

Bipolar Disorder

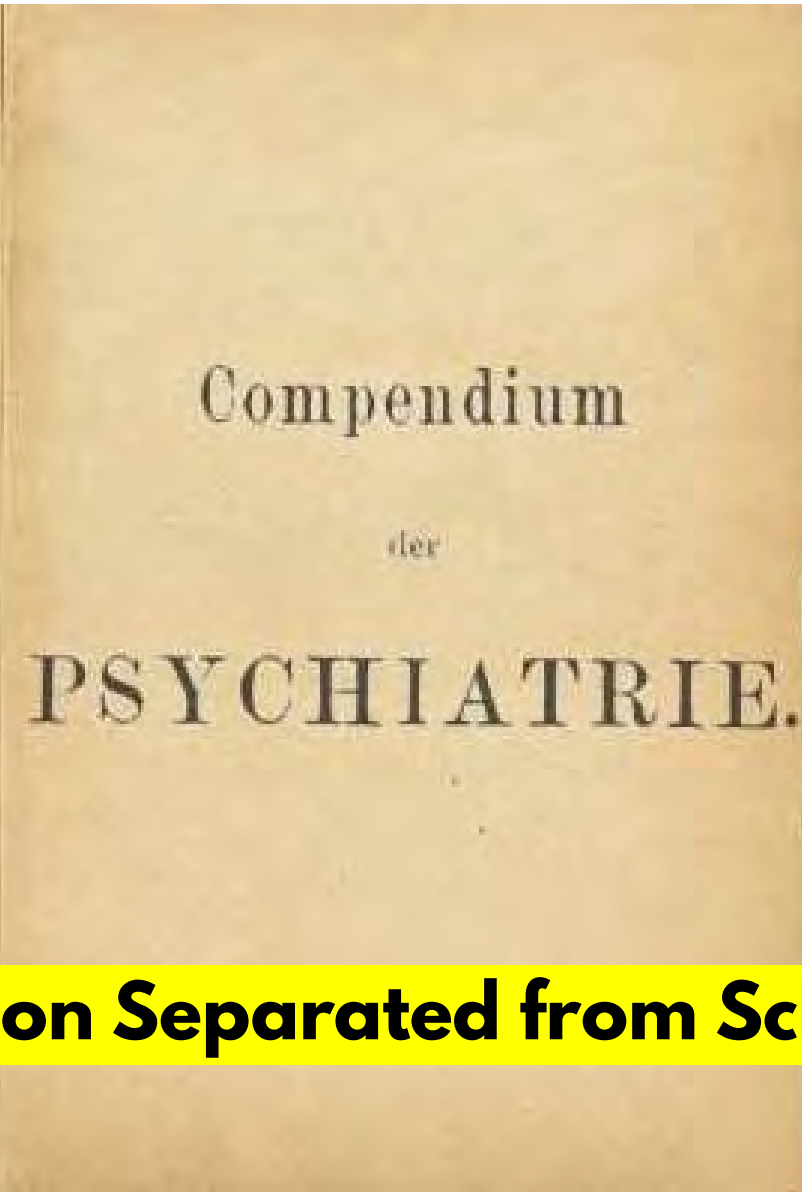
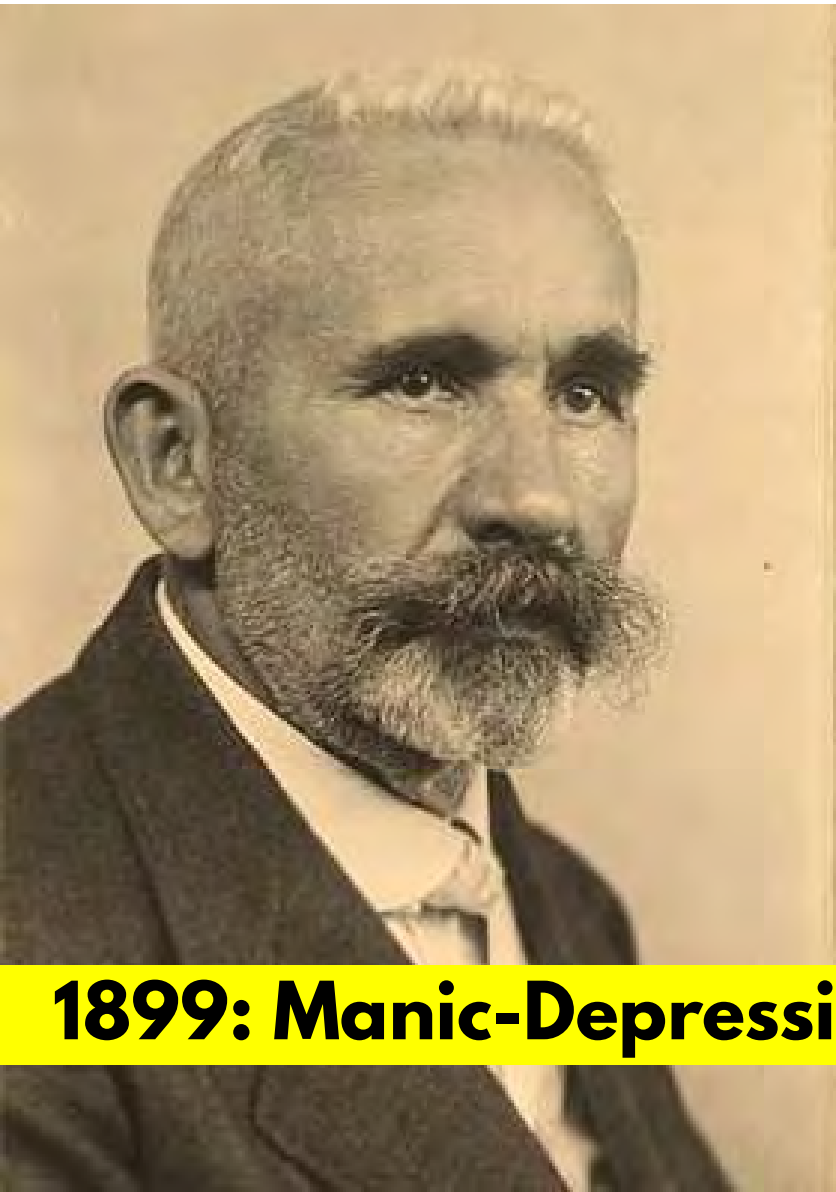
Chris Aiken, MD

Editor-in-Chief, *The Carlat Psychiatry Report*
Assistant Professor, NYU School of Medicine

