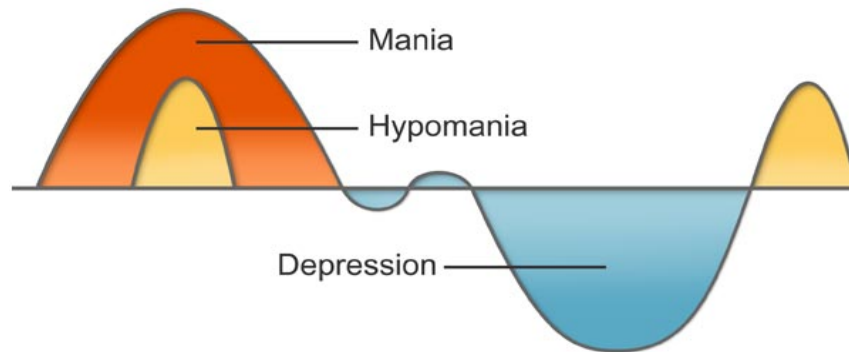


## Introduction to bipolar disorder

- Bipolar I is when the individual experiences 'manic' episodes when high as well as episodes of depression
- Bipolar II is when the individual experiences 'hypomanic' episodes when high as well as episodes of depression



First, some definitions. Once we talked about manic depressive illness, now we talk about bipolar disorder. As you can see from the graphic, bipolar I refers to the more severe expressions, when people have manic episodes during their highs, whereas bipolar II describes those who have milder elevations, which are called hypomanic episodes during those highs. Of course, episodes of depression oscillate with the manic or hypomanic episodes. In bipolar I, episodes tend to last longer, be they highs or lows, and the oscillation rate is probably slower than in bipolar II where people tend to cycle much more rapidly.

## Definitions

- Bipolar III is when starting or stopping an antidepressant drug 'causes' a high (i.e. 'switching')
- 'Mixed states' involve the individual having both high and depressive symptoms at the same time.

Bipolar III defines when an anti-depressant drug has caused someone to go high, and here we also use the term 'switching'. Mixed states involve the individual being both high and depressed at the same time.

The slide features a background with silhouettes of people. In the top left, a person is shown in a dark grey silhouette with arms raised. In the bottom right, a person is shown in a light orange silhouette with arms raised. The central text is overlaid on a white rectangular area with a grey border.

## Characteristics of bipolar disorder

- Individuals generally have severe 'clinical depression' as well as the highs.

An important characteristic for true bipolar disorder is that individuals have episodes of severe clinical depression as well as having the highs.



## Severe 'clinical' depression

- Here, the depression is usually experienced as melancholic or psychotic depression
- Inability to “fire up” and lack of energy (e.g. difficult to get out of bed and have a bath or shower)
- Lack of pleasure and inability to be cheered up
- Impaired cognition (“brain feels foggy”)
- Physically slowed and/or agitated
- Mood and energy levels far worse in the morning.

In the depressed phase, people tend to develop melancholic or psychotic depression, as described on our website. In such episodes, the individual feels a profound lack of energy, an inability to get out of bed or even have a bath or shower. They lack any sense of pleasure in life and they can't be cheered up. Their concentration is impaired and they often report their brain as feeling 'foggy'. They're commonly physically slowed or agitated and they generally experience their mood and energy levels to be far worse in the mornings.



## The 'highs'

- Feeling neither depressed nor 'normal' and
- Having an overshoot, feeling 'wired and energised'.  
Highly likely to...
  - Talk more than usual and/or over people
  - Spend money on things not really needed
  - Be indiscrete verbally or in action
  - Need less sleep and not feel tired
  - Have increased libido
  - Find nature more beautiful
  - Dress more colourfully.

In terms of diagnosing highs, the individual should report times when they're neither depressed nor feeling normal, but they're having an overshoot where they feel more wired and energized. During those times they tend to talk more than usual, spend money on things that are not really needed, say things or do things that they regret later, need less sleep and not feel tired, notice increased libido and that nature is more beautiful and even dress more colourfully.

## Symptom groups of a high



### CREATIVITY

- More confident
- See things in new light
- Creative ideas & plans
- Things vivid/crystal clear
- Spend more money
- Increased libido



### MYSTICISM

- Lots of coincidences
- Feel at one with nature
- See special meaning in things
- Mystical experiences



### DISINHIBITION

- Say outrageous things
- Feel 'high as a kite'
- Laugh more
- Do outrageous things



### IRRITABILITY

- Talk over people
- Feel angry
- Thoughts race
- Feel irritated

[Go to our online self-test](#)

In our web-based bipolar self-test, the items form four symptom groups, capturing the reality that people during their highs are more creative, find more mystical experiences in day-to-day activities, they become more disinhibited and, commonly, more irritable and angry.



## Other characteristics

- **Clear onset** – most usually in adolescence/early adulthood and with highs differing from previous personality style
- **Duration** – usually highs last for days or longer but may also be brief (e.g. hours or only a day)
- Possible **family history**
- Be **observed by others** – but not always.

