Entitlement Eligibility Guideline

Bipolar and Related Disorders

Date reviewed: 22 January 2025

Date created: May 2011

ICD-11 **codes:** 6A60, 6A6Z, 6A61

VAC medical code: 00608 Bipolar disorder

Definition

Bipolar and related disorders is a category of conditions in the *Diagnostic and Statistical Manual of Mental Disorders Fifth Edition- Text Revision* (*DSM-5-TR*). The common features of bipolar and related disorders are the presence of significant shifts in mood, energy, thinking and behaviours. Bipolar and related disorders are episodic mood disorders defined by the occurrence of manic, mixed, or hypomanic episodes or symptoms. These episodes typically alternate with depressive episodes or periods of depressive symptoms.

For the purposes of this entitlement eligibility guideline (EEG), the following bipolar and related disorders are included:

- bipolar I disorder
- bipolar II disorder
- cyclothymic disorder.

Note:

- Bipolar and related disorders, other than those listed, may be considered. However, the disorder should be adjudicated on the evidence provided and its own merits. Consultation with a disability consultant or medical advisor is recommended.
- If a substance, medication, or another medical condition is claimed to be related to the clinical onset or clinical aggravation of a bipolar and related disorder, consultation with a disability consultant or medical advisor is recommended.

Diagnostic standard

A diagnosis from a qualified medical practitioner (family physician or psychiatrist), nurse practitioner, or a registered/licensed psychologist is required.

The diagnosis is made clinically. Supporting documentation should be as comprehensive as possible.

Clinical features

The pathophysiology of bipolar and related disorders indicate there are specific considerations and links between genes, the environment, and symptoms consistent with bipolar and related disorders. However, none of the considerations for bipolar and related disorders alone are sufficient for the development of a bipolar and related disorder, and they operate at various levels to contribute to the onset and progression of the bipolar and related disorders.

Magnetic resonance imaging (MRI) has shown there are underlying brain alterations associated with bipolar disorder. Structural and functional neuroimaging show abnormalities in the neural circuitry of emotion and reward processing in individuals with bipolar disorder, compared to individuals without bipolar disorder.

Brain MRI research has revealed widespread patterns of lower cortical thickness, subcortical volume, and disrupted white matter integrity associated with bipolar disorder. Challenges remain in identifying strong and reproducible biomarkers to better understand the neurobiology of bipolar disorder and related disorders.

Biological considerations: Genetics strongly affect an individual's predisposition to developing a bipolar and related disorder. An increasing number of genetic variants have been associated with bipolar disorder. Genome-wide analyses have revealed hundreds of common genetic variants that are reliably associated with many psychiatric disorders, including bipolar disorder. Some twin studies have shown heritability estimates of bipolar disorder around 90%. Studies in identical twins show concordance rates less than 100%, indicating genes alone do not explain risk and environmental or other factors are also involved.

Environmental considerations: Childhood adversity influences the risk for developing bipolar disorder, and appears to predispose individuals to early onset of bipolar disorder. Cannabis and other substance use is associated with developing first onset of manic symptoms in the general population, as well as worsening of manic symptoms among individuals diagnosed with bipolar disorder.

Bipolar disorder affects males and females at nearly equal rates, but there are important sex differences in how bipolar disorder is experienced. While studies generally show no major differences in the overall prevalence of bipolar disorder between sexes, females are more likely to experience bipolar II, rapid cycling, and mixed episodes. A key factor for females is the impact of reproductive events, especially childbirth, which can trigger severe episodes of the disorder. Females with bipolar disorder often face more rapid mood changes, depressive episodes, and a higher risk of suicide attempts compared to males, who more frequently experience suicide deaths. Additionally, males are more likely to have their first episode as

mania, while females are more likely to experience depression first. The challenges of bipolar disorder during pregnancy are significant, as females are at a higher risk for negative outcomes and relapses after giving birth.

Criteria sets

The bipolar and related disorder criteria sets are derived from the *DSM-5-TR*. Diagnosis begins by diagnosing mood episodes and requires knowledge of the criteria sets for a manic episode, hypomanic episode, major depressive episode, bipolar I disorder, bipolar II disorder, and cyclothymic disorder. Diagnosis also requires clinicians to exclude other relevant disorders.

This EEG provides the *DSM-5-TR* diagnostic criteria; however, the *International Classification of Diseases 11th Revision (ICD-11)* is also considered an acceptable diagnostic standard.

Criteria set for manic episode

Criterion A

A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least one week and present most of the day, nearly every day (or any duration if hospitalization is necessary).

Criterion B

During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms (four if the mood is only irritable) are present to a significant degree and represent a noticeable change from usual behaviour:

1. inflated self-esteem or grandiosity
2. decreased need for sleep (e.g., feels rested after only three hours of sleep)
3. more talkative than usual or pressure to keep talking
4. flight of ideas or subjective experience that thoughts are racing
5. distractibility (e.g., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed
6. increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (e.g., purposeless non-goal-directed activity)
7. excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

Criterion C

The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

Criterion D

The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment) or another medical condition.