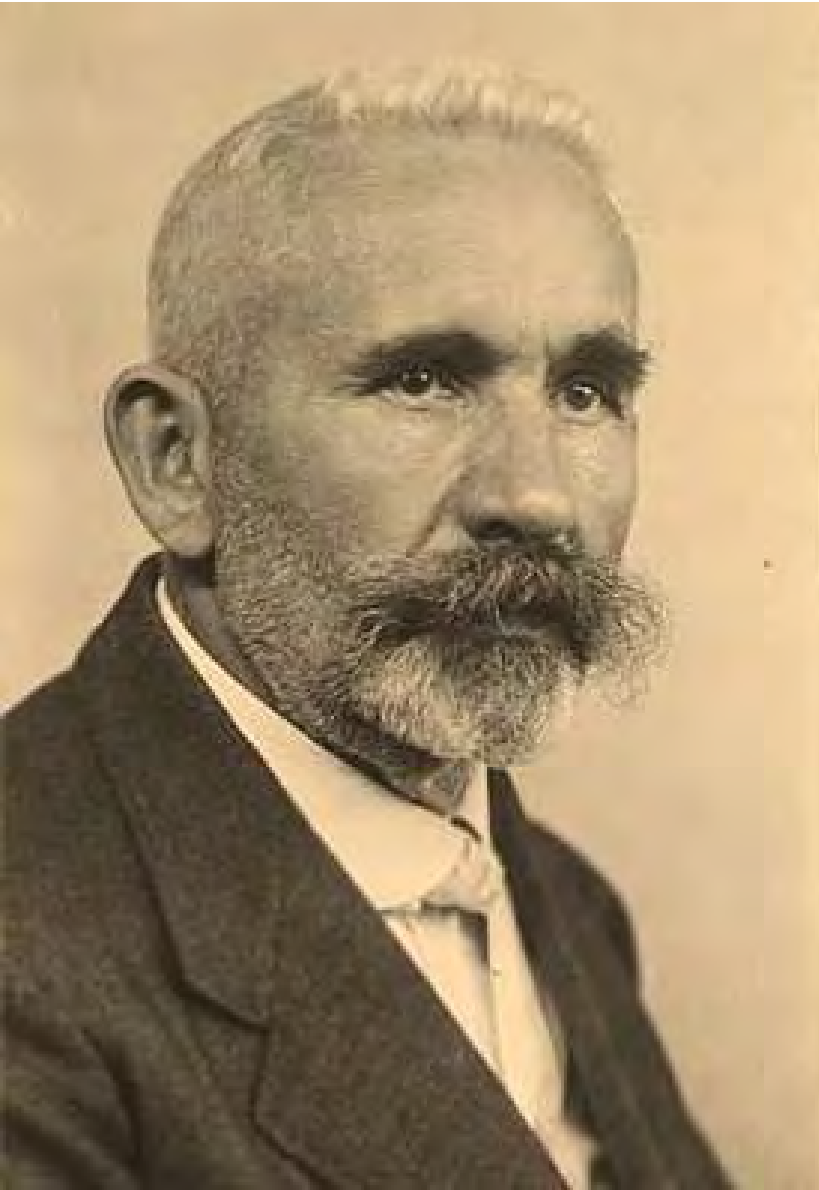
Conflicts and Disclosures

None






1899: Manic-Depression Separated from Schizophrenia



"This classification,
apparently so simple,
really encounters
manifold difficulties."



DIAGNOSTIC AND STATISTICAL
MANUAL OF
MENTAL DISORDERS
(THIRD EDITION)

DSM-III

1980: Bipolar I vs Unipolar Depression

Ka



**What about the
bipolar spectrum?**

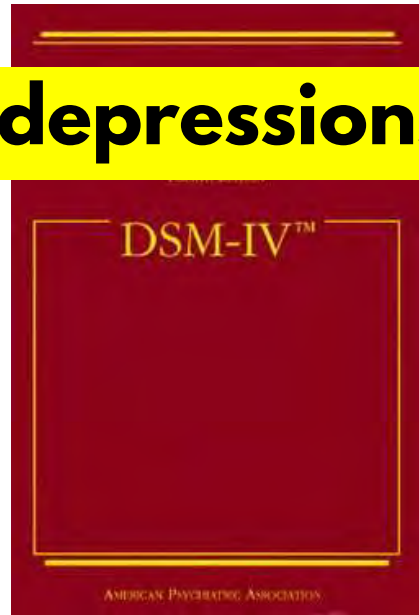
Hagop Akiskal, MD

25% of recurrent depressions have *mixed features*



1980

Bipolar I
Cyclothymic
Depression



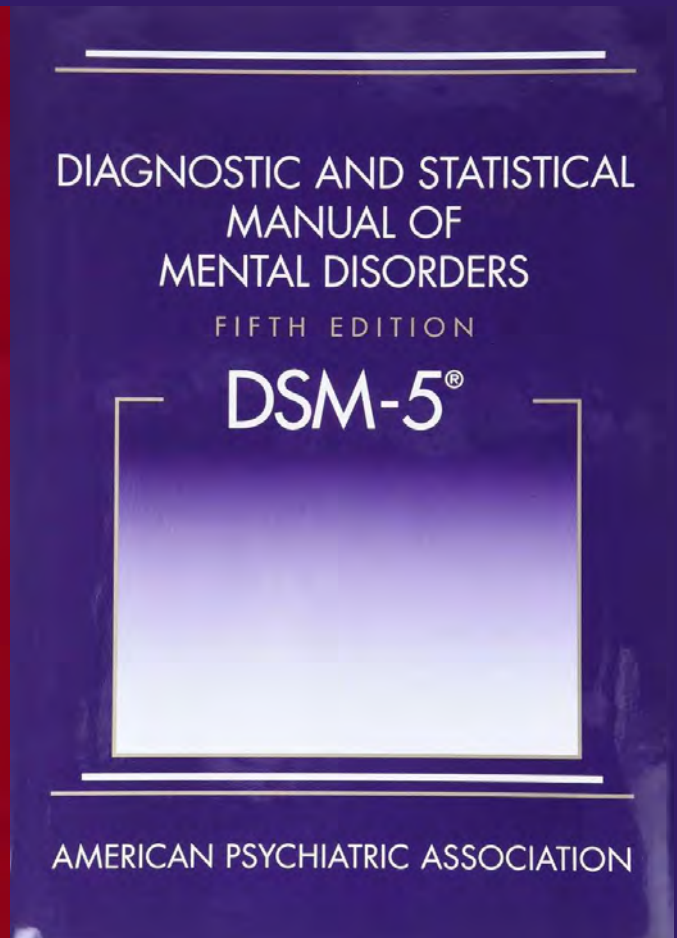
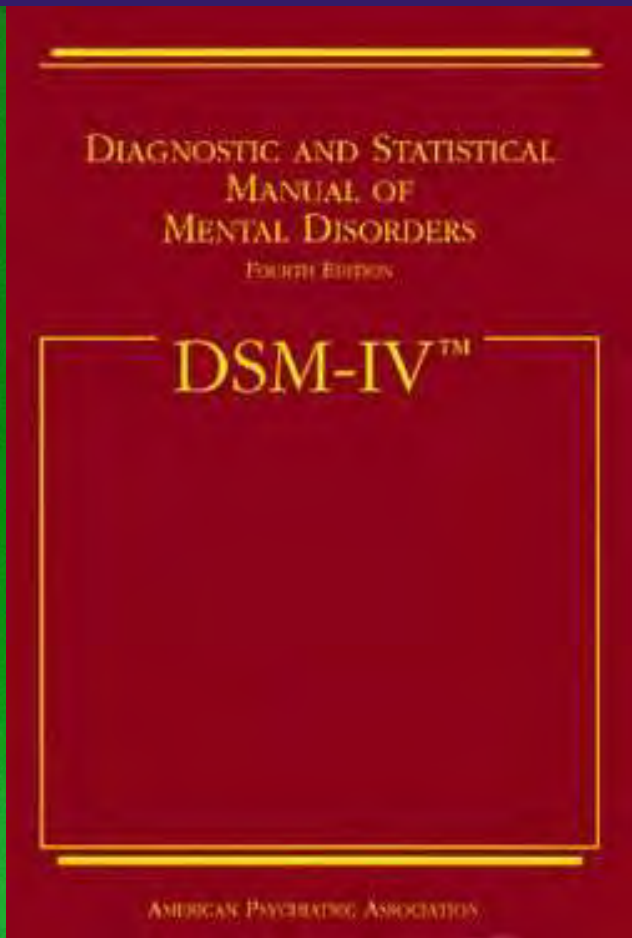
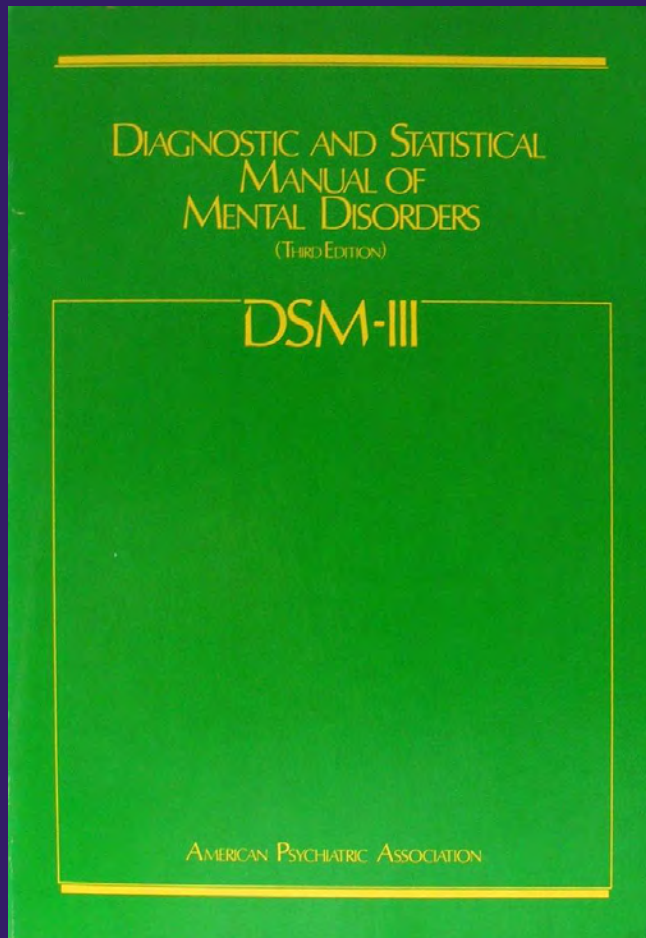
1994

