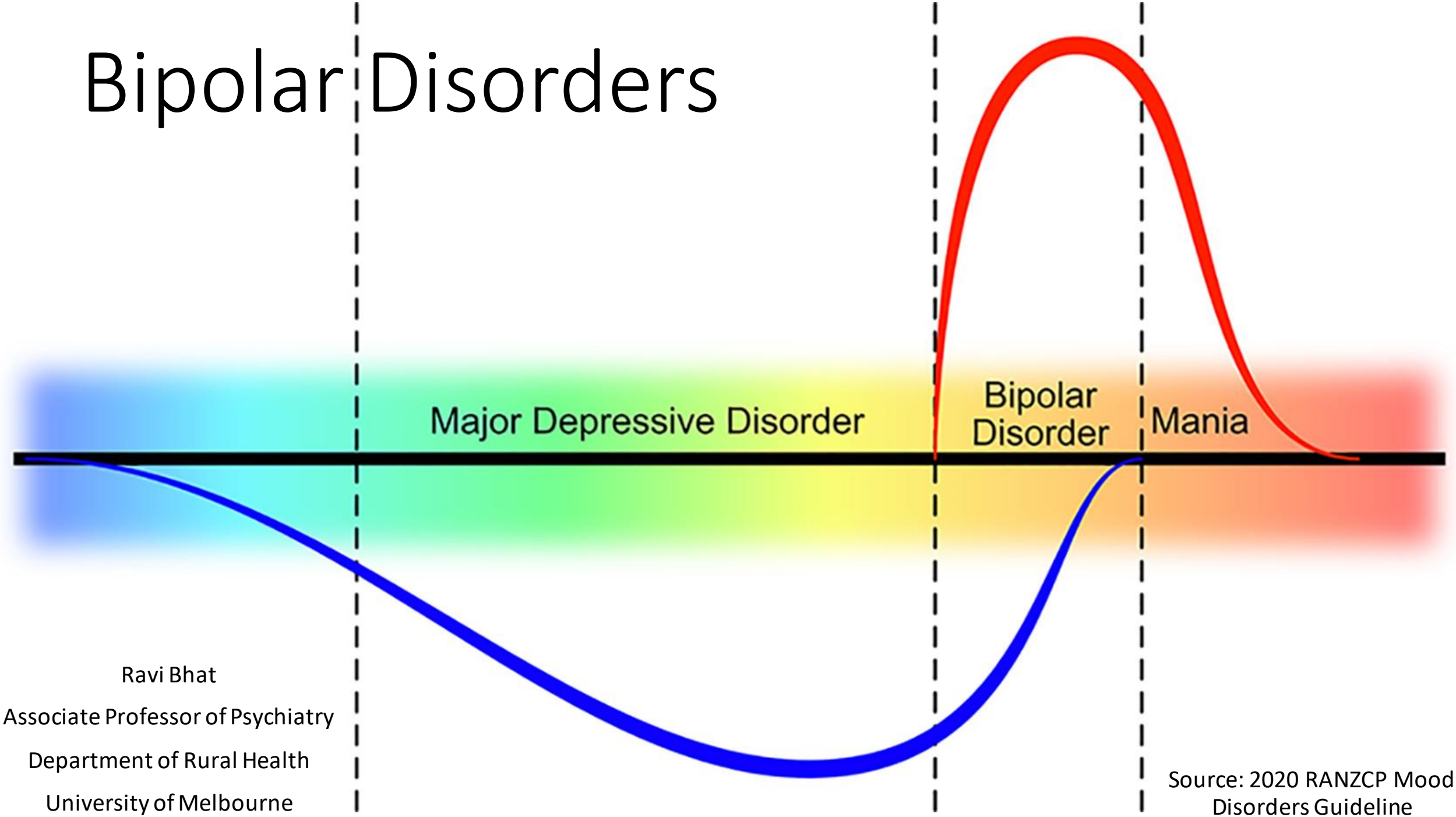
When it is two o'clock in the morning, and you're manic, even the UCLA Medical Center has a certain appeal. The hospital – ordinarily a cold clotting of uninteresting buildings – because for me, that fall morning not quite twenty years ago, a focus of my finely wired, exquisitely alert nervous system. With vibrissae twining, antennae perked, eyes fast-forwarding and fly faceted, I took in everything around me. I was on the run. Not just on the run but fast and furious on the run, darting back and forth across the hospital parking lot trying to use up a boundless, restless, manic energy. I was running fast, but slowly going mad.