Other diagnostic clues are the mood disorders having a clear onset, most usually in adolescence and therefore distinguished from the ongoing personality style. Duration of highs is not as important as we used to think. People with true highs may have them only for hours or a day or so. A family history and having the highs observed by others are helpful, but not always reported by people.



## Psychotic features

- **Psychotic features** (e.g. delusions or false beliefs, hallucinations such as hearing voices) common in Bipolar I states.
- May be **mood-consistent** (e.g. grandiosity or overconfidence) or **mood-inconsistent** (e.g. feeling of being persecuted or harmed)
- Thus, a wrong diagnosis of schizophrenia is risked.

Psychotic features help to define the manic or bipolar I condition. These can involve delusions or false beliefs as well as hallucinations. For many people these are consistent with the mood state so they may reflect either overconfidence or grandiosity, but in other instances they can be quite inconsistent with the mood state. For instance, somebody might feel that they are being persecuted or harmed. In latter cases, the diagnosis of schizophrenia can be made by mistake.

The slide features an orange header with the title "Psychotic features" in white text. Below the header is a white box with a grey border containing two bullet points. The background of the slide is a blurred image of people in a social setting.

## Psychotic features

- While usually SEVERE at the time, response to treatment is generally very good
- Those who have early severe onset (e.g. adolescence) often get better over time (i.e. disorder softens).

While psychotic features indicate severity and are very distressing to most individuals and their families, response to treatment is usually good. Other good news is that for people who have severe bipolar disorder come on at a young age, it usually improves over the next decade or so.

The slide features a background with silhouettes of people with their arms raised in celebration. The top section is an orange banner with the word "Detection" in white. The main content area is white with a grey border, containing text about bipolar disorder detection. The bottom of the slide is white with a page number.

## Detection

Bipolar disorder is poorly detected.

(12 to 15 years from onset in US,  
18 years in our Sydney study).

Detection is a problem with studies in the US and in Australia showing that it often takes up to 2 decades to get the right diagnosis.



## Detection

### Why poor detection?

- Most people seek treatment during a depressive episode (their priority)
- Highs may be enjoyed and productive and therefore not reported
- Failure by interviewer to ask the proper screening questions.

Why is detection difficult? Firstly, most people seek treatment only during their depressed episodes, and that is their priority, to come out of their depression. Secondly, the highs, particularly those for bipolar II, are often enjoyed and productive and, therefore, not so disabling. And finally, it can reflect the interviewer not asking the correct screening questions.

## Chance of developing bipolar disorder

- 0.5 - 1% lifetime community risk of developing bipolar I
- Risk of bipolar II not clearly known but may be in the order of 5 - 6%. Slightly higher risk for females
- Rate of bipolar II appears to be increasing. Could reflect:

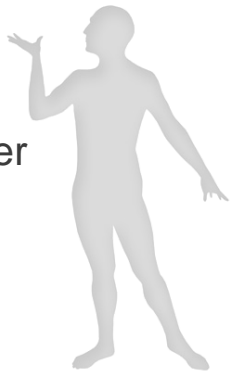


- Awareness
- New diagnostic rules
- True increase.

The chance of developing bipolar I disorder is less than 1% over an individual's lifetime. It's significantly higher for bipolar II and appears to be increasing. Reasons include: increasing awareness of this condition; new diagnostic rules; and, perhaps, a true increase.



## Those who develop bipolar disorder

- Anxiety or eating disorder before onset or drug/alcohol/gambling problems following onset can mask identification of bipolar disorder
  - Bipolar disorder is associated with higher intelligence and greater creativity.
- 

As people who develop bipolar disorder are much more likely to have an anxiety or eating disorder beforehand, and drug, alcohol or gambling problems subsequently, these diagnoses can mask the true identification of bipolar disorder. Some good news is that bipolar disorder is associated with higher intelligence and greater creativity.

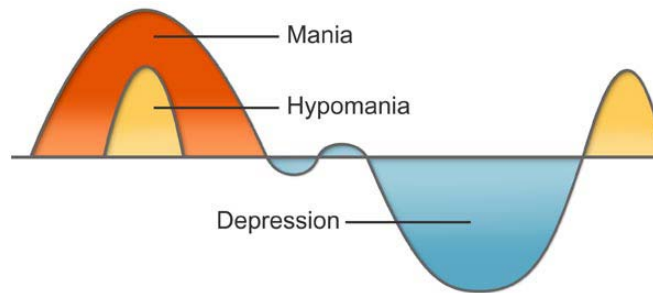
Bipolar I and bipolar II:  
The same or different?

General view... is  
that bipolar II is a  
'much milder'  
disorder

How similar or different are bipolar I and II disorders?

