IN THIS CHAPTER

- Meeting the manual used to diagnose bipolar disorder
- Recognizing the two "poles" of bipolar: mania and depression
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Chapter 1
Grasping Bipolar Disorder: Symptoms and Diagnosis

When you initially encounter bipolar disorder, one of the first questions you're likely to ask is, "What is it?" The short answer is this: *Bipolar disorder* is a medical illness characterized by alternating periods of persistent abnormally elevated and depressed mood. The second question that most people ask is, "Can I get tested for it?" And the short answer is no. Doctors arrive at a diagnosis by conducting a physical and mental status examination; taking a close look at a person's symptoms, medical history, and family history; and ruling

out other possible causes. For guidance, doctors use a book called the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*), which presents the diagnostic criteria for determining whether a person is likely to have bipolar disorder.

This chapter digs deep into the *DSM* to reveal what bipolar disorder is and isn't. It describes what elevated and depressed moods look like and provides you with the details you need to tell the difference between the various bipolar diagnoses, including bipolar I, bipolar II, and a related cycling mood disorder called cyclothymia. We discuss diagnostic *specifiers* that enable doctors to more precisely describe a person's symptoms and inform their treatment decisions. We distinguish bipolar disorder from conditions that may have similar symptoms and discuss other conditions that commonly accompany bipolar disorder, such as alcohol and substance use disorder. We wrap up with a discussion of the challenges of diagnosing bipolar in children and young adults.

Cracking Open the Diagnostic Manual: DSM-5-TR

When a doctor in the United States diagnoses a mental illness, such as bipolar disorder, they turn to the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders (DSM)* for guidance. This manual defines numerous patterns of symptoms and illnesses that are supported by scientific research and a consensus among a wide variety of experts. During the writing of this book, the APA recommends using *DSM-5-TR,* the fifth edition text revision, which was published in March 2022. Don't be surprised if you see references to earlier editions, such as *DSM-IV,* the fourth edition.

Throughout this chapter, we describe the symptoms of bipolar disorder according to the diagnostic criteria presented in *DSM-5-TR.* Although the fundamental criteria haven't changed much over the past decade, some of the language has been modified and criteria have been added in the most recent edition to help doctors arrive at and describe a person's condition more precisely.

REMEMBER

Diagnosis isn't a simple matter of matching a list of symptoms to a label. Doctors are expected to use the *DSM* along with their training, clinical experience, and professional judgment to arrive at the correct diagnosis.

THE INTERNATIONAL CLASSIFICATION OF DISEASES (ICD)

Doctors in countries throughout the world rely on the World Health Organization's (WHO) *International Classification of Diseases*, a classification system for all health issues. Chapter V of the *ICD* specifically addresses mental and behavioral disorders. The first edition of DSM (DSM-I), in 1952, grew out of ICD-6, which was the first ICD to include a section on mental disorders. Since 1980, Medicare and Medicaid (and therefore all other insurers) have required an ICD-9 code to be submitted for payment to be made. The DSM-III was released at the same time, and it designated ICD-9 codes for all psychiatric diagnoses. When DSM-5 was released in 2013, the authors added ICD-10 codes in anticipation of the 2015 transition of all medical billing systems to ICD-10. Although the two systems have always had their differences, the current systems are closely aligned.

The APA and WHO work together closely to coordinate their efforts. So, in clinical practice, a doctor using one manual should arrive at a similar diagnosis as a doctor using the other.

Exploring the Poles of Bipolar Disorder: Mania and Depression

Bipolar diagnoses rely heavily on the type of mood episode(s) a person is experiencing or has experienced in the past, so to understand the different diagnoses, you need to know what constitutes a mood episode — specifically a manic, hypomanic, and major depressive episode. In the following sections, we present the *DSM-5*-TR diagnostic criteria for each type of mood episode.

Manic episode

A *manic episode* is a period of abnormally elevated energy and mood that interferes with a person's ability to function as typical for that individual. Merely having some manic symptoms isn't the same as experiencing a manic episode. The symptoms must meet the following four criteria.

Distinct period

The episode must last for at least one week *or* require hospitalization, and it must be characterized by atypically and persistently elevated, expansive, or irritable mood and atypically and persistently increased goal-directed activity or energy that's "present most of the day, nearly every day."

Three or more manic symptoms

Three of the following symptoms must also be present during the week of mania (four, if the mood is irritable rather than elevated or expansive). The symptoms must be present to a significant degree and represent a change from the person's usual behavior.

