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Clearing up the Confusion Surrounding Bipolar Disorder

Stacey Williams
sdrury1@murraystate.edu

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Stacey Rae Williams

Murray State University

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Scott M. Douglas, Ed.D.

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Abstract

This paper aims to clear up the confusion the surrounds bipolar disorder. Extensive research examines the societal misconceptions about bipolar disorder. The research will show how celebrity impact, media perception, and self-stigmatization all contribute to the confusion of what it means to have bipolar disorder. After identifying the misconceptions, this research will identify clinical definitions of bipolar disorder along with existing comorbidities with other mental illnesses such as borderline personality disorder, depression, ADHD, and anxiety disorder. The disease can be under or over diagnosed when these comorbidities are not taken into account during a patient assessment. Bipolar disorder is often misdiagnosed and this research will explore how that can occur and how it can be prevented. With a proper diagnosis, a treatment plan can be put into place. The research here will show that several treatments can be effective, with each patient being different in their response to treatment. Traditional pharmaceutical, non-traditional pharmaceutical, and psychotherapeutic treatment options are all available and can be used in conjunction with each other or independently of one another depending on the patient's symptoms, medical conditions, and responsiveness to treatment. Finally, this paper will include interviews from two local clinicians that explain their perspective on bipolar disorder, along with some insight from my own personal experience with my husband's illness. It is my hope that this research will educate people on what bipolar disorder truly looks like, therefore reducing the stigmatism surrounding the disease.

Clearing up the Confusion Surrounding Bipolar Disorder

Bipolar disorder is a mental illness that has had a stigma around it for many years. People that are diagnosed are often seen as "crazy" or unable to care for themselves. I want to clear up some confusion around bipolar disorder so that people can have a better understanding of both common and less common symptoms and what treatments exist. Bipolar has many faces and it doesn't always fit into a certain model. There can be a spectrum of behaviors involved, yet many doctors still lock it within this paradigm. There is also a comorbidity with other mental health disorders that can also obscure how it presents itself. People most often look for help during periods of depression, so bipolar disorder is very often misdiagnosed as depression or misconceived as substance abuse. It is my hope that my research can help serve as a "road map" for understanding what bipolar disorder looks like and can direct others to getting the right help and resources for a friend or loved one that is suffering.

Defining Bipolar Disorder

Defining bipolar disorder has proven to be somewhat difficult. It was not until the late 19th and 20th centuries that bipolar disorder had even gained awareness (Malhi et al., 2021, p. 537). It is fascinating that more than a hundred years later mood disorders and their societal and clinical definitions have been a large topic of discussion and deliberation. Bipolar disorder has acquired a diverse collection of meanings, partially because its clinical definition has never been made clear (Malhi et al., 2021, p. 537). It is because of this unclarity that not only much of society, but also those that are diagnosed are unsure of the scope of what it means when someone is diagnosed with bipolar disorder (Malhi et al., 2021, p. 537).

Misconceptions

Recently, one of the most disturbing consequences of the misunderstanding of bipolar disorder has been the descriptive way in which the term 'bipolar' is used (Malhi et al., 2021, p. 537). Bipolar disorder has been used to "describe someone who is emotionally flippant, indecisive, volatile or generally 'moody'" (Malhi et al., 2021, p. 537). The illness has not been understood with any type of clarifying definition, so using the term in this manner only increases stigmatism and perceived ideas on what it means to have bipolar disorder (Malhi et al., 2021, p. 537). Other mental illnesses such as anxiety and depression, although still have their own misconceptions, are more well known in society than bipolar disorder. They have been given clearer definitions, and their labels are more relatable to what people may see as typical mood changes because at some point in life, most people have experienced anxiety or have been sad for a period of time or just had a depressed mood (Malhi et al., 2021, p. 537). Hence, it is easier to recognize the emotions an individual that has been diagnosed with anxiety or depression may experience (Malhi et al., 2021, p. 537).

Recently, I had the pleasure of interviewing Ms. Lori O'Nan, LCSW, and I asked her what she felt the most common misconceptions were about bipolar disorder. She said that most outsiders, or even family and friends, will assume that someone is involved in drug abuse instead of having bipolar disorder. Drug addiction and bipolar disorder mimic each other, and she described bipolar disorder as often appearing like someone addicted to methamphetamines (L. O'Nan, personal communication, August 20, 2021).

Changing Societal Views

In more recent years, there has been a revived interest and a positive shift in the societal views of what it means to be diagnosed with bipolar disorder. Much of this interest has been

fueled by celebrities that are "coming out" publicly with their diagnosis (Chan & Sireling, 2010, p. 103). Previously, people that were diagnosed with bipolar disorder were seen as "crazy" or "unstable". Because of celebrities such as Mariah Carey, Bebe Rexha, Demi Lovato, Catherine Zeta- Jones, and Mel Gibson speaking out about their diagnoses, the disorder is slowly becoming more accepted in the mainstream.

In more recent research, it has been shown that there is a wide spectrum of behaviors that may or may not exist in each individual patient. There are also many comorbidities of other mental illnesses or even addictions that can skew one's view of what bipolar disorder looks like. There are many misconceptions about what bipolar disorder is, and how it presents itself in an individual. Because of a lack of a clear definition, many people are assumed to be "crazy" if they are known to have a bipolar disorder diagnosis. "Crazy" could not be further from the truth and my research will hopefully help to uncover some of the misconceptions and also reveal some facts that will hopefully give some insight into this mysterious illness and what it really looks like.

Anger and Irritability

One of the most common misconceptions about bipolar disorder is the existence of anger and irritability as part of a manic state. The traditional paradigm has been manic episodes of elevated mood and depression. The wider spectrum of moods associated with bipolar disorder is only more recently being researched. In my interview with Ms. Lori O'Nan, LPSW, she described her observations of the clients that she works with who are diagnosed with bipolar disorder. She stated that in her experience, the symptoms of bipolar that most of her clients exhibit are severe mood swings that most often consist of depressive and elevated states but do include anger as well. She stated that the families and spouses of those with bipolar disorder

often live in fear and feel like they are constantly “walking on eggshells” because a manic episode can come about at a moment's notice (L. O’Nan, personal communication, August 20, 2021).

Understanding the wider spectrum of moods that can exist in patients with bipolar disorder will not only help with treatment but is also imperative to uncovering a correct diagnosis. Irritability and anger are two prevalent emotions that have been studied in bipolar patients. According to Dr. David J. Miklowitz, PhD, author of *The Bipolar Disorder Survival Guide*, “In the manic high state, people experience different combinations of the following: elated or euphoric mood (excessive happiness or expansiveness); irritable mood (excessive anger and touchiness); an increase in activity and energy levels; a decreased need for sleep; grandiosity (an inflated sense of themselves and their abilities); increased talkativeness; racing thoughts or jumping from one idea to another; changes in thinking, perception, and attention (for example, distractibility); and impulsive, reckless behavior. Manic episodes cause significant impairments to a person’s work, social or family life” (Miklowitz, 2019).

Dr. Miklowitz specifically points out anger and irritable mood in his description of mania, which clinicians may overlook as a serious symptom when diagnosing a mood disorder. Irritability is clinically important because it can cause serious anxiety and mental distress. It also exists in many different mood disorders. Understanding irritability and how it works in these mood disorders is imperative in discovering various ways of treating patients with the disorders where irritability is prevalent (Bell et al., 2020, p. 781). It has been discovered that in adults, irritability is a foundational indicator of mania. This is important to note because irritability is often correlated with depressive symptoms in adults, but if the irritability and depression are not present with the other symptoms of mania, the irritability may be discarded during diagnosis and

not be part of the clinical treatment. Even though irritability is considered to be one of the main symptoms of mania, it is disregarded as an indicator for a mixed episode of depression. Therefore, its relevance is limited in the DSM, which will also lessen its importance in clinical practice (Bell et al., 2020, p. 782). Its importance is currently diminished, although irritability has a serious impingement on day-to-day functioning for someone with bipolar disorder. Recognizing irritability as an indicator of mixed states in bipolar disorder will allow for treatments to be more progressive (Bell et al., 2020, p. 783).

In 2002, a group of researchers published a brief report entitled "The prevalence and clinical correlate of anger attacks during depressive episodes in bipolar disorder". The authors define anger attacks as "characterized by sudden episodes of intense anger with autonomic arousal" (Perlis et al., 2004, p. 291). In the report, rates of anger attacks in patients with major depressive disorder or bipolar disorder were assessed. The researchers found that anger attacks were substantially more prevalent in bipolar patients than in individuals diagnosed with depression (Perlis et al., 2004, p. 291). They also point out that irritability is often a noticeable aspect in manic or mixed states in those with bipolar disorder. Their research also showed that irritability is noticeable in depressive episodes of bipolar disorder (Perlis et al., 2004, p. 292).

Based on this research, they theorized that anger attacks along with irritability would also be typical. The researchers conducted a study that consisted of people at the age of 18 or above whose primary diagnosis was either bipolar disorder or major depressive disorder. They conducted their study using several assessments, including the Anger Attacks Questionnaire. As cited by the authors, "Criteria for anger attacks require a background of irritability and a tendency to overreact to minor annoyances, including at least one episode of excessive or situationally inappropriate anger with four or more associated features in the past month.

Features may be physical, psychological, or behavioral" (Perlis et al., 2004, p. 292). Among the group of patients with mood disorders that the researchers tested, they discovered that anger attacks during depressive states were 62% more common in bipolar disorder patients versus major depressive disorder patients (Perlis et al., 2004, p. 293). Results from this type of research can affect diagnosing mood disorders. Clinicians should be aware that anger attacks are highly present in patients with bipolar disorder, and, keeping this in mind, should use this information as an important criteria in diagnosing bipolar disorder. The outcomes of this research also shed light on potentially further specifying mood state criteria for bipolar disorder in the DSM-V to include anger attacks (Perlis et al., 2004, p. 294).

