Women And Bipolar Spectrum Disorders

Introduction

While bipolar disorder is a mental illness that affects both men and women, clinicians who provide care for female patients with bipolar disorder must consider the unique manifestations and treatment needs of the condition in this patient population. Not only do women express symptoms of bipolar disorder differently than men, they are also at risk of other gender-related complications, such as hormone level fluctuations and the effects of the disorder on lifestyle. Women and men are diagnosed with bipolar disorder equally. Women also have unique needs that must be considered with treatment of bipolar disorder, conditions such as pregnancy, menopause, and secretion of hormones that are particular to their gender. Prompt recognition of bipolar disorder, continued monitoring for changes, and ongoing communication about disease progression and treatment effectiveness are all essential elements for management of bipolar disorder in women.

The Bipolar Spectrum

Traditionally, bipolar disorder has been classified according to specific categories: bipolar I, also called “manic-depressive” illness and considered the most severe form of bipolar disorder; and, bipolar II, which consists of one or more episodes of depression interspersed with periods of hypomania, or mixed episodes, and possible periods of level mood in between. Bipolar II is often misdiagnosed as major depression when hypomanic episodes go unrecognized. Mood dysregulation known to occur with bipolar II disorder may include cyclothymia, which is described as periods of hypomania alternating with depression. Despite the diagnostic and statistical manual of mental disorders (DSM) descriptions of the bipolar spectrum, many people
who present with symptoms may have variants of the disorder that do not necessarily fit into these exact categories. The concept of a spectrum of bipolar disorder has emerged with the clinical research and work of Hagop Akiskal and colleagues, who proposed that instead of distinct states of bipolar disorder, there actually exists a mood spectrum, with a range of symptoms and subtypes. A patient with bipolar disorder that falls within the spectrum may have clinical symptoms and may struggle with depression and mania, but not necessarily to the specific extent needed for a diagnosis of bipolar type I or type II. Therefore, the idea of the spectrum is that a patient can present for care of symptoms that fall within the range of severe mood swings between mania and depression on one end of the spectrum and symptoms of major depressive disorder (without any manic or hypomanic episodes but with family history of bipolar disorder) on the other end of the spectrum. Because many patients suffer from symptoms that fall within a range, rather than a specific diagnostic category, a bipolar spectrum is beneficial to provide boundaries for diagnosis.

Former studies have shown that bipolar disorder is prevalent in approximately 1 percent of the population; however, experts now identify this group of people as being diagnosed with bipolar I disorder. With the bipolar spectrum in place, there are many more people being identified with the condition. Some studies have shown that up to 5 percent of the general population has some form of illness on the bipolar spectrum. Bipolar disorder is a complicated condition that has been associated with other types of mental illnesses, including panic, bulimic, addictive, and personality disorders. Further, bipolar disorder is also associated with some forms of chronic physical illnesses, including heart disease, diabetes, and obesity.
Historically, bipolar disorder was identified as a mental illness that manifested as swings in mood and behavior between episodes of mania, in which the affected person experienced hyperexcitability, sleep difficulties, racing thoughts, feelings of grandiosity; and, episodes of severe depression, in which the person struggled with self-care, feelings of sadness or guilt, and suicidal ideation on the other. The switch back and forth between mania and depression is what supported the idea of calling the condition manic-depressive illness.

Over time, bipolar disorder was further categorized according to behaviors because many people affected with the mental illness were also experiencing other symptoms that did not exactly fit the indications associated with either mania or depression. Hypomania was recognized as a form of manic behavior in which the affected person struggled with many of the symptoms of mania but not necessarily with the same intensity; the symptoms associated with hypomania also lasted longer than mania and the person was able to continue to function, albeit with more difficulty.

With the recognition of the potential variety of symptoms associated with the illness, clinicians have distinguished that bipolar disorder is not classified as a specific illness with all of the same symptoms manifesting in the same way. Rather than being a specific diagnosis of only one type of bipolar disorder, in this model, bipolar disorder is actually on a spectrum or a range that is classified between category I and category V. The severity of the illness does not necessarily run from most severe to least as the categories change. Instead, there may be complications and obstacles associated with each category of bipolar disorder, and those diagnosed with category I are not necessarily worse off when compared to those diagnosed with category
V. As an example, some people function very well despite a diagnosis of category I bipolar disorder, while others in various categories of the condition may have much more significant problems.

While a spectrum of bipolar disorder can be helpful in considering the many different presentations of patient symptoms that may be evident, not all healthcare providers are convinced that it is the most appropriate method of managing bipolar disorder. Classifying bipolar disorder according to a spectrum can cause some problems associated with the diagnostic process. Dissidents to the diagnostic process claim that categorizing bipolar disorder on a spectrum may cause overdiagnosis, or too many people being diagnosed, and difficulties with differentiating between categories. They claim that some people who suffer from marginal (softer) cases of bipolar disorder may receive more serious diagnoses that lead to over-medication and too aggressive of treatments. They further argue that classification of these categories only includes the basic categories of bipolar disorder with other symptoms that would be otherwise included as illness-specifiers when considering diagnosis.

Still, the importance of categories cannot be underestimated. Classifying bipolar disorder according to a spectrum of categories allows clinicians to identify more comorbid disorders, understand the pathophysiology of the illness, and improve management techniques for those who are diagnosed. Further, the ability to diagnose patients on the spectrum of bipolar disorder, rather than by the more limited options of either bipolar I, bipolar II, or with mixed specifiers improves clinicians’ abilities to diagnose and manage some very complex conditions seen with bipolar disorder. The idea of bipolar disorder not as one specific mental illness, but as a range of varying clinical
manifestations and subtypes of the disorder, provides greater freedom in recognition and diagnosis of bipolar disorder.

**Category I**

Category I of bipolar disorder may be considered the classic form of the condition. Its symptoms are what many people consider when they think of bipolar disorder: periods of mania interspersed with bouts of severe depression. The person with bipolar I disorder often has a psychologically normal and stable personality and character that is punctuated by periods of mood and behavior changes that can last for days or weeks at a time. These periods of change in symptom presentation are referred to as mood episodes.

The patient with bipolar type I has episodes of depression, which are often described as being profound and debilitating. The patient may then have a mood change and undergo an episode of mania, including irritability and elevated mood, which has the opposite symptom presentation. Bipolar type I is characterized and diagnosed based on the alternating episodes of depression and mania in the patient.

An actual diagnosis of bipolar category I is made when a patient exhibits symptoms of a manic episode that lasts for at least one week and that is significant enough to impair the patient’s functioning in social or occupational responsibilities. The patient may have been hospitalized because of manic symptoms as well. When the provider makes a diagnosis of bipolar I disorder it must be because the patient is experiencing symptoms specifically related to the illness itself and not because of other factors, such as drug or alcohol use or another type of mental illness.
**Mania**

During the manic phase, the patient typically experiences feelings of either irritability or expansiveness, which involves believing and behaving in a grand or superior manner, and significantly elevated mood or elation. For diagnosis, the symptoms must be present most of the day, every day, for at least one week. Other symptoms that the patient may experience during the manic phase of the illness include:

1. Feelings of grandiosity, which may include delusions or feelings of special powers or the belief in being set apart because of being special.

2. An increased pursuit of activities, in which the person keeps a frenetic pace of activity and busyness with projects, ideas, and work.

3. Sleep disruptions and insomnia, including an overall decrease in the amount of sleep and difficulties falling asleep and staying asleep when attempted.

4. Talking a lot and at a rapid pace, with rapid speech and rambling dialogues.

5. Distractibility and an inability to stay on track or focus on current surroundings; the person often jumps from one task or topic of conversation to the next.

6. Racing thoughts and flight of ideas, which is often associated with distractibility. The person jumps from one topic to the next while talking and has difficulty focusing on or concentrating on the same idea to be able to complete anything.

7. Increased pursuit of pleasure; the person may seek out pleasurable activities, which may or may not be safe and could result in harmful consequences.
Upon examination of the person experiencing mania, the clinician may note hyperactive or restless behavior, with rapid speech and seemingly boundless energy. A patient may wear clothing that is very revealing or has loud or clashing colors, displaying the internal feelings of her mood in her taste and style of clothing. The patient’s mood is euphoric and elevated and she may appear happy and giddy; she may demonstrate an inflated sense of self-importance and self-involvement with her own activities and interests. If the mania has been prolonged, euphoria may be overtaken by irritability and the person may be easily annoyed.

When a woman experiences symptoms of mania, she is typically unable to continue functioning in a normal manner, including keeping up with personal and social obligations. A mother who is experiencing mania may have serious difficulty taking care of her children and may neglect their needs to pursue other adventures. Another woman may decide not to go to work because she decides she has another project she would rather do. Some women may have so many problems with concentrating on school or work that they give up or simply stop going for a while, which can lead to very negative consequences, such as loss of a job or failing classes.

**Depression**

The other end of the spectrum of bipolar category I is severe depression, which may or may not be just as common as symptoms of mania. The depression associated with bipolar type I is often disabling in that the patient has difficulty completing tasks or performing normal activities of daily living. The symptoms of depression may be quite debilitating and they are associated with other types of physical illnesses and mood imbalances. The deep depression often seen with bipolar disorder is also associated with a high level of mortality, most often by suicide. The patient experiencing
depression from bipolar disorder is more likely to develop suicidal ideation; and each year, approximately 11 percent of people with a type of bipolar disorder successfully commit suicide.⁹

The patient who is deeply depressed may be less likely to attempt suicide when compared to the patient with bipolar disorder who is coming out of an episode of depression. The caregiver of the patient with bipolar disorder should remember that her feelings of depression might be intense to the point of incapacitation, in that she is unable to perform many tasks at all. However, as depressive symptoms abate and the patient starts to come out of the fog of depression, there is a greater risk of suicide attempts, as she may start to think more clearly and may have more energy and motivation to carry out her suicide plan.
Although some of the symptoms of depression associated with bipolar disorder are similar to those of major depressive disorder, the patient with bipolar depression often struggles more than someone with major depressive disorder. This is because the mood fluctuations between depression and mania can be confusing and are very difficult to treat. Standard antidepressants may not be effective in treating bipolar depression and may lead to mania. Management of mania itself may be difficult to control with medication and the patient may spend a considerable amount of time switching back and forth between moods but never entirely achieving control.

Episodes of depression associated with bipolar disorder cause symptoms that last for at least two weeks. Diagnosis of bipolar depression involves a prolonged depressed mood and at least five of the following symptoms, with one being either a loss of pleasure in normal activities or a generalized depressed mood. Other symptoms seen with this diagnosis include:
1. Weight changes, either demonstrated as weight gain or weight loss and/or changes in appetite signified as either increased or decreased desire to eat.
2. Sleep changes, either demonstrated as insomnia with difficulties falling asleep and staying asleep, or hypersomnia, characterized by a deep desire to sleep almost all the time.
3. Slow behavior and psychomotor retardation, evidenced by difficulty completing tasks and slowed movements.
4. Fatigue, motor weakness, lethargy, and loss of energy.
5. Difficulties with focus and concentration, increased distractibility, and indecisiveness.
6. Feelings of hopelessness, worthlessness, and guilt.
7. A preoccupation with death, frequent talk of suicide, or suicide attempts.

As with diagnosis of mania, the patient who experiences depression has mood changes that are not associated with environmental factors, such as a substance use disorder or another condition, that would cause a depressed mood. Upon examination, the clinician may note that the person has an unkempt appearance and does not practice appropriate self-care, manifested by poorly fitting or dirty clothes and lack of grooming or poor personal hygiene. The patient may demonstrate a sense of fatigue or sadness; she may have little eye contact, move in slow or depressed movements, and may keep a distance between herself and the provider.

The outcome is worse for patients who have comorbidities in addition to bipolar disorder. Although many comorbid conditions are types of psychiatric disorders that can further perpetuate symptoms of depression, mania, or psychosis, there are physical disorders that are associated with bipolar
disorder that can complicate treatment outcomes. Substance use is also much more common among people with bipolar disorder. A person may start to use substances inappropriately to attempt to combat some of the emotions and mood changes they experience. This can lead to a co-occurring substance use disorder that also requires treatment. Other situations that may signify a poor outcome for the patient when treating bipolar disorder include a lack of support systems in place, a poor work history, a poor history of treatment compliance, and previous history of suicide attempts or significant depressive symptoms.

Manic episodes may also lead to periods of psychotic behavior that may require hospitalization if the patient loses control. During a period of acute psychosis, the patient experiences delusions and hallucinations; these alterations in sensory perception may or may not be associated with the current flight of ideas or the mood the patient is exhibiting. The patient may have feelings of paranoia or may feel judged for her behavior. Alternatively, many delusions are associated with grandiosity and may involve feelings of supremacy and power. The mechanisms for why a person experiencing a manic episode develops psychotic features continue to be investigated and researched. Mania associated with bipolar I illness shares some of the same genetic susceptibility and risks as some other types of psychosis, including schizophrenia and schizoaffective disorder. This suggests that there is a commonality between the genetic predisposition toward bipolar disorder and those illnesses on the schizophrenia spectrum.⁹

*Risk Factors and Considerations*

The risk of developing bipolar type I among women is increased due to several factors, including genetic aspects, neurochemical factors, and environmental causes.⁹ People who have a first-degree relative with bipolar I
disorder are much more likely to develop the condition as well. Studies of families in which one or more close relatives had bipolar disorder have shown a significant increase in the risk of family members also having symptoms. Bipolar type I may also be associated with certain genes that are directly involved in its development, including the ANK3 and CACAN1C genes.\(^9\) A study found in *The American Journal of Psychiatry* demonstrated that children born to a parent with bipolar disorder had a higher risk of developing manic, hypomanic, or mixed episodes later. These children, known as high-risk offspring, were also found to be at much higher risk of developing other types of psychiatric disorders when a parent had bipolar disorder, including attention-deficit hyperactivity disorder, anxiety, and substance use disorders.\(^10\)

Bipolar disorder type I has another family component that contributes as well, which is the family environment that the patient grows in. A patient who has a family member with bipolar disorder is not only at higher risk of developing the condition as well because of genetic influences, but her environmental influences may also put her at higher risk. The person may witness erratic behavior on the part of her affected parent; likewise, she may grow up in an environment that is unstructured or very unstable because of her parent’s illness. Other environmental stressors have also been shown to affect women in their development of bipolar disorder type I. Some examples include the stressors of work and raising a family, difficulties with relationships, caring for children, and managing financial concerns, which may all contribute to mood alterations.

Hormone changes that may also affect bipolar illness development include dysregulation of thyroid hormone and cortisol. Decreased secretion of thyroid hormone, causing hypothyroidism, can result in symptoms of
depression, while elevated thyroid hormone — hyperthyroidism — may have the opposite effect and may cause an elevated mood. Thyroid dysfunction has a strong association with bipolar symptoms; researchers estimate that up to half of patients who experience rapid cycling of bipolar disorder have hypothyroidism.\textsuperscript{12} Management of either hyper- or hypothyroidism, when present, may help to prevent and control bipolar symptoms.

Cortisol, the steroid hormone produced by the adrenal glands and that impacts the stress response, can impact the intensity of depressive feelings associated with bipolar disorder. A study by Maripuu, \textit{et al.}, in the journal \textit{PLOS One} found that the symptoms of bipolar depression activate the stress response, which leads to elevated blood cortisol levels. Abnormal levels of cortisol, whether by overactivation or underactivation of the stress-response system, can lead to increased symptoms and deeper levels of depression in people who struggle with bipolar disorder.\textsuperscript{13}

It has been noted that environmental factors, including stress, can act as a trigger for bipolar disorder symptoms and can cause an affected patient to have more frequent episodes of depression or mania. The unregulated excretion of cortisol that impacts the intensity of depression can significantly reduce the quality of life for an affected patient, which means that part of prevention and management of the illness should involve stress management as well.

The neurochemical factors associated with the development of bipolar disorder include changes in the levels of neurotransmitters in the body. Alterations in neurotransmitter levels have been found in the brains of people with bipolar disorder and these levels are different than those who do not have bipolar disorder. The common neurotransmitters associated with
bipolar disorder include changes in levels of dopamine, norepinephrine, serotonin, and GABA.\textsuperscript{12}

The average age of diagnosis of bipolar I disorder is 21 years, which does not vary between men and women. Despite an average diagnosis at this age, though, many people who have bipolar I disorder start to manifest symptoms during adolescence, most prominently between the ages of 15 and 19 years. On the other end of the spectrum, some patients may suffer from symptoms of depression on and off throughout their young adult lives but then develop episodes of mania and subsequent bipolar disorder as older adults. The frequency of the cycles also increases as a person grows older, and affected individuals often experience more frequent switches between mania and depression as they age.

There is much information available to discuss the epidemiology, causes, risk factors, and manifestations of bipolar disorder. Although bipolar type I may cause some of the more significant mood swings between mania and depression, many of the causes and risks are evident in other stages of the bipolar spectrum as well. The healthcare provider, when assessing the patient and formulating a diagnosis, will need to consider the many potential factors that are contributory to this particular type of bipolar disorder, including age, gender, medical history, and symptoms. The risk factors of the illness and clinical manifestations are also essential to diagnosis and will eventually guide appropriate treatment.