The man I was with, a colleague from the medical school, had stopped running an hour earlier and was, he said impatiently, exhausted. This to a saner mind, would not have been surprising: the usual distinction between day and night had long since disappeared for the two of us…

Suddenly a police car pulled up. Even in my less-than-totally lucid state of mind I could see that the officer had his hand on his gun as he got out of the car. "What in the hell are you doing running around the parking lot at this hour?" he asked…My colleague, fortunately, was thinking far better than I was and managed to reach down into some deeply intuitive part of his own and the world's collective unconscious and said, "We're both on the faculty in the psychiatry department." The policeman looked at us, smiled, went back to his squad car, and drove away.

Being professors of psychiatry explained everything.

Bipolar Disorders



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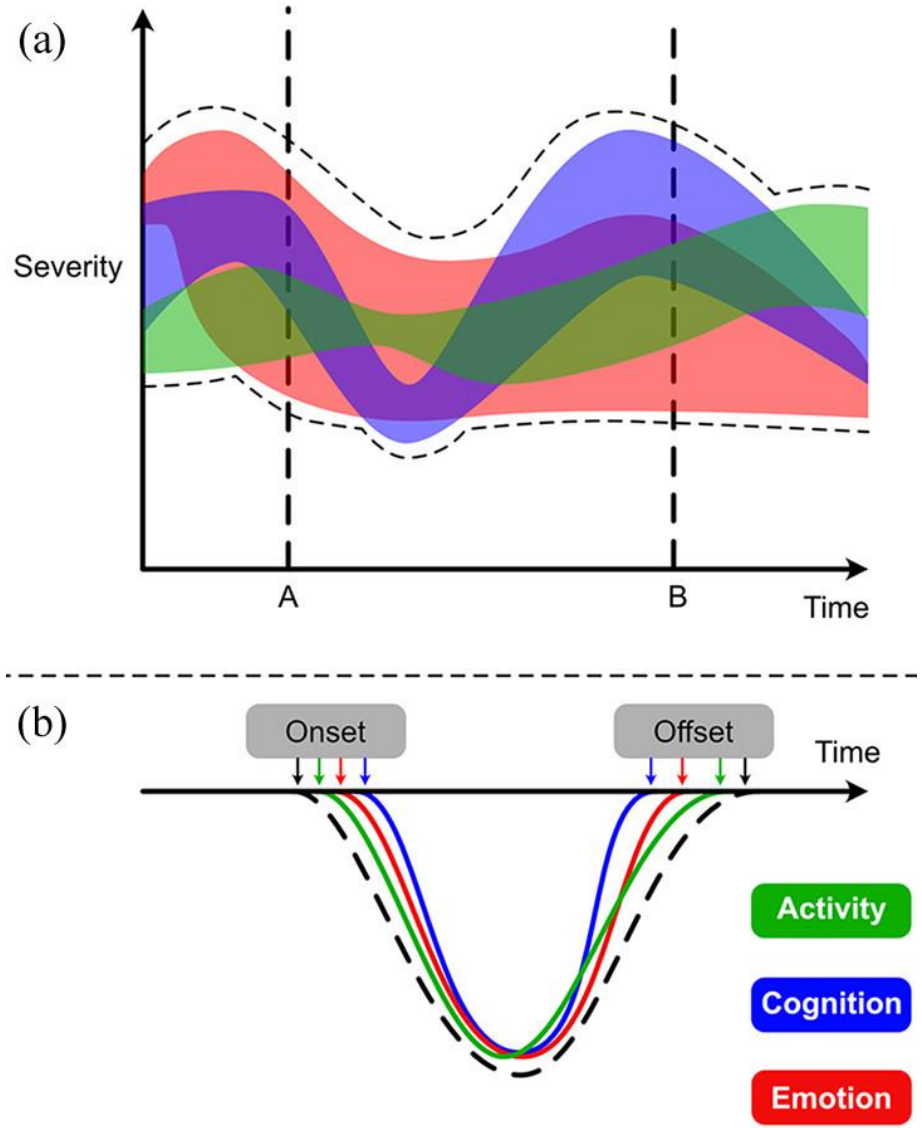
