

Alison Mathey

Abnormal Psychology MWF 9AM

College of William & Mary

April 22, 2005

Bipolar Disorder as Displayed in Elliott Smith*, a Male Teenager

Bipolar disorder, or manic depression, is a mood disorder that can drastically change the direction of one's life. Affecting approximately .8-1.6% of the adult population (Kessler et al., 1994), this disorder impacts the mental, physical, emotional, and cognitive aspects of one's life. Bipolar disorder actually comprises a spectrum of affective disorders, some of which are related to unipolar depression. Bipolar disorder is different from unipolar depression in that symptoms of mania and hypomania arise that are often associated with varying degrees of agitation, euphoria, impulsivity, irritability, and psychotic ideation.

The following case study will track the course of bipolar disorder in an eighteen-year old male, Elliott Smith. This paper will compare his course of bipolar disorder to that of the *DSM-IV* criteria, while also highlighting some of the causes, treatments, and research about bipolar disorder.

The *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* or *DSM-IV* serves as the basis for the diagnosis of many mental disorders that are commonly accepted throughout the country. The *DSM-IV* defines bipolar disorder to be a mélange of affective disorders, which may include the following: (a) major depressive episode, (b) manic episode, (c) mixed episode, and (d) hypomanic episode. (Beck, et al., 2002).

* Name changed to protect subject identity

In the diagnosis of a major depressive episode, anhedonia, or a low depressed mood with the loss of interest or pleasure in the ability to enjoy things, is the most profound occurrence. These symptoms must occur everyday during a two-week period. If the severity of the these symptoms affects the functioning in everyday life, then low energy, guilt, self-reproach, feelings of worthlessness, poor concentration and difficulty with decisions, sleep disturbances, significant changes in appetite and weight, extremes in psychomotor activity, marked reduction in libido, and suicidal ideations are assessed as well (Beck, 2002). However, a patient need only display five of the above symptoms to be diagnosed with a major depressive episode. In order for the diagnosis to be accurate, the symptoms must not be due to the direct physiological affects of a substance, psychotropic medication, normal bereavement, or a general medical condition (Rosenhan, et al., 2001).

A full-blown manic episode must take place at some point in the course of bipolar disorder in order to have the appropriate diagnosis. In manic episodes, a distinct period of abnormally and persistently elevated, expansive, or irritable mood that lasts at least one week must occur. Inflated self esteem, decreased need for sleep, pressured speech, flight of ideas and racing thoughts, disorganization, distractibility, excessive goal-directed activity, and pursuit of high stimulation are common occurrences (Beck, 2002). As with major depressive disorder, the symptoms in manic episodes are not due to the direct physiological effects of a substance or a general medical condition.

A mixed episode can take place when a clinically significant disruption in interpersonal-social and academic–vocational functioning occurs. These individuals demonstrate rapidly alternating moods within the context of an overarching manic presentation. Thus a mixed episode is a severe manic state that involves a mixture of excessive depressive features. Mixed episodes

represent a more serious form of bipolar disorder, and they are accordingly more difficult to treat from a pharmacological standpoint (Boland & Keller, 1999).

Finally, a hypomanic episode is comprised of mood disturbances that are similar to a full-blown manic syndrome with less duration, intensity, and disruption of life activities (Beck, 2002). Patients often demonstrate an expansive mood, decreased need for sleep, distractibility, increased goal-directed activity, and sometimes impulsivity regarding hedonistic behaviors.

Elliott Smith was about fifteen years old when he first started demonstrating atypical moods that mirrored bipolar disorder. These symptoms appeared during his freshman year of high school. Whether or not it was the new, overwhelming environment, or the change of pace, or a fear in general of school, his behaviors definitely reflected a change. Luckily, his parents were knowledgeable enough to recognize these symptoms in their son and Elliott was able to receive therapy and medication. It is notable that Elliott has a maternal uncle who had also been diagnosed with bipolar disorder. Also notable is the fact that Elliott had been receiving on-going treatment since childhood for Attention Deficit Disorder. Because the highly skilled and experienced mental health professionals involved were aware of the family history of bipolar disorder, the professionals were able to diagnose and treat Elliott in a timely and effective manner. Elliott and his family were very fortunate to have the highly skilled and sympathetic professionals to guide them in this treatment.

