Frontal-Amygdala Connectivity Alterations During Emotion Downregulation in Bipolar I Disorder

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Background: The symptoms of bipolar disorder suggest dysfunction of emotion regulatory networks. In healthy control populations, downregulation of emotional responses activates the ventral lateral prefrontal cortex (vPFC) and dampens amygdala activation. This study investigated frontal and limbic function and connectivity during emotion downregulation in euthymic subjects with bipolar I disorder (BPI) and healthy control subjects.

Methods: Thirty BPI and 26 control subjects underwent functional magnetic resonance imaging scanning while performing an emotion processing task with passive viewing and emotion downregulation conditions. Contrasts were made for each group comparing the downregulation and passive viewing conditions, and these were entered into a between-group random effects analysis to assess group differences in activation. Psychophysiological interaction analyses were conducted to test for significant group differences in functional connectivity between the amygdala and inhibitory frontal regions (i.e., vPFC).

Results: Control subjects showed the expected robust bilateral activation of frontal and limbic regions during passive viewing and emotion downregulation tasks. Between-group analyses revealed similar activation of BPI and control subjects during passive viewing but significantly decreased activation in bilateral vPFC, bilateral anterior and posterior cingulate, medial frontal gyrus, and bilateral dorsal lateral prefrontal cortex during emotion downregulation in subjects with BPI. Connectivity analysis demonstrated that control subjects had significantly greater negative functional connectivity between the left amygdala and bilateral vPFC compared with subjects with BPI.

Conclusions: This study provides evidence that dysfunction in the neural networks responsible for emotion regulation, including the prefrontal cortex, cingulate, and subcortical structures, are present in BPI subjects, even while euthymic.

Key Words: Amygdala, bipolar disorder, emotion regulation, functional connectivity, functional neuroimaging, vPFC

Emotion processing involves detection and evaluation of salient stimuli, as well as regulation of affective response to these stimuli (1). Dysregulated emotional responses can lead to pathological mood states (2,3). This is exemplified by bipolar disorder, a mood disorder characterized by symptoms of dysregulated emotional states that include mania and depression. This mood instability suggests possible dysfunction of neural networks involved in emotion regulation. Despite the fact that emotion dysregulation is its defining criteria, neural network connectivity remains understudied in bipolar disorder.

The amygdala, insula, anterior cingulate cortex (ACC), medial prefrontal cortex (mPFC), and ventral lateral prefrontal cortex (vPFC) are considered key neural substrates of an emotion processing and regulation circuit (1). Neuroimaging studies have demonstrated a role for the amygdala and insula in normal emotion processing and for the medial and lateral regions of the vPFC in mood regulation (4,5) and associative emotional memory functions (6,7).

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gions, including dorsal lateral prefrontal cortex and mPFC, have been reported during mania (29,31). Few network connectivity studies have been performed during mania. Reports of decreased negative connectivity between vlPFC and amygdala (32) and between amygdala and anterior cingulate (33) suggest deficient prefrontal modulation over limbic structures during mania.

Most bipolar disorder neuroimaging studies have evaluated subjects during acute mood states. To date, no studies have investigated emotion downregulation and functional connectivity in subjects with bipolar disorder during euthymia, which could elucidate trait-level dysfunction in key neural circuitry. One recent study demonstrated that euthymic bipolar disorder subjects did not differ in amygdala activation during emotion processing compared with control subjects but had vlPFC hypoactivation during an emotion labeling condition (34). Persistent dysfunction in prefrontal regions involved in emotion regulation during euthymia might contribute to an abnormal inhibitory vlPFC-amygdala network and might contribute to the vulnerability of patients with bipolar disorder to shift into acute mood states. The primary aim of this fMRI study was to assess regional activation and functional connectivity between the amygdala and frontal lobe in healthy control and euthymic bipolar I subjects. We hypothesized that during emotion regulation, euthymic bipolar I disorder subjects would show vlPFC hypoactivation and reduced functional connectivity in the frontolimbic network (specifically vlPFC-amygdala) compared with healthy subjects.