\textbf{Category II}

Although bipolar disorder category I may demonstrate severe episodes of manic behavior and extreme depression, there are other manifestations of the condition that fall along the spectrum. Bipolar disorder category II is
another form of the condition; while it is termed category II, it may or may not be as severe in manifestation when compared to category I. Persons with bipolar II still may suffer with complex issues such as debilitating depression and prolonged periods of hypomania, which is not as extensive as the mania of bipolar type I, but it may last much longer.

Patients with bipolar II disorder may have predominantly depressive symptoms that are interspersed with episodes of hypomania. The person with bipolar II may have frequent episodes of severe depression, characterized by weight changes, hopelessness, sadness, guilt, and thoughts of self-harm; these many symptoms can be ongoing for weeks or months at a time. The moods are then disrupted by symptoms of hypomania, often manifested as extreme irritability, labile moods, and anger, which may also last much longer when compared to mania associated with bipolar type I disorder.

_Hypomania_

Hypomania is the hallmark of diagnosis of bipolar disorder category II. It is manifested with the same symptoms as mania, and the person may struggle with a range of symptoms from grandiosity and racing thoughts to distractibility, increased goal-directed activity, and rapid speech. To be diagnosed with hypomania, the patient must exhibit characteristic moods of irritability, expansiveness, or euphoria for at least four days’ duration and must have three or more of the following symptoms:

1. Insomnia or decreased need for sleep
2. Feelings of grandiosity
3. Rapid speech
4. Racing thoughts or flight of ideas
5. Distractibility
6. Engaging in high-risk activities or pleasurable activities that have the potential for harmful consequences

7. Goal-focused activity and increased activity levels overall

The condition differs from actual mania in that the person with hypomania does not necessarily experience such extreme symptoms that she cannot continue to function. As an example, a patient with bipolar I disorder who experiences mania may go on a binge of activity and leave work and relationships behind to disappear for days during acute symptoms. Alternatively, the patient with hypomania may have increased behavior and thoughts, but is still able to maintain relationships and function at work or school. Hypomania also differs from mania in that the affected person does not experience the psychotic episodes that can occur during mania. Hospitalization of the hypomanic patient is much more rare when compared to treatment for mania.\(^8\)

Despite the reduced intensity of symptoms of hypomania when compared to mania, hypomania still can cause a multitude of other problems for the affected patient. Although the minimum amount of time for diagnosis is four days, the patient with hypomania often struggles for much longer periods. Some patients have been known to suffer from hypomanic episodes for weeks or months at a time. In this way, hypomania may be just as damaging as episodes of mania because the patient tends to struggle with hypomanic symptoms for much longer periods.

Some people may confuse symptoms of hypomania with generalized happiness; it may be confusing to a clinician and to others around an affected patient as to whether she is experiencing hypomanic symptoms or a prolonged good mood. Hypomania, like mania in some ways, can actually be
a productive time for some people, in that they experience good and positive feelings, increased feelings of pleasure or happiness, they are easily excited, and they may be motivated to complete more tasks. The differences between these symptoms and general happiness are subtle, but they exist. The person who is happy and not hypomanic will continue to experience feelings of pleasure and joy that return on a regular basis; these feelings are also typically not affected if the person were to begin treatment, such as with antidepressants.

Regarding the idea that hypomania may be a pleasurable and somewhat desirable state, in that it allows the patient to accomplish more and to feel good about her surroundings, it is important to note that these symptoms are not necessarily present all the time. Further, hypomania also consists of irritability, which is usually not a desirable state and typically causes the person to feel angry and short-tempered about minor, everyday occurrences. The person with bipolar II disorder that struggles with hypomania is experiencing symptoms and moods that are very different from her normal personality and temperament. She may act out in ways that are completely uncharacteristic to her normal traits and behavior, which can be very confusing to those she is around. Although the hypomanic symptoms can last for long periods, the behaviors are often so different from the person’s normal personality that those around her often will take notice and the person’s mood and behavior can impact social functioning and the ability to perform well at a job.

**Depression**

Alternating with periods of hypomania may be episodes of severe depression, similar to that seen in bipolar disorder type I. In between episodes of depression and mania, the patient may live a normal and
productive life. The period of time of normal mood and affect between episodes varies among patients. Some people switch back to depression after coming out of a time of hypomania and may spend much more time in a depressed state. Others may have much longer periods of normal moods before experiencing depression again.

The symptoms of depression during bipolar II are characterized by a low mood, decreased energy levels, fatigue, lack of motivation, loss of pleasure in everyday activities, feelings of guilt, and potential suicidal ideation. These symptoms may be like those seen with major depressive disorder and they are technically the same as both clinical depression and the depression associated with type I bipolar. The characteristic difference that distinguishes bipolar II from type I is presence of hypomania instead of mania, despite the depressive symptoms being relatively similar.

As with bipolar category I, bipolar II is most often diagnosed during the young adult years and the average age at diagnosis for both men and women is 21 years. Among older adults, bipolar II illness may also be diagnosed when a person begins to experience symptoms of hypomania later in life. The affected patient may have suffered from depressive symptoms already but does not develop hypomania until after age 50. When this occurs, the clinician may need to consider not only a diagnosis of bipolar disorder, but also of an underlying physical disorder that could be causing neurovascular changes. Women are diagnosed more frequently with type II bipolar disorder when compared to men. Women are also at higher risk of developing rapid cycling, which occurs as at least four mood episodes experienced in one year, they are at risk of more frequent periods of hypomania, and of having mixed
episodes, which involves near-simultaneous symptoms of both depression and mania.⁹

Some patients may suffer through mixed states, which are classified using a *specifier*, according to the DSM-5. The condition can occur in a person with either bipolar type I or type II; and, a mixed state would be included in a diagnosis of one of the types of bipolar disorder, specified as “with mixed features.” A mixed state occurs when a person experiences symptoms of both depression and mania or hypomania at about the same time. For example, a mixed state may be manifested as severe depression, in which the patient is unable to sleep and has difficulties with activities of daily living, may struggle with feelings of sadness and guilt, yet simultaneously suffer from racing thoughts and an inability to control behavior. This state is very difficult to control and treatment may become quite complicated as the clinician attempts to determine which medications or therapeutic interventions will work for the differing symptoms.

Despite the lack of mania present in bipolar II, patients who suffer from hypomania with this condition are still at great risk of complications of the illness. As with other forms of bipolar disorder found along the spectrum, type II requires careful management and monitoring. Because women are more commonly diagnosed with type II bipolar disorder, clinicians treating female patients who present with symptoms of depression should always consider the potential for bipolar disorder and ask about manic symptoms. Since the symptoms of hypomania are not as extreme as those of mania found in bipolar I, some patients may have trouble remembering or even recognizing whether they have had periods of hypomania. Diagnosis then requires continued discussions about the patient’s moods and how her behavior affects the patient’s daily activities and quality of life.
**Category III**

The categories of bipolar disorder beyond types I and II have sometimes been called the “softer” forms of the disorder, as those with categories beyond type I and II not only have different symptoms, but affected patients also may struggle for shorter periods of time when episodes develop. Although types III, IV, and V on the bipolar spectrum may be considered “softer” disorders, those who struggle with symptoms often have a mixture of severe symptoms that may be combined with other types of mental illness, including panic disorders or eating disorders. As diagnosis along the bipolar spectrum occurs, the affected patient may still have numerous symptoms and struggles with mood and behavior, despite not having a specific diagnosis of type I or II.

Bipolar disorder is commonly managed with medications, although the type of medication prescribed may vary depending on the patient’s symptoms and the clinical condition. Although the patient may suffer from depression as part of the illness, most antidepressants are not the first choice of treatment. Many people with bipolar disorder who are prescribed antidepressants as part of treatment end up switching from depressive symptoms to manic symptoms. The medication may work to treat the depressive symptoms, but it can also result in the destructive behavior of mania, which solves one problem but then creates another.

Clinicians have recognized the effects of some types of antidepressants on the treatment of bipolar disorder to the point that the results of antidepressant-induced swings in mood and behavior are seen as a subset of the condition. Category III on the bipolar spectrum represents the condition in which a patient takes antidepressants or possibly another type of
medication for treatment of depression and ends up suffering from hypomanic or manic symptoms of the illness. [3]

A patient may develop symptoms of category III bipolar disorder after undergoing other treatments for the disorder as well. Symptoms of mania have been known to develop in some patients who have not necessarily used antidepressants for depressive episodes, but who have undergone other forms of treatment, such as through electroconvulsive therapy (ECT) or light therapy. Sleep deprivation is associated with development of manic symptoms as well, as prolonged sleep deprivation from chronic depression can lead to symptoms of psychosis.

Akiskal, et al., reported that when working with patients experiencing category III bipolar disorder, the periods of treatment-induced mania tend to be short-lived and are usually not recurrent. Bipolar III has also been shown to be closely linked to substance use, to the point that it may be difficult to determine the root cause of the manic symptoms: the prescribed medications or the substance use itself.

This response of moving between depression and mania as a result of bipolar treatment is sometimes referred to as a “switch.” For some patients, the mood elevation of mania or hypomania may not occur at all before being treated with antidepressants. The patient may mistakenly be diagnosed with major depressive disorder first and be offered standard treatment with antidepressants. The theory behind the cause of the switch between moods is that antidepressants change neurotransmitter levels in the brain as part of treatment of depressive symptoms, but these changes then cause the patient to swing in the other direction of symptoms, resulting in the opposite of depression, or mania. If a patient was once thought to have major
depressive disorder but ends up experiencing manic symptoms because of antidepressant use, a diagnosis of bipolar disorder should be considered instead.

As a result, most patients with diagnosed bipolar disorder are not treated with antidepressants or, if they are, they are prescribed and used with great caution to avoid a switch in moods. Regular use of antidepressants is not necessarily helpful in the long-term management of bipolar depression. Because such a controversy exists, experts continue to issue recommendations about antidepressant use in bipolar patients to help guide healthcare providers when diagnosing and treating these conditions. A Task Force through the International Society for Bipolar Disorders has recommended that antidepressants should not be used in patients experiencing mania or in mixed episodes. When used for management of bipolar disorder, they should only be prescribed for a patient experiencing depression and only if the patient is someone who does not have a history of rapid cycling and who has responded well to such medications in the past.

When antidepressants are prescribed, they may be given in combination with mood stabilizing medications to avoid a rapid switch from depression into mania. Mood stabilizing medications are the most common types of drugs used in the management of bipolar disorder; they are usually quite effective in controlling symptoms of mania but they may also be prescribed to treat bipolar depression. Lithium is one of the oldest types of mood stabilizing drugs prescribed for bipolar disorder treatment; it is often very effective in preventing rapid swings between high and low mood levels. Lithium requires regular blood testing to check for therapeutic levels in the body and to avoid toxicity. Other types of mood stabilizers that are also commonly prescribed include valproic acid (Depakote®), carbamazepine
(Tegretol®), and lamotrigine (Lamictal®). These drugs also have anticonvulsant properties and were originally developed for treatment of seizures from epilepsy. Because of their abilities to control symptoms of mania and to prevent mood swings, they also are used for treatment of bipolar disorder.  

Antipsychotic medications may also be prescribed, particularly if a patient has periods of psychosis because of manic or depressive symptoms. They are typically used before treatment with antidepressants, and they may be considered if a patient has already tried mood-stabilizing medications with little success. Examples of antipsychotic medications commonly prescribed for bipolar treatment include risperidone (Risperdal®), quetiapine (Seroquel®), olanzapine (Zyprexa®), and aripiprazole (Abilify®).

Some patients do not respond well to medication for bipolar disorder and are unhappy with the idea of taking medications long term. However, it should be noted that it is important to continue to take medications for mood management and to prevent negative consequences. The patient may have to consider the potential for long-term medication therapy. The healthcare provider may need to discuss the situation with the patient to provide education about the benefits of mood stabilizing medications and their prevention of mania.

An important part of education is the recommendation that the patient continue to take the medication, even if she starts to feel better. The effects of feeling better while taking medicine for treatment most likely mean that the patient’s moods are stabilizing, but it does not mean that discontinuing the drugs is the next best course. The patient needs to continue to take the medication as prescribed in order to continue to keep a stable mood and to
prevent recurrence of bipolar symptoms. As with another medical illness or physical disease, medications for bipolar disorder may need to be an ongoing part of the patient’s life to best manage this mental health disorder.

**Category IV**

Bipolar type IV is another state on the range of the spectrum that is classified as depression that is superimposed on a hyperthymic temperament, according to Akiskal. Hyperthymia describes a condition in which a person has an elevated or euphoric mood. If someone has a hyperthymic temperament, they are said to be happy, outgoing, engaging, and often lovers of other people. Hyperthymia can be present in bipolar disorder, often during a manic or hypomanic episode if the person is experiencing the euphoria or the “high” associated with this mood condition.

Some people may have a hyperthymic temperament, in that they do not necessarily struggle with the ups and downs of bipolar disorder, they simply are upbeat and have a lot of energy. Hyperthymia has been described by some as a state of hypomania — with all of the energy and goal-focused activity — without the impairment. Technically, this means that a person with hyperthymia can be productive and live a normal and healthy life without the negative effects of mania.

Alternatively, hyperthymia has been considered to be a pre-cursor to a bipolar disorder diagnosis, as many studies continue to look at potential causes of the disorder or signs that the person is more likely to develop bipolar disorder if she has certain traits or characteristics. Although not everyone who has a hyperthymic temperament will go on to develop bipolar disorder, the presence of this type of temperament may increase the risk of the condition.
Category IV of the bipolar spectrum is then classified as someone having a hyperthymic temperament without hypomania but who also has periods of clinical depression. This is considered a soft form of bipolar disorder, in that the patient does not experience the major mood swings between mania and depression but instead experiences an almost constant state of hypomania without the negative effects of the condition. Additionally, the patient then has bouts of depression that influence her affect and behavior and they are noticeably different when compared to her normal mood. This category of bipolar disorder may be difficult to treat if the person has severe enough depression that it affects quality of life. Normally, clinical depression is treated with antidepressants; in this case, even if a person with category IV has a normally hyperthymic temperament, use of antidepressants could result in a manic or hypomanic state that is detrimental to the patient’s health.

This presents a complicated situation because it considers the basis of temperament on a person’s state of mental illness. All people have some form of temperament that affects their behavior and their ability to get along with others. If a person normally has a hyperthymic, or “up” temperament, but then experiences depression, it can be difficult to accurately diagnose bipolar disorder.

Clinicians disagree about the extent that a condition is called bipolar disorder and along with it, the requirement for providing treatment and medication. For instance, a person may have a naturally positive and happy personality and she may be successful because she has plenty of motivation to accomplish tasks and achieve her goals. Occasionally, though, she suffers from periods of depression, in which she struggles with feelings of
hopelessness and guilt, has difficulty sleeping, is very irritable, and has trouble getting along with others. Critics of the bipolar spectrum and the consideration of category IV and category V as diagnoses would still say that these conditions are related to temperaments, which are aspects of everyday life and that they do not necessarily need treatment.  

Despite criticism regarding the actual diagnosis of whether or not someone has category IV or V symptoms on the bipolar spectrum, category IV bipolar disorder can still cause significant changes in affect and can result in considerable changes in the affected person’s mood and behavior. Despite having a temperament that is described as extroverted, hyperthymic, or outgoing, the real problem begins when the person experiences difficulties and changes in mood, which is how bipolar disorder is diagnosed. If the patient in the above example had a hyperthymic temperament, the periods of depression she sometimes experiences may or may not affect her wellbeing and ability to continue with normal activities. It is when the person suffers from periods of depression that are interfering with her job and relationships that providers should get involved and possibly make a diagnosis of bipolar category IV.  

Another way of determining if a patient has bipolar disorder versus periods of depression is to consider the patient’s response to antidepressant medications. The clinician should not prescribe antidepressants with the end goal in mind of checking to see if they cause mania, but if a patient who has started on antidepressants has started to have subtle symptoms of mania, the provider can better determine that the patient most likely has bipolar disorder and not major depressive disorder.
Overall, women who struggle with category IV type bipolar disorder are not necessarily straightforward in their presentations for care. They may be struggling with some issues that do not fit into the typical pattern of diagnostic criteria, which can make actual diagnosis difficult, but it also better explains the necessity of the bipolar spectrum.