> **Note:** A full manic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a manic episode and, therefore, a bipolar I diagnosis.

Note: Criteria A–D constitute a manic episode. At least one lifetime manic episode is required for the diagnosis of bipolar I disorder.

Criteria set for hypomanic episode

Criterion A

A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy lasting at least four consecutive days and present most of the day, nearly every day.

Criterion B

During the period of mood disturbance and increased energy and activity, three (or more) of the following symptoms (four if the mood is only irritable) have persisted, represent a noticeable change from usual behaviour, and have been present to a significant degree:

1. inflated self-esteem or grandiosity
2. decreased need for sleep (e.g., feels rested after only three hours of sleep)
3. more talkative than usual or pressure to keep talking
4. flight of ideas or subjective experience that thoughts are racing
5. distractibility (e.g., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed
6. increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
7. excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

Criterion C

The episode is associated with an unequivocal change in functioning that is uncharacteristic of the individual when not symptomatic.

Criterion D

The disturbance in mood and the change in functioning are observable by others.

Criterion E

The episode is not severe enough to cause marked impairment in social or occupational functioning or to necessitate hospitalization. If there are psychotic features, the episode is, by definition, manic.

Criterion F

The episode is not attributable to the physiologic effects of a substance (e.g., a drug of abuse, a medication, other treatment).

> **Note:** A full hypomanic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a hypomanic episode diagnosis. However, caution is indicated so that one or two symptoms (particularly increased irritability, edginess, or agitation following antidepressant use) are not taken as sufficient for diagnosis of a hypomanic episode, nor necessarily indicative of a bipolar diathesis.

Note: Criteria A–F constitute a hypomanic episode. Hypomanic episodes are common in bipolar I disorder but are not required for the diagnosis of bipolar I disorder.

Criteria set for major depressive episode

Criterion A

Five (or more) of the following symptoms have been present during the same two-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

> **Note:** Do not include symptoms that are clearly attributable to another medical condition.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report, (e.g., feels sad, empty, or hopeless) or observation made by others (e.g., appears tearful).
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day, (as indicated by subjective account or observation).
3. Significant weight loss when not dieting or weight gain, (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or observation by others.
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

Criterion B

The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Criterion C

The episode is not attributable to the physiological effects of a substance or another medical condition.

Note:

- Criteria A–C constitute a major depressive episode. Major depressive episodes are common in bipolar I disorder but are not required for the diagnosis of bipolar I disorder.

- Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss.

Criteria set for bipolar I disorder

Criterion A

Criteria have been met for at least one manic episode (Criteria A–D under "manic episode" above).

Criterion B

At least one manic episode is not better explained by schizoaffective disorder and is not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.

Criteria set for bipolar II disorder

For a diagnosis of bipolar II disorder, it is necessary to meet the following criteria for a current or past hypomanic episode and the following criteria for a current or past major depressive episode:

Criterion A

Criteria have been met for least one hypomanic episode (Criteria A–F under hypomanic episode above) and at least one major depressive episode (Criteria A–C under major depressive episode above).

Criterion B

There has never been a manic episode.

Criterion C

At least one hypomanic episode and at least one major depressive episode are not better explained by schizoaffective disorder and are not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.

Criterion D

The symptoms of depression or the unpredictability caused by frequent alternation between periods of depression and hypomania causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Criteria set for cyclothymic disorder

Criterion A

For at least two years, there have been numerous periods with hypomanic symptoms that do not meet criteria for a hypomanic episode and numerous periods with depressive symptoms that do not meet criteria for a major depressive episode.

Criterion B

During the above two year period, Criterion A symptoms have been present for at least half the time and the individual has not been without the symptoms for more than two months at a time.

Criterion C

Criteria for a major depressive, manic, or hypomanic episode have never been met.

Criterion D

The symptoms in Criterion A are not better accounted for by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.

Criterion E

The symptoms are not attributable to the physiologic effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).

Criterion F

The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Entitlement considerations

Section A: Causes and/or aggravation

Causal or aggravating factors versus predisposing factors

Causal or aggravating factors directly result in the onset or aggravation of the claimed psychiatric condition.

Predisposing factors make an individual more susceptible to developing the claimed condition. They are experiences or exposures which affect the individual's ability to cope with stress. For example, severe childhood abuse may be a predisposing factor in the onset of a significant psychiatric condition later in life. These factors do not cause a claimed condition. Partial entitlement should not be considered for predisposing factors.

Physical/constitutional symptoms are prevalent in people living with psychiatric diagnoses and are often associated with psychological distress. Physical and mental health symptoms frequently co-occur. Physical symptoms associated with psychiatric conditions are included in entitlement/assessment. However, once a symptom has developed into a separate and distinct diagnosis, the new diagnosis becomes a separate entitlement consideration.

