Understanding Bipolar Disorder

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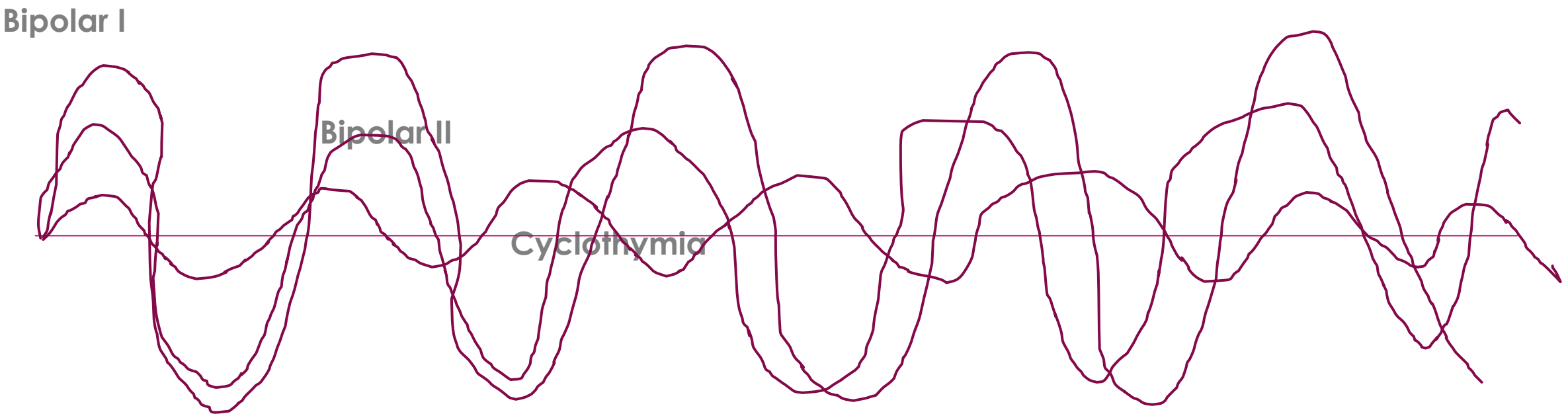
Objectives

- Review of the DSM-V diagnoses, rates, and aetiology of bipolar disorder
- Looking at co-morbidities, suicidality and other difficulties in living with BD
- Other important information to provide psychoeducation to clients
- Helping clients accept and understand their illness
- Brief review of evidence-based treatments for BD

Bipolar Disorder: Diagnostic Categories

- Previously known as Manic Depression, re-named in 1980 with the publication of DSM-III (one of the main benefits of this change is that it recognizes that the illness isn't as black and white as we once thought)
- Four types of BD in the DSM-V:
  - Bipolar I: manic or mixed episodes lasting at least one week, or manic symptoms severe enough for hospitalization (approximately 10% of people with BDI do not experience depressive episodes)
  - Bipolar II: hypomania, rather than mania, is experienced: a persistent, abnormally elevated or irritable mood, accompanied by unusually increased activity for most of the day over at least four days (as well as depressive episodes).
  - Cyclothymia: an individual has had episodes of sub-clinical hypomania and depression, at least 50% of the time, for at least two years (criteria for mania, hypomania and depression have never been met).
  - Other Specified Bipolar and Related Disorder (NOS): symptoms of bipolar disorder that don't fulfill the criteria necessary for a diagnosis of any of the other categories of BD, and symptoms are clearly out of character.

Bipolar Disorder: Diagnostic Categories



Mood Disorders Questionnaire (MDQ)
(Hirschfeld et al)

1. Has there ever been a period of time when you were not your usual self and…
…you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?
…you were so irritable that you shouted at people or started fights or arguments?
…you felt much more self-confident than usual?
…you got much less sleep than usual and found you didn't really miss it?
…you were much more talkative or spoke faster than usual?
…thoughts raced through your head or you couldn't slow your mind down?
…you were so easily distracted by things around you that you had trouble concentrating or staying on track?
…you had much more energy than usual?
…you were much more active or did many more things than usual?
…you were much more social or outgoing than usual; for example, you telephoned friends in the middle of the night?
…you were much more interested in sex than usual?
…you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?
…spending money got you or your family into trouble?
2. If you checked yes to more than one of the above, have several of these ever happened during the same period of time?
3. How much of a problem did any of these cause you—like being unable to work; having family, money, or legal troubles; getting into arguments or fights? Please circle one response only: No problem, Minor, Moderate, Serious

