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Bipolar I Disorder

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Bipolar I disorder is a diagnosis in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)*, that is characterized by episodes of depression and mania. People who have bipolar I disorder have periods of time in which they experience symptoms of depression, followed by periods of time in which they feel either manic or irritable. Bipolar depression is similar to unipolar or major depressive disorder. Individuals with bipolar depression experience depressed mood, loss of interest in the things they used to enjoy, changes in appetite, sleep disturbances, suicidal ideation, and other symptoms of major depressive disorder. When people with bipolar disorder are in a manic phase, they feel so good or "high" that it causes difficulties in their lives. Alternatively, some people have periods of time when they feel especially irritable. The term *bipolar* is meant to signify these two opposite ends of the mood spectrum. The "I" in bipolar I differentiates it from bipolar II, which is a distinct, but related, disorder whereby individuals do not display full bouts of mania. Rather, they experience a less severe form of mania, termed *hypomania*, that alternates with depressive episodes.

After placing the disorder in a historical context, this entry describes the symptoms and comorbidities, risk factors and etiology, and prevalence of bipolar I disorder. The entry concludes with a discussion of empirically supported treatments.

Historical Context

The history of bipolar disorder is one of the longest in psychiatry, with many historians tracing its roots to the Greco-Roman concepts of mania and melancholia. Although it is uncertain how closely these concepts approximate the modern understanding of the disorder, mania appears to be similar to its current description and melancholia may be similar to what is currently defined as depression. Ancient theorists attributed the symptoms to humoral imbalances, such as an excess of yellow bile in the brain. The first writings describing the episodic nature of mania and melancholia were composed by Aretaeus of Cappadocia, a physician living in Alexandria and Rome in 150 BCE. Aretaeus distinguished mania and melancholia from other disorders involving psychosis and from dementia in older adults. In the 6th century CE, medieval Islamic physicians categorized mania and melancholia among four major mental health disorders, also including *ghotrah* ("psychosis") and *ishgh* ("depression and anxiety"). The idea that mania and melancholia present in episodes in the same people began to solidify between the 12th and 16th centuries CE, and the concept of mania began to include what we would now call psychosis, including symptoms such as hallucinations and delusions. In the 17th and 18th centuries, physicians such as Friedrich Hoffman described mania and melancholia occurring together, such that melancholia was the baseline condition and mania represented acute exacerbations of the disorder.

The modern conceptualization of bipolar disorder is usually traced back to the 1850s in Paris, where Jean-Pierre Falret described *folie circulaire*, or circular madness. This conceptualization included alternating manic and depressive episodes as well as periods in which the individual is symptom free. Likewise, Jules Baillarger defined the illness as *folie a double forme*, or manic-melancholic episodes. These conceptualizations can be viewed within the broader framework provided by French and German physicians who were beginning to acknowledge the increasing importance of distinguishing among mental health disorders that were seen as discrete entities.

In 19th-century Germany, a debate raged on whether mental health disorders should be lumped together or split into separate categories. On one side, a "unitary psychosis" ideology

emerged in which nearly all mental health disorders were thought to share a single cause and process. In the 1890s, a German psychiatrist named Emil Kraepelin broke from the unitary psychosis ideology and proposed that mental health disorders can be broken down into two categories: manic-depressive insanity and dementia praecox. Manic-depressive insanity is broadly consistent with what is now called bipolar disorder. Dementia praecox, or early dementia, was discriminated from dementia in older adults by its early onset and is consistent with what is now called schizophrenia. Critically, Kraepelin's conceptualization of manic depression did not discriminate between people who experience both mania and depression and people who experience only depression. Nevertheless, Kraepelin's work in categorizing mental health disorders revolutionized the field and has led him to be viewed as the founder of modern psychiatry.

In the 20th century, Scandinavian psychiatrists, including Carl Wernicke, Karl Kliest, and Edda Neele, proposed that manic-depressive illness could be further discriminated into recurrent monopolar depression (now major depressive disorder) and bipolar varieties including both mania and depression (now bipolar I). When the American Psychiatry Association released the first edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* in 1952, *manic-depressive reaction* was included as a diagnosis. It was not until the third edition of the *DSM*, published in 1980, that the term *bipolar disorder* replaced *manic-depressive reaction* as an official diagnosis. The term *bipolar disorder* is meant to emphasize the polarity or varying moods associated with the disorder rather than to focus on the consequences of these mood episodes (i.e., mania and depression). At the same time, the change to bipolar I was meant to decrease the stigma associated with the term *manic depression*.

