Robert P. Reiser
Larry W. Thompson
Sheri L. Johnson
Trisha Suppes

Advances in Psychotherapy –
Evidence-Based Practice

Bipolar Disorder

2nd edition

hogrefe

Bipolar Disorder

About the Authors

Robert P. Reiser, PhD, is a cognitive behavioral therapist in private practice focusing on treatment of individuals and families with serious mental illness and a Fellow of the Academy of Cognitive Therapy. He supervises graduate clinicians in training and provides workshops, consultation, and technical assistance with a goal of improving treatment of bipolar disorder and schizophrenia in community mental health settings. Dr. Reiser currently works as a consultant with the Felton Institute in San Francisco providing supervision and training for clinicians and case managers using cognitive behavioural therapy for psychosis (CBT-P), and supervises medical residents at the University of California, San Francisco in the Department of Psychiatry.

Larry W. Thompson, PhD, received his doctorate from Florida State University in 1961. Since then he has held the rank of Professor at three universities, Duke University, University of Southern California, and Stanford University. Dr. Thompson's recent interests have focused on the problems and issues involved in transporting evidenced-based psychotherapeutic interventions from the research laboratory into community settings**.**

Sheri L. Johnson, PhD, is Professor of Psychology at the University of California Berkeley, and the Director of the Cal Mania (CALM) team. She has published over 200 manuscripts and five books. Her research has focused on psychological aspects of bipolar disorder for the past twenty years, with funding from the National Alliance for Research in Schizophrenia and Depression (NARSAD) and from the National Institute of Mental Health.

Trisha Suppes, MD, PhD, is Professor at Stanford University in the School of Medicine Department of Psychiatry and Behavioral Sciences and Director of the Bipolar and Depression Research Program at Palo Alto Veterans Affairs. Her research focuses on improving diagnoses, treatment, and best care practices for patients with bipolar disorder and depression. Recent work includes exploring the biological basis of mood disorders and personalized approaches to treatment.

Advances in Psychotherapy – Evidence-Based Practice

The basic objective of this series is to provide therapists with practical, evidence-based treatment guidance for the most common disorders seen in clinical practice – and to do so in a reader-friendly manner. Each book in the series is both a compact "how-to" reference on a particular disorder for use by professional clinicians in their daily work and an ideal educational resource for students as well as for practice-oriented continuing education.

The most important feature of the books is that they are practical and easy to use: All are structured similarly and all provide a compact and easy-to-follow guide to all aspects that are relevant in real-life practice. Tables, boxed clinical "pearls," marginal notes, and summary boxes assist orientation, while checklists provide tools for use in daily practice.

Bipolar Disorder

2nd edition

Robert P. Reiser
University of California, San Francisco, CA

Larry W. Thompson
Stanford University, Stanford, CA

Sheri L. Johnson
University of California, Berkeley, CA

Trisha Suppes
Stanford University, Stanford, CA

hogrefe

Library of Congress Cataloging in Publication information for the print version of this book is available via the Library of Congress Marc Database under the Library of Congress Control Number 2016956063

Library and Archives Canada Cataloguing in Publication
Reiser, Robert P., author
Bipolar disorder / Robert P. Reiser (University of California, San Francisco, CA), Larry W. Thompson (Stanford University, Stanford, CA), Sheri L. Johnson (University of California, Berkeley, CA), Trisha Suppes (Stanford University, Stanford, CA). -- 2nd edition.
(Advances in psychotherapy--evidence-based practice ; v. 1)
Includes bibliographical references.
Issued in print and electronic formats.
ISBN 978-0-88937-410-2 (paperback).--ISBN 978-1-61676-410-4 (pdf).-- ISBN 978-1-61334-410-1 (epub)
1. Manic-depressive illness. I. Thompson, Larry W., author II. Johnson, Sheri L., author III. Suppes, Trisha, author IV. Title. V. Series: Advances in psychotherapy--evidence-based practice ; v. 1

RC516.R45 2016 616.89'5 C2016-906770-X
C2016-906771-8

Cover image based on photo © KatarzynaBialasiewicz – iStock.com

http://www.hogrefe.com

PUBLISHING OFFICES
USA: Hogrefe Publishing Corporation, 7 Bulfinch Place, Suite 202, Boston, MA 02114
Phone (866) 823-4726, Fax (617) 354-6875; E-mail customerservice@hogrefe.com
EUROPE: Hogrefe Publishing GmbH, Merkelstr. 3, 37085 Göttingen, Germany
Phone +49 551 99950-0, Fax +49 551 99950-111; E-mail publishing@hogrefe.com

SALES & DISTRIBUTION
USA: Hogrefe Publishing, Customer Services Department,
30 Amberwood Parkway, Ashland, OH 44805
Phone (800) 228-3749, Fax (419) 281-6883; E-mail customerservice@hogrefe.com
UK: Hogrefe Publishing, c/o Marston Book Services Ltd., 160 Eastern Ave.,
Milton Park, Abingdon, OX14 4SB, UK
Phone +44 1235 465577, Fax +44 1235 465556; E-mail direct.orders@marston.co.uk
EUROPE: Hogrefe Publishing, Merkelstr. 3, 37085 Göttingen, Germany
Phone +49 551 99950-0, Fax +49 551 99950-111; E-mail publishing@hogrefe.com

