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Introduction to Psychological Assessment of Bipolar Spectrum Disorders

Definitions and Concepts

James H. Kleiger and Irving B. Weiner

The diagnosis of bipolar disorder is a more complex, nuanced, and controversial issue than many might assume (Ghaemi et al., 2000; Malhi et al., 2012). As always, the language of diagnosis can bring clarity but also conceptual confusion. Common clinical terms, past and present, such as “manic-depressive illness” (Kraepelin, 1886/1921), “mixed states” (Weygandt, 1899), “bipolar disorder” (Leonhard, 1957/1979), “bipolar I versus bipolar II” (Dunner et al., 1976), “bipolar spectrum” or “soft signs of bipolar disorder” (Akiskal, 1983; Angst & Gamma, 2002), or the more general descriptor “bipolarity” are not simply different names for the same phenomena but have different conceptual implications for how we understand, classify, and treat these kinds of mood disorders.

Clinicians and researchers pose key questions about the nature of bipolarity, which has implications for accurate diagnosis and treatment. Essentially, from a diagnostic perspective, is bipolar disorder a categorical or a dimensional phenomena? Similarly, are bipolar disorders best conceived by a narrow set of criteria or more broadly as a spectrum of clinical conditions that shares symptoms with multiple other disorders? Relatedly, what are the boundaries between bipolar disorders and these related conditions? Furthermore, when is it necessary to establish differential diagnoses among such conditions with overlapping symptoms, and when should they be considered comorbid? Finally, how do we

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minimize diagnostic false negatives while not risking a high rate of false positives? The dialectic between the narrow versus broader definitions of bipolarity has been heated, with each camp citing studies in support of their definition and cautioning how misdiagnosis leads to poor treatment outcomes. However, despite the current diagnostic status of bipolar disorders in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* and the *International Statistical Classification of Diseases and Related Health Problems (ICD)* systems and the criticism of the broader diagnostic conceptualization of the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5; Paris, 2009, 2012; Zimmerman et al., 2008)*, the widening scope of mood disorders has gained traction in how bipolar phenomena are understood and treated (Ghaemi et al., 2002; Phelps, 2016). Before examining the widening scope of what constitutes bipolarity, it is useful to review changes in diagnostic criteria introduced by the *DSM-5 Text Revision (DSM-5-TR; American Psychiatric Association, 2022)* and *ICD-11 (World Health Organization [WHO], 2019)*.

CHANGES INTRODUCED BY THE *DSM-5-TR* AND THE *ICD-11*

Both *DSM-5-TR* and *ICD-11* mark the evolving nature of the diagnostic classification of mental disorders. Compared to their predecessors, *DSM-5* (American Psychiatric Association, 2013) and *ICD-10* (WHO, 1992), changes introduced by *DSM-5-TR* and *ICD-11* are subtle but carry important clinical implications—especially in the case of *ICD-11*.

DSM-5 to DSM-5-TR

No major changes were introduced in the essential diagnostic criteria for bipolar I and II disorders. Modifications were made in the wording of Criterion B for bipolar disorders and Criterion C for bipolar II disorders, denoting the relationship between mood episodes and psychotic disorders (i.e., determining when manic or hypomanic episodes are better explained by other psychotic disorders). Additional changes were made to mood-congruent/mood-incongruent specifiers for bipolar I and II depending on the current or most recent type of mood episode. The manic specifier relies on the wording from the Bipolar and Related Disorders chapter, while the depressive specifier uses the wording from the Depressive Disorders chapter.

ICD-10 to ICD-11

Both *ICD-10* and *ICD-11* include bipolar and depressive disorders as separate categories of disturbances subsumed under a superordinate section of mood or affective disorders. Substantive changes in *ICD-11* criteria for diagnosing bipolar and related disorders are minimal, but those few changes have important implications (Angst et al., 2020). The mood disorders section of the *ICD-11* introduces uncoded mood episodes (depressive, manic, hypomanic, and mixed),

which may be transient but do not reflect a pattern that exists over time (Angst et al., 2020). The most significant change has to do with the more frequent diagnosis of hypomanic episodes. The implication of lowering the threshold for identifying hypomania means that far more people will be diagnosed as hypomanic than manic, and, as a result, bipolar II will become a more common diagnosis (Angst et al., 2020). The lower threshold that the *ICD-11* sets for diagnosing hypomania and bipolar II also stands in contrast to the higher threshold established in the *DSM-5* and, by extension, the *DSM-5-TR*. Thus, when using the *ICD-11* as a guide, one is more likely to identify the presence of hypomania and possibly increase the likelihood of diagnosing a patient with bipolar II disorder.

