FEATURES OF THE DEVELOPMENT OF MANIC AND MIXED EPISODES IN PATIENTS WITH BIPOLAR AFFECTIVE DISORDER WHO USE CANNABIOIDS

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Abstract. *Issues of diagnosis and therapy bipolar affective disorder is one of the most discussed among other problems of modern psychiatry. More than 60% of patients with bipolar disorder are diagnosed with comorbid disorders such as drug addiction bipolar affective disorder, often to alcohol and/or cannabioids. The presence of such comorbid pathology is associated with poor adherence to treatment, longer and more frequent affective episodes, an increase in mixed episodes and an increased risk of suicide attempts.*

Keywords: *bipolar affective disorder, comorbid disorders that use cannabioids, suicide.*

Introduction. A number of studies show that in patients with bipolar affective disorder, the course of the disease that begins to consume bipolar affective disorder before the onset of the first affective episode is less severe than in those with dependence bipolar affective disorder develops a second time against the background of the course bipolar affective disorder [1]. The pathoplastic effect of cannabioid abuse on the development of the first mixed episode or mania episode has received little coverage in the scientific literature [2].

Lack of unity in the diagnosis of mixed manic conditions in research practice P. It was clearly indicated by Gupta, showing different levels of sensitivity of existing criteria: Vienna mixed condition criteria in a sample selected for the presence of at least one depressive symptom in Mania structure [14] 94% of patients, Cincinnati criteria [3] – 78%, pisan criteria 53%, and ICD – 10 and DSM-IV criteria are only 16 and 9%, respectively. The latter figures correspond to the opinion of other researchers who have recognized mixed status criteria as restrictive in generally accepted standard classifications [4].

ICD-10 does not classify mixed mania into a self-diagnostic category, offering only general criteria for mixed cases. In this case, the mixed episode is defined as an affective episode that lasts at least 2 weeks and is characterized by the mixing or rapid change of hypomanic, manic and depressive symptoms. Both sets of symptoms should show up significantly for most of the current episode, but they may not reach the level of the syndrome [5-8].

In addition, the American DSM-IV classification, which until recently had been used to identify a joint episode (without showing a dominant pole), required a combination of simultaneously existing symptoms of an extended manic and depressive episode almost daily, for at least a week, which only implied a mixed case diagnosis bipolar affective disorder.

The researchers quest to expand the criteria for mixed States seen in the literature of recent decades is reflected in the new edition of DSM-V, which replaced DSM-IV [11], which offers a fundamentally new view of mixed states, including mixed mania, which treats the category not as a separate variant of the affective episode, but only as an additional feature of the manic episode. According to DSM-V, it is necessary to define manic/hypomanic episodes with ≥3 competing depressive symptoms with a "mixed characteristics" specifier. At the same time, competitive symptoms should be present almost every day for a week in a manic episode or a hypomanic episode for 4 days. Thus, DSM-V translates mixed States from an independent nosological category to the degree of auxiliary properties ("chert") of Affective episodes [12-14].

Such discrediting of mixed cases causes criticism [15] and does not take into account facts confirming their independent clinical significance. First, mixed manias are common in bipolar affective disorder (bar). E. Vieta et al. [16] prevalence of mixed manic episodes in patients admitted to i bar hospital is 12,9% under the DSM-IV-TR criteria, 9% under the ICD-10 criteria, S. L. 16,7% under McElroy criteria etc. [35] and 23,2% on clinical evaluation. A. According to González-Pinto et al. [17], about a third of patients with bipolar affective disorder tolerate mixed mania.

Second, mixed mania is associated with previous manifestational bipolar affective disorder [18], a more severe course of the disease, and a less favorable prognosis compared to pure manic episodes [19]. Repeated suicide attempts have been noted to be associated with the non-remission flow of mixed manic episodes [20]. In addition, mania with depressive symptoms is characterized by specific response to therapy: more likely to be resistant to therapy than pure mania, more effective lithium [21] compared to pure mania, and some atypical antipsychotics (Olanzapine) [22]. The data given supports the separation of mixed mania as an independent category of bipolar affective disorder.

Developed more than 100 years ago, E. Kraepelin and W. In the classical concept of Weigandt mixed Manics in manic-depressive psychosis are presented as 4 possible combinations of manic symptoms with opposite polar signs, which are formed by a mechanism to replace the individual components of the manic triad in the area of mood, movement or thinking: depressive mania, ineffective mania, manic stupor, inhibited mania. Typology E. Kraepelin has theoretical significance but is not widely used. At the present stage, the presence of depressive symptomatology during acute mania is defined by researchers with terms such as "mixed mania", "dysphoric Mania", "depressive Mania", "dysphoric/mixed hypomania" [23-26]. While extended mixed mania criteria have been used to allow combining the manic/hypomanic episode with depressive symptomatology at the subsyndromal level, the issue of specific symptom constellations in the mixed condition formation remains unclassified, not just bipolar affective disorder I, but bipolar affective disorder II. I will mention the Tay DSM-V classification, which is also limited to the enumeration of possible competitive depressive symptoms (depressive mood, decreased interest or pleasure, slowing of motor and emotional reactions, fatigue or loss of energy, repeated thoughts of death), without suggesting a more subtle differentiation of mixed manic states into subtypes according to the psychopathological structure [27-30].

The purpose of the study: Determination of the pathoplastic effect of cannabioiodes on the first manic or mixed episode and potential predictors of eutymia formation.