OTHER OFFICES
CANADA: Hogrefe Publishing, 660 Eglinton Ave. East, Suite 119-514, Toronto, Ontario, M4G 2K2
SWITZERLAND: Hogrefe Publishing, Länggass-Strasse 76, CH-3000 Bern 9

Format: PDF

ISBN 978-0-88937-410-2 (print) • ISBN 978-1-61676-410-4 (PDF) • ISBN 978-1-61334-410-1 (EPUB)
http://doi.org/10.1027/00410-000

Preface

In the 10 years since our first edition, interest has continued to grow in the psychosocial treatment of bipolar disorder. A number of new randomized clinical trials have been completed. In the preface of our first edition we noted that, despite the substantial evidence supporting several psychological treatment approaches for bipolar disorder, these treatments were often not used by practitioners. Unfortunately, even with better treatment resources available, a wide gap remains between effective evidence-based treatments and the actual standard of care delivered in the community. The present state of affairs remains consistent with the picture presented in the National Institute of Mental Health (NIMH) white paper on research in mood disorders more than 10 years ago, which summarized that only about 10% of the treatments for depression (a far more common mood disorder) meet the standard guidelines for evidence-based care. This need not be the case. There is a wealth of research and treatment information available, and we aim to make this readily accessible to the individual practitioner. We seek to provide updated practical guidance for an evidence-based treatment of bipolar disorder while trying to avoid an overly narrow or complex approach. We have also attempted to address important problems likely to be encountered with the more challenging patients often seen in treatment settings such as community mental health clinics. We aim to provide the practitioner with an evidence-based, comprehensive, integrated approach to the treatment of bipolar disorder that is practical, easily accessible, and can be readily applied in clinical practice.

Assumptions for Use of this Book

This book presents a psychosocial treatment approach that does not substitute for standard psychiatric care. The treatment program presented here is designed to provide supplemental treatment for individuals who are receiving standard psychiatric care and medication management. Medical treatment should be a requirement of participation in any psychosocial treatment program, and, in most cases, patients with bipolar disorder will need to be on medication. Providing psychotherapy to patients with bipolar disorder without psychiatric care presents a serious risk and is contraindicated in most cases.

This guide assumes that the reader has some knowledge of treating individuals with more serious mental disorders. As these individuals are often seen in community settings, we discuss adapting treatment strategies to minimize attrition, address motivational issues, and maximize gains for complex multi-disordered patients in diverse, multi-disciplinary, community-based settings. This guide is not intended to substitute for the clinical supervision and requisite training required to treat patients with bipolar disorder, nor is it intended as a substitute for seeking professional medical and psychiatric advice about treatments or medication for each patient.

Acknowledgments

The first two authors wish to thank The Health Trust, a nonprofit foundation in San Jose, California, that generously supported their work with bipolar disorder for two years. Robert Reiser dedicates this book to honor and keep alive the memory of Tony Masini, a young psychologist who cared for people with serious emotional disorders and was a passionate advocate and spokesperson. All book royalties from the first author will be donated to NAMI. He also wishes to acknowledge the generous contributions of ongoing supervision, assistance, and mentorship of Monica Basco and the initial project support from Ellen Frank. Larry Thompson wishes to acknowledge the value of his wife's ongoing love and support. We are also indebted to our patients and our students who have been our best teachers. Sheri Johnson dedicates this book to her partner, Daniel Rose. Trisha Suppes dedicates this book to her two daughters Rebecca Ann and Kaegan Lee, and to the many wonderful teachers and mentors that have made her journey possible.

Robert P. Reiser
Larry W. Thompson
Sheri L. Johnson
Trisha Suppes

Contents

Preface v
Acknowledgments vi

1 Description 1
1.1 Terminology 1
1.2 Definition 3
1.2.1 Additional Considerations in the Classification and Diagnosis of Bipolar Disorders 5
1.3 Epidemiology 6
1.4 Course and Prognosis 7
1.5 Differential Diagnosis 9
1.5.1 Major Depressive Disorders 9
1.5.2 Substance-Induced/Medication-Induced Bipolar and Related Disorder 9
1.5.3 Disruptive Mood Dysregulation Disorder 10
1.5.4 Psychotic Disorders 11
1.5.5 Attention-Deficit/Hyperactivity Disorder 11
1.5.6 Personality Disorders 11
1.5.7 Medical Illness 12
1.6 Co-Occurring Psychiatric and Medical Disorders 12
1.7 Diagnostic Procedures and Assessment Tools 13
1.7.1 Assessment of Mania 14
1.7.2 Assessment of Bipolar Depression 15
1.8 Implications for Clinical Practice 17

2 Theories and Models of Bipolar Disorder 18
2.1 Biologically Based Disease Models 18
2.2 Psychoeducation 20
2.3 Interpersonal and Social Rhythm Therapy 21
2.4 Family-Based Treatment 22
2.5 Cognitive-Behavioral Treatment 23