For Veterans Affairs Canada (VAC) entitlement purposes, the following factors are accepted to cause or aggravate the conditions included in the Definition section of this EEG, and may be considered along with the evidence to assist in establishing a relationship to service. The factors have been determined based on a review of up-to-date scientific and medical literature, as well as evidence-based medical best practices. Factors other than those listed may be considered, however consultation with a disability consultant or medical advisor is recommended.

The timelines cited below are for guidance purposes. Each case should be adjudicated on the evidence provided and its own merits.

Factors

1. Directly experiencing a **traumatic event(s)** within one year before the clinical onset or aggravation of a bipolar and related disorder.

   Traumatic events include, but are not limited to:

   - exposure to military combat
   - threatened or actual physical assault
   - threatened or actual sexual trauma
   - being kidnapped
   - being taken hostage
   - being in a terrorist attack
   - being tortured
   - incarceration as a prisoner of war
   - being in a natural or human-made disaster
   - being in a severe motor vehicle accident
   - killing or injuring a person
   - experiencing a sudden, catastrophic medical incident.

2. **In-person witnessing** of a traumatic event(s) as it occurred to another person(s) within one year before the clinical onset or aggravation of a bipolar and related disorder.

   Witnessed traumatic events include, but are not limited to:

   - threatened or serious injury to another person
   - an unnatural death
   - physical or sexual abuse of another person
   - a medical catastrophe in a close family member or close friend.

3. Experiencing **repeated or extreme exposure** to aversive details of a traumatic event(s) within one year before the clinical onset or aggravation of a bipolar and related disorder.

   Exposures include, but are not limited to:

   - viewing and/or collecting human remains
   - viewing and/or participating in the clearance of critically injured casualties
   - repeated exposure to the details of abuse and/or atrocities inflicted on another person(s)
   - dispatch operators exposed to violent or accidental traumatic event(s).

   Note: If the exposure under factor three is to electronic media, television, movies and pictures, the exposure must be work-related.

4. Living or working in a **hostile or life-threatening environment** for a period of at least four weeks before the clinical onset or aggravation of a bipolar and related disorder.

   Situations or settings which have a pervasive threat to life or body include, but are not limited to:

   - being under threat of artillery, missile, rocket, mine, or bomb attack
   - being under threat of nuclear, biologic, or chemical agent attack
   - being involved in combat or going on combat patrols.

5. Experiencing the **death of a close family member or close friend** within one year before the clinical onset or aggravation of a bipolar and related disorder.

   Note: The relationship between individuals in a leadership role and subordinates should be considered akin to close family or friend.

6. Experiencing a **stressful life event** within one year before the clinical onset or aggravation of a bipolar and related disorder.

   Events which qualify as stressful life events include, but are not limited to:

- being socially isolated and unable to maintain friendships or family relationships, due to physical location, language barriers, disability, or medical or psychiatric illness
- experiencing a problem with a long-term relationship including: the break-up of a close personal relationship, the need for marital or relationship counselling, marital separation or divorce
- having concerns in the work or school environment including: ongoing conflict with fellow work or school colleagues, perceived lack of social support within the work or school environment, perceived lack of control over tasks performed and stressful workloads, or experiencing bullying in the workplace or school environment
- experiencing serious legal issues including: being detained or held in custody, ongoing involvement with law enforcement concerning violations of the law or court appearances associated with personal legal problems
- having severe financial hardship including, but not limited to: loss of employment, long periods of unemployment, foreclosure on a property, or bankruptcy
- having a close family member or close friend experience a major deterioration in their health
- being a full-time caregiver to a family member or close friend with a severe physical, mental or developmental disability.

7. Being within the one-year period following **childbirth** at the time of the clinical onset or aggravation of a bipolar and related disorder.

8. Having a **substance use disorder** at the time of the clinical onset or aggravation of a bipolar and related disorder.

9. Having an **alcohol use disorder** at the time of the clinical onset or aggravation of a bipolar and related disorder.

10. Inability to obtain **appropriate clinical management** of a bipolar and related disorder.

Section B: Medical conditions which are to be included in entitlement/assessment

Section B provides a list of diagnosed medical conditions/categories which are considered for VAC purposes to be included in the entitlement and assessment of bipolar and related disorders.

- All other bipolar and related disorders
- All other trauma-and stressor-related disorders
- Adjustment disorder
- Anxiety disorders
- Depressive disorders

- Dissociative disorders
- Feeding and eating disorders
- Neurodevelopmental disorders
    - Attention-deficit/hyperactivity disorder
- Obsessive-compulsive and related disorders
- Pain disorder (*Diagnostic and Statistical Manual of Mental Disorders Fourth Edition-Text Revision* [*DSM-4-TR*] Axis I Diagnosis)
- Personality disorders
- Posttraumatic stress disorder
- Schizophrenia spectrum and other psychotic disorders
- Sleep-wake disorders
    - Insomnia disorder
    - Hypersomnolence disorder
- Somatic symptom disorder with predominant pain (previously pain disorder in the *DSM-4-TR*)
- Substance use disorders

Note:

- If specific conditions are listed for a category, only these conditions are included in the entitlement and assessment of a bipolar and related disorder. Otherwise, all conditions within the category are included in the entitlement and assessment of bipolar and related disorder.
- Separate entitlement is required for a *DSM-5-TR* condition not included in Section B of this EEG.
- Somatic symptom and related disorders, such as functional neurological symptom disorder (conversion disorder), somatic symptom disorder, illness anxiety disorder, and bodily distress disorder (*ICD-11* diagnosis) are entitled separately and assessed on individual merits.

