



MOOD DISORDERS ASSOCIATION OF MANITOBA INC.

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What is Bipolar Affective Disorder?

Source: Organization for Bipolar Affective Disorder (OBAD)

Bipolar Affective Disorder is an abnormal fluctuation in moods, varying between marked highs (mania) and lows (depression) with periods of stability.

Both men and women are affected equally, with the average age of onset said to be 28, yet children, adolescents, and seniors can also be affected. Approximately one percent of the population is believed to have the disorder.

‘Bipolar’ refers to the two poles of the continuum with mania being the higher pole and depression being the lower pole. ‘Affective’ means one’s mood or emotions.

The dramatic fluctuation in mood is sometimes referred to as an ‘episode’ or as a ‘mood swing’. The frequency, severity, and length of the episodes vary from one individual to another. Without treatment and proper care, the frequency and severity of this chronic disorder can increase.

Individuals with bipolar disorder often spend many years seeking professional help and may get from three to four diagnoses from doctors before receiving a correct diagnosis. Early diagnosis is important as it can lessen the effects of the disorder on the individual. Individuals with bipolar disorder have an approximately 90% risk of alcohol and substance abuse. Marital fluctuation, chronic unemployment, and suicide are also prevalent.

It is thought that the more episodes experienced by the individual before receiving a correct diagnosis, the more difficult it is to treat. Individuals who do not respond well to treatment are said to be “refractory”.

Many people will continue to lead successful and fulfilling lives after treatment. Revolutionary medications used to treat this disorder, combined with community supports, have decreased the effects of the disorder. Some individuals may experience grief and loss over their perceived selves prior to treatment. Most individuals experience feelings of denial: “I am fine, I don’t need medication” or “I felt better prior to treatment”, “I cannot tolerate the side effects of medication”. These are all part of the natural process that leads to acceptance.

History Of Bipolar Disorder

Bipolar Affective Disorder, sometimes referred to as manic-depression, has existed since the beginning of recorded time. Aerates, in the second century A.D., first used the “mania” to describe patients who would “laugh, play, dance night and day, and sometimes go openly to the market crowned, as if victors in some contest of skill”. He noted that they would later appear “torpid, dull, and sorrowful”. However, it was Theophile Bonet in 1686 who first connected the two distinct ends of the mood spectrum and coined the term “manico-melancolicus”.

In the 1830’s Falret and Baillarger isolated and identified symptoms that remain in many of today’s books and journals. They also believed that what they considered a “circular insanity” had hereditary factors. They encouraged physicians to experiment with drug therapies in the hopes of finding a cure. In 1904, Emil Kraepelin, a German physician, developed a symptomatic classification for mania and depression.

What Causes Bipolar Disorder?

A specific cause for Bipolar Disorder has not been identified; there is no diagnostic test and as yet, no cure for this condition. There are a number of factors; however, that contribute to its onset. They include physiology, heredity, and the environment in which you live and work.

Researchers have discovered that the increase or decrease of certain chemicals, called neurotransmitters, may be involved. The electrical charges in the brain are assisted by the neurotransmitters in the brain to move from one cell to another.

Neurons

There are many explanations as to how the chemistry of the brain affects our moods. Simply put, the brain needs certain chemicals in specific amounts to function “normally”. The condition known as bipolar is believed to result from an imbalance in these chemicals. The brain consists of many cells, called neurons that communicate with other cells throughout the body. Neurons are made of three major parts: the cell body, axon, and dendrite. To communicate messages, the neuron transmits electrical impulses that trigger chemicals to be released.

Chemicals (also known as neurotransmitters) such as norepinephrine, dopamine, serotonin and others, are released into a region between two neurons – called the synapse. Another neuron responds to the chemical in the synaptic junction by excitement or with inhibition. Once the receiving cell has responded, the chemicals remaining in the synaptic junction are either broken down by monoamine oxidase enzymes or retaken up by the transmitter cell.

Alterations in neuronal cell function can influence psychological behaviour. Depression can be caused by decreased chemical levels, especially serotonin and norepinephrine. On the other hand psychosis, schizophrenia, or other mental illnesses can be caused by increased chemical (mainly dopamine) activity in the synapse. Bipolar disorder may be caused by variable chemical extremes in the synapse and shifting inside the neuron.

