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Manic and Depressive Episodes in Bipolar Disorder

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ABSTRACT

Background: The clinical makeup of bipolar disorder consists of alternating manic and depressive episodes, a concept that is unique to this condition. Whether experiencing mania or depression, each affected individual will express themselves differently based on their traits. Given the complexity of bipolar disorder, identifying key manifestations of either episode is crucial in nursing care. Identifying the phase in which the patient is in will direct care providers in forming adequate decisions for overall care. **Purpose:** The purpose of this review was to identify the different signs and symptoms shown in bipolar disorder and assess how they are portrayed differently during manic and depressive episodes. **Method:** A literature review was conducted utilizing various scholarly articles and journals consisting of information related to this topic. **Findings:** Findings from these sources indicated that neurophysiological alterations may play a role in the difference between manic and depressive episodes. The rate of occurrence, as well as certain symptoms, varies among the two episodes; different age groups may also create a reason for differing manifestations. **Conclusion:** Based on these findings, nurses must remain attentive throughout the care of those with bipolar disorder, carefully identifying changes in behavior compared to baseline assessments. Doing so will provide patients with safe and effective care.

INTRODUCTION

The National Alliance on Mental Illness (NAMI) defined bipolar disorder as a mental illness that causes dramatic shifts in a person's mood, energy, and ability to think clearly [1]**.** The characteristics of this disorder include experiencing emotional highs and lows referred to as mania and depression. Mania is usually defined as an extreme elevation in mood. However, it is usually not a positive experience. While someone's mood may be elevated while they are experiencing mania, this can present itself in many ways. These patients are usually experiencing high levels of energy and can be fidgety, along with having difficulty sleeping. The other major component of bipolar disorder is depressive episodes. These episodes are characterized by extreme lows, difficulty getting out of bed, difficulty sleeping, sleeping more than usual, feeling overwhelmed, feeling lost, feeling helpless, and having thoughts of suicide [1]. This literature review aims to explore the question: To what extent do depression and mania affect those with bipolar disorder?

BACKGROUND

It is imperative to recognize the occurrence of different episodes among patients with bipolar disorder. In general, those with the condition experience alterations of mania followed by depression. According to NAMI, the number of manic episodes that occur during a lifetime varies from person to person along with the symptoms that are presented [1]. As for depressive episodes, these experiences can be extremely debilitating, and proper care is essential for addressing this concern [1]. In addition to NAMI, organizations such as the American Nurses Association (ANA) discuss this concept. Identifying for periods of mania accompanied by depression lead to reduced error in diagnosis and treatment [2]. Due to the complexity of bipolar disorder as well as the numerous mental disorders that overlap each other, careful attention must be put in place when distinguishing manifestations of either episode.

DSM-5 and ICD-11 Criteria

Bipolar disorder is identified by abnormalities associated with mood, including depressive and manic episodes. The ICD-11 and DSM-5 criteria for a bipolar manic episode incorporate increased energy levels or activity, and an expansive or irritable mood [3]. The prevalence of

lifetime bipolar disorder per the DSM-5 criteria is 2.1% [4]. The DSM-5 criteria for bipolar depression are the same as major depressive disorder [5]. As stated in DSM-5, to diagnosis major depressive disorder a person should manifest at least 2 weeks of persistent depressed mood, anhedonia, or hopelessness [6]. The DSM-5 criteria for a manic or depressive episode while paired with the history of the other must be present to diagnose bipolar disorder.

Manic Symptoms

Mania is presented in various forms for different patients with bipolar disorder (see Figure 1). Manic behavior has various symptoms, including abnormally elevated self-esteem, decreased need for sleep, increased talkativeness, flight of ideas, racing thoughts, abnormal distractibility, increased energy, and abnormally risky behaviors [7]. Another significant clinical manifestation of mania includes impulsivity [8]. These manic episodes are often shorter-lived than the bipolar depressive states [4].