Bipolar I
Bipolar II
Cyclothymic
Depression



2013

Bipolar I
Bipolar II
Cyclothymic
Depression + brief hypomania
Depression + mixed features
Depression





Depression and bipolar are part of “a continuum, with variable expressions of vulnerability to hypomania or mania”

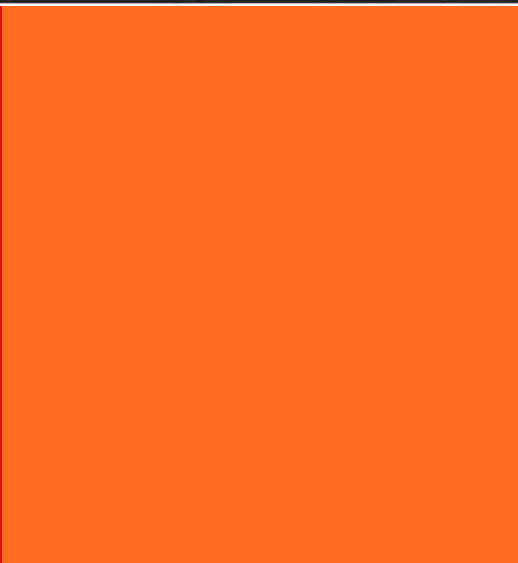
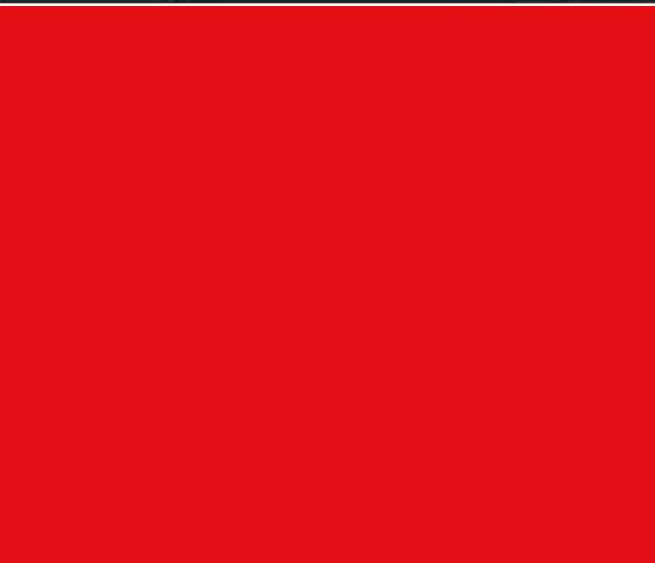
David Kupfer, Chair of DSM-5, 2013