Symptoms

Although the *DSM-5* places bipolar I disorder in the newly created category of Bipolar and Related Disorders, this disorder has historically been classified as a mood disorder, meaning that its symptoms alter one's affective state. Periods of abnormal mood can last anywhere from 1 week to several years and, depending on the predominant mood symptoms, are categorized as manic or major depressive episodes. To meet the diagnostic criteria for bipolar I disorder, an individual must have experienced at least one manic episode over the course of his or her lifetime. Although the majority of people with this disorder experience at least one major depressive episode as well, this is neither necessary nor sufficient for a diagnosis. To qualify as a manic episode, manic symptoms must be present most of the day, nearly every day, for at least 1 week, they must significantly interfere with one or more major life domains (e.g., school, work, social relationships), and they must not be otherwise caused by comorbid medical conditions, or prescription or nonprescription drugs.

Manic Symptoms

Mania can be conceptualized as a mood state that is abnormally elevated, far beyond simply being happy or feeling good. A person in the midst of a manic episode may report feeling euphoric, "high," or "on top of the world" and, as a result, may not notice that the symptoms are negatively interfering with functioning. For example, during a manic episode, many people experience decreased need for sleep, such that they feel awake and rested with 5 or fewer hours of sleep and become excessively productive, spending more time and energy than before on work, schoolwork, or household tasks. Although beneficial in some respects, this behavior can result in significant social impairment if one begins to neglect family, friends, or

self-care.

Other symptoms of mania include an increased rate or intensity of thoughts, speech, and gestures. One may become more talkative or distractible than usual and may express grandiose ideas or feelings (e.g., invincibility, an exaggerated sense of importance). Uncontrollable, racing thoughts are also common during this phase. Furthermore, an individual may show an increased tendency toward risky or dangerous behavior, including risky sexual behavior, extreme shopping sprees (sometimes to the point of incurring debt), and/or excessive gambling, drinking, or drug use. Criteria for a manic episode are met if an individual presents with three or more of these symptoms for at least 1 week (or shorter if hospitalization is necessary).

Irritability

An extended period of irritability can potentially warrant a diagnosis of bipolar I disorder, provided that at least four of the aforementioned symptoms are also present and, collectively, these symptoms persist for at least 1 week, interfere with social or occupational functioning, and are not caused by other conditions or substances.

Depressive Symptoms

Frequently, though not always, individuals with bipolar I disorder experience symptoms that constitute a major depressive episode. These symptoms usually consist of strong, persistent feelings of sadness, helplessness, hopelessness, or worthlessness. During a major depressive episode, one may lose interest in previously engaging activities and may begin to isolate or withdraw from social interactions. Significant changes in sleep are common (e.g., excessive sleep, insomnia, difficulty falling or staying asleep), as are changes in appetite or body weight, which may increase or decrease. Cognitive difficulties, such as memory impairment or decreased ability to concentrate, are also common and can perpetuate depressive symptoms by negatively affecting self-esteem. A person experiencing a depressive episode may report loss of energy or extreme fatigue, to the point where getting out of bed each day becomes overwhelmingly difficult. Friends or family may notice a reduction in the person's gestures, speech, and overall psychomotor ability. Conversely, the person may exhibit psychomotor agitation, which can manifest as purposeless body movements, such as pacing around a room or wringing one's hands. Suicidal ideations, plans, or attempts may occur.

If five or more of these symptoms are experienced concurrently, persist for 2 weeks or longer (or shorter, again, if hospitalization is required), and interfere with functioning or activities of daily life, the individual meets the criteria for a major depressive episode. In addition, one of the five or more symptoms must be either depressed mood or loss of interest in things. In the context of bipolar I disorder, this is known as bipolar depression, to distinguish it from a diagnosis of unipolar depression (i.e., major depressive disorder).

Psychotic Symptoms

Occasionally, individuals with bipolar I disorder experience symptoms of psychosis, such as auditory hallucinations, either during or outside of a mood episode. If primarily psychotic disorders (i.e., schizophrenia spectrum disorders) have been ruled out, the clinician may consider a diagnosis of bipolar I disorder with a psychotic features specifier.

