



Mood Disorders Society of Canada
La Société Pour **Les Troubles de L'Humeur** du Canada

What is Bipolar Disorder?





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What is Bipolar Disorder?



We all get excited by new ideas, pursue our goals with passion, have times when we want to party with our friends and enjoy life to its fullest. There will also be times when we are sad and withdraw into quiet contemplation or feel angry when things are not working out as planned.

For people with bipolar disorder, these normal emotions can become a roller coaster ride of wild highs and devastating lows. Moods are driven, not by the events of life, but by forces of their own within the brain. Bipolar disorder (previously called manic-depressive illness) is a medical condition that involves changes in brain function leading to dramatic mood swings, which include either mania or hypomania and (usually) depression. These mood swings can be so severe that they impair normal functioning at work, at school and in relationships.

What are these moods (or symptoms) like?

Mania

When manic, people have a persistently elevated, expansive or irritable mood and persistently increased goal-directed activity or energy. This can be accompanied by racing thoughts, being more talkative and distractable, a reduced need for sleep, an elevated sense of self-esteem, or being extremely irritable and angry. Mania comes in two types: “euphoric mania” and “dysphoric mania”. Mania of either type, by definition, involves symptoms that impact behaviour in a way that disrupts functioning in work, in school and/or in relationships.



Euphoric mania often includes increased creativity and social ease - feelings that can quickly progress to an extreme, continuously elevated mood involving an exaggerated sense of self-esteem and an expansive mood.

Someone with euphoric mania may not be aware that anything is wrong and may also enjoy the feeling euphoric mania brings before it becomes severe. However, judgment becomes impaired resulting in greater risk-taking behaviour, sometimes including overspending and involvement in sexual activity that the individual would not otherwise engage in.



Dysphoric mania includes persistently increased goal directed activity or energy, but rather than feeling “super good” dysphoric mania brings with it the opposite. Someone with dysphoric mania often feels an increase in anxiety and irritability. They may get especially frustrated at bright lights and loud sounds. Angry outbursts can occur. Dysphoric mania is part of what is referred to as a “mixed state” because it feels like a combination of symptoms of a depressive episode together with symptoms of mania. In a mixed state, manic and depressive symptoms occur at the same time or alternate frequently. As it turns out, almost half of all manic and hypomanic episodes have been found to actually be mixed states [1]. Due to the combination of high energy and depressed, agitated mood, mixed states present the greatest risk of suicide.



In severe cases of mania, the person may also experience psychotic symptoms such as hallucinations (hearing or seeing things that are not there) or delusions (believing things that are not true). A common delusion in the severe manic state is that others are “out to get” the person. Another possibility is the delusion that one has special powers due to direct contact with a supreme being. Psychotic symptoms can occur in either euphoric or mixed mania. They may be quite frightening and confusing for the person having them and for the people around them.

Hypomania

Hypomanic episodes also include abnormally and persistently elevated, expansive or irritable mood and abnormally and persistently increased activity or energy. Yet this is a milder form of mania and, by definition, symptoms are not severe enough to affect behaviour in a way that disrupts functioning. Hypomania is similar but less severe than mania. Hypomania can also be either of the classic euphoric kind or occur in a mixed state with dysphoric mood.



During a **euphoric hypomanic** episode, a person may have an elevated mood, feel better than usual and be more productive. During a **dysphoric or mixed hypomanic** episode a person may be more anxious or agitated and more easily angered than usual, but is still able to function adequately. In fact, often a person's functioning is exaggerated by hypomania. However, hypomania of either kind can not last for very long and is often followed by an escalation to full mania or a crash to a depressive episode. Because euphoric hypomania can be a state of greater self-confidence, excitement about life and productivity, it can often be very appealing and compelling. Euphoric hypomania may be hard to

recognize if the person is seen as normally excitable, highly energized, and very productive. It also can be missed because there are usually no negative social, school or work consequences.