Suicide

Understanding that anxiety and irritability are important factors to recognize when diagnosing bipolar disorder leads to the discussion of another unfortunate commonality of high rates of suicide in patients diagnosed with bipolar disorder. It has been estimated that individuals with bipolar disorder are at a risk of committing suicide of up to 15 times higher than other individuals. Out of all the deaths of those with bipolar disorder, up to 15% die by suicide. 30% of those diagnosed attempt to end their lives at some point. These rates are not always the general consensus. However, it is widely agreed upon that suicidal ideation is a common element of bipolar disorder. However, this is not caused by any flaw or frailty on the part of the individual, it is more connected to the chemical component of the illness and irregularities in serotonin genes (Miklowitz, 2019).

There are several risk factors for suicide that are important to be aware of that are prevalent in individuals with bipolar disorder. Some of these risk factors include clinical history, previous suicide attempts, periods before and after hospital discharge, age of onset of the illness,

comorbidity with other mental illnesses, and the course of rapid cycling. Clinical history is important because the knowledge of previous attempts can be a strong indicator of later attempts that may result in death. Hospital discharges are also relevant because if a patient is discharged too early or is not given the proper care after discharge, this can increase the likelihood of suicide. It should also be noted that a larger amount of previous hospitalizations due to suicide attempts also suggests that there will be a greater chance of suicidal behavior in the future (Dome et al., 2019, p. 2). After an individual is diagnosed with bipolar disorder, research has shown that the first years after the diagnosis have a higher risk. Comorbidity with other mood disorders, which will be further discussed later in this research, also indicate a greater chance of harmful actions. Rapid-cycling also presents a greater risk of suicidal behavior (Dome et al., 2019, p. 2). Rapid cycling involves moods switching from depression to mania multiple times at a fast rate. This switching back and forth can result in having many mood episodes in one month, one week, or even several times in one day (Miklowitz, 2019).

The depressive mood is what carries the greatest risk of suicide in individuals with bipolar disorder. Some individuals can remain in a depressed state for months at a time. The longer that someone remains in this state, the chances of them committing suicide is greater. Another risk factor involving suicide is the amount of time that the disorder goes untreated. Some people may be misdiagnosed or simply be unaware that they have any mental illness at all, therefore resulting in a much higher risk of self-harm (Dome et al., 2019, p. 3).

Family history can also play a role in the risk of suicide. Also, if an individual with bipolar disorder experiences intense life stressors, financial adversities, a history of past abuse, or has been or is currently involved in or convicted of criminal behavior. Personality characteristics

can also play a role. If someone is pessimistic by nature or they are naturally impulsive or aggressive, this can also heighten the risk for suicide (Dome et al., 2019, p.3).

Medications are available to patients to reduce the risk of suicide. The pharmaceutical lithium has been researched and shown to have the greatest effect on suicide prevention (Dome et al., 2019, p. 3). Research indicates that one of the best ways of reducing suicide risk in bipolar patients is medication management, therapy, and also removing any access to unmistakable routes of suicide (Dome et al., 2019, p. 4). Other positive factors are having strong support from family and friends and also taking a proactive approach by learning therapeutic coping strategies that an individual can practice on their own (Dome et al., 2019, p. 3).

Elevated Mood

On the other end of the spectrum of this mental illness is elevated mood. Many times, an elevated mood is interpreted as being extremely happy or seeming as if a person is on a personal high. While this can very well be the way a manic episode presents itself, there are other aspects to an elevated mood that must be acknowledged. It would be inaccurate to assume that an elevated mood only includes being exceptionally happy. This type of mood can lead to a number of issues. Individuals in this manic state often have poor impulse control. This can lead to behaviors such as frivolously spending too much money and risk-taking behaviors such as gambling, or sexual promiscuity (Miklowitz, 2019). This type of conduct can lead to serious financial trouble or health risks related to sexually transmitted diseases. Relationship and marital problems can occur due to growing financial issues or relationships can be compromised by cases of infidelity from being oversexualized in a manic state. Some experiencing mania can be extremely talkative with erratic thoughts that bounce around, making communication with that person quite difficult (Miklowitz, 2019). This type of speech can also cause one to say things

that are deemed inappropriate by society. Many times, it is behaviors such as these that will down-play bipolar disorder as being a serious illness because, individually, these types of conduct are not necessarily seen as alarming (Malhi et al., 2021, p. 538). Other potentially problematic symptoms worth mentioning are lack of sleep due to increased energy or racing thoughts, having a grandiose sense of self that will increase risk taking or reckless behaviors, and changes in attention span and perceptions (Miklowitz, 2019).

In a more positive perspective, being diagnosed with bipolar disorder can be somewhat of an explanation for otherwise misunderstood negative behaviors such as "poor impulse control, excessive spending, being oversexualized, and/or socially inappropriate" Where some might see someone as having inherently bad behavior, a diagnosis of bipolar disorder may give someone a great amount of relief in understanding some of their actions, feelings, and behaviors, and lead them on the road to properly managing their mental illness (Malhi et al., 2021, p. 538).

Being in a manic state has also been shown to increase creativity in an individual (Malhi et al., 2021, p. 538). This would be the case with the celebrities that have been acknowledged in this research. Many musicians, authors, actors, and comedians "come out" as being diagnosed with bipolar disorder. Some of them were mentioned in the beginning of this research. All of these careers have creative aspects to them, and as I will show in this research, some very well-known celebrities have credited bipolar disorder with their increased imagination, creativity, or inspiration. So much so that if given the choice, they would rather live with the disorder than without. It is suspected by psychologists that Van Gogh, Hans Christian Andersen, Sylvia Plath, Da Vinci, Isaac Newton, and even Michelangelo had bipolar disorder before therapies and medications existed. Imagine what the world would be like without the contributions of all of

these amazing artists. With all of these examples, it is no wonder that bipolar disorder has been coined as the "artist's disease" (Nelson, 2019, p. 2).

Stigmas Surrounding Bipolar Disorder

Stigmas surrounding bipolar disorder are a big issue in society. In the article, "Self-stigmatization in patients with bipolar disorder," the authors define stigma as follows: "Stigma is a general term that consists of three key components: ignorance (problem of absence of knowledge), prejudice (problems with attitude), and discrimination (problem with behavior) (Latalova et al., 2013, p. 266). They also go on to state that "Stigma of mental disorder is connected with a lack of knowledge about psychiatric disorder, fear, prejudice and discrimination of the patients (Latalova et al., 2013, p. 266). Since bipolar disorder can consist of so many different behaviors and moods and those with the illness sometimes seem to jump from one mood to another for what seems like no apparent reason, this can cause a great deal of stigma towards the disorder and those that are diagnosed. Some symptoms of bipolar disorder are more understood than others. Depression is an example of one of the easier symptoms to understand because most people have some familiarity with it, either through their own experiences, a family member, or learning about it through various media sources. However, the manic and psychotic episodes of bipolar disorder are much harder to discern because they can present themselves in many different ways and are different for each individual, and these symptoms are not as relatable for most people (Malhi et al., 2021, p. 538). Because of this misunderstanding, there can be many different emotions and perceptions towards bipolar disorder (Malhi et al., 2021, p. 538).

Celebrity Impact

In more recent years, many celebrities have been open about their mental illnesses, including bipolar disorder. This has raised awareness but can have both negative and positive impacts on the perceptions and stigma surrounding bipolar disorder. Many celebrities, such as Robin Williams, Kate Spade, Britney Spears, and Kanye West have been open about their diagnoses of bipolar disorder. This has created an entertainment aspect of the disease because fans of such celebrities are drawn to the negative behaviors or suicidal actions that these public figures can exhibit (Malhi et al., 2021, p. 538). Having this entertainment aspect attached to bipolar disorder can underrate the seriousness of the disorder and many may not understand that a person with bipolar disorder is dealing with a disease (Malhi et al., 2021, p. 538).

Further problems "with the label BD is that it has been further abbreviated to 'bipolar'- removing in effect, its disorder status" (Malhi et al., 2021, p. 538). The scattered meaning has caused the term to be used more expansively. 'Bipolar' is used in pop culture songs, movies, and even in the news to describe an individual's perspective or even the economy (Malhi et al., 2021, p. 538). Using the term in this manner can cause it to convey that anyone can have a characteristic or trait of being unstable or unreliable, which will give a perception that having bipolar disorder is intrinsically a negative quality and increases the stigma of the disease (Malhi et al., 2021, p. 538).

In contrast, celebrity status can also have a positive effect on the way the public perceives the illness. One of the celebrities that has spoken out the most is singer and actress Demi Lovato. Lovato has unabashedly spoken about bipolar disorder and shown the public that you can still be popular, successful, and powerful despite having the illness. She identifies herself as "bipolar and proud" (Franssen, G. 2020, p. 3). Throughout her teen years as a young celebrity, many

watched Lovato rise to fame in her *Camp Rock* series on the Disney Channel. She sold millions of albums as a music artist, had her own popular sense of style, and promoted a positive body image to young girls. Then, in October of 2010, the world watched as she began a downward spiral. While on tour with the Jonas Brothers, she physically assaulted one of the dancers, claiming that she "just lost it". Days later, Lovato checked herself in to a treatment center with "emotional and physical issues". Many rumors circled in the media, everything from trauma, drug and alcohol abuse, and mood disorders. A girl that was once seen as a pure and soft-hearted was now being reported as having a breakdown and heading towards failure (Franssen, 2020, p. 2).