Elliott's sleep patterns were the first sign of abnormal behavior. Although Elliott had suffered from periods of sleeplessness since he was nine years old, until his high school years, Elliott had been able to use standard relaxation techniques. In Elliott's teen years, sleep seemed to elude him. He often had trouble falling asleep and would claim to just lie in bed wide-awake, unable to fall asleep for hours at a time. His physicians examined many angles. Perhaps it was a result of his stimulant medication. But, because this pattern was especially evident in the winter

months, this cause was all but ruled out. Even though Elliott's parents regulated his bedtime at a decent hour, he was unable to fall asleep. He claimed that thoughts would race through his head and liked to blast rock music really loud when he was lying in bed trying to fall asleep. Additionally, he had "grandiose thoughts"(as defined by his psychiatrist) during the times when he could not sleep. Elliott often joked that he claimed to have invented a new Mathematical theorem during the sleepless periods. He often told of his "genius ideas". When Elliott finally did fall asleep, it was often not until 3AM, and then he would have trouble waking up in the morning to be ready for school on time. This resulted in a constant struggle in the mornings for Elliott to be ready for school. This turned into a couple of months of chronic tardiness on his behalf.

Regarding the causes of bipolar disorder, psychologists have determined that hereditary factors, biochemical imbalances, stressful life events, and cognitive styles all contribute to the manifestation of the disorder. Thus it appears to be the interactions between genetics and environment that produce the majority of cases. Bipolar disorder tends to run in families. Relatives of those with the disorder have higher rates of bipolar disorder than do relatives of those with unipolar depression or no disorder at all. (DePaolo, et al., 1989). Twin studies have shown a seventy percent concordance rate for bipolar disorder, which indicates a hereditary component. (Rosenhan, 2001). It is entirely possible that Elliott's bipolar tendencies are a genetic component because professionals have diagnosed at least one person in his extended family with the disorder.

Biochemical imbalances often create bipolar symptoms. Depression is a disorder of motivation caused by chemical abnormalities in the brain systems containing a class of transmitters known as monoamines. The specific monoamines implicated in this biogenic amine theory of depression are norepinephrine, dopamine, and serotonin (Rosenhan, 2001). Goodwin and Jamison (1990) proposed that fluctuations in serotonin levels might be responsible for the wide range of mood and activity states of manic-depressive illness. In Elliott's situation, after many trial and error

medicine dosages, he was eventually prescribed lithium carbonate, which made his mood more stable and his sleep more regular. Lithium carbonate is a drug that helps to regulate one's mood. It has been shown to be effective in both manic and depressive aspects of bipolar disorder.

Stressful life events can also act as triggers of bipolar disorder. A recent loss, or the thwarting of goals, a breakup, separation, or a failure precedes many cases depression. Johnson and colleagues (Johnson, et al., 2000) suggest that negative life events predict bipolar depression, but that in combination with a high behavioral activation system, they can trigger mania. Additionally, low social support and low self-esteem are more apt to trigger bipolar depression than mania, but excessive focus on goal attainment can stimulate the onset of a manic episode.

The final vulnerability factor toward bipolar disorder is a person's cognitive style. Certain attribution styles in combination with life events can predict hypomanic mood shifts (Alloy, et al., 1999). For instance, individuals with negative attribution styles exhibited affective symptoms following stressful life events (i.e., unexpected death of a loved one). Also, people who demonstrate abnormally negative mood problems, even in the context of occasional bouts of hypomania and mania, still have significantly more negative cognitive styles than those who had no clinically depressive episodes as part of their phenomenology (Alloy, 1999). Mania is often related to an ongoing sense of low self-worth, even though patients do not endorse this readily on self-report inventories.

As Elliott's freshman year became more demanding from the amount of schoolwork and the pressures of being on the high school dive team, his frustrations were often exhibited in the form of rage. These rage episodes often involved violence directed toward an object. It was not uncommon for him to punch through a wall in the house, or to break down his bedroom door, or to break the box spring on his bed. When he was in these rage mindsets, it was hard to calm him down, and the family learned that it was most productive to leave him alone to let the anger subside. The family

was given the professional guidance to treat these episodes as a “temper tantrum” might be treated in a preschooler. Elliott was left alone in his room until he eventually became more rational. These manic episodes were very taxing on the family

Coincidentally, these episodes were the worst in the middle of winter. Maybe the impact of the shortened, colder days affected Elliott’s mood swings. While everyone experiences some degree of seasonal effectiveness, Elliott was an extreme case. He was very unpleasant to be around in the winter months, his most manic season. It should be noted that treatment for Seasonal-Effective Disorder through use of a sun-box proved ineffective for Elliott. Often, he would come home from school and would just plop in front of the television for hours at a time, and would become angry when his parents tried to motivate him. His belligerent attitude was taxing and hard on the family. Fortunately for Elliott, he was extremely bright and had a good support system with his family, his school counselor, and his mental health professionals. Elliott’s mother reduced her work schedule to enable her to be Elliott’s full-time tutor. Upon several occasions, Elliott’s therapist made visits to school to assist Elliott or to inform his teachers. These difficult efforts were worth the price. Elliott’s grades remained in the average to above average categories, with notable achievements in science and math.