As with other forms of illness on the bipolar spectrum, the clinician's assessment of the patient’s condition can significantly impact the ability of the provider to formulate a diagnosis and to provide appropriate treatment for patients with category IV bipolar disorder. Assessment of the patient should include a physical exam to assess the patient’s clinical and functional status and to check for symptoms of medical problems that may be contributing to the patient’s psychiatric condition, including endocrine disorders, infectious diseases, or metabolic disorders. Other markers that have also been associated with a greater risk of bipolar disorder and that should be taken into account while taking the patient’s history include a history of migraine headaches, alcohol abuse, thyroid disease, obesity, or a childhood or adolescent history of sexual abuse. These markers have all been affiliated with earlier age of onset, greater demonstration of symptoms, and more difficulties with treating bipolar disorder.6

The medical history should also include the patient’s use of prescription and over-the-counter medications, as some of these agents can affect mood and could cause affective symptoms. Examples of drugs that may cause mood changes include corticosteroids, antidepressants, antihypertensives, and benzodiazepines.6 The clinician should also perform a health history and include questions about the patient’s psychosocial background, including history of erratic behaviors that may be associated with periods of mania or hypomania or bouts of severe and debilitating depression. If a patient
suggests that she suffers from either type of mood episode, the clinician should then delve further to find out more details about the situation, the extent of the symptoms, how long they have lasted, and when the last episode occurred.

Regardless of the type of symptoms apparent on the patient’s presentation for care and the potential location of diagnosis on the bipolar spectrum, the patient’s mental history and assessment of medication use and mood changes are critical components of diagnosing bipolar disorder in a timely manner and for providing appropriate treatment.

**Category V**

Bipolar disorder category V is the least common of types as far as diagnosis of the condition is concerned. As with some other categories on the spectrum, category V is not classified as a diagnosis according to the DSM-5; however, many clinicians still see patients who struggle with its symptoms. A person with bipolar disorder category V suffers from symptoms of major depression, but this person does not experience manic or hypomanic episodes. The condition differs from major depressive disorder, though, in that the person with category V also has at least one blood relative who suffers from bipolar disorder.4

The depressive symptoms associated with bipolar V are very similar to major depressive disorder. The patient typically has major depressive episodes that affect her mood and behavior through most of the day, every day; and these major depressive episodes cause difficulties with sleeping, appetite changes, lack of motivation or energy, distractibility, hopelessness, and possible thoughts of self-harm. Despite these similarities to major depressive disorder, it is important to consider category V bipolar as a different entity while providing treatment.
The two conditions may appear similar in their symptoms, but they may not be treated in the same way.

When assessing the patient with symptoms of depression, it is important to ask about any history of mania or hypomania, which is a determinant in categorizing bipolar disorder. However, it is also important to assess for a relative or for family history of mania and bipolar disorder, as this could change treatment considerations when managing major depressive disorder versus category V bipolar disorder. It is possible that a person with bipolar V who only experiences major depressive episodes could have a switch in moods and exhibit mania or hypomania with the introduction of treatment with antidepressants. The prescribing clinician must therefore carefully assess the patient’s history and clinical condition when making treatment decisions.

The patient affected with bipolar V disorder may or may not respond to antidepressants, which would be the typical form of treatment for the depressive symptoms. She may have some relief of symptoms for a while but then she may experience hypomanic symptoms that are not necessarily obvious but are a result of the antidepressants she is taking. For instance, after a period of time taking antidepressants a patient may exhibit subtle signs of mania, such as irritability and difficulties with sleeping. She may still struggle with some of the same symptoms of depression as well.

Finding the right type of treatment for the patient with category V bipolar can be tricky and may take a time of trial and error. The patient could benefit from psychotherapy interventions and may need medication to control the depression. Mood stabilizers, such as lamotrigine (Lamictal®) or quetiapine (Seroquel®) may be of benefit to control the patient’s mood.
without causing further episodes of depression and potentially avoiding the subtle manic symptoms that can occur with other types of antidepressants.

The diagnosis of bipolar category V may be difficult to determine. Formerly, a patient with symptoms of depression but without any manic episodes might have been classified as having major depressive disorder or bipolar disorder not otherwise specified (NOS), since the patient experiences depression but does not have enough manic or hypomanic symptoms to meet the criteria for diagnosis. Under the DSM-5, depressive disorders and bipolar and related disorders have been separated into two categories, making a person with category V bipolar disorder symptoms potentially difficult to diagnose. Category V bipolar disorder may be instead classified as a subtype of bipolar disorder instead of being a distinct category.\(^4\)

Based on the range of symptoms associated with the spectrum of bipolar disorder, diagnosis of any of the categories within the spectrum can be difficult for clinicians. The challenges specific to diagnosing and treating female patients may further complicate these considerations, as women may struggle with aspects such as mixed episodes, rapid cycling, or prolonged periods of depression associated with bipolar illness when compared to male patients. Further factors such as the influence of hormones, pregnancy, and postpartum status must also be considered when implementing treatment regimens for female patients. In addition to symptoms of bipolar disorder, some women may struggle with other conditions on the bipolar spectrum that can cause increased morbidity and mortality and drastically reduce quality of life when left untreated.

**Bipolar Spectrum Conditions**
The characteristics of mood swings and behaviors of bipolar disorder may vary widely across the spectrum. Women with bipolar disorder at any location on the bipolar spectrum may also be at higher risk of having comorbid conditions, which are distinct conditions that are diagnosed in addition to bipolar disorder. These are conditions that affect a woman’s health, behavior, and relationships with others and the combination of the two conditions can significantly disrupt normal activities and routines. The patient may have been diagnosed with a separate condition prior to her diagnosis of bipolar disorder or she may have been diagnosed somewhere on the bipolar spectrum and then later developed symptoms of another type of illness.

Women struggling with bipolar disorder may be more likely to develop certain comorbid conditions when compared to men. There are some medical or psychological conditions that tend to affect women more than men and having a diagnosis of bipolar disorder may perpetuate some of this risk; an example might be a comorbid diagnosis of an eating disorder, such as bulimia. The condition is more often seen in women than in men, even among those without bipolar disorder. The bipolar symptoms, though, could increase the risk that a woman develops problems with eating and her moods surrounding her eating habits and may be more likely to develop an eating disorder. Alternatively, some other comorbid conditions may more likely affect men but could be present among women, or they may affect men and women equally. Management of these conditions may require further exploration into the unique needs of female patients when providing the most appropriate treatment.

In addition to psychological conditions that may be connected with bipolar disorder, women are more likely to struggle with some types of medical
conditions as well, such as thyroid disease and migraine headaches. As stated, a comprehensive health history to assess for both medical conditions affecting health and mood conditions that can affect behavior is essential for proper diagnosis and to fully appreciate the effects of other bipolar spectrum conditions, which can be difficult to manage.

**Depression**

Depression is a component of most of the major categories of bipolar disorder on the spectrum. Depressive symptoms often occur more commonly in women when compared to men. The amount of depressive episodes a particular patient with bipolar disorder experiences, as well as her moods, behavior, and responses to treatment, will influence a clinician’s diagnosis along the bipolar disorder spectrum.

Formerly called unipolar depression, major depressive disorder shares some of the same symptoms as depression seen as part of bipolar disorder. Major depressive disorder causes severe symptoms of sadness, anxiety, and feelings of loss or emptiness that are pervasive and can affect the mood and activity levels of the depressed person. Similar to bipolar disorder, major depressive disorder may also cause feelings of guilt, fatigue, hopelessness, pessimism, loss of interest in activities, and helplessness. The person may suffer from physical symptoms as well, including headaches, insomnia or excessive sleepiness, weight loss or weight gain, muscle aches, and digestive problems.

The symptoms of depression may be so severe that they affect the person’s ability to function in every day life. Many people who suffer from depression have complained of feeling so low and so fatigued that they can barely get out of bed in the morning or they have difficulties completing routine
activities of daily living. Their personal lives suffer as they distance themselves from friends and family; they may have trouble keeping up at work and performing expected tasks needed to complete their jobs. In addition to the depression experienced by individuals with bipolar disorder, major depressive disorder is closely affiliated with other mental health conditions, including anxiety, traumatic stress, panic disorder, and social anxiety disorder. Despite the relatively high numbers of people diagnosed with depression, the condition tends to affect women more often than men. The National Institute of Mental Health states that women are 70 percent more likely than men to experience some form of depression during their lifetime.\textsuperscript{21}

Depression, as an illness, can be diagnosed on its own or it can be part of another disorder, such as bipolar disorder. The depression associated with bipolar disorder differs from major depressive disorder in that the affected person may not experience constant and pervasive feelings of sadness, guilt, hopelessness, and all of the other symptoms of depression all the time. Instead, the patient with bipolar disorder may have episodes, or periods of time when depression is present and is causing symptoms. The depressive episode may last weeks to months in the patient with bipolar disorder but characteristic of the illness, it does go away with a switch to an episode of mania or hypomania. The cycles of back and forth between depression and mania are what differentiate major depressive disorder from bipolar depression.

Clinicians can determine the difference between major depression and bipolar depression when performing an intake interview to determine whether the patient has ever had episodes of mania or hypomania. Even if the patient presents for care and her major complaints are symptoms of
depression, to properly diagnose the condition, the provider must ensure that the depressive symptoms are not affiliated with another type of disorder.

Although it shares many of the same symptoms and characteristics as that seen in bipolar depression, major depressive disorder does include some significant differences. As stated, major depression does not necessarily resolve without treatment and the person does not necessarily switch back to episodes of hypomania or mania as would be seen with bipolar disorder. Another difference between major depression and bipolar depression is the mode of treatment. When an individual has depression associated with bipolar disorder, the condition may more likely be treated by considering both the depression and the mania associated with the illness.

An antipsychotic or a mood stabilizing medication is often used to control symptoms of bipolar disorder in diagnosed patients. Alternatively, major depressive disorder may be successfully treated with antidepressant medication alone, which alters neurotransmitter levels in the brain that have changed because of the illness. Patients with bipolar depression usually are not prescribed antidepressants because they are at risk of transitioning into a period of mania when taking these drugs. It is as if the antidepressants work too well and cause the patient to not only overcome depressed feelings, but to further continue into a state of hypomania or mania on the opposite end of the spectrum.

Medications prescribed in the treatment of bipolar disorder and of depression also differ in the length of time that it takes for them to work. Antipsychotic medications prescribed for the treatment of bipolar disorder may start to exert their effects within a few weeks and can control primary symptoms.
Alternatively, antidepressants take several weeks and possibly as long as 1-2 months before they are effective in controlling depression. The patient who is prescribed antidepressants may need to wait much longer before she starts to see a change in symptoms of her illness.

Women who struggle with depression as part of bipolar disorder are at higher risk of self-harm and suicide, since they may struggle intensely with feelings of sadness and hopelessness during depressive episodes. The patient who experiences depression can benefit from a prescription of antidepressant medications for major depressive disorder but could experience a rapid switch into mania if the depression is associated with bipolar disorder. As stated, careful consideration must be taken when prescribing medications for these patients, and the provider must determine whether major depression or bipolar depression is present. Studies have shown that a combination of medication and psychotherapy is most beneficial for patients struggling with depression. Psychotherapy is helpful in treatment of depressed patients, whether the condition is major depression or bipolar depression.

Cognitive-behavioral therapy may be utilized for some women who are struggling with depression and bipolar disorder. Cognitive-behavioral therapy (CBT) is a type of psychotherapy that considers the patient’s thought patterns and how they affect her behavior. A patient with severe depression may work with a therapist to use CBT to initially learn to recognize negative thought patterns. For instance, a patient may walk away from an encounter with an acquaintance and think, “she doesn’t like me and she didn’t really want to talk to me. She was only talking to me because no one else was available.” This negative thinking, whether the situation was true or not, then may lead the patient to believe that she is worthless and
unlikeable, which can further perpetuate her feelings of depression. The patient’s negative feelings may propel her to struggle even more with motivation and completing any tasks and she may spiral even further into a state of negative thinking and slow, depressed, and unmotivated living.

If the patient uses CBT to help her recognize how thoughts contribute to her behavior, she can change her thoughts so that she may be less likely to act on them. She may initially think negatively of the encounter with an acquaintance, but may learn to realize that her thoughts are just that: thoughts, which may or may not be true. Thoughts do not force a person to behave in one way or another; they are simply a process of thinking. By recognizing this, the patient can learn to make a conscious choice to act differently in spite of her thoughts and to not let her negative thinking support depressed behavior.

The combination of CBT through psychotherapy and the appropriate kind of medication for the patient’s condition can successfully treat and manage symptoms of depression, whether it is caused by major depressive disorder or if it is related to bipolar disorder. It is important to remember that women may experience times of relief from depressive symptoms as well as greater instances of depressive episodes, which may depend on environmental stressors and significant life changes. For example, a female patient may be able to control her depression symptoms through a combination of CBT and medication quite successfully until she experiences a significant life change, such as the death of a parent or retirement from her job. When this occurs, the patient may need to restart therapy if it was successfully put on hold or she may need to change how her treatment is delivered so that it is flexible with her current situation.
Although depression can be extremely debilitating for women who are diagnosed on the spectrum of bipolar disorder, there is hope for treatment and for normal outcomes through medication and psychotherapy. The benefit of considering bipolar disorder as a spectrum is that women who suffer from depressive episodes and who may respond poorly to certain types of medications or treatments may still be given diagnoses that provide appropriate treatment. The more experience that providers have with clinical states of depression because of bipolar disorder, the greater the chances of appropriate and effective treatment for women who struggle in these areas.

**Impulse Control Disorders**

Impulse control disorders are those that affect a person’s ability to function normally within social or occupational situations because of their behavior. They are characterized by the inability to control impulses that lead to behaviors that can be harmful to the affected person or to others. The most common impulse control disorders include pathological gambling, kleptomania, pyromania, intermittent explosive disorder, and trichotillomania, which is the overwhelming impulse to pull out one’s own hair. Other kinds of impulse control disorders may include compulsive shopping, compulsive sexual behavior, and pathological skin picking.

Impulsive disorders are characterized by difficulty with controlling behavior, such that the affected person feels almost no ability to stop or an ability to manage the behavior. Prior to the impulsive action, the patient may start with a craving for the activity and then engages in the activity without being able to stop. The person typically knows that the behavior is problematic and may even try to stop or control it but is unable to. Most people who engage in the impulsive behavior feel a sense of pleasure at the time, but this may wane after the experience is over. As an example, a woman who struggles with compulsive spending may have a craving or strong desire to spend
money and experience a time spent in stores, shopping and spending money, and she may impulsively leave work or home to go shopping. She spends money on items that she may or may not need but decides in the moment that they are necessary to buy. She may have had enough episodes of impulsive buying that she has poor credit and little money and may have amassed a large amount of debt, but she continues to spend because she cannot stop. She may feel great pleasure while shopping and making purchases, but after the experience is over, she may feel down or guilty.

Women with bipolar disorder may struggle with impulsivity and may develop some of the problems associated with diagnosed impulse control disorders. A manic episode can lead to periods of impulsive behavior, in which the affected patient demonstrates little to no control over her actions without regard to the consequences. The patient with bipolar disorder and impulse control problems may exhibit poor decision-making, a negative response to unplanned changes in the environment, and she may make quick decisions without forethought. The impulsive characteristics are most often demonstrated during the manic phase of bipolar disorder.\textsuperscript{15}

Obviously, impulse control disorders can have disastrous effects and can cause problems with relationships, job function, and self-esteem. Impulsive gambling and buying can cause loss of money or a job and can lead to credit problems and debt. Kleptomania often results in hoarding of items but the person may keep stolen items for a time and then throw them away, as most stealing associated with kleptomania is for unnecessary items. Kleptomania can lead to arrest and jail time as well if the person is caught stealing. Pyromania is a considerably more dangerous disorder that, if left uncontrolled, can cause significant damage, injury, and death because of the urge to set fires.
Women who engage in pathological skin picking or who have trichotillomania can develop long-term skin and tissue damage, as well as hair loss. People who have these conditions have noticeable effects. Skin picking can cause infections or scarring; the patient who engages in compulsive skin picking may need treatment for injury imposed by the condition and is often embarrassed of the situation. Hair loss associated with trichotillomania is also often embarrassing for the affected patient. It results in noticeable hair loss, patches of baldness, and scalp damage, and has been known to affect relationships and job stability. Finally, women who struggle with intermittent explosive disorder can put their partners and loved ones at risk from harm because of their aggression. The condition also leads to destruction of property and severe stress and stress on relationships.

The amount of impulsivity exhibited by a patient with bipolar disorder is often affected by whether she takes medication for treatment of her disorder. Antipsychotic medications used to treat bipolar illness may affect impulsive behavior and can lead to greater demonstration of self-control. There are currently no FDA-approved antipsychotic medications for the management of impulse control disorders, but those who take antipsychotic medications for bipolar disorder may exhibit fewer problems with impulsivity. A study by Reddy, et al., in the journal *Neuropsychopharmacology* showed that patients with bipolar disorder who took antipsychotic medications were more averse to risk taking and impulsive behaviors when compared to those who did not take these drugs. Most of the patients involved were taking second-generation antipsychotics that affect dopamine and serotonin levels.
It is thought that impulse control disorders are caused in part by altered levels of neurotransmitters in the brain. Those neurotransmitters related to impulse control and risk-taking includes dopamine and serotonin. It would seem that control of risk-taking behavior and impulsivity associated with bipolar disorder and impulse control disorders should be well managed when a patient takes an antipsychotic medication or antidepressant drug to control neurotransmitter levels. However, studies continue to monitor these outcomes and not all patients are helped by utilizing these drugs to control their impulsivity. Antidepressant drugs, namely selective serotonin reuptake inhibitors, which work to reduce impulsivity and potentially reckless behavior, help some patients with impulse control disorders. A patient who has bipolar disorder may have difficulties with taking these medications because antidepressant use for bipolar disorder has been associated with a switch to manic episodes. Although there is much information available about the benefits and disadvantages of using certain types of medications to control both impulsivity and bipolar disorder symptoms, providers must carefully consider the unique aspects of the patient’s condition and her response to medical intervention when prescribing medications for management of both of these conditions.