- Markedly inflated self-esteem or grandiosity
- Decreased need for sleep (for example, feeling well rested after three hours or less of sleep)
- Excessive talking or the need to talk continuously (pressured speech)
- *Flight of ideas* — when thoughts flow rapidly and topics shift rapidly and indiscriminately — and/or the feeling that one's thoughts are racing
- Distractibility — attention too easily drawn to unimportant or irrelevant external stimuli as reported or observed
- Significant increase in goal-directed activity (socially, at work or school, or sexually) or *psychomotor agitation* — purposeless, non-goal-directed activity)
- Excessive involvement in activities that have a high potential for painful consequences, including sexual indiscretions, unrestrained shopping sprees, and/or overly optimistic investments

Functional impairment

The mood episode must be severe enough to

- Impair the person's ability to socialize or work, or
- Require hospitalization to prevent the person from harming themselves or others, or
- Cause psychotic features (paranoia, hallucinations, or delusions) indicating that the person is out of touch with reality (see the section, "Presence or absence of psychosis," later in this chapter)

Not caused by something else

For a manic episode to count toward bipolar diagnosis, the mania must satisfy the following conditions:

- **The mania can't be exclusively drug-induced or attributed to medical treatments.** For example, if you're taking an antidepressant, steroid, or

cocaine at the time you experience manic symptoms, then the episode doesn't count toward a diagnosis of bipolar disorder, unless symptoms persist after the effects of the substance have worn off.

- **The mania isn't attributable to another medical condition.** Mania caused by a medical condition is identified as a separate form of bipolar disorder, as described in the later section, "Distinguishing Types of Bipolar Disorder."

Hypomanic episode

A *hypomanic episode* requires the same number and types of symptoms as a manic episode that we discuss in the preceding section. For instance, the symptoms must represent a distinct change from a person's usual behavior patterns, and the changes must be observable by others. However, a hypomanic episode differs from a manic episode in the following ways:

- May be shorter in duration (just four consecutive days is enough to qualify as a hypomanic episode)
- Doesn't cause severe functional impairment
- Doesn't require hospitalization
- Doesn't include psychosis


REMEMBER

Hypomania doesn't typically result in serious relationship problems or extremely risky behavior, but it may make others feel uncomfortable. On the other hand, hypomania can make you more engaging, so you may become the center of attention, which may feel good to some people or awful to others. For some people, hypomania creates periods of high creativity and/or productivity that are positive experiences.

Major depressive episode

During a *major depressive episode*, you may feel like you're swimming in a sea of molasses. Everything is slow, dark, and heavy. To qualify as a major depressive episode, five or more of the following symptoms must be present for at least two weeks straight. These symptoms must be changes from usual behavior, and the episode must include at least one symptom of depressed mood or loss of interest or pleasure.

- Depressed mood most of the day nearly every day
- Markedly diminished interest nearly every day in activities previously considered pleasurable, which may include sex

- Notable increase or decrease in appetite nearly every day or a marked change in weight (five percent or more), up or down in a span of one month or less that isn't due to planned dietary changes
- Sleeping too much or too little nearly every day
- Psychomotor agitation or slowing (moving and thinking uncharacteristically slowly or experiencing mental and physical agitation) nearly every day, which is observable by others and not just internal sensations
- Daily fatigue
- Feelings of worthlessness, excessive guilt, or inappropriate guilt nearly every day
- Uncharacteristic indecisiveness or diminished ability to think clearly or concentrate on a given task nearly every day, experienced internally and/or observed by others
- Recurrent thoughts of death or suicide (*suicide ideation*), a suicide attempt, or a plan to commit suicide

These symptoms must cause significant problems in your day-to-day life and function to qualify as indicators of a major depressive episode. If they occur solely in response to use of a medication or substance, or another medical condition, then the episode has its own category, such as s*ubstance/medication-induced depressive disorder* or *depressive disorder due to another medical condition*, and, therefore, doesn't count toward a diagnosis of either unipolar or bipolar depression.

REMEMBER

Of course, people who experience a significant loss or crisis in their lives may have many of these same symptoms. Doctors must rely on their clinical experience, observations, and what their patient tells them to determine whether the person is experiencing a major depressive episode or intense sadness that's a normal part of the grieving process. In addition, cultural factors may play a role in how deeply a person feels and expresses emotion in response to a loss.

Not your average moodiness

Most people experience mood fluctuations to some acceptable degree, but bipolar mood episodes are amplified and extend far beyond the usual levels of discomfort — to the point of impairing a person's ability to function and enjoy life. Episodes associated with bipolar disorder make a person think, feel, speak, and behave in ways that are extremely uncharacteristic of the individual. And they may drag on for weeks or even months. They strain relationships, disrupt lives, and often land people in the hospital or in legal trouble. And they're not something a person can just snap out of. Figure 1-1 illustrates the difference between normal mood fluctuations and those related to bipolar disorder.

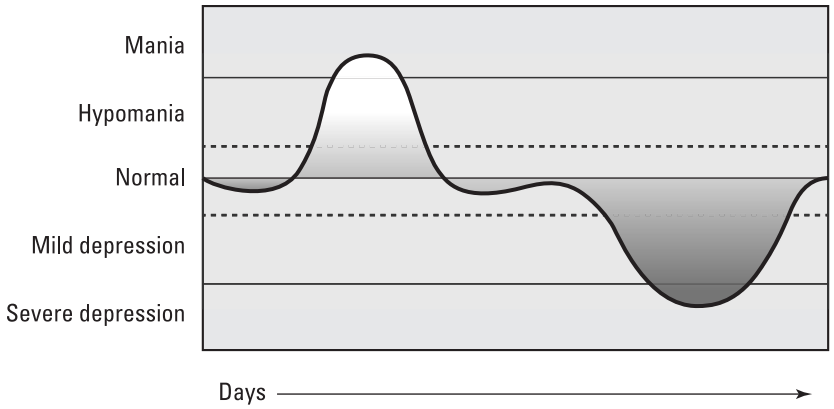

FIGURE 1-1: Normal mood variation versus bipolar mood episodes.

