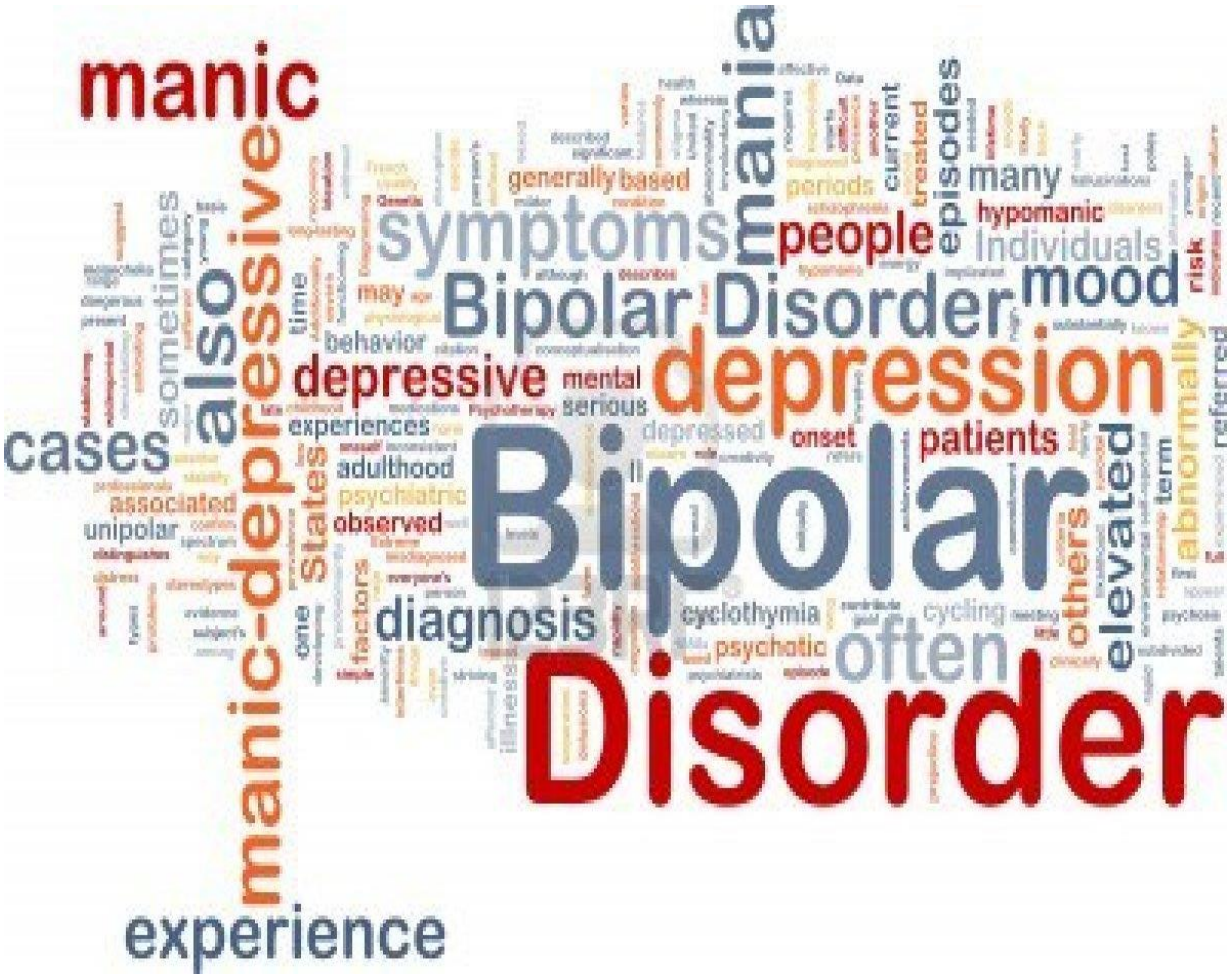
BIPOLAR I DISORDER

January 2016



Introduction

This article is intended to provide information about Bipolar I Disorder for both the general public and health care professionals. The objective of this article is to help in raising awareness about this specific mental health problem (Bipolar I Disorder) and to promote mental health literacy within the community. The article provides information about the Bipolar Disorder before moving on to talk specifically about Bipolar I and its various symptoms and diagnostic criteria. There have been many therapeutic interventions relevant to Bipolar I, which this brief leaflet attempts to compare and contrast. The intent of this article is also to clear any long-held myths related to Bipolar I, and decrease any stigma that people may face with the disorder.

Mental health literacy is important to increase awareness about a specific disorder, which the general public is otherwise unaware of, or if at all aware, have faulty perceptions on. Mental health literacy is not just the knowledge of a disorder, but also the management and prevention of it to help in overall wellbeing *(Jorm, 2011)*.