The combination of an impulse control disorder and symptoms of bipolar disorder can have disastrous results for the affected patient. The patient may respond to appropriate treatment when it is delivered in a manner that considers both the importance of medication administration and the results of psychotherapy on managing both of these types of conditions and helping the patient achieve greater control over her emotions and actions.

**Substance Use Disorders**
Substance use disorders are one of the most common comorbidities occurring with bipolar disorder. The term dual diagnosis refers to a co-occurring mental illness and substance use disorder. By referring to bipolar disorder and substance use disorders as comorbid conditions, it is understood that the two conditions are independent conditions. Although they may affect each other, one condition did not necessarily cause the other, however, the rates of these two conditions seen together often lead people to believe that they have a cause-and-effect relationship.

Bipolar disorder and substance use disorders can perpetuate symptoms and could potentially worsen the course of the other illness. They should be treated together or at least with consideration of each condition when the patient undergoes treatment. There are many reasons why individuals affected by bipolar disorder develop substance use disorders. Self-medication, the effects of age or gender, and neurochemical availability have all been shown to play a role and continue to be researched for further data to support this connection.

A woman with bipolar disorder may use drugs or alcohol as a coping mechanism or form of self-medication. Self-medication refers to a person’s use of substances, whether legal or illicit substances, to resolve some symptoms. It is termed self-medication in that the use of the substance is not necessarily appropriate for the condition being managed. The person typically also does not include a healthcare provider in the decision to self-medicate and may use the substances with little control or guidance as to how much or how often; instead, they are used as a response to symptoms and negative feelings related to the illness. The harm of substance use can be multiplied with the effects of bipolar disorder.
Women who experience bipolar disorder already struggle with emotional and behavioral instability during times of manic or depressive episodes. The thoughts and feelings that develop during these trying times can lead a person to use drugs or alcohol as a coping mechanism. Occasional use may not be problematic and the person may feel that these substances provide a break from the intensity of symptoms of bipolar disorder. However, alcohol and drug use are not solutions to bipolar disorder; despite the brief break in symptoms they may provide, the effects are short-term and can leave the person feeling worse when they later wear off. Furthermore, the primary symptoms of bipolar disorder also return, which can lead the person to again use drugs or alcohol to cope and thus create a cycle of inappropriate use that can lead to addiction.

While substance use associated with bipolar disorder tends to be more common among men when compared to women, there are many women who struggle with dual diagnosis as a result of substance use. Women who are in situations where it is more acceptable to use drugs or alcohol may be more likely to develop substance use disorders. If a woman with bipolar disorder has many friends and associates who use drugs or alcohol and has relatively easy access to these substances, she is more likely to use them, and to use them more often, as part of response to her illness.

The effects of gender must be considered on diagnosis and treatment of women with co-occurring substance use and mental health issues. There are many types of treatment centers and rehabilitation facilities that offer counseling and help for those struggling with a substance use disorder, but most are not specific to treating both bipolar disorder and substance use at the same time. More locations are increasingly recognizing the need to combine treatment for specific mental illnesses with substance use disorder
treatment. Gender-specific treatment further recognizes the unique needs of female patients and then strives to provide services that would best treat illness in these patients. This may mean separating men and women into units or floors to where all patients within a certain area are either male or female. Groups and counseling sessions may be composed of all female patients and a woman receiving treatment may be paired only with a female counselor or therapist.

Additionally, when a woman has co-occurring substance use disorder and bipolar disorder, treatment should be delivered in the form of integrated treatment, which takes into consideration how substance use and bipolar disorder affect each other. Regardless of whether the patient was first diagnosed with bipolar disorder and then developed problems with substance use or if it was the other way around, integrated treatment considers the unique needs of this special population of patients who may be struggling considerably with controlling their moods and with battling addiction.

Some forms of treatment for co-occurring bipolar and substance use include 12-step programs, which may address only the substance use but may also integrate the patient into a group that allows her to meet others of similar backgrounds; inpatient treatment provided within a facility that recognizes the importance of substance use and mental illness treatment, work with an interdisciplinary team of providers from different professional backgrounds who may impart their knowledge into the patient’s plan of care, and individual psychotherapy that may use principles of cognitive-behavior therapy or dialectical behavior therapy to help the patient to work through her thoughts and feelings.
When compared to men, women are more likely to develop adverse outcomes of drug and alcohol use more quickly.¹⁸ This means that it does not take as much use of a substance for a woman to become addicted and she may develop dependence to the substance over a shorter period of time when compared to a man using the same substance. Women are also less likely to seek treatment for substance use when compared to men because of the stigma of female substance use; unfortunately, it seems less acceptable for women to use drugs or alcohol when compared to men.

Neurochemistry and neurotransmitter levels also play a role in bipolar and substance use developments. People with bipolar disorder have altered levels of certain neurotransmitters in the brain, including serotonin, norepinephrine, and dopamine. These neurotransmitters have significant effects on a person’s ability to manage her mood and emotions. When a person with bipolar disorder then uses drugs or alcohol, the brain has more difficulty processing and regulating neurotransmitter levels, causing even further loss of control.

*Alcohol Use Disorder*

Alcohol use disorder (AUD) describes problem drinking to the point that the person is unable to control alcohol consumption. Approximately 5.7 million women over age 18 struggled with an AUD in 2012.¹² An AUD may be classified as being mild, moderate, or severe, and occurs when a person has a number of factors in place that signify problem drinking. The person may drink more alcohol than intended or may try to cut back on using alcohol without success; the affected person may also continue to drink alcohol despite the problems drinking has caused with relationships between family and friends. Other diagnostic criteria for an AUD include a craving for
alcohol, increased tolerance to the effects of alcohol, and the presence of physical symptoms when stopping use.

Alcohol use disorder is a common comorbidity associated with bipolar disorder. The exact reason for this commonality is still under investigation; however, some clinicians suggest that bipolar disorder symptoms may be more likely to develop during alcohol use or during withdrawal. The person with bipolar disorder may have relative control over her mood except when using alcohol or overcoming its effects, during which time the patient is more likely to experience rapid mood swings and erratic behavior. Alternatively, alcohol is relatively easy to access because it is legal for those over age 21 and can be inexpensive. The patient with bipolar disorder may turn to alcohol as a quick, short-term solution to mood instability.

An alcohol use disorder can worsen the prognosis of bipolar disorder and can significantly complicate treatment. Women with AUDs may be more likely to require hospitalization for management of mood symptoms; they are also more likely to experience rapid cycling of bipolar disorder symptoms and may be diagnosed with bipolar disorder at an earlier age.\textsuperscript{20} Alcohol use is also associated with a worse treatment response, increased depressive symptoms, increased risk of suicide, and poor overall outcome.\textsuperscript{22} The impact of this type of substance use cannot be overestimated among women who struggle with bipolar disorder.

\textit{Tobacco Use Disorder}

Up to 80 percent of people with bipolar disorder use nicotine by smoking cigarettes.\textsuperscript{22} The negative effects of tobacco smoking are well documented and certainly, many people who do smoke are well aware of the hazards placed on their health because of long-standing media coverage and
continued education about its health effects. Tobacco use disorder involves level of severity tobacco use and addiction to nicotine in that the affected individual craves this substance and experiences physical feelings of withdrawal when it is taken away. Among women, tobacco use is most commonly through smoking cigarettes, although some women will use tobacco in other methods, such as through chewing tobacco or pipes.

Tobacco use is associated with increased risks of various types of cancer, as well as risk of chronic lung disease, heart disease, and stroke. These risks are present whether the patient has a co-occurring diagnosis of bipolar disorder or not. The difficulties that bipolar disorder present with tobacco use involve attempts at quitting, in that it can be extremely difficult for a patient with bipolar disorder to successfully quit smoking. An average person without a mental illness who smokes cigarettes may have a very difficult time permanently quitting tobacco use; the patient with bipolar disorder may struggle even more.

It is theorized that the reasons for the very high co-occurrence of tobacco abuse and bipolar disorder are similar to those hypotheses for the connection between bipolar disorder and alcohol abuse disorders. The patient with bipolar disorder may turn to tobacco as a form of self-medication or to feel calm or relaxed when she is otherwise irritable. Nicotine stimulates the release of certain neurotransmitters and may help a depressed person to feel better by positively impacting mood and producing good feelings. In essence, the self-medication hypothesis for tobacco use is to turn to smoking when struggling with depression, as the nicotine in the cigarette may change and soothe the person’s emotions.
A person who starts smoking cigarettes typically does so in her teens; a majority of people who currently smoke started during the adolescent or young adult years. Early onset of tobacco use is another contributing factor to the connection between its use and bipolar disorder. Because bipolar disorder is also often diagnosed during adolescence or young adulthood, the connection between tobacco use and bipolar disorder may be further cemented. Studies have shown that adolescents with bipolar disorder are more likely to start smoking cigarettes during their teen years when compared to adolescents who do not have a mental illness.  

Finally, although regular smoking is a type of addiction, smoking may be much more common in certain environments. The person with bipolar disorder who has a tobacco use disorder may be faced with larger numbers of people who are all smoking, making it very difficult to quit. Cigarettes are legal for those over age 18 in most states and can be purchased in most grocery and convenience stores. In some situations, even within treatment centers for other forms of substance use, smoking may be the one vice that is still allowed among patients. For instance, a patient at a psychiatric treatment center may be allowed to go outside to smoke with others at certain times of the day. The person who is working to overcome and manage other types of mental illness may still be allowed to continue to smoke, particularly when staff members or family members are also smoking.

Women who smoke are not only at greater risk of physical illnesses associated with the habit, but they can also put others at risk that live or work around them. A woman who cares for children and who smokes in front of them exposes them to secondhand smoke, which is just as damaging to the body with regular exposure. A woman who is trying to get pregnant and who smokes may have a harder time achieving and maintaining a
pregnancy. When she does become pregnant, a woman who smokes is at higher risk of having a baby who is small for gestational age and developing other problems associated with the pregnancy, such as miscarriage or severe hemorrhage.

It is important to consider that tobacco use must be managed and treated as part of providing treatment for bipolar disorder. The negative consequences associated with smoking are too great to allow patients with bipolar disorder to continue to smoke while they work on their mental health treatments. Patients with bipolar disorder can and should integrate smoking cessation therapy as part of management of bipolar disorder.

**Prescription and Illicit Drug Use**

Women with bipolar disorder are not only at higher risk of alcohol or tobacco use disorders, but they are also more likely to develop substance use disorders with illicit or prescription drugs. A patient with a history of drug use and bipolar disorder is at greater risk of complications developing during treatment, increased numbers of manic or depressive episodes, higher rates of suicide, and poor general recovery.\(^{22}\) Drug use, whether through illicit drugs or improper use of prescription medications, is associated with a greater propensity for alcohol and tobacco use, and the patient who presents with co-occurring bipolar disorder and substance use disorder may need treatment for the use of several types of substances.

The reasons for increased numbers of patients with co-occurring drug use disorders and bipolar disorder are similar to those thought to support the connection between bipolar disorder and alcohol or tobacco use. Illicit drugs may not be as accessible for many patients and they may be more costly; however, there are still many patients who find that the effects of certain
types of drugs can help with the confusing and tiring symptoms of bipolar disorder.

Bipolar disorder symptoms, most often during the manic or hypomaniac stages, are often impulsive in nature and the affected person may engage in risk-taking behavior, such as using certain kinds of drugs. The bipolar patient may also spend an inordinate amount of time seeking those activities that will derive the most pleasure, and may be able to achieve this, albeit temporarily, with drug use.

As with tobacco abuse, there is a high proportion of individuals who are addicted to drugs and who started using illicit drugs during adolescence. Approximately one-third of people who have comorbid bipolar disorder and substance use say they started using drugs before their diagnosis of bipolar disorder. This would then demonstrate that drug use in these individuals is not necessarily caused by bipolar symptoms; however, some people who continue to use drugs after their bipolar disorder diagnosis may continue to seek “the high” they get from drugs to deal with symptoms of mania or depression. Those who have started using illicit drugs after being diagnosed with bipolar disorder may use drugs for self-medication. However, this does not necessarily explain why some patients use stimulants when they feel manic or if they use drugs that are central nervous system depressants even though they are experiencing depression.

There continues to be ongoing debate as to the distinct connection of why patients with bipolar disorder are more likely to use drugs. Although self-medication is a relatively common reason as to why many people with bipolar disorder use drugs or alcohol, it does not account for the true reason in every case. A woman who struggles with bipolar disorder may turn to alcohol or drugs to get away from some of the negative feelings she is
experiencing, but because of the effects of these substances on brain chemistry, she may be more likely to struggle even after the drug or the alcohol has worn off. Some patients with bipolar disorder feel a great desire or unconscious need to stabilize their moods, often this is because their other attempts at control have not been successful, so they may turn to drugs or alcohol. Despite causing the opposite effects after the drug has worn off, many people continue to try and achieve some fleeting relief from symptoms through substance use.

The effects of substance use can be devastating for a patient with bipolar disorder. Substance use is very difficult to control when a woman does not make extensive changes in her lifestyle and does not develop coping skills to face the challenges of bipolar disorder. A comprehensive treatment program is necessary. The program should consider the comorbidity of substance use and bipolar disorder, and it is best if the program meets the gender-specific needs of the female patient.

**Eating Disorders**

Bipolar disorder and eating disorders are co-occurring conditions that often happen together, yet there is limited research available about the connections between these two types of conditions as well as their specific treatments. Unfortunately, because of the lack of research in this complex topic, patients with comorbid bipolar disorder and eating disorders may not receive the appropriate treatment and their quality of life can be significantly diminished.

Approximately 14 percent of patients with bipolar disorder also struggle with some sort of eating disorder; moreover, women with bipolar disorder are at an increased risk of developing some type of eating disorder. If they do
develop one of these conditions, they also tend to have a more difficult clinical course and a harder time recovering. Eating disorders tend to occur in women more often than in men. The reasons for this may include the effects of the media and society and their focus on appearance, as well as underlying self-esteem issues that may cause a woman to struggle with her weight and what she looks like.

An eating disorder is an abnormal pattern of eating that is based on a psychological condition. Eating disorders are typically classified as either anorexia nervosa, bulimia nervosa, or binge eating disorder (BED). Each may be associated with at least one psychological condition that affects mental health, including bipolar disorder but also other forms of anxiety disorders, depression, and substance use. Eating disorders carry a high rate of mortality when they are not controlled and treated properly.

**Anorexia Nervosa**

Anorexia nervosa is a lack of eating due to a complete focus on weight and fear of being overweight. A person with anorexia may see herself as overweight even when she is not. She may restrict food to a few calories per day in an obsession to limit putting on weight or she may otherwise control her food intake by only eating very small portions of certain kinds of foods. A patient with anorexia nervosa may also demonstrate other behaviors that support her obsession with weight, including weighing or measuring herself multiple times a day and portioning out foods by measuring very small quantities of foods to eat.

Anorexia nervosa can cause severe health consequences if the condition is left unmanaged. In addition to the extreme weight loss, accompanied by an unnaturally thin appearance, bones jutting out from under the skin, thinning
hair, and sallow skin, the patient may also develop harmful health consequences that cause a medical illness. Other complications of anorexia nervosa may include osteoporosis and frequent fractures, menstrual irregularities, constipation, anemia, heart dysfunction, and infertility. The person may suffer from extreme exhaustion and becomes so malnourished that she has little energy. If left uncontrolled, anorexia may lead to death from organ failure.27

Bipolar disorder has been identified as a relatively rare comorbid condition associated with anorexia nervosa; bipolar disorder is often more closely related to bulimia and binge eating disorder and their behaviors.31 Nevertheless, some women do struggle with comorbid bipolar disorder and anorexia nervosa and exhibit significant issues with anxiety, fear, and self-control. Because anorexia is more commonly affiliated with anxious states and has been associated with such conditions as generalized anxiety disorder, panic disorder, obsessive-compulsive disorder, and post-traumatic stress disorder, the patient with bipolar disorder and anorexia nervosa may be at greater risk of exhibiting eating disordered behaviors during depressive episodes when anxiety could be more likely. Anorexia nervosa is manifested as an extreme desire for control of body weight, size, and food portions, but bipolar disorder may or may not manifest as periods of time in which the patient has an extreme need for control. This is not to say that a patient cannot have co-occurring bipolar disorder and anorexia nervosa, but there may be other comorbid conditions present as well.