Section C: Common medical conditions which may result in whole or in part, from a bipolar and related disorder and/or its treatment

Section C is a list of conditions which can be caused or aggravated by bipolar and related disorders and/or their treatment. Conditions listed in Section C are not included in the entitlement and assessment of bipolar and related disorders. A consequential entitlement decision may be considered where the individual merits and the medical evidence of the case support a consequential relationship.

Conditions other than those listed in Section C may also be considered; consultation with a disability consultant or medical advisor is recommended.

- Bruxism
- Irritable bowel syndrome
- Ischemic heart disease

- Obstructive sleep apnea
- Periodic limb movement disorder
- Restless leg syndrome
- Salivary gland hypofunction disorder (xerostomia)
- Sexual dysfunction

If it is claimed a medication required to treat a bipolar and related disorder resulted in whole, or in part, in the clinical onset or aggravation of a medical condition the following must be established:

- The medication was prescribed to treat a bipolar and related disorder.
- The individual was receiving the medication at the time of the clinical onset or aggravation of the condition being claimed to the medication.
- The current medical literature supports the medication can result in the clinical onset or aggravation of the condition being claimed to the medication.
- The medication use is long-term, ongoing, and cannot reasonably be replaced with another medication or the medication is known to have enduring effects after discontinuation.

Note: Individual medications may belong to a class of medications. The effects of a specific medication may vary from the grouping. The effects of the specific medication should be considered.

Links

Related VAC guidance and policy:

- Adjustment Disorder – Entitlement Eligibility Guidelines
- Anxiety Disorders – Entitlement Eligibility Guidelines
- Bruxism – Entitlement Eligibility Guidelines
- Depressive Disorders – Entitlement Eligibility Guidelines
- Feeding and Eating Disorders – Entitlement Eligibility Guidelines
- Ischemic Heart Disease - Entitlement Eligibility Guidelines
- Posttraumatic Stress Disorder – Entitlement Eligibility Guidelines
- Salivary Gland Hypofunction Disorder (Xerostomia) - Entitlement Eligibility Guidelines
- Schizophrenia – Entitlement Eligibility Guidelines
- Sleep-Related Breathing Disorders – Entitlement Eligibility Guidelines
- Substance Use Disorders – Entitlement Eligibility Guidelines
- Pain and Suffering Compensation – Policies
- Royal Canadian Mounted Police Disability Pension Claims – Policies
- Dual Entitlement – Disability Benefits – Policies
- Establishing the Existence of a Disability – Policies
- Disability Benefits in Respect of Peacetime Military Service – The Compensation Principle – Policies

- Disability Benefits in Respect of Wartime and Special Duty Service – The Insurance Principle – Policies
- Disability Resulting from a Non-Service Related Injury or Disease – Policies
- Consequential Disability – Policies
- Benefit of Doubt – Policies

References as of 22 January 2025

Anttila, V., Bulik-Sullivan, B., Finucane, H. K., Walters, R. K., Bras, J., Duncan, L., Escott-Price, V., Falcone, G. J., Gormley, P., Malik, R., Patsopoulos, N. A., Ripke, S., Wei, Z., Yu, D., Lee, P. H., Turley, P., Grenier-Boley, B., Chouraki, V., Kamatani, Y., … Brainstorm Consortium (2018). Analysis of shared heritability in common disorders of the brain. *Science*, *360*(6395). https://doi.org/10.1126/science.aap8757

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders- text revision* (4th ed., text rev.).

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5* (5th ed.).

American Psychiatric Association (Ed.). (2022). *Diagnostic and statistical manual of mental disorders: DSM-5-TR* (5th ed., text rev.).

Australian Government. (2009). *Statement of Principles concerning bipolar disorder (Balance of Probabilities) (No. 28 of 2009).* SOPs - Repatriation Medical Authority

Australian Government. (2009). *Statement of Principles concerning bipolar disorder (Reasonable Hypothesis) (No. 27 of 2009).* SOPs - Repatriation Medical Authority

Australian Government. (2018). *Statement of Principles concerning bipolar disorder (Balance of Probabilities) (No. 54 of 2018)*. SOPs - Repatriation Medical Authority

Australian Government. (2018). *Statement of Principles concerning bipolar disorder (Reasonable Hypothesis) (No. 53 of 2018)*. SOPs - Repatriation Medical Authority

Bipolar disorder: Clinical and neurobiological foundations. (2013). Wiley.