Methods and Materials

The study protocol was approved by the Institutional Review Board at the University of California, Los Angeles (UCLA); each participant gave written consent before initiating the study. Subjects with a DSM-IV diagnosis of bipolar I disorder, currently euthymic, were recruited through the UCLA Outpatient Clinic, local advertising, or other research projects of the UCLA Mood Disorders Research Program. Control subjects were recruited by advertisement. All subjects were interviewed using the Structured Clinical Interview for DSM-IV (35) to confirm a bipolar diagnosis or absence thereof. Subjects with bipolar I disorder were excluded if they met criteria for any other current Axis I disorder. Twenty subjects with bipolar I disorder met criteria for past history of substance abuse or dependency, with a minimum of 3 months free from substance abuse (mean = 4.2 years ± 5.9 years). Control subjects were medication-free and excluded for current or past psychiatric diagnoses. Exclusions for all subjects included left-handedness, hypertension, neurological illness, metal implants, and history of head trauma with loss of consciousness >5 minutes.

Mood symptoms were evaluated on the day of the scan using the Young Mania Rating Scale and the 21-item Hamilton Depression Rating Scale. Bipolar I disorder subjects were eligible if they had been euthymic by self-report and Structured Clinical Interview for DSM-IV for >1 month before scanning (Young Mania Rating Scale score <7 and Hamilton Depression Rating Scale score <7).

fMRI Procedure

Subjects underwent fMRI scanning on a 3-Tesla Siemens Allegro (Siemens AG, Munich, Germany). Blood oxygen level-dependent contrast was evaluated using a T2-weighted echo planar image gradient-echo pulse sequence (repetition time = 2500 msec, echo time = 35 msec, flip angle = 90°, matrix 64 × 64, field of view = 24 cm, 28 axial slices, 3 mm thick, 1 mm gap). Echo planar image high-resolution structural images (spin-echo; repetition time = 5000 msec, echo time = 33 msec, matrix 128 × 128; field of view = 24 cm, 28 axial slices, 3 mm thick, 1 mm gap) were obtained co-planar to functional scans.

Activation Task

Subjects performed a validated emotion reactivity and regulation task that required viewing neutral or negative images and either reacting normally or reducing their emotional response through cognitive reappraisal. Images were taken from the International Affective Picture System set (36). Images were chosen (negative: 0–3 and neutral: 4–5) based on a valence rating (0–8 scale with 0 the most negative). Image types (animal, faces, scene), valence (mean = 2.8; analysis of variance [ANOVA]: F = .10, df = 45,2, p = .91), and arousal (mean = 6.5; ANOVA: F = .17, df = 45,2, p = .84) ratings were balanced across blocks.

Subjects passively viewed neutral (observe neutral) or negative (observe negative) images. For these two blocks, subjects were instructed to attend to and naturally experience the emotional state elicited by the images. During the emotion downregulation block (decrease emotion), subjects were instructed to cognitively re-evaluate the image. (Sample instructions: “If you see an image of a snake you might think, ‘That snake isn’t poisonous—it can’t hurt me’”). All subjects were trained to ensure they could perform this cognitive reappraisal in the given time. Finally, to ensure participation and attention, in a final block, subjects selected the word that best described the image using a button box (scene description) (e.g., with an image of a snake, subjects selected between venom and wreck). Images were presented for 4 seconds, with instructions (3 seconds) beginning each block. Each experimentation block (observe negative, decrease negative, and scene description) contained eight images and was repeated twice (35 seconds per block). Experimental blocks were interleaved with control blocks (observe neutral), containing three neutral images (15 seconds per block). Experimental conditions were counter-balanced across subjects.