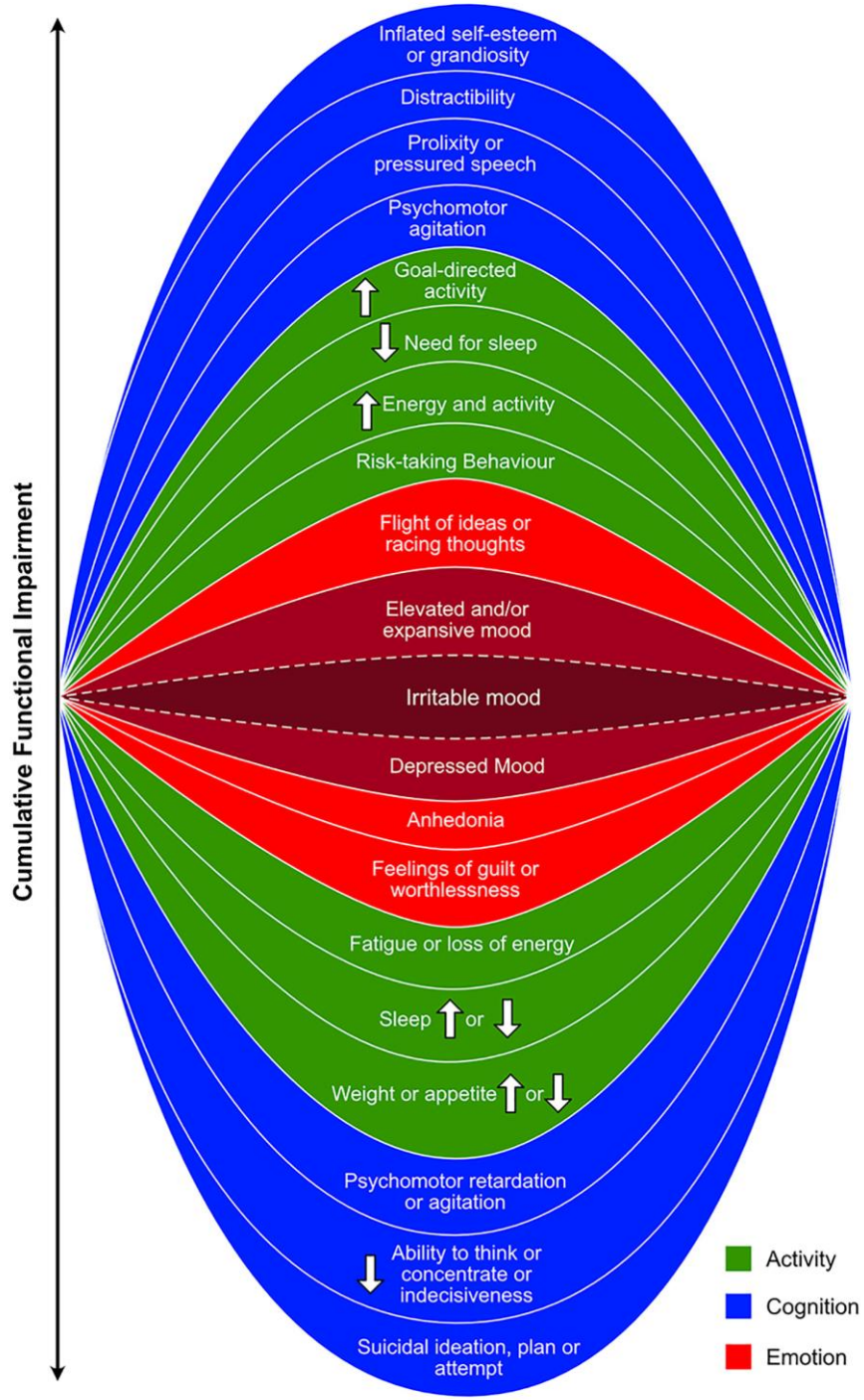
Source: 2020 RANZCP Mood Disorders Guideline

Characteristics

- Bipolar I disorder is defined by the presence of a syndromal manic episode with an estimated global lifetime prevalence of 0·6–1·0%.
- Bipolar II disorder is defined by the presence of a syndromal hypomanic episode and a major depressive episode with an estimated global lifetime prevalence of 0·4–1·1%.
- Early age of onset – 70% of individuals with bipolar disorders manifest clinical characteristics of the illness before the age of 25 years.
- Associated with *creativity* and considerable illness-related *disability*, including that due to comorbid, chronic non-communicable diseases.
- At age 15 years, the remaining life expectancy for a person with bipolar disorder is 9–13 years less than that of the general population.
- ~30–50% of adults with bipolar disorders have a lifetime history of suicide attempts, with an estimated 15–20% of affected people dying by suicide