Bipolar Disorder: Mania vs. Hypomania

- **Both manic and hypomanic episodes require the presence of at least 3 of the following symptoms during the mood disturbance for diagnosis:**
  - **inflated self-esteem or grandiosity;**
  - **decreased need for sleep;**
  - **increased talkativeness or pressured speech;**
  - **racing thoughts or flights of ideas;**
  - **distractibility;**
  - **an increase in goal-directed activity or psychomotor agitation;**
  - **excessive involvement in activities that have a high potential for painful consequences**
- Although symptoms are described in the same manner, and there is a change in functioning that is uncharacteristic of the individual when not symptomatic, hypomania leads to less impairment than mania (or even an improvement in functioning). Hypomania does not require hospitalization; and does not involve psychosis that may be present in a Manic Episode.

Bipolar Disorder: Mania & Hypomania

Mania & hypomania as a double-edged sword:

- People often enjoy experiencing feeling happy and energetic, especially if they spend a lot of time in depressive episodes (as in BDII).
- People often feel more productive, especially while in hypomania; and feel more creative during a "high" episode
- Hypomanic episodes can potentially turn into full-blown mania if left untreated; or, for those with bipolar II, untreated hypomania can lead to a crash into depression.
- At its extreme, however, mania can be dangerous and destructive.
  - Manic episodes can lead to problematic behaviors that can cause problems with family, friends, the community, and the law.

Bipolar Disorder: Important Information for Clients (and clinicians!)

- CANMAT (2018) noted that the risk of recurrence increases with the number of previous episodes; data examining the effect of episodes on the course of illness shows that the number of previous episodes is associated with increased duration and symptomatic severity of subsequent episodes; and that the number of episodes is associated with a decreased threshold for developing further episodes and with an increased risk of dementia in the long term
- According to Post's (1992) kindling hypothesis, major life stress is required to trigger initial onsets and recurrences of episodes, but successive episodes become progressively less tied to stressors and may eventually occur autonomously.

Bipolar Disorder: BDI versus BDII

Bipolar Disorder II is **not** "less severe" or "less debilitating" than BDI! (i.e. it's not "Soft"!)

- Over 13 years of follow-up, individuals with BDI were symptomatic 47% of the time, with depressive weeks outnumbering manic/hypomanic by 3:1; clients with BDII were symptomatic 54% of the time, with depressive weeks outnumbering hypomanic 39:1 (Judd et al, 2002)

What is Bipolar Depression?

A person may be experiencing the depressive phase of bipolar disorder if at least five of the following symptoms are present for at least two weeks and experienced on most days:

- depressed mood
- loss of interest or pleasure in activities that used to be enjoyable
- weight loss or gain
- difficulty sleeping or sleeping too much
- apathy or agitation
- loss of energy
- feelings of worthlessness and guilt
- inability to concentrate
- thoughts of suicide

(Centre for Addiction and Mental Health: https://www.camh.ca/en/health-info/mental-illness-and-addiction-index/bipolar-disorder)

Bipolar Disorder: Diagnostic Categories

BDII 90% BDI	All	All	BDI & II	BDI

Depression	Dysthymia (low-grade dep)	Euthymia (stable mood)	Hypomania (low-grade mania)	Mania

On average, individuals with bipolar disorder go undiagnosed for 9 years (Thase, 2006); and 7 of 10 individuals with BD are mis-diagnosed at least once (Depression & Bipolar Support Alliance)

Bipolar Disorder: Mixed Episodes

What is a Mixed Episode (now "BD with mixed features")?

- Features of mania/hypomania *and depression* at the same time – occurs in 10-30% of cases, with studies suggesting mixed features are indicative of a more severe and disabling course (CANMAT, 2018)
- Especially important for people to be aware of because of heightened risk of suicide in this state (CANMAT, 2018)
- Different medications for mixed episodes?