Depressive Symptoms

Depressive symptoms associated with bipolar disorder are characterized by two weeks of presenting symptoms (see Figure 1). Depressed mood, loss of interest or pleasure in activities, weight loss or gain, insomnia or hypersomnia, agitation, fatigue, worthlessness, lack of focus, suicidal ideation, and significant impairment are common signs of a bipolar depressive episode [9]. Bipolar depression symptoms use the same criteria as a major depressive disorder so for an episode to be considered bipolar depression it must be accompanied by a history of mania [9].

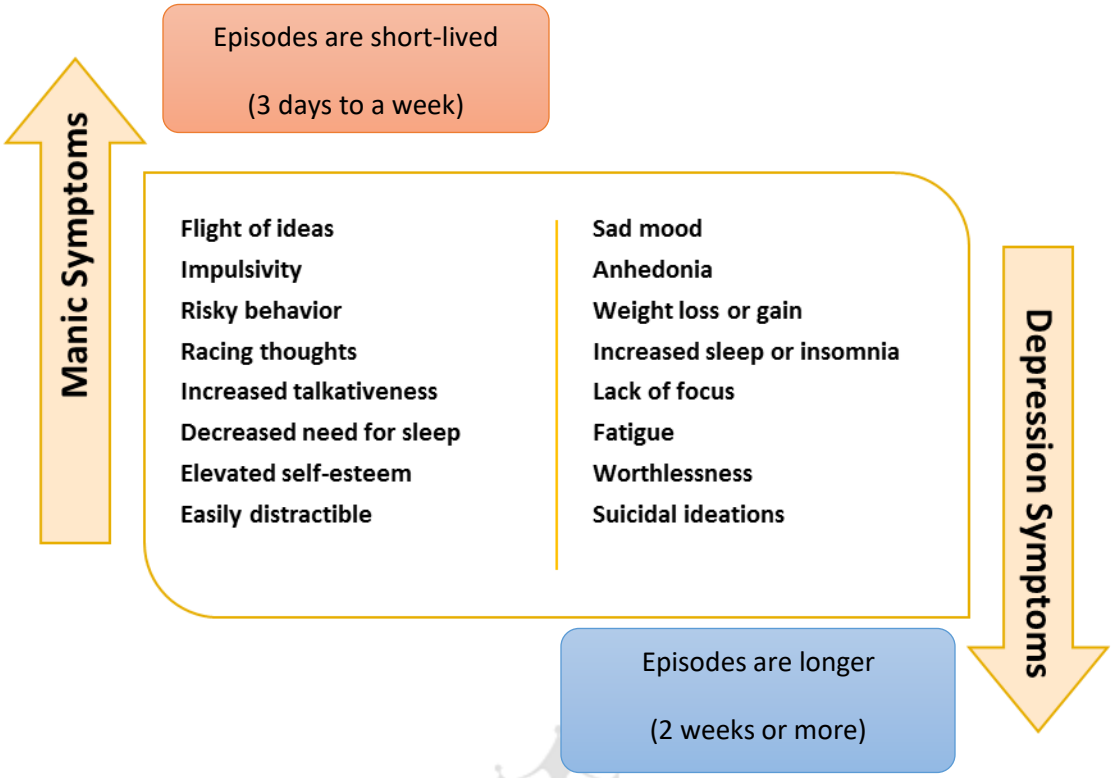

Figure No. 1. Symptoms associated with bipolar disorder

Note. Depressive symptoms must be associated with a history of mania to be considered bipolar.

CASE STUDIES

Three people were interviewed and found to present strong clinical manifestations of current manic episodes with a history of depressive episodes; these people have all been diagnosed with bipolar disorder. All three people were hospitalized for risky behaviors associated with family problems and currently exhibit a manic state. Their mania is demonstrated through various signs and symptoms. In addition, the following people represent different age groups.

