Chapter #18

CLINICAL AND ETIOPATHOGENIC PERSPECTIVES IN BIPOLAR AFFECTIVE DISORDER

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ABSTRACT
Bipolar affective disorder (BAD) represents a psychiatric pathology defined by changes in mood and voluntary activity, with a marked resonance on role functionality. Although it is relatively common, BAD is still an under-diagnosed disorder, mainly due to the misdiagnosis of unipolar depression. The diagnosis and treatment of BAD are two aspects of real importance, due to the high morbidity and mortality rates of this pathology, so an early identification of the symptoms and an individualized therapeutic approach improve the prognosis of the disease and, implicitly, the quality of life of the patients. Although the attitude of the general population in relation to psychiatric pathologies has had a positive evolution during the last years, towards the acceptance of these patients, the stigmatization is still present in the society. Along with stigmatization, the fluctuating awareness of the disease, the low adherence to treatment, the predisposition to engagement in activities with potentially negative consequences and the use of psychoactive substances represent factors that contribute to the decrease in the quality of life of patients with bipolar affective disorder.

Keywords: affective disorder, diagnostic, therapy, bipolar disorder, manic episode.

1. INTRODUCTION

The term manic-depressive psychosis was introduced by the German psychiatrist Emil Kraepelin, at the end of the XIXth century, it including at that time, all affective disorders (McClellan, Kowatch, Findling, & Work Group on Quality Issues 2007). Bipolar affective disorder is a mental disorder that mainly affects mood, emotions, thinking, and behaviour. Patients with bipolar disorder present periods of euphoria or agitation (defined as manic states), which alternate with states of depression (overflowing energy is combined with feelings of sadness and uselessness).

Aretaeus of Cappadocia described the manic episode in a way similar to what we know today and he noted the connection between melancholic and manic symptoms that occur cyclically. Jean Falret (1854) described the affective disorder as folie circulaire, and Jules Baillarger (1880) called it folie à double forme. In 1917, Emil Kraepelin classified all the forms of affective disorders he had described until then (mania, melancholia, recurrent depression, etc.) into a single clinical entity, with the same etiopathogenic (genetic) substrate, called "manic- depressive psychosis" (Ebert, 2010). In addition to this disorder of an endogenous nature, he also identified other affective disorders of exogenous origin that can occur during unpleasant life events (McClellan et al., 2007).

2. BACKGROUND

According to DSM-V, the diagnostic criteria of bipolar I disorder reflect the modern understanding of classic manic-depressive disorder and affective psychosis, described in the XIXth century, which differ from the classic description only in that neither psychosis nor the presence throughout the whole life of a depressive episode is no longer a mandatory requirement. However, the vast majority of individuals whose symptoms meet the criteria for a full manic episode syndrome also experience major depressive episodes during their lifetime.

Bipolar II disorder, within which the requirement is the presence throughout life of at least one major depressive episode and at least one hypomanic episode, is no longer considered to be a "milder" condition than bipolar I disorder, especially because individuals with this condition are depressed for a long time and because the instability of mood, characteristic to individuals with bipolar II disorder, is typically accompanied by a significant deficit in professional and social functioning.

The diagnostic of cyclothymic disorder is established in adults who have presented at least two years (in children, one whole year) of hypomanic and depressive periods, without having ever met the criteria for a manic, hypomanic or major depressive episode.

Many abuse substances, some recommended medications and some medical conditions can be associated with manic-type phenomena. This fact is reflected by the diagnostics: bipolar disorder and related disorders induced by substances or drugs.

The manic episode is manifested by a well-defined period, characterized by an abnormal and persistently euphoric, expansive or irritable mood, as well as by goal-directed activity and abnormally or persistently increased energy, lasting at least one week and present almost all day long, almost daily.

The hypomanic episode is manifested by a well-defined period, characterized by an abnormal and persistently euphoric, expansive and irritable mood, as well as by activity directed towards a goal or abnormally or persistently increased energy, which lasts at least four consecutive days, and which is present almost all day long, almost daily (American Psychiatry Association, 2013).

