BIPOLAR DISORDER

FOR PATIENTS AND FAMILIES

Bipolar disorder, also called manic-depressive disorder, is a recurrent illness in which the individual's mood cycles between depression and mania with periods of normality. The illness is a *mood disorder*. The individual's moods may swing from manic euphoria, with boundless energy in pursuit of grandiose plans, to depths of depression, with feelings of despair and hopelessness.

During a depressive episode, the patient presents with depressed mood and loss of interest or pleasure. The patient may complain of fatigue, loss of energy almost every day, difficulty sleeping or sleeping too much, diminished ability to concentrate or think, and loss of appetite with significant weight loss. The depressed mood is reported as feelings of sadness, hopelessness, indifference, or worthlessness. Thinking may be slowed, muddled, and confused. The patient often complains of aches and pains, appears tearful, and reveals inappropriate guilt. These symptoms may be accompanied by recurrent thoughts of death or suicide and suicide attempt.

Cycling into a manic episode, the patient's mood may turn abnormally elevated and expansive—inflated with self-confidence or self-importance, euphoria, and exuberance. There is decreased need for sleep. The manic patient typically possesses elevated levels of energy in pursuit of grandiose plans or pleasurable activities. For example, the patient may engage in unrestrained spending sprees, make outrageous business deals, or have heightened sexual drive. Judgment may become severely impaired, resulting in impulsive, uncharacteristic, or inappropriate behavior.

Manic patients generally have rapid thinking, and their speech is rushed or pressured to keep pace with their racing thoughts. They talk excessively, and their speech is marked by a rapid flow of thought or flight of ideas, incoherence, and distractibility. Their mood, at one time euphoric and exuberant, may just as quickly shift, becoming irritable or agitated, especially when they are tired and exhausted from hours without sleep.

In both depressive and manic states of bipolar disorder, patients may manifest psychotic symptoms. However, psychosis is more frequent during manic than depressive states. Psychotic symptoms may include hallucinations and delusions. The content of the hallucinations and delusions is usually consistent with the patient's expansive mood (**mood congruent**). For example, the patient may talk of possessing special powers or abilities, and the delusion would be consistent with the patient's euphoric and grandiose mood. Sometimes the delusions may not be consistent with the mood (**mood incongruent**). For example, the patient may have paranoid delusions of thinking someone is after him or her, although the patient is in a state of euphoria.

There are patients with bipolar disorder who have symptoms of depression and mania simultaneously—that is, a mixture of both depressive and manic symptoms within a single episode. This condition is known as a **mixed state**. In the mixed state, the patient's moods and symptoms are rapidly shifting, at one moment tearfully depressed and suicidal and the next moment engagingly talkative, grandiose, and euphoric.

There is another type of bipolar disorder that presents with manic symptoms that are milder, less severe, and of shorter duration than full-blown mania. This milder form of mania is known as **hypomania**. During a hypomanic episode, patients may experience many of the symptoms of mania but are usually not so impaired as to require hospitalization. Moreover, they do not have hallucinations and delusions. In this type of bipolar disorder, the patient cycles between major depression and hypomania with periods of remission.

Bipolar disorder also exists in a milder condition in which the patient fluctuates between chronic hypomanic and mild depressive states. This type of mood disorder is called **cyclothymia**. During depressive and hypomanic episodes, the patient's symptoms are less severe and incapacitating than during major depression and mania.

COURSE OF ILLNESS

Bipolar disorder usually begins with depression during adolescence. The depression often waxes and wanes until the appearance of the first manic episode. The onset is frequently abrupt but may also occur gradually over the course of several weeks. The prognosis for mania is generally good, especially as treatment has improved with recent medications. Unfortunately, the illness has a significant risk of recurrence, and commonly, after a manic episode the patient cycles into depression. On the other hand, some patients may not experience a full manic episode but exhibit hypomanic states that alternate with depressive episodes.

Generally, untreated individuals have an increased frequency of cycling and longer periods of disability, especially as they get older. In contrast, patients who receive treatment usually do better, with less frequent and severe mood swings. However, there are patients who have an illness marked by **rapid cycling** despite treatment. These patients have at least four episodes of major depressive, manic, hypomanic, or mixed state within 12-month period, and they require closer monitoring and management of their medications.

CAUSE OR ETIOLOGY

The observed patterns of transmission from family studies have provided the best evidence that mood disorders are hereditarily (genetically) linked. In patients with bipolar disorder, family members (particularly among immediate relatives) show a significantly higher rate of mood disorders, especially bipolar disorder, as compared with other psychiatric patients. Approximately 50% of all bipolar disorder patients have at least one parent with a mood disorder, and when both parents have bipolar disorder, there is a 50%–75% chance that a child will have a mood disorder.

