Bipolar 1 Disorder

Bipolar 1 disorder is a subtype of bipolar disorder, and is characterised by either recurrent manic episodes or serial manic and depressive episodes. It is commonly known as just bipolar disorder, or misspelt as bi-polar disorder.

This disorder is relevant to this site because often the distinction between schizophrenia and bipolar 1 disorder can be challenging even to the most experienced clinician. The distinction is important because sometimes this can have implications for treatment. Both schizophrenia and bipolar 1 disorder can present with psychotic symptoms, elevated or irritable mood and disturbed behaviour.

The hallmark which will distinguish bipolar disorder from schizophrenia will be the emphasis on the mood disturbance and behavioural changes.

The incidence of bipolar 1 disorder is similar in men and women and it affects about 2-3% of the population. The patient will typically present with an acute manic episode. The diagnosis is based on the following diagnostic criteria:

A - There is a distinct period of elevated, expansive or irritable mood of at least one week's duration

B - Inflated self-esteem or grandiosity rapid speech or more talkative than normal (pressured speech) flight of ideas (jumping form one topic to the next with no apparent connection between them) or subjective feeling that thoughts are racing decreased need for sleep increased pursuit of pleasurable activities with negative consequences distractibility increased goal-directed activity or psychomotor agitation

C - Also there is a marked disturbance in functioning at work, at school, or socially causing interpersonal problems, hospitalisation is required to prevent harm to self or others, or there are psychotic features

Naturally one has to exclude a physical illness of a drug-induced state.

Bipolar 1 disorder tends to be a chronic lifelong illness with recurrent relapses and it is characterised by recurrent manic episodes or recurrent manic and depressive episodes. It can start with a depressive or a manic episode and one often precedes the other. There is a bimodal peak at which the first episode appears; in the early 20s and again in the 30s. The manic episode can present with the symptoms as described in the criteria which could for example consist of promiscuity, spending
lots of money, becoming involve in large business projects, excessive house cleaning and angry irritable outbursts with significant hostility and sometimes violence. The manic episode can also be accompanied by psychotic symptoms which are usually of a grandiose nature, but could also be persecutory.

As mentioned before, schizophrenia shares some of the same symptoms. Both schizophrenia and bipolar disorder can present with delusions; but the delusions in bipolar disorder are usually of a grandiose nature whilst in schizophrenia it is persecutory in nature. The degree of restlessness and agitation may be more in bipolar disorder compared to schizophrenia.

If one looks back over the lifetime of someone with bipolar disorder, there may have been previous episodes of mania or depression that went undiagnosed. Sometimes the manic episodes are not recognised as being unwell because the patient may have been very productive during such an episode, and in fact may have liked it very much.

Untreated, these episodes of mania and depression can still resolve without medication - it only takes longer. What medication does is shorten the duration of the episode, and it decreased the risk of relapse i.e. increases the period between relapses.

The cause of bi-polar 1 disorder is unfortunately unknown. Often there is a strong family history of depression of bipolar disorder. Drug-induced manic episodes can be indistinguishable from one where there is a genetic predisposition.