Prevalence rates for bipolar disorders are as follows: bipolar I disorder – 0.4-1.6%; bipolar II disorder < 1%. The average age of onset of bipolar disorders is between 20 and 30 years. Worldwide, approximately 4% of the population suffers from bipolar disorder. The prevalence of the disease is similar in both sexes, as in the case of different cultures and/or ethnic groups. A World Health Organization study conducted in 2000 demonstrated that the prevalence and incidence of bipolar affective disorder are very similar throughout the world. However, the severity and evolution of the disorder can be very different in different areas of the globe. Genetic factors are determinant regarding the risk of developing bipolar disorder, but, at the same time, environmental factors are also involved. People with bipolar disorder who exhibit psychotic symptoms can sometimes be mistakenly diagnosed as having schizophrenia. The ages of onset of the condition are late adolescence and young adulthood (15-44 years). A recent study highlights the fact that in 10% of cases of bipolar disorder, the onset of manic episodes occurred after the age of 50.

3. THE DETERMINING FACTORS

3.1. Genetic Factors

In the most recent studies, for bipolar I disorder, the concordance rates in monozygotic twins were 40%, compared to only 0-10% in dizygotic twins. The relatively low levels of concordance noticed in dizygotic twins suggest that family environmental factors have a limited importance in the genesis of the condition. The genetic studies carried out have highlighted multiple chromosomal regions and genes involved in the development of bipolar disorder. The studies also demonstrated the importance of heterogeneity, with different genes being involved in different families. As regards the parents, advanced paternal age increases the risk of developing bipolar disorder in the offspring, which is consistent with the hypothesis of an increase in the number of new genetic mutations, at the genomic level.

3.2. Physiological Factors

Abnormalities of the structure and/or function of certain brain circuits may be responsible for the development of bipolar disorder. The meta-analysis of magnetic resonance imaging studies carried out in subjects with bipolar disorder highlighted the increase in the volume of the lateral cerebral ventricles and the globus pallidus, as well as a hyperfunction of the deep cortical white matter (Arnone et al., 2009). There are also studies that have highlighted, in bipolar disorder, abnormalities in the hypothalamus-pituitary-adrenal axis caused by stress, as well as affecting circadian rhythms and melatonin secretion (Fries et al., 2014).

3.3. Environmental Factors

Individual psychosocial characteristics interacting with predisposing genetic factors lead to the emergence and evolution of bipolar affective disorder. Prospective studies have shown that recent stressful events and poor interpersonal relationships contribute significantly to the onset and relapses of bipolar disorder (Sam, Nisha, & Varghese, 2019). Numerous studies highlight that approximately 50% of adults diagnosed with bipolar disorder have experienced abuse and/or trauma in childhood, these cases being generally characterized by an earlier onset of the disorder, a more severe evolution and comorbid associations such as posttraumatic stress (Quidé, Tozzi, Corcoran, Cannon, & Dauvermann 2020; Watson et al., 2014).

3.4. Risk Factors

The main risk factors are: positive family history for bipolar affective disorder; drug or alcohol abuse; negative stressful life events (divorce, death of a loved one) or positive (marriage); the presence of another somatic disease; work in night shifts.

The onset/development of bipolar affective disorder risk factor is corelated:

• slightly increased risk for higher socio-economic groups (Sadock, Sadock, & Kaplan, 2017);

• increased risk when family history of mania/bipolar disease is present (Sadock et al., 2017);

• estimated morbid risk of 3-8% in first-generation relatives of the proband with BAD (Sadock et al., 2017);

• a child with a bipolar parent has a 10-25% risk of developing the disease (Sadock et al., 2017);

• the child with both bipolar parents has a 20-50% risk of developing the disease (Sadock et al., 2017);

• bipolar MZ twin concordance=40-70%, Bipolar BZ twin concordance=20% (Sadock et al., 2017);

• over 90% of individuals who have experienced a single manic episode will subsequently experience recurrent depressive episodes;

• about 60% of manic episodes occur shortly before a major depressive episode;

• women are more likely to exhibit rapid cyclicity and mixed states and have a different pattern of comorbidities than men, including higher frequency of eating disorders throughout life;

• women with bipolar disorder type I or type II are more likely to suffer from depressive symptoms compared to men. They also have a higher lifetime risk for alcohol use disorders compared to men and a much higher likelihood of associated alcohol use disorders than women in the general population;

• approximately 5-15% of individuals with bipolar disorder type II will eventually develop a manic episode that will change the diagnosis to bipolar disorder type I, regardless of subsequent evolution;

• the prevalence of cyclothymic disorder in clinical services specialized in affective disorders may be between 3% and 5%;

• there is a 15-50% risk that an individual with cyclothymic disorder will later develop bipolar disorder type I or type II. In children with cyclothymic disorder, the average age of onset of symptoms is 6.5 years (DSM-5).