Studies of identical and fraternal twins provide even stronger evidence that mood disorders are genetically linked. Data from these studies show that when one identical twin has a mood disorder, there is, on average, a 60% chance that the other sibling will also develop the disorder, whereas in fraternal twins, the rate is only about 5%–25% that the other sibling will develop the disorder.

TREATMENT

Medications are the principal treatment for bipolar disorder. Treatment is directed at treating acute episodes of mania and depression and preventing the recurrence of symptoms after an acute episode. Medications that are used for treating mania are referred to as *mood stabilizers.* This handout shall focus primarily on the treatment of mania. For a discussion on the treatment of depression, refer to the handout *Information About Depressive Disorders for Patients and Families* (Form 2–5). Also, refer to the handouts for discussion of mood stabilizers and antidepressants.

Lithium carbonate is one of the first-line mood stabilizers used in the management of acute mania. It is effective for treatment of acute mania and for prophylaxis to prevent recurrence of mania and depression. Lithium must be dosed cautiously and monitored closely because of its potential for toxicity. Physicians usually prescribe lithium at a dosage of 1,200 to 2,400 mg/day, administered in divided doses, for acute mania. The goal is to attain a blood level of 0.6 to 1.4 mEq per liter. Within this range, the lithium is generally at a therapeutic level, but above the range, lithium toxicity becomes a concern. One of the disadvantages of lithium in treating acute mania is that there is a delay of 5–10 days before patients become fully responsive to the medication.

Another frequently used first-line mood stabilizer for acute mania is valproate, which comes in two different forms: valproic acid and divalproex. The most widely used form is **divalproex** (Depakote). Valproate is also an anticonvulsant that is used for treating and preventing seizures. For mania, divalproex may be given as a single dose or in divided doses in the range of 1,250 to 2,500 milligrams per day. The goal is to achieve therapeutic blood levels in the range of 50 to 125 micrograms per milliliter. Other anticonvulsants used as mood stabilizers for bipolar disorder include **carbamazepine** (Tegretol), **gabapentin** (Neurontin),

lamotrigine (Lamictal), and **oxcarbazepine** (Trileptal). However, these agents are used as alternatives when patients do not respond to lithium or valproate.

During an acute manic episode, the patient may be severely agitated or psychotic. An antipsychotic or benzodiazepine (Valium-like medications) can be administered to control psychotic symptoms and agitation. For example, if the patient is severely psychotic, agitated, or violent and is not cooperating, haloperidol (Haldol), an antipsychotic, and lorazepam (Ativan), a benzodiazepine, may be administered by injections via an intramuscular route. As these symptoms abate, the antipsychotic and benzodiazepine may be gradually discontinued. For some patients with residual psychosis or manic symptoms, continuing the antipsychotic medication may be necessary. Invariably, manic patients will need to be maintained on a mood stabilizer to prevent relapse. To prevent recurrence of depression in bipolar disorder, antidepressants may be added to the medication regimen.

ELECTROCONVULSIVE THERAPY (ECT)

ECT may be a life-saving treatment for severe depression, particularly in patients who at risk for suicide, since it tends to work more quickly than antidepressant medications. Generally, it is indicated when the patient is not responding to medications.

SUPPORTIVE PSYCHOTHERAPY

Supportive psychotherapy may be an invaluable adjunct to medications. A goal of psychotherapy is to identify the external, as well as the internal, issues in the patient's daily life that can exacerbate his or her illness and to devise copying skills to deal with these stressors. Psychotherapy may help the patient deal with the shame, fear, and anxiety of his or her illness. In supportive psychotherapy, the therapist provides the patient with encouragement and directions to cope and overcome difficult situations.

If you have any questions about this handout, please consult your physician.

SUPPORT AND ADVOCACY GROUPS

Lithium Information Center
Madison Institute of Medicine
7617 Mineral Point Road, Suite 300
Madison, WI 53717
Phone: (608) 827-2470
Web site: www.miminc.org/aboutlithinfoctr.html
Provides information on use of lithium for treatment of bipolar disorder and other medical uses.

Depression and Bipolar Support Alliance (DBSA)
730 N. Franklin Street, Suite 501
Chicago, IL 60610-3526
(312) 642-0049
(800) 826-3632
www.dbsalliance.org
A patient-directed support alliance that promotes education about depressive and bipolar illnesses.

National Foundation for Depressive Illness, Inc.
P.O. Box 2257
New York, NY 10116
Phone: (800) 239-1265
Web site: www.depression.org
Serves to educate the public about depressive illness and to provide information and referrals to professional help.

National Mental Health Association (NMHA)
2001 N. Beauregard Street, 12th Floor
Alexandria, VA 22311
(703) 684-7722
(800) 969-NMHA
www.nmha.org
A nonprofit organization that serves to promote education and research of mental health and mental illness.