3 Diagnosis and Treatment Indications 28
3.1 Decision Tree for Determining Optimal Treatments 29
3.1.1 Treatment Options for Young Adults 30
3.1.2 Treatment Options for Potentially Self-Damaging Behaviors . . 30
3.1.3 Treatment Options for Repeated Episodes of Mania/Hypomania Despite Medication Adherence 30
3.1.4 Treatment Options for Poor Recognition of Symptoms 32
3.1.5 Treatment Options for Persistent Subsyndromal Depression . . . 32

4 Treatment 33
4.1 Biological Approaches to Treatment 33
4.2 Psychosocial Approaches to Treatment 40
4.2.1 Structure and Course of Psychosocial Treatment 40

4.2.2 The Initial Phase of Treatment: Orientation and Engagement . . 42
4.2.3 The Middle Phase of Treatment: Skill Building – Filling the Tool Box. 52
4.2.4 The Final Phase: Maintaining Treatment Gains 69
4.3 Family-Focused Treatment 75
4.4 Self-Help Approaches and the Recovery Model 80
4.4.1 Combating Social Stigma 81
4.4.2 The Role of Self-Help and Support Groups 82
4.5 Mechanisms of Action of Psychosocial Approaches. 83
4.6 Efficacy and Prognosis of Psychosocial Approaches 84
4.7 Problems in Carrying Out Treatment 87
4.7.1 Addressing Manic Symptoms in Session 87
4.7.2 Suicide Risk Assessment and Management 90
4.7.3 Improving Treatment Adherence 92
4.7.4 Treatment of Co-Occurring Substance Use Disorders 95
4.8 Summary 96

5 Further Reading 97

6 References 98

7 Appendix: Tools and Resources 109

1

Description

Many people who are diagnosed with bipolar disorder are initially referred for medication treatment, with little consideration of psychosocial treatments. Many therapists worry about their capacity to treat bipolar disorder, as they are keenly aware of potential risks and (correctly) accept that medications are the first line of treatment. Reluctance to treat this disorder has increased therapists' doubts about treating bipolar disorder in private practice settings. When you consider how many facets of life and well-being are influenced by bipolar disorder, though, this would seem to be the perfect disorder to target for psychosocial treatment. Indeed, our own personal experiences suggest that, armed with some humility and some appreciation for the severity of the challenges, along with a well-stocked toolkit, helping people with bipolar disorder gain back a sense of control, promoting understanding of the disorder and its triggers, and considering ways to rebuild life domains damaged by episodes, is an incredibly rewarding endeavor. This book attempts to give the practitioner a firm foundation and background to undertake this work.

Medication plus psychosocial treatment is optimal in many cases

Because accurate diagnosis is a foundation for successful treatment, we begin by considering the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; APA, 2013), with fine-grained attention to differential diagnosis and the implications for clinical practice. Based on growing evidence of partial genetic overlap between schizophrenia and bipolar disorder, "Bipolar and related disorders" is now a separate chapter in the DSM-5. Some additional small changes were made in the criteria set, discussed below and throughout the book, based upon the best available evidence.

1.1 Terminology

Bipolar disorder (BD), previously known as manic depressive illness, is a mood disorder defined by manic symptoms of varying severity. Most people with BD will also experience depressive symptoms. Manic symptoms may involve changes in energy, impulsivity, behavior, and cognition. BD is usually characterized by an episodic course throughout the lifetime, resulting in significant impairment in social, interpersonal, and occupational functioning.

Emil Kraepelin compiled an enduring set of observations regarding the presentation and course of illness for patients with manic-depressive illness (Kraepelin, 1921), and many of the manic symptoms he observed continue to be featured in diagnosis. The DSM-5 (APA, 2013) and the *International Classification of Diseases* of the World Health Organization (Maier &

Sandmann, 1993) are the major systems in use internationally (see online materials for comparison). In the DSM-5, bipolar disorders (BDs) are grouped into the following mutually exclusive categories depending upon the severity and duration of symptoms during the lifetime.

- **Bipolar I disorder (BD I)** is characterized by at least one manic episode during the lifetime. Manic episodes, in turn, are defined by manic symptoms of sufficient severity to cause marked impairment in social and occupational functioning, to result in a psychiatric hospitalization, or to involve psychosis.
- **Bipolar II disorder (BD II)** is characterized by at least one hypomanic episode, as well as one or more major depressive episodes, during the lifetime. Hypomanic episodes are defined by manic-type symptoms in which symptoms are not long in duration nor as severe to cause marked impairment in social or occupational functioning, to warrant psychiatric hospitalization, or to involve psychosis. Depression episodes may be associated with psychotic symptoms, though this is seen less frequently then in patients with BD I depression.
- **Cyclothymic disorder** is characterized by mood instability over a 2-year period (or one year in children and adolescents) with hypomanic and depressed symptoms that do not meet full criteria for a manic episode or a major depressive episode.
- **Substance/medication-induced bipolar and related disorder** is defined by mood symptoms that have been triggered by use of or withdrawal from substances.
- **Bipolar and related disorder due to another medical condition** is defined by manic type symptoms that appear to be consequent to a medical condition.
- **Other specified bipolar and related disorders** has replaced the *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV-TR* (4th ed.) (DSM-IV-TR; APA, 2000) category of "Not otherwise specified." This category is now used to note four subcategories that do not meet full criteria for one of the above listed disorders: Short-duration hypomanic episodes (2–3 days) and major depressive episodes; hypomanic episodes with insufficient symptom count and major depressive episodes; hypomanic episode without a history of major depression episodes; and short-duration cyclothymia (less than 24 months).
- **Unspecified bipolar and related disorders** is intended for temporary use when insufficient information is available but it appears likely the person has some manic symptom history.