Not attributable to other psychotic disorders

To make a diagnosis of bipolar I, bipolar II, or cyclothymia, the doctor must determine that at least one manic episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum or other psychotic disorder.

Schizoaffective disorder is a separate diagnosis from bipolar disorder. With schizoaffective disorder, psychotic symptoms persist after the mood episode resolves. The point is to clarify that a bipolar diagnosis can't be made if symptoms include disordered thinking and reality testing that aren't part of a mood episode.

For more about psychosis, see "Presence or absence of psychosis," later in this chapter. The other psychotic disorders listed in that section do not include mood symptoms in their diagnostic criteria. If someone with one of these conditions experiences a manic episode on top of their pre-existing diagnosis, it would not be coded as bipolar disorder.

Distinguishing Types of Bipolar Disorder

Bipolar disorder wears many masks. It can be happy, sad, fearful, confident, sexy, or furious. It can seduce strangers, intimidate bank tellers, throw extravagant parties, and steal your joy. However, based on research, psychiatrists have managed to bring order to the disorder by grouping the many manifestations of bipolar into categories that include bipolar I, bipolar II, and cyclothymic disorder. In the following sections, we offer guidance for distinguishing among the many different types of bipolar disorder.

YOU'RE IN GOOD COMPANY

Bipolar disorder is often considered the Cadillac of brain disorders because so many famous and creative individuals — Vincent van Gogh, Abraham Lincoln, Winston Churchill, and Virginia Woolf — are thought to have struggled with it and perhaps even benefited from it. This may be small comfort when your symptoms are severe and painful, but it can give you a sense of kinship with people who made a positive impact despite this disorder. Maybe it can motivate you to find and focus on the talents that make you stand out in this world.

More good news: With advances in treatment, people with bipolar no longer have to swap creativity for good health. In fact, most people with bipolar find that they're more consistently creative and productive with the right combination of medication, self-help, and therapy.

Bipolar I

To earn the *bipolar I* label, you must experience at least one manic episode sometime during your life (see "Manic episode," earlier in this chapter). A major depressive episode isn't required for the bipolar I diagnosis, although most people with bipolar I have experienced one or more major depressive episodes at some point in their lives. In fact, depression is actually the phase of bipolar that causes the most problems for people with bipolar.

REMEMBER

Bipolar I requires a manic episode. If you've never had a manic episode, you don't have bipolar I. If you've only ever had a hypomanic episode, you don't have bipolar I.

Bipolar II

Bipolar II is characterized by one or more major depressive episodes with at least one hypomanic episode sometime during the person's life. The major depressive episode must last at least two weeks, and the hypomania must last at least four days. (For more about what qualifies as hypomania, check out the earlier section "Hypomanic episode.")

Although hypomanic episodes on their own don't cause severe functional impairment, the diagnosis of bipolar II does entail impaired function. The criteria state that the depressive episodes or the unpredictability caused by frequent alternation between depression and hypomania causes significant distress or impairment in important areas of function.

REMEMBER

Bipolar II requires at least one major depressive episode and one hypomanic episode that together or apart cause significant distress or impairment in important areas of function. If you've ever had a manic episode that can't be attributed to some other cause, then you have bipolar I, not bipolar II.

Cyclothymic disorder

Cyclothymic disorder involves multiple episodes of hypomania and depressive symptoms that don't meet the criteria for a manic episode or a major depressive episode in intensity or duration. Your symptoms must last for at least two years (or one year in children or adolescents) without more than two months of a stable, or *euthymic,* mood during that time to qualify for a cyclothymic disorder diagnosis.

Additionally, the symptoms must not be caused by substances or a medical condition and cannot be attributed to schizoaffective disorder. And the pattern of shifting mood states must cause significant distress or impairment in important areas of function.

REMEMBER

Some people with cyclothymic disorder eventually experience a full-blown manic or major depressive episode, changing the diagnosis to either bipolar 1 disorder or unipolar major depressive disorder. Medical supervision is important so treatment planning can change if symptoms change.

Substance/medication-induced bipolar disorder

The *substance/medication-induced bipolar disorder* diagnosis applies when someone presents with all the symptoms of bipolar disorder (elevated, expansive, or irritable mood with or without depression), but only in the context of acute substance intoxication or withdrawal or medication effects.

Bipolar and related disorder due to another medical condition

When a person's mania or hypomania can be traced to another medical condition, such as *hyperthyroidism* (overactive thyroid), based on medical history, physical examination, or lab results, the person may receive a diagnosis of bipolar and related disorder due to another medical condition, and the doctor will identify that other medical condition.

