

Millennium Psychiatric Associates, LLC

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Manic-depressive illness, known in medical terms as bipolar illness, is the most distinct and dramatic of the depressive or affective disorders. Unlike major depression, which can occur at any age, manic-depressive illness generally strikes before the age of 35. Nearly one in 100 people will suffer from the disorder at some time in their lives.

People with bipolar illness differ from those with other depressive disorders in that their moods swing from depression to mania, generally with periods of normal mood between the two extremes. The length of this cycle, from towering elation to near despair, varies from person to person.

Symptoms

When patients first suffer a manic phase, they feel a rather sudden onset of elation, euphoria or extreme irritability that increases in a matter of days to a serious impairment. Symptoms of the manic phase are:

- *A mood that seems excessively good, euphoric, expansive or irritable.* The patient feels “on top of the world,” and nothing—bad news, horrifying event or tragedy—will change his happiness. However, this euphoria can quickly change into irritability or anger. In either case, the mood is way out of bounds, given the situation and the individual’s personality.
- Expressions of *unwarranted optimism* and lack of judgment. Self-confidence reaches the point of *grandiose delusions* in which the person thinks he has a special connection with God, celebrities, or political leaders. Or he may think that nothing—not even the laws of gravity—can stop him from accomplishing any task. As a result, he may

think he can step off a building or out of a moving car without being hurt.

- *Hyperactivity and excessive plans or participation in numerous activities that have a good chance for painful results.* Patients become so enthusiastic about activities or involvements that they fail to recognize they haven’t enough time in the day for all of them. For example, a person with bipolar illness may book several meetings, parties, deadlines and other activities in a single day, thinking he or she can make all of them on time. Added to the expansive mood, mania also can result in reckless driving, spending sprees, foolish business investments, or sexual behavior unusual for the person.
- *Flight of ideas.* The person’s thoughts race uncontrollably like a car without brakes careening down a mountain. When the person talks, his or her words come out in a non-stop rush of ideas that abruptly change from topic to topic. In its severe form, the loud, rapid speech becomes hard to interpret because the patient’s thought processes become so totally disorganized and incoherent.
- Decreased need for sleep, allowing the patient to go with *little or no sleep for days* without feeling tired.
- *Distractibility* in which the patient’s attention is easily diverted to inconsequential or unimportant details.
- *Sudden irritability, rage or paranoia* when the person’s grandiose plans are thwarted or his excessive social overtures are refused.

Untreated, the manic phase can last as long as three months. As it abates, the patient may have a period of normal mood and behavior. But eventually the depressive phase of the ill-

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ness will set in. In some, depression occurs immediately or within the next few months. But with other patients there is a long interval before the next manic or depressive episode. The depressive phase has the same symptoms as major or unipolar depression:

- Feelings of worthlessness, hopelessness, helplessness, total indifference and/or inappropriate guilt; prolonged sadness or unexplained crying spells; jumpiness or irritability, withdrawal from formerly enjoyable activities, social contacts, work or sex.
- Inability to concentrate or remember details.
- Thoughts of death or suicide attempts.
- Loss of appetite or noticeable increase in appetite; persistent fatigue and lethargy, insomnia or noticeable increase in the amount of sleep needed.
- Aches and pains, constipation, or other physical ailments that cannot be otherwise explained.

Theories About Causes

Recent studies into the roots of bipolar illness have centered on genetic research. Scientists believe these studies will eventually help them identify the genetic culprits that cause manic depressive illness in its various forms among different populations. This research will also help psychiatrists to understand the biochemical reactions that are controlled by these genes and that contribute to the disorder.

Close relatives of people suffering from bipolar illness are 10 to 20 times more likely to develop either depression or manic-depressive illness than the general population. In fact, between 80 and 90 percent of people suffering

from manic-depressive disorder have relatives who suffer from some form of depression. If one parent suffers from manic-depressive illness, a child has a 12–15 percent risk of suffering from a depressive disorder; if both parents suffer from manic-depressive illness, the children have a 25 percent chance each of developing a depressive disorder or manic-depressive disorder.

Other studies hint that environmental factors may contribute to the illness. Psychoanalytic studies suggest that such environmental factors as difficult family relationships may aggravate manic-depressive illness.

Still other studies suggest that imbalances in the biochemistry controlling a person's mood could contribute to manic-depressive illness. For example, people suffering from either manic-depressive disorder or major depression often respond to certain hormones or steroids in a way that indicates they have irregularities in their hormone production and release. Some research points to the possibility that bipolar patients' neurotransmitters—chemicals by which brain cells communicate—become imbalanced during various phases of the disease. Finally, some people suffering from depressive illnesses have sleep patterns in which the dream phase begins earlier in the night than normal. These studies indicate that manic-depressive illness and major depression may be caused by biochemical imbalances. Such research also helps develop scientific theories about how medications work, and offers hope that psychiatrists some day will use laboratory tests to identify unipolar or bipolar illnesses.

Diagnosis

Anyone who suspects they or a loved one suffers from manic-depressive illness should receive a complete medical evaluation to rule out

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any other mental or physical disorders. Many other medical disorders can mimic manic-depressive illnesses. For example, a person with symptoms of manic depression could be reacting to substances such as amphetamines or steroids or could suffer from thyroid, liver or kidney problems or other illnesses, such as multiple sclerosis. A comprehensive medical and psychiatric evaluation by a qualified psychiatrist or other physician is vital to an accurate diagnosis. With this diagnosis a psychiatrist can then work with the patient to design the right treatment plan.

Treatment

Though manic-depressive disorder can become disabling, it is also among the most treatable of the psychiatric illnesses. Proper medication is essential to this treatment, and psychotherapy may also be helpful.

The most common medication, lithium carbonate, successfully reduces the number and intensity of manic episodes for 70 percent of those who take the medication. Twenty percent of those who use lithium become completely free of symptoms. Those who respond best to lithium are patients who have a family history of depressive illness and who have periods of relatively normal mood between their manic and depressive phases. In recent years psychiatrists have also been successful with several medications—such as carbamazepine and valproate—in treating those for whom lithium is not effective.

Very effective in treating the manic phase, lithium also appears to prevent repeated episodes of depression.

Lithium works by bringing various neurotransmitters in the brain into balance. Scientists think the medication may affect the impact neu-

rotransmitters have on the brain cells, thus altering moods.

Like all medications, lithium can have *side effects* and *must be carefully monitored by a psychiatrist*. The physician should measure the level of lithium in the patient's blood and determine how well the patient's kidneys and thyroid gland are working. Among the side effects are weight gain, excessive thirst and urination, stomach and intestinal irritation, hand tremors, and muscular weakness. If a patient overdoses on medication, it may cause confusion, delirium, seizures, coma and may result, rarely, in death.

However, when properly monitored, lithium, sometimes used with other medications, has returned thousands of people to happy, functioning lives that would not be possible without medication.

Like all serious illnesses, manic-depressive disorders disrupt a person's self-esteem and relationships with others, especially with spouses and family. Without treatment, people with the illness may risk consequences such as financial and occupational disintegration, or even suicide. Because of these consequences of their illness, people under treatment for manic-depressive disorder also benefit from psychotherapy.

The patient and the psychiatrist work out the problems created by the disorder and reestablish the relationships and healthy self-image that are shaken by the illness. In many cases, a patient needs the psychiatrist's support to ensure that he complies with his treatment.

Family members of manic-depressive patients also may benefit from professional care. This illness can cause serious disruptions of the family's life, as the stresses of living with a person suffering from manic depression are in-

tense. Not only may family members learn coping strategies from the psychiatrist but they can also to be an active part of the treatment team.