ASSESSING BIPOLAR DISORDERS

With the increased likelihood of diagnosing hypomania and a broadening of the spectrum of bipolarity, assessment psychologists are increasingly called upon to evaluate the diagnostic nature of dysregulated and labile moods. Bipolar disorders demonstrate a range of symptoms, including alterations in mood, energy levels, speed and fluency of thinking, shifts in self-esteem, and behavioral disinhibition. These features occur across a continuum of severity, from milder manifestations to severe impairment in mood regulation, impulse control, grandiosity, thought organization, and reality testing. As such, it is important in clinical practice to assess for the presence and severity of symptom dimensions that might signal a bipolar condition and then, on the basis of this assessment, make informed decisions about an individual's current functioning capacities, possible needs for psychotherapy or hospitalization, indications to refer for medication consultation, and, if an inpatient, readiness for discharge.

Despite the importance of assessing disorders within the bipolar spectrum, the guidelines for doing so are limited. This book fills a void in the literature by presenting a broad array of evidence-based methods that can aid in diagnostic decision making. The chapters are written by assessment psychologists, all of whom are recognized for their expertise and contributions in developing and researching specific assessment instruments or clinical syndromes. Their chapters provide up-to-date information about identifying psychological and behavioral features of bipolar spectrum disorders with widely used assessment methods, including a review of their conceptual basis, psychometric properties, empirical support, and key interpretive elements. Additionally, a separate group of clinical experts provide differential diagnostic guidance for evaluating clinical conditions that need to be distinguished from or are comorbid with disorders within the bipolar spectrum.

Additionally, this book offers students, clinicians, and researchers a single resource to deepen their understanding of diagnostic issues and methods as they relate to assessing disorders within the bipolar spectrum. When bipolarity is addressed in the assessment literature, it is scattered in book chapters and articles about particular tests or assessment procedures. Psychologists seeking information about assessing bipolar spectrum disorders with their assessment methods need

to search through multiple sources to find the material they need. A single, comprehensive volume will close this gap with an integrated presentation of the psychological dimensions within the bipolar spectrum that can be assessed by each of the most widely used measures. Introductory chapters are devoted to conceptual issues, with subsequent sections on self-report methods, implicit and performance-based measures, differential diagnosis, and case examples.¹

Although this volume includes the term “spectrum,” we are not imposing a strict diagnostic framework. “Spectrum” is the broadest and most inclusive term, which we mean to include both the narrow phenotype of bipolar disorder, as well as the broad phenotype of a spectrum of bipolar/mood disorders.

Before saying more about the role of psychological assessment in the diagnostic process, it is critical to examine more closely the origins of the bipolar diagnosis and the factors that gave rise to current concepts and controversies in diagnostic decision making. Understanding both the narrow or conventional definition of bipolar disorders and equally, the concept of a bipolar spectrum or, more broadly, a spectrum of mood disorders and mixed states, is crucial for diagnostic precision and clarity of communication with clinicians who refer these individuals to us.

ORIGINS, ISSUES, AND CONTROVERSIES

The history of the bipolar concept has been well-documented and traces the origins of contemporary diagnostic issues and controversies (Angst & Marneros, 2001; Mason et al., 2016). Pathological states of depression and euphoria, as well as the linkage of the two extreme mood states, were described by pre-Hippocratic philosophers and physicians. Nineteenth-century French and German psychiatrists gave life to the modern concept of bipolarity (Angst & Marneros, 2001), which integrated depression, or melancholia, and mania to form the concept of “folie circulaire” (circular madness). Emil Kraepelin, arguably the “father of modern psychiatry,” developed the ideas of his predecessors to establish the concept of “manic-depressive insanity.” Melancholic depression was characterized by despondency, irritability, restlessness, reduced activity and cognition, loss of appetite, sleeplessness, and suicidality. Three traditional signs and symptoms of mania included elevated affect/euphoria, racing thoughts/flight of ideas, and psychomotor excitement/hyperactivity. Depression was characterized chiefly by depressed mood, inhibition of thought, and weakness of volition (Jain et al., 2017).