Person A

Person A is a 55-year-old male admitted to the hospital. His current diagnosis is bipolar disorder, as he experiences a manic episode with homicidal and suicidal ideations. He has a history of family conflict where he disowned his family when he was 15 years of age because they were "terrible people." He had not seen them in more than 30 years and recently tried to rekindle with

them. He explained that he has tried to kill his family twice, even causing them to move away and change their phone numbers. He expresses homicidal and suicidal ideation. He stated that after he takes his family out, he is going to take himself out too because he does not want to go to jail. This aggressive and risky behavior lingers only for a few days during his manic episodes. He expressed his hatred for his family only occurs during his manic state. He has a manic episode roughly every three months that last anywhere from three days to one week. He explained he does not sleep much during these times, only getting about four hours of sleep a night. Decreased sleep is a common symptom of a manic episode. These episodes are followed by a depressive period that can last at least two weeks. During this time, he isolates himself and does not leave his room.

Person B

Person B is a 71-year-old male admitted to the hospital for experiencing severe manic episodes without psychotic features. He was found to not be adhering to his medication regimen based on the thought that he could do without them for the first time in 30 years. This ultimately led to an altercation with his brother-in-law with whom the patient resided. He was requested to leave this residence by his brother-in-law, leaving him without a place to stay. He appeared to be in a very pleasant mood in the hospital, and he claimed to feel good enough to be discharged. He has a history of multiple admissions since 1977, all of which likely pertain to his manic and depressive episodes. He continued to display a flight of ideas as he stated that he wanted to go back to college, go up north to his cabin, and buy a gas station as well as open a dance/party room for teenagers. He currently has a poor social history. His lack of social support systems likely contributes to his depressive episodes.

Person C

Person C is a 32-year-old male admitted to the hospital. His diagnosis is bipolar disorder with psychotic features. His wife has accused him of threatening her and their children, which led to his self-admission. Although he claims that he did not threaten his family and that his wife is lying, threats and aggression would be consistent with a manic episode. He states that his wife has placed a restraining order against him and that she has threatened divorce if he does not get psychiatric help. He has not heard from them since he was admitted. He states that he has

isolated himself and has not socialized with anybody outside of his household in the past year. It is unclear whether he is correct in his recall of events as his wife tells an opposing story. He has had past hospitalizations including being admitted after an attempted suicide. He had been experiencing a depressive episode related to his bipolar disorder diagnosis and attempted a drug overdose.

LITERATURE REVIEW AND FINDINGS

The databases searched to compose this literature review were The Cumulative Index to Nursing and Applied Health Literature (CINAHL) database, Psyc Info, and the university library. The following sources were published between the years 1972 and 2021. The concept of mania in a person with bipolar disorder is lesser researched than bipolar depressive states.

Functional Connectivity

Neurological abnormalities play an important role in the symptoms shown during manic and depressive episodes. Although studies continue to investigate this area, the focus has been placed on the amygdala and prefrontal cortex. Wei *et al.* [10] discussed this concept to identify structural differences between manic and depressive episodes of bipolar disorder. Results from this study showed an abnormality within the amygdala-right prefrontal cortex specific to manic episodes as compared to depressive episodes [10]. Regarding the left side, abnormalities were found for both depressive and manic episodes [10]. Although such findings provide significant progress in understanding the mechanism behind bipolar disorder, symptoms may still be unique depending on each individual which will require further investigation.

Bipolar Depressive State

Diagnosis of bipolar disorder is a complex process. McIntyre and Calabrese [4] stated that 69% say they were misdiagnosed at first. These misdiagnoses can be attributed to the use of the same DSM-5 criteria for major depressive disorder and bipolar depression as well as, that a depressive episode is generally the first symptom. Although, to have bipolar disorder the patient must also have a history of mania or hypomania [4]. As listed in the NAMI, diagnosing a patient with bipolar disorder can be somewhat difficult [1]. There are no tests to be done as the diagnosis is

strictly symptomatic. A person with bipolar disorder may go undiagnosed for years because it has symptoms in common with several other mental health disorders [1].