Depression

Depression is not something every person with bipolar disorder experiences. Yet the majority of bipolar individuals do have bouts of depression and some types of bipolar disorder involve depressive episodes, by definition. Depressive symptoms are common in bipolar disorder [2-4] and are more likely to be responsible for problems functioning than manic symptoms are [5]. Consequently, depressive episodes are often what drives a person to reach out for help.

Depression can take many forms. Unlike normal sadness, depressive symptoms can be intense, pervasive, persistent feelings of despair, hopelessness, and frustration. Some people feel angry and irritable or are consumed by feelings of worthlessness or guilt. Some people feel that the colour has been drained out of life and they feel empty. There is a loss of energy, limited interest in normal activities, changes in appetite and weight and difficulties with sleep. Thinking is slowed, concentration impaired and decision-making becomes a challenge. When depressed, some people describe having a "brain fog". At its extreme, depression can involve psychosis with hallucinations and delusions. Suicide is a serious risk. Depression can cause considerable interruptions in all aspects of life, including functioning at work, school and in relationships.

Are there different types of bipolar disorder?

Yes. The different types are based on the nature of the mood swings the person experiences. These differences can be important, as they will influence treatment approaches.



In Bipolar I disorder (bipolar “one” disorder), the person has manic episodes and usually (but not always) experiences depression at some point. Bipolar I disorder is the same diagnosis given to people with either euphoric or dysphoric mania. Bipolar I disorder is defined by having manic episodes severe enough to cause interrupted functioning.



In Bipolar II disorder (bipolar “two” disorder), the person has episodes of depression and also has hypomanic episodes (the milder form of mania that does not cause disrupted functioning) but never full manic episodes. Episodes of depression in bipolar II disorder are generally severe enough to cause problems with daily functioning. One way that some people experience bipolar disorder is as rapid-cycling bipolar disorder, which can occur in either bipolar I or bipolar II disorder. This means that there are at least four episodes in a year, in any combination of mania, hypomania or depression. This is seen in approximately 16% of people with bipolar disorder [6]. Rapid cycling can be precipitated or worsened by reduced activity of the thyroid gland, which can be checked using a blood test [6].

Cyclothymia is a somewhat milder form of bipolar disorder. Cycles of hypomania and depression are less severe, but last at least 2 years in adults (1 year for children). For that period of time, the mood symptoms are present most of the time, with less than 2 months of relief from them. Mood episodes typically last for months. Cyclothymia



does not include hallucinations or delusions because the symptoms are milder than the other types of bipolar disorder. Nevertheless, cyclothymia can still be distressing and affect functioning and may need to be treated.

What causes bipolar disorder?



No one knows for sure what causes bipolar disorder. It is not caused by bad parenting nor is it a consequence of moral weakness or a fault in character.

Research shows that genes play a strong role, according to twin and other family studies [7]. This means that if you have a close relative with bipolar disorder your chances of having it are higher than they would be otherwise. Additionally, older age of either a mother or father at birth can increase the risk of bipolar disorder [8]. People with the disorder may have an onset of an episode in association with emotional and physical stresses, a lack of sleep, the loss of an important relationship, or drug and alcohol use. Changes in routine or excessive stimulation may predispose to a manic episode. Certain environmental risk factors are known to be associated with bipolar disorder, such as childhood adversity [14], which, unfortunately, is also associated with more severe illness and less favourable treatment outcomes [15].

Although recent brain scan research is making progress in understanding differences in brain functioning that may accompany bipolar disorder, there is no laboratory test, x-ray or brain scan that can be used to make a definitive diagnosis yet. Instead, a physician (usually a psychiatrist) takes a careful history and bases diagnosis on a group of symptoms that occur together.

Bipolar disorder usually begins in early adulthood, with the peak (most common) age of onset around 19 and a half years [9], although it can occasionally start in childhood or as late as the 40s or 50s. The younger a person is when they develop bipolar disorder, the more likely it is to have a genetic component. Bipolar disorder affects approximately 1.4% of the adult population in Canada [10]. This is thought to be higher in the United States, with rates up to 4.4% when including all the forms of bipolar disorder [11]. Men and women are equally affected. Some populations have a much higher rate of bipolar disorder, such as people who are homeless, where it is present at rates closer to 11% [12], or individuals with HIV where it is 8%.