Kraepelin’s Model of Manic Depression

Kraepelin (1886/1921) further unified depression with mania and introduced the concept of “manic-depressive insanity,” which he differentiated from the

¹ All clinical studies presented in this book have been disguised to protect the patient’s identity.

other form of endogenous psychosis, “dementia praecox,” which Eugen Bleuler later termed “schizophrenia.” Kraepelin championed the concept of “circular insanity,” where melancholic depression and mania were part of the same illness.

However, Kraepelin was aware of intermediate conditions that bridged manic depression and dementia praecox. Although not the first to identify schizoaffective disorders as an intermediate condition, Kraepelin viewed the boundaries between the two endogenous psychoses as elastic. Later, the soft boundary between modern-day bipolar and schizoaffective disorder led researchers to posit a closer relationship between schizoaffective and bipolar disorders than between schizoaffective disorders and schizophrenia (Angst & Marneros, 2001).

Kraepelin’s model of manic-depressive illness as a unitary, dimensional concept was rejected with the advent of *DSM-III* (American Psychiatric Association, 1980), which split the mood disorder into two categorical diagnoses: major depressive disorder, on the one hand, and bipolar disorder, on the other. The dichotomy continued through subsequent iterations of the *DSM* (*IV*, *IV-TR*, *5*, and *5-TR*).

Bipolar Subtypes

Included in the current *DSM-5-TR* and *ICD-11* family of bipolar disorders are cyclothymia and bipolar II disorder. Cyclothymia is an older diagnostic concept that describes either a temperamental predisposition or a milder disorder characterized by brief fluctuating states of attenuated depression and subthreshold mania, referred to as “hypomania.” Bipolar II was recognized as a bipolar subtype, which differed from the classic, cyclical form of manic-depressive insanity, called bipolar I (Dunner et al., 1976). Type I, characterized by at least one disruptive manic episode, differs from Type II, which is characterized by the occurrence of a major depressive episode (MDE) along with at least one hypomanic episode.

Angst (1978) attempted to identify bipolar subgroups that extended beyond the Type I and Type II dichotomy. He proposed classifying mood symptoms as combinations of varying degrees of severity of manic and depressive symptoms. He designated upper-case “M” for full-blown mania, “m” for hypomania, “D” for MDE, and “d” for less-severe symptoms of depression. The symptom groups could combine to form additional subgroups such as MD, Md, DM, md, and m. The permutations of mood-related states have major implications for the concepts of mixed states and a continuum of mood disorders.

Mixed States

Although the concept of mixed states dates back to antiquity, Kraepelin and his student Weygandt (1899) described states in which there were mixtures of depression and mania in the same condition. Some predominantly depressed patients exhibited manic symptoms and vice versa. Kraepelin believed that mixed states could either represent a transition between depression and mania (or, conversely between mania and depression) or that the mixed states marked the presence of a more stable disorder. More than a century later, Akiskal (1992)

extended some of Kraepelin's ideas about mixed symptoms in depressive, cyclothymic, hypomanic, and manic states. Today, there is a great detail of focus on the diagnosis and treatment of individuals with mixed features (Jain et al., 2017; McIntyre et al., 2016).

DSM-5-TR (American Psychiatric Association, 2022) included mixed features as a specifier (mixed feature specifier) and lowered the threshold for making this designation. At least three depressive symptoms are required for specifying mixed features for those who meet the criteria for a manic/hypomanic episode, and the same criteria must be met in reverse for individuals who meet the criteria for an MDE. In all cases, the mixed symptoms should be observable to others and represent a departure from usual behavior. However, three "overlapping" symptoms (irritability, distractibility, and insomnia) were excluded from the *DSM-5* and *DSM-5-TR* specifier list because they are common in both manic/hypomanic and depressive conditions. Yet, research has demonstrated that these are some of the most frequently experienced symptoms in those who have mixed features (Malhi et al., 2014). Others determined that distractibility occurred in 50% of patients with mixed symptoms, whereas "nonoverlapping" symptoms such as increased activity and risk taking, decreased need for sleep, and elevated self-esteem were present in only 10% of depressed patients with mixed features (Goldberg et al., 2009). Another group of researchers (Koukopoulos et al., 2013; Sani et al., 2014) identified more clinically relevant criteria for mixed states, finding the following symptoms most characteristic of mixed states: psychic agitation/inner tension (found in 97% of mixed states), absence of retardation (82%), dramatic description of suffering and crying spells (53%), talkativeness (49%) racing thoughts (48%). To this list, Phelps (2016) added extreme insomnia. These patients are "lying awake with racing negative ruminations. This is not a 'decreased need for sleep' (no wonder they don't endorse that)" (p. 29).