4. DIAGNOSIS AND DIFFERENTIAL DIAGNOSIS

According to the Manual of Diagnostic and Statistical Classification of Mental Disorders DSM-5, BAD is divided into bipolar affective disorder type I (BAD I) and bipolar affective disorder type II (BAD II). To be able to put the diagnostic of BAD I, the presence of at least one manic episode is necessary, major depressive episodes being not mandatory for the diagnosis, instead the diagnostic of BAD II requires the presence of both a manic or hypomanic episode and a depressive episode.

Manic and hypomanic episodes are dominated by an elevated mood, with variable severity and duration. The difference between the two is marked by the level of functioning in social roles, the possibility of the presence of psychotic symptoms and the need for hospitalization, characteristics mostly specific to manic episodes.

Another aspect that deserves attention is that of the diagnostic of BAD in adolescents, where it should be established whether the hyperthymia in some of them remains within the normal limits of the variations encountered during emotional development or exceeds the limits of normality, already talking about something pathological (American Psychiatry Association, 2013).

Hypomania is a milder degree of mania, in which mood and behaviour abnormalities are too persistent and marked to be included in cyclothymia, but it is not accompanied by hallucinations or delusions. There is a mild, persistent elevation of mood (for at least several consecutive days), increased energy and volume of activity, and, usually marked feelings of “goodness” and mental and physical efficiency (which the patient perceives as completely natural). Sociability increases, verbal communicativeness, hyperfamiliarity, often sexuality increases, and the need for sleep decreases, but all these cannot seriously affect the ability to work or to lead to social rejection. Irritability, arrogance and rude

behaviour can take the place of the usual euphoric sociability. Mood and behavioural disturbances are not accompanied by hallucinations or delirium.

In the case of manic episode without psychotic symptoms the mood is elevated regardless of individual circumstances and can range from carefree joviality to almost uncontrollable excitement. Elevation is accompanied by an increase in energy, resulting in hyperactivity, slurred speech, and decreased need for sleep. Normal social inhibitions are lost, attention cannot be maintained, and there is often marked distractibility. Self-esteem is usually exaggerated, and grandiose or over-optimistic ideas are freely expressed. The loss of normal social inhibitions can lead to frivolous, uncontrolled, or inappropriate and inappropriate behaviour in relation to the circumstances.

If we are referring at manic episode with psychotic symptoms, in addition to the criteria for mania, delusions (especially delusions of grandeur, parentage, innovation) and/or hallucinations (most often voices, speaking directly to the patient) occur. In addition, the irritability, accentuated physical activity, and flight of ideas may be so intense that the patient will be unable to communicate normally. Includes: manic stupor.

Bipolar affective disorder is characterized by repeated episodes (at least 2) in which the subject's mood and activity levels are markedly disturbed. This disorder consists in some episodes of elevated mood, increased energy and activity (mania or hypomania), and in other episodes - of low mood, as well as a decrease in energy and activity (depression). (Hypo)manic episodes should also be classified as bipolar. It includes: bipolar affective disorder, psychosis or manic-depressive reaction and excludes: bipolar disorder, single episode manic and cyclothymia.

Comorbidities are common, and the most common are anxiety disorders (panic attacks, social anxiety disorder, and specific phobias) that occur in approximately three quarters of these individuals. ADHD, as well as any disruptive behaviour disorder, impulse and conduct control (intermittent exposure disorder, opposition and defiant behaviour disorder, conduct disorder) and all substance use disorders (alcohol use disorder) occur in over half of individuals. Adults with this disorder have a high frequency of association with severe and/or untreated medical conditions. Metabolic syndrome and migraine occur more often in individuals with bipolar disorder than in the general population. Over half of individuals whose symptoms meet the criteria for BAD also have an alcohol use disorder, and those who have both disorders are at higher risk for suicide attempts.