Now, despite all the negativity reported in her past, Demi Lovato is as much of a star as ever, if not even more. She has seen incredible success since 2011 as a singer and actress. Furthermore, she is owning her mental illness and speaking out about it. It has become a part of who she is as a celebrity. She is very honest about her struggles with addictions, eating disorders and mental health (Franssen, 2020, p. 2). She has shown that you can live a successful life with bipolar disorder. Demi Lovato's story and personal testimonials can offer a more promising outlook on how celebrities can not only educate society about mental illness, but also influence their views towards illnesses like bipolar disorder.

In 2006 and 2007, two documentaries were aired on television. The first was an episode from MTV as part of their popularly established 'True Life' documentary series. It was titled 'True Life: I'm Bipolar', and the second was aired by the BBC network and was titled 'The Secret Life of the Manic Depressive'. Both of these documentaries were able to display an authentic representation of what an individual experiences when they have bipolar disorder (Chan & Sireling, 2010, p. 103). In the MTV documentary, actor and comedian Steven Ferrara,

who has bipolar disorder, detailed his own experiences with the illness and also interviewed other celebrities diagnosed with mood disorders. The celebrities included singer Robbie Williams and actress Carrie Fisher from the Star Wars franchise. Steven also interviewed non-celebrity people that were diagnosed with bipolar disorder or another mood disorder. Knowing that mood disorders can greatly affect someone's life and career, these people were asked that if they could choose, would they rather keep their illness or live without it? Many of them described that they enjoyed the manic state of bipolar disorder, which allows them to be creative. Also, they liked their elevated moods because they were more active, and it made them feel powerful. They expressed that it would be hard not to have these experiences. Research has shown bipolar disorder to enhance creativity, and it was obvious from the interviews that the interviewees considered this a very strong positive attribute to having bipolar disorder (Chan & Sireling, 2010, p. 103).

Media Perception

As far as the BBC documentary, it seemed to be positively excepted by the viewers, which also included psychiatrists. The manner in which the documentary depicted mental illness did not have heavy correlations of danger and disturbance as it often appears in the media. The responses to these documentaries may begin to encourage a change to a more positive perspective towards bipolar disorder. It was reported that often verbiage is what can cause negative connotations in society. When people hear the word “mania”, which is often used as a descriptor of bipolar disorder, it is much more negatively received than the word “depression”. Stigmas can be lessened by making simple changes to our phraseology. For instance, over 70 years ago, “manic-depression” was the term used to describe what we now know as bipolar disorder. Although mania is a part of the description of the disorder, simply removing the word

"manic" from the label can greatly decrease the negative connotation and help to change societal views in a positive way (Chan & Sireling, 2010, p. 103).

Self-Stigmatization

Another type of stigmatization that can occur with this disease is self-stigmatization. In 2013, a group of researchers investigated this idea and how it originates and affects those with bipolar disorder. The researchers noted that the stigma of mental illness is caused by society not having the correct knowledge about bipolar disorder and the potential fear that it can create. Often this fear is produced by the media, which often portrays people with mental disorders as dangerous or harm to society. These stigmatizations often become stereotypes and lead people to think that those with mental illness are social deviants (Latalova et al., 2013, p. 266-267). Unfortunately, because of the narrative that the media will often present when reporting about serial killers or mass shooters, mental illness often gets connected to these types of behaviors (Nelson, 2019, p. 24).

Self-stigmatization can happen as a result of many different scenarios. First, as I just spoke of, stereotypes represented negatively in the media can cause someone to apply that stereotype to themselves. Therefore, they will believe that those characteristics are a part of who they are as a person (Latalova et al., 2013, p. 266). If the individual also does not have a strong support system and is instead surrounded by a family that is critical or has a negative attitude towards them can also lead to strong self-stigmatization (Latalova et al., 2013, p. 269).

Internalizing stigma can have a significant negative effect on someone that suffers from bipolar disorder. Low self-esteem is common due to the fact that a person believes a negative stereotype about themselves. Their quality of life may suffer because, due to their low self-esteem, they may also avoid social situations in being around family and friends. Sometimes they

avoid these situations because they are afraid of rejection. Also, their work life may suffer because of these same fears of rejection and the existence of low self-esteem (Latalova et al., 2013, p. 268). One of the biggest impacts that self-stigmatization has is its effect on deciding to get proper treatment. An individual, being so ashamed, may choose not to seek treatment at all or delay it considerably, which will only worsen their quality of life. Society has also stigmatized certain treatments or medications, which can further enforce the idea in an individual to not seek treatment in order to avoid the additional stigma (Latalova et al., 2013, p. 269). Failing to seek the proper treatment will only increase the difficulties that someone with bipolar disorder is already facing.

So, what can we do to make a change? Social media can be a part of the solution. Allister Nelson from the Department of Communication at George Mason University conducted research entitled, "Ups and Downs: Social Media Advocacy of Bipolar Disorder on World Mental Health Day." He acknowledges that bipolar disorder is gaining more awareness with celebrities such as Mariah Carey, Demi Lovato, Stephen Fry, Carrie Fisher, Robin Williams, and Kanye West acknowledging their own battles with the disease (Nelson, 2019, p 1-2). He conducted a study based on social media posts from World Mental Health Day on October 10th, 2018. Since the recent death of Robin Williams in 2014 from suicide, and Carrie Fisher opening up about her lifelong battles in her book, *Wishful Drinking*, more celebrities have been willing to reveal that they also suffer from bipolar disorder. It is encouraging many of them to become advocates in order to reduce the stigma against the illness. On World Mental Health Day in 2018, many celebrities shared their own stories on social media in hopes of reducing stigma and promoting support of those who suffer (Nelson, 2019, p. 2).

The year 2018 was prominent because it was then that Mariah Carey revealed that she had been diagnosed with bipolar disorder. This was also the year that Kanye West created a media storm not only with Twitter rants, but also gave questionable performances on television. In his public appearances he made absurd tirades, and eventually showed his support for Donald Trump and the Republican Party, although he had always previously been a Democrat. With these high-impact celebrities being the center of attention in 2018, it has made World Mental Health Day a trending phenomenon on all social media platforms, including Facebook and Twitter. Demi Lovato was the leading advocate (Nelson, 2019, p. 3).

Considering the mortality rate is extremely high in those with bipolar disorder, reducing the risk of suicide is vitally important. According to Nelson, "Reducing mental health stigma is a form of risk management, and awareness campaigns are part of the solution to the health risks of mental illness. No time is more popular for mental health advocacy than World Mental Health Day" (Nelson, 2019, p. 3). No one has a louder voice than a prominent celebrity. When they use their platforms to campaign for changes in the stigma and attitudes against bipolar disorder and inspire people to get help, they can bring about huge changes in public perceptions. Individuals that may be suffering in silence and feeling alone may find a sense of fellowship, knowing that people with such popularity may be facing the same issues as them. It can inspire hope in people with bipolar disorder and encourage them to take their lives back and flourish (Nelson, 2019, p. 3).

Nelson conducted his study by gathering a list of celebrity names with bipolar disorder through a google search. Overall, he found that the posts shared by celebrities on World Mental Health Day shed positivity on bipolar disorder and many of the posts included encouragement, comfort, and hope. They also included messages designed to reduce stigma against mental

illness. There was very little negativity in the posts that he surveyed. In short, the good overshadowed the bad. Nelson also had follow up research on social media posts a month after World Mental Health Day, and he still observed the majority were positive and encouraging regarding mental illness, particularly bipolar disorder (Nelson, 2019, p. 5). Nelson's research was important and impactful as to what we as a society can do to shift perspectives on mental illness. He finalized his research with the following: "Strength lies in numbers, and with more opinion leaders advocating emotional support of bipolar disorder on World Mental Health Day, the world could see a real change in the stigma surrounding the disorder and a lasting frame shift toward understanding and acceptance. More importantly, those that suffer would know they were not alone, and would be encouraged to take positive steps toward treatment and recovery" (Nelson, 2019, p. 7).

Clinical Definitions of Bipolar Disorder

Now that some of the more common misconceptions surrounding bipolar disorder have been discussed, it is important to recognize the clinical definitions of bipolar disorder. An important clarification is to first point out that there are various subtypes of bipolar disorder: bipolar I, bipolar II, and unspecified bipolar disorder. In 2019, researchers studied a group of 8766 individuals to examine the characteristics of bipolar I and bipolar II disorder. How these classifications present in individuals can be very different. Research has shown that all of the classifications include depressive episodes. However, the distinguishing factor between bipolar I and bipolar II are the characteristics of the manic episodes in an individual. Bipolar I is mostly associated with mania, while bipolar II is most often associated with hypomania. It is important to understand the difference between mania and hypomania. Both manic states include the same behavioral symptoms but differ in how long they last, how intense they are, and how much they

disrupt someone's functionality in everyday life. In this particular study, unspecified bipolar disorder was not included in the subgroups (Karanti et al., 2019, p. 392-393).

I also had the pleasure of speaking with a highly respected psychiatrist in Evansville, Indiana, Dr. Henry Kaplan. I asked him his thoughts as to the biggest difference between mania and hypomania, and he said, most definitely hospitalization. Mania requires hospitalization, while hypomania does not, because it comes and goes rather quickly, while mania lasts for weeks or even months. Bipolar I is most often associated with mania. I also asked him to clarify unspecified bipolar disorder and he said his professional opinion was that it really did not exist and had actually been taken out of the DSM-V. He acknowledged that both bipolar I and bipolar II may have mixed states, but being able to define a patient's diagnoses as either I or II is absolutely possible. To characterize it as "unspecified" really means that all of the patient's symptoms and characteristics are not being closely examined (H. Kaplan, personal communication, December 6, 2021).

