Bipolar Disorder: Overview, Diagnostic Evaluation and Treatment
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Bipolar disorder, also called manic-depressive illness, is a serious mood disorder characterized by wide swings in mood, energy and activity levels. Though most patients with bipolar disorder experience depressions as a part of their illness, a manic, hypomanic, or mixed-manic episode is required to make the diagnosis of bipolar disorder.

A manic episode is characterized by an uncharacteristically elevated or irritable mood accompanied by disturbances of behavior including:
- Rapid and uninterruptible speech (pressured speech)
- Racing thoughts
- Restlessness
- Distractibility
- Decreased need for sleep
- Elevated self-esteem and unrealistic assessment of one’s capacities
- Increased goal-directed behaviors (e.g., new projects)
- Excessive engagement in pleasurable activities that are likely to have negative consequences (spending, gambling, substance use, sexual promiscuity)

In mania, the disturbances in mood or behavior can be so damaging, or the loss of sense of reality so extensive that patients must be hospitalized for their own protection. In a manic state, patients frequently do considerable damage to themselves through impulsive and risky behaviors and by damaging important relationships.

Hypomanic episodes are also characterized by elevated mood and energy levels and increased goal directed activities. The main difference between mania and hypomania is the degree of impairment (impulsivity, loss of reality). Patients with hypomania may also be quite high functioning, though hypomanic behaviors also frequently exact a toll on relationships.

Mixed manic episodes may be particularly destructive and dangerous, as the energy and impulsivity of mania are combined with intense dysphoria and/or depression rather than euphoria or grandiosity.

The depressions associated with bipolar disorder may resemble typical major depressive states, with disturbances of sleep, appetite, energy, and concentration, physical slowing (or agitation), loss of interest, feelings of hopelessness and worthlessness, and suicidal thoughts. Sometimes, there are subtle differences between regular (unipolar) depression and bipolar depression (e.g., bipolar may more frequently present with
excessive sleep and weight gain while unipolar depression tends more to present with sleeplessness and weight loss).

**How common is bipolar disorder? What are its causes?**

Bipolar disorder affects about 1 in every 100 people. There is a tendency for bipolar disorder to run in families. Children with a parent or sibling who has bipolar disorder are four to six times more likely to develop the illness, compared with children who do not have a family history of bipolar disorder. However, most children with a family history of bipolar disorder will not develop the illness. Painful life experiences play a similarly powerful role in the development of bipolar disorder. Early loss and/or trauma, in particular, predispose children to the development of bipolar disorder. Children who have lost their mother before the age of 5 are particularly vulnerable, with a fourfold increase in bipolar diagnosis. From a psychodynamic perspective, patients with bipolar disorder are frequently seen as struggling with issues of grief and loss.

**Diagnostic Evaluation for Bipolar Disorder**

Treatment of bipolar disorder begins with careful diagnosis. Because bipolar disorder frequently presents first with depression, or because patients with manic or hypomanic states frequently do not recognize themselves as having a problem, accurate diagnosis is frequently delayed. Though historically under-diagnosed, recent research suggests that bipolar disorder is currently over-diagnosed almost half of the time. There are no laboratory tests for bipolar disorder. Diagnosis is made by a detailed appraisal of symptoms and of family history, and by ruling out other conditions that present in similar ways.

Bipolar disorder may be confused with a number of different psychiatric conditions, including major depressive disorder, schizophrenia, substance use disorders, borderline personality disorder, narcissistic personality disorders, and reliance on manic psychological defenses. Effective treatment for any and all of these conditions hinges on accurate diagnosis.

Major depressive disorder sometimes presents with irritable mood and prominent agitation, restlessness and sleeplessness, features that are also common in mania. However, in the presence of a depressed or intensely dysphoric mood, a diagnosis of bipolar disorder should not be made unless the patient meets other criteria of bipolar disorder (described above).

Patient with schizophrenia can also present with extreme agitation, difficulty sleeping, grandiosity, paranoia, and difficulty making accurate assessments about what is real. Like some patients with bipolar disorder, patients with schizophrenia often experience hallucinations and delusions. Patients in an acute schizophrenic decompensation or a severe manic episode may be impossible to differentiate. Often, it is the history of the illness that allows an accurate diagnosis. Some patients have features of both bipolar disorder and schizophrenia and are diagnosed with schizoaffective disorder.
Patients who use substances may also be confused with bipolar disorder, presenting with drug induced sleeplessness, agitation, irritability, impulsivity, and grandiosity. If apparently manic states have occurred exclusively in the context of substance abuse, it can be difficult to make an accurate diagnosis. It is especially complicated given that patients with bipolar disorder often have co-occurring substance abuse disorders.

Borderline personality disorder is also frequently mistaken for bipolar disorder. Patients with borderline personality disorder can also present with marked shifts in mood, difficulty making realistic appraisals of the current situation (particularly when under stress), irritability, and impulsive pursuit of pleasurable activities with a high likelihood of negative consequences. Sleep disorders are also common in this population. Patients may also have both conditions, complicating the treatment of either condition.