Bland, R.C., Newman, S.C., & Orn, H. (1988a). Period prevalence of psychiatric disorders in Edmonton. *Acta Psychiatrica Scandinavica, Supplementum*, *338*, 24–32. https://doi.org/10.1111/j.1600-0447.1988.tb08545.x

Bland, R.C., Orn, H., & Newman, S.C. (1988b). Lifetime prevalence of psychiatric disorders in Edmonton. *Acta Psychiatrica Scandinavica, Supplementum, 338*, 24–32. https://doi.org/10.1111/j.1600-0447.1988.tb08544.x

Blosnich, J., Foynes, M. M., & Shipherd, J. C. (2013). Health Disparities Among Sexual Minority Women Veterans. *Journal of Women's Health*, *22*(7), 631–636. https://doi.org/10.1089/jwh.2012.4214

Blosnich, J. R., Gordon, A. J., & Fine, M. J. (2015). Associations of sexual and gender minority status with health indicators, health risk factors, and social stressors in a national sample of young adults with military experience. *Annals of Epidemiology*, *25*(9), 661–667. https://doi.org/10.1016/j.annepidem.2015.06.001

Blumberg, H. P., Krystal, J. H., Bansal, R., Martin, A., Dziura, J., Durkin, K., Martin, L., Gerard, E., Charney, D. S., & Peterson, B. S. (2006). Age, rapid-cycling, and pharmacotherapy effects on ventral prefrontal cortex in bipolar disorder: A

cross-sectional study. *Biological Psychiatry*, *59*(7), 611-618. https://doi.org/10.1016/j.biopsych.2005.08.031

Buoli, M., Serati, M., & Altamura, A. C. (2017). Biological aspects and candidate biomarkers for rapid-cycling in bipolar disorder: A systematic review. *Psychiatry Research*, *258*, 565-575. https://doi.org/10.1016/j.psychres.2017.08.059

Carbone, J. T., Holzer, K. J., Vaughn, M. G., & DeLisi, M. (2020). Homicidal Ideation and Forensic Psychopathology: Evidence From the 2016 Nationwide Emergency Department Sample (NEDS). *Journal of Forensic Sciences*, *65*(1), 154–159. https://doi.org/10.1111/1556-4029.14156

Chan, P. K. (2016). Mental health and sexual minorities in the Ohio Army National Guard [Case Western Reserve University School of Graduate Studies]. http://rave.ohiolink.edu/etdc/view?acc_num=case1458924994

Chang, C. J., Fischer, I. C., Depp, C. A., Norman, S. B., Livingston, N. A., & Pietrzak, R. H. (2023). A disproportionate burden: Prevalence of trauma and mental health difficulties among sexual minority versus heterosexual U.S. military veterans. *Journal of Psychiatric Research*, *161*, 477–482. https://doi.org/10.1016/j.jpsychires.2023.03.042

Chin, S., Carlucci, S., McCuaig Edge, H. J., & Lu, D. (2022). Health differences by entry stream among Canadian Armed Forces officer cadets. *Journal of Military, Veteran and Family Health*, *8*(3), 45–57. https://doi.org/10.3138/jmvfh-2021-0124

Ching, C. R. K., Hibar, D. P., Gurholt, T. P., Nunes, A., Thomopoulos, S. I., Abé, C., Agartz, I., Brouwer, R. M., Cannon, D. M., de Zwarte, S. M. C., Eyler, L. T., Favre, P., Hajek, T., Haukvik, U. K., Houenou, J., Landén, M., Lett, T. A., McDonald, C., Nabulsi, L.,

Patel, Y., … ENIGMA Bipolar Disorder Working Group (2022). What we learn about bipolar disorder from large-scale neuroimaging: Findings and future directions from the ENIGMA Bipolar Disorder Working Group. *Human Brain Mapping*, *43*(1), 56–82. https://doi.org/10.1002/hbm.25098

Cochran, B. N., Balsam, K., Flentje, A., Malte, C. A., & Simpson, T. (2013). Mental Health Characteristics of Sexual Minority Veterans. *Journal of Homosexuality*, *60*(2–3), 419–435. https://doi.org/10.1080/00918369.2013.744932

Dell'Osso, B., Cafaro, R., & Ketter, T. A. (2021). Has Bipolar Disorder become a predominantly female gender related condition? Analysis of recently published large sample studies. *International Journal of Bipolar Disorders*, *9*(1), 3. https://doi.org/10.1186/s40345-020-00207-z

DellOsso, B., Cremaschi, L., Macellaro, M., & Cafaro, R. (. (2022). Gender and Sex Issues in Bipolar Disorder. Psychiatric Times. *Psychiatric Times*, *39*(6), 36–38.