Overview -- Bipolar Disorder

Bipolar disorder (BD) is a manic-depressive illness, characterized by brain malfunctioning and manifested in extreme mood swings, energy level shifts, inability to perform day-to-day activities consistently *(National Institute of Mental Health, NIMH)*. In this, the affected person is caught between two extremes -- mania (a form of elation) and acute depression.

It is quite common a disorder, as much as present in 1-5% of American children and

adults *(Collingwood)*. However, a disorder so common has no complete cure known to mankind, only the magnitude of the problem can be clinically diminished over years of treatment. A well-treated person can lead a productive and meaningful life too.

Detection

Unfortunately, the early signs of BD are so inconspicuous, that the illness goes undetected for long. And once detected, the only way forward is prolonged medication and support from friends, family and healthcare professionals. At a later stage of BD, the symptoms grow severe -- the mood shifts are so extreme that it usually takes a toll on the person's relationships, occupation or education. In certain cases, it also leads to suicide of the affected individual *(NIMH)*.

Causes

A definite cause for BD is not known yet. However, it is strongly connected to changes in certain brain chemicals *(Collingwood)*. Other reasons include genetic factors, traumatic life experiences, everyday stress, and sometimes even physical injury like head impacts that affect brain functions *(NIMH, Collingwood)*.

Types of BD

The types of BD depend on the length, frequency and nature of manic-depressive episodes that occur. There can be the following types:

- Bipolar I
- Bipolar II
- Cyclothymia
- Rapid Cycling

- Not Otherwise Specified

The focus of this article is Bipolar I.

Bipolar I

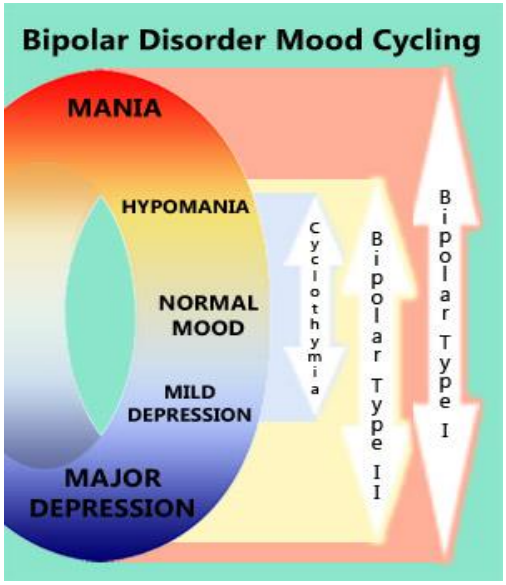
Bipolar I Disorder is the most extreme form of the ailment, characterized by severe episodes of mania. When symptoms of both mania (super euphoria/mania) and depression (deep sadness/dejection) occur almost every day for a stretch of at least a week, or only hypomania or only major depressive episodes occur spanning a week or more, it is a case of Bipolar I.

In Bipolar I, mood shifts are usually manic. But what is mood? How does it impact behaviour in individuals?

Mood

Simply put, mood is an emotional state. It is an internal, subjective state, triggered by external, objective stimuli. According to *Schinnerer (2007),* we are driven into a positive or negative mood by events happening around us -- joy of meeting an old friend or anguish of being betrayed by a partner, etc.

When a person demonstrates extreme positive mood or extreme negative mood or a mixture of both for one or multiple times during a span of a week, he or she is said to be suffering from Bipolar I. However, Bipolar I is usually marked by extreme elevated mood (mania).



Bipolar I -- Diagnostic Criteria

The *Diagnostic and Statistical Manual (DSM)* of Mental Disorders classifies mental disorders diagnostically with well-defined criteria, prevalence and other information that are useful to the

community. The latest, and more holistic, version of DSM is the DSM-5. This takes account of the sub-threshold syndromes, which were missing from the preceding DSM-4 *(Angst, 2013)*.

According to the DSM-5, the diagnostic criteria for Bipolar I can broadly be as follows:

- **Manic episodes** (a definite period of elevated or irritable mood and increased energy levels almost every day for at least one week)
- **Hypomanic episodes** (a definite period of elevated or irritable mood and increased energy levels almost every day for most part of the day for at least four consecutive days)
- **Major depressive episodes** (depressed or irritable mood prevails for most part of the day, almost every day, as reported by the patient or observed by others).

At least one manic episode in a person's lifetime is necessary to diagnose Bipolar I. At a more granular level, these three broad criteria can be further characterized by the following behavioural changes (DSM-5).

