We all experience variations in mood and energy. Drops into low motivation and inactivity are quite common, but we also recognise swings into activated, aroused states. For a minority of the population, complex variations in mood and energy are very pronounced, becoming clearly dysfunctional and requiring assistance. Until recently, psychiatry was the discipline that paid most attention to these extreme states, so they are typically framed in medical terms, and for about 30 years have been given the name bipolar disorder (BD).

Over the past decade, psychological theories and therapies have profoundly affected the description, explanation and management of BD. The aim of this article is to introduce this growing area of psychological activity.

**Description and diagnosis**

The opening sentences above suggest that diagnosable BD is an extreme form of normal human variation, rather than the distinct disease-like entity implied by DSM (American Psychiatric Association, 2000). Although the jury is still out, the majority of taxometric and genetic evidence is consistent with this dimensional position. There appear to be two quantitative traits underpinning the BD syndrome, namely, depression-proneness and mania-proneness. Depending partly on how they respond to environmental contingencies, people with high levels of these traits may manifest the symptoms labelled as BD. This diathesis-stress formulation underpins all psychosocial treatments for BD (see later in the article).

The BD diagnoses of the current DSM therefore have debatable validity. Nonetheless, the DSM constructs are important tools for two reasons: (i) they are familiar to patients, clinicians and health systems; and (ii) most of our knowledge about the phenomena and management are organised around these terms.

For DSM, the bipolar disorders are diagnosed on the basis of manic symptoms of varying severity. Bipolar I disorder (BD I), defined by at least one episode of mania (labelled a ‘mixed’ episode when a depressive episode is concurrent), receives most research and clinical attention. There is growing appreciation that Bipolar II disorder (BD II, defined by hypomanic episodes and depressive episodes) generates comparable impairment and suicide risk to BD I. While BD I and BD II are conceptualised as episodic disorders, cyclothymic disorder is a milder chronic variant. So defined, the bipolar disorders are not common, with lifetime prevalence of BD I typically estimated at approximately one per cent, and all bipolar disorders at approximately four to five per cent.

**Distinguishing BD from unipolar depression**

A 2010 inquest into the suicide of Sydney journalist Charmaine Dragun was highly critical of professionals (including a psychologist) treating her recurrent depressive episodes. The coroner concluded that a likely contributing factor to Ms Dragun’s death at age 29 was the failure to identify her mania-proneness, and consequent match to a diagnosis of BD II. Hypomania is not unambiguously pathological, and is under-reported by patients when depressed, increasing the risk that a presenting major depressive episode will be diagnosed as major depressive disorder (MDD). Indeed, some 40 per cent of people who ultimately receive a diagnosis of BD are initially misdiagnosed with MDD. Misdiagnosis of BD as unipolar depression is a serious problem because the two conditions require different treatments and carry different risks.

A full-blown manic episode is easy to recognise, but psychologists should proactively seek more subtle evidence of mania-proneness in a depressed client. Three signs are indicative: (i) a family history of mania or recurrent depression; (ii) a history of elated, excited or irritable mood or extraverted/impulsive traits (external corroboration may be needed); and (iii) melancholic features in the depressive episode (i.e., psychomotor retardation, anhedonia, non-reactive mood, hypersomnia, diurnal variation in mood, psychotic features). The excellent Black Dog Institute website includes a self-report diagnostic questionnaire for BD (www.blackdoginstitute.org.au/public/bipolardisorder).

**Course and outcomes**

BD is typically a lifelong, relapsing condition. Patients differ widely in terms of the length, number and type of episodes, severity of symptoms, the degree of inter-episode recovery experienced and consequent disability. The average length of episodes is around three to six months, and some type of episode is experienced on average every two or three years. Comorbidity with other psychiatric conditions is the norm: some 56 per cent of BD patients warrant a substance use diagnosis, and 80 per cent an anxiety disorder diagnosis.

The bipolar disorders are associated with significant morbidity, disability and mortality. It has been estimated that a woman who manifests BD at the age of 25 may lose nine years in life expectancy, 14 years of productivity, and 12 years of normal health. Besides costs for the individual patient, BD symptoms of depressive withdrawal and hypo/manic recklessness also place undue burden on partners and families. Comorbid medical problems (especially vascular disease) are very prevalent. Suicide is a particularly important risk in BD – 25 to 50 per cent of patients attempt suicide and 15 per cent complete.