Diflorio, A., & Jones, I. (2010). Is sex important? Gender differences in bipolar disorder. *International Review of Psychiatry*, *22*(5), 437–452. https://doi.org/10.3109/09540261.2010.514601

Gandal, M. J., Haney, J. R., Parikshak, N. N., Leppa, V., Ramaswami, G., Hartl, C., Schork, A. J., Appadurai, V., Buil, A., Werge, T. M., Liu, C., White, K. P., Commonmind Consortium, Psychencode Consortium, Ipsych-Broad Working Group, Horvath, S., & Geschwind, D. H. (2018). Shared molecular neuropathology across major psychiatric disorders parallels polygenic overlap. *Science*, *359*(6376), 693–697. https://doi.org/10.1101/040022

Ganzola, R., & Duchesne, S. (2017). Voxel-based morphometry meta-analysis of gray and white matter finds significant areas of differences in bipolar patients from healthy controls. *Bipolar Disorders*, *19*(2), 74–83. https://doi.org/10.1111/bdi.12488

Goodwin, F. K., & Jamison, K. R. (2007). *Manic-depressive illness: Bipolar disorders and recurrent depression* (Vol. 2). Oxford University Press.

Gorman, K. R., Kearns, J. C., Pantalone, D. W., Bovin, M. J., Keane, T. M., & Marx, B. P. (2022). The impact of deployment-related stressors on the development of PTSD and depression among sexual minority and heterosexual female veterans. *Psychological Trauma: Theory, Research, Practice, and Policy*, *14*(5), 747–750. https://doi.org/10.1037/tra0001102

Grant, B.F., Stinson, F.S., Hasin, D.S., Dawson, D.A., Chou, S.P., Ruan, W.J., & Huang, B. (2005). Prevalence, correlates, and comorbidity of bipolar I disorder and axis I and II disorders: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Journal of Clinical Psychiatry*, *66*, 1205–1215. https://doi.org/10.4088/jcp.v66n1001

Gressier, F., Calati, R., & Serretti, A. (2016). 5-HTTLPR and gender differences in affective disorders: A systematic review. *Journal of Affective Disorders*, *190*, 193–207. https://doi.org/10.1016/j.jad.2015.09.027

Hajek, T., Cullis, J., Novak, T., Kopecek, M., Blagdon, R., Propper, L., Stopkova, P., Duffy, A., Hoschl, C., Uher, R., Paus, T., Young, L. T., & Alda, M. (2013). Brain structural signature of familial predisposition for bipolar disorder: Replicable evidence for involvement of the right inferior frontal gyrus. *Biological Psychiatry*, *73*(2), 144–152. https://doi.org/10.1016/j.biopsych.2012.06.015

Hajek, T., Kopecek, M., Höschl, C., & Alda, M. (2012). Smaller hippocampal volumes in patients with bipolar disorder are masked by exposure to lithium: A meta-analysis. *Journal of Psychiatry & Neuroscience*, *37*(5), 333–343. https://doi.org/10.1503/jpn.110143

Hajek, T., Kopecek, M., Kozeny, J., Gunde, E., Alda, M., & Hoschl, C. (2009). Amygdala volumes in mood disorders - Meta-analysis of magnetic resonance volumetry studies. *Journal of Affective Disorders*, *115*(3), 395–410. https://doi.org/10.1016/j.jad.2008.10.007

Harper, K. L., Blosnich, J. R., Livingston, N., Vogt, D., Bernhard, P. A., Hoffmire, C. A., Maguen, S., & Schneiderman, A. (2024). Examining differences in mental health and mental health service use among lesbian, gay, bisexual, and heterosexual veterans. *Psychology of Sexual Orientation and Gender Diversity*. https://doi.org/10.1037/sgd0000712

Holloway, I. W., Green, D., Pickering, C., Wu, E., Tzen, M., Goldbach, J. T., & Castro, C. A. (2021). Mental Health and Health Risk Behaviors of Active Duty Sexual Minority and Transgender Service Members in the United States Military. *LGBT Health*, *8*(2), 152–161. https://doi.org/10.1089/lgbt.2020.0031

Hu, F.-H., Jia, Y.-J., Zhao, D.-Y., Fu, X.-L., Zhang, W.-Q., Tang, W., Hu, S.-Q., Wu, H., Ge, M.-W., Du, W., Shen, W.-Q., & Chen, H.-L. (2023). Gender differences in suicide among patients with bipolar disorder: A systematic review and meta-analysis. *Journal of Affective Disorders*, *339*, 601–614. https://doi.org/10.1016/j.jad.2023.07.060

Kato T. (2019). Current understanding of bipolar disorder: Toward integration of biological basis and treatment strategies. *Psychiatry and Clinical Neurosciences*, *73*(9), 526–540. https://doi.org/10.1111/pcn.12852

Kauth, M. R., & Shipherd, J. C. (2016). Transforming a System: Improving Patient-Centered Care for Sexual and Gender Minority Veterans. *LGBT Health*, *3*(3), 177–179. https://doi.org/10.1089/lgbt.2016.0047

Lehavot, K., Beckman, K. L., Chen, J. A., Simpson, T. L., & Williams, E. C. (2019). Race/ethnicity and sexual orientation disparities in mental health, sexism, and social support among women veterans. *Psychology of Sexual Orientation and Gender Diversity*, *6*(3), 347–358. https://doi.org/10.1037/sgd0000333