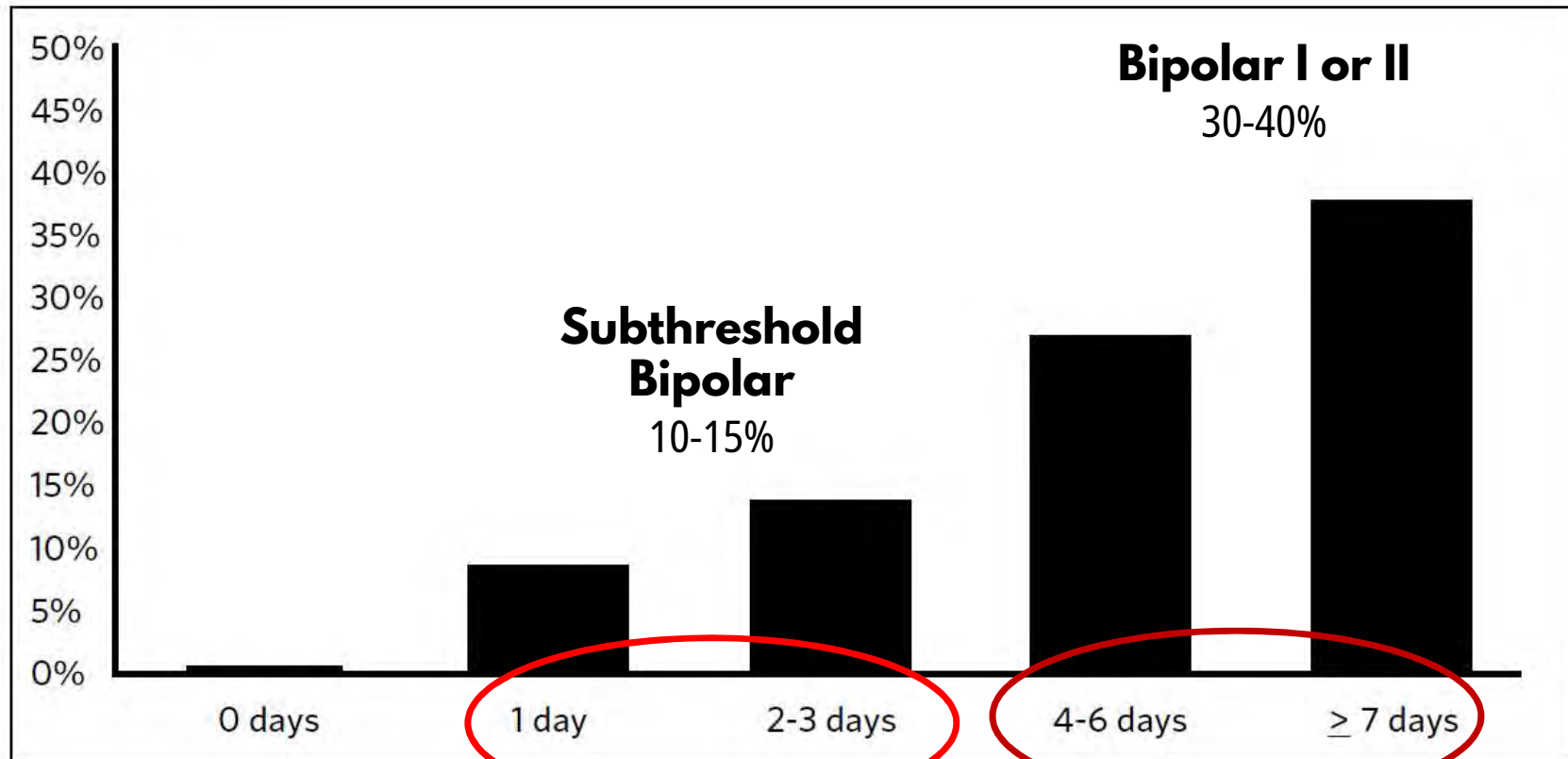


DSM-5 Bipolar

DSM-5 Unipolar

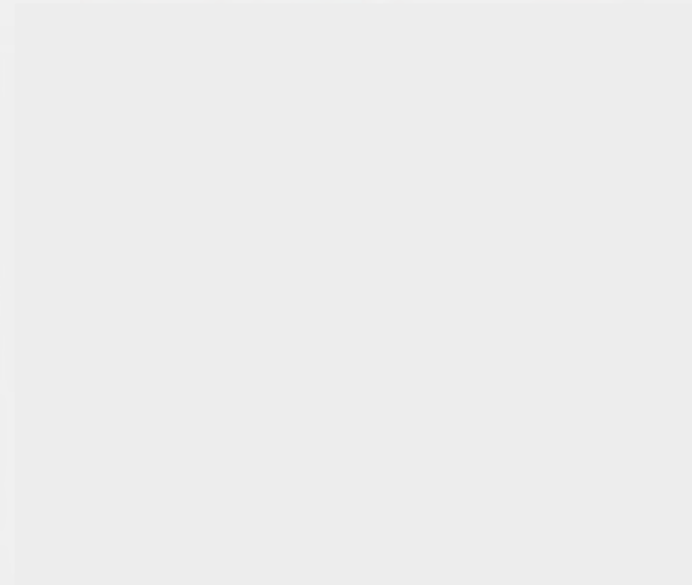
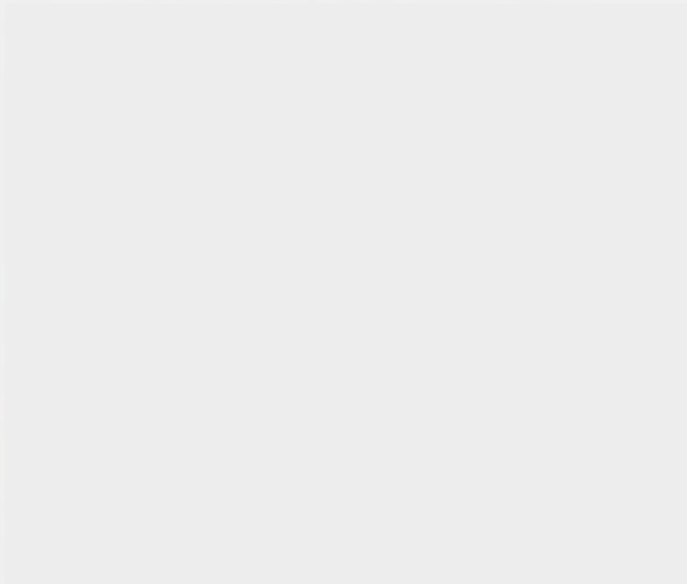
Bipolar I	Bipolar II	Cyclo-thymic	Brief hypomania	Mixed features	Pure depression
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Risk of mood worsening on an antidepressant rises with duration of hypomania (Angst et al., 2012)

BP II in Outpatient Depression



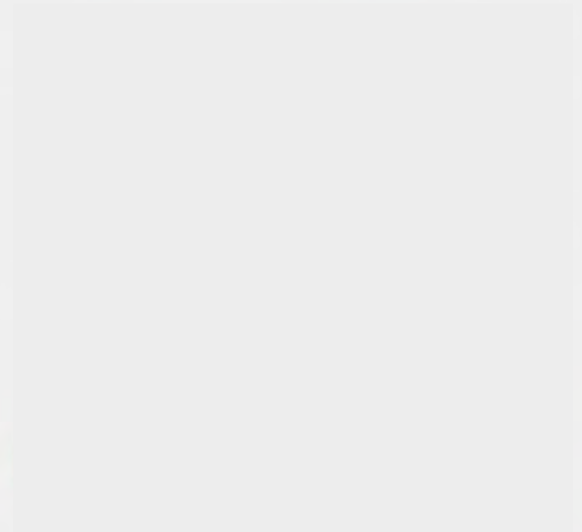
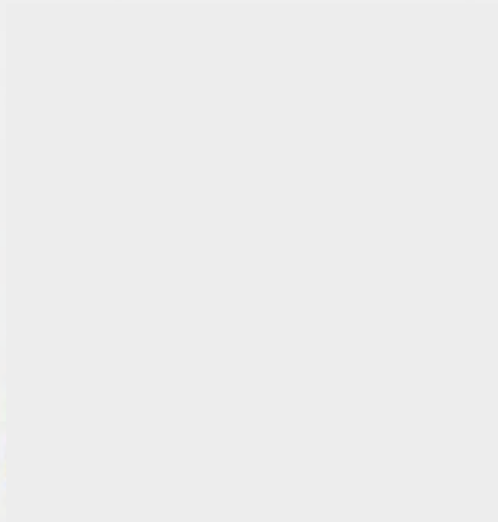
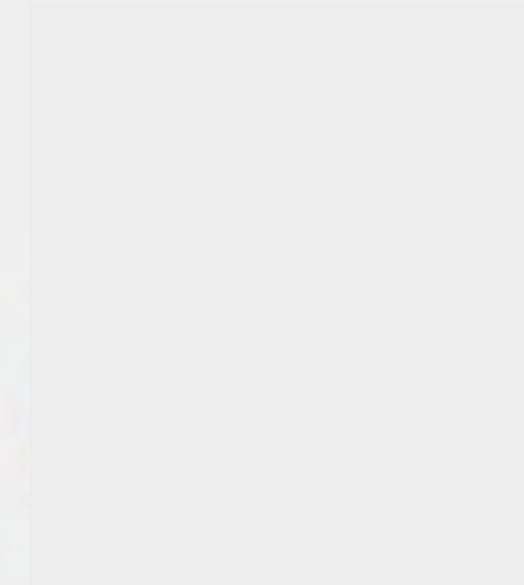
Hantouche EH et al, *J of Aff Disorders* 1998;50:163-173

Making the Diagnosis

Web quiz: vevox.app/126-111-834



DSM-5 Durations

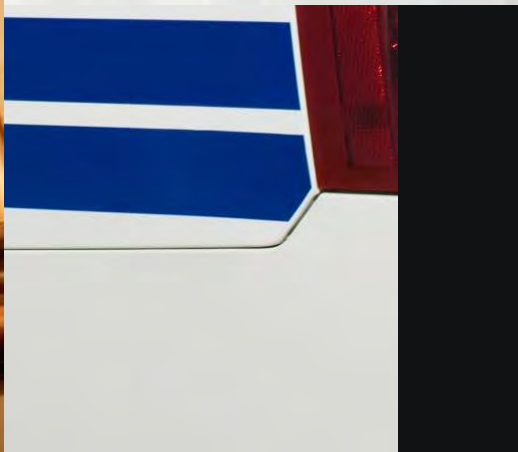





Mania = Irreversible consequences







A top-down view of a person's hands holding a black Bible. The Bible is centered in the frame, and the words "Holy Bible" are printed in a light-colored, serif font on the front cover. The background is a dark, textured wooden surface with a prominent grain pattern. The lighting is soft, highlighting the texture of the wood and the smooth surface of the Bible cover.

Holy Bible

“Have you ever had a period of time when you were feeling ‘up’ or ‘high’ or ‘hyper’ and so active or full of energy or full of yourself that you got into trouble, or that other people thought you were not your usual self?”

Pure Hypo/mania

Hypo/manic symptom	How it looks in real life
Elevated energy	Motivated, driven, able to accomplish a lot without getting tired.
Elevated mood	Happy, excited, giddy, good humored, feeling a spiritual sense of connection.
Irritable	Impatient, reactive, short-fused, feeling people have it out for them, starting fights or arguments.
Hyperactive	Exercising or moving more, feeling restless, socializing more, making lots of plans or starting many projects.
Impulsive	Spending more money, driving faster, engaging in sudden travel, starting new relationships or projects, gambling, using drugs, hypersexuality.
Decreased need for sleep	Able to stay active despite sleeping less than 6 hours a day.
Increased confidence	Being more certain of their ideas or abilities, optimistic, self-important, or arrogant.
Distracted	Changing tasks frequently, thoughts shift from topic to topic, easily distracted by things around them.
Racing thoughts	Having lots of ideas, thoughts may be crowded or hard to keep up with, or so intense that they can't shut them off.
Rapid or pressured speech	People can't follow what they're saying. They interrupt a lot or talk over people.

