COMMUNITY HEALTH CHOICE

BIPOLAR DISORDER

Overview:

Bipolar Mood Disorders are estimated to affect approximately 2.8% of American adults. Formerly referred to as manic depressive disorders, the bipolar disorders include four distinct disorders:

- Bipolar I Disorder
- Bipolar II Disorder
- Cyclothymic Disorder
- Bipolar Disorder Not Otherwise Specified

These disorders of mood and affect are characterized by periodic shifts of mood to a state where it is either abnormally elevated or problematically low. These episodes of elevated or depressed mood may impair daily life and have a negative effect on the individual's relationships and overall function.

The origins of Bipolar Affective Disorders are not believed to be attributable to any one cause or precipitating factor. Predisposition for bipolar disorder is believed to be largely genetic, with biological milieu and environmental factors also exerting influence. Genetics research in Bipolar Disorder is active, as it is one of the most heritable of all the mental illnesses, with concordance rates of up to 40-50% in monozygotic twins. In first degree relatives the heritability is believed to be over 10% when one parent is affected. Individuals with Bipolar Disorder are also highly likely to have relatives with other psychiatric disorders.

Bipolar Disorder often appears during late adolescence or young adulthood with an average age of onset of 25 years. Men and women are equally affected. Like Major Depression, Bipolar Disorder appears to affect neurologic modulation centers of the brain which regulate mood, energy, leep and circadian rhythms. Characterized by episodes of markedly elevated mood and manic energy, individuals may experience only days of symptoms or they may continue for weeks. SA history of depressive episodes is also common.

A history of a depressive episode is not necessary to make the diagnosis of Bipolar I Disorder. Essentially, one manic episode fulfills diagnostic requirements. Bipolar II is more complex. Bipolar II is differs from Bipolar I as symptoms of mania are attenuated and referred to as hypomania. Bipolar I disorder involves markedly abnormal periods of elevated or irritable mood, which is sometimes accompanied by psychosis and nearly always associated with impairment in judgment. A significantly decreased need for sleep, grandiosity, pressured speech, tangential thought processes, and lavish spending are not uncommon. Patients in the midst of acute mania can present a danger to themselves or to others. In contrast, Bipolar II Disorder does not include a history of manic episodes at any time. Hypomania is characteristic, a mood state characterized by less severe mood elevation or agitation which does not include psychotic symptoms or frank delusionality. Hypomania does not require hospitalization, by definition, and it is not generally considered acutely dangerous, though it may interfere with and individual's function to some degree. Interestingly, for a diagnosis of Bipolar II Disorder, a history of a depressive episode is required. In the absence of a depression history, an individual with a history of hypomania would meet criteria for Bipolar Disorder NOS.

Cyclothymic disorder is characterized by a longstanding pattern of cycling mood episodes of variable durations which are intense. These episodes may be hypomanic or dysthymic and vary in duration over many years. Cyclothymia is characterized by a chronically unstable mood state in which people experience hypomania or mild depression for at least two years. People with cyclothymia may have brief periods of normal mood, but these periods last less than eight weeks.

Bipolar disorders are mental illnesses which are episodic in nature, relapsing and remitting periodically throughout an individual's life at intervals which are unpredictable. The impairment which characterizes these periodic acute episodes can be marked, however most individuals also experience inter-episode recovery, during which they are without residual symptoms of the illness and functioning returns to normal. This poses challenges for patients who may find it difficult to stay on a medication when few indicators or reminders of their illness remain. It is common to question whether the medication is truly necessary.

Treatment Suggestions:

While Bipolar Disorder causes serious symptoms in many individuals, a number of treatments are available which are well supported by research. Medications effective for Bipolar Disorder include mood stabilizers such as Lithium, Depakote, Tegretol, and Lamotrigine, antipsychotic medications, benzodiazepines or other sedating medications, and for those who do not respond to medications or experience serious side effects, electroconvulsive therapy (ECT) is a rapid acting, highly effective treatment for mania (and for major depression).

A number of mood stabilizers have relatively narrow therapeutic windows, which demand monitoring of drug levels on a semi-regular basis. Level measurement allows for tailoring of the dose while also providing reassurance of medication adherence.