Other specified bipolar and related disorder

Introduced in *DSM-5*, this category enables doctors to diagnose bipolar disorder when symptoms characteristic of bipolar disorder significantly impair normal function or cause considerable distress, but don't quite meet the full diagnostic criteria for the other bipolar diagnostic classes. Here are some examples:

- Someone with major depression experiences hypomanic episodes that aren't long enough or don't include enough symptoms to meet criteria for the full bipolar II diagnosis.
- Cyclothymic symptoms that haven't gone on for the full two years needed to make the diagnosis.
- Hypomanic episodes that cause functional problems but aren't associated with major depression.
- Manic symptoms superimposed on schizophrenia or other psychotic disorder, but don't meet criteria for schizoaffective disorder.

REMEMBER

All bipolar diagnoses require that the symptoms cause significant clinical distress or functional impairment. Although doctors certainly want to diagnose and treat people with bipolar disorder and other conditions covered in the *DSM*, they don't want to overdiagnose and overmedicate. Treatment is provided only when it begins to disrupt a person's ability to function normally and enjoy life's pleasures.

Unspecified bipolar disorder

The *unspecified bipolar disorder* designation is used to diagnose individuals who present with symptoms characteristic of bipolar disorder that cause clinically significant distress or functional impairment but don't fully meet the diagnostic criteria for the other bipolar disorder diagnostic categories. This diagnosis is used instead of *other specified bipolar and related disorder* when a doctor, for whatever reason, doesn't want to go into detail about why the criteria for a specific bipolar diagnosis hasn't been met; for example, in emergency room settings by doctors who need to diagnose and treat the symptoms immediately and may not have the time or sufficient details to make a more specific diagnosis.

CLARIFYING THE PURPOSE OF THE BIPOLAR DIAGNOSIS

Your doctor doesn't use *bipolar disorder* to label you or minimize your worth as a human being. The diagnosis provides a convenient way to refer to your condition among insurance and healthcare providers. It helps all the people involved in your treatment to quickly recognize the illness that affects you and to provide the appropriate medications and therapy. You aren't bipolar disorder. Bipolar disorder is an illness you have, and you can manage it with the right treatments.

Digging Deeper with Bipolar Specifiers

The *DSM* provides *specifiers* to help doctors more fully describe a person's condition. Think of specifiers as adjectives used to describe nouns, the noun being the primary diagnosis.

Specifiers indicate the nature of the person's current or most recent episode, the severity of symptoms, the presence or absence of psychosis, the course of the illness, and other features of the illness, such as anxiety or a seasonal pattern. Specifiers serve two useful purposes:

- They allow for the subgrouping of individuals with bipolar disorder who share certain features, such as people who have bipolar disorder with anxious distress.
- They convey information that's helpful and relevant to the treatment and management of a person's condition. For example, someone who has bipolar with anxious distress likely needs treatment for both bipolar and anxiety.

In the following sections, we describe the bipolar specifiers in greater detail.

Current or most recent episode

This specifier identifies the most active or recent phase of illness, with a primary goal of identifying the most appropriate treatment. These specifiers are coded in the patient's medical record, where they're also important for insurance reimbursement purposes:

- **Manic:** The current or most recent episode is primarily mania.
- **Hypomanic:** The most recent or current episode is primarily hypomania.

- **Depressed:** The most recent or current episode is primarily depression.
- **Unspecified:** The most recent or current episode is unspecified, in which case severity and other specifiers presented in the following sections are not used.

Severity of illness

Severity specifiers have been part of the diagnostic system for a long time, and they continue to be part of the *DSM-5*-TR. They assist in treatment planning and in following the course of illness; for example, a patient moving from severe to mild symptoms suggests that the acute episode is resolving. Historically doctors making the diagnosis would use their clinical judgment and experience to estimate severity. *DSM-5*-TR encourages the use of more objective data, particularly by using scales that patients or doctors fill out, to provide more consistent ratings across patients and across treatment providers.

In DSM-5, severity ratings were the same for manic and depressive episodes. But because mild depression has only minor effects on functioning, and any manic episode has a major effect on functioning, DSM-5-TR introduces separate severity ratings for depression in mania.

For major depressive episodes, the severity ratings are as follows:

- **Mild:** Few, if any, symptoms in excess of those required to meet the diagnostic criteria are present, the intensity of the symptoms is distressing but manageable, and the symptoms result in minor impairment in social or occupational functioning.
- **Moderate:** The number of symptoms, intensity of symptoms, and/or functional impairment are between those specified for "mild" and "severe."
- **Severe:** The number of symptoms is substantially in excess of those required to make the diagnosis, the intensity of the symptoms is seriously distressing and unmanageable, and the symptoms markedly interfere with social and occupational functioning.