Typically, bipolar I has been considered the most severe of the subtypes because bipolar II episodes do not tend to last as long or require someone to be hospitalized. It has also been believed that individuals with bipolar II do not have symptoms that significantly impact their day-to-day functionality. However, some see bipolar II to be even more disabling than bipolar I because the toll that the illness as a whole takes on a person is the same regardless. Some bipolar II characteristics can be even more harmful to functionality (Karanti et al., 2019, p. 393). In their study of the 8766 individuals, the researchers discovered that those with bipolar II are much more likely to attempt suicide, yet those with bipolar I were twice as likely to have a psychiatric hospitalization (Karanti et al., 2019 p. 394). The characteristic of bipolar II having more frequent manic episodes was also found to be true in this study, as they found that bipolar II patients had

more episodes of depression over a lifetime due to the frequency of mood shifts than those with bipolar I (Karanti et al., 2019, p. 395-396).

Bipolar I vs. Bipolar II from the DSM-V

The DSM-V, the 5th Edition of the Diagnostic and statistical manual of mental disorders from the American Psychiatric Association, includes what is to be seen to be the "formal" diagnosis of bipolar disorder and defines the diagnostic criteria of bipolar I and bipolar II as follows:

Bipolar I Disorder

Diagnostic Criteria

For a diagnosis of bipolar I disorder, it is necessary to meet the following criteria for a manic episode. The manic episode may have been preceded by and may be followed by hypomanic or major depressive episodes.

Manic Episode

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased goal-directed activity or energy, lasting at least 1 week and present most of the day, nearly every day (or any duration if hospitalization is necessary).
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 behavior:
    1. Inflated self-esteem or grandiosity.
    2. Decreased need for sleep (e.g., feels rested after only 3 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 (i.e., 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 (i.e., 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).

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.

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

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

Hypomanic Episode

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least 4 consecutive days and present most of the day, nearly every day.

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 behavior, 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 3 hours of sleep).
3. More talkative that usual or pressure to keep talking.
4. Flight of ideas or subjective experience that thoughts are racing.
5. Distractibility (i.e., 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 (i.e., 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).

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

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

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.

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

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.

Major Depressive Episode

A. Five (or more) of the following symptoms have been present during the same 2-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). (**Note:** In children and adolescents, can be irritable mood).
   2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
   3. Significant weight loss when not dieting or weigh gain (e.g., a change of more than 5% body weight in a month), or decrease or increase in appetite nearly every day. (**Note:** In children, consider failure to make expected weight gain).
   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 as observed by others).
   9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or specific plan for committing suicide.

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

C. The episode is not attributable to 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.

Note: 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.

Bipolar I Disorder

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

B. The occurrence of the manic and major depressive episode(s) is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder

Bipolar II Disorder

Diagnostic Criteria

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:

Hypomanic Episode

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least 4 consecutive days and present most of the day, nearly every day.

B. During the period of mood disturbance and increased energy and activity, three (or more) of the following symptoms have persisted (four if the mood is only irritable), represent a noticeable change from usual behavior, 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 3 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 (i.e., 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).

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

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

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.

F. The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication or 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.

Major Depressive Episode

A. Five (or more) of the following symptoms have been present during the same 2-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 a 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). (**Note:** In children and adolescents, can be irritable mood.)

2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% body weight in a month), or a decrease or increase in appetite nearly every day. (**Note:** In children, consider failure to make expected weight gain.)
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day (observable by others; not merely subjective feelings or 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 as observed by others).
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, a suicide attempt, or a specific plan for committing suicide.

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

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

Note: Criteria A-C above constitute a major depressive episode.

Note: 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 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.

Bipolar II Disorder

A. Criteria have been met for at 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).
B. There has never been a manic episode.
C. The occurrence of the hypomanic episode(s) and major depressive episode(s) is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.
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.

(*Diagnostic and statistical manual of mental disorders: DSM-V* 2013)

Mixed Mood States

Mixed mood states are another piece in the puzzle of bipolar disorder. They can make the diagnosis between bipolar I and bipolar II somewhat difficult because a mixed mood state can sometimes cause them to resemble each other to the point it makes a diagnosis that much harder to pinpoint. When someone with bipolar disorder struggles with both depressive and manic

symptoms at the same time, this is what is referred to as a mixed state or mixed episode (Miklowitz, 2019). As shown previously, the DSM-V defines bipolar disorder as a range between two states: depression and mania. However, mixed episodes are what occur in between those two extremes and can cause confusion as to what they are and how to treat them effectively (Stahl, 2019, p. 560). Although the DSM does acknowledge mixed states, it does not define the common symptoms, which are agitation, irritation and loss of focus. These symptoms often occur in other disorders as well, but it is important that these are defined in order to avoid treatment complications. For example, antidepressants can worsen the symptoms of bipolar disorder, and attempting to treat a mixed state in a depressive episode with antidepressants, could potentially cause more harm to the patient (Stahl, 2019, p. 560).

Agitated Depression

Agitated depression is an example of a mixed mood state and was studied by a team of researchers in the UK. They defined agitated depression as "the presence of excessive repetitive activity (such as restlessness, wringing of hands, pacing up and down), all usually accompanied by expression of mental anguish" (Serra, 2019, p. 549). They found that around thirty percent of those with bipolar disorder experienced agitated depression, and the rates showed roughly the same in those with bipolar I and bipolar II. Also, they found that of their sample of participants, nearly 95% suffered from agitated depression during their most serious states of depression (Serra, 2019, p. 548-549). From this example, one can see a mixed mood state of agitation, depression, and a feeling of being in extreme distress.

Another group of researchers have noted a concern with "mixed mood states and emotion-related urgency in bipolar spectrum disorders (Jaggers & Gruber, 2020, p.1). They describe emotion-related urgency as the difficulty in maintaining impulse control and controlling

risky behavior when experiencing an intense emotion during a mixed episode. These behaviors were examined in connection with both positive and negative emotions. When experiencing severe negative emotions, an individual with a loss of impulse control may act out physically or verbally. They may also cause financial distress by spending money excessively. Those with peak positive emotions could exhibit risky behaviors and the desire to experience extreme sensations. They may also participate in sexual behaviors with negative consequences (Jaggers & Gruber, 2020, p. 1).

Understanding mixed episodes is imperative in not only developing an effective treatment plan for bipolar patients, but also in protecting their safety. Since there are so many emotions and characteristics involved in bipolar disorder, the combinations of mixed states is nearly endless. This emphasizes the importance of physicians not rushing to diagnosis, but rather examining all aspects of an individual's behavior over time.

There is another element to bipolar disorder that should not go without mentioning, which is rapid cycling. Not to be confused with a mixed state, but possibly appearing similar, rapid cycling can affect those with either bipolar I or II. When individuals go through rapid cycling, their moods will quickly shift between hypomania or mania to depression. This can happen several times a year or can even happen several times a month. It can even be as fast as several times in a day with ultradian rapid cycling (Miklowitz, 2019).

Comorbidity with Other Disorders

While mixed states and rapid cycling will feature rapidly shifting or overlapping symptoms, bipolar disorder commonly has a comorbidity with other mental disorders. Depression has been discussed and it is important to make the point that while depression is one of the poles, we must remember that it does not exist alone in bipolar disorder.

Borderline Personality Disorder

Borderline personality disorder is one of the most common mental illnesses that is comorbid with bipolar disorder. The two have many of the same characteristics and symptoms that can make them sometimes difficult to distinguish from one another. In his book, *I hate you, don't leave me: Understanding the borderline personality,* Dr. Jerold J. Kreisman and Hal Straus dissect and explain what borderline personality disorder looks like in an individual, and also how it can co-exist with other mental illnesses. Kreisman summarizes the nine criteria for borderline personality disorder that are listed in the DSM-V. Five must be present in an individual in order to diagnose them. He listed them as follows:

1. Frantic efforts to avoid real or imagined abandonment.
2. Unstable and intense interpersonal relationships.
3. Lack of clear sense of identity.
4. Impulsiveness in potentially self-damaging behaviors, such as substance abuse, sex, shoplifting, reckless driving, binge eating.
5. Recurrent suicidal threats or gestures, or self-mutilating behaviors.
6. Severe mood shifts and extreme reactivity to situational stresses.
7. Chronic feelings of emptiness.
8. Frequent and inappropriate displays of anger.
9. Transient, stress related feelings of unreality or paranoia.

(Kreisman & Straus, 2021)

Because we have already deeply examined the symptoms and characteristics of bipolar disorder, reading this list should clearly indicate how bipolar disorder and borderline personality disorder can appear very similar, if not the same in some cases. In their book, Kreisman and

Straus go on to explain how often times borderline personality disorder will be a secondary disorder, lying underneath a more prominent illness. For instance, bipolar disorder may exist in a patient, but once they are treated for bipolar disorder, the symptoms of borderline personality disorder may begin to emerge, requiring further evaluation and treatment. Borderline personality disorder can also imitate bipolar disorder, which may result in an incorrect diagnosis in a patient. For instance, mood swings and impulsive actions are common in those with bipolar disorder, so this often causes a clinician to quickly diagnose a patient with bipolar disorder, when in actuality, the individual may have only borderline personality disorder (Kreisman & Straus, 2021).

The authors note, however, that there are significant differences between the two mental illnesses. In bipolar disorder, the mood episodes of mania or hypomania and depression can last a great deal of time. These mood states, as we have previously discussed, can also cause a breakdown in an individual's ability to function on a daily basis. However, between the bipolar mood swings, a person can live a nearly normal life and the disorder can also be treated with medications. In contrast, borderline personality disorder mood swings last a very short period of time, typically hours, and are not able to be effectively treated with medication. Still, the two disorders have a 20 percent overlap rate (Kreisman & Straus, 2021).

In my interview with Ms. Lori O'Nan, CLSW, she briefly discussed the symptoms she sees in patients with bipolar disorder and how they can appear similarly to borderline personality disorder. In her experience, Mrs. O'Nan said that the symptoms of bipolar disorder most of her clients exhibit are mood swings (mostly happy/sad but sometimes anger) and impulsivity. Some examples of impulsivity that she gave were sexual promiscuity or talking inappropriately to people online, stealing, substance abuse or self-medicating, and shopping. She mentioned that all

of these traits are also seen in those with borderline personality disorder. The most common trait she sees is inappropriate sexual behavior, followed by substance abuse and shopping, which she noted that she sees more so in women (L. O'Nan, personal communication, August 20, 2021).