Specifiers, which have changed significantly in DSM-5, are used to denote important elements about the presentation or course of illness**.** Most specifiers are used for BD I and BD II illnesses, with some applicable to the other bipolar diagnoses**.** Current specifiers include:

- With anxious distress (new to DSM-5)
- With mixed features (new to DSM-5, applies to manic/hypomanic or depressive episodes)
- With rapid cycling
- With melancholic features

- With atypical features
- With psychotic features, which can be mood-congruent or mood-incongruent
- With catatonia
- With peripartum onset, which now includes peripartum as well as postpartum within 4 weeks of delivery
- With seasonal pattern (applies to depressive, hypomanic, and manic symptoms now)
- Further course specifiers:
- In partial remission or full remission
- Mild, moderate, or severe severity

The specifiers have significantly changed in DSM-5 compared to DSM-IV-TR. The new mixed features specifier is an important change in DSM-5. In an improvement over DSM-IV-TR, symptoms like irritability, distractibility, and agitation that are common to mania and depression, are not used in the mixed feature specifier criteria. Mixed states are important to detect, as they are related to the higher likelihood of suicidal behavior. Increased energy during depressive periods could also foster impulsive behaviors.

The new mixed features specifier, an important change in DSM-5

1.2 Definition

Table 1 presents the criteria for a **manic episode** or a **hypomanic episode** as described in the DSM-5. Increased activity or energy was added as a cardinal symptom in DSM-5, in part because this may be more reliably reported than mood states.

BD II criteria require the presence of at least one episode of major depression. Table 2 presents the criteria for a DSM-5 diagnosis of a **major depressive episode**. Although the diagnosis of BD I does not require the presence of an episode of major depression, the majority of people who experience manic episodes will experience at least one or more episodes of depression during their lifetime. Depressive and manic episodes can and do co-occur, and the mixed feature specifier is used when at least three symptoms of the opposite pole are present (see Table 3).

Over time, the DSM has given increasing attention to bipolar spectrum disorders. Cyclothymic disorder was introduced in DSM-III, and BD II was introduced in DSM-IV. As with BD I, both are considered long-term conditions. Accurate detection of bipolar spectrum disorders may require observing fluctuations over time. BD II is not just a subthreshold or a "light" version of BD I. This condition is stable over time, and involves significant depressive episodes, levels of functional impairment, and suicidality that are similar to those observed in BD I (Merikangas et al., 2011). As we will discuss, there is relatively little evidence concerning treatments for BD II.

BD II not a "light" version of BD I

As with other forms of BD, cyclothymic disorder is tied to poor outcomes. Youth with cyclothymic disorder have been found to have lower quality of life and fewer days of good quality of life than youth with serious medical illnesses (Freeman et al., 2009). Findings of two studies suggest that cognitive

behavioral treatment has promise for improving prognosis and quality of life (Van Meter & Youngstrom, 2012).

Table 1
DSM-5 Criteria for Manic and Hypomanic Episodes (Adapted from APA, 2013)

A. Abnormally and persistently elevated, expansive, or irritable mood and increased activity or energy
B. During this period, three or more (four if mood is only irritable) of the following changes from usual behavior are present to a significant degree and persistent:
   1. Increased self-esteem
   2. Little need for sleep (e.g., feels rested after 3 hours of sleep)
   3. More talkative than usual or pressure to keep talking
   4. Flight of ideas or subjective experience of racing thoughts
   5. Distractibility (attention overly drawn to irrelevant stimuli)
   6. Increased goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
   7. Excessive involvement in activities with potential painful consequences (e.g., reckless spending, sexual indiscretions, or unwise investments)
C. The episode is not caused by the direct effects of a substance (e.g., drug of abuse, an antidepressant medication, or other treatment) or medical condition (e.g., hyperthyroidism), unless symptoms persist after the effects of the somatic agent are no longer present
D. Symptoms are present most of the day, nearly every day

For a Manic Episode
Symptoms are present ≥ 1 week (or less if hospitalization is needed)
The symptoms cause marked occupational or social impairment, require hospitalization, or include psychotic features

For a Hypomanic Episode
Symptoms are present for ≥ 4 consecutive days
Unequivocal change in functioning, but not marked impairment or need for hospitalization
Psychotic symptoms are not present

Table 2
DSM-5 Criteria for a Major Depressive Episode (Adapted from APA, 2013)

A. Depressed mood or loss of interest or pleasure in almost all activities.
B. At least four of the following are present during the period of depressed mood or low interest:
   1. Significant weight loss or gain
   2. Sleeping too much or too little
   3. Psychomotor agitation or retardation that is observable by others
   4. Fatigue or low energy
   5. Worthlessness or excessive guilt
   6. Difficulty concentrating, making decisions, or thinking clearly
   7. Recurrent thoughts of death or suicide, or a suicide plan or attempt
C. Significant distress or impairment
D. Not due to a substance or medical condition
E. Symptoms are present nearly every day, most of the day, over a two week period