For manic episodes, the severity ratings are now as follows:

- **Mild:** The manic episode meets the minimum symptom criteria.
- **Moderate:** The manic episode causes a very significant increase in impairment.
- **Severe:** The person experiencing the manic episode needs nearly continual supervision to prevent harm from being done to themselves and/or others.

Presence or absence of psychosis

Perhaps the most frightening accompaniment to depression or mania is *psychosis*, which may include delusional thinking, paranoia, and hallucinations (typically auditory as opposed to visual). Although psychosis isn't a necessary part of the bipolar diagnosis, it can accompany a mood episode. The extremes of depression and mania are sometimes associated with profound changes in the reality-testing system of the brain, which lead to severe distortions in perception and thinking. When making a diagnosis of bipolar disorder, the doctor will specify whether any psychotic symptoms accompany the mood symptoms. If you experience psychosis during a mood episode you may experience any of the following symptoms:

- Feel as though you have special powers
- Hear voices that other people can't hear and that make you believe they're talking about you or instructing you to perform certain acts
- Believe that people can read your mind or put thoughts into your head
- Think that the television, newspaper, or Internet is sending you special messages
- Think that people are following or trying to harm you when they're not
- Believe that you can accomplish goals that are well beyond your abilities and means
- Believe that you have or can hurt others because you're a terrible person
- Believe that you're guilty of things that are outside your control

REMEMBER

Psychotic symptoms usually reflect the pole of the mood disorder. So, if you're in a major depressive episode, the psychotic thoughts are typically dark and negative; in a manic state, the symptoms tend to be more about super strengths, abilities, and insights. However, this doesn't always hold true; psychotic content can be all over the map.

Course of illness

This specifier overlaps with the presence or absence of psychosis when a diagnosis is coded. If the illness is active, the specifier notes whether psychosis is present.

If the illness is moving out of active phase, then one of the following specifiers is used:

- **In partial remission:** Symptoms have started to decline in severity and/or frequency, function has improved to some degree, and these improvements have been sustained over at least several weeks.
- **In full remission:** Function has returned to levels that existed before the illness, symptoms are much less active, and this state has sustained for several weeks to months.

Additional features that doctors use as specifiers in making the diagnosis

Bipolar is often accompanied by other conditions, such as anxiety, and may have some features that vary among those who have the diagnosis. The following specifiers are used to label these extras:

- **With anxious distress:** Anxiety commonly co-occurs with bipolar disorder even in the absence of a full-blown anxiety disorder, and the presence of significant anxiety symptoms may influence treatment decisions.
- **With mixed features:** Mood episodes in bipolar disorder often aren't completely clear-cut. People with mostly manic symptoms may still express symptoms of depression, such as guilt and hopelessness or suicidal thoughts. Or someone who is primarily depressed may have a lot of physical agitation and racing thoughts characteristic of mania. This specifier accounts for these types of presentations, which may affect treatment planning.
- **With rapid cycling:** *Rapid cycling* is a specifier that identifies bipolar disorder characterized by four or more mood episodes in a 12-month period. This subtype is thought to be more severe and often doesn't respond as well to medications.
- **With melancholic features:** This subtype of depression is quite severe. It includes features such as very low mood, with characteristics of despair and despondency, that shows little or no response to improved external circumstance, very low energy, almost no interest in or response to pleasurable stimuli, agitation or slowing of movements and thoughts, *diurnal variation* (mood and energy worse in the morning), sleep interruptions including early morning awakening, impaired thinking and concentration, and severe loss of appetite or weight loss. It's really the most extreme presentation of most or all the symptoms of a major depressive episode.

- **With atypical features:** This specifier describes a pattern of depression symptoms that used to be considered less typical of depression but are now recognized as a frequent feature of depression. The name has stuck though. Symptoms include responsiveness to changes in external stimuli — feeling better if things improve or worse if something bad is going on, increased appetite or weight gain, excessive sleep and severe fatigue, feelings of *leaden paralysis* (heaviness in the limbs), and longstanding patterns of interpersonal rejection sensitivity.
- **With catatonia:** *Catatonia* is a state of minimal responsiveness to the environment and abnormal thinking and movement. It can present as extremely slowed thinking, moving, and speaking or agitated, repetitive nonsensical movements and speech. Catatonia is an emergency medical condition that can occur with many psychiatric conditions, including depressive or manic poles of bipolar disorder. It can also be associated with medical conditions and autism.
- **With peripartum onset:** This specifier is used when the onset of the bipolar mood episode is any time during pregnancy or in the four weeks after delivery, which is important because pregnancy and childbirth influence treatment decisions. (See Chapter 10 for details.)
- **With seasonal pattern:** This label indicates a well-established pattern of mood episodes that start and end at specific times of the year.