The first signs and symptoms of bipolar disorder can be very confusing. This is because the illness can start out with symptoms of hypomania, depression or cy-

clothymia, which can easily be missed or misunderstood. When the illness starts in adolescence or emerging adulthood, the symptoms can be mistaken for normal hormonal changes or “teenage moodiness”. There are so many physical and emotional changes at puberty that a young person may not know themselves well enough to see when their mood is outside the range of typical adolescent mood fluctuations.

On average, people with bipolar disorder will see three to four physicians and spend almost 6 years seeking help before they receive any form of management for the illness [16]. Many individuals never get treatment [5].

Some diagnoses can look like bipolar disorder because of some overlap in symptoms. These include:

Attention Deficit Hyperactivity Disorder (ADHD), hyperactive or mixed type – this has distractibility and physical activation in common with bipolar disorder. In addition, some people with bipolar disorder also meet the criteria for ADHD, particularly when young [17].

Borderline Personality Disorder – this has mood swings and anxiety or irritability in common with bipolar disorders. Distinguishing these is not always clear and, in addition, there is an overlap of the two disorders in about 20% of people [18].

Major Depressive Disorder – this has depressive episodes in common with bipolar disorder. Because the depressive episodes in bipolar disorder are usual when people seek help, hypomanic episodes in the past, in particular, can be missed or overlooked. In addition, a person can have multiple depressive episodes before any signs of mania or hypomania occur. This leads to many “incorrect” diagnoses of Major Depressive Disorder, though early in the illness it would be impossible to know that the correct diagnosis is bipolar disorder. With time, mania or hypomania emerge more clearly and the correct diagnosis can be made.

The challenges of a correct diagnosis can be frustrating for people with bipolar disorder and their families alike. This is why it is so important that research on this illness continues to advance our understanding of it. Early diagnosis and proper treatment, including finding the right medication, are important because they lessen the effects of the disorder on individuals and families.

Bipolar disorder and substance use

Research has shown that a significant percentage of people with bipolar disorder (60.7%)[21] are also vulnerable to having substance use problems. By substance, we mean alcohol, nicotine, cannabis or illegal drugs. Specific substance use, including nicotine, alcohol, cannabis and hallucinogens (but not amphetamine or cocaine use), is much higher in help-seeking youth with bipolar disorder than those without bipolar disorder [21].

Substance Use Disorder in people with Bipolar Disorder



The most severe form of substance use, substance use disorder, is present in 51% of men with bipolar disorder over the course of their lifetime [22]. This rate is somewhat lower but still quite high in women with bipolar disorder, at 34% [22]. The rates of substance use disorders are slightly lower in bipolar II disorder than in type I [22]. There tends to be more hospitalizations in people with both bipolar disorder and substance use disorders combined [22], and the presence of both conditions occurs more frequently in males, in people with more manic episodes and in people who have had suicidal thoughts or actions [23]. [13].

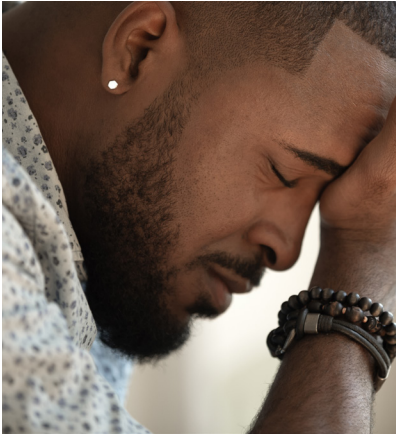
Rates of alcohol use disorder are especially high in people with bipolar disorder [22, 24], though in younger people with bipolar disorder cannabis use challenges may be even higher [21].

