

Mini Review

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 type 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

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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, schizophreniform 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

Table 1: A potential clinical staging model for bipolar disorder.

Clinical stage	Definition	Potential interventions
0	Increased risk of severe mood disorder (e.g., family history, abuse, substance use) No specific symptoms currently	Mental health literacy; self-help
1a	Mild or non-specific symptoms of mood disorder	Formal mental health literacy; family psychoeducation; substance abuse reduction; cognitive behavioral therapy
1b	Prodromal features: ultra-high risk	1a plus therapy for the episode: phase-specific or mood stabilizer
2	First-episode threshold mood disorder	1b plus case management, vocational rehabilitation
3a	Recurrence of sub-threshold mood symptoms	2 plus emphasis on maintenance meds and psychosocial strategies for full remission
3b	First threshold relapse	2a plus relapse prevention strategies
3c	Multiple relapses	3b plus combination mood stabilizers
4	Persistent unremitting illness	3c plus clozapine and other tertiary therapies, social participation despite disability

Table 2: Medical conditions that may mimic mania or increase mood cycling in children and adolescents [13].

Mimic mania	Increase mood cycling
Temporal lobe epilepsy Hyperthyroidism Closed or open head injury Multiple sclerosis Systemic lupus erythematosus Alcohol-related neurodevelopmental disorder Wilson’s disease	Tricyclic antidepressants Selective serotonin reuptake inhibitors Serotonin and norepinephrine reuptake inhibitors Aminophylline Corticosteroids Sympathomimetic amines (e.g., pseudoephedrine) Antibiotics (e.g., clarithromycin, erythromycin, amoxicillin)



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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References

1. Brickman HM, Fristad MA. Psychosocial Treatments for Bipolar Disorder in Children and Adolescents. *Annu Rev Clin Psychol.* 2022; 18: 20.1–20.37.
2. Lee H, Han D, Rhee SJ, Kim J, Lee Y, et al. Alterations in blood proteins in the prodromal stage of bipolar II disorders. *Sci Rep.* 2022; 12: 3174. **PubMed:** <https://pubmed.ncbi.nlm.nih.gov/35210508/>
3. Göteson A, Isgren A, Sparding T, Holmén-Larsson J, Jakobsson J, et al. A serum proteomic study of two case-control cohorts identifies novel biomarkers for bipolar disorder. *Translational Psychiatry.* 2022; 12: 55.
4. Ching CRK, Hibar DP, Gurholt TP, Nunes A, Thomopoulos SI, et al.