Behavioral Data Analysis

To assess group differences in response times and accuracy, performance data from the scene description condition were analyzed using a mixed effects analysis of variance model (unconstrained covariance matrix) with diagnosis as a grouping variable and task as a repeated measure. Two subjects (one from each group) were missing behavioral data.

fMRI Analysis

Functional images were examined for severe motion or spike artifacts, and scans with >1.5 mm of motion were excluded. Functional magnetic resonance imaging data were processed using FEAT (FMRl Expert Analysis Tool), part of FSL 4.0 (FMRIB Software Library, www.fmrib.ox.ac.uk/fsl). Preprocessing steps included motion correction, nonbrain removal using Brain Extraction Tool (BET) (37,38), spatial smoothing using a 5 mm Gaussian kernel, grand-mean intensity normalization; and high-pass temporal filtering (Gaussian-weighted least-squares fitting, sigma = 65 seconds). Time-series statistical analysis used FMRl Improved Linear Model (FLM) with local autocorrelation correction (38). Registration to standard space was performed with a two-step transformation of registering subjects’ functional images to their structural image and then to a standard space template.

First, contrasts were made for observe negative versus observe neutral, as this has been shown to robustly activate amygdalae (22). This contrast enables the comparison of simple passive viewing and emotion reactivity between bipolar and control groups. Next, decrease versus observe negative contrasts were created to investigate regions involved in emotion downregulation. This process has
been shown to activate lateral and medial prefrontal cortices and decrease amygdala activation in healthy subjects (20–23). These outputs were entered into second-level analyses, with subject as a random factor, to determine regions that were significantly different between groups (cluster threshold $Z > 2.0, p = .05$ corrected).

Region of Interest Analysis

For task validation, region of interest (ROI) analyses were conducted in the bilateral amygdala, using Pick Atlas structural masks (fMRI Laboratory, Wake Forest University School of Medicine, http://www.fmr.i.wfubmc.edu). We used structural amygdala ROIs to avoid issues of bias inherent with using functionally based ROIs in non-independent tasks (39) for review of this issue). The time course from each ROI was extracted and used to calculate the mean percent signal change per subject. We fit a $2 \times 2 \times 2$ repeated measure ANOVA with group (control and bipolar) as the between-subjects factor and condition (observe and decrease) and hemisphere (left and right) as within-subject factors, along with all possible interactions, to investigate patterns of amygdala activation during these conditions.

Psychophysiological Analysis

To assess functional connectivity (PPI analysis) (40) with SPM8 (www.fil.ion.ucl.ac.uk/spm) using the preprocessing steps described above. Psychophysiological interaction analyses use regionally specific activation to identify statistical interactions between brain activity and a psychological regressor represents task condition and is used to adjusted for effects of interest (i.e., despiked and denoised); 2) the amygdala structural ROIs, with the first principal component adjusted statistical threshold of $p = .005$ and an extent threshold of $k = 5$). For other regions, we used a more conservative threshold ($p = .005, k = 20$).

Results

Subjects

Table 1 provides demographic information. Thirty-six subjects with bipolar I disorder and 32 control subjects met inclusion criteria, while data from 6 subjects in each group were excluded due to excessive motion. Thus, the final analysis included 30 euthymic bipolar disorder and 26 control subjects. There were no significant differences between groups in gender ($\chi^2 = .19, p = .66$) or age ($T = .72, p = .47$). Nine (30%) bipolar disorder subjects were medication-free when scanned. The rest were on a range of medications to treat bipolar disorder, including anticonvulsants ($n = 14$) (valproic acid, lamotrigine, carbamazepine, or oxcarbazepine), antipsychotics ($n = 13$) (aripiprazole, olanzapine, quetiapine, ziprasidone, or risperidone), or antidepressants ($n = 9$) (bupropion, trazodone, or selective serotonin reuptake inhibitors).