Theories of Triggers for Mania and Depression

Bipolar disorder is commonly diagnosed during the patient's late teens and early twenties. Proudfoot *et al.* [11] interviewed young adults with bipolar disorder to identify possible triggers of manic and depressive episodes. The study indicated that the following are common triggers for manic episodes in young adults with bipolar disorder: falling in love, recreational stimulant use, starting a creative project, and listening to loud music [11]. There are two theories about the cause of bipolar disorder that these triggers support. The first is that a dysregulation of the behavioral activation system (BAS) can play a role in triggering mania [12]. This theory is supported by the evidence that falling in love, starting a new project, and listening to loud music may trigger mania. The second is that a disturbance in circadian rhythm can also be a trigger [13]. This theory is supported by the findings that late-night partying and going on vacation may trigger a manic episode. Proudfoot *et al.* [11] also identified common triggers of depressive episodes. These include stressful life events, general stress, fatigue, sleep deprivation, physical injury or illness, and menstruation. These triggers seem to be specific to the young adult population and can hopefully be used to help them better manage and predict their bipolar disorder episodes.

Increased Activity and Energy in Mania

An alteration from hyperactivity to depression is a typical indicator of a manic episode in a variety of patients. Individuals will begin to display specific symptoms unique to themselves that will signal the beginning of such episodes; energy levels may drastically change which can be apparent to others. Machado-Vieira *et al.* [14] conducted a study to determine the prevalence of activity changes as it related to the comparison of DSM-IV and DSM-5. The new diagnostic criteria introduced in DSM-5 included this change in activity and energy levels to be diagnosed. The study indicated that primary symptoms found throughout participants included changes in mood, increased energy or activity, and irritability [14]. With the added requirement in DSM-5, Machado-Vieira *et al.* [14] concluded that this would have the potential to prevent overdiagnosis of bipolar disorder and mania as well as affect the overall treatment of different mood disorders.

This is a critical point to make; mood disorders as well as the wide array of mental health disorders pose an issue regarding misdiagnosing and incorrect treatment. By creating more specific criteria for what constitutes a manic episode, provides room for less error. In addition, this can assist those to identify signs and symptoms that may be indicative of a manic or depressive episode.

Length of Manic and Depressive Episodes

Manic and depressive episodes can vary in length and amount between patients with bipolar disorder. Tondo *et al.* [15] performed a study on the duration and rate of manic and depressive episodes within a person who has bipolar disorder. This study found that manic episodes tend to last weeks to months and proved that milder episodes were shorter than severe episodes. The longer manic episodes were seen to be more severe and occurred with psychotic features. They noted that these manic episodes are normally followed by a time of mental exhaustion that turns into a depressive episode. Depressive episodes were demonstrated for longer periods, even lasting years. The data showed that manic and depressive episodes occurred one to two times a year, but overall, patients spent more time in a depressive episode [15]. This study confirmed that patients with bipolar disorder spend various amounts of time in manic periods depending on the severity and spend an increased amount of overall time in a depressive state.

Symptoms in Mania and Depression

Patients with bipolar disorder are unique in the way that they signal a manic or depressive episode; symptoms vary but can be consolidated into a general understanding of the disorder. Fountoulakis et *al.* [16] provide a comparison of the two acute phases and symptoms that are often specific to each. During a manic phase, patients often experience euphoria, mood lability, psychomotor acceleration, hyposomnia, and psychotic features. During a depressive phase, symptoms such as irritability, psychomotor retardation, weight fluctuations, oversleeping, and physical complaints are more common [16]. Although these are generalized findings, it is important to note that these signs and symptoms have the potential of overlapping. For example, when one with bipolar disorder presents with obvious and abrupt irritability, additional assessment should be necessary to determine whether they are experiencing a manic or depressive episode.