Distinguishing Bipolar from Conditions with Similar Symptoms

Before arriving at any medical diagnosis, doctors review a *differential diagnosis* to consider all the possible causes of the presenting symptoms. In bipolar disorder, the differential diagnosis often includes the following conditions that may involve symptoms similar to those of bipolar disorder:

- **Unipolar depression:** A major depressive episode without a history of mania or hypomania doesn't qualify as bipolar disorder. However, if you experience depression and you have a history of bipolar disorder in any first-degree relatives (parent, sibling, or child), your doctor may want to monitor you closely if you're prescribed an antidepressant, because of the increased risk that you may have bipolar disorder that hasn't shown its manic pole yet. Additionally, the differentiation between unipolar and bipolar depression can be quite difficult. If a symptom such as agitation is present, it can be part of a mixed-mood episode of bipolar disorder, but it can also just be part of

unipolar depression. Another difficult diagnostic situation is when during recovery from depression a person has periods of feeling particularly well. Are these periods symptomatic of hypomania or simply a strong recovery from a depressive episode?

- **Anxiety:** Anxiety may make you feel wired or tired with racing thoughts, poor sleep, and irritability, all of which overlap with symptoms characteristic of depression and mania. Many people with bipolar disorder also have an anxiety disorder, so these conditions can happen together, but determining whether anxiety is the primary disorder rather than bipolar is important.
- **Attention deficit hyperactivity disorder (ADHD):** ADHD and mania are both characterized by impaired concentration and attention, impulsivity, high energy levels, and problems with organization and planning. However, for those with bipolar disorder, these symptoms are present only during a manic episode, not all the time. In addition, diagnostic criteria for hypomania or mania include an increase in goal-directed behavior, a decreased need for sleep, and grandiose thinking; ADHD doesn't include any of these. The pattern of symptoms, especially the episodic nature of mood episodes, is a key way to distinguish bipolar disorder from ADHD.
- **Schizophrenia and schizoaffective disorders:** Schizophrenia and schizoaffective disorders are thought disorders characterized by psychosis — delusional thinking, paranoia, and hallucinations (usually auditory, rarely visual). Although psychosis may accompany mania and depression, in bipolar, psychosis is present only during an acute mood episode and goes away during times of normal mood. In schizoaffective disorders, psychosis occurs for at least some period of time separate from the mood episodes. Schizophrenia and related disorders are characterized by persistent and severe disruptions of thinking and reality testing unrelated to mood episodes.
- **Borderline personality disorder (BPD):** BPD shares a few characteristics with bipolar. For instance, someone with BPD may be impulsive, irritable, and argumentative much like someone who's experiencing a manic episode. However, BPD mood shifts are typically abrupt, short-lived, and in response to an external trigger, such as a conflict with another person; bipolar mood shifts are slower to develop, last longer, and may not appear to be in response to anything external. The rages that often characterize BPD aren't equivalent to mania. BPD symptoms are chronic, representing the person's baseline behaviors, whereas bipolar symptoms are episodic and different from the person's usual behavior patterns.
- **Other medical conditions:** Many medical conditions — including brain tumors, meningitis, encephalitis, seizure disorders, stroke, brain injury, various hormonal conditions, and autoimmune disorders, can produce symptoms similar to those of bipolar mania or depression. Infections, including COVID 19, can also affect bipolar symptoms.

- **Mood instability caused by medications, alcohol, or drugs:** A variety of prescription medications, alcohol, marijuana, and street drugs can affect moods. You and your doctor must rule out these possible causes before arriving at a diagnosis of bipolar disorder.

REMEMBER

Be sure to tell your doctor if anyone in your immediate or close extended family has been diagnosed with bipolar disorder, schizophrenia, or substance use disorder, especially if you're seeking treatment only for depression. A close family history of these conditions increases the risk that you may eventually experience a manic or hypomanic episode resulting in a bipolar diagnosis. Medication treatment of unipolar and bipolar depressions is different — treatment with antidepressant alone in someone with bipolar disorder can trigger a shift to mania. Knowing about a family history of bipolar, you and your doctor can make a plan for close monitoring of your response to treatment for depression.

Considering Comorbidity: When Bipolar Coexists with Other Conditions

Bipolar disorder carries the distinction of having some of the highest rates of *comorbidity* with other psychiatric illnesses, which means that someone diagnosed with bipolar disorder is likely to have at least one other psychiatric diagnosis. Some researchers suspect that because bipolar disorder may be closely related to some of these illnesses, in terms of underlying brain changes, they may not be separate disorders at all. Given how psychiatric illness is diagnosed at this point in time, we describe the disorders as separate entities and call them *comorbidities*.

Anxiety disorders

Anxiety disorders occur very frequently with bipolar disorder. According to one study, half of people diagnosed with bipolar disorder will have a co-occurring anxiety disorder at some point in their life. Rates for specific anxiety disorders vary:

- **Panic disorder** occurs in about 21 percent of people with a bipolar diagnosis, compared to about 3 percent in the general population
- **Generalized anxiety disorder** seems to occur in about 20 percent of individuals with bipolar, compared to about 3 percent in the general population.

- **Social and other specific phobias** seem to occur in about one third of people with bipolar — a rate much higher than the general population.
- **Post-traumatic stress disorder (PTSD)** occurs in about 16 percent of people with bipolar disorder, which is about twice as high as the rate found in the general population.