Manic episode

- During the mood shift, or increased activity/energy levels, the person demonstrates three or more of the symptoms below:

a) Increased self-esteem, thinks too high of oneself and shows off.
b) Sleep needs reduce to a great extent.
c) Talkativeness
d) Runs through excessive ideas and thoughts and subjective views/opinions/experiences.

e) Gets easily distracted (to meaningless and irrelevant subjects).

f) Performs more goal-directed activities (at school, job or otherwise). May also demonstrate psychomotor agitation (non-goal oriented activities).

g) Increasingly engages in activities, which lead to unpleasant consequences (e.g. impulsive buying or unplanned business investments).

- Some or all of the above symptoms occur so severely that it impairs the job-life or school-life or general social functioning of the affected individual to an extent that the person may need to be hospitalised.
- A manic episode is nowhere similar to physiological impacts of drug or alcohol or to any other medical state.

Hypomanic episode

- During the mood changes in hypomania, all of the manic episode symptoms from (a) to (g) may occur, however, a hypomanic episode will see obvious and explicit behaviour changes in a person that are otherwise completely missing in the individual in a normal state.
- The behavioural abnormality and mood changes are so explicit in hypomania that others can clearly see it.
- Unlike manic episodes, hypomania does not impair job, education or other social operations of the affected person. It also does not require hospitalisation. If behaviour is the least psychotic in nature, it is mania and not hypomania.
- Similar to mania, hypomania symptoms are also different from the physiological impacts of drug or alcohol or to any other medical state.

Hypomanic episodes are regular features of the disorder, but these are not essentially needed to diagnose Bipolar I disorder *(DSM-5)*. A manic episode in a person's lifetime determines the diagnosis.

Major Depressive Episode (MDE)

MDEs are also a feature of Bipolar I disorder and have the following manifestations in an individual:

- Five or more of the below-mentioned symptoms need to be manifested during the same two-week period, projecting a marked change in behaviour. For it to be called an MDE, one of the symptoms must be either depressed mood or reduced interest in life.
    a) Depressed mood for most part of the day, almost every day, either acknowledged by the affected person or observed by others.
    b) Reduced interest in everything around, either acknowledged by the affected person or observed by others.
    c) Unusual weight loss or weight gain (monthly +/- 5% of body weight change) or increase and decrease in appetite almost every day.
    d) Sleeplessness or oversleeping almost every day.
    e) Psychomotor disturbances almost every day, as observed by others.
    f) Diminished energy levels or fatigue almost every day.
    g) Experience lowered self-esteem or have a sense of worthlessness almost every day.
    h) Unable to think, focus, concentrate or decide in day-to-day activities, almost every day.
    i) Express morbid thoughts, talk about death and suicide ideas often, demonstrate suicidal tendencies in an unplanned way.
- MDE symptoms clinically harm the affected individual, and impair the

social and occupational operations of the person.

- But like mania and hypomania, MDE manifestations are also different from the physiological impacts of drug and alcohol or any other medical state.

MDE symptoms may look closely similar to the grief and depression arising out of a severe personal loss (losing a dear one, business loss, etc), but they are fundamentally different and can only be differentiated well by a medical practitioner, who has clinical judgement over the matter.

MDEs are not required for the diagnosis of Bipolar I disorder.

Prevalence of Bipolar I

According to *DSM-5*, the 12-month prevalence percentage in the US and other countries for bipolar I ranged from 0% to 0.6%. Bipolar I prevalence ratio in lifetime male to female is 1.1:1.

According to *WHO*, BD prevails in over 30 million people across the globe and is one of the top 20 reasons for disability in the world. Young adults are most susceptible to suffering from bipolar disorders, at least 50% of all cases occurring before 25 years *(Kessler, et al., 2005).*

Pharmacological & Psychotherapeutic Interventions

In treating mental disorders, the main therapeutic interventions comprise pharmacology and psychology. Either of these or both together are applied on the patient, depending on the case at hand.

In some instance, when a Bipolar I patient is hospitalised, intensive pharmacological intervention becomes the need of the hour to stabilise the patient before introducing psychotherapy. Mainstream medication include lithium and anticonvulsants, however some patients also respond to clozapine, thyroid augmentation, electroconvulsive therapy and calcium channel blockers *(Gitlin, 2006)*. Hormonal medications like tamoxifen or medroxyprogesterone acetate are found to help mania/hypomania in female patients *(Kulkarni et al., 2006).*

But pharmacology alone is not enough to improve Bipolar I conditions. It must be complemented with psychological interventions like interpersonal social rhythm therapy (ISRT), family-focused therapy (FTT) and cognitive-behavioural therapy (CBT). Psychotherapy should be applied as adjuncts to pharmacology whenever feasible to prevent BDs *(Vieta & Colom, 2004).*

Miklowitz (2006) has also explored the efficacy of pharmacological and psychotherapeutic interventions and concluded that psychotherapies like ISRT, FTT and CBT increase the effectiveness of medication (pharmacotherapy) and helps stabilise BD-affected individuals.