A patient with anorexia nervosa and bipolar disorder may exhibit eating disordered behavior during the manic phase of the illness as well. This could be evidenced by an unnatural focus on food and calorie intake, significant amounts of time spent weighing and measuring food, and distorted focus on
recipes or specific types of food. Some anorexic patients exercise excessively in addition to restricting their calorie intake. Prolonged exercise may also take place during the manic phase, particularly if the patient requires less sleep and becomes focused on goal-directed activity, in this case, excessive exercise with the goal to burn calories and lose weight.

Additionally, some patients with eating disorders may cycle between bulimia and anorexia. They may spend some time on a binge-purge cycle where they take in extra calories and then purge through self-induced vomiting; they may then switch to anorexic behaviors, including self-starvation and prolonged exercise. The switch back and forth between the two types of eating disorders is somewhat similar to switching between mania and depression during bipolar disorder. When this occurs, eating disordered behavior may parallel the back and forth of behaviors seen with bipolar disorder.

Treatment of co-occurring bipolar disorder and anorexia can be a challenge. Medications used to treat one condition may trigger symptoms of the other condition. Some antipsychotic medications that are commonly prescribed for the treatment of bipolar disorder could actually increase binge eating. The prescribing provider must consider the effects of the medications to control moods as well as psychotherapy, which may help to control not only the rapid switches in behavior but also better control of eating to avoid excessive self-deprivation and starvation associated with anorexia nervosa.

*Bulimia Nervosa*

Another type of eating disorder that also causes an unnatural focus on food and weight, bulimia is seen among people who continue to eat food but who also try to avoid the calories and weight gain from their food intake. The
person with bulimia does not necessarily practice self-starvation, but instead may eat large quantities of food and then find a way to get the food out of the body. In this way, the individual is able to still have the pleasure of eating, but may be overcome with guilt or fear of gaining weight, and so she purges to try to avoid using the calories and gaining weight. Purging may involve a number of activities that rid the body of the food or the calories from the food; it can include self-induced vomiting, excessive laxative use, excessive exercise following a meal, fasting for a period after eating, or any combination of these activities.

Bulimia is more of a hidden epidemic when compared to anorexia, in that the person with bulimia often has a normal or slightly elevated weight. When eating, the bulimic person may take in thousands of calories in one sitting, which can cause feelings of pleasure and satisfaction during the binge. Afterward, the patient may feel guilty for eating so much or may fear the effects of the intake of so many calories, so she then purges her body of the food. The purging behaviors may cause the person to feel intense shame; her focus on weight and appearance lead her to act in behaviors that can be upsetting to others as she tries to control her weight. As a result, she often purges in secret, such that others do not necessarily know that she even has a problem until harmful complications develop.

Because the body is not meant to go through such extreme measures of purging food and calories at the pace that is kept with bulimia, the effects can be quite harmful. The person with bulimia can develop tooth enamel erosion and damage to the esophagus and throat with repeated self-induced vomiting. The teeth may become eroded to the point that they break down more quickly after chronic exposure to stomach acid and the person may have tooth pain and caries. The neck and the back of the throat can become
swollen and inflamed, and the individual may have a chronic sore throat. The excessive vomiting also causes damage to the lower esophageal sphincter over time, and the patient may have damage to the esophagus and chronic reflux.

Excessive laxative use also damages the large intestine; in the short term, it can cause electrolyte imbalance and increase the risk of dehydration, while long-term laxative use can lead to constipation or other difficulties in passing stool. Laxative use in a person who is not constipated typically causes diarrhea, and the person may lose excessive water and electrolytes, leading to dehydration and electrolyte imbalance. Some of the alterations in electrolytes can be very dangerous, such as if the patient loses too much potassium or calcium, which could lead to life-threatening heart arrhythmias. Over time, the overuse of laxatives may actually inhibit the person’s ability to feel the need to pass stool because of damage to the nerves serving the large intestine. The person may develop chronic constipation after a long period of time.

Bulimia is associated with a number of mental health conditions, including bipolar disorder, attention deficit hyperactivity disorder (ADHD), substance use disorder, and anxiety disorders. The typical onset of bulimia is during late adolescence or early adulthood, similar to the average timeframe when a person is diagnosed with bipolar disorder. Bulimia may precede a bipolar diagnosis; alternatively, there are some patients who struggle with bulimia after being diagnosed with and experiencing symptoms of bipolar disorder.

The development of bulimia is related to environmental and genetic factors, which is similar to development of some other types of mental health conditions. Some people may be more likely to develop bulimia after
experiencing traumatic stress or because they have developed a low self-esteem or feelings of guilt or shame. Episodes of binging and purging may often take place during the depressive episode of bipolar disorder. Treatment parameters for combined management of bipolar disorder and bulimia nervosa may be somewhat trial and error. There is limited evidence and availability of guidelines about the best method of approaching care of female patients with co-existing bipolar illness and bulimia nervosa; however, providers often stick with a routine of combined medication for management of bipolar symptoms and psychotherapy for support for mood changes.

Medications may be prescribed as part of treatment for bulimia, which may help to reduce the patient’s urges to enter the binge-purge cycle. The most common medications prescribed for bulimia without co-existing bipolar illness are antidepressants. The U. S. Food and Drug Administration (FDA) has approved the use of fluoxetine (Prozac®) for treatment of bulimia; however, use of antidepressant in patients with bipolar disorder is somewhat controversial because of the potential for causing hypomanic symptoms. Antidepressants may be an option for some patients with both comorbidities, but should be considered more based on the patient’s psychiatric history and response to other forms of treatment.

A case study in the journal *Innovations in Clinical Neuroscience* reviewed a case of a woman who struggled with bulimia nervosa, bipolar disorder type I, ADHD, and substance use. The providers in the case were trying to find a way to manage this woman’s symptoms of affective mood episodes while also reducing her eating disorder behaviors. They were able to help her remit cycles of bingeing and purging, as well as symptoms of bipolar disorder and ADHD with the use of a combination of quetiapine, an atypical
antipsychotic, and lamotrigine, an anticonvulsant, as well as methylphenidate, a stimulant commonly used in the management of ADHD. The combination of the medications seemed to help the patient the most by not only controlling her moods associated with bipolar disorder, but also resolution of the bulimia. The clinicians believed that the methylphenidate was mostly responsible for causing a 12-month period where the patient did not practice bingeing or purging, when she had otherwise been practicing these habits for well over 10 years.

Bulimia has been thought to develop, in part, due to dysregulation of neurotransmitters in the brain, mainly dopamine and serotonin. Methylphenidate acts as a norepinephrine and dopamine reuptake inhibitor, which can increase levels of dopamine in the brain. In this particular case study, the clinicians hypothesized that use of methylphenidate could help with regulation of dopamine to the point that it could reduce bulimic activities. Use of stimulants has also been successful in regulating behaviors associated with binge eating disorder, even though this type of drug is not routinely prescribed as a first line of treatment, nor does the FDA approve it for these purposes. However, it could be an option to consider, when combined with other medications, as well as psychotherapy, when managing the complex symptoms associated with comorbid bipolar disorder and bulimia nervosa.

**Binge Eating Disorder**

Binge eating disorder (BED) is the intake of extreme amounts of food in a short period of time. It is similar to bulimia in some ways, except that the affected person usually does not try to purge the body of the food and calories. Binge eating disorder often leads to overweight and obesity, often because the person may consume thousands of calories in one eating
occasion when binging on food. The condition may be considered a type of compulsive overeating that is difficult to control. The affected patient may not be hungry at all when starting to eat and can consume huge amounts of food, often in one sitting. While binging, the person may eat very quickly without necessarily recognizing what she is eating. She may continue to eat until she feels full, has no further desire for food, or until she runs out of food. Afterward, the individual feels extremely full and uncomfortable.

Binge eating disorder tends to follow a cyclical pattern, in that the affected patient may go for periods of normal eating and consuming regular meals and normal-sized portions of food. The underlying theme of the condition seems to be associated with low self-esteem, self-loathing, and feelings of being out of control. A person may start to develop a desire to binge eat after a negative experience that reinforces her feelings of self-disgust or she may start to feel significant stress and chooses to relieve some of her feelings by eating. After a period of compulsive eating, the person with BED then may feel intense guilt and she may experience further feelings of self-disgust, self-hatred, and despair. Because the person typically does not try to purge the body of the food she takes in, she often gains weight because of the excess calories, which may only further support her self-loathing.

Binge eating disorder carries long-term effects associated with increased weight and obesity. In addition to the psychological effects of the condition’s cycle, the person may gain a large amount of weight over a short period of time and may suffer from gastrointestinal problems, joint pain, and gallstones. Further, the increased weight places the person at higher risk of certain types of cancer, diabetes, and heart disease.
When coinciding with a bipolar diagnosis, binge eating may occur more often when a bipolar patient is experiencing episodes of her illness. Patients with bipolar disorder may be overweight or obese, but if a patient is obese that does not necessarily mean she has BED. However, studies have shown that those patients with bipolar disorder who also have BED are more likely to suffer from other mental health issues, including anxiety disorders, substance use, and suicidal ideation.\(^{28}\) Those with co-existing bipolar disorder and BED are considered to be more seriously ill when compared to managing illness in those with bipolar disorder without a co-occurring eating disorder. Binge eating disorder complicates the treatment of a patient with bipolar disorder because the provider must not only manage both the types of episodes experienced from bipolar disorder, but also the underlying cause of the binge eating episodes.

Binge eating can be an emotional event for some women. Those who have concurrent bipolar disorder may be more likely to binge eat when they are also experiencing symptoms of bipolar disorder, either during depression or mania. The depression associated with bipolar disorder can lead to increased or decreased appetite, which could signal a binge. Additionally, a patient may binge eat because of the fear, self-loathing, sadness, or hopelessness encountered during a depressive episode. For example, a patient with co-existing bipolar disorder and BED may enter a depressive episode and may feel extremely sad and unmotivated. She may have a binge of food, which feels good for a few moments while eating, but then leads to further feelings of guilt. If the person has tried to control her binge eating in the past but then succumbed to the latest binge, she may feel hopeless about her chance to change and may feel further depressed. Patients may more likely present for treatment of BED based on their concerns about their weight, rather than concerns about anxiety, depression,
or mania. Among bipolar patients, BED may be seen more often with those diagnosed with bipolar II disorder, as depression and cycling mood tends to be more prominent among this group. Binge eating behavior can and does occur during times of hypomania and mania, which complicates treatment in that bipolar disorder must be well controlled to try to control the binge eating behavior. In other words, although binge eating more commonly takes place during times of depression, treating only the depression and anxiety in a person with co-occurring bipolar disorder and BED will not resolve the issue. The clinician must consider and treat the effects of BED if the person is having binge eating episodes during manic periods as well.

Binge eating disorder is thought to be associated with changes in neurotransmitter levels, including dopamine and serotonin. People who are obese and who have BED have been shown to have lower levels of dopamine receptors when compared to their normal-weight counterparts. Development of BED also occurs more often in situations that provide environmental support, such as under conditions where there is more food available and with exposure to a parent with depression or obesity.

Concurrent BED and bipolar disorder seem to be best treated with a combination of medication and psychotherapy. The clinician may need to focus the goal of treatment on management of bipolar episodes; however, it is important to keep some focus on BED treatment as well. If a patient is struggling more with episodes of binge eating during acute bipolar affective episodes, initial treatment should focus on control of manic and depressive symptoms. Additionally, further psychotherapy should involve tackling the underlying cause of the binge eating behavior, and may include counseling or therapy designed to manage a patient’s fears, low self-esteem, or other issues that are causing her to turn to food and binge eating.
With control of binge eating behavior, the patient may or may not lose weight, although some research has shown that CBT may be useful in considering the behaviors that contribute to weight gain and that prevent weight loss. Binge eating disorder that occurs alone without co-existing bipolar disorder may be treated with antidepressants; however, these drugs would need to be used with caution among patients with bipolar disorder to avoid a possible switch into manic behavior because of their use.

Persons with eating disorders often require treatment through hospitalization or specialized rehabilitation centers that help them to focus on their issues that could be causing abnormal eating patterns. When a woman has a co-existing diagnosis of bipolar disorder, this mental illness must be considered in light of treatment for the eating disorder. If the bipolar disorder is also causing manic or depressive symptoms or otherwise seriously impacting the patient’s quality of life and is affected by her eating habits, treatment through a program that simultaneously addresses the symptoms of both conditions is ideal.

**Personality Disorders**

The term “personality disorder” tends to signify that a person has something wrong with herself and her personhood, but a personality disorder is actually a psychiatric diagnosis that describes a pattern of behavior and relating to society. It most often includes difficulties with social settings and interpersonal relationships because of the affected person’s maladaptive behaviors, which often prevent meaningful and lasting relationships with others. A person who has a personality disorder tends to exhibit abnormal behavior that is characterized by unusual emotional responses to everyday...
occurrences, problems with impulse control, and difficulties with maintaining relationships. The affected person may also have abnormal patterns of thinking that are not necessarily based on reality. Diagnosis of a personality disorder occurs in adults, as the person must have demonstrated these defining characteristics over the course of time. Children are developmentally changing with growth and do not typically sustain these abnormal behaviors for a long enough period to be diagnosed.

Diagnosis of a personality disorder is often distressing to the person involved. In reality, the person’s symptoms and behaviors are typically the distressing and tension-causing aspects of a personality disorder. A woman diagnosed with a personality disorder is often aware of her characteristics and her personality, as well as how she relates to others. She may feel flawed as a person after receiving this type of diagnosis, not only because of the implications associated with the title, but also because of her patterns of relating with others. In other words, most people know when they do not relate well with others or if they have trouble getting along or socializing. A diagnosis of a personality disorder may further solidify negative feelings that already cause the affected person to feel troubled.

There are actually ten diagnosable personality disorders, which are further classified according to clusters because of their resemblances to each other in their symptoms and behavior. Cluster A consists is considered the “eccentric” cluster, and includes schizotypal, schizoid, and paranoid personality disorders. Cluster B includes the dramatic and emotional personality disorders, such as narcissistic, antisocial, histrionic, and borderline personality disorders. Cluster C is the anxious or fearful cluster of disorders and includes avoidant, dependent, and obsessive-compulsive personality disorders.
The comorbidity of personality disorders with bipolar disorder is relatively common. The effects of comorbid personality disorder can significantly impact the treatment for bipolar disorder. People with co-existing diagnoses of a personality disorder and bipolar disorder may be less likely to respond to treatment or to continue with treatment for long-term periods, they have increased rates of substance use, require longer terms of hospitalization when needed, and have more severe residual mood symptoms.\(^{41}\)

**Cluster A**

There is little information or research available about bipolar disorder and comorbid personality disorders in cluster A. This cluster of personality disorders is characterized by odd, eccentric, and suspicious behavior. The person may be mistrusting of others and paranoid, assuming that others are talking about her or that they do not like her. She may spend inordinate amounts of time trying to find evidence to back this theory. The patient often suffers in her relationships with others because she is untrusting and may question everything; she is typically isolated and seen by others as being aloof and judgmental, however this may not bother her at all.\(^{43}\)

Cluster A personality disorders, despite their bizarre and paranoid behaviors, are usually not given to delusions or an inability to connect with reality. They are typically not comorbid with bipolar disorder and instead may be more commonly associated with other types of personality disorders in the different clusters, as well as schizophrenia. The difference between schizophrenia and cluster A personality disorders is that a person with schizophrenia is typically delusional and is not based in reality; this cannot be said of patients with cluster A personality disorders, despite their demonstration of bizarre behaviors. Cluster A personality disorders may be
more commonly seen in a patient with bipolar disorder if there is evidence of psychosis during manic periods or the patient exhibits characteristic behaviors of paranoia and odd or eccentric behaviors, such as being suspicious of others and of spending time talking to oneself.

Behaviors associated with cluster A personality disorders can make diagnosis and treatment of bipolar disorder very difficult. The patient may have residual mood symptoms of bipolar illness and the behaviors and symptoms associated with the personality disorder may be difficult to separate from bipolar disorder symptoms. The diagnosing provider may have a difficult time determining what symptoms are associated with which disorder and it may be easier to manage bipolar disorder symptoms first and get the patient into a stable mood state before tackling the personality disorder. The patient who has mood symptoms of bipolar disorder under control with treatment of the condition may then reveal personality disorder symptoms.

Cluster B

Cluster B personality disorders are more commonly associated with bipolar disorder. Cluster B symptoms tend to affect a person’s ability to relate with others because of her emotions and affect; there may be a high degree of drama in the person with this type of personality disorder or she may exhibit more underhanded and manipulative behaviors.

Borderline personality disorder is commonly associated with bipolar disorder; some of the symptoms may overlap, making diagnosis difficult between the two conditions. The patient with borderline personality disorder may exhibit symptoms that characteristically occur during both periods of mania and depressive episodes of bipolar disorder. The person with borderline
personality disorder is characteristically unable to form close interpersonal relationships and can have rapid mood swings and changes in affect. She may have problems with impulse control and can be manipulative toward others. Borderline personality disorder is also associated with a high degree of self-harm such as through intentional self-mutilation as well as suicidal ideation.