What hypomania feels like // bipolar disorder



11:01 / 19:40



6 Ways to Miss Hypomania



1. Happiness Myth





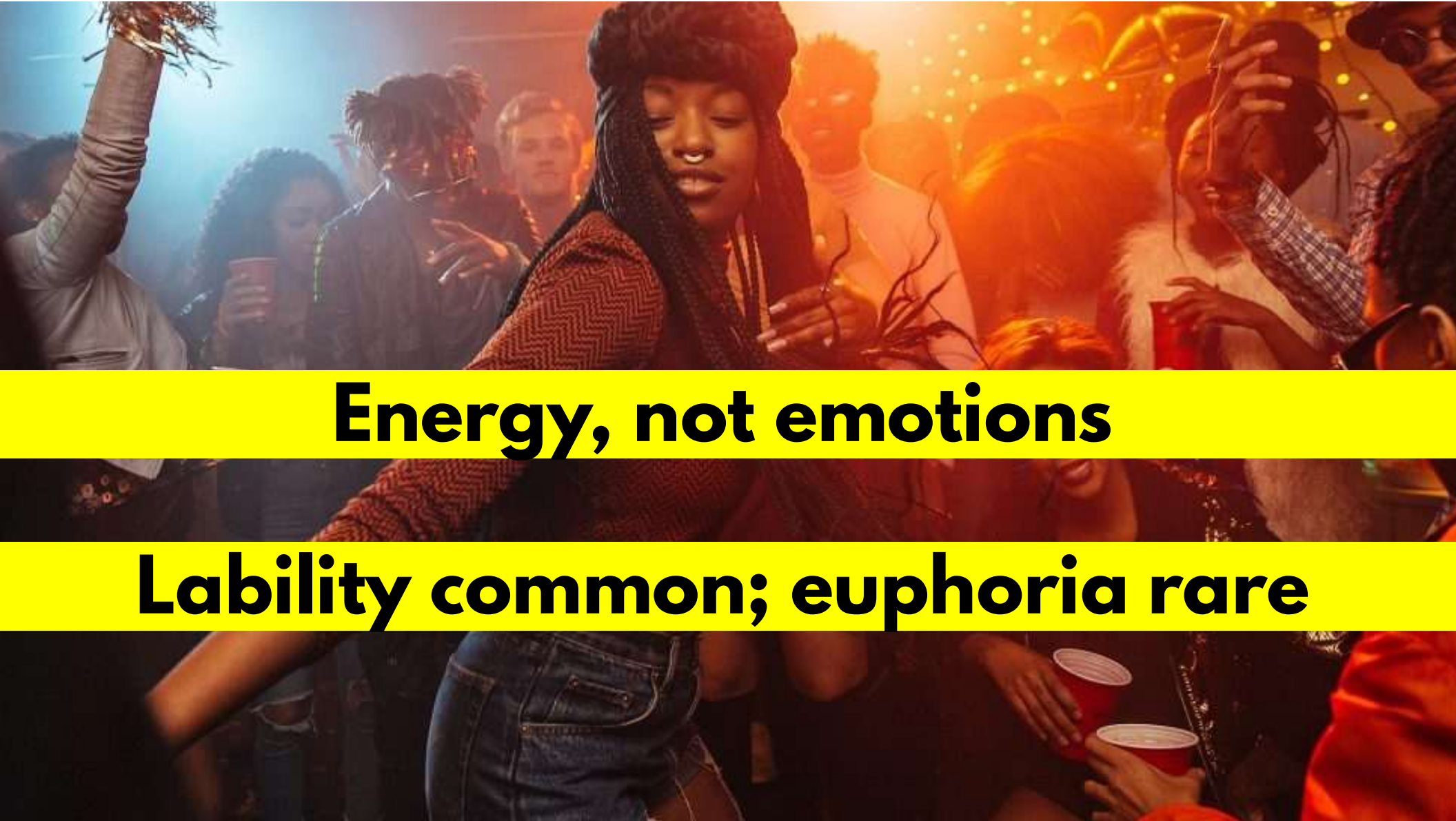
**“I felt infinitely worse
[during mania] than when in
the midst of my worst
depressions...”**

**—Kay Redfield Jamison,
An Unquiet Mind, 1996**



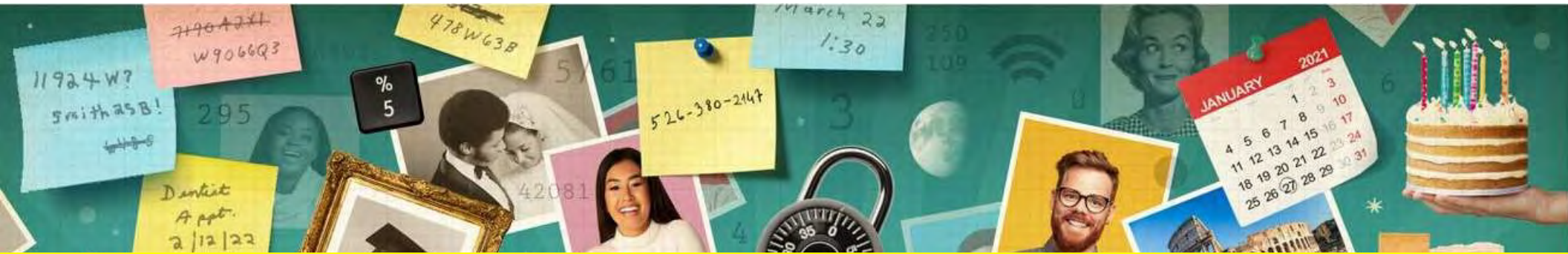
Loss of control over your own mind





Energy, not emotions

Lability common; euphoria rare



2. State Dependent Memory



**Feelings are difficult to recall.
Instead, look for behaviors.**



Doing much more than usual...

Taking on risks...

Driving aggressively

Spending too much, breaking the law

Making major life decisions

Suddenly starting/ending relationships

3. Rationalizations

“Yes, but...”



“Only when I have a lot to do”

“Just when good things happen”

“Having a good time with friends”



“Retail therapy, porn, gambling, binge eating...

the only way I can feel better when depressed”

A man with short dark hair and a light beard, wearing a white long-sleeved shirt, is shown from the chest up. He is looking off to the left with a thoughtful expression, his right hand resting on his chin. The background is a solid light blue. A bright yellow horizontal banner is superimposed over the middle of the image, containing the text '4. Ambiguous Answers' in bold black font.

4. Ambiguous Answers



These may mean yes...

“Not really”

“Sort of”



“Not really”



These may mean yes...

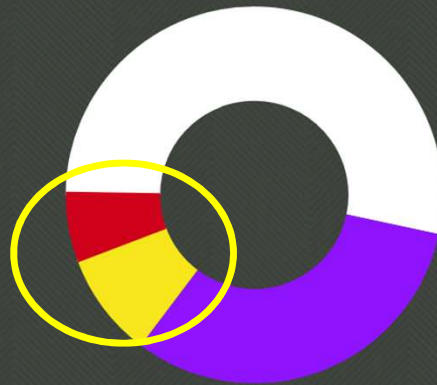
“Very rarely”

“Not in a long time”

Depression Predominates

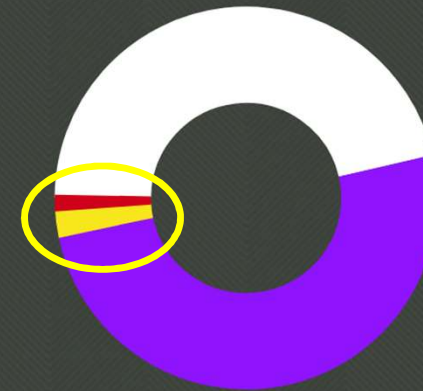
Manic/mixed = 4-15% of lifespan

Bipolar I



■ Relative well (53.30%) ■ Depression (31.90%) ■ Mixed (8.90%)
■ Mania/Hypomania (5.90%)

Bipolar II



■ Relative well (46.20%) ■ Depression (50.30%) ■ Mixed (2.30%)
■ Hypomania (1.20%)