(DSM5 Elimination of "Mixed Episode." Instead, a manic, hypomanic or depressive episode can be specified as "With Mixed Features," a specifier with its own definition in the manual; the Bipolar II diagnosis in the DSM-IV excluded a history of mixed episodes. This exclusion has been removed, an important change as mixed episodes happen more often with hypomania.)

Bipolar Disorder: Rapid Cycling

What is Rapid Cycling?

Diagnostically, an individual would receive a diagnosis of "rapid cycling" if they experience four or more episodes (in any combination of mania, hypomania, and depression) in a 12-month period; this is estimated to occur in 5-15% of individuals with BD (Mood Disorders Society of Canada, 2009)

- Women are diagnosed with rapid cycling more often than men
- Different meds for rapid cycling?
- Controversy regarding "rapid" versus "ultra-rapid" (or "ultradian") cycling (and controversy re: these versus BPD)
- Question of medication(or otherwise)-induced manic episodes (anti-depressants – especially in BDI; stimulants); hypothyroidism and substance use are often associated with rapid cycling as well

Bipolar Disorder: Defining Psychosis

A minority of individuals with BD will experience psychotic episodes with their illness (at least half of manic episodes are characterized by the presence of psychosis; and up to 20% of inpatients experience psychosis in the context of an acute bipolar depressive episode), but it's important for clients to be aware of these symptoms:

- Being out of touch with reality and experiencing delusions or hallucinations
- Most common delusions are religious, persecutory, and grandiose
- Most common hallucinations are auditory but can occur with any sense
- Clients need to know that these episodes are highly unlikely to resolve on their own

Bipolar Disorder: The Statistics

According to CANMAT (2009), reported lifetime prevalence of BD-I is estimated at 1.0%; BD-II at 1.1%; and sub-threshold BD at 2.4% (defined as recurrent hypomania without a major depressive episode or with fewer symptoms than required for threshold hypomania)

In 2013: CANMAT reported that The World Mental Health Survey Initiative, involving 61392 people in nine countries in North and South America, Europe, and Asia, reported lifetime prevalence estimates of 0.6% for BD I, 0.4% for BD II, and 1.4% for subthreshold BD. However, there were large cross-national differences in rates, with the lifetime rates ranging from 0 to 1% for BD I, 0 to 1.1% for BD II, and 0.1 to 2.4% for subthreshold BD.

Bipolar Disorder occurs equally between men and women, although women tend to be diagnosed with rapid cycling more often than men.

Although the onset of BD can occur at any age, the average age of onset is late teens (between 50 – 66% experiencing onset before age 19) to early 20's, with earlier age of onset typically associated with a worse course of illness (Perlis et al, 2006). Diagnosing BD in children and adolescents can be even more difficult than diagnosing it in adults, in part because of the affective shifts that often occur in normal child and adolescent cognitive and emotional development.

Bipolar Disorder: The Statistics

- "…the Global Burden of Disease Study attributed 9.9 million years lost to disability (YLD) to BD, making it the 17th leading cause of YLD worldwide. The impact that BD has on young people is even greater, with it being the sixth leading cause of disability-adjusted life years among people aged 10-24 years worldwide" (CANMAT, 2018)
- Worldwide annual costs per person with BD range from US$1904 to $33,090; higher per person costs associated with BDI, delayed or misdiagnosis, frequent psychiatric interventions, use of atypical antipsychotics, treatment non-adherence, poor prognosis, relapse, and comorbidity (CANMAT, 2018)
- Lower wages, higher unemployment, work absenteeism, reliance on workmen's compensation, lower levels of educational attainment, higher arrest rates, and hospitalization (Depp, Davis, Mittal, Patterson, & Jeste, 2006; Gardner et al., 2006; Glahn, Bearden, Bowden, & Soares, 2006; Michalak, Yatham, Kolesar, & Lam, 2006)
- BD increases rates of substance abuse and dependence, making the illness more difficult to treat (Altman et al, 2006)
- It increases rates of divorce (Leahy, 2007).