A person diagnosed with borderline personality typically includes assessment of difficulties with interpersonal relationships, which stem from a rapid switch between affection and hatred for others: the affected person may love someone intensely one minute and shower them with affection, only to switch moods and become disgusted and hateful the next. Borderline personality disorder can also be associated with other comorbid states that may be further related to bipolar disorder, such as substance use disorders or other types of cluster B personality disorders.

It can be incredibly difficult for the clinician to distinguish behaviors associated with borderline personality disorder and those of bipolar disorder, especially because of the mood swings and similarities in behavior, particularly during manic episodes. Diagnosis of borderline personality disorder, however, involves assessment of symptoms that typically do not meet the criteria for diagnosis of mania or hypomania. The patient may have extreme behaviors of borderline personality disorder but may not exhibit them for the same periods or to the same extent as required for diagnosis of bipolar disorder. It is more commonly seen in women than in men, with a 2:1 female-to-male ratio. Most patients undergo treatment and are able to decrease their impulsivity, but complete treatment and resolution of symptoms is rare.
Antisocial personality disorder may be an extension of conduct disorder when a child or teen with the condition grows into an adult. Antisocial personality disorder is characterized by unlawful and hurtful behavior, such as stealing or physically hurting others, with a general disregard for their wellbeing and a lack of remorse. Antisocial personality disorder is more commonly seen in men, but some women present with this personality and they may be charming and engaging one minute but sneaky and manipulative the next. They may commit crimes, engage in promiscuous behavior, and develop substance use problems with little regard for these effects on anyone else. This personality disorder is the most difficult to successfully treat. Antisocial personality disorder can occur with bipolar disorder and it may be difficult to separate some of the antisocial behavior of this personality disorder if a patient engages in devious or hurtful behavior during manic periods of bipolar disorder.43

Histrionic and narcissistic personality disorders are somewhat similar in that they are both part of cluster B disorders and they both reveal a level of extreme self-involvement and emotionality in the patient. A person with histrionic personality is self-absorbed, overly concerned with physical appearance, and requires an almost constant need for attention. She is very focused on dress and appearance and may dress provocatively or in a method to garner attention from others. Narcissistic personality is also demonstrated by self-involvement in that the person has an extreme sense of self-importance and feelings of grandiosity, not unlike that which is demonstrated during times of mania with bipolar disorder. A person with narcissistic personality disorder may exploit others for their own self-purposes and they may only want to associate with people of importance or those of a particular social class or position.
These types of personality disorders are often comorbid with other personality disorders and may overlap in some symptoms; they are also associated with mood disorders, including severe depression and bipolar disorder. The person with comorbid conditions of narcissistic or histrionic personality disorders may display more symptoms during periods of mania, when episodes of grandiosity, inflated self-image, and goal-directed behavior are present. Alternatively, periods of depression associated with bipolar disorder can be difficult for the patient with these types of personality disorders. The depressive phase of bipolar illness may cause them to struggle with lack of motivation and overall sadness or hopelessness that are typically contrary to their personality characteristics and they may struggle with maintaining the façade of self-importance or ostentation that is otherwise present with these disorders.

**Cluster C**

Cluster C personality disorders are considered to be the fearful disorders, and are characterized by anxiety and depression. A person with avoidant personality disorder may try to isolate herself and avoid others to the extreme, often to avoid embarrassing herself in some way or being forced to have a conversation or interaction. Predictability and routine may be important because they are safe and familiar. The person often has a chronically low self-esteem and has difficulty accepting praise from others.

Dependent personality disorder results in demanding and clingy behavior toward others; the person with this type of disorder is submissive toward others to the extreme, even when others might be wrong. Consequently, this disorder is associated with a higher number of women suffering from abuse and intimate partner violence because of their desire to be loved and to have someone care for them despite being hurt. A person with dependent
personality disorder fears being left alone or not having friends; she needs assurance that she is okay through almost everything that she does.

Obsessive-compulsive personality disorder is associated with a high level of obsessive and perfectionist behavior. The affected person needs and desires rules and order and may pay attention to details so much that other tasks are never completed. Although obsessive-compulsive personality disorder may seem similar to obsessive-compulsive disorder because of the title, the two conditions are actually quite different. Both may be rooted in anxiety, but obsessive-compulsive disorder causes compulsions in behavior and obsessions in thought that may pervade many other common activities in life.

Treatment of most types of personality disorders is based on psychotherapeutic interventions. Depending on the type of personality disorder, the type of therapy delivered may vary. For instance, a person who has been diagnosed with schizoid personality disorder and concurrent bipolar disorder may not respond well to group therapy or family-based dynamics because she may not care what others think or it may not matter to her to build relationships with peers or loved ones. Alternatively, a person with histrionic personality disorder may work better in a group of others to see that she is not the only person struggling with symptoms, as long as the group dynamic does not give the patient a further opportunity for attention-seeking behavior.

Dialectical behavior therapy was originally developed for the management of borderline personality disorder but it can also be successfully used to treat other forms of personality disorders, including those with severe symptoms such as suicidal ideation. Dialectical behavior therapy consists of skills
training, in which a person works in a group to learn and demonstrate appropriate behavioral skills; individual counseling, in which the patient meets one-on-one with a counselor for psychotherapy in conjunction with the skills training; and phone coaching, which provides support between sessions. Dialectical behavior therapy is just one method that may be successful in supporting patient treatment. The time it takes to complete treatment and the duration of the meetings and sessions depends largely on the patient’s condition and the presence of comorbid conditions. Some patients respond very well to psychotherapeutic intervention and demonstrate behavior changes relatively quickly; alternatively, those who struggle with other conditions and who have ongoing and distressing symptoms might need much more time to respond.

Although patients with personality disorders often have personality disturbances that can be difficult to deal with during treatment, their needs are further complicated and often require even more intensive therapy with a co-occurring diagnosis of bipolar disorder. Treatment of both conditions may require a time of trial and error to determine which blend of strategies is most successful for these patients.

**Childhood Behavioral Disorders**

Although all children misbehave at times and may have trouble accepting limits imposed by adults, children and teens with behavioral disorders have continuing patterns of difficult behavior that may appear as hostile, hyperactive, impulsive, or aggressive in nature. These situations are not usually temporary and they are unrelated to specific, short-term circumstances. Instead, childhood behavioral disorders require thorough examination of the child’s behavior and consistent treatment after diagnosis.
to help the child or teen as she grows and to help prevent harmful consequences of neglecting treatment.

A woman who has been diagnosed with a childhood behavioral disorder, such as oppositional defiant disorder, conduct disorder, or attention-deficit hyperactivity disorder may continue to display symptoms even when she is no longer a child or adolescent. Some childhood behavior disorders can continue into adulthood and are often associated with other psychiatric conditions that create comorbidities within the same patient. For example, a person with ADHD is at higher risk of developing a mood disorder such as bipolar disorder when compared to someone who has not struggled with a behavior disorder of childhood.

Some childhood behavior conditions remain the same in adults but are manifested differently because the person has grown. Other conditions may transition into other, more serious conditions, such as certain types of personality disorders. The co-occurrence of bipolar disorder alongside a childhood behavioral disorder that has continued into adulthood can cause significant problems with relationships, occupational responsibilities, and family obligations; these two types of conditions together can also be very difficult to treat and to manage successfully over the long term.

**Oppositional Defiant Disorder**

Oppositional Defiant Disorder (ODD) develops during childhood or adolescence and is characterized by negative, angry behavior. A person with ODD often has problems with authority and may be spiteful toward adults and those in charge; the person also often argues with those in positions of authority and exhibits hostility, negativity, and verbal aggression. Although all children and adolescents have periods of disagreement and negative behavior, a person with ODD tends to exhibit angry and uncooperative
behavior almost all of the time. The behavior is consistent and may last for months or years; it is usually disruptive to time spent with family or in school, and it is often directed at authority figures, such as parents or teachers.

Parents of those with ODD often struggle with caring for their children; it may be confusing to try and understand whether a child is having regular tantrums or is acting out because she is seeking attention or is trying to become independent, or whether it is due to oppositional defiant disorder. Among school-age children, the condition affects girls and boys equally, although girls may demonstrate symptoms differently when compared to boys. Girls with ODD tend to lie, manipulate others, or exhibit verbal aggression instead of yelling or arguing. An exact cause of ODD has not been identified, but it is believed that it develops due to environmental and biological factors. A child who has a parent with bipolar disorder may be at higher risk of developing ODD. It is also more frequently seen in children of parents with adult ADHD or substance use and in those who live in conditions of poverty, neglect, poor supervision, and inconsistent discipline.

Oppositional defiant disorder has been connected with several other mental health conditions and may occur as a co-existing illness along with conditions such as bipolar disorder, depression, learning disabilities, anxiety disorders, and ADHD. Many children and teens diagnosed with ODD will eventually outgrow the disorder and can become productive and adjusted adults. However, there are some people who do not outgrow ODD and continue to have symptoms well into adulthood. Studies have shown that those who were diagnosed with ODD at an earlier age, such as during the preschool years, are more likely to go on to develop concurrent mental health issues, including ADHD, anxiety disorder, and bipolar disorder later in
life. Approximately 10 percent of those diagnosed with ODD during childhood or adolescence will develop some form of personality disorder in adulthood.\textsuperscript{33}

Adults with oppositional defiant disorder may continue to display symptoms of aggression and anger at those around them. An adult with ODD may still have difficulties submitting to authority, such as with a boss at her job. The person may display frequent hostility and may lash out at others in anger; she may also feel victimized, misunderstood, and disliked by others.\textsuperscript{34} An adult may have ODD if she was diagnosed as a child or teen; additionally, some argue that ODD in adults develops in those who have grown up with ADHD, stating that symptoms of ADHD that are associated with impulsivity can make emotional regulation much more difficult, and the person may be prone to anger and frustration.

Treatment of underlying mood disorders such as bipolar disorder that occurs along with ODD may more likely help to lessen the oppositional symptoms. Interventions designed to manage difficult behavior, such as through psychotherapy and counseling, may also work to control behaviors associated with ODD. Social skills training, problem solving skills training, and education about coping mechanisms are also often implemented into management of oppositional defiant disorder and usually provide some success for treating the condition during childhood and adolescence. Medication alone is not necessarily effective in treating only symptoms of ODD, although medication can be used for management of other conditions that may co-exist with ODD. Medical management of bipolar disorder through prescription medications, along with psychotherapy and skills training may eliminate many of the problem behaviors and mood swings associated with both bipolar disorder and ODD.
Attention Deficit Hyperactivity Disorder

One of the most common childhood disorders affecting behavior and activity, attention deficit hyperactivity disorder (ADHD) causes extreme difficulties with attention, impulsivity, and uncontrolled behavior. The condition is diagnosed in children and in adolescents, but it can continue into adulthood.

In the United States, approximately 8 percent of children under age 18 have been diagnosed with ADHD at some point in their lives. The child with ADHD may have difficulties with memory and planning; she may be unable to transition well between activities or to remember to plan for shifting between one task and the next. Some forms of ADHD have predominant symptoms of hyperactivity, in which the person becomes extremely distracted and disorganized in behavior; the affected patient may have trouble with controlling herself to focus on the task at hand. This is particularly true in a distracting or noisy environment, such as in a classroom or in a shopping center. The person may also exhibit a lack of impulse control and may be unable to stop herself from such actions as shouting out responses or grabbing items out of others’ hands.

Impaired short-term memory is a key component of ADHD in that the affected person is unable to organize their thoughts and transition them into coherent language. The individual may think of something to say but may have difficulty in remembering it long enough to process the information to the point that she can put it into a sentence or response. Other difficulties often seen with this diagnosis include sleep problems, learning disabilities, problems with transitioning between activities, hypersensitivity to sensory input in the environment, and an inability to manage time.
Adults can have ADHD. Contrary to popular belief, an adult does not develop ADHD after becoming a grown up. It is a childhood disorder that only develops during childhood, but its effects can last into adulthood. If an adult has not been diagnosed with ADHD as a child and is instead diagnosed for the first time as an adult, the condition was most likely there during childhood and was undetected during that time.

Adult ADHD differs in its symptoms when compared to those symptoms exhibited by children. Among adults, ADHD may be manifested as becoming easily distracted or bored, being unable to complete tasks or to multitask between responsibilities, having trouble starting projects, forgetting appointments and commitments, and showing up late for activities. The person may have difficulties with social skills and may interrupt others while talking or try to talk over others; she may have poor self-control, and a quick temper. Adults with ADHD may be more likely to struggle with relationships because of insecurity, restlessness and difficulties with finishing conversations, irritability, hypersensitivity to criticism, and excessive talking.36

Many of the symptoms of ADHD seen in adults are similar to those experienced during the manic phase of bipolar disorder. The common theme is often manifested as inattention to important information or details and a high level of distractibility that causes difficulty for a person to be able to complete tasks. Other symptoms seen during manic phases, such as insomnia, restlessness, increased motor activity, talkativeness, and impulse control problems, are also often seen among people with ADHD. However, the mood dysregulation associated with concurrent bipolar disorder tends to be cyclic in nature and ebbs and flows with manic episodes.61
There are several theories as to potential causes of why some people develop ADHD. Studies have shown that alterations in neurotransmitter levels, particularly dopamine and norepinephrine, are involved with ADHD development. Because these neurotransmitters are also implicated in development of bipolar disorder symptoms, there may be a correlation related to neurotransmitter activity that explains why a certain amount of patients with ADHD have co-existing bipolar disorder.

Approximately 20 percent of adults with ADHD have co-occurring depression or bipolar disorder. Adults with ADHD are at greater risk of occupational problems, including more likely being fired from their jobs, earning less money, and generally attaining a lower level of education. Adults with ADHD are also at higher risk of developing substance use problems, particularly if they started using tobacco and smoking cigarettes during adolescence.

Treatment is available for adults with ADHD and although the symptoms may be managed, the condition typically is not totally resolved. The patient with co-existing bipolar disorder and ADHD should be treated for both conditions simultaneously to take into account the complex needs for medication and psychotherapy needed to manage both disorders. Many patients who go through psychotherapy to learn behavioral techniques can learn to control their behavior in spite of their impulses and moods; this is often more successful with the addition of medication. The patient may have more success when using a combination of stimulant drugs and antipsychotic or mood stabilizing medications to treat both bipolar disorder and ADHD.

Stimulant drugs such as methylphenidate (Ritalin®) can be used to increase dopamine levels in the brain, which can improve a person’s ability to focus on tasks and can increase attention span. Alternatively, use of stimulants
could worsen symptoms of mania in some patients with bipolar disorder, so they may not necessarily be the right answer for treatment of everyone with these comorbid conditions.

Although antidepressants are sometimes used to treat ADHD in adults, these drugs should be used very carefully or avoided entirely in patients who have co-existing bipolar disorder. It may also be confusing to consider an adult with ADHD when treating bipolar disorder; if the clinician has not taken a sufficient history or the patient has not been diagnosed with ADHD, the condition could be missed or mistaken for severe symptoms of mania.

According to Jain and Jain of Psychiatric Advisor, a patient who presents with comorbid bipolar disorder and ADHD should be treated first for bipolar disorder. The ADHD symptoms do not necessarily abate when underlying bipolar disorder is not thoroughly worked up and treated. Anyone who presents with symptoms of mania from bipolar that are similar to ADHD symptoms, such as impulsivity or hyperactivity, should be assessed for a history of ADHD within the patient or her family. Because ADHD often has comorbid psychiatric conditions, anyone who presents for treatment of ADHD should be assessed for signs or symptoms of an underlying mood disorder that may coexist with ADHD. Women who struggle with these two conditions are at high risk of complications associated with the behaviors that predominate within their lives. They require regular monitoring and sometimes close supervision to avoid the potentially disastrous outcomes that can occur from impulse or hyperactive behavior that occurs with these two conditions.

Conduct Disorder
Conduct disorder is a disturbing mental health disorder seen among some children and adolescents that is exhibited by hostility, aggression, and violent behavior. Some clinicians believe that oppositional defiant disorder, if left unmanaged and untreated, can lead to conduct disorder later. A person with conduct disorder may be physically aggressive with others and may pick fights or bully those around her; the person may engage in destructive acts such as vandalism, stealing, or cruelty to animals. It is associated with later development of antisocial personality disorder.

Conduct disorder is closely associated with oppositional defiant disorder, but it may also be seen in children and teens who have ADHD. A person with conduct disorder may also be more likely to have other types of mental health problems, including bipolar disorder, major depressive disorder, anxiety disorders, and substance use disorders. A child or teen is at higher risk of developing conduct disorder if she has a parent who also has the condition or if she lives in an unstable environment and experiences abuse, neglect, violence, or inconsistent parenting and discipline. A child is also at higher risk of developing conduct disorder if she has a parent who has bipolar disorder or another type of mood disorder, adult ADHD, or schizophrenia.

A study in the *Journal of Psychiatric Research* demonstrated that diagnosis of conduct disorder during childhood is associated with a number of mental health disorders, including substance abuse disorders and bipolar disorder. The study found that there are gender differences between men and women and the types of disorders they may develop after diagnosis with conduct disorder during childhood or adolescence. Women are more likely to develop substance use disorders in association with conduct disorder. The recognition of differences between men and women when considering the
effects of childhood behavioral conditions and later mental illness means that clinicians could study the course and progression of the childhood disorder as it develops into other conditions at a later time.