Another group of researchers conducted a study entitled, "The Influence of Borderline Personality Traits on Clinical Outcomes in Bipolar Disorder". Their study focused on how Borderline Personality Traits can influence Clinical Outcomes, such as diagnosis or misdiagnosis of bipolar disorder. The research was done on individuals diagnosed with bipolar I and bipolar II to determine if traits of borderline personality disorder also existed, and if so, examine the severity of those traits (Saunders et al., 2020, p. 368). They also wanted to see how these traits affect clinical outcomes as opposed to a formal diagnosis (Saunders et al., 2020, p. 369). Also discussed are overlapping symptoms between the two diagnoses and how this may cause misdiagnosis of either bipolar disorder or borderline personality disorder.

Although similar, it has been found that the two disorders have different causes, specific neuropsychological processes, and different developments and outcomes (Saunders et al., 2020, p. 369). The findings were consistent that high rates of borderline personality traits existed in individuals with bipolar I and II, although the frequency and severity were higher in those with bipolar II (Saunders et al., 2020, p. 371). In the clinical outcomes, it was found that individuals with bipolar I and borderline personality traits were at a higher risk of suicide attempts (Saunders et al., 2020, p. 371).

While finding that borderline personality traits existed in both bipolar I and bipolar II groups, it was also discovered that borderline personality traits often overlapped with bipolar I and II traits (Saunders et al., 2020, p. 368), which could easily lead to a misdiagnosis. Because bipolar II patients exhibited more severe borderline personality traits, there could be a

misdiagnosis in that the patient has borderline personality disorder instead of bipolar II (Saunders et al., 2020, p. 371). Patients could also be diagnosed with bipolar II alone, when borderline personality disorder may exist as an additional diagnosis. This research led to the conclusion that when managing patients with bipolar disorder, borderline personality disorder and traits must be considered in the management of patients (Saunders et al., 2020, p. 368).

Dr. Kreisman and the team of researchers who conducted the research on clinical outcomes have many of the same conclusions. Borderline personality disorder has many overlapping traits with bipolar I and bipolar II. They are often comorbid. Most importantly, clinicians need to pay close attention when diagnosing patients so that there is not an under or over diagnosis and an effective treatment plan can be established.

Attention-deficit Hyperactivity Disorder (ADHD)

Attention-deficit hyperactivity disorder, otherwise known as ADHD, is also commonly comorbid with bipolar disorder and can create its own challenges as well. Dr. Russell E. Scheffer studied this commonality and wrote of his finding in the article, "Concurrent ADHD and Bipolar Disorder." The correlation between ADHD and bipolar disorder is often found in a younger age demographic, and there have not been many studies in adults with the two illnesses. It has been estimated that the rate of comorbidity in patients with ADHD and bipolar disorder ranges anywhere from 29% to 98% (Scheffer, 2007, p. 415). Therefore, it is apparent that ADHD and bipolar disorder frequently exist in patients at the same time. There is some symptom overlap between the two disorders, but not enough that a clinician would not be able to distinguish one from the other. Overlapping symptoms such as impulsivity, talkativeness, irritability, lack of focus, and agitated activity such as wringing of hands or pacing in bipolar disorder patients can resemble the hyperactivity in those with ADHD (Scheffer, 2007, p. 416).

Dr. Scheffer noted that it is important for clinicians to medically treat these two disorders independently with medications, as some ADHD can exacerbate the symptoms of bipolar mania.

Another group of researchers, Lut Tamam, Gonca Karakus, and Nurgul Ozpoyraz, published an article entitled, "Comorbidity of adult attention-deficit hyperactivity disorder and bipolar disorder: prevalence and clinical correlation". Interestingly, their findings were much the same as Dr. Scheffer's. The rates of comorbidity were the same, although these researchers acknowledged that the rate decreases as one gets older. The two diagnoses exist together most frequently in children and the rate in adults is anywhere from 9% to 35%. Also, bipolar patients with ADHD tend to have more mixed states and more periods of depression. They also are more likely to be subject to other disorders such as drug and alcohol abuse. (Tamam et al., 2008, p. 385-386).

Anxiety

Anxiety is another disorder that is often found to be comorbid with both bipolar I and bipolar II. While a certain amount of anxiety can be a very normal emotion, anxiety disorders are more debilitating. A person with an anxiety disorder may experience worry or fear that produces physical symptoms of stress at a level that interferes with daily functioning (American Psychiatric Association, 2022). When paired with another mental illness, the outcomes can be even more serious.

In 2004, a group of physicians examined the correlation between anxiety disorder and bipolar disorder from a group of 500 participants. At the time of publication of their research, this sample of bipolar disorder patients was the largest well-characterized sample that had ever been studied (Simon et al., 2004, p. 2222). Their research separated anxiety disorders into subgroups such as PTSD, OCD, and agoraphobia. They found that anxiety disorder was present

in over half the group, and the greatest amount of anxiety was most often found in patients with bipolar I disorder versus bipolar II. They also discovered that the comorbidity of the two disorders greatly increased suicide attempt rates (Simon et al., 2004, p. 2223-2224).

Their research results of the comorbidity of anxiety disorders and bipolar disorder also suggested a large overlap in substance abuse disorders. In addition, a concerning observation is that those that are affected by both anxiety disorder and bipolar disorder have a poor quality of life and ability to function in daily life. Only those with OCD were the exception (Simon et al., 2004, p. 2224). The researchers noted that there is some increased awareness of recognizing the need for treatment of comorbid disorders such as anxiety disorders and bipolar disorder. However, they also mentioned that there has not been much emphasis on treating anxiety in bipolar patients. They believe there needs to be more "anxiety-targeted interventions", especially given the fact that their research shows such an increase in attempted suicide rates and the quality and function of life in those that suffer from the comorbidity between these two mental illnesses (Simon et al., 2004, p. 2227).

Areas of Misdiagnosis

As shown thus far, with the existing complex moods and comorbidities with other mental illnesses, misdiagnosis of bipolar disorder can easily occur, and due diligence is necessary in order to make sure patients are diagnosed and given the appropriate treatment plan.

Depression

Diagnosing bipolar disorder as depression is often one of the biggest areas of misdiagnosis. The initial state of bipolar disorder usually presents as depression, and depression episodes last longer than manic episodes in patients (Carvalho et al., 2020, p. 58). It is usually during this depressive episode that someone is most likely to seek help, as elevated episodes do

not always appear as an obvious problem. Also, it is common for those suffering from these depressive episodes to see their primary care physician, who may only see the "depression" that is presented and not investigate any other psychological problems (Carvalho et al., 2020, p. 60).

According to Dr. Tracey Marks, a psychiatrist in Atlanta, Georgia, it is fairly easy to view bipolar disorder as depression. She identifies signs that someone may have bipolar disorder rather than unipolar depression. One of the signs is that a patient no longer responds to antidepressants even though they may have responded well to them previously. This can be a sign that bipolar disorder is beginning to be more visible in the patient. Also, antidepressants can either not work at all in a patient or make them worse, causing mixed states, as discussed previously (Marks, 2018).

Bipolar disorder is also cyclical, in contrast to unipolar depression. Individuals with bipolar disorder will typically go from depression to mania to hypomania and these episodes can have a long time span of months or even a year between them, but regardless, they still cycle. Dr. Marks also noted that hypomania can commonly go unnoticed because people are just in a good mood and productive. Hypomania also does not always cause impairment in an individual. When someone alternates between hypomania and depression, it can appear they are having continual episodes of unipolar depression, when in fact they have bipolar disorder II, as hypomania is one of the main criteria (Marks, 2018).

Attention-Deficit Hyperactivity Disorder (ADHD)

Attention-Deficit Hyperactivity Disorder (ADHD) is another mental illness that can sometimes cause a diagnosis of bipolar disorder to be missed. Their symptoms are similar, but you have to look closely to see that there are very distinct differences. While the biggest difference between the two is the presence of mania in bipolar disorder that does not exist with

ADHD, both illnesses present issues and symptoms with speech, mood, impulsivity, and sleep (Marks, 2019). Mania causes issues with speech in that it causes people to feel as if they cannot stop talking, mostly because of the thoughts that are racing through their brain. This could cause someone with bipolar disorder to interrupt someone in the middle of a conversation. Individuals that have ADHD also may cause an interruption, but it is not because of racing thoughts, it is actually quite the opposite. Someone with ADHD may interrupt someone because they do not even realize another person is speaking because they have zoned out while that person is talking.

In terms of mood, bipolar disorder patients experience random changes in mood that are cyclical in nature, while those with ADHD have mood changes due to an event triggering that particular mood. Both illnesses cause impulsivity, but they are for very different reasons. ADHD can cause someone to make a bad choice or decision because they did not think it completely through and consider the repercussions. Bipolar disorder can cause impulsivity that is much more severe because they can experience hypersexuality, which can cause them to make devastating life choices. They also have poor spending habits, but it can be to the point that they spend thousands of dollars and then have no money to buy food or other necessities in their lives (Marks, 2019).

Sleep is also affected in both bipolar disorder and ADHD. However, those with bipolar disorder that are in a manic state can stay awake for days and have almost a “superhuman” type of energy (Marks, 2019). ADHD will cause someone to be hyper focused on a project or anything they are currently doing and they will not sleep, but that is simply because of the focus they are putting into what they are doing at the moment. They will also be tired afterwards, unlike those with bipolar disorder (Marks, 2019).