Patients with bipolar disorder are at risk for developing psychotic features; this primarily includes delusions and hallucinations [16]. The experience of psychotic features can be incredibly difficult to manage and places additional hardships on the patients. It may also increase their risk of self-violence. Caldieraro *et al.* [17] observed the occurrence of psychotic features in those with bipolar disorder and found that it more so corresponded with depressive episodes. This study found that the presence of suicidal ideation was more than double in those with psychotic features as compared to those without; this was also similar regarding the prevalence of suicide attempts [17]. Given that depressive episodes are often longer-lasting than manic episodes, this is a critical observation that impacts the overall care of those with bipolar disorder.

While mania is more specific to bipolar disorder than depression is, depression occurs more often in bipolar, and it lasts longer. Depressive episodes account for more than 6% of deaths by suicide within the first 20 years of diagnosis [1]. Most commonly, mania presents itself as feelings of happiness or irritability along with an increase in activity or energy level. The most common way that depression presents in those with bipolar disorder is that they will feel sad, hopeless, or indifferent and experience a decrease in activity level and energy [1]. According to the National Institute of Mental Health [18], people with this disorder can experience mania and depression separately, or they can have mixed episodes. Mixed episodes consist of components of mania and depression at the same time. All episodes usually last around two weeks, but sometimes last more. During the episode, the symptoms tend to last all day every day with no relief. Patients with bipolar may also experience symptoms of psychosis [1]. Psychotic symptoms include hallucinations and delusions, and these symptoms usually match the extreme mood of the person with bipolar disorder.

Impulsivity in Mania and Depression

Impulsivity is another common symptom presented in bipolar patients in both mania and depression. Swann *et al.* [8] researched to determine the different relationships that impulsivity has between manic and depressive episodes. Impulsive behavior is heavily linked to manic episodes and appears less in depressive episodes [8]. Patients with mania were seen to demonstrate motor impulsivity compared to patients with depression who presented non-

planning impulsivity. Attentional impulsivity was associated with both mania and depression. Overall, there was an increased demonstration of motor, attentional, and total impulsivity present in the manic state. Motor impulsivity associated with manic episodes demonstrated symptoms of hyperactivity whereas attentional impulsivity correlated with depressive episodes showed prominent symptoms of hopelessness and anhedonia [8]. When substance abuse is blended with bipolar disorder, non-planning impulsivity was prominent in both mania and depression which differed from a bipolar patient with no history of substance abuse. Impulsivity within bipolar disorder is also linked to an increased risk of suicide [8].

Najt *et al.* [19] also discussed how impulsivity is related to bipolar disorder in manic and depressive episodes. Impulsivity has been seen to be more prominent during manic episodes but can still be present in depressive episodes. Impulsive behavior is detected more in patients with bipolar disorder than in healthy individuals. An increased display of aggressive and impulsive behavior is commonly associated with periods of mania. There is a connection between impulsive behaviors and the increased risk of suicide in patients with bipolar disorder. Research shows that about 15% to 19% of patients in a bipolar depressive episode commit suicide [19]. McIntyre and Calabrese [4] also acknowledged that suicide is more prominent during a depressive episode than manic.

Clinical Characteristics in Older Adults

It should be recognized that bipolar disorder and mania can present among a wide age range within the population. Despite this, a large majority include older adults. Marino *et al.* [20] discussed findings regarding the efficacy of certain treatments for those 60 years and older who have a diagnosis of bipolar disorder I; this also incorporates treatment effects on the occurrence of manic episodes. The challenges that come with assessing the geriatric participants given the complexity of their signs and symptoms. Such characteristics include restlessness, distractibility, abnormal speech patterns, elated mood, irritability, delusions, and poor insight. Individuals of this age are also more commonly known to experience additional health disadvantages and comorbidities; with this in mind, they may be prescribed several medications. Polypharmacy may contribute to such negative experiences for those with bipolar disorder and mania [20]. This will potentially contribute to the unique symptoms displayed by each individual.