The connection between bipolar disorder and substance use is not entirely clear. For example, we know that cannabis use can lead to a 3-times increase in new onset of manic symptoms [25], and there is some evidence that nicotine use in pregnant mothers can predispose to bipolar disorder in their children [26]. Substance use, in general, is known to be a predictor of manic and hypomanic episodes [20, 27]. There are a variety of reasons a person may turn to drugs and/or alcohol. These can include trying to manage the symptoms of bipolar disorder, which when taken to extremes, can add further unwanted complications to their lives – and potentially troubling consequences. For example, sometimes people use alcohol to reduce the increased energy or excessive thinking that can come with mania and hypomania. Yet alcohol acts to “depress” the brain and can worsen the depressive episode that so often follows mania and hypomania.

It is very important to be aware of the risks involved in the consumption of any substance, and if a problem is beginning to emerge, recognizing the warning signs and taking steps to address the issue can prevent many problems.

Experiencing stigma

People can delay getting a diagnosis and seeking treatment for bipolar disorder for a variety of reasons. One of them is a fear of what friends, family and employers might think. Sadly, there is still some stigma attached to mental illnesses even though education about what mental illness is and isn't, has made great advancements and social attitudes are gradually changing.



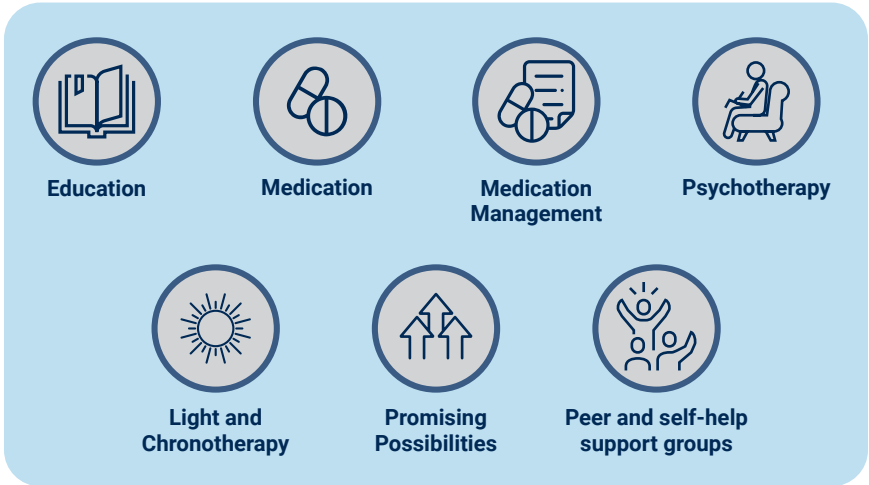
One of the challenges someone may face, after receiving a diagnosis is self-stigma – believing devaluing attitudes and blaming oneself for the illness.

Fortunately, people with mental illnesses can learn strategies to overcome this stigma. These strategies usually involve empowering oneself, through taking active involvement in your treatment and recovery and perhaps joining peer support groups. For some, speaking out about your experiences in public forums and becoming involved in advocacy efforts, not only overcomes self-stigma but helps educate others.

Often when a medication is prescribed to treat our illness, it may seem that being informed that you need medication can itself feel very stigmatizing. It is important to remember that you are experiencing a real illness, no different than someone who may need medication for other health conditions, like diabetes or high blood pressure. Because mental illnesses affect our behaviour and the way we think about ourselves, others and the world around us we tend to think they're different from other medical conditions. People may believe that having a mental illness is more of a commentary on their personality or who they are compared with, say, having diabetes and needing insulin. When the mind is affected it does seem more personal than when other parts of the body are affected. Sometimes, this needs to be a focus around which to support someone with bipolar disorder so they can recognize that they are not their illness and, therefore, they can accept any medication that is indicated.

How is bipolar disorder treated?

Effective treatment for bipolar disorder is a combination of many things, including education about the disorder to help with understanding the illness and self-management. Substance use treatment, medication, psychotherapy, peer and self-help groups, and support from family and friends may all be warranted.



