

## Chapter One

### Scope of Bipolar Spectrum Disorders in Adults

**B**ipolar spectrum disorders are mood disorders in which the core characteristic is the brain's inability to regulate mood within a normal range. Without normal mood regulation, moods swing from below the normal range (depression) to above the normal range (hypomania or mania) or have elements of below and above normal range (mixed mood). Bipolar spectrum disorders are severe, often lethal illnesses that affect 1.1 percent of the adult population, and Bipolar II affects 0.6 percent or approximately 2.2 million people in the United States. Due to misdiagnosis, as many as two out of three people with a Bipolar disorder do not receive appropriate treatment.<sup>1</sup> Bipolar I disorder is equally as common in men as in women. However, the mean age of onset for Bipolar I disorder is 21 years. The peak age of onset is the age group of 15 to 19 years.

Bipolar disorder has been recognized for over 2000 years. In 1921, Kraepelin was the first to apply the term manic-depressant insanity to cyclic episodes of mania coupled with periods of depression. The DSM-III was the first to include Bipolar disorder as a distinct diagnosis.<sup>2</sup>

Thirty-two percent of adults with BHI Medicaid mental health benefits who were hospitalized in 2002 and 2003 were diagnosed with Bipolar disorder.

### Diagnostic Principles

Once identified, episodes are evaluated together to diagnose Bipolar disorders according to further DSM IV criteria that define the actual disorders. The DSM identifies four disorders in the spectrum of Bipolar disorders. They are Bipolar I Disorder, Bipolar II Disorder, Cyclothymic Disorder and Bipolar Disorder Not Otherwise Specified.

In Bipolar spectrum disorders, a disturbance of mood is the predominant feature.<sup>3</sup> Cognitive, behavioral, physiologic and sometimes psychotic features accompany the core disorder of mood dysregulation. These features appear in the DSM IV criteria for episodes of depression, mania and mixed mood, and they will be described further in later chapters of this manual.

Once episodes of depression, hypomania, mania or mixed moods have been identified in an individual, the criteria for Mood Disorders are used to diagnose a mood disorder, based on the presence or absence of distinct episode criteria. Other diagnoses in the differential are ruled out as well. In addition to criteria for episodes of mood and criteria for diagnosis, the DSM also includes specifiers describing either the most recent mood episode or the course of recurrent episodes.<sup>3</sup>

### Course and Epidemiology

Bipolar spectrum disorders are classified in many systems as Serious Mental Illnesses (SMI's) or Serious Persistent Mental Illnesses (SPMI's) because they have a lifelong, recurring or chronic course and can cause significant disability and even death. Treatment is effective and is essential in preventing outcomes of suicide and disability. Over a lifetime, a person with untreated Bipolar I disorder suffers ap-

proximately eight to 12 major depressive episodes and approximately four to eight manic episodes. “While the length of episode does not show any consistent variation over time, some follow a pattern where the duration between the first few episodes seems to shorten progressively. Thereafter, it may level out and, later, may begin to lengthen again. In general, more depression and less mania are associated with advancing age.”<sup>4</sup>

With early diagnosis and appropriate treatment, Bipolar disorder is a manageable illness like heart disease or diabetes. As the lag time increases in obtaining accurate diagnosis and treatment, those who have Bipolar disorder report more difficulty with illness management, are less confident about lifelong prognosis, and worry that medications will stop working.<sup>5</sup> Since the initial episode of bipolar spectrum disorders typically occurs when clients are in their late teens to mid twenties, expedient diagnosis and treatment can lessen the impact of the disorder on school, early occupational choices and relationships.<sup>6</sup>

First-degree biological relatives of individuals with Bipolar I Disorder have elevated rates of Bipolar I Disorder (4 percent—24 percent), Bipolar II Disorder (1 percent—5 percent) and Major Depressive Disorder (4 percent—24 percent). Studies indicate two thirds of those with Bipolar disorders have a family history of the disorder. Twin and adoption studies support the evidence of genetic vulnerability for Bipolar I Disorder.<sup>1</sup> Women tend to experience more depressive and mixed mood states and, conversely, fewer manic states than men. Women are also about three times more likely than men to experience rapid cycling, arbitrarily defined as the occurrence of four or more episodes in a year.<sup>4</sup>

The course of bipolar spectrum disorders is

recurrent with the cumulative probability of recurrence reported to be more than 50 percent during the first year of follow-up, about 70 percent by the end of four years, and nearly 90 percent by five years. Recurrence of mood episodes has been associated with co-morbid, non-affective psychiatric disorders, particularly substance abuse. The presence of psychotic features, and a family history of mania or schizoaffective mania also increase the likelihood of recurrence. A five-year follow-up study of patients with Bipolar I Disorder found that the cumulative probability of relapse was 48 percent—57 percent for the first year after recovery and 81 percent—91 percent for the fifth year after recovery.<sup>7</sup>

In 1991, the total yearly cost of Bipolar illness was estimated at 45 billion dollars. The direct cost for treatment, both inpatient and outpatient and use of the criminal justice system accounted for seven billion dollars. The remaining 38 billion dollars were caused by indirect costs, such as lost productivity, institutionalization, suicides and costs to caregivers of family members.<sup>2</sup>

## **Suicide and Bipolar Spectrum Disorders**

Suicidal risk is extremely high. “20 to 25 percent of individuals with bipolar spectrum disorders attempt suicide. At least 19 percent of deaths among those with bipolar spectrum disorders result from suicide.”<sup>1</sup> The mortality rate for untreated Bipolar disorder is higher than that for most types of heart disease and some types of cancer.<sup>2</sup> In a study of adolescents who died by suicide, four factors accounted for 80 percent of the suicides: a diagnosis of Bipolar disorder, coexisting alcohol or drug abuse, lack of prior treatment, and the availability of

firearms. The strongest of these factors was diagnosis of Bipolar disorder.<sup>8</sup> In a survey of more than 20,000 people, the lifetime rate for attempted suicide for people with no mental illness was one percent, compared to 18 percent for those with a depressive disorder and 24 percent for those with Bipolar disorder.<sup>9</sup>

## Intellectual and Creative Gifts

Recognizing the seriousness of Bipolar disorders is important, but it is also helpful to recognize the special intellectual and creative gifts of people who experience Bipolar disorders. Failure to do so can lead to difficulties in the clinician-client relationship and can preclude identifying client strengths that can augment effective treatment. When intellectual and creative gifts are not acknowledged, individuals with Bipolar disorders can feel demeaned and may find it difficult to reach their human potential. Giftedness is not related to educational level. Difficulties in achieving educational goals may frustrate educational attempts without quelling giftedness. Examples from the past of individuals with Bipolar disorders include Abraham Lincoln, Winston Churchill, Georgia O'Keefe, Virginia Woolf and Robert Schumann.

## Role of Psychosocial Therapy and Psychoeducation

The assessment and treatment of people who have Bipolar disorders takes into consideration the complex interactions between biological factors, daily lifestyle, quality of relationships, cognitive schemas, coping skills and environmental stressors. Difficulties in any of the above areas can have a negative impact on the others. Individuals who have bipolar spectrum disorders can benefit more than ever from

psychosocial interventions due to the mood stabilization available with medication. In spite of this, psychosocial treatments are utilized less often than before the introduction of lithium.<sup>10</sup> Early research on the effectiveness of specific therapeutic interventions shows that many are effective in decreasing hospitalization rates, increasing medication adherence and fostering stable management of illness.<sup>10</sup> This manual draws from several of these interventions and from strategies with proven effectiveness from peer to peer and community resources.

## References

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