McIntyre RS, Berk M, Brietzke E, Goldstein BI, López-Jaramillo C, Kessing LV, Malhi GS, Nierenberg AA, Rosenblat JD, Majeed A, Vieta E, Vinberg M, Young AH, Mansur RB. Bipolar disorders. Lancet. 2020 Dec 5;396(10265):1841-1856. doi: 10.1016/S0140-6736(20)31544-0. PMID: 33278937.





Malhi GS, Bell E, Bassett D, Boyce P, Bryant R, Hazell P, Hopwood M, Lyndon B, Mulder R, Porter R, Singh AB, Murray G. The 2020 Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for mood disorders. Aust N Z J Psychiatry. 2021 Jan;55(1):7-117. doi: 10.1177/0004867420979353. PMID: 33353391.

Mental states

- Mixed state will often manifest symptoms of anxiety, agitation, anger-irritability, and attentional disturbance-distractibility (the four As).
- Depression often with melancholic features, atypical features (hyperphagia and hypersomnia), and psychotic symptoms.
- Hypomania:

If my elevated states last more than a few days, my spending can become uncontrollable and I have to hand over my credit cards to my husband, which takes a great effort of willpower otherwise I make purchases I will later regret. I remember being entranced by 18-metre lengths of coiled yellow extension wire. In my heightened state of awareness the coils of yellow looked exquisitely beautiful and irresistible. I wanted to buy several at once.

I will sometimes drive faster than usual, need less sleep and can concentrate well, making quick and accurate decisions. At these times I can also be sociable, talkative and fun, focused at times, distracted at others. If this state of elevation continues I often find that feelings of violence and irritability towards those I love will start to creep in. Concentration and memory start to wane and I can become hypersensitive to noise. The children making their usual noise and my husband singing can drive me to distraction.

Anonymous. On madness: a personal account of rapid cycling bipolar disorder. Br J Gen Pract. 2006 Sep;56(530):726-8. PMID: 16954013; PMCID: PMC1876649.

Co-morbidities

- Bipolar II disorder has a higher suicide rate than does bipolar I disorder, underscoring the complexity and severity of bipolar II
- Co-morbidities:
  - 70–90% meet the criteria for either generalised anxiety disorder, social anxiety disorder, or panic disorder.
  - About 30–50% of adults with bipolar disorders have either substance use disorder or alcohol use disorder
  - 25–45% meet the criteria for ADHD
  - 20–40% meet criteria for personality disorders, and
  - 10-20% meet criteria for binge eating disorder
  - high prevalence of cardiovascular disorders at index presentation in individuals with bipolar disorders

McIntyre RS, Berk M, Brietzke E, Goldstein BI, López-Jaramillo C, Kessing LV, Malhi GS, Nierenberg AA, Rosenblat JD, Majeed A, Vieta E, Vinberg M, Young AH, Mansur RB. Bipolar disorders. Lancet. 2020 Dec 5;396(10265):1841-1856. doi: 10.1016/S0140-6736(20)31544-0. PMID: 33278937.

Bipolar Disorders and Substance Use

Do not go gentle into that good night,
Old age should burn and rave at close of day;
Rage, rage against the dying of the light.

Though wise men at their end know dark is right,
Because their words had forked no lightning they
Do not go gentle into that good night.

Good men, the last wave by, crying how bright
Their frail deeds might have danced in a green bay,
Rage, rage against the dying of the light.

Dylan was now having blackouts at frequent intervals. On more than one occasion he had been warned by his doctor that he must go on a regime of complete abstinence from alcohol if he was to survive…Dylan seemed exhausted, self-preoccupied, and morbidly depressed. He went out alone, and an hour and a half later retuned to announce, “I’ve had eighteen straight whiskeys. I think that’s the record.” [Shortly afterwards] he died.