Table 3
DSM-5 Criteria for Mixed Features Specifier (Adapted from APA, 2013)

Manic or hypomanic episode with mixed features
At least three of the following are present most days during the episode:
1. Sad or depressed
2. Decreased interest or pleasure
3. Psychomotor slowing
4. Fatigue or decreased energy
5. Feelings of extreme worthlessness or guilt
6. Recurrent thoughts of death or suicidal ideation, plan, or attempt

Depressive episode with mixed features
At least three of the following are present most days during the episode:
1. Expansive or euphoric mood
2. Increased self-esteem or grandiosity
3. Hypertalkativeness or pressured speech
4. Flight of ideas or racing thoughts
5. Increased goal-directed activity or psychomotor agitation
6. Excessive involvement in pleasurable activities with likely painful consequences
7. Decreased need for sleep

1.2.1 Additional Considerations in the Classification and Diagnosis of Bipolar Disorders

The DSM-5 approach has been criticized because the diagnostic thresholds for the number of symptoms and duration was set in a relatively arbitrary fashion. Recent studies provide support for some of the thresholds defined, such as the four-day threshold for diagnosing hypomanic episodes (Miller et al., 2016).

Individuals whose symptoms do not surpass diagnostic thresholds for hypomania but whose symptoms still cause significant distress or impairment can be diagnosed with "Other specified bipolar and related disorder." Subthreshold variants such as this may be somewhat common in patients with depression. Up to 40% of patients presenting with a major depressive episode were found to have experienced at least one hypomanic symptom, with 20% experiencing at least 2 symptoms (Zimmerman et al., 2009). Detection of such symptoms can be improved by giving dimensional assessments of the relative severity of manic symptoms (as well as depressive symptoms), which we will discuss below.

Although there has been concern for some time that practitioners might be missing these important subsyndromal symptoms, there has also been a massive rise in the rate of diagnosis of BD. This increase in diagnosis has been particularly notable in youth in the US, with a 40-fold increase in rates of BD diagnosis observed between 1994 and 2003 among those younger than age of 18 years (Moreno et al., 2007). Two studies have now found that one-third to one-half of individuals who receive a clinical diagnosis of BD do not meet criteria when a more careful, structured diagnostic interview is used (Zimmerman et al., 2010). Once a patient is labeled with BD, the diagnosis typically remains

in the records for a long time. An inaccurate diagnosis could lead to inappropriate use of medication, stigma, and inappropriately targeted treatment such as diminished accessibility of antidepressant medication. Hence, one of our goals in this volume is to provide careful guidelines for accurate diagnosis. Clinicians will want to attend to hypomanic symptoms that lead to distress or impairment without surpassing the threshold for hypomania, but it is equally important to avoid over diagnosing BD. Efforts were made in the DSM-5 to increase diagnostic specificity without loss of sensitivity, for example, by adding increased activity to the criteria A for mania and hypomania. It was hoped that including a fuller range of symptoms as captured by the mixed features specifier would improve diagnostic reliability.

Specificity and diagnostic validity a concern

1.3 Epidemiology

As noted above, bipolar spectrum disorders are more common than BD I. The World Health Organization World Mental Health Survey Initiative is the largest available study on the prevalence of BD. In this representative sample of 61,392 adults in 11 countries, the lifetime prevalence was estimated to be 0.6% for BD I, 0.4% for BD II, and 1.4% for subthreshold BD. There is debate about how common these subthreshold variants are, with some arguing that variants of BD other than BD I and II may affect 2–4% or more of people depending on definitions and sample (Regeer et al., 2004). In the US, higher prevalence estimates have been observed: 1.0% for BD I, 1.1% for BD II, and 2.4% for subthreshold BD (Merikangas et al., 2007). Relatively little is known about whether these cross-national differences are genuine. It is important to consider that culture influences stigma, acceptance of mental health problems, and comfort discussing symptoms. Cross-national variation in the prevalence of bipolar disorder has also been tied to fish oil consumption (Noaghiul & Hibbeln, 2003), as well as cultural emphasis on individualistic striving (Johnson & Johnson, 2014a). In contrast to unipolar depression, which affects nearly twice as many women as men, men and women are equally likely to suffer from BD I, though the ratios suggest more women than men are diagnosed with BD II. Among those diagnosed with BD, however, overall women experience more episodes of depression than do men and so may be more likely to seek treatment.

Cultural stigma is a factor in underdiagnosis

The onset of BD tends to occur around age 18–20, with about 50% of patients having their first episode before this age. Initial onset in older individuals above 50 years of age is seldom seen, though when this is observed a thorough assessment for physical causes such as metabolic or neurologic issues is warranted. Prepubertal and early adolescent onsets are observed, and are more common among those with a family history of mood disorders (Rihmer & Angst, 2005). Early onset is associated with more difficulty completing education, and so may set the stage for lower occupational attainment throughout the life course. Early onset is also related to higher rates of recurrence, co-occurring psychiatric disorders, and suicidality (Perlis et al., 2004).