Misdiagnosis and Race

- 2004 study explored the relationship between ethnicity, symptom presentation, and diagnosis. African-Americans were four times as likely to have a schizophrenia diagnosis when compared to otherwise similar white Americans
- Reports suggest that these differences are mainly attributable to racial/ethnic bias and/or misattribution of psychotic symptoms.
- Gonzalez et al. compared 1-year treatment outcomes from the US Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD) among African-American, Hispanic, and white individuals; investigators noted that symptom reports during the clinical assessment, from some African-Americans may have been misattributed to psychopathology instead of sociocultural background (e.g. the authors proposed that a persecutory delusion classified as a psychotic symptom may have been more accurate to view as an anxiety symptom when sociocultural context was considered. This misattribution could fuel unsuitable treatment recommendations (i.e. using antipsychotic vs anti-anxiety treatment). (Akinhanmi et al, 2018)

Bipolar Disorder: Causes

Diathesis-Stress Model (Frank & Thase, 1999)

- Strong (70 – 80% of etiological variance) genetic link: concordance rate for identical twins varies from 50 to almost 100%, depending on how you define BD
- Abnormalities have been found in areas of brain thought to be associated with different aspects of emotional behavior (Vawter, Freed, and Kleinman, 2000; Roberts et al, 2013)
  - "Kids and Sibs" trial (Mitchell et al, 2018): recruited and monitored almost 200 young people (aged 12-30) who had a first degree relative with diagnosed bipolar disorder. fMRIs demonstrated that those young people who went on to develop bipolar had visible differences in their brain before they started showing symptoms. These variations occurred in the areas of the brain that are responsible for emotional regulation.
- Chemical component – yet to be determined
- Generally accepted hypothesis for mental illness: predisposition, then something triggers it

Bipolar Disorder: Co-Morbidities

Most clients diagnosed with BD will also have at least one comorbid psychiatric diagnosis; the most common comorbid disorders are anxiety disorder, SUD, PD, and impulse control disorder (ADHD, ODD, CD) (CANMAT, 2018)

Anxiety comorbidity appears to be highly prevalent in BD (51% in the STEP-BD (Systematic Treatment Enhancement Program for BD) study) and is associated with intensified symptoms of BD and additional comorbid disorders. The presence of anxiety in clients with BD is also associated with a lowered age at onset, hampered patient response to treatment such as lithium, increased rates of suicide and substance abuse, and decreased quality of life.

- Anxiety can be part of the BD episode, can be a separate diagnosis, and/or can occur during euthymic episodes; more prevalent in women

Substance Use disorders Estimates vary, but CANMAT (2018) estimates that the prevalence rate of comorbid SUD in BD is about 45% in clinical settings. SUD can be the result of self-medicating; a symptom of BD (i.e. related to impulsivity/risk-taking); or can have a separate etiology

Bipolar Disorder: Co-Morbidities

Personality disorders: 42% of patients with BD also have a comorbid personality disorder; most prevalent:

(according to CANMAT 2018: OCPD - 18%; BPD - 16%; Avoidant - 12%; Paranoid - 11%; Histrionic - 10%)

- Because of their overlapping symptomatology and chronic, persistent nature, distinctions between BD and BPD remain a source of unresolved clinical controversy (Sanches, 2019).

ADHD: ADHD comorbidity is "frequent" (according to CANMAT, 2018, approximately 10-20% of patients with BD meet criteria for adult ADHD, and up to 20% of adults with ADHD also meet criteria for BD); comorbidity of ADHD and BD is associated with a more severe disease course, more severe mood disorder symptoms, lower functional scores, and heightened risk of suicide. The co-occurrence makes ADHD diagnosis challenging because symptoms are often assumed to be part of BD; as a result, clients are often under-diagnosed and under-treated for ADHD.

(With BD, emphasis is on *episodes*)

- Physical health problems can also contribute to, or can mimic symptoms of BD: thyroid, hormonal conditions, physical conditions requiring use of stimulants (e.g. ADHD/ADD, asthma, prednisone); important to consider not just in BD.