Jamison KR. Touched with fire. Simon and Schuster; 1996 Oct 18.
https://www.brainpickings.org/2017/01/24/dylan-thomas-do-not-go-gentle-into-that-good-night/

Causes

- Twin studies report that the heritability of bipolar disorders is approximately 60–80%. The concordance of bipolar disorders is approximately 40–45% for monozygotic twins and 4–6% for dizygotic twins.
- Inflammatory disturbance might contribute to the pathogenesis of bipolar disorders – cause or effect?
- Neurobiological progression – people with bipolar disorders might exhibit progressive neurobiological changes as a function of illness duration and the number of previous episodes.
- Adverse childhood experiences (ACEs) – 50% report.
- No integrative account as yet.

McIntyre RS, Berk M, Brietzke E, Goldstein BI, López-Jaramillo C, Kessing LV, Malhi GS, Nierenberg AA, Rosenblat JD, Majeed A, Vieta E, Vinberg M, Young AH, Mansur RB. Bipolar disorders. Lancet. 2020 Dec 5;396(10265):1841-1856. doi: 10.1016/S0140-6736(20)31544-0. PMID: 33278937.

Differential diagnosis

- Includes other mental disorders characterised by impulsivity, affective instability, anxiety, cognitive disorganisation, depression, and psychosis.
- Major depression versus bipolar depression:
  - earlier age at onset of illness, phenomenology (e.g., hyperphagia, hypersomnia, and psychosis are more common in bipolar disorders than in major depressive disorder)
  - higher frequency of affective episodes
  - pattern of comorbidity (e.g., substance use disorders, anxiety disorders, binge eating disorders, and migraines all disproportionately affect people with bipolar disorders)
  - Family history of psychopathology.
- Attention-deficit hyperactivity disorder (ADHD) – age at onset earlier for ADHD
- Borderline personality disorder – has at its core a disturbance of attachment
- Substance use disorders (SUD)
- Schizophrenia – can be difficult.

McIntyre RS, Berk M, Brietzke E, Goldstein BI, López-Jaramillo C, Kessing LV, Malhi GS, Nierenberg AA, Rosenblat JD, Majeed A, Vieta E, Vinberg M, Young AH, Mansur RB. Bipolar disorders. Lancet. 2020 Dec 5;396(10265):1841-1856. doi: 10.1016/S0140-6736(20)31544-0. PMID: 33278937.

Bipolar II or Borderline Personality Disorder

History	Bipolar II	Borderline Personality Disorder
Heritability	More likely for there to be a first-degree relative with BP disorder (especially BP II)	Less likely to have a first-degree relative with BP disorder; more likely for relatives to have impulse control disorders (antisocial personality and substance abuse), unipolar depression or borderline features
Age of onset	Onset usually in late teenage years with a distinct 'trend-break'	Lack of clear onset, with emotional difficulties since childhood
History of childhood sexual abuse	Lower likelihood	Higher likelihood
Gender	Slight female predominance	Female preponderance in clinical settings
History of other developmental trauma (e.g., physical and emotional abuse)	Lower likelihood	Higher likelihood
Early parental relationships	Distant/rejecting parent unlikely	Distant/rejecting parent likely
Childhood depersonalization	Unlikely	Likely

Bayes A, Parker G, Paris J. Differential Diagnosis of Bipolar II Disorder and Borderline Personality Disorder. Curr Psychiatry Rep. 2019 Nov 20;21(12):125. doi: 10.1007/s11920-019-1120-2. PMID: 31749106.

Bipolar II or Borderline Personality Disorder

Clinical Feature	Bipolar II	Borderline Personality Disorder
Affective instability	Severity: May be present but generally not severe Quality: Shifts from euthymia to depression or elation Triggers: More likely autonomous	Severity: Commonly high Quality: Shifts from euthymia to anxiety or anger Triggers: More likely interpersonally driven
Emotional regulation	Maladaptive strategies less severe; adaptive strategies superior	Maladaptive strategies more severe; adaptive strategies impaired
Deliberate self-harm and suicide attempts	Less likely	More likely
Psychotic features	Hypomanic states lack psychotic features by definition; BP II depressive states may rarely include psychotic features	Transient psychotic features are common, especially under stress
Phenomenology of 'highs'	Grandiosity, euphoria (can be irritable); anxiety typically abates	Euphoria rare or brief (i.e., < 48 h); anxiety often distinctive
Depressive symptoms	More likely melancholic in nature	More likely non-melancholic in nature
Impulsivity	More likely during a hypomanic episode; 'attentional impulsiveness'	Not necessarily related to mood state; 'non-planning impulsiveness'

Bayes A, Parker G, Paris J. Differential Diagnosis of Bipolar II Disorder and Borderline Personality Disorder. Curr Psychiatry Rep. 2019 Nov 20;21(12):125. doi: 10.1007/s11920-019-1120-2. PMID: 31749106.

