CE

CONTINUING EDUCATION DIAGNOSING AND TREATING BIPOLAR SPECTRUM DISORDERS

BY ZARA ABRAMS

In the 1990s, bipolar disorder was seen as a severe, rare, incurable condition found only in adults. Medication, primarily lithium, was the sole treatment offered to most patients. Today, experts are learning that the disorder is more common—affecting about 4% of U.S. children and adults—and presents along a diverse continuum. More than half of patients have their first mood symptoms in childhood or adolescence, a full range of treatments exist, and people with the condition can survive and thrive (Moreira, A. L., et al., *The Journal of Clinical Psychiatry*, Vol. 78, No. 9, 2017; Van Meter, A., et al., *The Journal of Clinical Psychiatry*, Vol. 80, No. 3, 2019). ¶ "The more we study bipolar disorder, the more we appreciate its complexity, especially around the onset of symptoms and in the underserved," said Manpreet K. Singh, MD, an associate professor of psychiatry and behavioral sciences at Stanford University. "There isn't going to be a single genetic marker, research tool, or treatment plan that resolves this complexity."

Psychologists and psychiatrists studying bipolar disorder are characterizing complexities of the condition, including its earliest symptoms, longitudinal course, and the psychological factors that increase risk of recurrences. They are also applying new approaches (such as studying vascular contributions to the condition) and technologies (including using wearable devices) to obtain rich new data.

All of this is driving two major shifts that are already proving life-changing for patients: earlier and more accurate diagnosis and increasingly personalized treatments.

"For a long time, there has been so much stigma, so much confusion, and so much uncertainty about this illness," said Eric A. Youngstrom, PhD, a professor of psychology, neuroscience, and psychiatry at the University of North Carolina at Chapel Hill who studies bipolar disorder. "We now have a revolutionary new view for diagnosing and treating bipolar disorder that I'm positive can make a difference in people's lives."

COMPLEX DIAGNOSIS

Bipolar disorder is an episodic condition in which patients cycle between two or more mood states. Diagnosis is typically a two-step process: Clinicians first diagnose mood episodes—such as mania, hypomania, or depression—and then they diagnose the disorder itself.

Mania is a distinct period of an elevated or irritable mood, along with persistent goal-directed behavior or energy, that lasts at least 1 week and potentially up to a few months and causes marked impairment, according to the Diagnostic and Statistical Manual of Mental Disorders (Fifth Edition). Common symptoms include grandiosity, a decreased need for sleep, and excessive risky activity. A hypomanic episode is less severe: It lasts at least 4 days but does not cause marked impairment.

A depressive episode—which includes symptoms such as loss of interest, weight loss or gain, and thoughts of suicide—lasts 2 or more weeks and causes both impairment and distress. Mixed states, which are some of the hardest to treat, consist of phases with both manic and depressive symptoms. People with mixed states often have extreme irritability, volatility, and a high risk for suicide.

Euthymia, defined as mood functioning within normal limits, is crucial in diagnosing bipolar disorder because it helps clinicians find the beginning of a mood episode such as mania or hypomania. A patient who rapidly cycles between manic and depressive symptoms without a clear euthymia, for example, may be experiencing anxiety or attention-deficit/hyperactivity disorder (ADHD) rather than a mood disorder.

The DSM-5 lists four major categories of bipolar spectrum

EMILIE BARBIER/EYEEMGETTY IMAGES

CE credits: 1

Learning objectives: After reading this article, CE candidates will be able to:

1. Discuss how psychologists' understanding of bipolar disorder has changed over the past 3 decades.

2. Describe mood states, symptoms, and diagnostic criteria for the four bipolar spectrum disorders.

3. List front-line pharmacological and psychological treatments for bipolar disorder.

For more information on earning CE credit for this article, go to www.apa.org/ed/ce/resources/ce-corner.

