THE WETC PSYCHOLOGY NEWSLETTER

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Bipolar Disorders

"Bipolar Disorders are the most difficult disorders in the DSM-IV-TR to wrap your brain around since there are so many variations and they are so rarely seen. Nevertheless, in medical-legal examinations they are important to know about since it is widely accepted that these disorders do not result from injuries although they are susceptible to being aggravated or exacerbated by a person's experiences."

Bipolar Disorders are a group of disorders that used to be incorporated under the diagnostic category called Manic-Depressive Illness. They get their name from being characterized by mood swings, often described as mania and depression, i.e., the two poles of the disorder. Bipolar Disorders are the most difficult disorders in the DSM-IV-TR to wrap your brain around since there are so many variations and they are so rarely seen. Nevertheless, in medical-legal examinations they are important to know about since it is widely accepted that these disorders do not result from injuries although they are susceptible to being aggravated or exacerbated by a person's experiences.

Individuals who suffer from these conditions typically experience major changes in their moods, such as abnormally elevated and/or depressed moods. While there are many different forms of Bipolar Disorders, they are grouped into two types: Bipolar I Disorder and Bipolar II Disorder. Clearly, when one considers the many specifiers associated with each of these forms of Bipolar Disorders, their diagnosis is by far the most complex and technical of all the diagnostic problems arising in the use of the DSM-IV-TR. Nevertheless, I believe it is possible to provide a clear and relatively simple discussion of these diagnoses.

Bipolar I Disorder

The DSM-IV-TR specifies that the essential feature of a Bipolar I Disorder is a clinical presentation in which there are one or more Manic Episodes or Mixed Episodes.

In brief, a Manic Episode is defined by the presence of a distinct period during which there is an abnormally and persistently elevated, expansive or irritable mood. The full diagnostic criteria are discussed below.

In brief, a Mixed Episode is characterized by a period of time of at least one week's duration in which the criteria have been met for a Manic Episode and a Major Depressive Episode nearly every day. Individuals with a Bipolar I Disorder have also frequently had one or more Major Depressive Episodes. The full diagnostic criteria are discussed below.

Bipolar I Disorders are classified according to whether the individual is experiencing a first episode (i.e., a Single Manic Episode) or whether the disorder is Recurrent. Recurrence is indicated by either a shift in the polarity of the episode or an interval between episodes of at least two months without manic symptoms. A shift in polarity is defined as a switching back and forth between mania and depression or between an elevated mood and a depressed mood. Now that is a mouthful and one that you have to spend a good deal of time repeating to yourself in order to feel comfortable with the concepts.

Clearly, in order to diagnose a Bipolar I Disorder correctly, it is necessary to understand the criteria for both a Manic Episode and a Mixed Episode and then to make certain that the individual presents with sufficient evidence of at least one of these episodes.

The diagnostic criteria for a Manic Episode are given below.

A. A distinct period of an abnormally and persistently elevated, expansive and/or irritable mood that lasts at least one week unless the person has been hospitalized in which case the duration is deemed irrelevant.
B. During the period in which they have had the mood disturbance, the person must present with three or more persistent signs and/or symptoms, unless their mood has been characterized by irritability in which case they must present with four such signs and/or symptoms.

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(1) Inflated self-esteem or grandiosity.
(2) A decreased need for sleep such that the individual may feel rested after as little as three hours of sleep.
(3) Increased talkativeness or pressure to keep talking.
(4) A flight of ideas that is characterized by a continuous flow of accelerated speech with abrupt transitions from topic to topic, or the subjective experience that one's thoughts are racing.
(5) Distractibility as evidenced by one's attention being too easily drawn to "unimportant or irrelevant external stimuli."
(6) An increase in goal-directed activity, socially, occupationally, educationally or sexually, or psychomotor agitation.
(7) Excessive involvement in pleasurable activities that have a high probability of painful outcomes, such as sexual indiscretions, "foolish" business investments and unrestrained buying sprees.

C. The signs and/or symptoms do not meet the criteria for a Mixed Episode, as discussed below.
D. The disturbance in mood is sufficiently severe to cause a marked impairment in social and/or occupational functioning, or to require hospitalization, or there must be psychotic features such as delusions, hallucinations or grossly disorganized behavior.
E. The signs and/or symptoms are not due to the direct physiological effects of a substance and/or a general medical condition.

The diagnostic criteria for a Mixed Episode are given below.