Treatment of anxiety disorders may complicate or complement the treatments of bipolar disorder but reducing anxiety symptoms is an important part of managing bipolar disorder effectively.

Obsessive-Compulsive Disorder (OCD)

OCD used to be considered an anxiety disorder, but in DSM-5 and now DSM-5-TR it's a separate diagnosis. A painful and difficult disorder to live with, it's much more common in people with bipolar disorder than in the general population. The rates vary among studies, but somewhere between 10 and 20 percent of people with all types of bipolar disorder also suffer from obsessive-compulsive disorder, compared to the rate of about 2 percent in the general population.

Similar to the challenges in treating anxiety disorders, treating comorbid OCD can cause conflicting medication needs, but treating OCD along with bipolar disorder is key to improving quality of life for someone living with bipolar disorder.

Substance use disorder

Although the studies vary in exact numbers, studies overall suggest that about 60 percent of people with a bipolar diagnosis have had a substance use problem at least sometime in their lives, with more than 40 percent having current or past problems with alcohol use and similar but slightly lower numbers having had problems with other substance use disorders. Psychiatric hospitalization rates are generally higher for people with both bipolar and substance use disorder. The course of the illnesses seems to be more severe when both are present. Males with bipolar disorder have a higher incidence of substance use disorder than females, but the rates are high in both groups. The rates decline as people get older but are still higher than rates of substance use disorder in older people without bipolar disorder.

Treatment of both substance use and bipolar disorder is challenging, and having both adds many layers of challenges to the treatment. Resolution of bipolar symptoms may be quite difficult to achieve in the context of active substance use, and substance use is particularly difficult to address during active mood episodes. Successfully managing both disorders is necessary for long-term recovery.

Attention deficit hyperactivity disorder

Research in this area has suggested that between 10 and 20 percent of adults with all types of bipolar disorder have ADHD. This compares to about 3–4 percent of adults with ADHD in the general population. In children with bipolar disorder, the distinction between bipolar and ADHD and the levels of overlap in symptoms can complicate the diagnostic story. The diagnostic challenges make it difficult to pin down the rate of ADHD in children and teens with bipolar disorder. The research is ongoing.

REMEMBER

The general consensus is that those with ADHD and bipolar disorder have worse outcomes for their bipolar disorder. Treatment is complicated because use of stimulants such as Ritalin to treat ADHD can significantly exacerbate bipolar symptoms. And with the high rates of substance use disorder among those with bipolar, potential misuse of these medications must also be considered.

Personality disorders

Personality disorders are conditions in which the development of emotional, social, and behavioral systems is disrupted, causing significant, lifelong problems with function. Personality disorders are divided into *clusters* and then further into specific types; for example, Cluster B personality disorders include borderline, antisocial, histrionic, and narcissistic personality disorders. Studies suggest that about 30 percent of people with bipolar disorder also meet criteria for a personality disorder.

Personality disorders are difficult to treat and often don't respond to medications. Psychotherapies are becoming more and more effective; people with personality disorders often have difficulty gaining insight into how their patterns of thought, behavior, and emotion affect their lives, because they've never known different ways of functioning. Without insight, trying to address the problems is quite difficult. Layering bipolar disorder onto a personality disorder diagnosis adds tremendously to the difficulties of achieving sustained recovery.

Childhood trauma may be closely related to the development of some personality disorders, including borderline personality disorder. Early trauma can have damaging effects on the development of emotional and interpersonal skills. Identifying and addressing trauma is an important part of managing these conditions.

Memory and thinking problems

Problems with cognitive skills such as memory and attention and the ability to think clearly are common in bipolar disorder, both during and between mood episodes. Compounding the cognitive issues inherent in bipolar is that fact that some medications used to treat bipolar can cloud thinking as a side effect. Addressing

problems with thinking and memory is important in recovery from bipolar disorder to help people get back on their feet in terms of work, life management, and interpersonal and leisure time skills.


REMEMBER

Certain medications used to treat bipolar disorder may have *neuroprotective properties;* that is, they may prevent damage and perhaps help the recovery or regeneration of brain cells. Some recent studies have suggested that lithium, while sometimes causing short-term mental cloudiness, may actually protect brain cells over time and may prevent or reduce cognitive decline.

Confronting the Challenges of Diagnosing Children and Teens

The diagnosis of bipolar disorder in children (up to the age of 12) and adolescents (teenagers) had been the subject of significant controversies in the field of child psychiatry for decades. In recent years, though, the field has reached consensus. Child psychiatrists are now clear that manic episodes — necessary for a diagnosis of bipolar disorder — do occur in children under 12 years old, but not frequently. The vast majority of first manic episodes present in adolescence or early adulthood. For children to be diagnosed with bipolar disorder they need to exhibit the same patterns of energy and mood changes that adults do — at least one period of mania or hypomania, often associated with episodes of depression. When doctors use these criteria, it significantly reduces the risk of overdiagnosing bipolar disorder in children.