5. “Yes... When I’m *not* depressed”

The Sydney Bipolar Screener

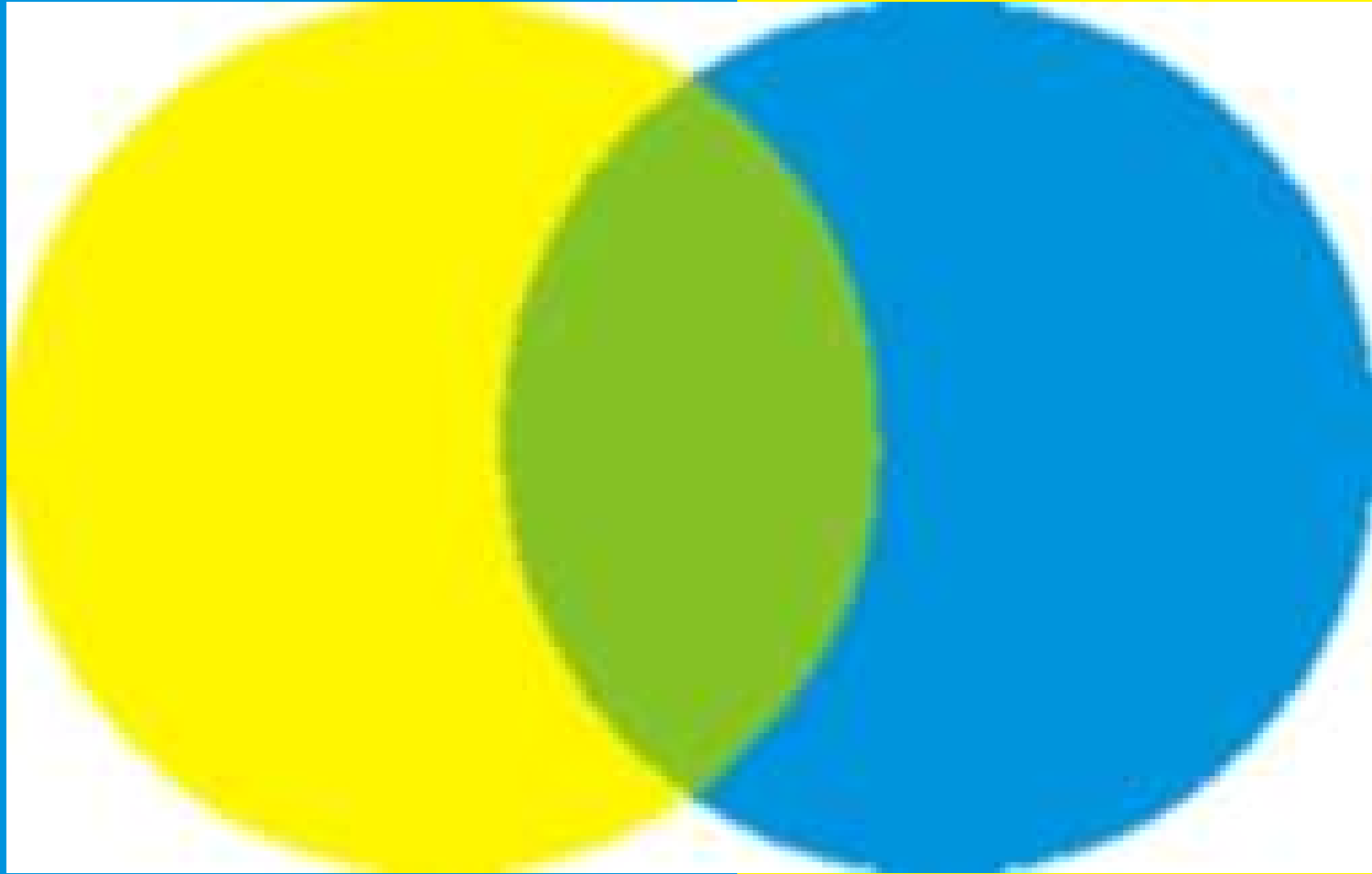
Apart from times when you are depressed or in a normal mood state, do you have times when you feel “up”? If so, check whether you experience any of the following features.

I have very high levels of energy	<input type="checkbox"/> Yes <input type="checkbox"/> No
I feel “bulletproof” or invulnerable	<input type="checkbox"/> Yes <input type="checkbox"/> No
I talk over people and am difficult to interrupt	<input type="checkbox"/> Yes <input type="checkbox"/> No
My thoughts race so quickly that it is difficult to retain them	<input type="checkbox"/> Yes <input type="checkbox"/> No
I am irritable and angry	<input type="checkbox"/> Yes <input type="checkbox"/> No
My judgment becomes impaired	<input type="checkbox"/> Yes <input type="checkbox"/> No
I am much more creative	<input type="checkbox"/> Yes <input type="checkbox"/> No
I am very distractible	<input type="checkbox"/> Yes <input type="checkbox"/> No
I feel that I can achieve great things	<input type="checkbox"/> Yes <input type="checkbox"/> No
I talk more quickly	<input type="checkbox"/> Yes <input type="checkbox"/> No

Score 1 point for each item endorsed. For patients with a history of depression, a score of 6 or more suggests a strong likelihood of bipolar disorder (97% sensitivity and 96% specificity).

6. Missing Mixed States







Mixed States

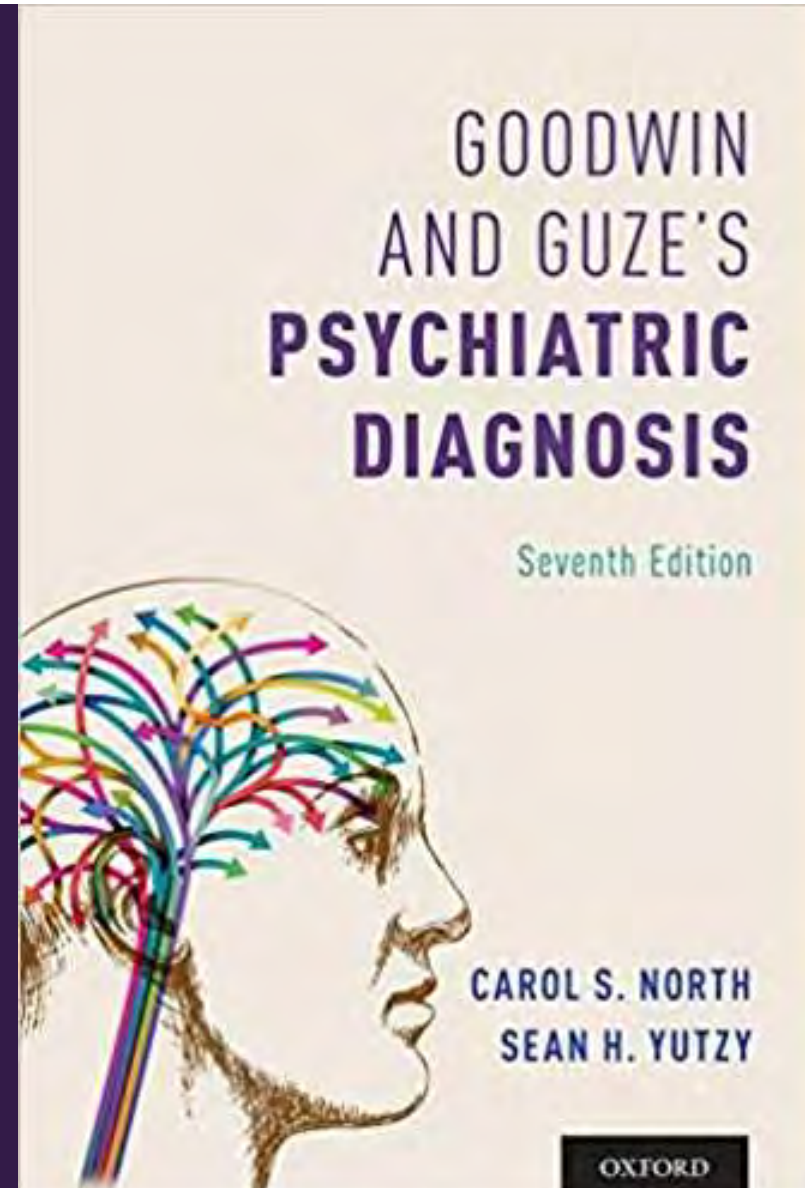
Hypo/manic symptom	How it looks in a mixed state
Elevated energy	An uncomfortable, anxious energy that is commonly described as “wired, restless, crawling out of my skin.”
Elevated mood	Emotions swing rapidly from one to another (e.g., oscillating between irritable, sad, anxious, despairing, and – rarely – giddy or happy).
Irritable	Angry, impatient, reactive, short-fused, feeling people have it out for them, starting arguments or isolating themselves to avoid other people.
Hyperactive	Pacing from room to room without a clear purpose, feeling agitated or tense, going on random walks or drives.
Impulsive	Engaging in reckless, destructive actions (e.g., suddenly leaving relationships or jobs, breaking things, driving aggressively). Sometimes, pleasure is pursued impulsively, in which case it feels like a desperate attempt to relieve the depression (e.g., overspending through “retail therapy,” binge eating, addictive behavior, pornography).
Decreased need for sleep	Sleep is random; they may be up all night and asleep during the day. When their amount of sleep is decreased, they still feel like they need it, in part because sleep offers some relief from the terrible anxiety of a mixed state.
Increased confidence	They probably don’t feel too good about themselves, but they may come across as demanding, pushy, or stubborn to others.
Distracted	Changing tasks frequently, disorganized, finding it hard to think, shifting thoughts from one anxious topic to another.
Racing thoughts	Their mind is crowded with depressive or anxious thoughts, imagining the worst-case scenario. It’s hard to shut their mind off, particularly at night.
Rapid or pressured speech	There’s an urgent, emotional tone to their speech.