Education



Learning about bipolar disorder, its signs and symptoms, treatment and triggers is an essential part of illness self-management. With knowledge, people with bipolar disorder and their families are better equipped to prevent future relapses and identify any that occur early.

This brochure is one-step in the process of education. An Internet search will reveal literally hundreds of sources of information. Look for sites published by credible organizations such as universities, hospitals and Lived Experienced organizations, patient and family groups. Visit www.mdsc.ca for your educational needs.

Substance use treatment: People who have both bipolar disorder and substance use problems (called concurrent disorders) need both problems addressed – in an integrated fashion. Addressing one problem while ignoring or neglecting the other often does not lead to a positive outcome. This can be challenging in a health care system that has fewer resources for either bipolar disorder or substance use disorders. Sometimes these components of the health care system are not well-integrated even when they are both available. Individuals and their families may need to advocate for both to be provided.

Medication



Medication is the cornerstone of treating bipolar disorder. The details of how medications alleviate the symptoms of bipolar disorder are not completely understood. There currently is no known cure for bipolar disorder (so that symptoms never come back), but medications are used to control the symptoms and may prevent progression of the illness. Because bipolar disorder symptoms reoccur, people require long-term treatment. Many people will need a number of medications to manage their symptoms and maintain wellness. All medications affect chemicals in the brain, often through neurotransmitters and complex mechanisms that are not completely understood.



Finding the right combination of medications requires monitoring and discussion with a family doctor or psychiatrist, and may involve consultation with a local dispensing pharmacist as well - noting that there are many choices and multiple combinations. While this process can be frustrating, the reality is that it can involve trying various treatments to get the most effective combination. Remember, it is your health, so be prepared to invest time, patience and persistence. Ultimately, the effort pays off when the most helpful medication regime is found and symptoms become well controlled.

The following are categories of medication choices. As mentioned, oftentimes more than one medication in more than one category of medications can be most useful.

Commonly, the use of a particular medication depends upon the side effects and other requirements of the medication. For example, some involve the need for regular blood work, particularly in the early stage of treatment and then intermittently thereafter. All have side effects, as does every medication – prescription or otherwise – and this can influence which medication is best for you. Sometimes it takes several trials to see which medication works best, with the fewest unwanted side effects.

Mood Stabilizers

Lithium was the first known mood stabilizer and is still in use today. It is the “gold standard” treatment against which others are compared. In addition to lithium, some of the anticonvulsants, which are prescribed for epilepsy, are recognized as excellent treatments as mood stabilizers for bipolar disorder.

Examples are valproate called valproic acid (many brand names) or divalproex sodium (Epival), carbamazepine (Tegretol), lamotrigine (Lamictal), gabapentin (Neurontin), and topiramate (Topamax). These have all been found to be helpful in the treatment of bipolar disorder [28].

Atypical Antipsychotics

The atypical antipsychotic medications are used to control psychotic symptoms in several types of mental illnesses and are also used in the management of symptoms of bipolar disorder in the manic, depressed or maintenance phases of the illness. The more commonly used anti-psychotics are olanzapine (Zyprexa), risperidone (Risperdal), ziprasidone (Zeldox), quetiapine (Seroquel, original formula and Seroquel XR, extended-release), aripiprazole (Abilify), lurasidone (Latuda), brexpiprazole (Rexalti), asenapine (Saphris), paliperidone (Invega), cariprazine (Vraylar), and clozapine (Clozaril). Several of these have been shown to be especially helpful in bipolar disorder, especially olanzapine, quetiapine, aripiprazole, risperidone, cariprazine and clozapine. Generally speaking, atypical antipsychotics are more helpful in children with bipolar disorder and are more problematic for elderly people with bipolar disorder because of side effects [28]. They may be used when a classical mood stabilizer alone is not effective or when psychotic symptoms are present.