Patients with bipolar disorder cycle between two or more mood states, such as mania, hypomania, or depression.

disorders, as well as versions of the illness induced by substances and other medical conditions, such as stroke or traumatic brain injury.

Bipolar I disorder is characterized by manic or mixed episodes, with or without depression, while bipolar II disorder involves episodes of hypomania and depression. Cyclothymic disorder involves depressive and hypomanic symptoms that cause impairment but do not meet the severity or duration criteria for bipolar I or II. The clinical picture of these disorders, including symptoms, prognosis, and comorbidities, typically looks similar in children and adults.

A fourth category, known as "other specified bipolar and related disorder," describes patients with episodic mood symptoms who do not meet the criteria for the other three disorders—for example, a patient with recurrent manic symptoms that cause impairment but last less than 1 week. This disorder is more common than bipolar I or II, especially in children and adolescents, and carries a similar risk for co-occurring psychiatric conditions, suicide attempts, and family history of bipolar disorder. Research also suggests that in patients with a family history of the illness, about half go on to develop bipolar I or II (Axelson, D. A., et al., *Journal of the American Academy of Child & Adolescent Psychiatry*, Vol. 50, No. 10, 2011).

Experts argue that this points to the importance of providing support early on, even if it is not yet clear whether a patient will develop more severe mood symptoms (Singh, M. K., et al., *Bipolar Disorders*, Vol. 22, No. 7, 2020).

"The field needs to move toward something similar to what we see in heart disease, where we don't wait for the full manifestation of the illness before acting," said Benjamin Goldstein, MD, PhD, a professor of psychiatry and pharmacology at the University of Toronto and director of the Centre for Addiction and Mental Health's Centre for Youth Bipolar Disorder in Toronto.

EARLIER IDENTIFICATION

Unfortunately, psychology and psychiatry have a poor record when it comes to the timely and accurate diagnosis of bipolar disorder, with a high rate of missed diagnoses and an average lag time of 5 or more years between the onset of mood symptoms and a diagnosis of bipolar disorder (Jensen-Doss, A., et al., *Journal of Consulting and Clinical Psychology*, Vol. 82, No. 6, 2014; Marchand, W. R., et al., *Journal of Psychiatric Practice*, Vol. 12, No. 2, 2006).

Part of the problem is that with their diverse range of states and symptoms, bipolar spectrum disorders can look like major depression, anxiety, psychosis, substance use disorders, autism spectrum disorders, ADHD, personality disorders, or conduct disorders.

Consider two patients who visited a mental health clinic. Tamika, an 11-year-old girl, came in with her mother, who reported that her daughter had sudden increases in anger, aggression, and trouble sleeping. At home, Tamika threw toys and broke dishes; at school, she was loud and disruptive. Lea, an 18-year-old in her senior year of high school, came in by herself, reporting problems with attention and anxiety about graduation and going to college. She thought she had ADHD. Could either of these patients have bipolar disorder?

To simplify the process of assessment and cut down on diagnostic errors when patients like Tamika or Lea come into a clinic, Youngstrom and his colleagues advocate that clinicians use a probability-based approach to diagnosis—akin to counting cards in blackjack—and they have created and tested a freely available model for doing so.

Youngstrom's evidence-based assessment (EBA) model relies on an algorithm that makes risk calculations using the clinical evidence base. For example, compared with someone with no family history of mood disorders, a person's chance of having bipolar disorder is 5 times higher if a parent or sibling has it, but only 2.5 times higher if a grandparent, aunt, or uncle does. The EBA model walks clinicians through a step-by-step evaluation that includes benchmark rates of various disorders, recommendations for high-quality clinical questionnaires, and reminders to ask about mitigating factors such as substance use, trauma, and bereavement (*Cognitive and Behavioral Practice*, Vol. 22, No. 1, 2015). Unlike machine-learning approaches, the EBA method keeps the clinician in the driver's seat, choosing whether to obtain more information and when and how to begin treatment.