The full-blown manic episodes of BD I often require hospitalisation, and psychotic symptoms are common. From a safety viewpoint, a critical symptom of mania is impaired judgment, which can lead to high risk reward-seeking behaviours such as inappropriate spending and sexual hyperactivity. Impaired judgment is a tricky symptom for clinicians to identify, because patients’ poor decisions are generally consistent with their mood state and sense of self at the time.

Although mania is the diagnostic hallmark of BD, patients spend much more time dealing with syndromal...
and subsyndromal depression than mania or hypomania. An influential longitudinal study found that BD I patients spent around 35 per cent of follow-up weeks depressed. In BD II, this figure rose to 50 per cent, underscoring the significant challenges of this ‘milder’ variant of BD. The World Health Organisation estimates BD to be the sixth leading cause of disability in the world, and the majority of this disability is attributable to the depressive component of the disorder.

Psychological interventions
Medications are the first line treatment for acute and maintenance phases of BD (see www.nimh.nih.gov/health/topics/bipolar-disorder), but outcomes are significantly improved with the addition of psychological interventions. Most of what we know about pharmacological and psychosocial treatments for BD refers to BD I, and evidence-informed practice for BD II and cyclothymia must rely on extrapolations from relevant data and theory.

More than 20 randomised controlled trials (RCTs) of adjunctive psychosocial interventions have now been published (see Castle et al., 2009). The particular interventions tested are: family-focused therapy (FFT – family psychoeducation focusing on family dynamics and emotional expression); adaptations of cognitive behaviour therapy (CBT – skill development using cognitive and behavioural strategies); interpersonal and social rhythm therapy (IPSRT – skills around stabilising social rhythms and managing relationships); integrated treatments (psychosocial intervention within routine care); and group psychoeducation (focusing on relapse prevention strategies). All of the tested therapies are highly structured, and not surprisingly have significant overlaps in content.

**SHARED CONTENT OF EFFECTIVE PSYCHOSOCIAL TREATMENTS FOR BD**

- Addressing biological rhythm instability (particularly IPSRT)
- Prodrome/warning signs identification and early intervention
- Medication adherence
- Communication and managing interpersonal stress (particularly FFT)
- Activity regulation and mood monitoring skills
- Critiquing unproductive thoughts and beliefs (particularly CBT)
- Education about BD and risks
- Addressing substance use

Adjunctive psychosocial interventions are efficacious, as measured in decreased relapse rates, quicker stabilisation from acute episodes, reduced symptom severity, or enhanced psychosocial and family functioning. Effect sizes are not large, but consistent positive findings have led to their inclusion in consensus treatment guidelines (e.g., Goodwin, 2009). Best practice treatment of BD is undoubtedly a combination of pharmacotherapy and psychotherapy.

The active ingredients of psychosocial interventions are not known, and there is no systematic evidence for preferring one treatment (FFT, IPSRT, etc.) over another, so the literature does not directly lead to a prescription for psychologists working with a particular client with BD. However, a defensible assumption is that core components shared across the branded interventions should be part of any treatment package. The therapeutic importance of these specific elements is corroborated by qualitative research with people who manage their BD well – wellness strategies reported by these ‘lived experience experts’ overlap substantially with the specific content elements in the branded psychological treatments (Suto et al., 2010). Therapists should familiarise themselves with each of these elements, and are directed to treatment manuals providing detailed guidelines (e.g., Lam et al., 2010).

**An integrative model**
Current evidence and understandings of BD can be integrated into a simple treatment-leaning model. As shown in Figure 1, this evidence-informed model characterises BD from a diathesis-stress framework and highlights opportunities for psychological intervention.

The model recognises two aspects of temperamental vulnerability in BD; namely, biological rhythm instability and abnormalities of reward system function. These pathways are useful foci for psychological treatments, because they are: (i) known to be causal pathways in BD; (ii) recognised by patients as moderators of their symptoms; and (iii) brain processes that loop through behaviour and are therefore responsive to cognitive and behavioural intervention.