Behavioral Data

Behavioral data analyses revealed no significant differences between bipolar and control groups in accuracy ($T = .63, p = .53$) or reaction time ($T = .57, p = .57$) during the scene description condition, indicating subjects were attentive during the task.

fMRI Results

Amygdala ROI: Emotion Reactivity Versus Emotion Regulation. Amygdala ROI results showed a significant main effect of condition (ANOVA: $F = 5.77, df = 1.54, p = .02$), with a significant

| Table 1. Demographic Information for Healthy Control and Euthymic Subjects with Bipolar I Disorder |
|---------------------------------|---------------------------------|---------------------------------|
| Demographics | Control Subjects | Bipolar I Disorder |
| n | 26 | 30 |
| Age (Mean ± SD) | 35.5 ± 12.4 years | 37.9 ± 12.6 years |
| Gender (M/F) | 15/11 | 19/11 |
| YMRS Score (Mean ± SD) | — | 1.7 ± 2.2 |
| HAM-D Score (Mean ± SD) | — | 3.8 ± 1.9 |
| Duration of Euthymia (Mean ± SD) | — | 15.4 ± 19.9 months |
| Duration of Illness (Mean ± SD) | — | 20.7 ± 13.6 years |
| Number Prior Manic Episodes (Median) | 4 | 4 |
| Number Prior Depressive Episodes (Median) | 5 | 4 |
| Medication | — | — |
| Unmedicated | — | 9 |
| Anticonvulsants | — | 14 |
| Antipsychotics | — | 13 |
| Antidepressants | — | 9 |

F, female; HAM-D, Hamilton Depression Rating Scale; M, male; YMRS, Young Mania Rating Scale.
decrease in amygdala activation during the decrease versus observe conditions. There were no other significant main effects of either group (ANOVA: $F = 1.34, df = 1.54, p = .25$) or hemisphere (ANOVA: $F = .63, df = 1.54, p = .43$), nor were there any significant interactions (all $p > .44$) (Figure 1). In addition, there were no significant correlations between ROI results and any clinical variable.

**Emotion Reactivity.** In our reactivity contrast (observe negative vs. observe neutral), bipolar disorder and control subjects extensively activated frontolimbic regions, including bilateral vlPFC (Brodmann area [BA] 44/45 and 47), bilateral insula, mPFC, ACC, and bilateral amygdala (Figure 2). There were no significant differences between bipolar disorder and control subjects ($Z > 2.0, p = .05$ corrected) in any frontal or limbic regions of interest.

**Emotion Downregulation.** In the emotion downregulation contrast (decrease negative vs. observe negative), control subjects activated frontolimbic regions reported in previous reappraisal studies, including bilateral vlPFC (BA 44/45 and 47), insula, dorsomedial prefrontal cortex (BA 8), and ACC (BA 32/24). Thus, there was significantly greater activation in the vlPFC during emotion downregulation than during passive viewing. Additional regions of activation included bilateral insula, bilateral superior frontal gyrus (BA 9/10), bilateral pre-SMA, bilateral hippocampal gyrus (BA 28/36), bilateral inferior parietal lobule (BA 40), left middle temporal gyrus (MTG), bilateral superior temporal gyrus, occipital regions (BA 17/18/19), and cerebellum (Figure 3A).

Bipolar disorder subjects also activated frontolimbic regions, including left vlPFC (BA 45/47), dorsomedial prefrontal cortex (BA 8), and ACC (BA 32/24). Other regions of significant activation included bilateral insula, bilateral superior frontal gyrus (BA 9/10), left pre-SMA, left MTG (BA 20/21), and left cerebellum (Figure 3B).

Between-group analysis revealed significantly greater activation in control compared with bipolar disorder subjects in the frontal lobe, including bilateral vlPFC (BA 47/44/45), insula, bilateral middle frontal gyrus (BA 46/9), bilateral cingulate (BA 24 and BA 23), and pre-SMA (BA 6). Other regions of greater activation in the control subjects were seen in the right inferior parietal lobule (BA 40), bilateral MTG (BA 18), bilateral lingual gyr, bilateral caudate, and right thalamus (Figure 4, Table 2). There were no areas of significantly greater activation in bipolar versus control subjects. An exploratory analysis of unmedicated bipolar disorder subjects ($n = 9$) showed a similar trend of reduced bilateral vlPFC activation compared with control subjects but did not reach significance as the sample size was small and underpowered.