Heredity

Observations have been made that both bipolar and unipolar disorders tend to run in families. Twin, adoption, and family studies have shown a strong possibility of a genetic component to these conditions. This seems to be even more prevalent in bipolar disorder where there seems to be a strong connection between the disorder in the individual and their biological parents. Inform your doctor of any family history of bipolar or other conditions such as alcoholism, drug dependence, or post partum depression. Include if possible, the types of medications they were treated with and any side effects they may have experienced. This information will be of immense benefit to your doctor and ultimately, you.

Chromosome 22: Unravelling The DNA Code

Recent breakthroughs in understanding the humane genome have suggested depression, bipolar disorder, schizoaffective disorder, and schizophrenia are all related on a spectrum in chromosome 22. This poses remarkable possibilities for the future of better understanding and fighting bipolar illness.

The Affective Disorders Spectrum

J. Hudson and H. Pope first proposed the affective spectrum concept. They theorized that individuals with an affective disorder (bipolar, unipolar, and schizoaffective disorder) tended to have many chronic symptoms of other disorders. They additionally discovered that substance abuse seems to be connected to the affective disorders.

The following is a list of the disorders that are thought to be pathologically linked: affective disorders (bipolar, unipolar, schizoaffective); attention deficit disorder (ADD & ADHD) (Strong Link); body dysmorphic disorder (altered perception of body shape and appearance); bulimia, and other eating disorders; cataplexy; chronic fatigue syndrome; fibromyalgia; intermittent explosive disorder; irritable bowel syndrome; kleptomania; migraines/severe headaches; narcolepsy; obsessive-compulsive disorder (Strong Link); panic disorder (Strong Link); pathological gambling; pyromania; tourette disorder.

Bipolar disorder can be difficult to treat if one has a secondary diagnosis such as alcohol or drug abuse or an anxiety disorder. Anxiety disorders are often treated with antidepressants. For individuals who have a primary diagnosis of bipolar disorder, who experience mostly manic symptoms, and who have a secondary diagnosis of anxiety disorder, the addition of an antidepressant may be contraindicated.

Environmental Factors: Does Stress Cause Bipolar Disorder?

Monitor yourself closely, as an increase in stresses could lead to an episode. Studies have confirmed that stress can precipitate manic and depressive episodes. The biochemical imbalance makes individuals more vulnerable to emotional and physical stressors such as lack of sleep, excessive stimulation, marital tensions and conflicts, or upsetting and traumatic life experiences. During times of stress, the brain chemistry lacks the mechanisms to function properly, triggering the onset of recurrence of an unwanted episode. Despite this reaction, the stress in and of itself is not the cause of the disorder.

Mania

Mania can be extremely destructive and can cause considerable impairment in social and occupational functioning. People are more likely to seek help when moderately depressed versus when they are experiencing an episode of mania.

Mania's main symptom is that of euphoria or an elevated, expansive mood. Everyone has feelings of happiness, pleasure and joy; however, in someone with this disorder, the mood progresses along a continuum from loss of self-control and judgment to psychotic thinking and behaviour. Symptoms can affect emotions, thinking, and behaviour.

Untreated, moderate to the more severe mania can be extremely destructive and cause considerable impairment in social and occupational functioning. Individuals are not likely to seek help when manic and they may deny that there is anything wrong with them. This can lead to involuntary hospitalizations.

Some typical symptoms of mania are:

- Persistently euphoric or 'high' states
- Irritability or excitability
- Appetite disturbance
- Decreased need for sleep
- Increased activity
- Increased sexuality
- Pressured speech or rhyming games
- Racing thoughts
- Loss of self-control and judgment
- Non-completion of tasks

- Financial extravagance
- Inflated self-esteem (grandiosity)
- Impulsive behaviours
- Laughing inappropriately
- Creative or bizarre thinking
- Participating in risk-taking activities
- Increased or delusional religious thoughts or experiences

Depression

Everyone has feelings of sadness and disappointment. Depression's main symptom is that of intense, pervasive, persistent feelings of sadness, hopelessness, and frustration that cause considerable impairment in social and occupational functioning. Untreated, moderate to the more severe depression can lead to suicide attempts or psychotic thinking and behaviour. People are more likely to seek help when moderately depressed versus when they are experiencing an episode of mania.