According to DSM-5, bipolar disorder can cause suicidal ideation and suicide attempts - one out of three patients resort to autolytic attempts or succeed in suicide, the average annual suicide rate in these cases being 0.4%, 10-20 times higher than in the general population. The standardized suicide mortality rate in bipolar disorder is between 18 and 25%. BAD contributes to a quarter of all successful suicide attempts. The history of suicide attempts and the percentage of days in which the individual was depressed in the last year are associated with a higher risk for a new attempt or for the success of suicide.

Swann (2002) notes that "depression is responsible in most cases of bipolar person's suffering". The author believes that "many of the unsolved problems of the diagnostic of bipolar disorder are related to the diagnosis of depression". In addition, he shows that there are bipolar persons who have only experienced clinically overt depressive episodes before the onset of hypo/manic manifestations and that there is a danger that they will be mistaken for unipolar depressive disorder and treated as such, which would have fatal implications for the subsequent evolution of bipolar disorder. Thus, the differential diagnosis of the depressive episode from the bipolar disorder aims to eliminate the other psychopathological conditions with depressive manifestation so that the current episode can be attributed with certainty to the bipolar affective disorder.

Differential diagnosis is very important for the determination of treatment methods. First of all, the differentiation of bipolar disorder from major depression (unipolar depression) will be considered, which is characterized by the absence of manic episodes, but during which states similar to a hypomanic episode may appear, transiently. Other conditions with which the differential diagnosis must be achieved are: borderline personality disorder, schizoaffective disorder, schizophrenia (Marneros, 2003).

Major depressive disorder may be accompanied by hypomanic or manic symptoms that do not meet full criteria (e.g., either fewer symptoms or a shorter duration than those/that typical for a hypomanic episode). It should be considered especially in the evaluation of individuals with symptoms of irritability that may be associated with major depressive disorder or bipolar II disorder (Vrasti & Papava, 2011). The diagnosis of "pseudo-depression" can be considered when there is a functional loss due to a somatic disorder, vegetative disorder (loss of appetite, weight loss, sleep disorders, etc.) as manifestations of the underlying somatic disease, stress and loss of hope due to the somatic illness and its treatments, pain or somatic adverse drug reactions present in the patient, because there is a whole series of drugs that induce depression. Under these conditions, depression can be directly determined by the somatic disease through specific pathophysiological mechanisms, it can only be favoured by the somatic disease in individuals with genetic vulnerability for depression, or it can be a psychological echo to organic suffering.

The differential diagnosis of the episode of mania/hypomania starts with the elimination of organic causes that could lead to the appearance of a similar clinical syndrome. This form of mania was called "secondary mania" by Krauthammer and Kereman (1978).

In cyclothymic disorder, there are numerous periods with hypomanic symptoms and others with depressive symptoms, which do not meet the symptoms or duration criteria for a major depressive episode. Bipolar II disorder is distinguished from cyclothymic disorder by the presence of one or more major depressive episodes. If a major depressive episode occurs after the first 2 years of evolution of the cyclothymic disorder, the diagnostic will be that of bipolar disorder type II.

Both bipolar I disorder and the other psychoses can have grandiose or persecutory delusions. Likewise, thinking may exhibit conceptual disorganization or relaxation of associations of ideas. Both can also include irritability and restlessness. According to the studies carried out by Reiser and Thompson (2005), the criteria for differentiating bipolar disorder (BAD) from psychoses (P) could be: predominance of affective symptoms (BAD > P); between episodes, psychotic symptoms continue in the absence of affective symptoms (BAD < P); family history of affective disorders in first-degree relatives (ADD > P); higher premorbid functioning (BAD > P); post-critical return (after episode) to the premorbid level of functioning (BAD > P); disorganized behavior (BAD < P); slow or insidious onset (BAD < P)

In the opinion of Marneros (2003), schizoaffective disorder differs from bipolar disorder, especially by the "mixed" aspect of affective symptoms, by high suicidality and by affecting functioning much earlier than in bipolar persons.

