Bipolar Disorder

Bipolar disorder, previously referred to as manic-depressive disorder (Weiten, 2005), is identified by the American Psychiatric Association [APA] (2000) as a mood disorder. Mood disorders share characteristics, not least of which is a tendency to occur in episodes (Weiten). This means that the symptoms of the mood disorder, such as depression, come and go. Between these episodes, patients with mood disorders generally experience a degree of stability and normalcy.

People diagnosed with bipolar disorder experience extreme swings in their moods between some form and degree of mania and depression. Different people experience different patterns and cycles in their mood shifts. However, each episode of either extreme usually lasts between three months and a year (Weiten, 2005). The symptoms can affect the patient in ways other than just their emotional state. Both cognitive and motor symptoms are also common (Weiten). Often patients with bipolar disorder also abuse alcohol or other substances which can make each episode worse (APA, 2000).

Manic episodes include emotional symptoms such as feeling euphoric or elated (Weiten, 2005). Patients will be extremely sociable, excitable, and are easily irritated by obstacles to their goals. Often patients describe racing thought and a tendency to experience tangential thought and communication. Their behavior often becomes reckless and impulsive, they are talkative and over confident, and may experience delusions of grandeur (Weiten). They may require minimal sleep, lose their appetite, appear hyperactive, and experience an increase in sex drive. In severe cases, manic episodes can lead to violent behavior (APA, 2000).

Depressive episodes, on the other hand, will leave the patient with feelings of hopelessness and sadness. They may become irritable and socially withdraw from others (Weiten, 2005). Their thinking process reportedly slows, and patients may worry excessively. Patients in a depressive episode often report feelings of guilt over things which they may not be able to control, have negative thoughts and feelings about themselves, and find it nearly impossible to make decisions (Weiten). From a physical standpoint, patients report increased fatigue, difficulty falling or staying asleep, and have a lower sex drive and appetite (Weiten).

Bipolar disorder is less common than non-cycling mood disorders such as major depression. It affects somewhere between one and two percent of the population, and affects men and women at about the same rate (APA, 2000; Weiten, 2005). It also occurs equally among races and ethnicity (APA). The first episode is usually seen when patients are in their twenties. The Diagnostic and Statistical Manual of Mental Disorder (4th edition, text revision) [DSM-IV-TR] (APA) identifies four different types of bipolar disorder: Type I, Type II, cyclothymic disorder, and bipolar disorder, NOS (an abbreviation for *not otherwise specified*).

Bipolar I disorder includes repeated episodes of mania and depression in cycles (APA, 2000). Among people suffering from Bipolar I Disorder, between ten and fifteen percent of patients commit suicide which usually occurs during a depressive cycle. Although the diagnosis itself is distributed equally between genders, men are more likely to experience a greater number of manic episodes, and women more likely to experience more depressive episodes (APA).

Similar to Bipolar I disorder, the second type, Bipolar II disorder also involves cyclical swings. However, the major difference between the two is that patients with Bipolar II disorder experience hypomania along with depression (APA, 2000). Hypomania is described as a "persistently elevated, expansive, or irritable mood, lasting throughout at least 4 days, that is clearly different from the usual nondepressed mood" (APA, p. 368). Similar to a manic episode, but less extreme, the person experiencing hypomania will have an over-inflated sense of self-esteem, will be more talkative and report that their mind is racing. They may be easily distracted, have some hyperactivity, and be extremely goal-directed in their activity (APA) such as taking on projects, working extra hours, or increased socializing. Often their excess in activity can lead to negative consequences. For instance they may spend too much money, engage in risk-taking or indiscrete sex, gamble or make risky investments (APA). These behaviors are considered hypomanic if they are out of character for the individual when that person is not in a depressed mood. Unlike Bipolar I disorder, Bipolar II disorder occurs more often in women (APA).

Cyclothymic disorder also causes a fluctuation in moods. However, the elevated moods do not constitute a manic or hypomanic episode, and the depressive symptoms do not meet the criteria for a major depressive event which is required for a diagnosis of Bipolar I or Bipolar II

disorder (APA, 2000). Cyclothymic disorder is usually diagnosed at a younger age than either Bipolar I or Bipolar II and usually has more rapid cycling (APA). It occurs equally between genders and affects one percent or less of the population.

A diagnosis of Bipolar Disorder Not Otherwise Specified is given when an individual has symptoms of either Bipolar I or Bipolar II disorder, but the symptoms do not meet the criteria to receive either of these diagnoses (APA, 2000). They may experience episodes of depression or mania, but those episodes do not last long enough to meet diagnostic criteria. Or the patient may have manic or hypomanic episodes which occur consecutively without the person experiencing depressive symptoms between them (APA).

Treatment of bipolar disorder includes both pharmacological and therapeutic interventions (Geddes & Miklowitz, 2013). Medication for the treatment includes mood stabilizers, anti-depressants and benzodiazepines. It is also recommended that patients engage in evidence-based therapy treatment such as cognitive behavioral therapy. In addition to identifying appropriate and effective coping skills, therapy can be used to assist the patient in regulating sleep patterns and recognizing the need for ongoing treatment after medical stabilization (Geddes & Miklowitz).

References

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