Bipolar disorder is a common cause of disability all over the world [4]. Disability associated with bipolar disorder is influenced by depression more than mania. The most common symptom experienced during a bipolar depressive episode is anhedonia. When anhedonia is present, disability is shown to be increased. Cognitive impairment is commonly demonstrated in bipolar disorder and can be seen to negatively influence social interactions, disability, and learning [4].

Comorbidities

Medical and psychiatric comorbidities are common among those with bipolar disorder (see Figure 2). The most frequent medical comorbidities for bipolar disorder include cardiovascular disease, hypertension, obesity, metabolic syndrome [4]. A bipolar patient with a medical comorbid condition generally exhibits a more severe form of bipolar disorder which needs a more extensive treatment course. The typical psychiatric comorbidities that occur with bipolar disorder include attention deficit hyperactivity disorder (ADHD), anxiety, personality disorders, eating disorders, and substance use disorders. Psychiatric comorbidities increase the risk of bipolar depression and suicide [4].

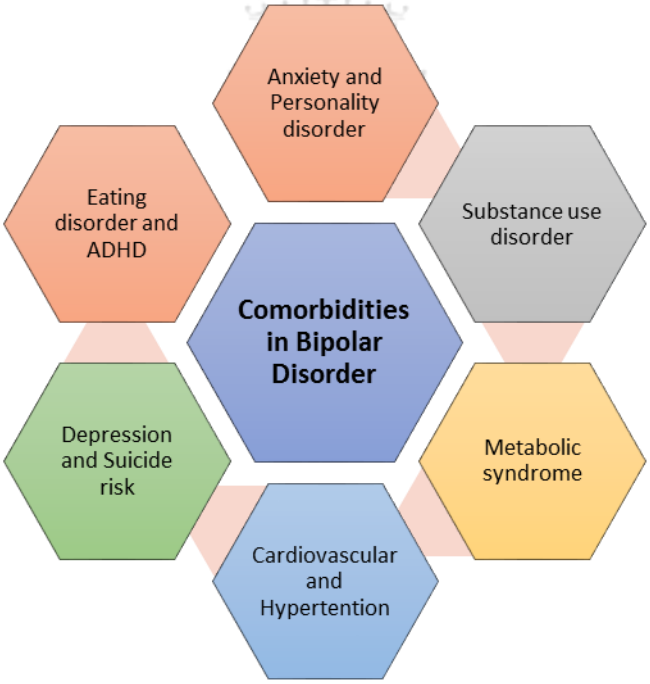

Figure No. 2. Some comorbidities in bipolar disorder

Insight into Illness

A common symptom of bipolar disorder that is often overlooked is a poor insight into illness. That is to say that people are unaware of the level of impairment that their disorder is causing. A study examined one's insight into illness among those with mania, mixed mania, bipolar depression, and unipolar depression. Before the study, it was already known that a large proportion of patients with bipolar disorder lack insight into having an illness [21]. Many people with this disorder may believe that they are not sick and that they are functioning well in society, even if that is not the case. Among patients with bipolar disorder, those who were experiencing mania had a greater lack of insight into their illnesses. It was also found that these patients had less awareness of their response to medications. After taking medications during a manic episode, they felt that they did not help alleviate their symptoms. These feelings lead to the patients having poor medication adherence [21].

Treatment Options for Bipolar

Treatment of bipolar depression and mania is more effective with early intervention because bipolar disorder progresses quickly (see Figure 3). The treatment goals of bipolar disorder are patient safety and symptomatic management [4]. Manic episodes have a greater amount of treatment options including antipsychotics and mood stabilizers. Bipolar depression has fewer pharmacological options available, including atypical antipsychotics [4]. The inadequate amount of treatment options poses a difficulty for those with bipolar disorder to have symptoms stabilized.