Like patients with borderline personality disorder, patients with narcissistic personality disorders can present with marked shifts in mood, but these patients also generally present with a façade of grandiosity, which serves to defend a deeply wounded sense of self-esteem. These patients may be irritable and may make unrealistic plans, similar to patients with bipolar disorder.

Some patients rely on manic defenses while not being, in actuality, manic. These “manic defenses” are psychological defensive operations, the intent of which is to ward off bad feelings. Patients who rely on manic defenses generally keep themselves extremely active, are often involved in various goal directed behaviors, and may be impulsive as well. One could say that these patients attempt to keep busy enough that they have few opportunities to think or, especially, feel. Manic defenses and mania are not mutually exclusive. Patients who have bipolar disorder may use manic defenses to ward off depressed feelings. Patients with bipolar disorder may also, consciously or unconsciously, do things to cause a manic episode (taking drugs, disrupting sleep, stopping medications), given that mania can feel preferable to a deep depression, or even a normal mood.

Treatment of Bipolar Disorder
It is harmful to leave bipolar disorder untreated. Not only are there the acute risks of untreated mania (interpersonal chaos, financial and occupational problems, health consequences, and the risk of suicide), but there is also evidence that each manic episode increases the likelihood of successive manic episodes, leading to a long-term worsening of the illness. Optimal treatment of bipolar disorder most often involves certain lifestyle changes, consistent use of mood-stabilizing medications, and psychotherapy.

Everyone should attempt to adopt a healthy lifestyle, but this is especially important for patients with bipolar disorder. Regular sleep routines are key, as sleep disruption or sleep deprivation commonly destabilizes moods in bipolar disorder. Avoiding substances of abuse and excessive alcohol also promotes stable moods. A healthy diet and regular exercise may contribute to improved sleep, better mood, and can counteract weight gain associated with some medical treatments of bipolar disorder. It is also crucial for patients with
bipolar disorder to learn to recognize and manage stress. Stressful life events are a major predictor for bipolar relapse, even when patients adhere to their prescribed medications. Patients with bipolar disorder may also be quite sensitive to the stress levels in their families. Distressed families lead to worse outcomes for patients with bipolar disorder, so interventions that promote the healthy functioning of families may be useful.

Medications are an important part of the treatment of most people with bipolar disorder, and especially of those with more severe forms of the illness. Common treatments include mood stabilizers (Lithium, Depakote, Tegretol, Lamictal, Trileptal, and others) and atypical neuroleptics (Risperdal, Zyprexa, Seroquel, Geodon, Abilify, and others). Often, patients with bipolar disorder may require combinations of medications (polypharmacy) to adequately control symptoms of mania or depression. Sometimes antidepressants are added in order to help manage the depressive phase of the illness, but this is controversial, as evidence suggests that, for the average patient with bipolar disorder, antidepressants are likely to destabilize mood and exacerbate mood swings and manias. Natural treatments such as high dose fish oil (ω-3 fatty acids) may also help improve and stabilize moods.

Medication alone is less helpful to patients with bipolar disorder than a combination of medication and psychotherapy. Anecdotal and research evidence suggests that psychotherapy benefits these patients in a number of ways. In the largest study of its kind, researchers found that patients in psychotherapy (either cognitive-behavioral therapy, psychodynamic psychotherapy with a focus on relationships and social rhythms, or family therapy) had significantly better outcomes than patients receiving medications alone. Bipolar patients in psychotherapy experienced the greatest increases in treatment adherence, and the greatest reductions in relapse and re-hospitalization rates. These patients got well faster and stayed well longer.

Two related factors which frequently complicate the treatment of bipolar disorder are medication non-adherence and impaired insight into illness. Patients may resist treating their bipolar disorder because the euphoria associated with mania is, at least for a while, quite pleasurable and reinforcing. However, even when returned to a normal mood, patients frequently continue to exhibit an impaired ability to recognize that they have an illness that operates beyond their conscious control. Psychodynamic therapies, cognitive-behavioral therapies, and family psychoeducational treatments have all been shown to improve medication adherence in patients with bipolar disorder.

Insight oriented psychotherapy may help patients to use medications in more healthy and responsible ways by helping them to more accurately appreciate their strengths and limitations, to understand specific vulnerabilities and triggers for illness, to recognize the toll that their illness has taken on themselves and those around them, and to acknowledge, bear, and put in perspective the grief associated with the recognition that one has a significant illness. In the post-manic phase, psychotherapy and its context of a trusting therapeutic relationship may help patients face the grief, shame, and remorse often experienced in the wake of a manic episode. In the long term, patients with bipolar disorder may have to develop not only insight into illness, but also insight into health. In these situations, patients who have experienced the frightful loss of control...
associated with mania and who recognize that they have an illness may come to mistrust themselves, fearing
that experiences of joy or excitement are simply manifestations of illness. Psychotherapy may provide a space
in which patients can develop comfort with these feelings while learning to recognize the difference between
healthy joy and manic euphoria.

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