Using the EBA model, a clinician diagnosed Lea with bipolar II disorder. By looking at screening questionnaires, gathering family history, and asking focused questions during the clinical interview, her provider found evidence that

ABOUT CE

"CE Corner" is a continuing-education article offered by APA's Office of CE in Psychology.

To earn CE credit, after you read this article, complete an online learning exercise and take a CE test. Upon successful completion of the test—a score of 75% or higher—you can immediately print your certificate.

To purchase the online program, visit www.apa.org/ed/ce/resources/ce-corner. The test fee is $25 for members and $35 for nonmembers. For more information, call (800) 374-2721.

As an APA member, take advantage of your five free CE credits per year. Select the free online programs through your MyAPA account.

built the case for bipolar. Lea often slept less than usual yet had more energy. During such periods, she was more likely to fight with her mother and friends. And her father, who no longer lived at home, had bipolar disorder. Tamika, on the other hand, did not meet the criteria for any bipolar spectrum disorder. Instead, her clinical interview uncovered a recent sexual assault, leading to a diagnosis of post-traumatic stress disorder.

In some cases, a clinician may not reach 100% certainty that a patient has bipolar disorder, but early psychosocial and lifestyle interventions can improve long-term prospects, Goldstein said, especially in youth. "The more we can support young brains in developing healthy executive functioning, the better youth will be able to manage the illness if it strikes them," he said.

Family-focused therapy (FFT), an intervention that teaches patients and family members about bipolar disorder and helps them communicate and solve problems related to mood episodes, can reduce depression and suicidal ideation in youth at risk for bipolar disorder (Miklowitz, D. J., et al., *JAMA Psychiatry*, Vol. 77, No. 5, 2020).

"When kids are showing early warning signs of bipolar disorder, the stress faced by families can be overwhelming, but how parents deal with these early signs can make a huge difference in kids' outcomes," said psychologist David Miklowitz, PhD, a professor of psychiatry at the University of California, Los Angeles.

MICROGEN/GETTY IMAGES

Early evidence indicates that wearing blue light–blocking glasses, which help trigger melatonin production, before bedtime can help stabilize manic symptoms.

KEY POINTS

1. New research reveals that bipolar spectrum disorders are more prevalent, treatable, and complex than experts once thought.
2. More than half of patients have their first mood symptoms in childhood or adolescence, and accurate assessment is crucial for early intervention.
3. Front-line treatment typically involves a combination of medication and psychotherapy.

FURTHER READING

Evidence-based assessment
Youngstrom, E. A., et al.
Wikiversity, 2021

Expanding bipolar outreach during college
Singh, M. K., et al.
Journal of Affective Disorders, 2021

The bipolar disorder survival guide (3rd ed.)
Miklowitz, D. J.
Guilford Press, 2019

LONG-TERM TREATMENT

Front-line treatment for most patients with bipolar disorder typically still includes medication, but there is also a growing recognition among many clinicians that drugs alone are not sufficient.

"We're now realizing we can't just treat everyone with medications," said Miklowitz. "Psychoeducational treatment is very important in helping people learn how to cope with the disorder."

Before starting psychotherapy, most patients who seek help during an acute episode of mania or depression receive an antipsychotic drug or mood stabilizer. Lithium is still considered the gold standard for both youth and adults, but it tends to work best for patients with bipolar I and a family history of the disorder (Grof, P., *Neuropsychobiology*, Vol. 62, No. 1, 2010). Long-term use of lithium, however, can lead to chronic kidney or thyroid problems, so providers and patients should carefully monitor side effects and seek the support of a physician when necessary (Forlenza, O. V., et al., *The British*

Journal of Psychiatry, Vol. 215, No. 5, 2019).

Another issue is that patients may stop taking lithium once they feel stable, which puts them at high risk for additional mood episodes, hospitalization, and suicide (Prajapati, A. R., et al., *Psychological Medicine*, Vol. 51, No. 7, 2021). For that reason, experts say it is particularly important to combine medications with psychotherapy.

