

# Stonebriar Psychiatric Services News & Views Bipolar Disorder

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## **Bipolar Disorder... Fact and Fiction**

Over the past several years, perhaps no psychiatric disorder has received more attention, research, or emphasis in continuing medical education seminars for psychiatrists than has bipolar disorder. I remember in the 1970s how many had difficulty in explaining what seemed to be the different incidence in this country of diagnosed schizophrenia compared to European countries. One theory was that frequently individuals in this country might have been diagnosed with schizophrenia for a variety of historical reasons, whereas in Europe the diagnosis might have been that of bipolar disorder, more frequently referred to at that time as manic-depressive illness. With time, research, and a more objective way of defining diagnoses, it seems that a greater sense of agreement is occurring. Nonetheless, bipolar disorder is frequently one of the most difficult diagnoses to make in psychiatry and frequently can only occur as one observes an individual over time.

## **What Is Bipolar Disorder?**

One reason for the difficulty in making the diagnosis is that frequently the elevated mood is not clearly recognized, and depression is what generally brings the individual in for treatment. It should also be understood that one does not step across some "magic threshold" in order to have a bipolar disorder, but rather the symptoms can occur along a continuum. For the diagnosis of bipolar disorder, one must have experienced what is known as a major depressive disorder, coupled with episodes of mania or hypomania or else have experienced mania alone. Now let's look at what these terms actually mean.

A major depressive episode must have lasted for at least two weeks with the individual experiencing symptoms such as changes in appetite or weight, sleep patterns, lack of energy, feelings of guilt and hopelessness/helplessness, decreases in concentration and motivation, and often with thoughts of suicide. Major depression may occur alone or as repeated episodes of depression, the latter being called recurrent major depression. Statistically we know that if an individual has one episode of major depression, the chances are approximately 50% that they will have another episode, although one cannot predict when that might occur. If they have had two episodes, the chances of the third is approximately 75%, and if they have had three the chances of further depressive episodes increases to about 90%. Where it frequently becomes difficult is in recognizing the mania or hypomania when it occurs.

A manic episode, by definition, represents a distinct period of time in which one's mood is persistently elevated, often described as euphoric or expansive, or else is extremely energetic but irritable or perhaps even still depressed. It must last for at least one week, or it may be less if the person is hospitalized and treated. An individual may lose touch with reality during a manic episode in terms of having grandiose beliefs about themselves or at times may even have hallucinations. A hypomanic mood must last at least four days and is similar in quality to the manic mood except for its not generally being severe enough to cause significant impairment in one's functioning, and no psychotic features are present. Because of its lesser degree of impairment, the hypomanic mood swing is at times especially difficult to identify, as it may often simply be interpreted as just "feeling really good" or even as one's usual personality style when coming out of the depression, especially if the individual generally tends to be outgoing and optimistic when not depressed. Both mania and hypomania are frequently associated with an exaggerated sense of self-worth, decreased need for sleep, distractibility with difficulty in following a train of thought, and particularly with mania one may frequently jump from one topic to another when talking, known as "flight of ideas." These high mood swings may also be associated with excessive spending or increased sexual interest or activity, which frequently results in the patient getting into many difficult situations which may then need to be addressed after the manic episode has resolved.

Frequently, the difficulty in diagnosing either a bipolar I (with manic episodes) or bipolar II (with hypomanic episodes) is in identifying the elevated mood swing. Often this is because the depressive episodes may begin earlier in life with one or more



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depressive episodes occurring before there is any evidence of mania or hypomania. These individuals are frequently diagnosed as having recurrent major depressions. Although a full manic episode is generally not difficult to recognize or diagnose, the lesser hypomanic episodes are frequently difficult to recognize as often the individual simply sees it as a time in which they again felt happy and well. Recognizing these changes in mood is also made more difficult because of the high incidence of co-morbid disorders that frequently occur with bipolar disorder, including alcohol and/or substance abuse, attention deficit-hyperactivity disorder, anxiety disorders, and at times various conduct disorders. Any, or all of these, can significantly affect one's behavior and mood.

## Characteristics and Etiology

The onset of bipolar I disorder tends to be earlier than major depressive disorders with onset occurring as early as childhood and occasionally as late as 50 or older with a mean age of approximately 30. The average age of onset for major depressive disorder is approximately 40 years with over half occurring initially between the ages of 20 and 50. We know that major depression can also occur in childhood and adolescence, and I have personally worked with many adolescents who struggle with this. It is important to keep in mind that frequently bipolar disorder may present with depressions of varying degrees of severity which may precede the manic or hypomanic episode by many years.

Both major depression and bipolar disorder tend to occur more commonly in individuals who are either divorced or single. Although no clear correlation has been found between socioeconomic status and major depression, some studies have indicated an association of bipolar I disorder among those of upper socioeconomic class. Numerous studies have indicated that mood disorders may be associated with a wide range of biological factors which affect various systems of the body, often through various neurotransmitters known as biogenic amines, including norepinephrine, serotonin, and dopamine. Various neuroendocrine functions can be affected, including those related to adrenal and thyroid function, growth hormone, and those systems controlling our natural body rhythms known as circadian rhythms. Sleep disorders are quite common with both depression and bipolar disorders, and one of the quickest ways to trigger a manic or hypomanic episode is through sleep deprivation, whether intentional or unintentional. I have seen a number of college students trigger a manic or hypomanic episode as they pulled "all-nighters" in studying for finals. There are numerous theories of how these various systems interact during these mood swings, although that would represent far more information than we can cover here.

Although various studies strongly indicate a significant genetic component regarding the development of mood disorders, the pattern of inheritance is quite complicated except to say that there seems to be a stronger genetic factor with bipolar I disorder than with major depression. However, this certainly does not rule out the role of life events and general life stress that may serve as a precipitant. One of the goals of therapy in all of these disorders is to better understand the role of these past events and their effect on how one interprets and reacts to current life events. Different schools of thought may have different areas of emphasis, whether it is cognitive theory, psychodynamic theory, or even those who take a more behavioral approach. Although we will continue to look at other aspects of bipolar disorder and its treatment in the October newsletter, I would like to leave on this keynote.

Whether one is struggling with bipolar disorder, depression, an anxiety disorder, an eating disorder, or any other type of disorder or addiction, it is important to remember that the illness does not define who the person is as an individual or their value and worth as a person. The illness is something that needs to be addressed so as to minimize its negative effects upon one's life, but hopefully neither the individual nor their loved ones will see the individual as simply "their illness" and nothing more. At times, that can be the worst and most difficult problem of all to cure.

*to be continued...*



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