Lehavot, K., Beckman, K. L., Chen, J. A., Simpson, T. L., & Williams, E. C. (2019). Race/ethnicity and sexual orientation disparities in mental health, sexism, and social support among women veterans. *Psychology of Sexual Orientation and Gender Diversity*, *6*(3), 347–358. https://doi.org/10.1037/sgd0000333

Lehavot, K., & Simpson, T. L. (2014). Trauma, posttraumatic stress disorder, and depression among sexual minority and heterosexual women veterans. *Journal of Counseling Psychology*, *61*(3), 392–403. https://doi.org/10.1037/cou0000019

Lynch, K. E., Gatsby, E., Viernes, B., Schliep, K. C., Whitcomb, B. W., Alba, P. R., DuVall, S. L., & Blosnich, J. R. (2020). Evaluation of Suicide Mortality Among Sexual Minority US Veterans From 2000 to 2017. *JAMA Network Open*, *3*(12), e2031357. https://doi.org/10.1001/jamanetworkopen.2020.31357

Mattocks, K. M., Kauth, M. R., Sandfort, T., Matza, A. R., Sullivan, J. C., & Shipherd, J. C. (2014). Understanding Health-Care Needs of Sexual and Gender Minority

Veterans: How Targeted Research and Policy Can Improve Health. *LGBT Health*, *1*(1), 50–57. https://doi.org/10.1089/lgbt.2013.0003

McDonald, J. L., Ganulin, M. L., Dretsch, M. N., Taylor, M. R., & Cabrera, O. A. (2020). Assessing the Well-being of Sexual Minority Soldiers at a Military Academic Institution. *Military Medicine*, *185*(Suppl 1), 342–347. https://doi.org/10.1093/milmed/usz198

McGuffin, P., Rijsdijk, F., Andrew, M., Sham, P., Katz, R., & Cardno, A. (2003). The heritability of bipolar affective disorder and the genetic relationship to unipolar depression. *Archives of General Psychiatry*, *60*(5), 497-502. https://doi.org/10.1001/archpsyc.60.5.497

McNamara, K. A., Lucas, C. L., Goldbach, J. T., Kintzle, S., & Castro, C. A. (2019). Mental health of the bisexual Veteran. *Military Psychology*, *31*(2), 91–99. https://doi.org/10.1080/08995605.2018.1541393

Mitchell, P.B., Slade, T., & Andrews, G. (2004). Twelve-month prevalence and disability of DSM-IV bipolar disorder in an Australian general population survey. *Psychological Medicine*, *34*, 777–785. https://doi.org/10.1017/s0033291703001636

Narita, K., Suda, M., Takei, Y., Aoyama, Y., Majima, T., Kameyama, M., Kosaka, H., Amanuma, M., Fukuda, M., & Mikuni, M. (2011). Volume reduction of ventromedial prefrontal cortex in bipolar II patients with rapid cycling: A voxel-based morphometric study. *Progress in Neuro-Psychopharmacology and Biological Psychiatry*, *35*(2), 439-445. https://doi.org/10.1016/j.pnpbp.2010.11.030

Oakley, T., King, L., Ketcheson, F., & Richardson, J. D. (2020). Gender differences in clinical presentation among treatment-seeking Veterans and Canadian

Armed Forces personnel. *Journal of Military, Veteran and Family Health*, *6*(2), 60–67. https://doi.org/10.3138/jmvfh-2019-0045

Pelts, M. D., & Albright, D. L. (2015). An Exploratory Study of Student Service Members/Veterans' Mental Health Characteristics by Sexual Orientation. *Journal of American College Health*, *63*(7), 508–512. https://doi.org/10.1080/07448481.2014.947992

Phillips, M. L., & Swartz, H. A. (2014). A critical appraisal of neuroimaging studies of bipolar disorder: Toward a new conceptualization of underlying neural circuitry and a road map for future research. *The American Journal of Psychiatry*, *171*(8), 829–843. https://doi.org/10.1176/appi.ajp.2014.13081008

Quevedo, J., & Yatham, L. N. (2018). Biomarkers in mood disorders: Are we there yet? *Journal of Affective Disorders*, *233*, 1–2. https://doi.org/10.1016/j.jad.2018.01.002

Richardson, J. D., Thompson, A., King, L., Ketcheson, F., Shnaider, P., Armour, C., St. Cyr, K., Sareen, J., Elhai, J. D., & Zamorski, M. A. (2019). Comorbidity patterns of psychiatric conditions in Canadian Armed Forces personnel. *The Canadian Journal of Psychiatry*, *64*(7), 501–510. https://doi.org/10.1177/0706743718816057

Rimol, L. M., Hartberg, C. B., Nesvag, R., Fennema-Notestine, C., Hagler, D. J., Jr., Pung, C. J., Jennings, R. G., Haukvik, U. K., Lange, E., Naksand, P. H., Melle, I., Andreassen, O. A., Dale, A. M., & Agartz, I. (2010). Cortical thickness and subcortical volumes in schizophrenia and bipolar disorder. *Biological Psychiatry*, *68*(1), 41–50. https://doi.org/10.1016/j.biopsych.2010.03.036