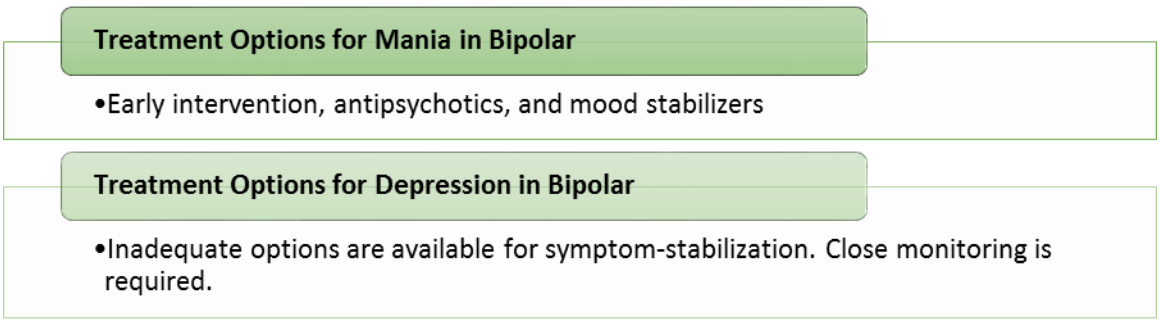

Figure No. 3. Treatment options for bipolar disorder

DISCUSSION

Findings from the literature review and case studies are listed in Figure 4. Based on the review, there are many things to consider when diagnosing and caring for individuals with bipolar disorder. Due to the DSM-5 criteria being the same for both bipolar depression and major depressive disorder, misdiagnosis is common [4,5,6]. This could be prevented by creating separate DSM-5 criteria specifically for bipolar depression. An adequate diagnosis will lead to nurses being able to provide accurate and quality care.

People with bipolar disorder are usually diagnosed in their late teens to early twenties. The research found common triggers for both manic and depressive episodes specific to young adults. This is prominent information for nurses to understand as they may have multiple patients with bipolar disorder, and this can help them to identify individual triggers. Identifying triggers can lead to early treatment and better management of episodes [11].

Along with identifying triggers, it's also important to be able to know if the patient is in a manic or depressive episode. This can be determined by a vast knowledge of the symptoms of each. Nursing care for those with bipolar disorder is based on symptomatic management. Interventions for a patient experiencing mania include remaining calm, reducing stimulation, and assessing for psychotic features. Interventions for depressive episodes include assessing for suicidal ideation, encouraging the patient to socialize, and providing emotional support. It’s imperative to assess for risk of suicide in patients experiencing a depressive episode because suicide is so prevalent in those with bipolar disorder [9,17]. By consistently assessing for suicidal ideation, nurses can ensure the safety of their patients.

Figure No. 4. Findings regarding manic and depressive episodes in bipolar disorder from the literature review and care studies

Comorbidities such as cardiovascular disease, anxiety, and substance abuse are common among those who have bipolar disorder [4]. These can complicate the prognosis and treatment of the disorder. Nurses need to understand this and be aware that comorbidities can cause the effects of bipolar disorder to be more severe.

Another common complication of bipolar disorder is the poor insight into their illness [20,21]. Individuals do not believe that they have a disorder, which leads to them becoming nonadherent

to their medications. When this occurs, the nurse needs to identify it, educate the patient on why adhering to their medication is important, and ensure that they are continuing to take it. To help ensure that they take their medications the nurse should work with the patient to create a schedule of when to take their prescriptions.

CONCLUSION

Bipolar disorder is a complicated illness. There are many components along with mania and depression that can cause severe debilitation in daily life. However, with the correct diagnosis, early identification of triggers and symptoms, and therapeutic management, the prognosis for these patients can be improved. Proper nursing interventions and making adequate treatment available can decrease the severity of bipolar disorder episodes.

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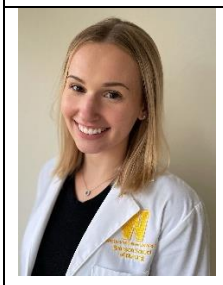	**Hannah E. Meissner** *Bronson School of Nursing, Western Michigan University, Kalamazoo, Michigan, USA*
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