Bipolar Disorder and Suicidality

- Suicide is one of the leading causes of death in BD, with approximately 6 – 7% of identified patients with BD dying by suicide (CANMAT, 2018)

- A meta-analysis of 15 studies identified a high prevalence of lifetime suicide attempts both in patients with BD I (36.3%) and in those with BD II (32.4%) (Dennehy et al, 2011); **40% of all the depressed patients (included in the study) who attempted suicide had a "mixed episode" rather than just depression (Popovic et al, 2015).**

Pharmacotherapy for BD

Medications are typically the cornerstone of treatment, and typically maintenance treatment is lifelong; but among clients taking medications:

- 19-25% will experience a recurrence every year (compared to 23-40% of those on placebo; CANMAT, 2018)
- Continued role impairment between episodes; poor medication adherence (Gitlin et al., 1995; Keck et al., 1998; O'Connell et al., 1991; Tohen et al., 1990)

Risk factors for recurrence include younger age of onset, psychotic features, rapid cycling, more (and more frequent) previous episodes, comorbid anxiety and SUDS, and persistent subthreshold symptoms; availability of psychosocial support and lower levels of stress are protective against recurrence (CANMAT, 2018)

On average, adjunctive psychosocial treatments reduce recurrence rates by about 15% (CANMAT, 2018)

Bipolar Disorder: Treatment Options

In an article reviewing efficacy of psychotherapies for BD, Miklowitz concluded that ***"…(BD) is a highly chronic, disabling, and recurrent illness, and our existing treatment options are inadequate for maintaining long-term stability. Even with optimal psychotherapy and pharmacotherapy, recurrences occurred in 50% - 75% of patients in 1 year" (2008, p. 1417)***

It is widely accepted that group psychoeducation and psychotherapy, such as Cognitive-Behavioral Therapy (CBT), Interpersonal Therapy (IPT), and Interpersonal Social Rhythm Therapy (IPSRT) are recommended treatments to complement medication management in BD (Rivzi and Zaretsky, 2007).

HOWEVER…clearly this isn't good enough!

Bipolar Disorder: Treatment Options

Recommended as 1st Line Treatment options by CANMAT: Psychoeducation!

Recommended as 2nd Line Treatment options by CANMAT:

Cognitive Behavioral Therapy (CBT): works to change emotions by addressing their connection to distorted thinking and problematic behaviors (evidence for CBT for BD is mixed)

Family-Focused Treatment (FFT): Focuses on helping the family to provide stable routines (e.g., sleep), and consistency in caretaking and external structure, which helps children develop internal controls and emotional self-regulation strategies. Family psychoeducation aims to provide a healthier environment with reduced expressed emotion (studies have demonstrated efficacy of FFT in reducing recurrence of new episodes of depression, but not mania)

Recommended as 3rd Line Treatment options by CANMAT:

Interpersonal and Social Rhythm Therapy (IPSRT): aims to improve mood by helping people identify and maintain the regular routines of everyday life, such as sleep patterns, and solving interpersonal issues and problems that may directly impact routine (few controlled trials of IPSRT have been conducted, with limited evidence of acute efficacy

Common elements among recommended treatments:

1. Psychoeducation providing a model of the disorder and risk and protective factors (e.g., the role of sleep and lifestyle regularity).

2. Communication and problem-solving training aimed at reducing familial, relationship, or external stress.

3. Review of strategies for the early detection and intervention with mood episodes (including increased support, pharmacotherapy, more-frequent monitoring).

Bipolar Disorder: Treatment Options

What are Targets for Psychotherapy for BD?

- Psychoeducation, including importance of medication/treatment adherence; and awareness of symptoms to allow for early detection and intervention in episodes
- Stress and lifestyle management
- Treatment of comorbid conditions
- Addressing Psychosocial stressors that impact the course of bipolar disorder:
  - Family/relationship stress
  - Negative life events
  - Cognitive style
  - Sleep disruptions

Bipolar Disorder: A DBT-Informed Treatment Approach

Dialectical Behavior Therapy (DBT)

- Studies have shown that Dialectical Behavior Therapy (DBT) is a highly effective treatment for Borderline Personality Disorder (BPD); similarities between BPD and BD include: emotion dysregulation, suicidality, impulsivity, interpersonal deficits and treatment non-adherence, all of which are targets of DBT (Goldstein et al, 2015)
- DBT inherently treats not just the BD, but also any co-morbid conditions

Bipolar Disorder: A DBT-Informed Treatment Approach

Van Dijk et al (2013): A RCT on a 12-week DBT skills group for Bipolar Disorder demonstrated overall benefits:

- a statistically significant reduction in depressive symptoms, increase in self-efficacy, and increase in one's ability to manage one's emotions;
- hospitalizations and ER visits were also reduced in the 6 months post-group compared to 6 months prior to group
- This was a pilot study involving 24 participants (12 in the study group and 12 in a waiting list control group); subsequent to the study, data was analyzed for a total of 75 participants that provided further evidence for the results of the RCT.

