Graphorrhea as a ‘Soft’ Bipolar Sign

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Short Communication

Juvenile bipolar disorder (JBD) poses a clinical conundrum, both diagnostically and therapeutically. In part, this could be ascribed to the developmentally-insensitive diagnostic criteria of our current classificatory systems, fairly common atypicality of presentations in this population, mixed psychotic ultra-rapid cycling course, high rates of comorbidities, and overall less-than-optimal response to medications [1]. Bipolar Spectrum Disorder (BSD), or Cade’s disease, stipulates a history of a depressive episode with ‘red flags’ that draw the clinicians’ attention to the possibility of underlying bipolarity for what clinically manifests as ‘pseudounipolar’ depression [2]. These are depicted in Table 1. And conceivably, this is of paramount importance with prognostic and therapeutic implications as antidepressants use in such cases could destabilize mood, induce manic shifts and/or accelerate cyclicity [3]. Hypergraphia, or graphorrhea, has been tied to organicity, e.g. interictal personality and stroke but also reported in schizophrenia and mania, where the patient has a compulsive tendency to write at a length. Munhas defined hypergraphia as a tendency to excessive writing that goes beyond any social, occupational, or educational requirements. This needs to be differentiated from organic automatic writing behaviour where writing perseveration without elaboration is evident [4-7].

Here, we are reporting a case of ‘pseudounipolar’ depression in an adolescent with a striking graphorrhea that turned out to be in BSD after antidepressant exposure. We opine that graphorrhea in context of mood disorders to be considered the visual analogue of logorrhea, and hence, a ‘soft’ bipolar sign.

A 17-year-old, Jordanian, Female, youngster was casualty petitioned by her parents for 3 week history of insomnia, anorexia, ostensibly low mood, and damened mood, anergia, apesoxia, being indrawn, and notably hypergraphia, unusual for her, all reflecting self-derogatory, depressive cognitions coupled with passive death wishes. No psychotic features could be detected.

Restricted affectivity with reported hollowed mood, depressive themes spoken with terse, skimpy answers only to direct succinct questioning, restricted affectivity with reported hollowed mood, depressive themes and passive death wishes. No psychotic features could be detected.

As this case amply portrays, graphorrhea, retrospectively, was the only sign that could have pointed to bipolarity lurking in the background. As similar cases abound in the literature, we opine that clinicians should be vigilant as well as cognizant interpreting graphorrhea in mood setting as a visual analogue of logorrhea, indicative of accelerated thought processes, and hence, a ‘soft’ sign of bipolarity. Kraepelin noted that “manics may produce astonishing number of documents all from the pleasure in writing”. We posit some criteria for graphorrhea as a soft bipolar sign summarized in Table 2 [8,9].

Disclosures

Authors declare no conflicts of interest nor financial affiliations or industry-sponsored research.

References

2. Ghaemi SN, Ko JY, Goodwin FK (2002) Cade’s disease and beyond:

Table 2: Graphorrhea as a soft bipolar sign

Table 1: Soft Signs of Bipolarity

- Recurrent depression, possibly seasonal
- Brief depression (less than 3 months)
- Early-occurring first-onset depression (before the age of 25)
- A first-degree relative with bipolar disorder
- Hypothyroid predisposition
- Atypical depression
- Severe psychotic depression
- Postpartum onset
- Antidepressant-emergent mania or hypomania (bipolar III)
- Poop-out of antidepressants acutely (tachyphylaxis)
- Failure of three or more antidepressants trials
misdiagnosis, antidepressant use and proposed definition for bipolar spectrum disorder. Can J Psychiatry 47: 125-34.