As with many other types of mental illness, conduct disorder is associated with altered levels of neurotransmitters in the brain that can affect behavior. People with conduct disorder have a decreased dopamine response to such factors as external rewards. They also have been shown to have slight differences in brain structure and function that appear similar to the brains of children who suffer from other conditions that can cause problems as well, including reactive attachment disorder or chronic child abuse.\textsuperscript{39} Although conduct disorder may be more likely to develop among children and adolescents who are raised in unstable environments or are exposed to mental illness in their parents, these types of changes in the structure and chemistry of the brain suggest that even if a child is raised in a stable environment, the potential for development of conduct disorder is still present and it is not entirely based on environmental factors.

Conduct disorder is typically associated with childhood and adolescence and if a person with conduct disorder becomes an adult and is still having difficulties with behavior, the condition may be instead classified as antisocial personality disorder. Because bipolar disorder can be diagnosed during adolescence and conduct disorder also occurs during adolescence, the two conditions may overlap. Some young women may struggle with both conduct disorder and bipolar disorder and their symptoms can be frighteningly similar when there is an aggressive component present. A patient who is experiencing a manic episode may be more irritable, aggressive, and hyperactive and may act out more in defiance or violence due to conduct disorder during this time. For example, a young woman with
co-existing diagnoses of conduct disorder and bipolar disorder may engage in violent behavior and may become much more aggressive during manic episodes of her bipolar disorder but may have fewer conduct problems during times when she is not experiencing either mania or depression due to bipolar disorder.

The symptoms often vary between patients and although there is a connection between conduct disorder and bipolar disorder, patients may demonstrate highly variable behaviors based on their mood dysregulation. Treatment involves behavior management through counseling and family therapy, as well as medication. Some families have sent their children to camps designed to train proper behavior and to eliminate the poor conduct, such as through boot camps designed as intervention services. Studies have shown that these types of interventions may produce better behavior early on after graduation from the program, but the long-term results are less effective and the participants often revert back to their former behavior.

Instead, a program of family therapy, in which the patient works with a therapist and with loved ones to foster relationships and to intensify bonding and appreciation may be more helpful in working through the behaviors associated with conduct disorder. Stimulant medications, including methylphenidate used to treat ADHD, may also help to control some behavior, particularly when a co-existing diagnosis of ADHD is present. These types of drugs have not been shown to improve relationships with peers or family. These drugs should be used with caution if the patient has co-occurring substance use disorder as well.

Stimulants are the first choice of treatment for conduct disorder, even when bipolar disorder is present. Other medications that have also been used
successfully in co-occurring conditions include mood stabilizers such as carbamazepine and lithium. The combination of these drugs with psychotherapeutic interventions is the most appropriate course of treatment for these complex comorbid conditions.

**Gender-Specific Concerns**

In addition to the intricacies associated with managing comorbid conditions of bipolar disorder, healthcare providers who treat women with bipolar disorder also must consider the concerns that are specific to the female gender. Women demonstrate symptoms of bipolar disorder differently than men and they may struggle with physiological issues that are not apparent in male patients at all. The role of hormones, as related to the menstrual cycle and menopause as well as the effects of pregnancy and lactation, are just some of the concerns that may need to be dealt with during the span of time caring for a female patient with bipolar disorder. A healthcare provider may work with a patient for many years to provide medication and treatment for her diagnosis of bipolar disorder. During this time, the provider may have many opportunities to address certain gender-specific factors that can affect the woman’s care as she continues to develop and change through the course of her life. It is important to anticipate these changes before they occur so they can be addressed well before they become an issue.

**Depression versus Mania**

Women with bipolar disorder will demonstrate some symptoms that are unique to their gender, including their manifestations of depression and mania. While women with bipolar disorder display symptoms of both depression and mania, they tend to experience depression more often when
compared to men with bipolar disorder. The depression of bipolar disorder, as seen in a female patient, requires the provider to consider the negative effects of these episodes on the health and well being of the affected patient. A woman who experiences depression associated with bipolar disorder may have some of the same symptoms, but they are often manifested differently in her life when compared to a man.

The basic premise of this idea is that women often have different roles than men in society. While women often share the same occupations as men and can capably perform many of the same tasks as men in the workplace and in society at large, women also have distinct roles as mothers, wives, sisters, and daughters; their relationships with their peers are different than friendships between men, and they may work in jobs that are predominantly female or that are meant to be nurturing. Regardless of the many roles a woman has in her life, she is bound to be affected by the depression experienced with bipolar disorder.

As stated, depression associated with bipolar disorder causes a person to feel tired, unmotivated, and down; the person may feel extremely sad and hopeless or guilty. When a woman cares for others and experiences these symptoms, it can be difficult for her to complete her tasks or to properly care for others. For example, a woman with bipolar disorder may work to care for young children, but when she experiences a depressive episode, she may have a very hard time planning activities for the children or even having the motivation to get up and care for them. It can be difficult for a woman with bipolar disorder to care for herself during a time of depression; if the woman is also a caregiver for others, she may have an even harder time and the person receiving the care will most likely suffer.
Depression can cause changes in sleep patterns and appetite and the patient may have an irritable or extremely depressed mood. These moods and behaviors can affect her relationships with others and her ability to complete tasks, such as within her job. Difficulties with getting out of bed in the morning due to hypersomnia may make it hard to get to work on time and the affected patient may have trouble focusing on tasks or having the motivation to work if she does make it to the workplace. When struggling with depressed feelings, the affected patient may isolate herself from her family or friends to avoid disagreements or having to deal with their needs or desire for her time. She may come across as irritated, unfriendly, or negative and may have little energy to try to spend time with others or to be supportive of anyone else’s needs beyond her own.

Similarly, a woman who experiences manic episodes characteristic of bipolar disorder may be overly happy and joyful, which might be pleasant to be around, but it often takes a turn for the worse. Initial glee and happiness may be apparent early on, but this may be later followed by irritation, restlessness, and easy annoyance with others, particularly the longer the manic period goes on. The woman who is in a manic phase may be very distracted from her normal routine and could have difficulties completing tasks. For instance, a person who cares for others and is responsible for picking them up may become so distracted because of manic symptoms that she forgets to show up and leaves the person waiting. A mother who would normally be responsible for taking her child to a doctor’s appointment may forget the appointment or become distracted while driving to the office and may never show up.

Impulsivity associated with manic phases can cause difficulties with meeting responsibilities in a woman’s life. Instead of completing her normal activities
and routines, a person may instead decide to engage in other, more interesting behaviors that could lead to dangerous or harmful outcomes. Pursuit of risk-taking behaviors is a common theme during the manic phase, and the patient could be harmed at the expense of her behavior. For instance, a woman may experience an episode of mania and decide to leave home and start driving, leaving her family and friends behind without any particular destination in mind. She may disappear for days at a time, leaving others to wonder where she is or if she is safe.

The changes between mania and depression that a patient with bipolar disorder exhibits take a toll on those around her who care for her wellbeing. Others in the patient’s life may be frustrated, irritated, or angry because they feel they must deal with the consequences of her behavior. It is important to include family members and close friends of the patient in the treatment program; the people who care for the patient and who live with her are often struggling almost as much as the patient when bipolar disorder episodes develop.

The switch in mood from depression to mania characterizes bipolar disorder and can be extremely confusing for those who know the affected patient. Children who depend on their mother with bipolar disorder may become confused or fearful, especially if they do not know what to expect as a response to their needs. A mother who is depressed may neglect her child’s needs and even become irritated over having to help a child with routine and normal needs of growing up. The child may not know if her mother will lash out in anger in response to a question because of the depression or if her mother will be joyful, playful, and energetic with her because of mania. When bipolar disorder is not well controlled, the person’s parenting styles are often chaotic and unsupervised. Children of a parent with bipolar
disorder may feel confused or upset if they do not know what to expect from their parent because of her mood fluctuations.

When a woman with bipolar disorder has a history of suicide attempts because of her moods, her friends and loved ones may feel very afraid that she will continue to try to hurt herself or take her own life. They may feel very confused when they see their friend down or hurting herself at one time but then happy and energetic the next. These and other types of mood dysregulation can make it difficult for others to care for a patient with bipolar disorder because they may feel that they never know what to expect or how the person’s behavior will turn.

The major consideration of dealing with mood swings from depression to mania in bipolar disorder is to reflect on the role of the woman and determine how mood changes impact her daily life. A woman may have various roles, all of which could be affected by her mood changes from her disorder. The healthcare provider may need to consider those areas that are most affected or that are causing difficulties for the woman and assist her with finding a treatment process that will help her to be successful in the major roles in life she plays.

**Role of Hormones**

The hormone changes associated with the menstrual cycle and that continue during the perimenopausal period often cause variations in bipolar symptoms. The exact connection between regulation of estrogen and progesterone that occurs during these times and how it can increase the risk of bipolar disorder is not entirely clear. These hormones do have an effect on mood disorders and conditions that may affect moods; a woman who has burst into tears from a minor misunderstanding because she was suffering
from premenstrual syndrome (PMS) can attest to this connection. Alternatively, the reasons why these same hormones can further impact moods to the point of needing a bipolar disorder diagnosis are still being investigated.

Women go through certain times when their hormone levels fluctuate, particularly during the premenstrual period, during pregnancy, and during the perimenopausal period of life. These hormone fluctuations can impact symptoms of bipolar disorder and may affect its course of treatment.

*The Menstrual Cycle*

Menstruation signifies a woman’s ability to become pregnant. The onset of menstruation occurs with puberty and the typical age of onset can vary between ages 9 and 15 years. A woman undergoes a menstrual cycle approximately every 28 days, although the length of time for each cycle can vary between women. Because the average menstrual cycle is 28 days, the menstrual period is said to be monthly. Most women begin having menstrual periods and have them approximately every month — with exceptions during times of pregnancy or surgical hysterectomy — until they reach menopause around age 50 to 55 years.

During each menstrual cycle, the woman’s body produces various hormones that each has responsibilities for preparing the body in case of fertilization and pregnancy. Estrogen levels increase early in the menstrual cycle to build up the endometrial layer of the uterus. If the woman does not become pregnant, estrogen levels decline in the few days prior to menstrual bleeding. Follicle-stimulating hormone, created in the
pituitary gland, prepares the ovary to release an egg through ovulation, while luteinizing hormone actually stimulates the ovary to release the egg. The egg that has been released produces progesterone, which stimulates the uterus to prepare for pregnancy. If pregnancy does not occur following ovulation, the lining of the uterus is shed in the form of menstrual bleeding.

A considerable number of women with bipolar disorder experience mood changes during the perimenstrual period and in the time leading up the menstrual bleeding. The premenstrual period is known as the luteal phase, which is the time following ovulation until the time of menstrual bleeding if pregnancy does not occur. This is also the time when most women experience premenstrual symptoms that include mood changes and physical discomfort. Many women, including those who do not have bipolar disorder, suffer from premenstrual syndrome (PMS), which is thought to be related to hormone changes during the menstrual cycle and leads to many physical and emotional symptoms. Premenstrual syndrome may cause such effects as mood swings, fatigue, sleep difficulties, headache, joint pain, memory problems, and irritability. Women with bipolar disorder are at higher risk of developing symptoms of menstrual bleeding irregularities, mood lability, irritability, and dysphoria in a cyclical pattern surrounding monthly menses.

Those with bipolar I disorder are also more likely to experience rapid cycling around the times of the menstrual period. A study in the Journal of Affective Disorders noted that when compared to women without mental health issues, 65 percent of women with bipolar type 1 and 70 percent of women with bipolar type II reported changes in mood symptoms during the time surrounding the menstrual period. Only 33 percent of women without bipolar disorder reported symptoms during the same time.
Some medications used for the treatment of bipolar disorder can impact the menstrual cycle and can cause irregularities and physical discomfort. Some women who use valproate for the management of manic symptoms have developed ovarian dysfunction and increased menstrual abnormalities after using the medications. Despite this data, many women are able to achieve mood stability while taking medications for bipolar disorder and are unaffected by menstrual irregularities. A study by Sit, et al., in the journal *Bipolar Disorders* showed that there is a lack of relationship between bipolar symptoms and decreased functionality and the menstrual cycle among women receiving treatment for bipolar disorder.\(^47\)

Further, hormone changes surrounding menstruation can impact the efficacy of some types of medications taken for management of bipolar disorder. The hormones released during the menstrual cycle can affect drug absorption in the body, leading to changes in symptoms and fluctuations in levels of efficacy. Altered levels of lithium have been seen in some patients, in which serum levels are higher during the time just before the menstrual period.\(^60\) Because lithium is a relatively common drug used in the management of bipolar disorder, it may be necessary to make modifications in the drug regimen if symptoms are extreme enough that they impact the patient’s quality of life.

**Menopause**

Menopause is the time of cessation of menstrual periods; although a woman will cease to have menstrual periods completely at some point, she will undergo a perimenopausal period in which she experiences some symptoms of menstrual irregularities, night sweats, decreased fertility, hot flashes, and vaginal dryness during the transition time.\(^46\) This transition period may occur up to four years before menstruation actually stops permanently. In addition
to some of the physical changes experienced during the transition to menopause, a woman may have psychological changes that affect her mood. Studies have shown that women are more likely to suffer from depression, insomnia, obsessive-compulsive behaviors, new onset of panic disorder, and bipolar disorder symptoms.

During the perimenopausal period, a woman’s ovaries stop producing estrogen and progesterone, which is why she often experiences physical and emotional symptoms. The levels of estrogen do not decline all at once during perimenopause; instead, they may fluctuate and drop in an irregular manner. Estrogen is normally responsible for maintaining the health of a woman’s reproductive organs, including promoting adequate blood supply to the uterus, ovaries, and vagina. Progesterone, which is mainly responsible for preparing the lining of the uterus for a potential pregnancy, also drops during this time. The fluctuating levels of progesterone result in menstrual irregularities, and a woman may have some menstrual periods followed by other periods of amenorrhea. A woman is said to have gone through menopause and has become postmenopausal after the absence of menstrual periods for 12 months.

Women with bipolar disorder may be more likely to struggle with depression during the perimenopausal period, including worsening of bipolar symptoms of depression during the time leading up to menopause as well as during the post-menopausal period. Women with pre-existing bipolar disorder before menopause tend to experience more frequent episodes of depression during transition to menopause when compared to the number of episodes they experienced during the premenopausal years. Women may also be more likely to experience rapid cycling during menopausal transition as the
Hormone changes occurring during this time can affect mood and behavior in previously diagnosed bipolar patients. Hormones such as estrogen affect the production of neurotransmitters in the brain, and decreasing levels of estrogen that occur during menopause. Because estrogen increases the effects of serotonin and norepinephrine, two neurotransmitters related to development of depression, the patient might be more likely to suffer from depressive episodes when estrogen levels are low. However, not everyone who is transitioning to menopause suffers from bouts of depression, so estrogen levels are not necessarily the only explanation. Hormone concentrations, when measured in perimenopausal and postmenopausal women with depression, are not necessarily found to be abnormal. Instead, researchers believe that women who are more likely to experience depression because of fluctuations in estrogen levels during perimenopause are those with pre-existing mood disorders, such as those with bipolar disorder.46

There has been some research done on the use of hormone replacement as part of treatment for bipolar disorder. Hormone replacement may play a role in regulating manic symptoms among women with bipolar disorder, and could be used in situations when bipolar disorder is otherwise non-responsive to traditional medications used for treatment. A study in the Journal of Behavioral and Brain Science demonstrated that tamoxifen, a drug primarily used in the treatment of certain types of cancer, has anti-manic and anxiety-reducing properties that can help to control symptoms of mania in patients with bipolar disorder.45 Tamoxifen is a hormonal agent that is a selective estrogen receptor modulator, which works as both an estrogen agonist and an estrogen antagonist at different sites in the body. It is primarily used for the treatment of breast cancer, and it also may decrease the development of osteoporosis in some women. It also tends to produce
fewer neurologic side effects that may occur with typical antipsychotic medications used for treatment of bipolar disorder. Its short-term use in patients with bipolar disorder has demonstrated better control of manic symptoms associated with the disorder, although the long-term effects of tamoxifen use for control of these symptoms has not been studied.

Other hormone replacement medications may be used to manage some of the vasomotor symptoms that occur during menopause; some of these drugs may also have an impact on a woman’s moods if she has bipolar disorder. Hormone replacement therapy is prescribed for some women to help with symptoms of menopause. Some studies have shown that hormone replacement therapy with use of estrogen and progesterone replacement has lead to greater mood stabilization with use as evidenced by fewer mood swings when compared to those who do not use hormone replacement therapy.\(^45\) The results of these studies should prompt further interest in the potential for management of mood swings and switches between depression and mania through the use of hormone replacement therapy.