Cognitive Symptoms

Recent research has identified cognitive impairments as consistent, core deficits in bipolar I disorder that are present during mood episodes as well as during euthymic periods. Relatively stable deficits have been found within the domains of verbal memory and executive functioning, though impairment has also been identified in attention, working memory, and language processing.

Comorbidities

Because of the complex nature of the disorder, patients with bipolar I disorder are likely to present with—and are at an increased risk of subsequently developing—many different types of comorbid mental health and medical conditions. Indeed, many patients with bipolar I disorder are diagnosed with at least one mental health disorder, and a smaller yet significant subset carry three or more diagnoses.

Anxiety disorders are among the most common comorbid mental health conditions in bipolar I disorder; estimates suggest that some form of anxiety disorder (e.g., generalized anxiety disorder, panic disorder, specific phobia) is present in approximately 75% of patients with bipolar I disorder. Furthermore, research has demonstrated an increased prevalence of personality disorders in individuals with bipolar I disorder when compared with the general public.

Many people with bipolar I disorder also exhibit some variation of substance use disorder (SUD), with alcohol appearing to be the most commonly used and abused substance. This has serious implications for treatment, as alcohol use tends to reduce the efficacy of medication and increases the risk of suicide attempts. Although the directionality of this comorbidity is unclear (i.e., whether bipolar I disorder increases the risk of developing a SUD or whether substance use increases the likelihood of developing bipolar I disorder), estimates suggest that as many as 50% of people with bipolar disorder also have a SUD.

The most prevalent comorbid medical conditions in patients with bipolar I disorder include asthma, migraine headaches, endocrine disease, and cardiovascular disease, which may stem largely from lifestyle changes brought on by depressed mood, such as overeating due to increased appetite or sedentariness resulting from lack of energy. As with healthy individuals, substance use certainly increases the risk of developing physical illness, and these comorbid medical conditions may, in part, reflect the higher instance of substance abuse in patients with bipolar I disorder.

Risk Factors and Etiology

The precise etiology of bipolar disorder is not known. However, the most widespread model for its development is the diathesis-stress model. The diathesis-stress model suggests that bipolar disorder develops when an individual who has a predisposition to developing bipolar disorder (i.e., a diathesis) encounters a stressor in the environment. This combination of preexisting risk factors and stress is thought to result in the development of bipolar disorder. Risk factors for bipolar disorder can be divided into three groups: 1) demographic, (2) environmental, and (3) biological.

Traditionally, bipolar disorder was thought to be about as common in men as in women. More

recent work suggests, however, that the prevalence of bipolar I disorder is higher in males whereas the prevalence of bipolar II disorder is higher in females. This may suggest that bipolar disorder tends to be more severe in men than in women. In addition to sex differences, the National Epidemiologic Survey on Alcohol and Related Conditions study found that Native American participants had higher rates of bipolar disorder than White participants but Hispanic, Asian, and Pacific Islander participants had lower rates. In clinical settings, African Americans may have lower rates due to a diagnostic bias whereby more African Americans who should be diagnosed with bipolar disorder instead receive a diagnosis of schizophrenia or schizoaffective disorder.

The most common environmental risk factor for bipolar disorder is the experience of a stressful life event; research shows that these events precede the onset of bipolar disorder and may trigger manic and depressive episodes in individuals who already have the disorder. Stressful life events are particularly likely to result in bipolar disorder if they disrupt an individual's circadian rhythm or sleep cycle or are related to failure or success in achieving a major goal. Childhood adversity, such as the loss of a parent, neglect, or physical or sexual abuse, is also a risk factor for the development of bipolar disorder. However, it is unclear how childhood adversity contributes to the development of bipolar disorder specifically because childhood adversity is also associated with the development of other mental health disorders later in life, such as depression, schizophrenia, and anxiety disorders.

