

# What are the Elements to Identify the Anticipatory Signs of Mania or Depression When Bipolar Disorder is Present?

Michel Bourin<sup>1,\*</sup>

<sup>1</sup>Neurobiology of anxiety and mood disorders, University of Nantes, 98, rue Joseph Blanchart, 44100 Nantes, France

\*Correspondence should be addressed to Michel Bourin, michel.bourin@univ-nantes.fr

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## Editorial

Bipolar disorder is a medical condition defined by mood fluctuation, oscillating between periods of elevated mood and periods of depression. Bipolar disorder is generally characterized by three conditions:

- a state of euphoria or agitation, called mania;
- a state of despondency, called depression;
- a symptom-free state (called euthymia) during which the person feels balanced and functions well [1].

Bipolar disorder, like any long-term pathology, presents prodromes of recurrent depressive, manic or mixed episodes [2]. A systematic review attempted to point out two main issues: is there a prodrome of bipolar disorder for a given patient and, if there is, what are its characteristics? It was concluded that lability/mood swings and depression symptoms were the most usual putative prodromal characteristic, followed by fast thoughts, anger/irritability, physical disturbance, and anxiety [3]. It is evident that some clinical signs are milder expression of bipolar disorder, some are symptoms could be found in many mental disorders, or others are linked with personality disorders as cyclothymia. Most studies reviewed do not provide data on specificity and sensitivity [4]. The review concluded that elevated and/or irritable and/or depressed mood, mood lability and voice elevations were specific (>90%) but their sensitivity was generally low (all <80%) [5].

The literature is scarce on the prodrome of recurrences in established bipolar disorder. A study examines the ability of relatives and not just patients to identify the prodrome.

Most studies examine whether patients can recognize the prodrome on their own, which is not usual unless research is done with the psychiatrist [6]. However, studying the ability of immediate relatives to recognize signs of prodrome plays an essential role in planning overall care, particularly in preventing full-blown mood episodes. The main finding was that the ability of parents to detect the prodrome of mania was significantly higher than that of bipolar disorder patients (97 vs. 70%) than in unipolar depression. Additionally, the prodrome of mania was much shorter than that of depression. This study also identified mania prodrome symptoms and idiosyncratic prodromal symptoms called “relapse signatures” [7].

This study has important clinical implications. Most importantly, it highlights the need to educate relatives about prodromal symptoms because they are better able to recognize the prodrome than patients. This is especially vital because the onset of mood disorder episodes appears to be rather rapid for mania. A relapse into a manic episode can be extremely dangerous, often ending in prolonged hospital care and the resulting catastrophic situation for the patient and their family. Educating family members can play a vital role in preventing a full relapse. The results also highlight the need to include prodrome education in psychosocial interventions [8]. However, such a conclusion may be spurious, given an important methodological limitation of this study. In other words, the study shows that it is easier to predict a prodrome of manic relapses than depressive relapses in bipolar disorder. This may be because the study included those who had recently suffered a manic episode [9]. A comparison with the depressive prodrome of unipolar depression is not helpful because there are no manic or hypomanic episodes in unipolar depression.

Hostility, grandiosity, distractibility, lack of cooperation, and persecutory thoughts were reported significantly more frequently in manic than depressed patients. Among plenty of symptoms, several symptoms were common for both depression and mania prodromes [10]. "Idiosyncratic" prodromal symptoms included increased religiosity, easy decision-making, red eyes, violence, listening to loud music, recalling past events, and obsessive thoughts. Common prodromal symptoms closely resemble the symptoms of the disorder itself. Unusually, one might have thought that sleep disturbances and mood changes could have led to prodromes of mania, while it is widely recognized that changes in sleep patterns (mainly insomnia) followed by changes in mood (expansive mood, volatility, despair), changes in sexual behavior, financial exaggeration, considering an excessive number of projects and impaired judgment are seen as pathognomonic of impending episodes of mood swings [11]. The resemblance of the prodromes of the disorder to the symptoms of the disorder itself may be linked to the fact that it may have been difficult to differentiate the residual and subsyndromal symptoms from the prodrome. Additionally, prodrome assessment was performed within 2 weeks of mania remission, which may have biased symptom recall. Considering, that a considerable number of bipolar patients can never fully recover from baseline episodes and continue to experience residual symptoms between episodes, the results of this study appear to be generalizable only to patients who experience a typical relapse course despite almost complete recovery from previous episodes [12].

In studies of the putative prodrome of bipolar disorder, it has not been possible to determine whether the symptoms represent a distinct prodrome of bipolar disorder. In patients with advanced bipolarity, it may be possible to demonstrate a distinct prodrome of recurrences of depressive and manic episodes [13]. However, the specificity and sensitivity of prodromal characteristics must be established. High specificity is desirable given that a prodrome indicative of an impending fall warrants pharmacological treatment. At the same time, the prodrome must have acceptable sensitivity [14]. This can be achieved if bipolar patients are followed prospectively in a longitudinal study with close monitoring of the evolution of the clinical profile of the disease. Although retrospective studies are easy to perform, they may not provide reliable results. Studies of the prodromal characteristics of bipolar disorder have important clinical implications. In this context, emphasis should be placed on the need to educate patients and relatives, provided that the recurrence prodrome has potential implications for effective long-term management of patients with bipolar disorder [15].

What should be remembered is that we are in the stone age of knowledge of the anticipatory signs of mania or depression in treated bipolar patients. It is therefore necessary to look for these signs, which are so important in the genesis of manic or depressive episodes [16]. The psychiatrist can sometimes, but

often after the fact, discover these signs with the patient, which can provide warning in the future. For example, I observed that some patients had obsessive ideas which anticipated a depressive episode, making it possible to anticipate by increasing the mood stabilizer or even prescribing an antidepressant for a fortnight. Psychoeducation for bipolar patients and their relatives could be useful in anticipating mania or depression [17].

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