Cultural differences have not been fully examined for BD. Although the prevalence of BD does not appear to differ by race or ethnicity, there are pro-

found concerns about the misdiagnosis and under treatment of minorities. A large body of research suggests that African-Americans with BD are highly likely to be misdiagnosed with schizophrenia (Snowden, 2001). In a nationally representative sample, not a single black person diagnosed with BD I was receiving adequate care (Johnson & Johnson, 2014b), and non-white Hispanic patients were also unlikely to receive adequate care (Salcedo, McMaster, & Johnson, in press). Poor treatment of minorities does not appear to be just an artifact of patient characteristics such as insurance status or treatment-seeking, suggesting that systematic provider biases in making diagnoses and selecting treatment options may be involved. Tendencies to misdiagnose minority individuals can be combated by using systematic, rigorous assessment tools. Given that culture influences emotion labeling and regulation, sleep patterns, individualistic striving, willingness to seek treatment, and expectations about treatment, this would appear to be an important area for ongoing research.

There are serious cultural disparities in care

Cultural differences influence diagnosis and treatment

BD is a major source of disability (Thomas, 2004). As might be expected, the economic burden for families, health care programs, and industry is immense. Some authors have argued that BD may be the most costly psychiatric disorder in the US (Peele, Xu, & Kupfer, 2003). Although family members of those with BD often achieve above average levels of success and creative accomplishment (Johnson, Edge, Holmes, & Carver, 2012; Kyaga, Lichtenstein, Boman, & Landen, 2015), the effects of the recurrent episodes take their toll on careers and employment. More than two-thirds of individuals fail to return to work in the year after a hospitalization for mania (Harrow, Goldberg, Grossman, & Meltzer, 1990), and, on average, those with BD (I or II) are unable to work for more than 2 months per year (Kessler et al., 2006). Accordingly, BD is related to higher risks of unemployment, poverty, and homelessness. These risks may be particularly high for those with BD I (Rihmer & Angst, 2005). Nonetheless, for both BD I and BD II disorder, severity of depression is a major predictor of difficulty in functioning (Judd et al., 2005; Kessler et al., 2006). The psychological toll on families and friends of bipolar patients is also of major importance. Often the economic and emotional stresses of coping with these symptoms eventually become so great that family members and other loved ones become overwhelmed. Addressing these social and occupational costs of BD is a core goal of psychotherapy for BD.

BD is a major source of disability

1.4 Course and Prognosis

The course of BD varies across individuals and across time, and also by subtype of disorder. Episodes can vary in duration from days to months, and in frequency, ranging from a single lifetime manic episode to rapid cycling of mania to depression within a single 24-hour period. The severity of depressive and manic symptoms can also range from minor perturbations in functioning to marked functional impairment with psychotic features. Bipolar spectrum conditions may differ in consisting predominantly of depression or mania.

BD I and II show a number of similarities as well as differences. For example, in one prospective longitudinal multisite study over a 10-year period (Judd et al., 2003), BD I and II were characterized by similar demographic

characteristics, high rates of substance use disorders and anxiety disorders, and persistent subsyndromal depressive symptoms that were a dominant concern. On the other hand, a number of differences between the two subtypes were observed. Substance use disorder was somewhat more common in BD I than BD II. Contrary to what one might think, BD II was related to slightly longer and more frequent mood episodes, including more subsyndromal depression than was BD I, leading to fewer weeks well (46% vs. 53%). These findings underline the need to aggressively treat both BD II and BD I.

BD II is associated with significant subsyndromal depression

Patients diagnosed with BD typically experience recurring mood episodes over their lifetime, even with best available pharmacologic treatment. The recurrent relapses and persistent subsyndromal symptoms interfere with day-to-day functioning for many patients. Co-occurring disorders will make the prognosis even worse. Without treatment this disorder can be particularly devastating, resulting in major disruptions in functioning accompanied by substantial losses of friends, family, and finances. The magnitude of the problems is illustrated in the findings of the Stanley Foundation Bipolar Network (Post et al., 2003). This multisite program implemented aggressive, highly flexible pharmacotherapy strategies to address mood disorders and other co-occurring conditions. Using the NIMH-Life Chart Methodology (Denticoff et al., 2000), these researchers followed more than 600 patients in treatment for 30 months. Two-thirds of the bipolar outpatients continued to be affected by symptoms. Even when researchers have carefully documented adequate blood serum levels of lithium, rates of relapse remain high (Keller et al., 1992). Even with the best available medication treatment, many patients will report concerns about break-through symptoms, and hospitalizations are too frequent. While medications are the cornerstone of BD treatment, additional modalities of treatment are needed.

Even with optimal medical treatment, there may be continuing symptoms

Suicide is a major concern in BD. People with BD have been estimated to be 20–30 times as likely to die from suicide as the general population (Pompili et al., 2013; Schaffer et al., 2015), and it has been argued that BD is the psychiatric condition with the highest rates of suicide (Ilgen et al., 2010; Nordentoft, Mortensen, & Pedersen, 2011). In one national study that followed people for 36 years after their first psychiatric treatment, 8% of men and 5% of women diagnosed with BD died from suicide (Nordentoft et al., 2011). More than half of those with BD report suicidal ideation within the past 12 months, and one in four persons diagnosed with BD I report that they have tried to attempt suicide (Merikangas et al., 2011).

