and suicide attempts. Although not a core symptom of mania, children with borderline personality disorder are at extremely high risk of suicidal ideation, intent, plans, and attempts during a depressed or mixed episode or when psychotic [24,25].

**Symptoms of bipolar disorder in children and teens and adults:** Bipolar disorder that commences during childhood or during the teen years is called early-onset bipolar disorder. Early-onset bipolar disorder appears to be more severe than the forms that first appear in older teens and adults. Youth with bipolar disorder are different from adults with bipolar disorder. Young people with the illness appear to have more frequent mood switches, are sick more often, and have more mixed episodes. Averagely, people with early-onset bipolar disorder have a higher risk of attempting suicide than those whose symptoms launch in adulthood [26,27]. Youth with bipolar disorder experience unfamiliarly intense emotional states that happen in distinct periods called “mood episodes.” The extreme highs and lows of mood are accompanied by extreme changes in energy, activity, sleep, and behavior. Each mood episode represents a drastic change from a person’s usual mood and behavior. An overly joyful or overexcited state is called a manic episode. An extremely sad or hopeless state is called a depressive episode. Sometimes, a mood episode involves symptoms of both mania and depression. This is called a mixed state. People with bipolar disorder also may be explosive and irritable during a mood episode [28,29].

**Conclusion**

Bipolar disorder is classically described as clinically significant episodes of depression and elevated mood (mania or hypomania) with intervening periods of normal mood (euthymia). A distinction is made between types I and type II bipolar disorders that depend on the duration and severity of the episodes of mood elevation. Stage 3a is defined as recurrence of sub-threshold mood symptoms and intervened as 2 plus emphasis on maintenance meds and psychosocial strategies for full remission. Distractibility is a condition of being easily sidetracked from the primary purpose, unable to pay attention, or staying on task. For distractibility to be considered a manic symptom, it needs to reflect a change from baseline functioning, needs to occur in conjunction with a “manic” mood shift, and cannot be accounted for exclusively by another disorder, particularly attention-deficit/hyperactivity disorder.

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**Availability of data and materials:** The datasets generated during the current study are available with the correspondent author.

**Competing interests:** The author has no financial or proprietary interest in any of the material discussed in this article.

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