Bipolar Markers



Disease Validators

1. Symptoms
2. Course of illness
3. Exclusion of other disorders
4. Treatment response
5. Genetics



Bipolarity Index

1. Episode Characteristics

2.

3.

4.

5.

Cut off = 50 out of 100

Sensitivity/Specificity = 0.9

Aiken C et al, *Journal of Affective Disorders* 2015

I. Episode Characteristics	
20	• Acute manic or mixed episode with prominent euphoria, grandiosity or expansiveness and no significant medical or other secondary etiology.
15	• Acute mixed episode or dysphoric or irritable mania with no significant medical or other secondary etiology.
10	• Hypomanic episode with no significant medical or other secondary etiology; or • Cyclothymia with no significant medical or other secondary etiology; or • A manic episode within 12 weeks of starting an antidepressant.
5	• A hypomanic episode within 12 weeks of starting an antidepressant • Episodes with characteristic symptoms of hypomania, but symptoms, duration, or intensity are subthreshold for hypomania; or • A single MDE with psychotic or atypical features (atypical is ≥2 of the following: hypersomnia, hyperphagia or leaden paralysis of limbs); or • Any postpartum depression.
2	• Recurrent unipolar major depressive disorder (≥3 episode); or • History of any kind of psychotic disorder (i.e., presence of delusions, hallucinations, ideas of reference or magical thinking).
0	• No history of significant mood elevation, recurrent depression or psychosis.
II. Age of Onset (first affective episode or syndrome)	
20	• 15 to 19 years.
15	• Before age 15 or between age 20 and 30.
10	• 30 to 45 years.
5	• After age 45.
0	• No history of affective illness (no episodes, cyclothymia, dysthymia or bipolar-NOS).
III. Course of Illness & Associated Features	
20	• Recurrent, distinct manic episodes separated by at least 2 months of full recovery.
15	• Recurrent, distinct manic episodes with incomplete inter-episode recovery; or • Recurrent, distinct hypomanic episodes with full inter-episode recovery.
10	• Any substance use disorder (excluding nicotine/caffeine); or • Psychotic features only during acute mood episodes; or • Incarceration or repeated legal offenses related to manic behavior (e.g. shoplifting, reckless driving or bankruptcy).
5	• Recurrent unipolar MDD with ≥3 or more major depressive episodes; or • Recurrent, distinct hypomanic episodes without full inter-episode recovery; or • Borderline personality disorder, anxiety disorder (including PTSD and OCD), eating disorder; or history of ADHD with onset before puberty; or • Engagement in gambling or other risky behaviors with the potential to pose a problem for patient, family or friends; or • Behavioral evidence of perimenstrual exacerbation of mood symptoms.
2	• Baseline hyperthymic personality when not manic or depressed; or • Marriage 3 or more times (including remarriage to the same individual); or • In two or more years, has started a new job and changed jobs after less than a year; or • Has more than two advanced degrees.
0	• None of the above.
IV. Response to Treatment	
20	• Full recovery within 4 weeks of therapeutic treatment with a mood stabilizer.
15	• Full recovery within 12 weeks of therapeutic treatment with a mood stabilizer or relapse within 12 weeks of discontinuing treatment; or • Affective switch to mania (pure or mixed) within 12 weeks of starting a new antidepressant or increasing dose.
10	• Worsening dysphoria or mixed symptoms during antidepressant treatment subthreshold for mania (exclude worsening that is limited to known antidepressant side effects such as akathisia, anxiety or sedation); or • Partial response to one or two mood stabilizers within 12 weeks of therapeutic treatment; or • Antidepressant-induced new or worsening rapid-cycling course.
5	• Treatment resistance: lack of response to complete trials of 3 or more antidepressants; or • Affective switch to mania or hypomania with antidepressant withdrawal.
2	• Immediate, near-complete response to antidepressant withdrawal within 1 week or less.
0	• None of the above, or no treatment.
V. Family History	
20	• At least one first-degree relative with clear bipolar disorder.
15	• At least one second-degree relative with clear bipolar disorder; or • At least one first-degree relative with recurrent unipolar MDD and behavioral evidence suggesting bipolar disorder.
10	• First-degree relative with recurrent unipolar MDD or schizoaffective disorder; or • Any relative with clear bipolar disorder or recurrent unipolar MDD and behavioral evidence suggesting bipolar disorder.
5	• First-degree relative with clear substance use disorder (excluding nicotine/caffeine); or • Any relative with possible bipolar disorder.
2	• First-degree relative with possible recurrent unipolar MDD; or • First-degree relative with anxiety disorder (including PTSD and OCD), eating disorder or ADD/ADHD.
0	• None of the above or no family history of psychiatric disorders.

