Review Article

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Review of Literature Mania Disorder

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Abstract

Bipolar disorder, mania is a maladaptive response to loss and his been referred to as the "mirror image of depression". Genetic influences have been strongly implicated in the development of the disorder. Various other physiological factors, such as biochemical and electrolyte alterations, as well as cerebral structural changes, have been implicated. Side effects of certain medications may also induce symptoms of mania . No single therory can explain the etiology of bipolar disorders,and it is likely that the illness is caused by a combination of factors. Symptoms of mania may be observed on a continuum of three phases,each identified by the extent of severity : phase I, hypomania; phase ll , acute mania; and phase lll, delirious mania.

Keywords: Bipolar disorder; Mania disorder; Genetic influences; hypomania.

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Introduction

Bipolar disorder is characterized by mood swings from profound depression to extreme to euphoria (mania), with the intervening periods of normally. Delusions or hallucinations may or may not be a part of the clinical picture and onset of symptoms may reflect a seasonal pattern.

A somewhat milder reprentation of this clinical symptoms picture is called Hypomania. Hypomania is not sevre enough to cause marked impairment in social or occupational functioning or to require hospitalizations,and it does not include psychotic features.

Bipolar disorder is a serious illness associated with significant psychosocial morbidity and excess mortality. Recent research carried out by world health organization initiative in community adults from 11 centuries worldwide indicated that bipolar disorder, when defined to include milder variants such as bipolar ll disorder and subthershold bipolar disorder , has a lifetime prevenlence of 2.4%.

Definition

Mania is a distinct period which there is an abnormally and persistently elevated, expansive and irritable mood.

This period of abnormal mood must last atleast 1 week and present most of the day, nearly everly day (Or any duration if hospitalization is necessary).

Etiology: Neurotransmitter and structural hypotheses.

-Elevated Norepinephrine and dopamine

- Genetic consideration

- Higher risk in monozygotic twins.
- First degree relatives 5-10%

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- Identical twin (monozygotic) with bipolar disorders 40-70%.

- Psychodynamic theroies

- Faulty family dynamics therory early life.
- Defense or denial of depression.

Affected symptoms

- *Euphoria (stage l):* Increase sense of psychological well being and happiness not in keeping with ongoing events.
- *Elation (stage ll):* Moderate elevation of mood with increased pyschomotor activity.
- *Exaltation (stage lll):* Intense elevation of mood with delusions of grandeur.
- *Ecstasy (stage lV):* Severe elevation of mood, intense of rapture or blissfullness seen in delirious or stuporous mania.

Symptom

- Feeling very happy
- Talking very quickly
- Feeling self important
- Suicidal thoughts
- Waking up early
- Feelings of guilt and despair
- Self doubt
- Difficulty in sleeping

Treatment

Antipsychotics drugs: quetiapine, ziprasidone, and aripiprazole.

- Pharmacotherapy

- *Lithium:* 900 - 2100 mg/day
- *Carbamazepine:* 600 - 1800 mg/day
- *Sodium valproate:* 600 - 2600 mg/day .
- *Others drugs:* Clonazepam, calcium channel blockers etc.

- Electroconvuslive Therapy (ECT).

- Psychosocial Treatment

- Family and marital therapy

Material and Methods

The study was Vimhans hospital in Delhi. It was a cross-sectional descriptive study for which we did purposive sampling technique according to certain inclusion and exclusion criteria. The study included bipolar-I patients (according to DSM-IV criteria) that had a ≥ 2-year history of either lithium or valproate prophylaxis as monotherapy. The response rate in the patients with unipolar mania and classical bipolar disorder were compared. Then, the response rate to lithium in all the patients with a manic episode rate <50% and >50%, and <80% and >80% during their course were compared. Finally, the above comparisons were repeated, excluding the patients with unipolar mania.

Discussion

Traditionally, observed rated: scales have used to measure manic states only more recently. The latter have the advan-tage of being able to assess the patient's internal states and avoiding possible misinterpretation of clinicians, al-though some authors argued that their subjective nature makes them at risk of exaggeration or understatement of symptoms.

In contrast, in routine clinical practice no one would argue that rating scales eliminate the need for a competent psychiatric evaluation, considering that there are no special questions on the scales that are unfamiliar to a competent clinician 50. Nonetheless, scales are very useful in clinical practice when it comes to making sure that specific and standardized questions (e.g. suicidal ideation) are consistently asked and recorded.

Moreover, evidence that the administration of rating scales might improve the efficiency of diagnostic evaluation outside clinical trials (characterized by well-defined inclusion/exclusion criteria) is still controversial 30 28 51. In particular, two potential negative consequences have been commonly reported with the systematic assessment pro-vided by self-rating scales for mania in clinical settings. On the one hand, the sensitivity of several instruments is around 60-65%, and clinicians who rely on screening scales that use the first stage in a two stages Process for diagnosing for bipolar disorders are at high risk of missing the correct diagnosis in approximately one-third of patients.

Conclusion

Once an accurate diagnosis is established, hypomania and mania associated with bipolar I disorder need to be managed effectively. Depending on patient characteristics, support systems, and the acuity of the episode, the treatment may be administered in an ambulatory or hospital setting.

In assessing risk factors, it is important to consider marital status, gender, age, religion, socioeconomic status, ethnicity, occupational, precipitating stressors, coping strategies, seriousness of intent and lethality and availability of method.

Treatment of mood disorders includes individual, group, family, and cognitive therapies. Somatic therapies include psychopathology and ECT. Nursing care is accomplished using the six steps of nursing process.

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