Psychotherapy for Bipolar Disorder may be helpful in establishing insight into the nature of the illness, the importance of medications, and the importance of healthy lifestyle conducive to wellness. Additionally, cognitive behavioral therapy (CBT) helps change the negative thinking and behavior associated with depression. The goal of this therapy is to recognize negative thoughts and to teach coping strategies.

As the systems which regulate mood, sleep and energy are assumed to be central in the pathophysiology of Bipolar Disorder, considerable research has focused on the role of circadian rhythms in mediating the condition. Aside from this research, the importance of established routines, monitoring of light levels good sleep hygiene, and a strict sleep wake schedules, and has been shown to decrease the rate of recurrence of bipolar symptoms.

Clinical Practice Guidelines:

Practice Guideline for the Treatment of Patients with Bipolar Disorder (PDF), Second Edition. (April 2002) - American Psychiatric Association

Guideline Watch: Practice Guideline for the Treatment of Patients with Bipolar Disorder (PDF), 2nd Edition - American Psychiatric Association

https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/bipolar.pdf

Lakshmi N Yatham, Sidney H Kennedy, Sagar V Parikh, et al. *Canadian Network for Mood and Anxiety Treatments (CANMAT) and International Society for Bipolar Disorders (ISBD) 2018 guidelines for the management of patients with bipolar disorder:*https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5947163/pdf/BDI-20-97.pdf

British Association for Psychopharmacology

Evidence-based guidelines for treating bipolar disorder: Revised third edition recommendations from the British Association for Psychopharmacology (2017) :

TEXAS MEDICATION ALGORITHM PROJECT PROCEDURAL MANUAL BIPOLAR DISORDER ALGORITHMS M. Lynn Crismon, PharmD, BCPP Tami R. Argo, PharmD, MS, BCPP Sherrie D. Bendele, BS Trisha Suppes, MD, PhD https://jpshealthnet.org/sites/default/files/tmap_bipolar_2007.pdf

FACT SHEET: BIPOLAR DISORDER

Bipolar disorder is a mental illness that causes dramatic shifts in a person's mood, energy and ability to think clearly. People with bipolar experience high and low moods—known as mania and depression—which differ from the typical ups-and-downs most people experience.

The average age-of-onset is about 25, but it can occur in the teens, or more uncommonly, in childhood. The condition affects men and women equally, with about 2.6% of the U.S. population diagnosed with bipolar disorder and nearly 83% of cases classified as severe.

If left untreated, bipolar disorder usually worsens. However, with a good treatment plan including psychotherapy, medications, a healthy lifestyle, a regular schedule and early identification of symptoms, many people live well with the condition.

Symptoms

Symptoms and their severity can vary. A person with bipolar disorder may have distinct manic or depressed states but may also have extended periods—sometimes years—without symptoms. A person can also experience both extremes simultaneously or in rapid sequence.

Severe bipolar episodes of mania or depression may include psychotic symptoms such as hallucinations or delusions. Usually, these psychotic symptoms mirror a person's extreme mood. People with bipolar disorder who have psychotic symptoms can be wrongly diagnosed as having schizophrenia.

Mania. To be diagnosed with bipolar disorder, a person must have experienced at least one episode of mania or hypomania. Hypomania is a milder form of mania that doesn't include psychotic episodes. People with hypomania can often function well in social situations or at work. Some people with bipolar disorder will have episodes of mania or hypomania many times throughout their life; others may experience them only rarely.

Although someone with bipolar may find an elevated mood of mania appealing—especially if it occurs after depression—the "high" does not stop at a comfortable or controllable level. Moods can rapidly become more irritable, behavior more unpredictable and judgment more impaired. During periods of mania, people frequently behave impulsively, make reckless decisions and take unusual risks.

Most of the time, people in manic states are unaware of the negative consequences of their actions. With bipolar disorder, suicide is an ever-present danger because some people become suicidal even in manic states. Learning from prior episodes what kinds of behavior signals "red flags" of manic behavior can help manage the symptoms of the illness.

Depression. The lows of bipolar depression are often so debilitating that people may be unable to get out of bed. Typically, people experiencing a depressive episode have difficulty falling and staying asleep, while others sleep far more than usual. When people are depressed, even minor decisions such as what to eat for dinner can be overwhelming. They may become obsessed with feelings of loss, personal failure, guilt or helplessness; this negative thinking can lead to thoughts of suicide.