Rimol, L. M., Nesvag, R., Hagler, D. J., Jr., Bergmann, O., Fennema-Notestine, C., Hartberg, C. B., Haukvik, U. K., Lauge, E., Pung, C. J., Server, A., Melle, I., Andreassen, O. A., Agartz, I., & Dale, A. M. (2012). Cortical volume, surface area,

and thickness in schizophrenia and bipolar disorder. *Biological Psychiatry*, *71*(6), 552–560. https://doi.org/10.1016/j.biopsych.2011.11.026

Ruderfer, D. M., Ripke, S., McQuillin, A., Boocock, J., Stahl, E. A., Pavlides, J. M. W., Mullins, N., Charney, A. W., Ori, A. P. S., Loohuis, L. M. O., Domenici, E., Di Florio, A., Papiol, S., Kalman, J. L., Trubetskoy, V., Adolfsson, R., Agartz, I., Agerbo, E., Akil, H., … Wellcome Trust Case-Control Consortium (2018). Genomic dissection of bipolar disorder and schizophrenia, including 28 subphenotypes. *Cell*, *173*(7), 1705-1715.e16. https://doi.org/10.1016/j.cell.2018.05.046

Russell, P. D., Judkins, J. L., Blessing, A., Moore, B., & Morissette, S. B. (2022). Incidences of anxiety disorders among active duty service members between 1999 and 2018. *Journal of Anxiety Disorders*, *91*, 102608. https://doi.org/10.1016/j.janxdis.2022.102608

Sadock B. J., Sadock V. A. (Eds.). (2010). *Kaplan & Sadock's comprehensive textbook of psychiatry* (8th ed.). Lippincott Williams & Wilkins Publishers.

Seedat, S., Scott, K. M., Angermeyer, M. C., Berglund, P., Bromet, E. J., Brugha, T. S., Demyttenaere, K., de Girolamo, G., Haro, J. M., Jin, R., Karam, E. G., Kovess-Masfety, V., Levinson, D., Medina Mora, M. E., Ono, Y., Ormel, J., Pennell, B. E., Posada-Villa, J., Sampson, N. A., Williams, D., … Kessler, R. C. (2009). Cross-national associations between gender and mental disorders in the World Health Organization World Mental Health Surveys. *Archives of General Psychiatry , 66*(7), 785–795. 10.1001/archgenpsychiatry.2009.36

Shipherd, J. C., Lynch, K., Gatsby, E., Hinds, Z., DuVall, S. L., & Livingston, N. A. (2021). Estimating prevalence of PTSD among veterans with minoritized sexual

orientations using electronic health record data. *Journal of Consulting and Clinical Psychology*, *89*(10), 856–868. https://doi.org/10.1037/ccp0000691

Stahl, E. A., Breen, G., Forstner, A. J., McQuillin, A., Ripke, S., Trubetskoy, V., Mattheisen, M., Wang, Y., Coleman, J. R. I., Gaspar, H. A., de Leeuw, C. A., Steinberg, S., Pavlides, J. M. W., Trzaskowski, M., Byrne, E. M., Pers, T. H., Holmans, P. A., Richards, A. L., Abbott, L., Agerbo, E., … Bipolar Disorder Working Group of the Psychiatric Genomics Consortium (2019). Genome-wide association study identifies 30 loci associated with bipolar disorder. *Nature Genetics*, *51*(5), 793–803. https://doi.org/10.1038/s41588-019-0397-8

Vieta, E., Berk, M., Schulze, T. G., Carvalho, A. F., Suppes, T., Calabrese, J. R., Gao, K., Miskowiak, K. W., & Grande, I. (2018). Bipolar disorders. *Nature Reviews Disease Primers*, *4*, 18008. https://doi.org/10.1038/nrdp.2018.8

Vieta, E., & Phillips, M. L. (2007). Deconstructing bipolar disorder: A critical review of its diagnostic validity and a proposal for DSM-V and ICD-11. *Schizophrenia Bulletin, 33*(4), 886–892. https://doi.org/10.1093/schbul/sbm057

World Health Organization. (2019). *International statistical classification of diseases and related health problems* (11th Revision). https://icd.who.int/

Wray, N. R., Ripke, S., Mattheisen, M., Trzaskowski, M., Byrne, E. M., Abdellaoui, A., Adams, M. J., Agerbo, E., Air, T. M., Andlauer, T. M. F., Bacanu, S. A., Bækvad-Hansen, M., Beekman, A. F. T., Bigdeli, T. B., Binder, E. B., Blackwood, D. R. H., Bryois, J., Buttenschøn, H. N., Bybjerg-Grauholm, J., … Sullivan, P. F. (2018). Genome-wide association analyses identify 44 risk variants and refine the genetic architecture of major depression. *Nature Genetics*, *50*(5), 668-681. https://doi.org/10.1038/s41588-018-0090-3