Antidepressants

Antidepressants are often used together with a mood stabilizing medication. Common ones are fluoxetine (Prozac), paroxetine (Paxil), sertraline (Zoloft), citalopram (Celexa), escitalopram (Cipraxel), fluvoxamine (Luvox), venlafaxine (Effexor), desvenlafaxine (Pristiq), duloxetine (Cymbalta), mirtazapine (Remeron), bupropion (Wellbutrin SR), and vortioxetine (Trintillex). Older antidepressants include amitriptyline (Elavil), nortriptyline (Aventyl), imipramine (Tofranil), and desipramine (Norpramin), but these are only occasionally used today because they have more side effects than newer medications.

Antidepressants must be used with caution in people with bipolar I disorder. A mood stabilizer should always be in place first because otherwise an antidepressant can trigger mania or precipitate a cycle of frequent mood swings (rapid cycling) in bipolar I disorder [28]. It is not unusual for people with bipolar I disorder to need a low dose of an antidepressant with their mood stabilizer for some time in the year if they have seasonal drops in mood over the dark months.

The use of antidepressants is generally not seen as a problem in bipolar II disorder, where antidepressants can sometimes be used as a single medication to control the illness symptoms [28, 29]. The newer antidepressants are better for this than the older ones [28].

Sedative-hypnotic medication

These medications can be effective during manic episodes to instill much needed calm, but should be prescribed only for short periods of time because they are addictive. Examples are the benzodiazepines (Valium), lorazepam (Ativan), alprazolam (Xanax), and clonazepam (Rivotril).

Medication maintenance



People with bipolar disorder – just like people with other illnesses – may take their medications in an inconsistent manner, and they may discontinue medication once they are feeling better. There are a number of reasons this may trigger a relapse. First, suddenly stopping a medication that is used to control the symptoms of bipolar disorder can lead to a more likely recurrence of those symptoms [30]. Second, even with gradual discontinuation, there is a likelihood that symptoms will recur. It is a hard fact, but there is currently no cure for bipolar illness. People with bipolar disorder can and do lead healthy, happy and productive lives. A critical ingredient in their wellbeing is managing their medication effectively and for the long term.



Electroconvulsive therapy (ECT) can be useful for bipolar disorder, particularly for depressive episodes [31]. This is especially useful when other medication combinations have been tried and have failed. ECT sounds scary, but it has been around for decades and has been well researched and is generally safe [31].

Psychotherapy



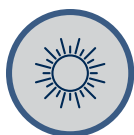
Psychotherapy is often used in conjunction with medications to treat bipolar disorder. Psychotherapy includes interpersonal psychotherapy (examination of patterns in relationship to self and others), cognitive-behavioural therapy (CBT) (examination of how thoughts and moods influence behaviours, and vice versa) and family therapy (examination of how close relationships can become healthy and supportive).



Psychoeducation is often quite helpful and may focus in on helping people identify their “early warning signs” of an impending episode of either mania/hypomania or depression, and can also help people learn to balance their lives better.

Leading a balanced life and circadian rhythm consistency: Everyone benefits from a balance in life but, for people with bipolar disorder, balance is even more important. Regular and healthy sleep patterns are crucial because lack of sleep or fluctuating sleep-wake habits can lead to relapse. Good nutrition, exercise, financial stability, something meaningful to do, participation in community, an enjoyment of nature or the arts, as well as attention to spirituality may be important additional ingredients in healthy living. Because of the mood destabilizing consequences of prolonged or extreme stress, people with bipolar disorder need to pay close attention to the quality of their personal and work relationships. No one can avoid stress all the time, but an understanding that excessive stress is, in fact, dangerous for people with bipolar disorder is truly important.

Light and Chronotherapy



For depressive episodes, light therapy can be useful for people with bipolar disorder and does not have the typical side effects of medications [33], though care must be taken to avoid inducing mania or hypomania with too much light exposure. Upcoming treatments for the full range of bipolar symptoms may include chronotherapy, with emphasis on adjusting circadian rhythms and sleep [34, 35].