Bipolar Disorder: A DBT-Informed Treatment Approach

- Afshari et al, 2019: "DBT, alongside medication can be an effective therapy for BD…leading to reduced manic and depression symptoms and improved executive functions, emotion regulation, and mindfulness"
- Eisner et al, 2016 adapted DBT for bipolar disorder & found it increased participants' well-being
- Recent studies are starting to provide evidence for the use of mindfulness (which is a core skill in DBT) with bipolar disorder (e.g. Weber et al, 2017; Perich et al, 2014)
- In addition, multiple studies of mindfulness have shown it to be effective in the treatment of severe mental illness such as depression and depression relapse; GAD; and panic disorder, which could be taken as further evidence for the hypothesis that DBT and mindfulness practice would be an effective treatment for BD.

If you're interested in next steps regarding treatment: DBT Informed Treatment of Bipolar Disorder webinar through Core Wellness.

Resources 1-10

Afshari, B., Omidi, A., and Sehat, M. (2019). The effects of dialectical behavior therapy on executive functions, emotion regulation, and mindfulness in bipolar disorder. Journal of Contemporary Psychotherapy: published online: 08 October 2019 https://doi.org/10.1007/s10879-019-09442-7

Akinhanmi, M., Biernacka, J., Strakowski, S., McElroy, S., Balls Berry, J., Merikangas, K., Assari, S., McInnis, M., Schulze, T., LeBoyer, M., Tamminga, C., Patten, C., Frye, M. (2018). Racial disparities in bipolar disorder treatment and research: a call to action. (2018) Bipolar Disorder: Sep;20(6):506-514.

Altman S, Haeri S, Cohen LJ, Ten A, Barron E, Galynker II, Duhamel KN. (2006). Predictors of relapse in bipolar disorder: A review. Journal of Psychiatry Practice. Sep;12(5):269-82.

Bendera R, and Alloya L. (2011). Life Stress and Kindling in Bipolar Disorder: Review of the Evidence and Integration with Emerging Biopsychosocial Theories. Clinical Psychology Review. Apr; 31(3): 383–398.

Canadian Network for Mood and Anxiety Treatments (CANMAT) and International Society for Bipolar Disorders (ISBD) 2018 guidelines for the management of patients with bipolar disorder. Bipolar Disorders. 2018; 1-74.

Dennehy EB, Marangell LB, Allen MH, Chessick C, Wisniewski SR, Thase ME. (2011). Suicide and suicide attempts in the Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD). *Journal of Affective Disorders*; 133: 423–427.

Depp CA, Davis CE, Mittal D, Patterson TL, Jeste DV. (2006). Health-related quality of life and functioning of middle-aged and elderly adults with bipolar disorder. *Journal of Clinical Psychiatry.* Feb;67(2):215-21.

Depression and Bipolar Support Alliance (DBSA): https://secure2.convio.net/dabsa/site/SPageServer/?pagename=home

Eisner L., Eddie D., Harley R., Jacobo M., Nierenberg A., and Deckersbach, T. (2017). Dialectical Behavior Therapy Group Skills Training for Bipolar Disorder. Behavior Therapy. 2017 July; 48(4): 557–566.

Gardner HH, Kleinman NL, Brook RA, Rajagopalan K, Brizee TJ, Smeeding JE. (2006). The economic impact of bipolar disorder in an employed population from an employer perspective. *Journal of Clinical Psychiatry.* Aug;67(8):1209-18.

Resources 11-20

Gitlin MJ, Swendsen J, Heller TL, Hammen C. (1995). Relapse and impairment in bipolar disorder. American Journal of Psychiatry. 1995 Nov;152(11):1635-40.

Glahn DC, Bearden CE, Bowden CL, Soares JC. (2006). Reduced educational attainment in bipolar disorder. *Journal of Affective Disorders.* Jun;92(2-3):309-12.