Findings such as these emphasize that while essential pharmacotherapy alone is often not sufficient to eliminate symptoms and restore function completely, many patients want help coming to terms with their illness and learning prevention skills. In recent surveys, those with BD reported prioritizing the restoration of quality of life above symptom prevention. Psychotherapy is designed to help improve understanding of the illness and of the need for medications, to reduce relapse and subsyndromal symptoms, and to restore domains of life impacted by this illness.

Psychosocial treatment can impact quality of life and reduce relapse

1.5 Differential Diagnosis

In this section, we aim to give advice on differentiating the subtypes of **BD** from **major depressive disorder, disruptive mood dysregulation disorder, psychotic disorders, attention deficit disorder, personality disorders**, and medical illnesses that may trigger manic-type symptoms. For each, we highlight symptoms and other forms of overlap, and then consider characteristics that differ between disorders, such as diagnostic criteria, key signs and symptoms, family and patient history, and other qualitative factors.

1.5.1 Major Depressive Disorders

Even though major depressive disorder (MDD) might seem easy to differentiate from BD, differential diagnosis of MDD is the most common source of misdiagnosis and improper treatment of BD. BD II by definition involves episodes of depression. Although not all persons with BD I will experience depression, people are much more likely to seek treatment for depression than for mania. About 60% of patients with BD I or II present in an initial depressive episode (Judd et al., 2003). Many of these people may not spontaneously describe their history of manic symptoms, and so it is critical that therapists ask about experiences of manic symptoms carefully when patients report depressive symptoms because antidepressants administered without a mood stabilizer may induce mania among persons with BD I. Even in patients who initially deny a history of manic symptoms, it is important to continue to monitor for onset of manic symptoms. In one sample of patients followed for 15 years after hospitalization for a major depressive disorder episode, about 27% went on to develop hypomania and 17% went on to develop a manic episode (Goldberg, Harrow, & Whiteside, 2001).

Most patients present in the depressed phase

The most common reason for a failure to distinguish BD I is the failure to ask about mania history when a person presents with depression (Brickman, LoPiccolo, & Johnson, 2002). Taking a careful history of previous manic symptoms, supplemented by reports from family members and significant others, is key to proper diagnosis, and we will discuss tools to facilitate this below.

Always inquire carefully about a history of mania, hypomania

Remember that hypomanic episodes may not entail significant impairment, and so patients and caregivers may not be concerned by these episodes or raise them for consideration. In addition, patients may not correctly label symptoms of hypomania unless education is provided, especially if the individual is prone to mixed symtoms or "energized depression."

1.5.2 Substance-Induced/Medication-Induced Bipolar and Related Disorder

As noted in Table 4, many substances can trigger mania-like symptoms, including antidepressant medications. When a patient reports changes in substance use before the onset of mood symptoms, consider the timing of onset and whether symptoms remitted with discontinuation of substances. Generally, substance

Many substances can trigger mania-like symptoms

and antidepressant-triggered episodes are diagnosed as medication-induced mood disorder, and would not be considered toward a diagnosis of BD I or II. However, if symptoms persist after the effects of the physiological substances are not present, this can be considered evidence for a BD (see DSM-5).

Table 4
Substance/Medication-Induced Mood Disorder

- Mood symptoms developed while the patient was exposed to substances. The symptoms remit when the physiologic effects of the substance(s) are not present.
- The substances are capable of producing mood symptoms. Substances that commonly trigger mood changes include alcohol, amphetamines, cocaine, hallucinogens, other psychedelics, inhalants, phencyclidine, sedatives, hypnotics, anxiolytics, and antidepressants.
- Substances and medications may elicit many manic symptoms including elevated, irritable or expansive mood, altered activity, impulsive decisions, diminished sleep, or depressive symptoms, including depressed mood, diminished interest or pleasure in activities, guilt, or suicidal feelings.
- Mood symptoms may develop during intoxication, during initiation or discontinuation of a substance, or within one month of withdrawal from a substance.

1.5.3 Disruptive Mood Dysregulation Disorder

One of the cardinal symptoms of mania is irritability and anger, and there is some evidence that BD in children is also characterized by anger and irritability. Anger and irritability are also central features of disruptive mood dysregulation disorder (DMDD), a new diagnosis introduced in the DSM-5. The diagnostic criteria specify recurrent temper outbursts that occur an average of three or more times per week and are present for 12 months or more without remission of more than 3 months. Between temper outbursts, the child demonstrates persistent irritability. The diagnosis can be considered when symptoms develop before age 10.

DMDD added to diagnostic system to account for symptoms of anger and irritability

DMDD was added to the diagnostic system in part to address concerns over the growing misdiagnosis of BD in youth, which we discussed above. When clinicians focus strictly on rages as a reason for diagnosing BD, highly inaccurate diagnoses may result. In one study, one-third of youth who were hospitalized with clinical records of rages had been diagnosed with BD; with careful interviewing, however, only 9% met diagnostic criteria for BD (Carlson, Potegal, Margulies, Gutkovich, & Basile, 2009). Chronic irritability, arguing, and tantrums are predictive of anxious and depressive disorder onset over time, but do not predict BD (Stringaris, Cohen, Pine, & Leibenluft, 2009). Hence, when youth present with irritability and rages, consider whether those difficulties are associated with other manic symptoms, such as elevated self-esteem, decreased need for sleep, hyper talkativeness, goal-directed activity, or reckless behavior.