While menstruation and menopause are common to all women, the physical and emotional responses to these situations differ between people. Even one particular patient may have varying responses to hormone fluctuations on a month-by-month basis. Because of the variation in response and the potential issues involved for patients with bipolar disorder, treatment and management of mood dysregulation because of hormone irregularities and the chronicity of the menstrual cycle for most women can pose quite a challenge to caregivers and healthcare providers.

**Relationship with Pregnancy**
The average age of diagnosis of bipolar disorder coincides with a peak reproductive time for many women; consequently, the odds of a woman diagnosed with bipolar disorder becoming pregnant after her diagnosis are much higher than if the condition were typically diagnosed much later in life. Women who have been diagnosed with bipolar disorder in their late teens and early 20s may soon be interested in becoming pregnant or may become pregnant within a few years after diagnosis.

Women with bipolar disorder may be at increased risk of unplanned pregnancies if they tend to engage in risky sexual activities during manic phases. Approximately half of all pregnancies in the United States are unplanned anyway, so women with bipolar disorder should be counseled about contraceptive use and family planning regardless of whether they engage in risky sexual encounters, of their family status, or whether they intend to become pregnant or not. A significant part of prenatal planning includes education about the woman’s choices for pregnancy in the near future. The clinician should bear in mind that these choices would most likely change over time and repeat discussions about pregnancy planning will be necessary. A woman with bipolar disorder may initially have no plans to become pregnant during the first discussion of pregnancy planning, but within a year, she may have changed her mind because of her circumstances. Contraception use should ideally be discussed at every visit when a woman is taking prescription medications for bipolar disorder that can cause teratogenic effects.

Further discussion through pregnancy planning involves discussion of birth control options based on the woman’s current situation and her choices for pregnancy. Again, some women may want to use a specific type of birth control based on the risks and side effects, while other women may choose a
different form. The clinician should also discuss with the woman about what to consider if she does have an unplanned pregnancy, even while using birth control as discussed. It is a time to talk about the type of support present, the woman’s sexual partner or spouse’s involvement in the pregnancy, and long-term outcomes associated with becoming pregnant when the pregnancy is not planned.

Some medications used for treatment of bipolar disorder can decrease the effectiveness of certain types of birth control. The woman who relies on oral contraceptive pills as her primary form of birth control should be taught about the possibility of decreased effectiveness with certain types of medications, including some mood stabilizers. Some medications also cause teratogenic effects when taken during pregnancy; valproic acid, a mood stabilizer, is an example of one such medication. Ideally, prenatal counseling and planning should begin at least three months before pregnancy occurs.

If a patient with bipolar disorder becomes pregnant, the clinician must discuss with her the plan for continued treatment of her mental health diagnosis while simultaneously managing the effects of pregnancy and keeping the growing baby safe. If the patient is taking medications for bipolar disorder treatment that have been shown to be teratogenic, the provider should change the type of drug as soon as possible. This may mean slowly tapering of a drug and transitioning to a different kind when the initial drug cannot be abruptly discontinued. If the woman is beyond the first trimester of pregnancy, it may not be necessary or safe to completely change medications if they have been successfully managing bipolar disorder. This is because most teratogenic effects occur during the first
trimester at the very early stages of development and stopping the drug after this point may have little to no effect on further fetal development.

Certain drugs that are commonly used in treatment of bipolar disorder can have serious effects on the health of the fetus. For example, lithium, one of the more common drugs prescribed for treatment of bipolar disorder, is associated with cardiac defects in the fetus.²² Ideally, the pregnant patient with bipolar disorder should not take medications during pregnancy to decrease the risk of harm to the fetus, however, if this is not possible, the next best option is to use only one type of drug, use the minimum dose possible for its effects, and continue with frequent monitoring.⁴⁸ The potential change in prescription and dose to use during pregnancy may increase the risk of relapse of symptoms for the patient with bipolar disorder; a woman who once may have controlled her moods and behaviors very well with medication may have an increase in depressive or manic episodes during pregnancy because of the changes in treatment.

Despite the risks associated with some types of medication used during pregnancy, stopping treatment and discontinuing medications because of pregnancy is not necessarily the best option either. Women with uncontrolled mania or depressive symptoms are at higher risk of premature delivery, miscarriage during the first trimester, and poor fetal development.²² The clinician who cares for a pregnant patient who has bipolar disorder must weigh the benefits against the disadvantages of medication use and should strive to find a solution that involves medical management of both pregnancy and the patient’s moods and behavior.

Women who have been diagnosed with bipolar disorder before pregnancy are at increased risk of having a manic or depressive episode during or just
after a pregnancy. Pregnancy causes changes in the body’s production of hormones, which can impact mood and behavior of the mother, even if she does not have pre-existing bipolar disorder. For someone who already struggles with bipolar disorder, the hormone changes and emotional and physical stress associated with pregnancy can lead to mood swings and changes in behavior.

For some women, pregnancy can cause significant problems that can be manifested with mood changes and with problems in regulating affect and mood. When a pregnancy is unplanned, a woman may have a very difficult time coping with the situation. There are many elements to think about, including the physical stress on the body, the emotional toll pregnancy takes both because of hormone changes life will have on the mother and her family, the financial strain that may develop because of the cost of prenatal visits and hospital care for delivery, and the idea of taking care of a newborn and then a child, which will require years of dedication and care. The idea of pregnancy is often overwhelming when the pregnancy is unplanned; this holds true for women who are not already struggling with bipolar disorder. When a mood disorder such as bipolar disorder is present, the affected patient may have an extremely difficult time coping with the idea of pregnancy and with trying to care for herself and her body during this time.

If the pregnant patient with bipolar disorder is also in a relationship that is unstable or she is pregnant but has little to no relationship with the baby’s father, she may suffer from significant stress of the situation and may have difficulty coping. When this occurs, the patient needs to consider her other sources of support through family or friends to help her through this difficult time. The patient may need to meet with the healthcare provider more often not only for monitoring of her condition through prenatal visits and care, but
also for continued vigilance in monitoring her psychological state and for ensuring that she is managing her bipolar disorder well despite the unanticipated circumstances.

Even when pregnancy is planned and a woman with bipolar disorder is being treated for her illness, she still has a greater chance of having episodes of mania or depression during pregnancy. These episodes increase the risk of other complications to both the mother and the fetus during pregnancy. If the mother experiences such intense mood swings that she has difficulty coping, she may avoid seeing her healthcare provider or may not follow up with routine care to stay healthy during pregnancy.

When a woman with bipolar disorder experiences episodes of depression due to her illness, she puts herself and her unborn baby at greater risk. The pregnant patient with severe depression may lack the motivation to take good care of herself and her body to be sure that she remains healthy. She may have difficulties sleeping or experience appetite changes because of her depression, which can ultimately cause fatigue, irritability, and poor nutrition. If the patient has suicidal ideation, she puts herself and her baby at great risk, particularly if she attempts suicide during pregnancy. Women who are depressed during their pregnancies are at higher risk of experiencing difficulties associated with the pregnancy, they are more likely to have premature deliveries, and their infants may have poor fetal growth.

Additionally, symptoms associated with mania during pregnancy may increase risks for the pregnant mother and her baby. The patient with bipolar disorder who experiences mania may demonstrate more risk-taking behaviors, which can be harmful to her and her baby. She is at an increased risk for substance use, which can be harmful even if the patient is not
pregnant; substance use during pregnancy causes further problems with fetal growth and the mother’s health. Manic episodes can lead to a number of other harmful behaviors, including a decreased need for sleep and increased distractibility. The pregnant patient who experiences mania may have difficulty focusing on caring for herself or attending prenatal appointments and may subsequently develop health problems as a result of her behavior.

Clinicians who care for pregnant women with bipolar disorder face a challenging task of determining which is better for the health of the mother and the fetus; to continue with medication during pregnancy and therefore control manic episodes to avoid harm to the mother or the baby, or to taper off and stop medications during pregnancy because medications can cause health problems in the baby and the mother and there may be other side effects that result in physical consequences as well. Each situation requires careful monitoring of the mother’s behavior and her response to medication or discontinuation of medication, if the choice is made. Additionally, the provider must have an ongoing dialogue with the pregnant patient to discuss her support systems, the stressful events present in her life, the physical complaints of pregnancy, and her ability to recognize if she is having symptoms of bipolar disorder. Because pregnancy lasts for months and the effects of medications may change over time with the development of the fetus, the discussions will need to be repeated a number of times.

Bipolar disorder symptoms may develop during pregnancy, during the postpartum period, or during both periods for the woman with bipolar disorder. Postpartum is the period of time following delivery of an infant and it is considered to last up to about six weeks. For some women, postpartum may be the time that they first experience a relapse or cycling of their mood.
symptoms of bipolar disorder and they did not necessarily experience any changes in mood during pregnancy. If a woman experiences severe mood changes and develops a depressive or manic episode with psychotic features during the first four weeks postpartum, she would be considered to have a relapse of symptoms with peripartum onset, which is the diagnosis given according to the DSM-5.66 Although the technical diagnosis is only for appearance of symptoms within the first four weeks after delivery, there are still many women who develop symptoms during the first several months postpartum.

Severe and debilitating depression, sometimes leading to psychosis, may also be more likely to develop during pregnancy or the postpartum period due to hormone fluctuations associated with these events. Postpartum depression is a well-known health risk among childbearing women, but some of these cases may also be associated with bipolar disorder. Many providers screen for postpartum depression because of the physiological changes associated with pregnancy, labor, and delivery, but they do not necessarily recognize alternating symptoms of mania or hypomania.11 A patient may appear joyful, excited, and full of energy after giving birth, but these feelings could also be related in part to the happiness of a new child or becoming a parent. It can be confusing to determine if the patient has an elevated mood because of bipolar disorder or because of contentment with a new baby. Thus, postpartum bipolar disorder should be evaluated in the client who demonstrates mood changes abruptly after pregnancy.

Postpartum depression is a potential complication for some women after giving birth; the hormone changes that occur during the postpartum period, along with the demands of feeding and caring for a newborn and the exhaustion felt by many new mothers contributes to the condition. It is
beyond the extent of postpartum blues, in which a woman feels down or sad and has fluctuations in her emotions. With postpartum depression, a mother may experience extreme sadness, guilt, isolation from family and friends, and loss of appetite; she may have difficulty with caring for her child or mustering the strength to get up and care for the child’s needs. Postpartum depression can lead to suicidal ideation, often with disastrous results.

Even without recent labor or delivery, a woman with bipolar disorder may experience some elements of psychosis during a manic episode. However, postpartum psychosis may develop during the time following infant delivery if a mother experiences a manic episode that causes her to behave abnormally and to have delusions or hallucinations. Postpartum psychosis in a mother with bipolar disorder may also occur with a severe depressive episode following delivery. The patient may start to have very rapid mood cycling and behavioral changes, and she may become confused about the correct time or place. If manic symptoms are present, the patient may experience bursts of energy and may act out in unusual ways, often becoming disconnected with reality. Eventually, the condition can lead to hallucinations or delusions in the mother.

According to Monzon, et al., of the Psychiatric Times, up to 30 percent of women with previously diagnosed bipolar disorder experience some element of postpartum psychosis after giving birth. The risks continue to increase if a postpartum mother has a previous history of a psychotic episode after giving birth in the past. Women with bipolar disorder who experience postpartum psychosis have demonstrated symptoms of delusions, which are often related to care of the infant or wanting to hurt the infant, as well as hallucinations and disorganized behavior. Although the condition is rare, it is considered an emergency because of the high risk of harm to the mother.
and the baby. Most women who experience psychosis require rapid assessment and treatment through hospitalization for management of symptoms.

When providing prenatal care to a pregnant patient, the clinician can screen for risks of postpartum psychosis by assessing whether the patient has a history of mania or hypomania, whether she has any blood relatives diagnosed with bipolar disorder; and, if she has had any problems with mood episodes, including mania or depressive episodes, or if she has had a history of postpartum depression or psychosis with previous births. If the risk of postpartum psychosis is apparent because of the patient’s medical and psychological histories, the clinician may need to consider prophylactic administration of medications to control bipolar disorder symptoms and to prevent postpartum psychosis.

If psychosis does develop during the postpartum period, it can be treated with combinations of medications and therapies to manage the symptoms and to get the patient back into a state of controlled moods. The most common form of treatment is medication, often in the form of a mood stabilizer. If the woman had discontinued her medication use during pregnancy, she would need to be restarted on medications; if the patient is currently taking medications for bipolar disorder treatment but still develops postpartum psychosis, the medication regimen needs to be altered and managed accordingly.

Electroconvulsive therapy (ECT) may be another option to administer to some women. A study found in the *Archives of Women’s Mental Health* showed that ECT is an effective form of treatment for postpartum psychosis and is well tolerated without adverse effects to the mother or the infant.68
Although ECT may not be a first line treatment of postpartum psychosis, it can be considered for some women based on their symptoms and history of their disorder.

The risk of relapse into bipolar episodes is particularly high for women during the postpartum period; because of this, the clinician should discuss the medication regimen with the patient, depending on the type of medication prescribed and the patient’s history with medication compliance during pregnancy. If a woman decides that she wants to breastfeed, the provider needs to ensure that the medication is safe for breastfeeding and that it will not cross into breast milk to affect the infant. Some of the drugs that have been found among breastfeeding infants because they were passed from the mother to the child include lamotrigine, lithium, valproate, and carbamazepine. Negative outcomes can occur among infants exposed to these drugs and who build up serum levels in their bodies; the mother must therefore be carefully monitored in her medication regimen to determine the effects of medication and breastfeeding, and she may need to consider other options for infant feeding, such as through formula feeding after birth.

In addition to the routine discussions with a pregnant or postpartum mother about her symptoms, monitoring for mood and affect changes, and continued vigilance to protect the mother and to prevent harm to both the mother and the baby, the clinician should also encourage the pregnant or postpartum mother to follow a healthy and nutritious diet, get plenty of rest, drink enough fluids, and exercise on a routine basis. These lifestyle factors are important for any woman who is pregnant or is postpartum, but they are especially significant for women who also have bipolar disorder. These behavioral interventions can better help a patient with bipolar disorder to manage and control her symptoms and to prevent her from feeling worse.
Teaching and education about positive lifestyle intervention should be included as part of routine care for all women seeking treatment for bipolar disorder symptoms.

**Misdiagnosis**

The complexities of bipolar disorder make this condition very difficult to identify and treat among different populations, and the potential for misdiagnosis can be great. Because of the differences in how symptoms are manifested between women and men, it can be clinically challenging to properly diagnose bipolar disorder among women. A report by Duerr in the *Psychiatric Times* stated that it takes much longer to recognize and diagnose bipolar disorder when it occurs among women when compared to men with bipolar disorder.\(^6\) Additionally, because of the spectrum of bipolar disorders, women may manifest symptoms differently at different phases along the bipolar spectrum. As stated, women are more likely to experience rapid cycling and more depressive episodes when diagnosed with bipolar disorder, but they may also be more likely to be diagnosed with the soft bipolar disorders found along the spectrum, which would include bipolar categories II, III, IV, and V.\(^6\)

Because major depressive disorder is more prevalent in women when compared to men, a woman who presents for medical care who complains of symptoms of depression may be more likely to be misdiagnosed as having major depression, rather than bipolar depression. This is unfortunately true, even though both men and women develop bipolar disorder at about the same rates. Additionally, women with bipolar disorder are more likely to demonstrate more depressive symptoms of bipolar disorder compared to manic or hypomanic symptoms, making major depressive disorder one of the most common misdiagnoses for this condition. A woman may also be
more likely to present for care because of depressive bipolar symptoms rather than manic symptoms.

The misdiagnosis of major depressive disorder instead of depressive bipolar disorder places many women at risk, since misdiagnosis will not effectively treat and manage the actual condition and the patient may continue to suffer. It is therefore important that when assessing a patient who struggles with symptoms of depression, the clinician must consider the potential for major depressive disorder or bipolar depression and assess accordingly. This involves questioning the patient for any history of manic or hypomanic episodes, determining the length and severity of depressive episodes, whether symptoms seem to abate at times, and if there are factors that cause symptoms to resolve.

It is only through appropriate and accurate diagnosis of the patient’s condition that effective treatment can be found. Because of the evidence of the bipolar spectrum, many more women today are being treated appropriately for symptoms of bipolar disorder, rather than struggling with disruptions in their lives due to symptoms or being misdiagnosed with the wrong conditions.

**Summary**

Bipolar disorder is a complex state that presents with a variety of symptoms that can be challenging to accurately detect and diagnose. The bipolar disorder spectrum allows for greater flexibility for providers to manage variations and subtypes of standard bipolar disorder when a woman presents with symptoms that are not specifically within the diagnostic parameters. Caregivers of female patients must also consider the risks and complications associated with the specific needs of women, whether it is managing
fluctuating hormone levels, assessing and treating co-occurring substance use, or dealing with one of the many other conditions that could impact the health of a woman with bipolar disorder. Gender-specific treatment and considerations of the unique needs of women with this condition can ensure appropriate and successful treatment for this special population of patients.
REFERENCE SECTION

The reference section of in-text citations include published works intended as helpful material for further reading. Unpublished works and personal communications are not included in this section, although may appear within the study text.


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