Materials and methods. Diagnosed patients were observed within 6 months of their first hospitalization for bipolar affective disorder (N=47), manic, or mixed episode. They were divided

into two groups. 1) 26 patients (17 men and 9 women) who are dependent on cannabioids (F12) according to ICD-10. The age of the patients was 26,32 (SD = 4,35), the abuse experience was 6,7 (SD = 5,46) 2) the control group was 21 patients (16 men and 5 women) bipolar affective disorder that is not dependent on cannabioids or other surfactants. The age of patients is 34,2 (SD = 6,85). Three aspects of recovery were studied: syndromic (ICD-10 criteria), symptomatic (HADS, YMPS) and functional (premorbid labor and social status recovery), as well as the duration of hospitalization, the appearance of new affective episodes, the degree of adherence to treatment were evaluated. Multi-factor analysis was used to evaluate the results. The results were deemed significant at $p<0,05$.

Among those examined, a sample of patients with mixed manic episodes was formed according to the following criteria: 1) compliance with the criteria of one of the rubrics:" bipolar affective disorder, the current episode of mania without psychotic symptoms "F31. 1;" bipolar affective disorder, current episode of hypomania " F31. 0,"bipolar affective disorder, current mixed episode" F31. 6 according to ICD-10; 2) clear advantage in the case of manicure/hypomanic polar signs; 3) S. L. the presence of ≥3 competitive depressive symptoms in a mixed manic state structure according to the approved criteria of. [35], DSM-V. the following exclusion criteria were established: 1) substance abuse; 2) psychotic levels of Affective Disorders.

The sample was characterized by a predominance of age (median age 30,8±7,1 years) and females (63.3%), consistent with higher female susceptibility to mixed manic/hypomanic conditions. The main contingent of patients is represented by socially prosperous individuals – patients with higher education (46,2%) with secondary special (30.8%) and Secondary Education (23,1%), married (38,4%) - single (34,6%) and divorced (26.9%), with permanent employment (61,5%), over the unemployed (38,5%).

In 53,9% of the patients examined, a certain type of Affective temperament was examined according to the classification of depressive (19,2%) and less cyclothymic (11,5%) - dominated temperaments according to Anamnesis, corresponding to the high prevalence of premorbid affective dysregulation among mixed manialis. Patients included in the sample were examined clinically-psychopathologically and psychometrically to assess the severity of competitive symptomatology (Hamilton Depression Scale (HDRS-17) and R. C. Young mania et al.

Results and discussions. Patients in the first group ($p<0,05$) were diagnosed with manic episodes (45%) with psychotic symptoms that did not correspond to irritability, and mixed episodes (34%) with anxiety symptoms predominating. According to a 6-month catamnestic follow-up, the majority of patients in the control group (n=26) experienced symptomatic recovery (92%) and only 37% of subjects in the first group achieved symptomatic recovery. Also, patients with bipolar affective disorder subjects who do not use cannabioids have a much shorter duration of hospitalization ($p<0.05$) and a higher rate of adherence to treatment than patients with bipolar affective disorder, the use of cannabioids. Only 35% of these patients achieved functional recovery and 53% syndrome. In the first group of patients in 6 months-26% were hospitalized with a repeated episode of mania or depression (13%), and 11% went to a depressive stage without a period of euthymia.

However, there was no difference in the frequency of exacerbation with adherence to drug treatment and refusal to use cannabioids (12% of patients of the first group).

Patients in this group, despite the general raised background of mood, complained about excessive lability of the affective state, accompanied by ideological and motor revival, often

irritability, inability to hold their reactions, high amplitude fluctuations that do not correspond to the strength of the triggering factors. The affective state of patients was characterized by a combination of signs of manic syndrome with irritability, aggressiveness, dissatisfaction. A distinctive feature of the timic component was a raised-excited mood with an angry-blurred tone. Externally, patients did not look as "Sunny" as in pure mania, often demonstrating mood, tension and external anxiety. The manic nature of influence was manifested, first of all, by self-esteem, arrogance, increased demand for others and bragging.

Patients have shown motor hyperactivity, which is often ineffective. Intensification of hedonistic movements was noted. The acceleration of the ideator reached the leaping point of ideas, manifested by the need for versatility, communication, along with distraction, which was often reduced to conversation in the form of a monologue.

The symptomatological profile shown corresponds to the definition of mixed dysphoric mania (pronounced irritability and internal tension, a feeling of hostility in response to external stimuli, aggressive or disruptive behavior, suspicion), as well as the dysphoric version of the mania described. The group selected on the MAThyS scale was characterized by high averages on the factors "psychomotor sphere" (8,7±1,8), "motivational-behavioral sphere" (7,0±1,7), "emotional sphere" (8,3±0,4) [high averages on symptoms characterizing levels of emotional reactivity: intensity of emotions (9,2±1,1), affective lability (9,5±0,4), sensitivity to external events (8,9±1,0), emotional 9,1±0,8)] and the ideator sphere on the low factor (3,2±2,7).

Conclusions. The use of cannabioids in patients' bipolar affective disorder is an important factor in frequent recurrence, low adherence to treatment, and low levels of performance during euthymia. In such patients, psychotic symptoms are more common in the structure of manic syndrome, they are not suitable for the effect.

In the latter case, mixed mania is more frequent with the clinical picture of dysphoric mania. The analysis of bipolar affective disorder, associated with mixed manic conditions, made it possible to identify 2 variants of the disease. The first option was characterized by single or irregular, well-defined mixed manias that appear periodically or sporadically, intersecting with depressive or mixed depressive phases that are dominant throughout the disease, long intermediate periods, and favorable prognosis. The second variant was characterized by regular repetitions of mixed manias, which were frequently crossed with successive phases (mostly manias) without well-defined intermissions and with a tendency to unfavorable constant flow. Cycloid temperament, as well as dysphoric-type mixed mania, have been found to be predictors of more unfavorable flow bipolar affective disorder.

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