A. The criteria are met for a Manic Episode and a Major Depressive Episode every day or nearly every day for at least one week. While it is necessary for the signs and/or symptoms of a Major Depressive Episode to have been present for at least a week, it is not necessary for those signs and/or symptoms to have been present for two weeks.
B. The disturbance in the individual's mood is sufficiently severe to cause a marked impairment in social and/or occupational functioning, or to require hospitalization to prevent the individual from harming him or herself or others, or there must be psychotic features such as delusions, hallucinations or grossly disorganized behavior.
C. The signs and/or symptoms must not be due to the direct physiological effects of a substance and/or a general medical condition.

Most importantly, according to DSM-IV-TR criteria there are multiple types of Bipolar I Disorders that can be specified. Clearly, the type of Bipolar I Disorder that is diagnosed in any given case depends on whether there has been a single Manic Episode or Recurrent Manic Episodes, if the most recent episode is a Manic Episode or a Mixed Episode, or if the most recent episode is a Major Depressive Episode. It is also possible to diagnose a Bipolar I Disorder if the individual's most recent episode has been a Hypomanic Episode, a condition normally occurring in Bipolar II Disorders, discussed below. Regardless, each of these different types of Bipolar I Disorder carries a different numerical diagnostic code.

Additionally, a further complication is that the DSM-IV-TR provides methods for the doctor to specify the severity of the disorder as Mild, Moderate, Severe Without Psychotic Features, Severe With Psychotic Features, In Partial Remission, In Full Remission and a catch-all category of "Unspecified" to be used when the doctor does not have sufficient information to make a decision. For each of these different possibilities there are distinct five digit numerical diagnostic codes that all begin with "296." As noted in the DSM-IV-TR, when all of the above possible factors are taken into consideration there are 30 basic diagnoses for a Bipolar I Disorder, each designated by a different numerical diagnostic code.

As if this were not enough, there are also specifiers that the doctor can use to report additional conditions further describing the Bipolar I Disorder. These are: "With Catatonic Features," "With Postpartum Onset," "With Melancholic Features," "With Atypical Features," "With Full Interepisode Recovery," "Without Full Interepisode Recovery," "With Seasonal Pattern," and "With Rapid Cycling." Moreover, if there has been a Manic or Mixed Episode that is Severe With Psychotic Features the doctor can proceed to specify if those features are "Mood-Congruent Psychotic Features" or "Mood-Incongruent Psychotic Features." Unfortunately, when one considers all of the mathematically possible combinations of specifiers, a full discussion of these factors is way beyond the scope of this newsletter especially considering that Bipolar I Disorders are relatively rare. In this regard, while the sum total of all of the multiple types of Bipolar I Disorders has been

estimated at about 1% in the general population, considering that there are hundreds of possible combinations, the likelihood of encountering any one of the possibilities is obviously substantially less than 1%.

Okay, so from the simplest point of view, a person with a Bipolar I Disorder will have episodes where they either show an abnormally and persistently elevated, expansive or irritable mood or they might alternate between such an elevated, expansive or irritable mood and a significant clinical depression.

Bipolar II Disorder

According to the DSM-IV-TR, a Bipolar II Disorder is diagnosed correctly when one or more Major Depressive Episodes has been accompanied by at least one Hypomanic Episode.

A Major Depressive Episode is characterized by symptoms of a depressed mood and/or a loss of interest in pleasure. There also must be additional symptoms, such as from this list: a significant and unintended weight change, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or a loss of energy, feelings of worthlessness or inappropriate guilt, a diminished ability to think or concentrate, and recurrent thoughts of death or suicide. In order to state that an individual has experienced a Major Depressive Episode they must have had at least 5 of these 9 symptoms. However, the diagnosis of a Major Depressive Episode is a bit more complicated, so for a full discussion of this disorder see my newsletter of October, 2009.

A Hypomanic Episode is defined as a distinct period during which there is an abnormal and persistently elevated, expansive or irritable mood that lasts for at least four days. This period of abnormal mood must be accompanied by at least three additional symptoms from a list that includes inflated self-esteem or grandiosity, a decreased need for sleep, a pressure of speech, a flight of ideas, distractibility, an increased involvement in goal-directed activities with psychomotor agitation and an excessive involvement in pleasurable activities, which have a high potential for painful consequences. If the mood is irritable rather than elevated or expansive, at least four of the above symptoms must be present.

The criteria for a Hypomanic Episode are given below.