**PPI: Emotion Downregulation.** In the within-group analysis, control subjects showed significant negative functional connectivity between left amygdala and left vlPFC (BA 44/45). Control subjects showed significant negative functional connectivity between right amygdala and right vlPFC (BA 44/47), left fusiform gyr (BA 18), and left occipital gyrus (BA 18/19).

Bipolar disorder subjects showed significant negative functional connectivity between left amygdala and right vlPFC (BA 47), as well as significant negative functional connectivity between right amygdala and left vlPFC (BA 44).

Between-group analyses using the left amygdala as a seed region revealed significantly greater negative functional connectivity in control > bipolar disorder in left vlPFC (BA 44/45), left occipital gyrus (BA 19), and right posterior cingulate (BA 23/31) (Figure 5, Table 3). The bipolar disorder > control comparison showed no significantly greater negative connectivity between the left amygdala and any regions. For confirmation, we ran additional connectivity analyses using main effect of task to functionally define amygdala seeds; the main results did not change significantly.

Using the right amygdala as a seed region, there were no regions of significantly greater connectivity between control > bipolar dis-

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**Figure 1.** Region of interest (ROI) results show significant decreased activation in left (L) and right (R) amygdala during emotion downregulation (decrease negative compared to observe negative) in control and euthymic subjects with bipolar I disorder. Analysis of variance results show significant main effects of condition ($F = 5.77, df = 1.54, p = .02$). There were no significant main effects of group ($F = 1.34, df = 1.54, p = .25$) or hemisphere ($F = .63, df = 1.54, p = .43$), nor were there any significant interactions (all $p > .44$). BP, bipolar disorder.

**Figure 2.** Within-group results during emotion reactivity (observe negative vs. observe neutral) show robust bilateral amygdala activation in both (A) control and (B) euthymic subjects with bipolar I disorder (left = left).

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order. The bipolar disorder > control comparison showed significantly greater negative connectivity between right amygdala and right middle frontal gyrus (BA 9).

Discussion

This is the first functional connectivity study exploring neural network functioning during emotion downregulation in euthymic subjects with bipolar I disorder. During emotion regulation using cognitive reappraisal, which recruits vIPFC, significant group differences emerged. Consistent with our hypothesis, control subjects showed significantly greater engagement of prefrontal structures, including bilateral vIPFC, compared with bipolar disorder subjects. Psychophysiological interaction analysis revealed subjects with bipolar disorder had significantly less negative functional connectivity between left amygdala and bilateral vIPFC during downregulation. These findings support our second hypothesis that during emotion regulation, there are specific neural network frontal-amygdala functional connectivity differences in bipolar disorder.

During passive viewing of emotional images, both groups demonstrated significant bilateral amygdala activation consistent with prior studies (10,45) of control subjects. No differences in frontolimbic functioning were present between euthymic bipolar and control groups during passive viewing, consistent with some (34,46), but not all (47), prior studies. Differences in the type of emotional stimuli used (valence and salience), as well as sample size, may explain some of these inconsistencies. However, tasks requiring simple emotion reactivity (bottom-up processing, as in passive viewing) consistently show greater amygdala activation than tasks requiring emotion regulation (top-down, as in cognitive reappraisal) (10,32,48); we replicate these findings in both groups. Similar amygdala activation between control and bipolar groups suggests no amygdala dysfunction during euthymia, at least with these stimuli, while persistent vIPFC hypoactivation in euthymic subjects may suggest a trait abnormality.

Our results are consistent with prior emotion regulation studies demonstrating healthy control subjects engage frontal regions, including vIPFC and anterior cingulate (32,49,50), significantly more during regulation than passive emotion conditions and downregulate limbic regions via vIPFC activation (10,45). During emotion downregulation, control subjects show increased activation in vIPFC, mPFC, and anterior cingulate (18,51). These regions have extensive anatomical connectivity to the amygdala (13,14,52). Human (53) and nonhuman (54) primate anatomical studies show reciprocal connections between amygdala and prefrontal cortex (PFC), and neurochemical studies in animals suggest an inhibitory amygdala-PFC connection (55,56). Studies of control subjects re-
port significant effective connectivity between amygdala, vIPFC, insula, and anterior cingulate (57) and significant negative functional connectivity between amygdala and frontal regions during emotion regulation (10,32). These latter findings of significant negative connectivity between limbic and frontal regions are consistent with our results of control subjects.