However, as the school year drew to a close, a remarkable change occurred in Elliott’s attitude and mood. In May and June, he was actually ready on time for school and developed a more regular sleeping schedule. Was this new shift a result of the nicer weather, the fact that the stressors of school were about over for the summer, or a combination of both? He was very engaging and his sense of humor had returned. His rage outbursts had decreased and everything seemed to be better. Once school was out, he worked his first summer job as a lifeguard. And his mood seemed to really improve, almost to a happy level. He thrived as a lifeguard and enjoyed teaching swim lessons. He was very dedicated to his work. At one point, Elliott’s family believed

that maybe this whole past year was just a prolonged adjustment to high school. Sadly, this was not the case.

Although Elliott was extremely positive in his attitude for about five months, his raging moods and sleep disturbances came back around November of that year. The same symptoms of inability to sleep, rage, thoughts racing through his head, violence, etc., arose. The winter months were just unbearable at some points. Although Elliott remained on his medication schedule, he hit his all time low. At one point, hospitalization was a great possibility. Elliott's family and his mental health professionals did all they could to support his situation to the best of their abilities. After many months of persistence and care, eventually, they found a therapist who Elliott enjoyed seeing on a weekly basis. Also, the dosage of lithium carbonate was increased and the medication Risperidone was added to Elliott's medication list along with a small dose of Gabapentin added at bedtime. Risperidone helped to control the more manic symptoms, or in Elliott's case, the anger and rage symptoms of his disorder. The Gabapentin helped the racing thoughts at night so he could sleep. It took the physicians many consultations and trials to find the optimum dosage to minimize Elliott's mood swings.

The treatment for bipolar disorder should be broad based. A combination of pharmacotherapy, cognitive therapy, family interventions, and social support are the most effective in the outcome of bipolar disorder. Although antidepressants have been reported to be effective in treating bipolar depression, they have also been reported to induce manic switch and rapid cycling (Yatham, 2000). In Elliott's case, he was unable to tolerate antidepressant treatment. Also, Elliott's psychiatrist felt strongly that treating the mood issue would result in an improvement in Elliott's depression. He was correct.

Although many people with bipolar disorder are given doses of lithium, which has been proven to alleviate some symptoms, this often works best when it is combined with other

interpersonal therapies. However, some side effects of lithium can result in quite toxic overdoses, and thus it is a precarious drug to prescribe to patients with bipolar disorder who are far from conscientious about taking their medications (Rosenhan, 2001). As in Elliott's case, a conscientious mental health professional required regular blood tests to rule out lithium toxicity. Other medicines that have similar results include Valproate, Carbamazepine, Gabapentin, Topiramate, and Lamotrigine.

In the diathesis-stress approach to treating bipolar disorder, therapists can emphasize the use of cognitive skills to weigh against emotional waves and behavioral impulses. The initial therapy involves a mutual education process between the patient and the therapist in which patients provide information about their personal history and the course of their illness. The aim is to improve hopefulness and reduce the risk of suicide. Other cognitive therapy techniques involve weighing the pros and cons of important life decisions, modifying perceptions of marital and family interactions, and reducing the harmful sense of stigma and shame that is often associated with bipolar illness (Beck, 2002). Teaching these skills is a significant aide to the overall treatment of bipolar patients and goes a long way toward improving the quality of their lives.

In an extreme situation, when other treatments and medicines are not effective, Electroconvulsive Therapy, or ECT, may be effective. ECT gives a small electric charge to the body to make the person convulse for a few minutes. ECT provides quick relief and usually results in the end of a depressive or manic episode, but it may leave the person with little memory of the events around the time of ECT (Court & Nelson, 1996).

After that really bad winter, Elliott continued his medications of Lithium, Risperidone and Gabapentin. Again, the lithium dose was adjusted and he continued his cognitive therapy on a weekly basis. He developed a close relationship with a therapist that he trusted and could relate to. The therapist helped him to realize that his manic phases would often contrast with his depressive

phases, and that in order to balance these out, he needed to have a regular sleep schedule that did not involve him staying up until 3AM. The therapist made him realize that a shift in a normal sleep pattern brought on a bad day. At first, this was an adjustment for Elliott. He had no control over his sleep. However, his parents were very devoted to ensuring that he receive the proper amount sleep. They imposed strict sanctions on the household. All the lights that could be seen from his bedroom had to be off by 11PM every night and the house was to be silent. That was an order. He was only allowed to play music for a certain amount of time. This approach did indeed help his sleep patterns to be more regular. Even on the weekends, the therapist recommended that he be in bed before midnight to prevent lag in the middle of the week.