Another useful concept, which can be translated into assessment paradigms, is to think in terms of three core mood-related symptom dimensions that can vary independently. MacKinnon and Pies (2006) proposed a "waves model." The three dimensions to consider are (a) mood, (b) energy level, and (c) speed of thought and creativity, which can shift independently. Clearly, when all three go up simultaneously, we would diagnose a manic state, and when all three go down, a depressive episode. However, consider when mood goes down but energy and speed of thought increase. Here, we may find a high degree of psychomotor agitation and negative, ruminative thought. The individual may feel wound up with restlessness. They may be trapped in overthinking, trapped in negative cycles of rumination over past or future events. A high degree of anxiety may be present.

Bipolar Spectrum

The existence of mixed states lent itself to the evolving concept of a spectrum of bipolar, or more broadly, mood disorders. Over the past 40 years, the impetus to broaden the concept of bipolarity into a spectrum was based on clinical

experience, where clinicians were seeing increasing numbers of patients presenting with an MDE, who simultaneously had subthreshold symptoms of mania/hypomania that eventually converted to bipolar I or II. A group of researchers concluded that bipolarity was being underdiagnosed and ineffectively treated (see Phelps, 2016).

Although the concept of a spectrum of bipolar conditions has generated contemporary interest and criticism, the notion of a continuum of manic conditions itself is not new. Klerman (1981) identified varying expressions of bipolarity, including mania, hypomania, drug-induced hypo/mania, and depression with a family history of bipolar disorders. When some speak of a bipolar spectrum, they are referring to varying degrees of severity of manic symptoms. *DSM-5* and *DSM-5-TR* bipolar disorders, with the primary subtypes of Type I, II, and cyclothymia (not including substance/medication-induced or other/unspecified variants), form a narrow grouping of related conditions, based on the severity of manic symptoms. However, technically, these subtypes are viewed as separate, but related, disorders as opposed to a continuum or spectrum. Also, it bears repeating that although the *DSM-5* attempted to establish a more dimensional, less exclusively categorical approach to diagnosis, it did classify bipolar and depressive disorders as distinct groups of disorders. This categorical separation is continued in *DSM-5-TR*.

Akiskal (1983) proposed an expanded spectrum of bipolar disorders beyond Types I and II, and proposed Type III, defined as recurrent depressive episodes without hypo/mania but a positive family history of bipolar disorder (also referred to as Type V) or as recurrent depression with antidepressant-induced hypomania. Type IV describes major depression superimposed on a hyperthymic temperament. Akiskal and Pinto (1999) further split their subtypes to develop a continuum within the broad bipolar spectrum as they identified intermediate forms, such as “bipolar I ½, bipolar II ½, and bipolar III ½.” Marneros (1999) argued for a broader continuum of affectivity, which included bipolar and unipolar courses, ranging from normal fluctuations to psychotic expressions. Stahl (2013) presented an 11-point spectrum, ranging from depressive episodes that stop responding to antidepressants (Bipolar ¼) all the way to bipolarity in settings of dementia (bipolar VI). Between these anchor points are bipolar I and II, in addition to various combinations of depression, associated with cyclothymic or hyperthymic temperament and antidepressant or substance-induced hypo/mania.

Mood Disorder Spectrum

A spectrum model of mood disorders assumes a continuum, not within the bipolar category of *DSM-5-TR* but across the range of mood disorders, extending from major depression to dysthymia to bipolar spectrum to other specified bipolar disorder to bipolar II to bipolar I (Phelps, 2016). Interestingly, this continuum includes the bipolar spectrum within a broader spectrum of mood disorders.

The spectrum concept has been further expanded transdiagnostically to include other mental health conditions that share common symptoms with bipolar disorders. The transdiagnostic spectrum subsumes disorders with overlapping symptoms of depression, increased energy, mood swings, impulsivity, prolonged irritability, and “soft bipolar signs,” all of which are thought to be variants of a broader bipolar spectrum. Among these related but separate disorders are highly treatment-resistant depression, impulse control disorders, substance abuse, eating disorders, personality disorders (especially borderline personality disorder), trauma-based disorders, and childhood behavioral disorders (attention-deficit/hyperactivity disorder, conduct and oppositional defiant disorders, and disruptive mood dysregulation disorders).