A research group from the Institute of Mental Health published an article “Reimagining the spectrum of affective disorders” in 2020. In their article, they discussed how mental disorders can be misdiagnosed. According to the authors, “In clinical practice, physicians would have encountered patients fulfilling the diagnostic criteria for multiple diagnoses at the same time or singly at different times, and it is known that the differential or provisional diagnosis may be rather imprecise and depends largely on the timing, progression, and overlap between mood and psychotic symptoms” (Ng et al., 2020, p. 638). They gave examples of schizophrenia being misdiagnosed as depression if a clinician were to miss psychotic features. Another example was if severe depression was treated only as depression rather than bipolar disorder if signs of mania were overlooked (Ng et al., 2020, p. 638).

There are several reasons why bipolar disorder can be difficult to differentiate from other disorders, potentially causing a misdiagnosis. Mood variations can occur for many reasons. Personal stress, difficulties with sleep, the effects of drugs and alcohol, or personality disorders can all cause changes in mood (Miklowitz, 2019). Distractability can occur in bipolar disorder and ADHD. Mood variations can occur in borderline personality disorder as well as bipolar disorder. Taking the time and patience to examine an individual’s symptoms is key in the diagnostic process so that proper treatments can be administered (Miklowitz, 2019).

Substance abuse

Many studies have shown that the rates of comorbidity of substance abuse and bipolar disorder are exceptionally high. Although substance abuse is not a symptom of bipolar disorder, it weaves into an individual’s mood swings, causing the substance abuse and mood swings to both become worse (Miklowitz, 2019). Alcohol can be used to help with coming down from mania and lessen the anxiety and sleep disturbances that often accompany manic states. On the

other hand, narcotics such as cocaine and amphetamines may be used to increase elated states of mania. Individuals may also use these drugs to induce the high feelings of mania (Miklowitz, 2019). During depression, drugs or alcohol may be used to numb the negative feelings that occur (Miklowitz, 2019).

A study conducted in Bangladesh on the comorbidity of substance abuse and bipolar disorder found that 57% of their 151 participants with bipolar disorder also abused drugs or alcohol. They suggested that the symptoms of mania involving risk-taking behaviors and engaging excessively in gratifying activities could be one of the reasons for the co-occurrence (Rashid et al., 2019, p. 31). The researchers also noted the comorbidity can cause "delayed recovery, hastened relapse, greater inter-episode symptom burden, and increased disability and mortality" (Rashid et al., 2019, p. 32).

Bipolar Disorder Treatment Options

Over the last several decades, there have been numerous treatment options available for bipolar disorder. They include traditional pharmaceuticals, non-traditional pharmaceuticals, and non-pharmaceutical treatments. Many clinicians recommend a mix of pharmaceutical treatments along with non-pharmaceutical treatments. One of the challenges of bipolar disorder is that everyone responds differently to various treatments, so there is no one way to treat the illness. Treatment plans often involve more of a trial-and-error process in order to get a patient stabilized.

Traditional Pharmaceutical Treatments

The use of traditional pharmaceuticals may be one of the most socially recognized treatments for bipolar disorder, but as research continues on this elusive illness, new medications and treatment methods are being discovered.

Anti-depressants

Anti-depressants are commonly used in the treatment of bipolar disorder as a mood stabilizer. However, there are questions about how effective they are and if they are safe for treating bipolar disorder. Research has indicated traditional mood stabilizers are more effective than anti-depressants. It has also been proven through research that anti-depressants only work in the short term and that mood stabilizers are a better and more effective choice for long-term treatment. Although depression is one of the main symptoms of bipolar disorder, treating it with anti-depressants is not always a favorable course of action (Kusumakar, V. 2002, p. 23). Research has shown that anti-depressants can make bipolar disorder worse by bringing on manic or hypomanic episodes. They can also increase cyclical activity between depressive and manic episodes or cause episodes to last longer (Kusumakar, V. 2002, p. 25).

Their efficacy is also fairly short-lived. Since many bipolar patients initially present to their clinician in a depressive episode, depression is usually the diagnosis, therefore the initial treatment is anti-depressants. In an effort to investigate their efficacy in bipolar patients, a close examination of a large database in Taiwan showed that "patients who require two or more changes of anti-depressant (i.e., those whose depression is more difficult to treat) have a substantially increased probability of receiving a revised diagnosis of bipolar disorder" (Goodwin, G. 2012, p. 5). Overall, the use of anti-depressants in treating bipolar disorder is not always ideal, as research has shown the disadvantages far outweigh any advantages.

Antipsychotics and Mood Stabilizers

Antipsychotics are often used as mood stabilizers in the treatment of bipolar disorder. They are able to do most of the "work" in treating depression, mania, and mixed symptoms. Some examples of antipsychotics used in the treatment of bipolar disorder are: Abilify, Vraylar,

Seroquel, Risperdal, Saphris, Zyprex, Geodon, and Latuda. Drugs such as Tegretol, Lithium, and Depakote have been used for many years but require frequent blood level testing until the correct usage level is found. Once the mood swings are under control, a patient will enter what is called a maintenance phase, where another drug may be added to extend time between episodes, eliminate them completely, or lower their intensity (Marks, 2020). Research has shown that antipsychotics carry a much lower risk of inducing mania as opposed to anti-depressants and are much more effective for long-term use. Some antipsychotics can work very quickly and even stop mania from occurring (Kusumakar, V. 2002, p. 25).

A research team in Japan did a study to see if conventional mood stabilizers alone were as effective as pairing them with second-generation (newer, also referred to as atypical) antipsychotics. Patients that were stabilized using both medications and then terminated the use of the second-generation antipsychotic had increased recurrences of mood episodes. The frequency of episodes also increased over time while no longer using the second-generation antipsychotics (Kishi, 2021, p. 796). Ultimately, it was found that patients were able to stabilize for longer periods of time by using conventional mood stabilizers along with the second-generation antipsychotics (Kishi, 2021, p. 799).

Anti-Anxiety Medications

With the rate of comorbidity between anxiety and bipolar disorder being significant, it is often necessary to treat the patient's anxiety in addition to the bipolar disorder treatment. Benzodiazepines are often used for this purpose. While useful for calming, helping to control anxiety and panic, and sleep, moderation and caution must be considered when utilizing them. Benzodiazepines, while affective, can also be addictive and may lose their effectiveness over time, causing a need for a dosage increase in order to maintain their effects (Miklowitz, 2019).

Researchers in the department of psychiatry at a hospital in Tunisia studied certain personality traits that may increase dependency on benzodiazepines in patients with bipolar disorder. Their study found that "personality characterized by less extraversion, agreeableness, and emotional stability may increase the risk of BZD-dependence among bipolar patients (Charfi et al., 2021).

A group of researchers in Sweden conducted a study on the initiation and long-term use of benzodiazepines in bipolar disorder. They discovered that 22% of bipolar patients that had never used benzodiazepines eventually became long-term users, which in their measurements was greater than 6 months (Wingård et al., 2018, p. 642). Their findings concurred that the use of benzodiazepines for the treatment of anxiety in bipolar disorder should be used with restriction and utilizing more than one benzodiazepine should be avoided altogether (Wingård et al., 2018, p. 644).

Non-traditional pharmaceutical treatments

Non-traditional pharmaceuticals are becoming increasingly more popular in the treatment of bipolar disorder. Traditional pharmaceuticals that include anti-depressants, atypical antipsychotics, mood stabilizers, and anti-anxiety medications are still vital in the treatment of bipolar disorder, however, some patients are treatment-resistant, and there is a need for alternative treatment methods. What is meant by "non-traditional" is using a drug that has previously been used for a completely different purpose to treat bipolar disorder.

Ketamine

Ketamine has a great deal of buzz around it in popular media as being used as a treatment for depression. Traditionally, ketamine is a surgical sedative used for anesthesia. It is most frequently used in treatment-resistant patients when no other drug treatments have worked. It has been shown to quickly improve mood and have fast antidepressant properties. So far, it has only

been studied as an addition to a mood stabilizer in the treatment of bipolar depression. Its method of delivery can be complicated. As of right now, racemic ketamine can only be administered intravenously, but the FDA has recently approved a much more practical nasal spray that delivers esketamine, which is made from ketamine (Miklowitz, 2019).

In April of 2021, a team of researchers published a systematic review of the efficacy and tolerability of ketamine in the treatment of bipolar depression in the *International Journal of Neuropsychopharmacology*. All of their studies involved the use of intravenous ketamine in patients that had also been using a mood stabilizer for some time (Bahji et al., 2021, p. 537). The results they found were concurrent with those stated in Dr. Miklowitz's book. Patients experienced their depression symptoms decreasing quickly after they were administered the drug. They also found that suicidal thoughts can be lowered at an accelerated rate. The ideations can be diminished within one day and the lasting effects of ketamine for suicidal patients can last up to one week. Although true efficacy still needs to be proven through more studies, this study found that a dose of ketamine was effective for 2 weeks. However, those in their study that received six dozes over a 2 week time span experienced greater efficacy (Bahji et al., 2021, p. 537). Overall, their study found ketamine to be an effective treatment for bipolar depression (Bahji et al., 2021, p. 539).

Another group from the Department of Psychiatry at a Medical University in Finland also conducted research on the effects of ketamine on bipolar disorder. Their findings were similar to the other research groups, but they also discovered additional information about the use of ketamine in bipolar patients. Not only does it have the ability to significantly reduce depression symptoms, but it can also reduce inflammation in the body and has positive effects on gut

bacteria, which has been shown to be a problem in patients with bipolar disorder (Wilkowska et al., 2020, p. 2713).

Non-pharmaceutical treatments

There are several treatments for bipolar disorder that do not involve pharmaceutical drugs. However, it has been shown that the use of medication alone will only give patients limited reprieve from their symptoms. It is commonly recommended that therapy specifically related to bipolar disorder be a vital part of managing the illness (Swartz & Swanson, 2014, p. 251).