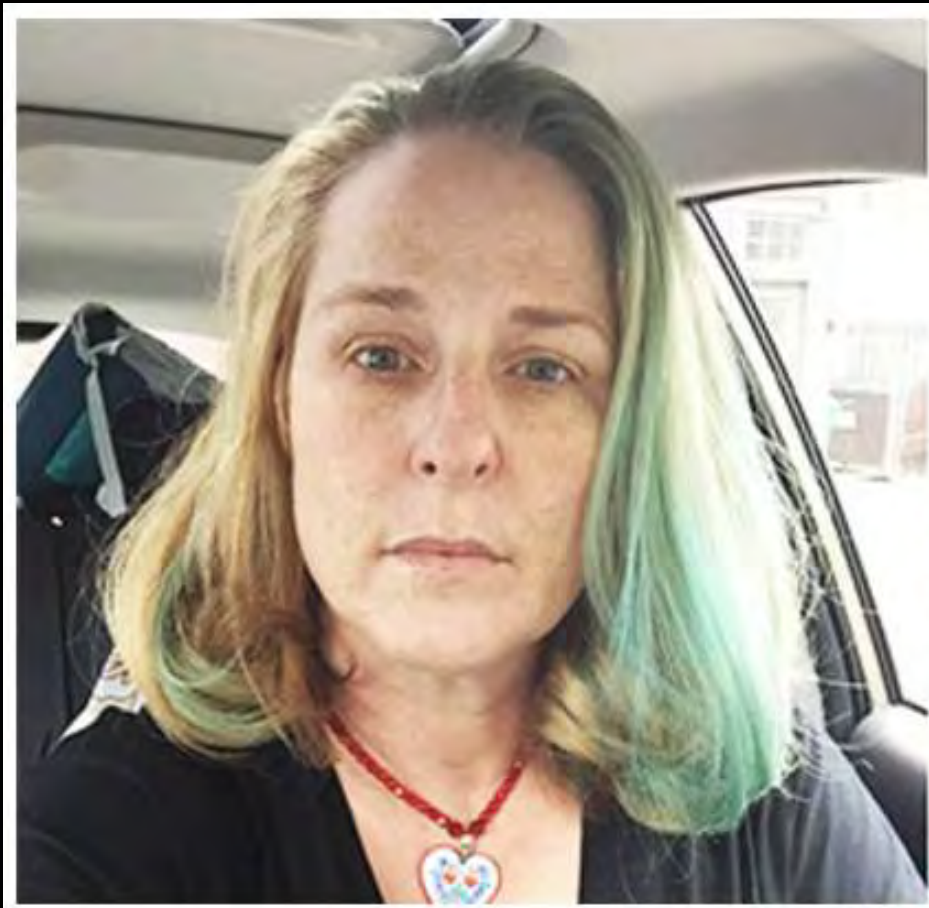
I. Episode Characteristics	
20	<ul style="list-style-type: none"> Acute manic or mixed episode with prominent euphoria, grandiosity or expansiveness and no significant medical or other secondary etiology.
15	<ul style="list-style-type: none"> Acute mixed episode or dysphoric or irritable mania with no significant medical or other secondary etiology.
10	<ul style="list-style-type: none"> Hypomanic episode with no significant medical or other secondary etiology; or Cyclothymia with no significant medical or other secondary etiology; or A manic episode within 12 weeks of starting an antidepressant.
5	Recurrent subsyndromal hypomania (< 4 days or not enough symptoms)
2	Recurrent depression (≥ 3 episodes)
0	<ul style="list-style-type: none"> No history of significant mood elevation, recurrent depression or psychosis.
II. Onset	
20	Onset age 17
15	<ul style="list-style-type: none"> Before age 15 or between age 20 and 30.
10	<ul style="list-style-type: none"> 30 to 45 years.
5	<ul style="list-style-type: none"> After age 45.
0	<ul style="list-style-type: none"> No history of affective illness (no episodes, cyclothymia, dysthymia or bipolar-NOS).
III. Course of Illness & Associated Features	
20	<ul style="list-style-type: none"> Recurrent, distinct manic episodes separated by at least 2 months of full recovery.
15	<ul style="list-style-type: none"> Recurrent, distinct manic episodes with incomplete inter-episode recovery; or Recurrent, distinct hypomanic episodes with full inter-episode recovery.
10	<ul style="list-style-type: none"> Any substance use disorder (excluding nicotine/caffeine); or Psychotic features only during acute mood episodes; or Incarceration or repeated legal offenses related to manic behavior (e.g. shoplifting, reckless driving or bankruptcy).
5	Recurrent depression Comorbid PTSD and OCD
2	<ul style="list-style-type: none"> Baseline hyperthymic personality when not manic or depressed; or Marriage 3 or more times (including remarriage to the same individual); or In two or more years, has started a new job and changed jobs after less than a year; or Has more than two advanced degrees.
0	<ul style="list-style-type: none"> None of the above.

30
Score

50
Score

IV. Response to Treatment	
20	• Full recovery within 4 weeks of therapeutic treatment with a mood stabilizer.
15	• Full recovery within 12 weeks of therapeutic treatment with a mood stabilizer or relapse within 12 weeks of discontinuing treatment; or • Affective switch to mania (pure or mixed) within 12 weeks of starting a new antidepressant or increasing dose.
10	• Worsening dysphoria or mixed symptoms during antidepressant treatment subthreshold for mania (exclude worsening that is limited to known Worsened dysphoria after starting an antidepressant
5	Non response to ≥ 3 antidepressants
2	• Immediate, near-complete response to antidepressant withdrawal within 1 week or less.
0	• None of the above, or no treatment.
V. Family History	
20	• At least one first-degree relative with clear bipolar disorder.
15	• At least one second-degree relative with clear bipolar disorder; or • At least one first-degree relative with recurrent unipolar MDD and behavioral evidence suggesting bipolar disorder.
10	Father also had a gambling problem
5	• First-degree relative with clear substance use disorder (excluding nicotine/cocaine); or • Any relative with possible bipolar disorder.
2	Father has recurrent depression
0	• None of the above or no family history of psychiatric disorders.
← Total score (0 – 100). Add the highest number in each section. A score ≥50 indicates a high probability of bipolar disorder.	

Mental Status



Depression

Validation of BP Index

Comparison	N	Sensitivity	Specificity	Cut-off	
BP vs. All outpatients	1903	0.91	0.90	50	Aiken et al 2015
BP vs. MDD	220	0.96	0.88	42	Ma et al 2016
BP-II vs. MDD-recurrent	389	0.74	0.72	22	Mosolov et al 2014
BP vs Borderline	63	0.90	0.88	50	Apfelbaum et al 2013
Conversion to BP from MDD over 9 years	1857	0.67	0.52	30	Meulen et al 2020

The Rapid Mood Screen

1	Have there been at least 6 different periods of time (at least 2 weeks) when you felt deeply depressed?	Y	N
2	Did you have problems with depression before the age of 18?	Y	N
3	Have you ever had to stop or change your antidepressant because it made you highly irritable or hyper?	Y	N
4	Have you ever had a period of at least 1 week during which you were more talkative than normal with thoughts racing in your head?	Y	N
5	Have you ever had a period of at least 1 week during which you felt any of the following: unusually happy; unusually outgoing; or unusually energetic?	Y	N
6	Have you ever had a period of at least 1 week during which you needed much less sleep than usual?	Y	N

Cut off ≥ 4 items

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**The final scale had
better predictive
properties than than
most self-rated
screening instruments
for bipolar disorder**

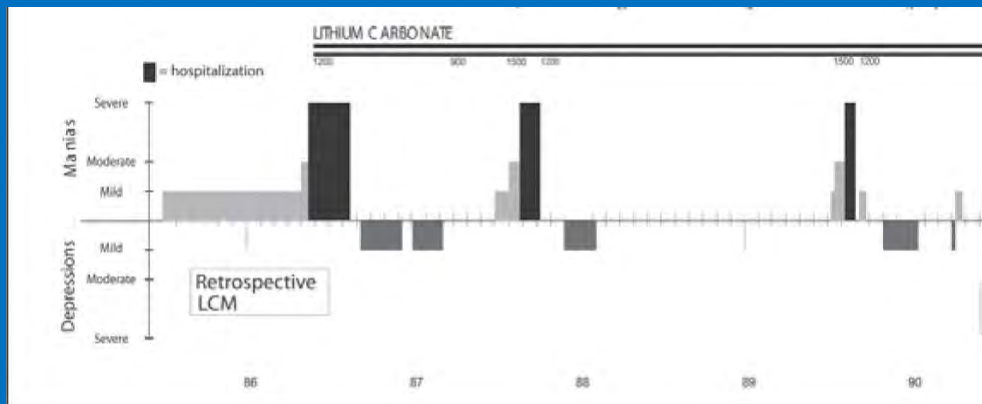
≥ 4
Cut-off

0.88
Sensitivity

0.80
Specificity

Classic Bipolar

- Euphoric mania or hypomania
- Clear separation of mania, depression, and normal self
- Rare mixed states and rapid cycling
- Healthy personality with few comorbid conditions
- Very responsive to lithium



“The most noxious assumption that we can fulfill is the feeling by patients that we represent the “system,” the status quo of power and privilege.

We will label the patient as sick, and then send them through a rigamarole of diagnosis and treatment that will end up with his extrusion as a “patient,” often without an active and productive role in society or a strong sense of self-worth.”

—Ghaemi and Havens,
American Journal of Psychotherapy, 2005



Questions? caiken@thecarlatreport.com