Nonmanic Markers

Those who advocate for the spectrum model recommend considering an underlying bipolar diathesis when individuals present with signs and symptoms that may not include a history of manic/hypomanic episodes (Phelps, 2016). Ghaemi et al. (2002) referred to these features as “nonmanic” markers and listed the following set of criteria:

- at least one MDE
- no spontaneous hypo/manic episodes
- a family history of bipolar disorder in a first-degree relative
- antidepressant-induced hypo/mania
- recurrent MDEs
- early age of onset of MDE between ages 18 and 24
- postpartum depression
- history of psychosis without drugs
- antidepressant “wear off”
- lack of response to at least three antidepressant trials

Anxiety as a Symptom of Bipolarity

The *DSM-5* does not list anxiety as a symptom of bipolar disorder; however, a review of mixed states by the International Society for Bipolar Disorders described anxiety as a “core” feature of bipolarity (Swann et al., 2013). The committee identified general hyperarousal, inner tension, irritability/impatience, and agitation as key features of mixed states. Phelps (2016) added the presence of “negative energy” or antsy-ness and ruminative overthinking as anxiety-related features found in mixed states.

Controversies

The diagnosis of bipolar disorders has been fraught with controversy, chiefly in terms of whether clinicians are underdiagnosing or overdiagnosing these disorders. Bipolar spectrum and mood spectrum advocates argue that too many

cases have been missed in which patients present with depression. They point out that, too often, presenting symptoms of depression halt further diagnostic exploration and result in misdiagnosis and poor treatment outcomes. Thus, from their perspective, it is important to expand the spectrum to identify individuals who do not present with the standard symptoms of bipolarity. Conversely, critics point out that the expansive concept has led to overdiagnosis without a valid basis for including a broader range of conditions under the umbrella of bipolar disorders. Critics have been especially wary of a transdiagnostic extension of the bipolar spectrum, which conflates overlapping symptoms of mood instability and impulsivity with a bipolar phenotype (Kuiper et al., 2012; Zimmerman et al., 2008). In particular, critics argue that symptom overlap with borderline personality disorder and complex trauma has led to diagnostic overreach and inappropriate treatment decisions. Further muddying the already turbulent diagnostic waters is the controversial issue of pediatric bipolarity.

To complicate matters more, many of these disorders that share overlapping symptoms with bipolar disorders can also be comorbid conditions. In the real world, pure-culture cases are often the exception, not the rule. Thus, our diagnostic task is complicated not only by the need to balance false positives with false negatives but also by the need to recognize the both-and nature of clinical diagnosis. Under what set of conditions can we make an accurate differential diagnosis and, conversely, when is it appropriate to diagnose comorbid conditions?

THE IMPORTANCE OF MAKING AN EARLY AND ACCURATE DIAGNOSIS

A correct diagnosis of bipolar disorder within the first year of symptom onset is surprisingly low. More alarmingly, it may take up to 10 years for bipolar patients to receive a correct diagnosis and appropriate treatment (McIntyre & Calabrese, 2019). Additionally, the majority of patients eventually diagnosed as having bipolar II disorder are initially diagnosed with unipolar depression.

The reason for the initial misdiagnosis is that the majority of bipolar patients present when they are depressed. Furthermore, clinicians often do not ask about a history of subthreshold hypo/manic symptoms or a family history of bipolarity. Patients may not mention hypomanic experiences because they are pleasant and may be normalized. Finally, clinicians may be looking for euphoria and grandiosity and overlook irritability and flight of ideas (McIntyre & Calabrese, 2019).

The consequences of missing the presence of bipolar depression are enormous (Conus et al., 2014). Not only do misdiagnosed patients suffer a worse quality of life, but delayed diagnosis carries with it increased suicide risk. Suicide rates are twice as high in bipolar as compared with major depressive disorder. Failing to identify bipolar disorder early on can subject the individual to potentially harmful treatment and increase cycling and the risk of relapse. Finally, the longer individuals go without being correctly diagnosed, the greater the likelihood of subsequent morbidity.