Goldstein T, Axelson D, Birmaher B, and Brent D. (2007). Dialectical Behavior Therapy for Adolescents With Bipolar Disorder: A 1-Year Open Trial. Journal of American Academy of Child and Adolescent Psychiatry. Jul; 46(7): 820.

Goldstein T, Fersch-Podrat R, Rivera R, Axelson D, Merranko J, Yu H, Brent D, and Birmaher B. (2015). Dialectical Behavior Therapy for Adolescents with Bipolar Disorder: Results from a Pilot Randomized Trial. Journal of Child and Adolescent Psychopharmacology. Mar 1; 25(2): 140–149.

Hirschfeld R, Williams J, Spitzer R, Calabrese J, Flynn L, Keck P, Lewis L, McElroy S, Post R, Rapport D, Russell J, Sachs G, Zajecka J. (2000). Development and Validation of a Screening Instrument for Bipolar Spectrum Disorder: The Mood Disorder Questionnaire. *The American Journal of Psychiatry*

Jacobson, P., Richardson, M., Harding E., Chadwick, P. (2019). Mindfulness for Psychosis Groups; Within-Session Effects on Stress and Symptom-Related Distress in Routine Community Care. Behavioral and Cognitive Psychotherapy, Jan. 18th, 2019.

Judd LL, Akiskal HS, Schettler PJ, Endicott J, Maser J, Solomon DA, Leon AC, Rice JA, Keller MB. (2002). The long-term natural history of the weekly symptomatic status of bipolar I disorder. *Archives of General Psychiatry.* 2002 Jun;59(6):530-7.

Judd L, Akiskal H, Schettler P, Coryell W, Endicott J, Maser J, Solomon D, Leon A, and Keller M. (2003). A Prospective Investigation of the Natural History of the Long-Term Weekly Symptomatic Status of Bipolar II Disorder. *Archives of General Psychiatry*. 60(3):261-269

Keck PE Jr1, McElroy SL, Strakowski SM, West SA, Sax KW, Hawkins JM, Bourne ML, Haggard P. (1998). 12-month outcome of patients with bipolar disorder following hospitalization for a manic or mixed episode. American Journal of Psychiatry. 1998 May;155(5):646-52.

Leahy R. (2007). Bipolar disorder: causes, contexts, and treatments. Journal of Clinical Psychology. May;63(5):417-24.

Resources 21-30

Lenroot R, Roberts G, Fullerton J, Overs B, Schofield P, Mitchell P. (2015). Bipolar Disorder Kids & Sibs Study: Neuroimaging Findings in Young People at High Risk for Bipolar Disorder. *Australian and New Zealand Journal of Psychiatry* 49:82-82.

Magill C. (2004). The Boundary between Borderline Personality Disorder and Bipolar Disorder: Current Concepts and Challenges. *The Canadian Journal of Psychiatry*, Volume: 49 issue: 8, page(s): 551-556.

Marangell LB, Bauer MS, Dennehy EB, Wisniewski SR, Allen MH, Miklowitz DJ, Oquendo MA, Frank E, Perlis RH, Martinez JM, Fagiolini A, Otto MW, Chessick CA, Zboyan HA, Miyahara S, Sachs G, Thase ME. (2006). Prospective predictors of suicide and suicide attempts in 1,556 patients with bipolar disorders followed for up to 2 years. *Bipolar Disorder* 8:566-575.

Masi G, Perugi G, Toni C, Millepiedi S, Mucci M, Bertini N, Pfanner C. (2006). Attention-deficit hyperactivity disorder – bipolar comorbidity in children and adolescents. *Bipolar Disorder*: published July 18th, 2006 https://doi.org/10.1111/j.1399-5618.2006.00342.x

Michalak EE, Yatham LN, Kolesar S, Lam RW. (2006). Bipolar disorder and quality of life: a patient-centered perspective. Quality of Life Research Journal. Feb;15(1):25-37.

Miklowtiz DJ. (2008). Adjunctive psychotherapy for bipolar disorder: state of the evidence. *American Journal of Psychiatry.* Nov;165(11):1408-19.

Miklowitz DJ, Johnson SL. Social and familial factors in the course of bipolar disorder: Basic processes and relevant interventions. *Clinical Psychology: Science and Practice.* 2009;16(2):281–296.