Depending on context (resources, client preference, therapist expertise, etc.), the elements of Figure 1 can be addressed at various levels of depth. A short-term or group-based program may focus on basic psychoeducation about the key elements of the model. Targeted skill development can be added to this foundation in a 10-session Medicare-funded block of individual work. A longer-term model of treatment will progressively deepen the client’s knowledge and skill by attending to his or her schema and interpersonal styles (Ball et al., 2006). For example, disrupted social rhythms in a musician with BD could be addressed as a short-term goal of understanding the importance of regular sleep/wake schedules, a medium term goal of moderating alcohol use to improve sleep quality, or a longer term goal of critiquing achievement-oriented schema that may be limiting career options.

**Grounds for optimism**
Consumers tell us that BD’s significant challenges and risks should not be over-emphasised, as these ‘misery stats’ can engender hopelessness and stigma amongst clinicians, patients and the community. Indeed, a more hopeful perspective on BD can be argued.

In a major longitudinal study of BD, approximately 50 per cent of patients did not suffer significant ongoing difficulties with their symptoms (Angst & Sellaro, 2000). These data were based on contact with mental health centres and probably underestimate the proportion in the general population who manage their condition without too much trouble. Furthermore, recent developments in describing, explaining and treating BD (particularly the first wave of psychosocial treatments) will improve outcomes over time, and psychologists who commit to developing expertise will further benefit their own clients. Significant advances in patient empowerment and social interventions against stigma are also having positive effects (see...
Finally, BD is associated with capacities that are highly valued by patients and the community. Across studies, BD has been associated with a range of strengths, including academic ability, empathy and realism. The quality that may be most definitive of BD, however, is creativity.

A creativity-BD link has been confirmed through a range of measures and methods, including biographical investigations, self-reported creativity, occupational choice, generation of novel solutions and aesthetic preferences (Murray & Johnson, 2010). The extent of the association can be quantified from the prevalence of mania amongst creative people: in one large sample of eminent artists, 8.2 per cent warranted a retrospective diagnosis of BD compared with the roughly one per cent population prevalence. Mechanisms underpinning the creativity-BD link are unclear, but the known association between positive affect and divergent thinking may be part of the story, as may the elevated achievement-striving and drivenness that associates with BD.

Professor Kay Redfield Jamison, clinical psychologist and co-author of the classic textbook on BD, is not alone in her net positive view of having the disorder. In a recent qualitative study, patients reported a range of valued features, including amplification of experiences and internal states, enhanced abilities and more intense human connectedness. A theme in this sample was that, on balance, patients felt lucky to have BD.

For the clinician, growing research into a ‘positive psychology of BD’ is important, because it reminds us to explore our clients’ positive experiences of BD. This exploration will strengthen collaboration and help address the ambivalence about treatment that is common in BD. It also reminds us that the person sitting in the other chair may be uniquely placed to have creative input into the treatment process.

Future directions and conclusions
The optimal description, explanation and psychosocial treatment of BD is a work in progress. Fundamental questions remain about the evolution of BD across development, and the relationship between BD and related conditions (particularly unipolar depression and psychosis). A first wave of adjunctive psychological treatments has demonstrated efficacy, but understanding of active ingredients is limited. Further research into the psychological treatment of BD in the context of common comorbidities is urgently needed. Similarly, systematic investigation of moderators of outcome (duration of illness, patient preference, medication, phase of illness, etc.) is needed to determine who benefits when. On another front, future psychological treatments may bypass diagnosis, instead targeting relevant transdiagnostic processes (e.g., substance use, anxiety, impulsivity). Research and practice in BD will also be impacted by consumers’ calls to prioritise subjective quality of life as an outcome measure (Michalak & Murray, 2010).

Limitations of the science notwithstanding, sufficient evidence and theory exists to provide practising psychologists with a broad map for assisting clients with BD. Therapeutic elements specific to BD have been emphasised here, but of course these rest on the therapeutic alliance that underpins all our work. Many of the skills psychologists already have for dealing with other problems are eminently transferable to BD.

The rapid expansion of psychological work in BD has had important consequences. The assumptions and strategies of psychology complement the traditional biomedical approach to BD, producing synergies which have already improved patient outcomes. More fundamentally, BD can now be understood as shorthand for a very human set of states, traits, strengths and challenges. Working with BD therefore illuminates universal issues such as unstable motivations and the embodied nature of cognition. Hopefully this paper has piqued your interest in this exciting work.

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The list of references cited in this article can be accessed from the online version of the article (www.psychology.org.au/publications/inspsych/2012/february/murray).