REMEMBER

Central to the controversy about childhood bipolar disorder has been the symptom of chronic irritability. For some time, some researchers speculated that high levels of irritability in children were a symptom of or a predictor of bipolar disorder.

With the benefit of time, research has now followed highly irritable preschoolers into adolescence. The studies suggest that these children have higher rates of many emotional and behavioral symptoms, problems in school and social function, and poorer physical health. The research doesn't support any specific connection to bipolar disorder.

For irritable mood to count toward a diagnosis of bipolar disorder in a child, it must occur or notably worsen in cycles — sustained periods of time in which it's much more severe than the child's usual temperament. *DSM-5* added a new diagnosis called *disruptive mood dysregulation disorder (DMDD),* which is unchanged in DSM-5-TR. The purpose of introducing this diagnosis is to have a way to describe and research chronically irritable and explosive children without inappropriately labeling them as having bipolar disorder. The criteria for DMDD include the following:

- Severe recurrent temper outbursts that are grossly out of proportion in intensity or duration to the situation or provocation.
- The temper outbursts are inconsistent with developmental level.
- The outbursts occur on average three or more times per week.
- The mood between outbursts is persistently irritable or angry most of the day, nearly every day, and is observable by others.
- The symptoms have been present for 12 or more months without a period of three or more months free of patterns of irritability and outbursts.
- The symptoms are present in at least two of three settings — school, at home, with peers.
- Age of onset is before 10 years. Diagnosis isn't made before 6 years or after 18 years.
- The symptoms aren't part of a manic episode or better explained by major depression or other psychiatric or neurodevelopmental disorders, including anxiety disorders and autism.
- This diagnosis cannot coexist with bipolar disorder, oppositional defiant disorder, or intermittent explosive disorder.
- The symptoms can't be attributed to substances, medications, or medical or neurologic condition.

Also key to the evolving consensus about bipolar disorder in children is that the high energy and impulsivity that are part of an ADHD diagnosis don't count toward a manic episode diagnosis unless they form a cyclic pattern — episodes — in which those symptoms get notably worse and then stay worse for a sustained period of time (days to weeks, not hours).

This research is ongoing and understanding mood, behavior, and energy symptoms in children is a priority in the field of child psychiatry. But, whatever the studies reveal, doctors know that they must be cautious and diligent when evaluating young patients with mood symptoms. The medications used to treat mania are powerful and have many side effects, and a diagnosis of bipolar may prevent the use of medications to treat ADHD or anxiety and depression. Therefore, a misdiagnosis in a child can have significant long-term consequences.

Obtaining an early, accurate diagnosis of a child's difficulties and identifying whether the cause is bipolar disorder or something else is the most critical step in helping the child or adolescent manage a mood problem. Often, diagnoses in children may evolve over time as they get older, so doctors also need to remain vigilant for and open to changing their diagnoses over time. See Chapter 21 for more about diagnosis and treatment options for children and teenagers who may be dealing with a mood disorder.

BIPOLAR BIO

BATTLING THE STIGMA OF A BIPOLAR DIAGNOSIS

During my battle with bipolar disorder, I was unaware of the consequences of my risky behavior — abusing substances, having promiscuous sex, staying up all night, and counterfeiting art — but I was high-functioning.

My diagnosis put me in a category of the population called *bipolar*. In my mind, I was a lunatic, freak, psycho, crack-up, and mental case. I had officially stigmatized myself, long before anyone else had the chance.

I invited my parents to dinner to tell them the news, and they had a ton of questions. "Are you sure your doctor is right? Where did it come from? What's going to happen to you? Is it genetic?" They struggled with the stigma of having a son with bipolar, and, even worse, they worried that it might run in the family — we might have more like me!

Family and friends didn't come rushing to my side to support me in my battle. In 1993, the mere mention of bipolar disorder frightened people; someone with bipolar was "crazy." And because my insidious illness wasn't tangible, like diabetes or MS, it was easier for people to blame it on me. At a time when I was most in need of support from my friends and family, stigma pushed them away.

Most people thought I had the skills and strength to "kick" my bipolar disorder and get better on my own because the symptoms didn't show up on my body as a wound. Many people thought it was a figment of my imagination, that I was lazy or just seeking attention, and I started believing these ideas. But when symptoms surfaced, I was reminded that I really was suffering from bipolar disorder.

When medication didn't quell the mania, I opted for the last resort — electroshock therapy. That decision in itself pretty much confirmed that I was officially mentally ill. It was too much for some of my friends to handle, and they simply disappeared. Nobody seemed to want a friend who was now a psychiatric patient and, after electroshock, a "certifiable zombie."

Stigma prevents many us from seeking help and isolates us when we're most in need of supportive friends and family. Even in my recovery today, when I speak openly about my diagnosis, I'm keenly aware that many people are uncomfortable and afraid. Stigma is a form of discrimination, and debunking the myths about bipolar disorder and disseminating the truths are critical to educating the public and creating a social environment that's more conducive to mental health and recovery.

— Andy Behrman, author of *Electroboy: A Memoir of Mania*