Finally, there are biological, or genetic, risk factors for the development of bipolar disorder. One of the strongest predictors of the development of bipolar disorder is a family history of the disorder. Estimates for the heritability of bipolar disorder are as high as 80% to 90%, making it one of the most heritable of all mental health disorders. Researchers take two approaches to understanding genetic risk for disorders: (1) behavioral genetics and (2) molecular genetics. Behavioral geneticists examine patterns of disorders within families, and higher concordance rates of a disorder in close genetic relatives suggest that the disorder is more heritable. Studies suggest that an individual with a first-degree family member with bipolar disorder has a 6 to 8 times increase in the risk of developing bipolar disorder. Individuals who have a monozygotic twin (i.e., an identical twin who has the exact same DNA) with bipolar disorder have a 40% to 70% chance of developing the disorder themselves, whereas individuals with a dizygotic twin (i.e., a fraternal twin who has approximately 50% of the same DNA) with bipolar disorder have only a 5% to 10% chance of developing bipolar disorder. The large difference in concordance rates between monozygotic and dizygotic twins suggests a strong genetic component in bipolar disorder. At the same time, the fact that monozygotic twins are not 100% concordant suggests that environmental factors also play a role.

Although behavioral genetics studies have found a strong genetic link for bipolar disorder, molecular geneticists have had a difficult time identifying which individual genes confer a risk for the disorder. It is likely that bipolar disorder is caused by many individual genes, each conferring a small increase in risk. Three gene variants that have been shown to be associated with bipolar disorder are *CACNA1C*, which encodes part of the cell's calcium channel; *ODZ4*, which encodes proteins involved in cell communication; and *NCAN*, which encodes a glycoprotein in the brain called neurocan.

Prevalence

The lifetime prevalence of bipolar I disorder has long been thought to be 1%. This means that 1% of the population will meet the criteria for bipolar I disorder at some point in their lives. However, more recent research suggests that bipolar disorder might be more common than

originally thought, with estimates ranging from 0.2% to as high as 3.3%. Bipolar disorder tends to have an onset in late adolescence or early adulthood, and studies across the lifetime suggest that it is most common in individuals between the ages of 18 and 25 years.

Empirically Supported Treatments

Treatments for bipolar disorder often involve both medication and psychotherapy. The most common medications used for the treatment of bipolar disorder are called mood stabilizers because they reduce the highs of mania and lows of depression. The first mood stabilizer to be used to treat bipolar disorder was lithium, which was discovered by John Cade in 1949. Other mood stabilizers include valproic acid, divalproex sodium, carbamazepine, and lamotrigine. People with bipolar disorder are also often prescribed antipsychotic and anxiolytic medications depending on the specific symptoms of the individual. Antidepressant medications are sometimes used, but they may trigger a manic episode in some individuals with bipolar disorder.

Most psychiatrists and psychologists recommend psychotherapy in addition to medication treatment. Therapies with empirical support for treating bipolar disorder include cognitive behavioral therapy (CBT), interpersonal and social rhythm therapy, psychoeducation, and family-focused psychotherapy. CBT is a skills-based treatment that can take place in an individual or group setting. The main goal of CBT is to help people change their cognitions (i.e., thoughts) and their behaviors to healthier alternatives. Interpersonal and social rhythm therapy is an individual therapy that includes psychoeducation, techniques to improve social rhythms (i.e., daily routines), sleep training, and interventions focused on interpersonal roles and disputes. Psychoeducation is an element of many types of therapy that aims to educate the client about the symptoms, etiologies, prognosis, and treatment of bipolar disorder. It also provides approaches for identifying new episodes and coping strategies. Finally, family-focused psychotherapy involves the family (e.g., parent, sibling, spouse) in the therapeutic process to take advantage of the individual's existing support network. It includes psychoeducation, communication training, and family problem-solving skills training.

See also [Behavioral Inhibition System](#); [Bipolar Disorders: Diagnosis](#); [Bipolar Disorders: Gender and Sex Differences](#); [Bipolar Disorders: Lifespan Perspectives](#); [Bipolar Disorders: Psychological Factors](#); [Bipolar Disorders: Risk for](#); [Bipolar Disorders: Social Factors](#); [Bipolar Disorders: Treatment](#); [Bipolar Disorders in Childhood](#); [Comorbidity](#); [Dementia Praecox](#); [Epidemiology](#); [Family Studies](#); [Genetic Research](#); [History of Mental Health Diagnoses](#); [Hypomania](#); [Mania](#); [Mixed Episode](#); [National Comorbidity Survey](#); [Subthreshold Diagnoses](#); [Twin Studies](#)

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Further Readings

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