

## The Bipolar Disorder

If you're seriously interested in knowing about bipolar disorder, you need to think beyond the basics. This informative article takes a closer look at things you need to know about what it is to be bipolar.

Bipolar illness has two distinct forms. Bipolar I disorder, previously called manic-depressive illness, characterizes patients who experience episodes of mania and depression or mania only. Any single episode can be manic, depressive, or mixed. The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) gives specific criteria for both mania and depression. A diagnosis of mania does not require a set duration of illness or impairment. For a diagnosis of depression, however, the symptoms must last at least two weeks.

A patient who has mainly depressions and a few hypomanic episodes (the same symptoms as for mania but without social impairment) would receive a diagnosis of bipolar II, a form much more common in women. These illnesses typically start with a depressive episode.

Thirty percent of patients who have bipolar I illness first experience symptoms as teenagers. In the usual course, episodes of illness are followed by periods of wellness (euthymia), at first punctuated by years but later settling into a pattern that is often seasonal. The depression can become very chronic and unremitting; suicide is the most serious potential consequence. Despite new and successful treatments, about 12% of manic-depressives commit suicide, almost always during the depressive stage of the illness.

Research has shown that genetic factors play a significant role in the etiology of bipolar disorder. Biochemical, neurophysiologic, and sleep abnormalities also have been reported, but none seems specific to bipolar disorder. It is not known how recurrent unipolar depression, bipolar I disorder, and bipolar II disorder are related. In addition, many studies identify bipolar patients but do not specify whether the patient is in the depressive, manic, or mixed state, much less whether the patient is manic or hypomanic when studied.

The information about bipolar disorder presented here will do one of two things: either it will reinforce what you know about this disorder or it will teach you something new. Both are good outcomes.

Bipolar disorder is a recurring illness. A few people are lucky enough to have only two or three episodes, but the average patient has more than 10. Studies have found that the depressive episodes in bipolar disorder are shorter than the depressive episodes in unipolar illness. Unfortunately, however, some bipolar patients have chronic depressions. Between 15% and 20% of bipolar patients experience rapid cycling, defined as four or more episodes of depression, mania, or hypomania in a year.

Psychological treatment cannot be accomplished when a patient with bipolar illness is in a manic state. The patient will be highly talkative, irritating, sexually aroused, overconfident, expansive, and completely lacking in insight and good judgment. Because of the uplifted mood, the patient will feel no need for treatment and will vehemently refuse assistance. This is particularly evident with respect to a spouse. If in your practice you see a spouse who suddenly becomes extremely derogatory and accusatory toward the partner, consider the possibility of mania. A history of depressive episodes will help you make the diagnosis. Treatment, usually on an inpatient basis, is imperative for a patient with mania.

The best treatment for a manic episode is lithium, the oldest mood stabilizer. Neuroleptics also are extremely helpful for treating mania. How to treat the depression, however, is still open to question. Although most experts agree that it is best to try to avoid antidepressants, or to use them short term, this is difficult to do in practice. The monoamine oxidase inhibitor tranylcypromine has been shown to be more efficacious than the tricyclic antidepressant imipramine. The other MAO drugs, phenelzine and isocarboxazid, also seem useful. Patients need to be on a special diet with these drugs. Clearly, patients do better in the treatment of their depressive episode if they also take a mood stabilizer.

In addition to treatment for the mania and depression, a mood stabilizer is indicated for long-term maintenance. A recent 40-year longitudinal study of bipolar illness found that mood stabilizers and atypical antipsychotics (in this case, mostly clozapine) proved to be the best combination to prevent suicide.

Now you can be a confident expert on bipolar disorder. OK, maybe not an expert. But you should have something to bring to the table next time you join a discussion on this particular issue.

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About the Author