1.5.4 Psychotic Disorders

Patients with BD I can experience psychotic symptoms. Although the rate of hallucinations and delusions in some community samples diagnosed with BD appears to be less than 30% (Kessler et al. 2005), psychotic symptoms increase the likelihood of treatment and hospitalization in BD. Psychosis can also be present during depressive episodes of BD I or BD II, but are very uncommon in BD II (< 1%) (Judd et al., 2003). Most commonly, psychotic symptoms during bipolar episodes are mood-congruent, but they can be mood-incongruent.

When psychotic symptoms persist two weeks after all mood symptoms remit, a diagnosis of schizoaffective disorder is appropriate. Generally, BD patients rarely show psychotic symptoms unless mood symptoms are severe. Both BD I and psychotic disorder (PD) patients can have grandiose or persecutory delusions, as well as disorganized thinking and loose associations, suggestive of a thought disorder. Both are frequently agitated, highly irritable, and may show catatonic symptoms. However, there are a number of distinguishing features between BD and PD. Most importantly, BD I patients by definition have mood-related symptoms, whereas only some PD patients, such as those with schizoaffective disorder do (APA, 2013). BD I patients generally have higher premorbid functioning than do PD patients, lapse into an episode more precipitously than PD patients, and are more likely to return to a premorbid level between episodes. BD I patients are also more likely to have relatives who suffer from BD I or II.

Differential diagnosis: BD I vs. psychotic disorders

1.5.5 Attention-Deficit/Hyperactivity Disorder

Symptoms of **attention deficit with hyperactivity (ADHD**) and BD overlap significantly, as both can involve hyperactivity, distractibility, and impulsivity (Kent & Craddock, 2003). The mood-related symptoms, such as euphoric mood, inflated self-esteem, and grandiose ideas, though, are not included in the ADHD diagnostic criteria and so are helpful for differential diagnosis. Inattention co-occurring with these mood symptoms would not be considered evidence of ADHD. When inattentiveness persists in the absence of mood symptoms, this is more consistent with an ADHD profile.

Inattention in the presence of mood symptoms should not be diagnosed as ADHD

1.5.6 Personality Disorders

Mood symptoms may mimic symptoms of personality disorders and may intensify impulsivity, anger, reactivity, and other behavioral problems that are often seen as signs of a personality disorder. During depression, people may also overestimate the degree of difficulty they have had in their functioning. Consistent with this potential for over diagnosis, studies identify a 50% reduction in the rate of personality disorder diagnoses among remitted samples as compared to samples assessed during mood episodes (George, Miklowitz, Richards, Simoneau, & Taylor, 2003). Accordingly, avoid making firm diagnoses of personality disorders during acute mood episodes. In considering differential diagnoses, the most central issue is that BD is typically character-

Use caution when diagnosing personality disorders as BD symptoms can mimic other disorders

ized by fluctuating symptoms, whereas personality disorders represent more enduring patterns of behavior, typically beginning in adolescence or young adulthood. Gathering data about functioning over time, with corroboration from relatives and significant others, is advised in differentiating personality disorders from BD.

Both **borderline personality disorder** and BD I or II are characterized by primary problems with affective instability, difficulty regulating emotions, impulsivity, and significant periods of depressive symptoms. In particular, patients with BD with rapid cycling (more than four mood episodes in a 12-month period) may be inappropriately overdiagnosed as having borderline personality disorder. Manic symptoms, but not borderline personality symptoms, are related to heightened positive moods and intensive pursuit of goals (Fulford, Eisner, & Johnson, 2015). Residual mood symptoms related to BD can appear as a borderline personality disorder. If this is the case more aggressive medication treatment may address such residual symptoms. Significant response to medication is diagnostic for BD.

Manic symptoms also show some overlap with some symptoms of antisocial personality disorder. During a manic episode, individuals may become excessively involved in impulsive or pleasure-seeking behaviors (gambling, sexual indiscretions, etc.). Antisocial behavior that occurs exclusively during the course of a manic episode should not be diagnosed as antisocial personality disorder. The lack of remorse or indifference that characterizes antisocial personality disorder can be contrasted with the extreme regret, guilt, and remorse that individuals with BD I or II typically experience after a manic or hypomanic episode. Personality disorders are optimally diagnosed after symptoms remit or as a differential related to mood disorders.

1.5.7 Medical Illness

Medical illnesses, including neurologic disease, head trauma, concussion, endocrine disorders, and psychoactive substances, can cause bipolar-like symptoms. In most patients, BD symptoms will begin by the early twenties. Although neurological diseases are rare in this early age group, any such underlying cause of symptoms would be important to know as it would influence the course of illness and might suggest other treatments. There is debate if all BD patients should consider a brain scan to rule out neurological conditions such as tumor, because these explanations of symptoms are rare. For new onset of BD after the age of 50 though, secondary causes are likely and medical and neurological examinations are justified.

1.6 Co-Occurring Psychiatric and Medical Disorders

Co-occurring disorders are more the rule than the exception in BD; most people with BD will meet criteria for an additional disorder (Merikangas et al., 2011). About 75% of bipolar patients meet diagnostic criteria for anxiety disorders during their lifetime, and 42% meet the diagnostic criteria for alcohol