Increasingly, psychopharmacology research is offering alternatives, such as the new antipsychotic drug lurasidone (Pikalov, A., et al., *International Journal of Bipolar Disorders*, Vol. 5, No. 9, 2017) and the anesthetic ketamine, which has been proven effective for treatment-resistant depression (Kryst, J., et al., *Pharmacological Reports*, Vol. 72, 2020). Rapid transcranial magnetic stimulation, which involves electrical activation of the frontal cortex, is also showing promise for depression and may help patients with bipolar disorder, Miklowitz said, but more research is needed (Nguyen, T. D., et al., *Journal of Affective Disorders*, Vol. 279, 2021).

"Many people who live with bipolar disorder spend more days depressed than they do manic," said Singh. "Researchers are now putting some muscle and grease into understanding how we treat bipolar depression over the long term."

Once a patient is stable, psychotherapy can help them learn to navigate life with bipolar disorder. FFT, which Miklowitz developed, educates patients and their families about the disorder, including how to recognize early warning signs of a mood episode, such as altered sleep patterns. Typically delivered after a person's first or second mood episode and lasting up to 9 months, FFT helps families create a relapse prevention plan and learn how to communicate effectively (*Family Process*, Vol. 55, No. 3, 2016).

"With this disorder, psychotherapy is typically time-limited," Miklowitz said. "Research has shown that 3-, 6-, or 9-month treatments focused on education and skill-building are effective in preventing recurrences and improving overall functioning."

Psychosocial interventions such as FFT can be modified to help patients manage the symptoms of bipolar disorder across the life span. In adults, the sessions often include a spouse and cover additional concerns, such as physical intimacy. For older adults, sessions may include an adult child who is a caretaker. Clinicians may also incorporate neuropsychological testing to determine whether a patient is also experiencing dementia.

Interpersonal and social rhythm therapy (IPSRT), developed by psychologist Ellen Frank, PhD, a professor of psychiatry and psychology at the University of Pittsburgh School of Medicine, and her colleagues, also delivers psychoeducation and helps patients regulate their daily routines, including work, social interactions, and sleep-wake cycles. IPSRT has been shown to reduce manic and depressive symptoms and to improve overall functioning in people with bipolar spectrum disorders (Steardo, L., et al., *Annals of General Psychiatry*, Vol. 19, No. 15, 2020). Cognitive behavioral therapy, dialectical behavior therapy, and group therapy—which offers the added benefit of peer support—are similarly effective (Novick, D. M., & Swartz, H. A., *Focus*, Vol. 17, No. 3, 2019; Goldstein, T. R., et al., *Journal of Child and Adolescent Psychopharmacology*, Vol. 25, No. 2, 2015).

Teaching patients and their families how to solve problems related to mood episodes can reduce depression and suicide ideation in youth at risk for bipolar disorder.

JANE/GETTY IMAGES

IPSRT works partly by stabilizing mood through establishing regular sleep-wake cycles. Another inexpensive, low-risk way to regulate sleep is with blue light–blocking glasses, which help trigger melatonin production. Indeed, early evidence indicates that wearing blue light–blocking glasses before bedtime can help stabilize manic symptoms (Hester, L., et al., *Chronobiology International*, Vol. 38, No. 10, 2021).

Growing evidence also supports lifestyle changes in nutrition and physical activity. Eating and exercising in accordance with U.S. Department of Health and Human Services guidelines can improve emotional well-being, Goldstein said, and it can also boost cardiovascular health, which is implicated in bipolar disorder. Research by Goldstein and others shows that chronic inflammation harms brain health and may predict worse treatment outcomes in bipolar disorder (*Bipolar Disorders*, Vol. 22, No. 5, 2020).