THE TASK FOR ASSESSMENT PSYCHOLOGISTS

Given the complexity of bipolar disorder and the risks associated with delayed or inaccurate diagnosis, there is a clear role for assessment psychologists in the diagnostic process. With a thorough grounding in the conceptual issues relating to the traditional diagnosis of bipolar disorders and newer concepts of a bipolar and mood spectrum, psychologists can utilize multiple methods of history taking, clinical interviews, self-report inventories and rating scales, and performance-based approaches to identify cognitive and psychological features associated with bipolar conditions. However, the armamentarium of assessment methods is incomplete without an understanding of related conditions that may either masquerade as bipolar disorders or be comorbid with them. In particular, assessors need to understand medical conditions that may complicate the diagnostic picture, as well as childhood disorders, personality disorders, and trauma and dissociative disorders, all of which challenge differential diagnostic decision making. Additionally, psychologists need to understand the boundaries between bipolar and schizophrenia-spectrum disorders. Finally, understanding bipolarity within a multicultural context is necessary to remain alert to how sociocultural factors intersect with diagnostic practices.

OVERVIEW OF THE BOOK'S CONTENTS

The chapters of this book have been written for students, researchers, and seasoned practitioners alike. In a single volume, we present a collection of 20 conceptual and practice-oriented chapters that provide detailed information about the nature of the widely used clinical assessment measures and guidance in applying these measures in the assessment of bipolar spectrum disorders.

The book begins in Part I with a chapter on the value of multimethod psychological assessment and its role in assessing bipolar spectrum disorders. Part II includes six chapters on assessing bipolarity with widely used self-report methods, including the clinical interview, the Minnesota Multiphasic Personality Inventory, 3rd edition, the Personality Assessment Inventory the Millon Clinical Multiphasic Inventory-IV, the SPECTRA Indices of Psychopathology, and clinical rating scales. Assessment psychologists often include one or more of these multiscale self-report inventories to assess personality functioning for diagnostic clarification and treatment recommendations. Clinical rating scales include a range of screening measures used by researchers and clinicians to screen for the presence of bipolar spectrum disorders and to monitor patients' responses to treatment. Part III follows with four chapters on frequently used performance-based assessment measures useful in evaluating personality functioning relevant to the assessment of bipolar spectrum disorders. These methods include the Rorschach Comprehensive System, the Rorschach Performance Assessment System, the Thematic Apperception Test and other similar tests, and cognitive/neuropsychological assessment of bipolar spectrum conditions.

Performance-based methods complement self-report inventories and provide a fuller picture of personality functioning beyond what individuals are able to report directly about themselves. Separate chapters on the Rorschach Comprehensive System and Rorschach Performance Assessment System are included as both Rorschach methods continue to be used by assessment psychologists.

Part IV contains seven chapters that focus on the differential diagnosis of conditions that may overlap or co-occur with disorders with bipolar spectrum. Beginning with a chapter on childhood disorders that may be associated or conflated with bipolarity, Part IV includes a chapter on medical issues or conditions that are related to the diagnosis of bipolar disorders. Several chapters in this section examine symptom overlap, differential decision making, or comorbidity with personality disorders, trauma-related disorders, and schizophrenia. Chapters also focus on the concept of a manic-depressive personality type, as well as multicultural issues in the assessment of bipolar spectrum disorders. Highlighting multicultural issues is of critical importance in any text about the practice of psychological assessment. Although chapter authors could have briefly mentioned multicultural considerations when using specific inventories and performance methods, we decided instead to devote a separate chapter to the assessment of bipolar spectrum disorders from a multicultural perspective.

Part IV concludes the book with two case illustrations. The cases were selected to demonstrate how multimethod assessment data can be utilized to describe two individuals: one an adolescent who was diagnosed with major depression with possible indications of borderline personality or bipolar disorder, the other an adult who presented with a history and symptoms of bipolarity.

Finally, with respect to current diagnostic systems for classifying bipolar disorders, when relevant, chapter authors include references to both *DSM-5-TR* and *ICD-11* criteria. In order to ground diagnostic discussions in contemporary models and to make the volume relevant to an international audience, any significant changes in diagnostic criteria in these current revisions are noted throughout the volume.