Bipolar II or Borderline Personality Disorder

Other Features	Bipolar II	Borderline Personality Disorder
Mood state precipitant	More likely autonomous (but can also be reactive)	More likely to be triggered by interpersonal interactions (such as perceived abandonment)
Social cognition	Impaired theory of mind; likely moderated by mood state	Failure of 'mentalization'
Relationships	Generally stable relationships; less avoidance due to fear of rejection	Distinctive relationship difficulties; avoidance due to fear of rejection
Self-identity	May be impacted during mood episodes, but more stable when euthymic	'Painful incoherence'
Prognosis	Does not remit with age, and can often worsen	Tends to improve over time, and criteria for the disorder may not be met by middle age
Treatment response	Mood episodes likely to respond to mood stabilizers and atypical antipsychotic drugs	Poor response to mood stabilizers; non-specific response to medications (e.g., sedation)

Bayes A, Parker G, Paris J. Differential Diagnosis of Bipolar II Disorder and Borderline Personality Disorder. Curr Psychiatry Rep. 2019 Nov 20;21(12):125. doi: 10.1007/s11920-019-1120-2. PMID: 31749106.

Treatment Objectives

- Prevention and treatment of syndromal hypomania, mania, and depression
- Abatement of inter-episodic depressive symptoms
- Normalisation of circadian disturbances (e.g., in sleep)
- Improvement and preservation of cognitive function
- Treatment and prevention of psychiatric and medical comorbidity
- Improvement of patient-reported outcomes (e.g., quality of life)
- Reduction of suicidality.

McIntyre RS, Berk M, Brietzke E, Goldstein BI, López-Jaramillo C, Kessing LV, Malhi GS, Nierenberg AA, Rosenblat JD, Majeed A, Vieta E, Vinberg M, Young AH, Mansur RB. Bipolar disorders. Lancet. 2020 Dec 5;396(10265):1841-1856. doi: 10.1016/S0140-6736(20)31544-0. PMID: 33278937.

Treatments

- Acute Mania
  - Lithium 0.6-0.8 mmol/L
  - Sodium valproate
  - Antipsychotic medications – aripiprazole, quetiapine etc.
  - Electroconvulsive therapy
- Acute Depression
  - Quetiapine, lurasidone
  - Electroconvulsive therapy
  - Antidepressants (risk of switch, consider in people who have stable episodic bipolar depression and do not present with rapid cycling, mixed features, a history of previous antidepressant induced destabilisation, or combinations of these presentations.)
- Maintenance treatment
  - Lithium
  - Quetiapine
  - Lamotrigine (depression)
  - Psychotherapy

McIntyre RS, Berk M, Brietzke E, Goldstein BI, López-Jaramillo C, Kessing LV, Malhi GS, Nierenberg AA, Rosenblat JD, Majeed A, Vieta E, Vinberg M, Young AH, Mansur RB. Bipolar disorders. Lancet. 2020 Dec 5;396(10265):1841-1856. doi: 10.1016/S0140-6736(20)31544-0. PMID: 33278937.

At this point in my existence, I cannot imagine a normal life without both taking lithium and having had benefits of psychotherapy. Lithium prevents my seductive but disastrous highs, diminishes my depressions, clears out the wool and webbing from my disordered thinking, slows me own, gentles me out, keeps me from ruining my career and relationships, keeps me out of hospital, alive, and makes psychotherapy possible. But, ineffably, psychotherapy **heals**. *It makes some of the confusion, reins in the terrifying thoughts and feelings, returns some control and hope and possibility of learning from it all. Pills cannot, do not, ease one back into reality; they only bring one back headlong, careening, and faster than can be endured at times. Psychotherapy is a sanctuary; it is a battleground; it is a place I have been psychotic, neurotic, elated, confused, and despairing beyond belief. But, always, it is where I have believed – or have learned to believe – that I might someday be able to contend with all of this.*

Jamison KR. An unquiet mind: A memoir of moods and madness. Pan Macmillan; 2015.

Also see: https://youtu.be/eAC6jC4giu0