The phenomenon of bipolar affective disorder

Psychology, Psychotherapy

The phenomenon of bipolar affective disorder has been a mystery since the 16th Century. History has shown that this affliction can appear in almost anyone. Even the Great painter Vincent Van Gogh is believed to have had bipolar disorder. It is clear that in our society many people live with bipolar disorder; however, despite the abundance of people suffering from it, we are still waiting for definite explanations for the causes and cure.

The one fact of which we are painfully aware is that bipolar disorder severely undermines its" victims ability to obtain and maintain social and occupational success. Because bipolar disorder has such debilitating symptoms, it is imperative that we remain vigilant in the quest for explanations of its causes and treatment. Affective disorders are characterized by a smorgasbord of symptoms that can be broken into manic and depressive episodes. The depressive episodes are characterized by intense feelings of sadness and despair that can become feelings of hopelessness and helplessness.

Some of the symptoms of a depressive episode include anaerobia, disturbances in sleep and appetite, psychomotor retardation, loss of energy, feelings of worthlessness, guilt, ifficulty thinking, indecision, and recurrent thoughts of death andsuicide(Hollandsworth, Jr. 1990). The manic episodes are characterized by elevated or irritable mood, increased energy, decreased need for sleep, poor judgment and insight, and often reckless or irresponsible behavior (Hollandsworth, Jr. 1990). Bipolar affective disorder affects approximately one percent of the population (approximately three million people) in the United States.

It is presented by both males and females. Bipolar disorder involves episodes of mania anddepression. These episodes may alternate with profound epressions characterized by a pervasive sadness, almost inability to move, hopelessness, and disturbances in appetite, sleep, in concentrations and driving. Bipolar disorder is diagnosed if an episode of mania occurs whether depression has been diagnosed or not (Leiby, 1988). Most commonly, individuals with manic episodes experience a period of depression.

Symptoms include elated, expansive, or irritable mood, hyperactivity, pressure of speech, flight of ideas, inflated self-esteem, decreased need for sleep, distractibility, and excessive involvement in reckless activities (Hollandsworth, Jr. 1990). Rarest symptoms were periods of loss of all interest and retardation or agitation (Gurman, 1991). As the National Depressive and Manic Depressive Association (MDMDA) have demonstrated, bipolar disorder can create substantial developmental delays, marital andfamilydisruptions, occupational setbacks, and financial disasters.

This devastating disease causes disruptions of families, loss of jobs and millions of dollars in cost to society. Many times bipolar patients report that the depressions are longer and increase in frequency as the individual ages. Many times bipolar states and psychotic states are isdiagnosed as schizophrenia. Speech patterns help distinguish between the two disorders (Turner, 1989). The onset of Bipolar disorder usually occurs between the ages of 20 and 30 years of age, with a second peak in the mid-forties for women. A typical bipolar patient may experience eight to ten episodes in their lifetime.

However, those who have rapid cycling may experience more episodes of mania and depression that succeed each other without a period of remission (DSM III-R). The three stages of mania begin with hypo mania, in which patients report that they are energetic, extroverted and ssertive (Hirschfeld, 1995). The hypomania state has led observers to feel that bipolar patients are " addicted" to their mania. Hypo mania progresses into mania and the transition is marked by loss of judgment (Hirschfeld, 1995). Often, euphoric grandiose characteristics are displayed, and paranoid or irritable characteristics begin to manifest.

The third stage of mania is evident when the patient experiences delusions with often- paranoid themes. Speech is generally rapid and hyperactive behavior manifests sometimes associated withviolence(Hirschfeld, 1995). When both manic and depressive ymptoms occur at the same time it is called a mixed episode. Those afflicted are a special risk because there is a combination of hopelessness, agitation, andanxietythat makes them feel like they " could jump out of their skin"(Hirschfeld, 1995). Up to 50% of all patients with mania have a variety of depressed moods.

Patients report feeling dysphonic, depressed, and unhappy; yet, they exhibit the energy associated with mania. Rapid cycling mania is another presentation of bipolar disorder. Mania may be present with four or more distinct episodes within a 12-month period. There is now evidence to uggest that sometimes rapid cycling may be a transient manifestation of the bipolar disorder. This form of the disease exhibits more episodes of mania and

depression than bipolar. Lithium has been the primary treatment of bipolar disorder since its introduction in the 1960's.

It is main function is to stabilize the cycling characteristic of bipolar disorder. In four controlled studies by F. K. Goodwin and K. R. Jamison, the overall response rate for bipolar subjects treated with Lithium was 78% (Turner, 1998). Lithium is also the primary drug used for long- term maintenance of bipolar disorder. In a majority of bipolar patients, it lessens the duration, frequency, and severity of the episodes of both mania and depression. Unfortunately, as many as 40% of bipolar patients are either unresponsive to lithium or cannot tolerate the side effects.