REFERENCES

- Akiskal, H. S. (1983). The bipolar spectrum: New concepts in classification and diagnosis. In L. Grinspoon (Ed.), *Psychiatric update: The American Psychiatric Association annual review* (Vol. 2, pp. 271–292). American Psychiatric Association.
- Akiskal, H. S. (1992). The distinctive mixed states of bipolar I, II, and III. *Clinical Neuropharmacology*, 15(Suppl. 1, Pt. A), 632A–633A. <https://doi.org/10.1097/00002826-199201001-00327>
- Akiskal, H. S., & Pinto, O. (1999). The evolving bipolar spectrum: Prototypes I, II, III, and IV. *Psychiatric Clinics of North America*, 22(3), 517–534. [https://doi.org/10.1016/S0193-953X\(05\)70093-9](https://doi.org/10.1016/S0193-953X(05)70093-9)
- American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.).
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.).

- American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders: DSM-5-TR* (5th ed., text revision).
- Angst, J. (1978). The course of affective disorders. II. Typology of bipolar manic-depressive illness. *Archiv für Psychiatrie und Nervenkrankheiten*, 226(1), 65–73. <https://doi.org/10.1007/BF00344125>
- Angst, J., Ajdacic-Gross, V., & Rössler, W. (2020). Bipolar disorders in *ICD-11*: Current status and strengths. *International Journal of Bipolar Disorders*, 8(1), Article 3. <https://doi.org/10.1186/s40345-019-0165-9>
- Angst, J., & Gamma, A. (2002). A new bipolar spectrum concept: A brief review. *Bipolar Disorders*, 4(Suppl. 1), 11–14. <https://doi.org/10.1034/j.1399-5618.4.s1.1.x>
- Angst, J., & Marneros, A. (2001). Bipolarity from ancient to modern times: Conception, birth and rebirth. *Journal of Affective Disorders*, 67(1–3), 3–19. [https://doi.org/10.1016/S0165-0327\(01\)00429-3](https://doi.org/10.1016/S0165-0327(01)00429-3)
- Conus, P., Macneil, C., & McGorry, P. D. (2014). Public health significance of bipolar disorder: Implications for early intervention and prevention. *Bipolar Disorders*, 16(5), 548–556. <https://doi.org/10.1111/bdi.12137>
- Dunner, D. L., Fleiss, J. L., & Fieve, R. R. (1976). The course of development of mania in patients with recurrent depression. *The American Journal of Psychiatry*, 133(8), 905–908. <https://doi.org/10.1176/ajp.133.8.905>
- Ghaemi, N., Sachs, G. S., & Goodwin, F. K. (2000). What is to be done? Controversies in the diagnosis and treatment of manic-depressive illness. *World Journal of Biological Psychiatry*, 1(2), 65–74. <https://doi.org/10.3109/15622970009150569>
- Ghaemi, S. N., Ko, J. Y., & Goodwin, F. K. (2002). “Cade’s disease” and beyond: Misdiagnosis, antidepressant use, and a proposed definition for bipolar spectrum disorder. *Canadian Journal of Psychiatry*, 47(2), 125–134. <https://doi.org/10.1177/070674370204700202>
- Goldberg, J. F., Perlis, R. H., Bowden, C. L., Thase, M. E., Miklowitz, D. J., Marangell, L. B., Calabrese, J. R., Nierenberg, A. A., & Sachs, G. S. (2009). Manic symptoms during depressive episodes in 1,380 patients with bipolar disorder: Findings from the STEP-BD. *The American Journal of Psychiatry*, 166(2), 173–181. <https://doi.org/10.1176/appi.ajp.2008.08050746>
- Jain, R., Maletic, V., & McIntyre, R. S. (2017). Diagnosing and treating patients with mixed features. *The Journal of Clinical Psychiatry*, 78(8), 1091–1102. <https://doi.org/10.4088/JCP.su17009ah1c>
- Klerman, G. L. (1981). The spectrum of mania. *Comprehensive Psychiatry*, 22(1), 11–20. [https://doi.org/10.1016/0010-440X\(81\)90049-3](https://doi.org/10.1016/0010-440X(81)90049-3)
- Koukopoulos, A., Sani, G., & Ghaemi, S. N. (2013). Mixed features of depression: Why *DSM-5* is wrong (and so was *DSM-IV*). *The British Journal of Psychiatry*, 203(1), 3–5. <https://doi.org/10.1192/bjp.bp.112.124404>
- Kraepelin, E. (1921). *Manic-depressive insanity and paranoia* (G. M. Robertson, Ed., R. M. Barclay, Trans.). E and S Livingstone. <https://doi.org/10.1097/00005053-192104000-00057> (Original work published 1886)
- Kuiper, S., Curran, G., & Malhi, G. S. (2012). Why is soft bipolar disorder so hard to define? *The Australian and New Zealand Journal of Psychiatry*, 46(11), 1019–1025. <https://doi.org/10.1177/0004867412464063>
- Leonhard, K. (1979). *The classification of endogenous psychoses* (R. Berman, Trans.; 5th ed.). Irvington. (Original work published 1957)
- MacKinnon, D. F., & Pies, R. (2006). Affective instability as rapid cycling: Theoretical and clinical implications for borderline personality and bipolar spectrum disorders. *Bipolar Disorders*, 8(1), 1–14. <https://doi.org/10.1111/j.1399-5618.2006.00283.x>
- Malhi, G. S., Bargh, D. M., Cashman, E., Frye, M. A., & Gitlin, M. (2012). The clinical management of bipolar disorder complexity using a stratified model. *Bipolar Disorders*, 14(Suppl. 2), 66–89. <https://doi.org/10.1111/j.1399-5618.2012.00993.x>