Some typical symptoms of depression are:

- Poor appetite and weight loss or marked increase in appetite and associated weight gain
- Sleep disturbance
- Loss of energy
- Excessive fatigue or tiredness
- Slow speech and movements
- Change in activity level
- Loss of interest or pleasure in usual activities
- Decreased sex drive
- Diminished ability to think or concentrate
- Indecisiveness
- Withdrawal and isolation from family
- Decreased memory function and lack of concentration
- Disorganization
- Highly critical of self
- Low self-esteem
- Feelings of worthlessness or excessive guilt that may reach delusional proportions
- Recurrent thoughts of death or self-harm contemplating or attempting suicide
- Heightened or changed perceptions

Classifications of Bipolar Disorder

Bipolar I

Individuals diagnosed with Bipolar I have experienced at least one manic episode and almost always have experienced depression. They may have experienced psychotic symptoms (delusions, hallucinations) during either a manic or depressive episode.

Bipolar II

At their most severe, individuals diagnosed with Bipolar II experience moderate mania (hypomania); however, they have not experienced psychotic symptoms (delusions and hallucinations) during either a manic or depressive episode.

Rapid Cycling

Drs. Ronald Fieve and David Dunner first coined the term 'rapid cycling' to refer to individuals who experience four or more episodes, in any combination of manic, hypomanic, mixed, or depressive episodes in a one-year span. Approximately five to 15 percent of individuals with bipolar disorder will experience rapid cycling. It is thought that some antidepressants can contribute to rapid cycling while others such as Wellbutrin don't. This form of bipolar disorder generally responds better to anticonvulsant drug therapy, as opposed to lithium therapy. Electroconvulsive therapy (ECT) may be another treatment option for individuals with this form of the disorder.

Mixed States

There are a small percentage of patients who seem to be trapped in the transitional phase where mania switches to depression; and as a result, simultaneously displaying symptoms of both depression and mania. These individuals are said to be in a 'mixed state'. Correct diagnosis is important to ensure proper treatment. Though this condition is statistically small, it is one of the most common problems seen at hospitals.

Cyclothymia

Cyclothymia is a milder form of bipolar disorder. Cycles of depression and hypomania are shorter, irregular, and less intense. Episodes typically last for days rather than weeks. Mood states can change rapidly so that an individual can experience a distinct change in mood from day to day. About 50 percent of these patients respond to lithium therapy.

Dual Diagnosis

'Dual diagnosis' is defined as having a severe mental illness associated with dependence on alcohol or other substances. There are two subgroups of patients:

- Major substance abuse disorder coupled with another major psychiatric disorder
- Abuse of alcohol and/or other drugs in ways that affect the course of treatment of the mental disorder

Surveys have shown that one third of dual diagnosis psychiatric patients will abuse, or depend on alcohol, and that one third of individuals suffering from alcohol abuse will be additionally diagnosed with a psychiatric disorder. Fifty percent of individuals who abuse drugs other than alcohol will be dually diagnosed.

For individuals who experience mania, the lifetime risk for developing alcoholism is six times greater than compared to the general population while major depression carries a risk of twice the average. Individuals who are dually diagnosed may have a slower rate of recovery than individuals without major substance abuse. Currently, there are few comprehensive, integrated, recovery programs for these individuals, although research is continuing. A moderate lifestyle will help control the illness.

Unipolar Disorder or Major Depressive Disorder

Unipolar Affect Disorder is an abnormal fluctuation in moods, varying lows (depression) with periods of stability. Unlike bipolar disorder, individuals with unipolar disorder do not experience the high end of the continuum (mania). Although unipolar disorder usually occurs in adulthood, adolescents and seniors can also be affected; however, it is more difficult to recognize and diagnose in these groups.

The symptoms for unipolar disorder are the same as for bipolar disorder depression. However, there are a few sub-types of this disorder:

- Melancholia
- Psychotic depression
- Dysthymic disorder

Melancholia

This is a very severe depression, having a number of major symptoms such as: sleep and appetite disturbance, weight loss, and social withdrawal.

Psychotic Depression

This is also a very severe class of depression including the symptoms of melancholia, but also includes psychotic symptoms such as hallucinations or delusions.

Dysthymic Disorder

This is a long-term mild depression that lasts for at least two years. This can be a debilitating form of depression that can span over several decades and can have an adverse effect on personality.

“Mental Illness Is Everybody’s Business.”