Some of the side effects include thirst, weight gain, nausea, diarrhea, and edema. Patients who are unresponsive to lithium treatment are often those who experience dysphonic mania, mixed states, or rapid cycling bipolar disorder. One of the problems associated with lithium is the fact the long-term lithium treatment has been associated with decreased hyroid functioning in patients with bipolar disorder. Preliminary evidence also suggest that hypothyroidism may actually lead to rapid-cycling (Gurman, 1991).

Pregnant women experience another problem associated with the use of lithium. Its use during pregnancy has been associated with birth defects, particularly Ebstein's anomaly. Based on current data, the risk of a child with Ebstein's anomaly being born to a mother who took lithium during her first trimester of pregnancy is approximately 1 in 8, 000, or 2. 5 times that of the general population (Leiby, 1988). There are other effective treatments for

bipolar disorder that are used in cases where the patients cannot tolerate lithium, or have been unresponsive to it in the past.

The American Psychiatric Association's guidelines suggest the next line of treatment to be Anticonvulsant drugs such as valproate and carbamazepine. These drugs are useful as antimanic agents, especially in those patients with mixed states. Both of these medications can be used in combination with lithium or in combination with each other. Valproate is especially helpful for patients who are ithium noncompliant, experience rapid-cycling, or have comorbid alcohol ordrug abuse. Neuroleptics such as haloperidol or chlorpromazine have also been used to help stabilize manic patients who are highly agitated or psychotic.

Use of these drugs is often necessary because the response to them are rapid, but there are risks involved in their use. Because of the often severe side effects, Benzodiazepines are often used in their place. Benzodiazepines can achieve the same results as Neuroleptics for most patients in terms of rapid control of agitation and excitement, without the severe side effects. Antidepressants such as the selective serotonin reuptake inhibitors (SSRI" s) fluovamine and amitriptyline has also been used by some doctors as treatment for bipolar disorder. A double-blind study by M. Gasperini, F. Gatti, L. Bellini, R. Anniverno, and E.

Smeraldi showed that fluvoxamine and amitriptyline are highly effective treatments for bipolar patients experiencing depressive episodes (Leiby, 1988). This study is controversial however, because conflicting research shows that SSRI" s and other antidepressants can actually precipitate manic

episodes. Most doctors can see the usefulness of ntidepressants when used in conjunction with mood stabilizing medications such as lithium. In addition to the mentioned medical treatments of bipolar disorder, there are several other options available to bipolar patients, most of which are used in conjunction with medicine.

One such treatment is light therapy. One study compared the response to light therapy of bipolar patients with that of unipolar patients. Patients were free of psychotropic and hypnotic medications for at least one month before treatment. Bipolar patients in this study showed an average of 90. 3% improvement in their depressive ymptoms, with no incidence of mania or hypomania. They all continued to use light therapy, and all showed a sustained positive response at a three month follow-up (Turner, 1998).

Another study involved a four week treatment of bright morning light treatment for patients with seasonal affective disorder and bipolar patients. This study found a statistically significant decrement in depressive symptoms, with the maximum antidepressant effect of light not being reached until week four (Hollandsworth, Jr. 1990). Hypomanic symptoms were experienced by 36% of bipolar patients in this study. Predominant hypo manic symptoms included racing thoughts, deceased sleep and irritability. Surprisingly, one-third of controls also developed symptoms such as those mentioned above.

Regardless of the explanation of the emergence of hypo manic symptoms in undiagnosed controls, it is evident from this study that light treatment may be associated with the observed symptoms. Based on the results, careful

professional monitoring during light treatment is necessary, even for those without a history of major mood disorders. Another popular treatment for bipolar disorder is electro-convulsive hock therapy. ECT is the preferred treatment for severely manic pregnant patients and patients who are homicidal, psychotic, catatonic, medically compromised, or severely suicidal.

In one study, researchers found marked improvement in 78% of patients treated with ECT, compared to 62% of patients treated only with lithium and 37% of patients who received neither, ECT or lithium (Gurman, 1991). A final type of therapy is outpatient group psychotherapy. According to Dr. John Graves, spokesperson for the National Depressive and Manic Depressive Association has called attention to the value f support groups, and challenged mentalhealthprofessionals to take a more serious look at group therapy for the bipolar population.

Research shows that group participation may help increase lithium compliance, decrease denial regarding the illness, and increase awareness of both external and internalstressfactors leading to manic and depressive episodes. Group therapy for patients with bipolar disorders responds to the need for support and reinforcement of medication management, and the need foreducationand support for the interpersonal difficulties that arise during the course of the disorder.