The depressive symptoms that obstruct a person's ability to function must be present nearly every day for a period of at least two weeks for a diagnosis. Depression associated with bipolar disorder may be more difficult to treat and require a customized treatment plan.

Causes

Scientists have not yet discovered a single cause of bipolar disorder. Currently, they believe several factors may contribute, including:

- **Genetics.** The chances of developing bipolar disorder are increased if a child's parents or siblings have the disorder. But the role of genetics is not absolute: A child from a family with a history of bipolar disorder may never develop the disorder. Studies of identical twins have found that, even if one twin develops the disorder, the other may not.
- **Stress**. A stressful event such as a death in the family, an illness, a difficult relationship, divorce or financial problems can trigger a manic or depressive episode. Thus, a person's handling of stress may also play a role in the development of the illness.
- **Brain structure and function**. Brain scans cannot diagnose bipolar disorder, yet researchers have identified subtle differences in the average size or activation of some brain structures in people with bipolar disorder.

Diagnosis

To diagnose bipolar disorder, a doctor may perform a physical examination, conduct an interview and order lab tests. While bipolar disorder cannot be seen on a blood test or body scan, these tests can help rule out other illnesses that can resemble the disorder, such as hyperthyroidism. If no other illnesses (or medicines such as steroids) are causing the symptoms, the doctor may recommend mental health care.

To be diagnosed with bipolar disorder, a person must have experienced at least one episode of mania or hypomania. Mental health care professionals use the Diagnostic and Statistical Manual of Mental Disorders (DSM) to diagnose the "type" of bipolar disorder a person may be experiencing. To determine what type of bipolar disorder a person has, mental health care professionals assess the pattern of symptoms and how impaired the person is during their most severe episodes.

Four Types of Bipolar Disorder

1. **Bipolar I Disorder** is an illness in which people have experienced one or more episodes of mania. Most people diagnosed with bipolar I will have episodes of both mania and depression, though an episode of depression is not necessary for a diagnosis. To be diagnosed with bipolar I, a person's manic episodes must last at least seven days or be so severe that hospitalization is required.

2. **Bipolar II Disorder** is a subset of bipolar disorder in which people experience depressive episodes shifting back and forth with hypomanic episodes, but never a "full" manic episode.

3. **Cyclothymic Disorder or Cyclothymia** is a chronically unstable mood state in which people experience hypomania and mild depression for at least two years. People with cyclothymia may have brief periods of normal mood, but these periods last less than eight weeks.

4. **Bipolar Disorder, "other specified" and "unspecified"** is when a person does not meet the criteria for bipolar I, II or cyclothymia but has still experienced periods of clinically significant abnormal mood elevation.

Treatment: Bipolar disorder is treated and managed in several ways:

- **Psychotherapy**, such as cognitive behavioral therapy and family-focused therapy.
- **Medications**, such as mood stabilizers, antipsychotic medications and, to a lesser extent, antidepressants.
- **Self-management strategies**, like education and recognition of an episode's early symptoms.
- **Complementary health approaches**, such as aerobic exercise meditation, faith and prayer can support, but not replace, treatment.

The largest research project to assess what treatment methods work for people with bipolar disorder is the Systematic Treatment Enhancement for Bipolar Disorder, otherwise known as Step-BD. Step-BD followed over 4,000 people diagnosed with bipolar disorder over time with different treatments.

Related Conditions:

People with bipolar disorder can also experience:

- Anxiety
- Attention-deficit hyperactivity disorder (ADHD)
- Posttraumatic stress disorder (PTSD)
- Substance use disorders/dual diagnosis

People with bipolar disorder and psychotic symptoms can be wrongly diagnosed with schizophrenia. Bipolar disorder can be also misdiagnosed as Borderline Personality Disorder (BPD).

These other illnesses and misdiagnoses can make it hard to treat bipolar disorder. For example, the antidepressants used to treat OCD and the stimulants used to treat ADHD may worsen symptoms of bipolar disorder and may even trigger a manic episode. If you have more than one condition (called co-occurring disorders), be sure to get a treatment plan that works for you.

August 2017: excerpted from:NAMI: https://www.nami.org/Learn-More/Mental-Health-Conditions/Bipolar-Disorder