Stigma Associated with Bipolar I

Stigma is a negative impression or disgraceful view of a person, suffering from certain diseases and negative life experiences. Not just mental disorders, many other ailments like AIDS and cancer are also stigmatised in the society we live in. Although there have been numerous educative and awareness programmes related to the physiological nature of mental illnesses, mood disorders, especially BD, are still looked down upon and the affected persons kept away from the social discourse *(DBSA)*. This causes stigma.

Results of a survey commissioned by the DBSA clearly indicate how mental illnesses are misunderstood even today and how incorrect beliefs around BDs still prevail, although public knowledge about these disorders have generally improved. The results show *(DBSA)*:

- 66% respondents believed mental illness medications are habit-forming.
- 29% believed that persons with bipolar disorders cannot lead normal lives post treatment.
- 26% held that these people are easy to spot in workplaces.
- 19% felt they should never have children.
- 18% were of the opinion that these people were distinctly different.

The saddest part of stigmatisation of mental disorders is that the affected people hesitate to seek professional help and delay a proper diagnosis. They also run the risk of self-stigmatisation, which is even more damaging than stigma from others. Patients need to open up to and not withdraw from treatment.

Conclusion

Bipolar disorder is an extensive subject with its own variations and types. Hence, this article focuses only on one type -- Bipolar I -- and discusses the disorder for everyone to understand it and reposition any misconceptions held around it so far. Bipolar I treatment has led to successful cases, where patients have had normal lives and rediscovered themselves in a positive way. Hence, early acknowledgement of problems is necessary, without fearing ridicule, seclusion and other stigmatisation.

References

- Angst, Jules (2013). Bipolar disorders in DSM-5: strengths, problems and

perspectives. *International Journal of Bipolar Disorders*, Vol 1(12).

- Collingwood, Jane. *An Overview of Bipolar Disorder*. Psych Central. Retrieved from: http://psychcentral.com/lib/an-overview-of-bipolar-disorder/ on December 30, 2015.
- Depression and Bipolar Support Alliance (DBSA). *Fighting Stigma*. Retrieved from: http://www.dbsalliance.org/site/PageServer?pagename=help_advocacy_stigma on January 1, 2016.
- *Diagnostic and Statistical Manual (DSM), Fifth edition*. American Psychiatric Association
- Gitlin, M (2006). Treatment-resistant bipolar disorder. *Journal of Molecular Psychiatry*, PubMed. Vol. 11(3), pp:227-40
- Jorm, A. F. (2011, October 31). Mental Health Literacy: Empowering the Community to Take Action for Better Mental Health. *American Psychologist*. Advance online publication. DOI: 10.1037/a0025957
- Kessler RC, Berglund P, Demler O, et al. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Co-morbidity Survey Replication. *Arch Gen Psychiatry*; Vol.62 (6), pp:593–602.
- Kulkarni, J., Garland, K.A., Scaffidi, A., Headey, B., Andersdon, R., De Castella, A., et al. (2006). A pilot study of hormone modulation as a new treatment for mania in women with bipolar affective disorder. *Psychoneuroendocrinology* , Vol.31(4), pp:543-7.
- Miklowitz, David J. (2006). A Review of Evidence-based Psychosocial Interventions for Bipolar Disorder. *Journal of Clinical Psychiatry*. Vol.67(11), pp:28-33.
- National Institute of Mental Health (NIMH). *Bipolar Disorder*. Retrieved from: https://www.nimh.nih.gov/health/topic

s/bipolar-disorder/index.shtml on December 30, 2015.

- Schinnerer, J.L. (2007). *Temperament, Mood, and Emotion*. Changing Minds. Retrieved from: http://changingminds.org/explanations/emotions/temperament_mood_emotion.htm on December 31, 3015.
- Tracy, Natasha. *What is Bipolar 1 Disorder? Bipolar I Symptoms*. Healthy Place. Retrieved from: http://www.healthyplace.com/bipolar-disorder/bipolar-types/what-is-bipolar-1-disorder-bipolar-i-bipolar-i-symptoms/ on December 31, 2015.
- Vieta, E. and Colom, F. (2004), Psychological interventions in bipolar disorder: From wishful thinking to an evidence-based approach. *Acta Psychiatrica Scandinavica*, Vol.110, pp: 34–38. DOI: 10.1111/j.1600-0447.2004.00411.x
- World Health Organisation (WHO). *The global burden of disease*. 2004 update. Retrieved from: www.who.int/healthinfo/global_burden_disease/2004_report_update/en/index.html on December 31, 2015.