Differentiating either type I or type II bipolar disorder from BPD presents difficulties for any clinician, because many of the diagnostic criteria are shared by both clinical entities. The differential diagnosis becomes even more problematic if we are dealing with rapid cycle bipolar disorder. Frank (2005) claims that the cardinal features that distinguish the two entities would be for bipolar persons the longer affective periods, accompanied by vegetative changes in the case of depression or judgment disorders in mania, and for BPD

would be more specific, the desperate efforts to prevent abandonment and parasuicidal behavior. The studies carried out by Reiser and Thompson (2005) demonstrate that the two entities differ in that BPD presents impulsivity, significant periods of depression and major difficulties in controlling emotions. These patients also frequently present bouts of mania and suicidal ideation, a feeling of unfulfillment and instability in the formation of interpersonal relationships.

Anxiety disorders must be considered in the differential diagnosis and they can often be present as comorbid disorders with bipolar affective disorder.

Attention deficit/hyperactivity disorder (ADHD) can be misdiagnosed as bipolar disorder type II, especially in adolescents and children. Many symptoms belonging to ADHD such as: rapid speech, flight of ideas and reduced need for sleep overlap with hypomanic symptoms. Dual attribution of symptoms to both ADHD and bipolar II disorder may be obvious when the physician determines if the symptoms represent a distinct episode and if there is a marked increase from the usual (baseline) level required for the diagnosis of bipolar disorder type II.

Bipolar disorder type II must be differentiated from bipolar disorder type I by investigating the presence in the past of some episodes of mania, but also from other specified and unspecified bipolar disorders and related disorders, by confirming the presence of a complete hypomanic and depressive syndrome.

In children and adolescents, the diagnostic is controversial. Careful psychic and physical evaluation are necessary to exclude other pathologies such as: ADHD, psychoses, learning disorders, problems with alcohol consumption.

5. THERAPEUTIC OPTIONS

5.1. Medication and Psychotherapy

The approach of an early comprehensive therapeutic attitude can reduce the severity of symptoms and improve the evolution of the disease. BAD treatment has the role of restoring euthymia in the acute phases, preventing relapses, to minimize residual symptoms and to improve functionality. The risk of a manic or depressive turn makes the treatment of BAD a complex one.

In order to maximize the effectiveness of the treatment and to establish the optimal therapeutic approach, it is necessary to evaluate the ability to adhere to the treatment, the functionality, the existence of the psychosocial support network and the presence or absence of the risk of suicide.

Effective diagnosis and treatment, established since the first episode, are positive prognostic factors in the evolution of the disease, being able to improve or even remove the cognitive deficit already installed, preventing brain structural changes, provided that relapses are avoided during the first year of treatment. Cognitive impairment has been shown to be directly proportional to the number of episodes of BAD, with low adherence to treatment having a significant negative impact on neurocognition (Leclerc, Mansur, & Brietzke, 2013).

A number of medications and psychotherapy techniques are used in the treatment of bipolar disorder. Self-aid techniques are applied in order to recover the subjects and relieve symptoms.

The goals of the treatment are the following:

- reducing the severity and frequency of episodes, stabilizing the mood
- restoration of social functioning
- reducing the risk of suicide and future relapses

• increasing the patients' ability to control their disorder and their own lives 10

In order to achieve these goals, it is necessary to combine psychotherapy with pharmacological treatment under the careful supervision of a specialist psychiatrist, because studies have shown that this association leads to a significant decrease in relapses.

Psychotherapy is used to reduce the intensity of key symptoms of bipolar affective disorder, timely identification of risk factors in triggering disease episodes, reduction of negative emotions in the patient's interpersonal relationships, recognition of prodromal symptoms of relapses and favouring factors that have proven useful in maintaining the state of remission. The patient can be better motivated to follow the prescribed pharmacological treatment.

Psychotherapy objectives: • Main objective – reduction of functional impairment • Secondary objectives: – emotional / family support – patient education – helps the patient adapt to a chronic disorder – teaches the patient to recognize prodromal symptoms – increases the patient's ability to adapt to the psychosocial consequences caused by the disorder – develops the patient's coping mechanisms to deal with stressors from the external environment.

Cognitive-behavioral therapy, family therapy, group therapy, crisis intervention and psychoeducation proved to be the most effective relapse prevention techniques, while interpersonal, social rhythm and cognitive-behavioral therapy were the most effective in the treatment of residual depressive symptoms.