- What we learn about bipolar disorder from large-scale neuroimaging: Findings and future directions from the ENIGMA Bipolar Disorder Working Group. *Hum Brain Mapp.* 2022; 43: 56–82.
PubMed: <https://pubmed.ncbi.nlm.nih.gov/32725849/>
5. Post RM, Grunze H. The Challenges of Children with Bipolar Disorder. *Medicina.* 2021; 57: 601.
PubMed: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8230664/>
 6. Duffy A, Goodday S, Keown-Stoneman C, Grof P. The Emergent Course of Bipolar Disorder: Observations Over Two Decades from the Canadian High-Risk Offspring Cohort. *Am J Psychiatry.* 2019; 176: 720–729.
PubMed: <https://pubmed.ncbi.nlm.nih.gov/30525908/>
 7. Hafeman DM, Rooks B, Merranko J, Liao F, Gill MK, et al. Lithium Versus Other Mood-Stabilizing Medications in a Longitudinal Study of Youth Diagnosed with Bipolar Disorder. *J Am Acad Child Adolesc Psychiatry.* 2020; 59: 1146–1155.
PubMed: <https://pubmed.ncbi.nlm.nih.gov/31369795/>
 8. Findling RL, McNamara NK, Pavuluri M, Frazier JA, Rynn M, et al. Lithium for the Maintenance Treatment of Bipolar I Disorder: A Double-Blind, Placebo-Controlled Discontinuation Study. *J Am Acad Child Adolesc Psychiatry.* 2019; 58: 287–296.e284.
PubMed: <https://pubmed.ncbi.nlm.nih.gov/30738555/>
 9. Velosa J, Delgado A, Finger E, Berk M, Kapczinski F, et al. Risk of dementia in bipolar disorder and the interplay of lithium: A systematic review and meta-analyses. *Acta Psychiatr Scand.* 2020; 141: 510–521.
PubMed: <https://pubmed.ncbi.nlm.nih.gov/31954065/>
 10. Anmella G, Fico G, Lotfaliani M, Hidalgo-Mazzei D, Soto-Angona Ó, et al. Risk of cancer in bipolar disorder and the potential role of lithium: International collaborative systematic review and meta-analyses. *Neurosci Biobehav Rev.* 2021; 126: 529–541.
PubMed: <https://pubmed.ncbi.nlm.nih.gov/33831461/>
 11. Raison CL, Siu C, Pikalov A, Tocco M, Loebel A. C-reactive protein and response to lurasidone treatment in children and adolescents with bipolar I depression: Results from a placebo-controlled trial. *Brain Behav Immun.* 2020; 84: 269–274.
PubMed: <https://pubmed.ncbi.nlm.nih.gov/31857217/>
 12. Post RM, Goldstein BI, Birmaher B, Findling RL, Frey BN, et al. Toward prevention of bipolar disorder in at-risk children: Potential strategies ahead of the data. *J Affect Disord.* 2020; 272: 508–520.
PubMed: <https://pubmed.ncbi.nlm.nih.gov/32553395/>
 13. Wang G, Wu L, Su H, Feng X, Shi M, et al. Association of urinary matrix metalloproteinase 7 levels with incident renal flare in lupus nephritis. *Arthritis Rheumatol.* 2021; 73: 265–275.
PubMed: <https://pubmed.ncbi.nlm.nih.gov/32892475/>
 14. Fu H, Zhou D, Zhu H, Liao J, Lin L, et al. Matrix metalloproteinase-7 protects against acute kidney injury by priming renal tubules for survival and regeneration. *Kidney Int.* 2019; 95: 1167–1180.
PubMed: <https://pubmed.ncbi.nlm.nih.gov/30878215/>
 15. Chen S, Jiang H, Hou Z, Yue Y, Zhang Y, et al. Higher serum VGF protein levels discriminate bipolar depression from major depressive disorder. *J Neurosci Res.* 2019; 97: 597–606.
PubMed: <https://pubmed.ncbi.nlm.nih.gov/30575991/>
 16. Rhee SJ, Han D, Lee Y, Kim H, Lee J, et al. Comparison of serum protein profiles between major depressive disorder and bipolar disorder. *BMC Psychiatry.* 2020; 20: 145.
PubMed: <https://pubmed.ncbi.nlm.nih.gov/32245436/>
 17. Jeppesen P, Wolf RT, Nielsen SM, Christensen R, Plessen KJ, et al. Effectiveness of Transdiagnostic Cognitive-Behavioral Psychotherapy Compared with Management as Usual for Youth with Common Mental Health Problems: A Randomized Clinical Trial. *JAMA Psychiatry.* 2021; 78: 1–12.
PubMed: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7758821/>
 18. Smirnova L, Seregin A, Boksha I, Dmitrieva E, Simutkin G, et al. The difference in serum proteomes in schizophrenia and bipolar disorder. *BMC Genomics.* 2019; 20: 535–535.
PubMed: <https://pubmed.ncbi.nlm.nih.gov/31291891/>
 19. Pascual-Sánchez A, Jenaro C, Montes-Rodríguez JM. Quality of life in euthymic bipolar patients: a systematic review and meta-analysis. *J Affect Disord.* 2019; 255: 105–115.
PubMed: <https://pubmed.ncbi.nlm.nih.gov/31150940/>
 20. Munkholm K, Vinberg M, Pedersen BK, Poulsen HE, Ekstrøm CT, et al. A multisystem composite biomarker as a preliminary diagnostic test in bipolar disorder. *Acta Psychiatr Scand.* 2019; 139: 227–236.
PubMed: <https://pubmed.ncbi.nlm.nih.gov/30383306/>
 21. Brandon M, Greenwell BCB. Variable importance plots—an introduction to the vip package. *R J.* 2020; 12: 343–366.
 22. Wiener CD, Moreira FP, Portela LV, Strogulski NR, Lara DR, et al. Interleukin-6 and Interleukin-10 in mood disorders: a population-based study. *Psychiatry Res.* 2019; 273: 685–689.
PubMed: <https://pubmed.ncbi.nlm.nih.gov/31207853/>
 23. Barbosa IG, Ferreira RA, Rocha NP, Mol GC, da Mata Chiacchio Leite F, et al. Predictors of cognitive performance in bipolar disorder: The role of educational degree and inflammatory markers. *J Psychiatr Res.* 2018; 106: 31–37.
PubMed: <https://pubmed.ncbi.nlm.nih.gov/30261412/>
 24. Mørch RH, Dieset I, Færden A, Reponen EJ, Hope S, et al. Inflammatory markers are altered in severe mental disorders independent of comorbid cardiometabolic disease risk factors. *Psychol Med.* 2019; 49: 1749–1757.
PubMed: <https://pubmed.ncbi.nlm.nih.gov/30688187/>
 25. Poletti S, Vai B, Mazza MG, Zanardi R, Lorenzi C, et al. A peripheral inflammatory signature discriminates bipolar from unipolar depression: a machine learning approach. *Prog Neuropsychopharmacol Biol Psychiatry.* 2021; 105: 110136.
PubMed: <https://pubmed.ncbi.nlm.nih.gov/33045321/>
 26. Sahin B, Inanli I, Caliskan AM, Uysal S. Chitinase-3-like protein 1 levels in bipolar disorder. *Saudi Med J.* 2019; 40: 26–32.
PubMed: <https://pubmed.ncbi.nlm.nih.gov/30617377/>
 27. McIntyre RS. Is obesity changing the phenotype of bipolar disorder from predominately euphoric toward mixed presentations? *Bipolar Disord.* 2018; 20: 685–686.
PubMed: <https://pubmed.ncbi.nlm.nih.gov/30412345/>
 28. Burdick KE, Millett CE, Bonnín CDM, Bowie CR, Carvalho AF, et al. The International Consortium Investigating Neurocognition in Bipolar Disorder (ICONIC-BD). *Bipolar Disord.* 2019; 21: 6–10.
PubMed: <https://pubmed.ncbi.nlm.nih.gov/30720913/>
 29. Altshuler LL, Sugar CA, McElroy SL, Calimlim B, Gitlin M, et al. Switch Rates During Acute Treatment for Bipolar II Depression With Lithium, Sertraline, or the Two Combined: A Randomized Double-Blind Comparison. *Am J Psychiatry.* 2017; 174: 266–276.
PubMed: <https://pubmed.ncbi.nlm.nih.gov/28135846/>