Promising Possibilities



There is some evidence that ketamine and related medications can be used to successfully treat bipolar disorder [31, 32] and research trials are taking place to evaluate this in Canada and elsewhere. Additionally, “neuro-modulatory” therapies (direct or indirect brain stimulation, for example) may be available in the future, but are not currently approved for treatment. Researchers in the field continue to look for ways to improve the symptoms and the lives of people with bipolar disorder.

It is important to understand that it can be especially challenging for someone with bipolar disorder to “give up” hypomanic or mildly manic moods. This is because hypomania (especially euphoric hypomania) can lead someone to feel emotions more intensely and to have extra energy and accomplish more of their goals. A person may feel special, strong, smart or happy in ways they never do in a more balanced state of mind. Some people feel like they’re missing out on important parts of themselves and their lives if their mood is very well-controlled and they no longer have these extreme emotional states. This is why psychotherapy, peer and family supports can all be helpful.

Peer and self-help support groups



Peer and self-help groups are an important part of treatment. These groups offer the welcome message, “you are not alone.”

Members may exchange personal stories, effective (and not so effective) treatment experiences, share coping strategies and support one another through good and challenging times. They also talk about experiences of stigma and share ways to support one another. This can help with self-esteem in the face of challenging times with the illness.



Families and caregivers



Families and friends who support people with bipolar disorder may need support, themselves. Peer and self-help groups are considered an important way for them to understand what their loved one is experiencing and to help them to cope with their illness. These groups also offer families and caregivers the opportunity to share information, resources, and coping mechanisms to maintain their own mental health. Through personal experience, peers who have

“been there” can help families discuss difficult topics such as medication maintenance - something families and caregivers struggle with regularly - as well as the painful aftermath of a manic or depressive episode. Provincial peer and self-help support associations and other useful resources can be found at: www.mdsc.ca under ‘Finding Help’.

What does the future hold?



With proper treatment, people with bipolar disorder live full, productive lives.

“Recovery” is the word that people are using to describe living with bipolar disorder. Recovery is not about a cure. It’s about living a meaningful, healthy and hearty life - despite the challenges of a mental illness. Medical research is ongoing to find a cure, so remaining hopeful is realistic. As we learn more, a long-lasting cure may be forthcoming.

Where Can You Get More Information?

Mood Disorders Society of Canada (MDSC) is a national, not-for-profit, registered charitable organization formally launched and incorporated in 2001 with the overall objective of providing people with mood disorders with a strong, cohesive voice at the national level to improve access to treatment, inform research, and shape program development and government policies with the goal of improving the quality of life for people affected by mood disorders. MDSC has evolved to become one of Canada's best-connected mental health Non-Governmental Organizations with a demonstrated track record for forging and maintaining meaningful and sustained partnerships with the public, private and non-profit sectors throughout Canada.

The website (www.mdsc.ca) contains more information on bipolar disorder, as well as medications, depression and other mood disorders. You will find a wide array of educational resources, supports, programs and tools, and links to provincial Mood Disorders Associations. Of particular note is a popular MDSC publication called Quick Facts on Mental Illness and Addictions in Canada, which offers hundreds of facts and statistics about mental illness in an easy-to-read format.

Our website www.depressionhurts.ca provides further information on depression, including causes and symptoms, information on recovery and managing your depression symptoms, questions to ask your doctor, information for family and friends and much more. With over 3 million visitors, and available in four languages, we are sure this resource will be of great assistance in your journey.

How Can You Help?

At Mood Disorders Society of Canada, we strive to support the needs of Canadians impacted by mental illness. Without ongoing core funding, we rely on generous donations from the public to assist us in this work. If you would like to support our efforts, you can make a tax-deductible donation on our website or by mailing your donation to:

Mood Disorders Society of Canada,
46 Hope Crescent, Belleville, ON K8P 4S2

info@mdsc.ca | www.mdsc.ca

MDSC also leads the national mental health Defeat Depression campaign. You can take part in a walk, run and other physical and social activities to raise funds in support of mental health programs and services. Take your stand, let's support each other and tackle mental illness together. Please visit www.defeatdepression.ca

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Third Edition Publication May 2022



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