## Bipolar I and bipolar II: The same or different?

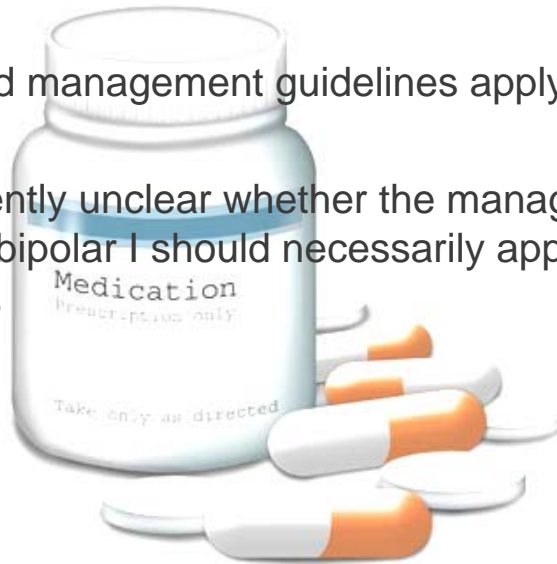
- For bipolar II, less severe highs
- Depression as severe for bipolar I as for II
- Since bipolar II has more swinging of mood – overall impairment levels are equally severe for bipolar I and II.



In essence, the highs are distinctly less severe in bipolar II. For depression, it's just as severe in bipolar II as bipolar I. Because people with bipolar II are spending more of their time oscillating, the overall impact on their life and on their impairment levels averages out making each condition equivalent in terms of severity.

## The treatment of bipolar disorder

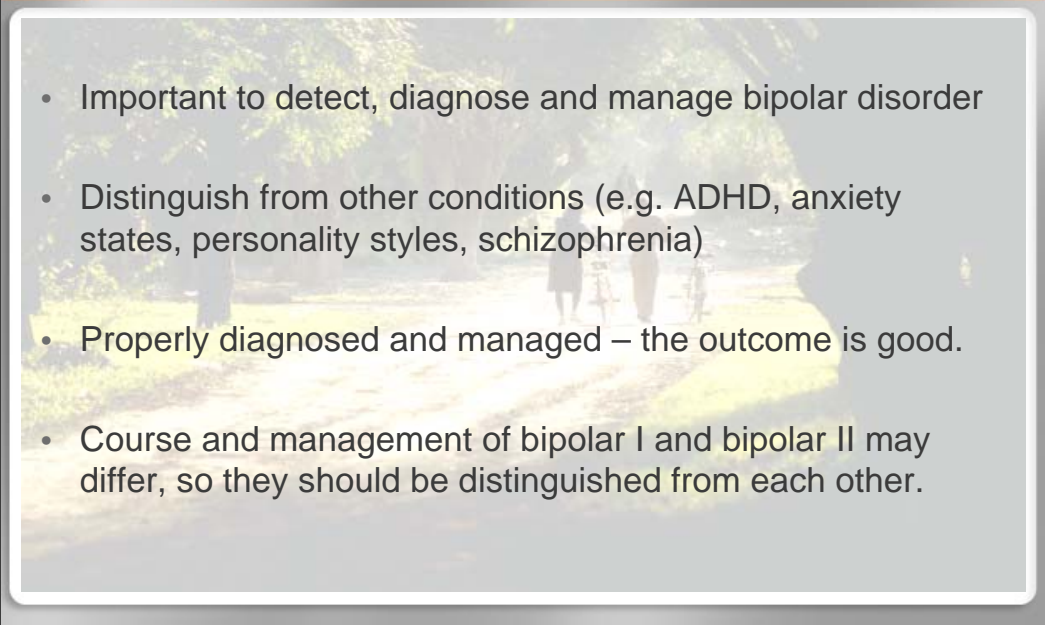
- Published management guidelines apply to bipolar I
- It is currently unclear whether the management rules for bipolar I should necessarily apply for bipolar II.



In terms of treatment, all the guidelines available are based on the management of bipolar I and it may be quite a mistake to assume that the rules of management apply for bipolar II. For example, many people with bipolar II disorder don't require a mood stabilizer and often get benefit from receiving an anti-depressant alone.



## Conclusions

- 
- Important to detect, diagnose and manage bipolar disorder
  - Distinguish from other conditions (e.g. ADHD, anxiety states, personality styles, schizophrenia)
  - Properly diagnosed and managed – the outcome is good.
  - Course and management of bipolar I and bipolar II may differ, so they should be distinguished from each other.

This introduction argues for the importance of detection, diagnosis and management of the bipolar disorders and distinguishing them from other conditions such as Attention Deficit Hyperactivity Disorder (ADHD), anxiety states, personality styles and, in particular, schizophrenia. With proper diagnosis and management, the outcome is good. We further suggest that, as the course and management of bipolar I and II may well differ, so the management of these two conditions is also likely to differ. At this stage, research into the conditions relates mainly to bipolar I and further research into the management of bipolar II is needed. However, aside from our sessions on medications, all of the information you will hear in the rest of this program relates to bipolar I and II. This overview, therefore, sets the stage for our next few sessions, considering causes, treatment and management options.