For older patients, cognitive rehabilitation therapies, which are currently still in early trials, may become increasingly important, Miklowitz said. Research suggests that memory and other cognitive functions can deteriorate over time with successive mood episodes, and such therapies may help patients regain functioning (Solé, B., et al., *International Journal of Neuropsychopharmacology*, Vol. 20, No. 8, 2017).

To fully support patients with bipolar disorder, a coordinated effort between psychologists, who excel at developing and delivering psychosocial interventions, and psychiatrists, who have a sophisticated understanding of how medications can help, is crucial—and can even ameliorate depressive symptoms (Van der Voort, T. Y. G., et al., *The British Journal of Psychiatry*, Vol. 206, No. 5, 2018).

"It takes a village to treat bipolar disorder," said Singh. "When patients, caregivers, psychiatrists, and allied mental

STEFANAMER/GETTY IMAGES

SYMPTOMS

DIAGNOSING BIPOLAR DISORDERS

MOOD EPISODES

Mania

- Elevated or irritable mood and persistent goal-directed behavior or energy
- Lasts at least 1 week
- Causes marked impairment

Hypomania

- Elevated or irritable mood and persistent goal-directed behavior or energy
- Lasts at least 4 days
- Does not cause marked impairment

Depression

- Depressed mood or loss of interest in life
- Lasts at least 2 weeks
- Causes impairment and distress

Mixed

- Episode includes both manic and depressive symptoms
- "Mixed mania" lasts at least 1 week or triggers hospitalization
- "Mixed hypomania" lasts at least 4 days with both depressed and hypomanic symptoms
- "Mixed depression" lasts at least 2 weeks with additional manic symptoms
- Causes marked impairment

BIPOLAR DISORDERS

Bipolar I

- Manic or mixed-manic episodes required for diagnosis
- Can diagnose with or without depressive episodes

Bipolar II

- No history of manic or mixed episodes
- Diagnosis requires combination of hypomania and depression

Cyclothymia

- Combination of depresive and hypomanic episodes, but patients do not meet criteria for bipolar II

Other specified bipolar and related disorder

- Manic symptoms that do not fit into the other diagnostic categories
- Common diagnosis for children and adolescents

health professionals work collaboratively, outcomes may be better than treatment by either a psychologist or psychiatrist alone."

OPPORTUNITIES FOR RESEARCH

Even with these major strides in diagnosing and treating bipolar disorder, challenges remain. For one, interventions for bipolar depression are still less effective than those used for unipolar depression, and clinicians urgently need better options for their patients, said Goldstein. Some mood episodes, such as mixed states, and certain symptoms, such as irritability, attention problems, and anhedonia—or lack of motivation—also remain tough to treat, said Singh, and may ultimately require a multipronged approach. "Our patients are hungry for it. Usually, it's those symptoms that linger that bring them to see us," she said.

More attention is also needed to the longitudinal course of the illness, researchers say, which can continue to help delineate tailored treatment options. Clinicians hope to increasingly make personalized recommendations for medication and psychotherapy based on a patient's symptom presentation, genetic risk, family history, recent environmental stressors, lifestyle factors, and more. For example, providers may soon be able to better predict which patients will do well with a 6-month course of psychotherapy and which will require regular check-ins with a provider.

Researchers are also further exploring how wearable devices and smartphone apps can help patients track and manage mood symptoms. Miklowitz is testing a version of FFT that includes app-based mood tracking and communication skill-building tasks in an effort to improve patient engagement and outcomes (*Journal of Affective Disorders*, Vol. 281, 2021).

While research continues to home in on effective treatments, Youngstrom has directed his focus toward improving early recognition. That work involves comparing different questionnaires and rating scales, making them as short and convenient as possible without compromising accuracy, and improving accessibility for a variety of mental health providers and even patients.

"We're reaching a point where we can deliver shortcuts that allow clinicians to work faster, be more accurate, and deliver better outcomes for their patients," he said. "The science really does make this possible." ■