Talk-therapy

Throughout history, it has previously been believed that medication was the only and best treatment for bipolar disorder. It wasn't until the 20th century that a psychotherapeutic approach was introduced, but the techniques used did not prove to be helpful. Many of them focused on bringing about change through transference and developing insight. Since patients experiencing manic episodes have debilitated insight, psychotherapy was not given much credit (Swartz & Swanson, 2014, p. 251).

Dr. Holly Swartz and Joshua Swanson conducted a study of various types of psychotherapies with bipolar patients that were already on medication for treatment. Individual, group, family, and cognitive-behavioral therapies were all studied. Their findings were that adding psychotherapy to medication had enormous benefits for individuals with bipolar disorder. The combination resulted in a vast improvement in the speed of recovery from depressive episodes, as well as aiding in the recurrence of a new episode. While the majority of the benefits were on the depressive symptoms, the study did also find that daily function and the patient's quality of life were also greatly enhanced. These benefits were not specific to any one kind of

psychotherapy but seemed to give the same results with any type (Swartz & Swanson, 2014, p. 263). From the evidence in their study, they were able to conclude that combining medication with psychotherapy has consistent advantages. Combining therapies can lessen symptoms and prevent more episodes, as opposed to utilizing medicinal treatment alone (Swartz & Swanson, 2014, p. 251).

EMDR

Eye movement desensitization and reprocessing, also known as EMDR, has also been shown to be an effective treatment for patients with bipolar disorder, particularly in those with comorbid conditions such as PTSD, depression, anxiety and addiction (Valiente-Gómez et al., 2019, p. 307). The authors of the review, "EMDR beyond PTSD: A Systematic Literature Review" defined EMDR as "a psychotherapeutic approach developed in the late 80's by Francine Shapiro that aims to treat traumatic memories and their associated stress symptoms. This therapy consists of a standard protocol which includes eight phases and bilateral stimulation (usually horizontal saccadic eye movements) to densensitze the discomfort caused by traumatic memories and the aim of the therapy is to achieve their reprocessing and integration within the patient's standard biographical memories" (Valiente-Gómez et al., 2017, p. 1).

The authors of "Theoretical Background and Clinical Aspects of the Use of EMDR in Patients With Bipolar Disorder" found that EMDR can be effective in patients with bipolar disorder. It is acknowledged that there is a connection between psychological trauma and mental health. Childhood trauma can often cause an onset of bipolar disorder and taking this into account gives adequate reasoning that EMDR can be used to treat that trauma and be effective in reducing trauma-related symptoms in individuals with bipolar disorder (Valiente-Gómez et al., 2019, p. 310).

Mood monitoring

Another treatment that is more dependent on the individual that is diagnosed is a method called mood-monitoring. A team of researchers from the United Kingdom evaluated mood monitoring of individuals diagnosed with bipolar disorder, which is a commonly used practice in the treatment of the disorder. While mostly seen as a positive method, they wanted to consider the potential negative side effects of mood monitoring, so that professionals could determine if the practice should be used in the treatment plan for an individual on a case-by-case basis (Palmier-Claus et al., 2021, p. 430).

Individuals diagnosed with bipolar disorder have often been taught the tool of mood monitoring as a part of their treatment plan. It is a means of self-management of the mood swings associated with bipolar disorder. Its primary purpose to this point has been to help bipolar patients by increasing their self-awareness and helping them to understand their moods so that they can equip themselves for potential changes in their mood that would lead to or trigger a manic episode. It is intended to serve as a warning system in the hopes of keeping manic episodes to a minimum (Palmier-Claus et al., 2021, p. 429). The monitoring can come in the form of something as simple as a journal, but also in more technological forms, such as mood monitoring smartphone apps and electronic journals (Palmier-Claus et al., 2021, p. 430).

While it has been an effective form of treatment in many individuals, it must be evaluated to see if there is potential for it to be harmful to some patients. The process of mood monitoring presumes that individuals having greater self-awareness of their mood states is always beneficial. However, there are also theories that it can put patients in a precarious situation (Palmier-Claus et al., 2021, p. 429). These theories are based on the fact that people may exaggeratedly view their moods, fearing a relapse. Paranoia is a common symptom of bipolar disorder and there can

be a great potential for an individual's self-assessment to be greatly magnified. Patients may have trouble detecting the difference between a normal fluctuation in mood versus an early sign of mania, therefore making it very difficult to gauge an appropriate response to a mood (Palmier-Claus et al., 2021, p. 429). In turn, an individual may struggle with increased anxiety and paranoia. They may also find that focusing so much energy on assessing their symptoms could cause a downturn in mood (Palmier-Claus et al., 2021, p. 430). They may also limit their lifestyle or daily activities in preparation for a manic episode that may never materialize (Palmier-Claus et al., 2021, p. 429). These actions can lead to "unintended interpersonal, financial, and emotional consequences" (Palmier-Claus et al., 2021, p. 431).

Researchers at the Copenhagan Clinic for Affective Disorder approached mood-monitoring in a different way by developing a smartphone monitoring system called the MONARCA I. It was designed to collect data from real-time usage of a smartphone combined with self-monitoring data that was manually input into the phone (Faurholt-Jepsen et al., 2015, p. 724). The system monitored speech, social activity, and physical activity continuously on the smartphone. For example, text messaging and phone usage would give insight into speech activity (increased speech could indicate mania while decreased may suggest depressive symptoms). Increased or decreased social media activity could also be an indicator of episodes, as is physical activity (Faurholt-Jepsen et al., 2015, p. 716). Monitoring this data in the "background" had the advantage of being completely objective.

The patients self-monitored their moods daily by responding to an alarm that would alert them at a time the patient had chosen themselves. They were asked to evaluate their mood, sleep length, medication taken, activity, irritability, mixed mood, cognitive problems, alcohol consumption, stress, and individualized warning signs. All of these evaluations were done by a

rating system or “yes/no” answers with the exception of sleep, in which the patient would input the length of hours slept (Faurholt-Jepsen et al., 2015, p. 717-718). Once both sets of information were gathered, the researchers were able to evaluate the correlations. They were able to conclude that the data that was collected could be used as biomarkers of illness activity (Faurholt-Jepsen et al., 2015, p. 724).

One of the limitations of the smartphone study was that it does require a very high level of trust between the provider and the patient so that they do not feel as though they are being “watched” (Faurholt-Jepsen et al., 2015, p. 726). This correlates with Palmier-Claus and his team as a caution not to increase the level of paranoia that is already present in many bipolar patients. It is wise to place focus on educating those with bipolar about everyday moods and explaining to them the array of moods and associated behaviors that are acceptable and appropriate. Getting input from spouses, family members, and other therapists or doctors that may have treated the individual is another helpful tool in assessing and gathering various perspectives in evaluating if mood monitoring is a good course of treatment for them (Palmier-Claus et al., 2021, p. 430).

Self-treatment

Clinicians have made strong correlations between one’s physical health and their mental health. While maintaining physical health alone is not a proper treatment for bipolar disorder, maintaining certain aspects can increase the quality of one’s overall mental health. Experts have identified a targeted set of self-management strategies by conducting a written study among a group of participants with bipolar disorder. The results identified factors the individuals found to be most beneficial and have increased overall functioning when managing bipolar disorder (Suto et al., 2009, p. 76).

Getting enough regulated sleep was one of the most essential strategies. Participants acknowledged that there can even be a correlation between sleep and depression, stating that they have noticed that as long as they get enough sleep, they do not experience depressive symptoms. It was also noted that resting while awake was also important. It allows the body to recharge so that the demands of daily life are able to be met. Exercise was next on the list and there was emphasis on identifying the type of exercise that worked best for each person individually. Types of exercise ranged from slow, short walks to dancing and yoga. Outdoor activities appeared to be even more helpful and the right location could provide further benefits. (Suto et al., 2009, p. 77).

Diet and nutrition were another strategy that participants deemed very important. Eating healthy foods on a regular schedule and taking vitamin supplements were all pieces of a well-balanced routine that helped give the participants much needed structure in their lives. It was noted by one participant that when they did not eat well or on a regular schedule, it seemed to cause shifts in her mood. Another participant mentioned that it was beneficial to avoid caffeine, sugar, and alcohol as much as possible. All of these components of diet are important in order to give a sense of balance and control in their lives (Suto et al., 2009, p. 77).

Finally, insightfulness and mindfulness practices helped those with bipolar disorder to maintain stability and also be responsible for their own actions. Recognizing when certain feelings come up and being able to address them in a healthy way is important. The participants described using methods such as Tai Chi, meditation, music and journaling as just some of the ways to increase their insight and keep a watch on their emotions (Suto et al., 2009, p. 78).

Bipolar Disorder from a Clinician's Perspective

I had the privilege of interviewing two individuals in the mental health field. Ms. Lori O'Nan is a Licensed Professional Social Worker in Henderson, Kentucky. Dr. Henry Kaplan is a Psychiatrist specializing in medication management in Evansville, Indiana. They shared with me their experiences with bipolar disorder.

Ms. Lori O'Nan

Speaking to Ms. O'Nan about her experience in treating patients with bipolar disorder was very enlightening. There were many things she said that concurred with the research here and some additional perspectives as well. In her experience, Mrs. O'Nan said that the symptoms of bipolar disorder most of her clients exhibit are mood swings (mostly happy/sad but sometimes anger) and impulsivity. Some examples of impulsivity that she gave were sexual promiscuity or talking inappropriately to people online, stealing, substance abuse or self-medicating, and shopping. She mentioned that all of these traits are also seen in those with borderline personality disorder. The two disorders are often hard to distinguish from one another and have overlapping traits. The most common trait she sees is inappropriate sexual behaviors, followed by substance abuse and shopping, which she noted that she sees more so in women.