A. A distinct period of a persistently elevated, expansive and/or irritable mood that lasts at least four days and is clearly different from the usual non-depressed mood.
B. During the period of the disturbed mood the individual must present with three or more of the following signs and/or symptoms (four if the individual's mood is only irritable).
    (1) Inflated self-esteem or grandiosity.
    (2) A decreased need for sleep as characterized, for example, by the individual feeling rested after only three hours of sleep.
    (3) Increased talkativeness or a pressure to keep talking i.e., a pressure of speech.
    (4) A flight of ideas or the subjective experience that one's thoughts are racing.
    (5) Distractibility or behavior in which one's attention is easily drawn to unimportant and irrelevant external events.
    (6) Increased social, occupational, sexual and/or educational goal-directed activity and/or psychomotor agitation.
    (7) Excessive involvement in pleasurable activities that have a high probability of leading to painful consequences, such as engaging in unrestrained buying sprees, sexual indiscretions or poor business investments.
C. The episode is characterized by a clear change in functioning from the individual's normal or non-symptomatic level of functioning.
D. The disturbances in mood are observable by others.
E. The episode is not sufficiently severe to cause a marked impairment in social and/or occupational functioning and there are no psychotic signs and/or symptoms or a need for hospitalization.
F. The signs and/or symptoms are not due to the direct physiological effects of a substance and/or a general medical condition.

Most importantly, it should be noted that, according to the DSM-IV-TR, all Bipolar II Disorders are specified with a single numerical diagnostic code, 296.89. However, there are actually multiple types of Bipolar II Disorders that can be verbally designated by using multiple specifiers. For example, the specific type of Bipolar II Disorder that is reported depends on whether the current or most recent episode is a Hypomanic Episode or a Major Depressive Episode. Additionally, if the current or most recent episode has been a Major Depressive Episode, the DSM-IV-TR provides methods for the doctor to specify the severity of the Major Depressive Episode as Mild, Moderate, Severe Without Psychotic Features, Severe With Psychotic Features, In Partial Remission, In Full Remission or Chronic. Further, with regard to the overall designation of a Bipolar II Disorder, the doctor can specify "With Catatonic Features," "With Melancholic Features," "With Atypical Features," "With Postpartum Onset," "With Full Interepisodic Recovery," "Without Full Interepisodic Recovery" in a "Seasonal Pattern" or "With Rapid Cycling." Clearly, when one considers all of the many possible combinations, a full discussion of these many factors is beyond the scope of this newsletter especially considering that Bipolar II Disorders are also relatively rare, with the sum total of all of the multiple types occurring in about .5% in the general population.

Okay, so reverting to the simplest possible denominator, a Bipolar II Disorder is diagnosed correctly when there is a history of a Major Depressive Episode, i.e., a significant clinical depression, as well as a history of a distinct period during which there is an abnormal and persistently elevated, expansive or irritable mood, i.e., a Hypomanic Episode.

The Cause of Bipolar Disorders

The exact cause of Bipolar Disorders is not yet known although the evidence points to a chemical imbalance in the brain that is probably due a combination of heredity and one's environment. Although thinking is that these disorders are probably the result of genetic, neurochemical and environmental factors, no one knows how these variables interact with one another to produce the disorder. Evidence supporting the importance of genetics is in the research that demonstrates that there is a familial component to the incidence of this disorder. If your Uncle Charley had it, you're more likely to get it. Since, at the simplest level, all behavior is neurochemical, one has to be correct in concluding that a Bipolar Disorder is on some level neurochemical. Support for this notion comes from medications that work on the nervous system and have been shown to be effective in treatment, as well as other substances that are known to produce episodes in individuals with the disorder. Finally, environmental factors, or what some people like to call "stress," are known to be relevant since various life experiences are also known to produce episodes of the disorder. However, just why some people are more vulnerable than others to the same "stressors" is simply unknown.

Treatment of Bipolar Disorders

Mood stabilizers are one class of drugs that have been successfully used to treat Bipolar Disorders. These are effective in stabilizing and keeping the manic or Hypomanic symptoms in remission. The names you'll probably recognize are lithium, Depakote, Tegretol and Neurotin. More recently there is a class of drugs being used that is called "atypical antipsychotics." These are so labeled because they were initially thought to help people with a psychosis, such as schizophenia, but have been shown to help people with the mood swings typical of a Bipolar Disorder. The names you'll probably recognize are Abilify, Risperdal, Zyprexa and Seroquel.

Final Word

When it comes to Bipolar Disorders there is good news and bad news! The bad news is that there are no easy Bipolar Disorder medical-legal cases. There are so many different types of Bipolar Disorders, and the differential diagnosis and determining causation is so complex, that it is a nightmare for all the doctors, attorneys and adjusters. However, the good news is that Bipolar Disorders are relatively rare and with a little bit of luck they will only infrequently appear in your caseload. But when they do, watch out, you can be in for a long and rocky ride.

This is the eighteenth of a series of monthly newsletters aimed at providing information about psychological evaluations and treatment that may be of interest to attorneys and insurance adjusters working in the areas of workers' compensation and personal injury. If you have not received some or all of our past newsletters, and would like copies, send us an email requesting the newsletter(s) that you would like forwarded to you.