- Malhi, G. S., Lampe, L., Coulston, C. M., Tanious, M., Bargh, D. M., Curran, G., Kuiper, S., Morgan, H., & Fritz, K. (2014). Mixed state discrimination: A *DSM* problem that won't go away? *Journal of Affective Disorders*, 158, 8–10. <https://doi.org/10.1016/j.jad.2014.01.008>
- Marneros, A., (1999). *Handbuch der unipolaren und bipolaren Erkrankungen*. Thieme.
- Mason, B. L., Brown, E. S., & Croarkin, P. E. (2016). Historical underpinnings of bipolar disorder diagnostic concept. *Behavioral Sciences*, 6(3), Article E14. <https://doi.org/10.3390/bs6030014>
- McIntyre, R. S., & Calabrese, J. R. (2019). Bipolar depression: The clinical characteristics and unmet needs of a complex disorder. *Current Medical Research and Opinion*, 35(11), 1993–2005. <https://doi.org/10.1080/03007995.2019.1636017>
- McIntyre, R. S., Lee, Y., & Mansur, R. B. (2016). A pragmatic approach to the diagnosis and treatment of mixed features in adults with mood disorders. *CNS Spectrums*, 21(S1), 25–33. <https://doi.org/10.1017/S109285291600078X>
- Paris, J. (2009). The bipolar spectrum: A critical perspective. *Harvard Review of Psychiatry*, 17(3), 206–213. <https://doi.org/10.1080/10673220902979888>
- Paris, J. (2012). *The bipolar spectrum: Diagnosis or fad?* Routledge. <https://doi.org/10.4324/9780203121061>
- Phelps, J. (2016). *A spectrum approach to mood disorders: Not fully bipolar but not unipolar—practical management*. W.W. Norton.
- Sani, G., Napoletano, F., Vöhringer, P. A., Sullivan, M., Simonetti, A., Koukopoulos, A., Danese, E., Girardi, P., & Ghaemi, N. (2014). Mixed depression: Clinical features and predictors of its onset associated with antidepressant use. *Psychotherapy and Psychosomatics*, 83(4), 213–221. <https://doi.org/10.1159/000358808>
- Stahl, S. M. (2013). *Stahl's essential psychopharmacology: Neuroscientific basis and practical applications* (4th ed.). Cambridge University Press.
- Swann, A. C., Lafer, B., Perugi, G., Frye, M. A., Bauer, M., Bahk, W.-M., Scott, J., Ha, K., & Suppes, T. (2013). Bipolar mixed states: An international society for bipolar disorders task force report of symptom structure, course of illness, and diagnosis. *The American Journal of Psychiatry*, 170(1), 31–42. <https://doi.org/10.1176/appi.ajp.2012.12030301>
- Weygandt, W. (1899). *Über die Mischzustände des manisch-depressiven Irreseins* [On the mixed states of manic-depressive insanity]. Lehmann.
- World Health Organization. (1992). *The ICD-10 classification of mental and behavioural disorders: Clinical descriptions and diagnostic guidelines*. <https://apps.who.int/iris/handle/10665/37958>
- World Health Organization. (2019). *International statistical classification of diseases and related health problems* (11th ed.).
- Zimmerman, M., Ruggero, C. J., Chelminski, I., & Young, D. (2008). Is bipolar disorder overdiagnosed? *The Journal of Clinical Psychiatry*, 69(6), 935–940. <https://doi.org/10.4088/JCP.v69n0608>