Pharmacological treatment is the central therapy of the bipolar affective disorder. Its objectives are the complete remission of symptoms of the current episode, the decrease in the recurrence rate of the symptoms and the improvement of the patient's quality of life.

The side effects of pharmacological treatment can be important considering polypragmasy and they are represented by:

• weight gain (almost all mood stabilizers and neuroleptics produce this effect)
• type 2 diabetes (neuroleptics)
• extrapyramidal (neuroleptic) symptoms
• dermatological (Carbamazepine, Lamotrigine)
• sexual dysfunctions (SSRIs, neuroleptics)
• drug interactions (Carbamazepine, Lamotrigine)

Alarm signs: weight gain of approximately 2 kilos/month

Hospitalization may be necessary, especially in the case of manic episodes of bipolar disorder type 1. Hospitalization may be voluntary or involuntary, as the case may be. Long-term hospitalization is rare at the present time, the treatment of the condition being done on an outpatient basis, but sometimes it is necessary. Other services that have specialized teams can be also involved in therapy, the so-called partial or day admissions. In most cases, the treatment is done for life, even if the symptoms have disappeared.

In the acute phases, antipsychotic medication is elective, but to prevent relapses, an agent with long-term efficacy is preferable, such as lithium or haloperidol, Risperidone, Olanzapine, Quetiapine, Aripiprazole, Carbamazepine, Ziprasidone, Asenapine or Valproate.

The first-line treatment for manic episodes in patients who are not under treatment is an oral antipsychotic. According to some studies, haloperidol, followed by Risperidone and Olanzapine, represents the most effective treatment in manic episodes.

If monotherapy is ineffective, the antipsychotic can be combined with a mood stabilizer, preferably lithium or Valproate. Associated symptoms, such as restlessness or psychomotor agitation, can be relieved by short-term administration of a Benzodiazepine.

In the case of manic relapses in patients already under antipsychotic treatment, increasing the antipsychotic dose and eventually its association with a mood stabilizer are considered.

The association of Olanzapine with Fluoxetine in the treatment of the depressive episode in BAD has been shown in some studies to be the most effective. Other researches show that Ziprasidone and Quetiapine have the lowest rate of manic reversal. As therapeutic alternatives for the relief of depressive symptoms in bipolar disease, we have Lurasidone, Valproate and SSRIs (selective serotonin reuptake inhibitors). Antidepressant agents present a high risk of manic reversal and low efficiency, reason for which they are not part of the first-intention medication. However, results have been noticed in some cases, fact justifying their association with a mood stabilizer (Udriștoiu & Marinescu, 2014).

As regards the maintenance treatment, it is recommended to continue the therapeutic scheme from the acute episodes, if it was an effective one. At this stage, the net superior benefit of lithium in the prophylaxis of BAD and in combating suicidal risk was demonstrated.

For many individuals with bipolar disorder, a good prognosis is the result of a proper therapy. Because bipolar disorder is often undiagnosed, under-diagnosed or misdiagnosed, treatment is not correct and is not instituted in time. Although it can be a disabling medical condition, many patients with bipolar disorder lead a normal and full life (drug treatment is necessary). Between episodes of illness, persons with bipolar disorder can have periods of total or near-total normality. A recent prospective study, carried out on cases of bipolar disorder type I and II, throughout 20 years, showed that the life of the patients can be from good to acceptable and up to unsatisfactory. During periods of severe mania/depression, the social life of the patients was on average mediocre, depression being more frequently associated with disability than mania. The social and occupational functionality of these patients, between episodes of illness, was on average good, more or less normal. However, subclinical symptoms remained distressing, excepting hypomanic episodes, which were associated with increased functioning. Other studies have confirmed the severity of the disorder – the standardized mortality rate of any cause among patients with bipolar disorder is approximately twice that of the general population. In the USA, bipolar disorder is considered the mental disorder with the highest costs. The risk of suicide is high, especially during depressive episodes (McClellan et al., 2007).