Studies of mania report amygdala hyperactivation (27,58) and bilateral vIPFC hypoactivation (27,29,59). Manic subjects have shown significantly reduced negative functional connectivity between left amygdala and bilateral vIPFC and anterior cingulate (32), suggesting neural network differences of emotion downregulation in bipolar disorder subjects during mania. Such results are consistent with the present study and suggest these connectivity differences persist in euthymia. A recent effective connectivity study of euthymic subjects implicated a dysfunctional ventromedial neural system in automatic emotion regulation, as impairment here is associated with manic and depressive symptoms (65,66). In the present study, vIPFC hypoactivation in bipolar disorder subjects was more prominent in the left hemisphere, perhaps due to the verbal nature of this cognitive reappraisal paradigm. Most emotion studies in euthymia found hypoactivation of bilateral vIPFC or left vIPFC, depending on paradigm specifics (32,62,67). The current functional connectivity results are consistent with another study of bipolar euthymia that reported abnormal frontolimbic connectivity while viewing emotional faces (68). Furthermore, resting state studies support decreased corticolimbic functional connectivity in unmedicated subjects with bipolar disorder (69). A second resting state study found reduced negative functional connectivity specifically in vIPFC-amygdala activity between bipolar disorder versus control groups (70). These studies, using bipolar disorder subjects in acute and euthymic mood states, are consistent with the present study’s results in bipolar disorder euthymia. Thus, vIPFC hypoactivation may represent a trait neural marker of bipolar disorder that endures across mood states (71).

Neuropsychological studies suggest bipolar disorder patients continue to display mood instability and increased mood reactivity in the absence of an acute episode (72,73). Chronic vIPFC hypoactivation and/or reduced modulatory control of limbic structures may explain these findings. The vIPFC may act as a brake on extreme emotion through its inhibitory connections with limbic structures. It is possible that abnormal PFC function and the resultant frontolimbic circuit alterations may create dysregulation of emotional reactions and increase the vulnerability of patients to lapse into mood episodes (74) for review.

Although our hypothesis focused on amygdala and vIPFC activation, other areas showed significant group differences. Control subjects showed significantly increased activation in bilateral insula and bilateral anterior cingulate and increased negative connectiv-

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**Table 2. Between-Group Results Show Areas of Significantly Increased Activation in Healthy Control vs. Euthymic Subjects with Bipolar I Disorder During Emotion Downregulation (Decrease Negative vs. Observe Negative Contrast)**

<table>
<thead>
<tr>
<th>BA</th>
<th>x</th>
<th>y</th>
<th>z</th>
<th>Z Statistic</th>
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*BA, Brodmann area; IFG, inferior frontal gyrus; IPL, inferior parietal lobule; LG, lingual gyrus; MFG, middle frontal gyrus; MTG, middle temporal gyrus; SMA, supplementary motor area; vIPFC, ventral lateral prefrontal cortex.  
*aIndicates more than one local maxima within a 10 mm radius.
ity between left amygdala and posterior cingulate compared with bipolar disorder subjects. The anterior insula is part of the salience-emotion network (75) and is integral in introspection (76). Extensive reciprocal connections exist between the insula and amygdala (77), and decreased amygdala-insula connectivity in bipolar euthymia suggests another emotion network difference that may contribute to the presentation of bipolar disorder. The ACC, particularly the rostral portion that shows hypoactivation in bipolar disorder subjects during downregulation, is also part of the emotional salience network and has extensive frontal and limbic connections (78). The posterior cingulate is important for internal awareness, processing spontaneous thought, and is part of the default mode network (79), engaged in the absence of task-specific challenges and suppressed during task demands (80). In primates, the posterior cingulate receives direct efferent connections from the amygdala (81). The amygdala and posterior cingulate may be part of two functionally distinct networks that are on and off at different times (i.e., have significant anticorrelations) (82). The decreased negative (or equivalently, increased positive) connectivity between these regions in bipolar disorder suggests less functional segregation between networks, findings reported in other psychiatric populations (83, 84).