Mitchell and Colleagues Kids and Sibs study https://www.blackdoginstitute.org.au/news/news-detail/2018/03/28/world-bipolar-day-what-we-know-in-2018

Mood Disorders Society of Canada (2009). What is Bipolar Disorder (brochure): https://mdsc.ca/docs/Bipolar%20Brochure%20English%20FINAL%20150109.pdf

National Institute of Mental Health, STEP-BD study: https://www.clinicaltrials.gov/ct2/show/NCT00012558

Resources 31-45

O'Connell R, Mayo J, Flatow L, Cuthbertson B, and O'Brien B. (1991). Outcome of Bipolar Disorder on Long-Term Treatment with Lithium. *The British Journal of Psychiatry*, 159 (1): 123-129

Perich T, Manicavasagar V, Mitchell P, Ball J. (2014). Mindfulness-Based Approaches in the Treatment of Bipolar Disorder: Potential Mechanisms and Effects. *Mindfulness* 5 (2): 186–191

Perlis RH1, Ostacher MJ, Patel JK, Marangell LB, Zhang H, Wisniewski SR, Ketter TA, Miklowitz DJ, Otto MW, Gyulai L, Reilly-Harrington NA, Nierenberg AA, Sachs GS, Thase ME. (2006). Predictors of recurrence in bipolar disorder: primary outcomes from the Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD). *American Journal of Psychiatry.* Feb;163(2):217-24.

Plans L., Barrot C. Nieto, E., Rios, J., Schulze T.G., Papiol S., Mitjans M., Vieta E., Benabarre A. (2019). Association between completed suicide and bipolar disorder: A systematic review of the literature. Journal of Affective Disorders Volume 242, 1 January 2019, Pages 111-122.

Popovic D, Vieta E, Azorin JM, Angst J, Bowden CL, Mosolov S, Young AH, and Perugi G. (2015). Suicide attempts in major depressive episode: evidence from the BRIDGE-II-Mix study. Bipolar Disorder. Nov;17(7):795-803.

Ramirez Basco M. (2006). The Bipolar Workbook. New York: The Guilford Press.

Rizvi S, Zaretsky A. (2007). Psychotherapy through the phases of bipolar disorder: Evidence for general efficacy and differential effects. *Journal of Clinical Psychology*. Volume 63, (5): 491-506.

Roberts G, Green MJ, Breakspear M, McCormack C, Frankland A, Wright A, Levy F, Lenroot R, Chan HN, Mitchell PB. (2013). Reduced inferior frontal gyrus activation during response inhibition to emotional stimuli in youth at high risk of bipolar disorder. *Biological Psychiatry*, Jul 1; 74(1):55-61.

Sanches, M. The Limits between Bipolar Disorder and Borderline Personality Disorder: A Review of the Evidence. *Diseases* 2019, 7, 49.

Thase M. (2006). Bipolar depression: diagnostic and treatment considerations. Develpmental Psychopathology. Fall;18(4):1213-30.

Resources 41-45

Tohen M, Waternaux C, Tsuang M, and Hunt A. (1990). Four-year follow-up of twenty-four first-episode manic patients. *Journal of Affective Disorders,* 19 (2): 79-86.

Van Dijk S, Jeffery J, and Katz M. (2013). A randomized, controlled, pilot study of dialectical behavior therapy skills in a psychoeducational group for individuals with bipolar disorder. Journal of Affective Disorders, 145 (3): 386 – 393.

Van Dijk, S. (2009). The Dialectical Behavior Therapy Skills Workbook for Bipolar Disorder. Oakland: New Harbinger Publications.

Vawter MP, Freed WJ, Kleinman JE. (2000). Neuropathology of bipolar disorder. *Biological Psychiatry*. Sep 15;48(6):486-504.

Weber B, Sala L, Gex-Fabry M, Docteur A, Gorwood P, Cordera P, Bondolfi G, Jermann F, Aubry J, and Mirabel-Sarron C. (2017). Self-Reported Long-Term Benefits of Mindfulness-Based Cognitive Therapy in Patients with Bipolar Disorder. The Journal of Alternative and Complementary Medicine Vol. 23, No. 7.

Thank You!