5.2. Diagnostic Tools

The Mood Disorder Questionnaire (MDQ) can be used for bipolar disorder screening. A positive test result does not certainly indicate the presence of bipolar disorder, but it is a signal for further diagnostic evaluation. A negative test result necessarily involves the absence of the disorder and makes the diagnosis of BAD less likely.

In case of a positive result of the MDQ test, an additional psychiatric assessment is required. Such assessment will be based on longitudinal history, longitudinal history from an informant, physical examination.

The Mood Disorder Questionnaire (MDQ) (Hirschfeld, et al., 2000) is a brief, self-report, screening tool from the bipolar spectrum of disorders. Psychometric quality was assessed (Hirschfeld, et al., 2003) among the general (USA) population (sensitivity = 0.28 and specificity = 0.97). Due to low sensitivity, the tool is not suitable for testing the general population. MDQ is suitable for monitoring bipolar disorder in adults with depressive symptoms or a diagnostic of major depression (e.g., high-risk patients).

Young mania rating scale (YMRS) – is the most used scale to evaluate manic symptoms. It was published in 1978 (Young, Biggs, Ziegler, & Meyer, 1978) with the intention to provide an observation scale just as there is an observation scale for depression. It is designed to assess the severity of symptoms and to evaluate the effectiveness of anti-manic treatment. The items of the scale were selected based on clinical descriptions of mania and reflect the symptoms existing in both mild and severe forms of mania (Young et al., 2000).

Quick Inventory of Depressive Symptoms (self-report) (QIDS) is most often used to assess depression within BAD.

The 30-item Inventory of Depressive Symptomatology (IDS) (Rush et al. 1986, 1996) and the 16-item Quick Inventory of Depressive Symptomatology (QIDS) (Rush et al., 2003) were designed to assess the severity of depressive symptoms. Both IDS and QIDS are available in clinical (IDS-C30 and QIDS-C16) and self-assessment (IDS-SR30 and QIDSSR16) versions. The IDS and QIDS assess all criteria on the symptom domains designated by the American Psychiatric Association to diagnose a major depressive episode. These assessments can be used to detect depression, although they have predominantly been used as measuring tools of symptom severity. The seven-day period prior to assessment is the usual time frame for assessing symptom severity. The QIDS-C30 and QIDS-SR16 cover only the nine symptom domains used to characterize a major depressive episode, with no items to assess atypical, melancholic symptoms, or symptoms frequently associated with it. All 16 items on the QIDS are included in the IDS. The IDS-C30 and IDS-SR16 include symptom criteria, as well as frequently associated symptoms (e.g., anxiety, irritability) and items relevant to melancholic characteristics or atypical symptoms. Both IDS and QIDS are easy to administer in either the clinical versions IDS-C30 and QIDS-C16, or the self-assessment version (IDS-SR30 and QIDS-SR16); they require minimal training. Both versions are sensitive to change with medication, psychotherapy, or somatic treatments, making them useful for both research and clinical purposes. The psychometric properties of the IDS and QIDS have been established in various study samples.

6. FUTURE RESEARCH DIRECTIONS

Future researches should focus on highlighting the clear differences between mania and hypomania within BAD and on identifying genes that confer vulnerability. At the same time, optimizing psychosocial interventions and destigmatizing the patient with bipolar affective disorder. It is also important to solve the diagnostic controversies, the controversies on the relevance of auxiliary symptoms, in parallel with the resolution of the controversies regarding the administration of antidepressants. The new drugs, with increased efficacy and tolerability represent an important point of research that has not yet been sufficiently developed at the present time; and, last but not least, the understanding of the evolution and superior quality management, together with early identification, diagnosis and treatment.

7. CONCLUSION/DISCUSSION

An integrated and individualized approach can diminish the problem of the effectiveness of BAD treatment, with the implicit reduction of mortality and morbidity associated with this pathology. Maintaining remission is the clear proof of the effectiveness of the treatment, and it represents a necessary aspect in stopping the evolution of the cognitive deterioration within BAD.

The most important goal of the management and correctly administered treatment in the case of bipolar affective disorder is to preserve the functionality of the individual, translated by maintaining autonomy, cultivating some harmonious personal and professional relationships and adherence to long-term treatment. For this purpose, psychosocial measures are encouraged, the reintegration of the psychiatric patient being closely related to raising the awareness and combating stigma.

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