We are currently conducting studies investigating these networks in bipolar disorder. While this is the first study of emotion regulation in euthymic subjects with bipolar I disorder and has the largest sample size of a functional connectivity study in this population, this study has several limitations. First, while ~30% bipolar disorder subjects were unmedicated, this sample remained underpowered to provide meaningful subanalyses into medication effects on frontolimbic networks, findings reported in other psychiatric populations (83, 84). We are currently conducting studies investigating these networks in bipolar disorder. More than one local maxima within a 10 mm radius.

| Table 3. Between-Group Psychophysiological Interaction Results Show Significantly Greater Negative Functional Connectivity between the Left Amygdala and Left vlPFC in Healthy Control vs. Euthymic Subjects with Bipolar I Disorder During Emotion Downregulation (Decrease Negative vs. Observe Negative) |
|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| BA              | x               | y               | z               | Z Statistic     | k (Voxels)     |
| Frontal         |                 |                 |                 |                 |                 |
| Left vlPFC      | 44/45           | −48             | 2               | 5               | 3.72            | 29              |
| Right vlPFC     | 47              | 27              | 35              | −1              | 3.05            | 6               |
| Cingulate       |                 |                 |                 |                 |                 |
| Posterior       | 23/31           | 21              | −67             | 14              | 3.88            | 51              |
| Occipital       |                 |                 |                 |                 |                 |
| Left MOG        | 19              | −18             | −67             | 17              | 3.48            | 23              |

BA, Brodmann area; MOG, middle occipital gyrus; vlPFC, ventral lateral prefrontal cortex. *More than one local maxima within a 10 mm radius.

patterns of vlPFC hypoactivation in unmedicated and medicated subjects. Also, as bipolar and control groups showed similar activation of many structures (e.g., amygdala) during passive emotion reactivity, it is doubtful that medication per se caused selective vlPFC hypoactivation during emotion regulation in the bipolar group. A review study (85) found medication either had no significant or ameliorative effects on abnormal functional neuroimaging results, suggesting medication alone likely does not explain the current findings. Second, this study utilized a paradigm previously used in healthy control subjects but not used in subjects with bipolar disorder. As such, these results require replication. Future studies may determine whether amygdala differences emerge between bipolar and control subjects as demands for emotion regulation increase beyond the relatively simple condition used in this study. Finally, as subjective ratings were not collected at the time of scanning, we were unable to make direct conclusions regarding neural responses and subjective affective experiences. However, we spent considerable time training subjects to complete cognitive reappraisal of images during the time frame. Future studies that collect subjective and physiological measures simultaneously during fMRI can provide a more complete picture of the success of emotion regulation strategies used in bipolar disorder and control subjects.

This study provides evidence of decreased vlPFC activation, decreased vlPFC-amygdala connectivity, and amygdala-posterior cingulate abnormalities during emotion downregulation in bipolar I disorder. Ventral lateral prefrontal cortex hypoactivation in bipolar I disorder is consistent with several studies in this population and suggests that these abnormalities persist in the absence of acute mood episodes. Reduced frontolimbic connectivity in euthymia may underlie the decreased ability of bipolar disorder subjects to regulate emotions and the proclivity to relapse into acute mood states. Ventral lateral prefrontal cortex inhibitory inputs to the amygdalae may be abnormal in bipolar disorder due to local alterations (e.g., neuronal) and/or disrupted connections (e.g., white matter tracts) between regions. Follow-up studies tracking subjects longitudinally across mood states may help determine whether the degree of vlPFC hypoactivation and decreased frontolimbic connectivity can help predict future mood episodes.

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