It appeared that sleep was a large factor in the quality of Elliott's days. If he fell out of the regime for even one night, things went wrong the next day. The therapist helped him to realize this. Elliott became more accustomed to following a bed schedule. A few times when he did not adhere to the sleep schedule, a migraine headache would emerge within twenty-four hours. At the onset of a migraine, he was incapable functioning and had to remain in bed all day. His doctor prescribed migraine medication. Fortunately, Gabapentin was useful in treating the migraines.

Gradually, Elliott has learned to monitor his sleeping habits through the support of his family and the aide of his therapist. It has been a long road. However, he appears to be on the right balance of medication and has fewer and fewer manic and depressive episodes. And although these episodes will never go away forever, they are less frequent in duration. He has been stable for over eight months currently. At this time, it appears that Elliott must regard his lithium as a life-long medication. Studies have shown that often lithium is less effective if a patient disregards the medication for a period and then restarts his medication. It is notable that Elliott's uncle, who regularly takes lithium, has been able to control his symptoms for over a decade.

In summary, the stages of bipolar disorder are often quite disturbing and the opposite extremes can be very taxing on the patient and their family. Episodes of rage, elated abnormal feeling of elation, sleeplessness, and lack of being in touch with reality are but some of the symptoms of bipolar disorder. Bipolar disorder has many hypothesized causes including genetic-biochemical variables, socio-environmental stressors, and cognitive styles. From the professional standpoint, bipolar disorder is very difficult to diagnose because the symptoms must be viewed over a long period of time. For Elliott, his cyclical difficult periods are during the winters. Many bipolar patients cycle in and out of the highs and lows on a daily basis. However, there is hope with the new treatments that are emerging. Treatments have the best chance of succeeding if they are applied early and consistently. Over eighty percent of bipolar depressions can now be greatly helped by lithium and cognitive therapy. It is most notable that Elliott was able to receive an early and definitive diagnosis and a variety of behavioral and pharmacological treatments. Elliott has taken direct responsibility for his medication and sleep schedule. Because of his excellent progress he will be attending a major university and living on campus in the fall. Because his physician and therapist are located in the same city as the university, he will maintain his regular appointment schedule.

Bibliographical References

- Alloy, L.B., Reilly-Harrington, N.A., Fesco, D.M., Whitehouse, W.G., & Zechmeister, J.S. (1999). Cognitive styles and life events in subsyndromal unipolar and bipolar disorders: Stability and prospective prediction of depressive and hypomanic mood swings. *Journal of Cognitive Psychotherapy: An International Quarterly*, 13, 21-40.
- Beck, A. T, Gyulai, L., Leahy, R., Newman, C.F., & Reilly, N. (2002). *Bipolar disorder: A cognitive therapy approach* . Washington DC: American Psychological Association, 4-38.
- Boland, R.J., & Keller, M.B. (1999). Mixed-state bipolar disorders: Outcome data from the NIMH Collaborative Program on the psychobiology of depression. In J.F. Goldber & M. Harrow (Eds.), *Bipolar disorders: Clinical course and outcome* 115-128. Washington DC: American Psychiatric Association.
- Court, B.L., & Nelson, G.E. (1996). *Bipolar puzzle solution: A mental health client's perspective*. Washington D.C.: Accelerated Development.
- DePaolo, J.R., Simpson, S.G., Folstein, S., & Folstein, M. (1989). The new genetics of bipolar affective disorder: Clinical implications. *Clinical Chemistry*, 35 (7). 28-32.
- Goodwin, F.K., & Jamison, K.R.,. (1990). *Manic-depressive illness*. New York: Oxford University Press.

- Johnson, S.L., Meyer, B., Winett, C., & Small, J. (2000). Social support and self-esteem predict changes in bipolar depression but not mania. *Journal of Affective Disorders, 58*, 79-86.
- Kesler, R.C., McGonagle, K.A., Zhao, S., Nelson, C.B., Hughes, M., Eshleman, S., Wittchen, H.U., & Kendler, K.S. (1994). Lifetime and 12-month prevalence of SWM psychiatric disorders in the United States: Results from the National Comorbidity Survey. *Archives of General Psychiatry, 51*, 8-19.
- Rosenhan, D.L., Seligman, M.E., & Walker, E.F. (2001). Abnormal psychology 4th edition. 249-300. New York: W.W. Norton & Company, Inc.
- Yatham, L.N. (2000). Safety and efficacy of risperidon as combination therapy for the manic phase of bipolar disorder: Preliminary findings of a randomized, double-blind study. *International Journal of Neuropsychopharmacology, 22*, 1-21.