Tangential speech is another symptom of bipolar, especially when in a manic episode. They talk for hours on end and it's very difficult to get a word in or even work with them in a therapeutic environment because they don't stop talking. She also discussed that obsessive-compulsive tendencies are also a big symptom of bipolar disorder, especially when in a manic state. The tendencies are not necessarily the ones most are familiar with, such as needing to do something a certain number of times, needing things in just the "right" place, or excessive thoughts. The behaviors most associated with bipolar are of a mindset of "I can fix it, I can do it

all", but then shifts to "I need to do this, but I get overwhelmed, so I need to move on to something else." Tasks are started but never finished, and new tasks are begun, which can resemble ADHD. She said that patients with bipolar disorder also tend to behave like teenagers when they are manic. In her words, "when they are manic, they don't care about anything but themselves, and when they are depressed, they don't care about anything but themselves. They don't care about anyone else's feelings. They want to do what feels right to them and when someone opposes, that person will be accused of 'controlling them'." These are just more examples of impulsivity and the symptoms of acting like a teenager. She often sees a lot of legal issues with impulsive behavior due to self-medicating which often occurs when the disorder is going untreated, or the treatment isn't the right fit.

When asked what she felt the most common misconceptions were about bipolar disorder, she said that most outsiders, or even family and friends, will assume that someone is involved in drug abuse instead of having bipolar disorder. Drug addiction and bipolar disorder mimic each other, and she described bipolar disorder as often appearing like someone addicted to methamphetamines. The other misconception is that people think they can't get better, yet it is possible with the right medication regimen and therapy. Therapy is vital.

Mrs. O'Nan has no doubt, as studies have shown, that there is something "off" in the brain chemistry of those with bipolar disorder. However, the right medication regimen combined with therapy can be very effective at regulating behavior. Eye Movement Desensitization and Reprocessing, better known as "EMDR" therapy, has proven to be very effective in the treatment of bipolar disorder. The most vital part of improving, however, is the patient must WANT to get better. They must be honest about their symptoms, take their medications, and not only go to therapy, but put in the work at home that they have learned

through their therapy sessions. They can live fairly normal lives. There is hope, and new medications and treatments are developed every day that will hopefully give us even more effective ways of treating bipolar disorder (L. O'Nan, personal communication, August 20, 2021).

Dr. Henry Kaplan

Dr. Kaplan is a psychiatrist that specializes in medication management, and he sees many patients with bipolar disorder. He said that the most common symptom that he sees in these patients is depression. He mentioned not only the importance of using a PHQ9, the depression test questionnaire as dictated by the DSM-V, but also feels it is vital to have the patient fill out an MDQ which is a mood symptom questionnaire because patients spend more time in a depressed phase and clinicians often do not see the manic phase. If a clinician does not even potentially look at the fact that the depression could be a depressed phase of bipolar, a clinician can easily be fooled and possibly put them on an anti-depressant not considering that they are in a depressed phase and it may worsen things….it is like adding fuel to the fire. When asked about the two polars he sees in his patients, Dr. Kaplan said he also sees many patients that are irritable and sad, not just the classic happy and sad paradigm.

Regarding medication, Dr. Kaplan said that many clinicians will only use a mood stabilizer for treatment. There are only two, Seroquel and Vraylar, that are approved for all three phases of bipolar disorder, mixed, manic and depressive. The other atypical antipsychotics are used often for the depressed phase because most of them are approved for manic state and long-term treatment. Anti-depressants are used with caution in bipolar patients because they have to be changed often due to losing their efficacy or making things worse. He also reported that there is data to show that the more you change medication, the less likely someone is going to reach

remission. Mood stabilizers do not always have to combined with an atypical antipsychotic because some of the atypicals are approved specifically for bipolar disorder. However, there are times when you have someone with major depressive symptoms, you may need to combine the two and slightly increase dosages and see what happens and what works. It very much is a trial-and-error process. He mentioned that most studies are only eight weeks before a medication goes before the FDA, and they do not take patients with comorbidity. The majority of the patients he has seen experience comorbidity because it is extremely common, so it can be a bit of a puzzle of trying to figure out just the right combinations of medications to see what works.

Part of the disease process in bipolar disorder is that people hit stability then decide they no longer need medication. He spoke of an instance with a patient that stopped taking their medication for depression, and the depressive symptoms came back after a few months. The patient tried to restart his medication and it no longer worked. Dr. Kaplan has seen several patients like this. He does not have a clinical explanation for it but he suspects that chemical changes in the brain have occurred no longer allow the medication to work. He said that a patient with bipolar disorder should take their medication just like a diabetic would take insulin or someone would take a daily vitamin. Stabilization does not mean remission, and voluntarily choosing to stop taking medication will only complicate things because the process of finding what will work will have to start from scratch (H. Kaplan, personal communication, December 6, 2021).

Conclusion

Bipolar disorder is a mental illness that is often misunderstood and is also somewhat difficult to define. There is a spectrum of behavioral symptoms that may be involved. Not every individual with bipolar disorder experiences exactly the same symptoms. Depression and anxiety

are two symptoms of bipolar disorder that society can relate to, but other moods such as anger, irritability, elated mood, impulsive and risk-taking behavior are also a part of bipolar disorder that not everyone recognizes. There are many misconceptions about bipolar disorder in society because it's definition can be very difficult to pin down. Many people mistakenly view those with bipolar disorder to be crazy, volatile, moody, or emotionally unstable. The truth is that they are suffering with random mood swings that are beyond their control without the help of proper medication, therapy, and self-care.

Changing societal views on mental illness is important now more than ever. Suicidal rates are highly increased in those with bipolar disorder, so public awareness and knowledge is vital. Self-stigmatization is also an issue for individuals with bipolar disorder. Some feel that they are labeled and feel that having bipolar disorder is who they are versus an illness that they have. In recent years, more celebrities have spoken up about their own struggles with bipolar disorder, and they are showing that you can lead a normal, productive, and very successful life despite a mental illness diagnoses. They are leading the way for a more positive view on mental health. Celebrity, language, and the softer approach to terminology can all change societal views of bipolar disorder for the better.

Comorbidity with other mental illnesses such as borderline personality disorder, depression, ADHD, substance abuse, and anxiety are extremely common and can make diagnosis and treatment of bipolar disorder more difficult. Often there are overlapping symptoms between these mental illnesses, and one can "mask" another. Being self-aware of one's own moods and having a strong family support system is extremely important in the journey of finding the right doctors, therapists, and treatment.

There are several available treatments for bipolar disorder, but just as symptoms are not the same for every individual, there is also no one standard treatment. Treatments with traditional pharmaceuticals such as atypical antipsychotics, mood stabilizers, and anti-anxiety medications are commonly used in conjunction with psychotherapies including talk-therapy, EMDR, mood monitoring, and self-care. Ketamine is being explored as a new therapy for those that are treatment resistant, and researching is proving it to be successful.

My husband was diagnosed with bipolar disorder over a year ago, after years of being diagnosed with depression and treated with anti-depressants, which lost their efficacy quickly. Some made his episodes much worse. It has been a difficult road getting the correct diagnosis. Several clinicians did not want to diagnose him with bipolar disorder because he does not experience very happy and very sad moods, which was a traditional paradigm in which the illness was defined. He spends a large amount of time in a depressed state, and he never has times where he has an elated mood, instead he is either irritable or angry. He also has comorbidity with severe depression, borderline personality disorder, anxiety, and PTSD. This has made his treatment difficult, but finding a good doctor, being patient with trying medications and honest about their effects and being consistent with weekly therapy sessions has led him to a place where he is stable and functioning better than he has in several years. I have supported him every step of the way, viewing his mental illness no differently than I would view a physical illness. I also have my own support system with friends, church, and seeing my own therapist. It is not an easy illness to live with in any way. However, if we can all learn to educate ourselves a little more about mental illness and perhaps not rush to judgments at times, then perhaps we can make a huge shift in societal views and reduce the number of lives lost. Healing IS possible.

"Think of it as an opportunity to be heroic—not 'I survived living in Mosul during an attack' heroic, but an emotional survival. An opportunity to be a good example to others who might share our disorder."-quote from Carrie Fisher

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

American Psychiatric Association. (2022, January 13). *What are anxiety disorders? | symptoms, diagnosis, and ...* YouTube. Retrieved February 27, 2022, from https://www.youtube.com/watch?v=JOKS9Bx8-Sw

Bahji, A., Zarate, C. A., & Vazquez, G. H. (2021). Ketamine for Bipolar Depression: A Systematic Review. *The international journal of neuropsychopharmacology*, *24*(7), 535–541. https://doi.org/10.1093/ijnp/pyab023

Bell, E., Boyce, P., Porter, R. J., Bryant, R. A., Malhi, G. S. (2020). Could irritability be the key to unlocking the enigma of mixed states? *Bipolar Disorders*, *22*(8), 781–784. https://doi.org/10.1111/bdi.13029

Carvalho, A. F., Firth, J., & Vieta, E. (2020). Bipolar Disorder. *New England Journal of Medicine*, *383*(1), 58–66. https://doi.org/10.1056/NEJMra1906193

Chan, D., & Sireling, L. (2010). 'I want to be bipolar'…a new phenomenon. *The Psychiatrist*, *34*(3), 103–105. Cambridge Core. https://doi.org/10.1192/pb.bp.108.022129

Dome, P., Rihmer, Z., & Gonda, X. (2019). Suicide Risk in Bipolar Disorder: A Brief Review. *Medicina (Kaunas, Lithuania), 55*(8), 403. PubMed. https://doi.org/10.3390/medicina55080403

Faurholt-Jepsen, Maria, et al. "Smartphone Data as an Electronic Biomarker of Illness Activity in Bipolar Disorder." *Bipolar Disorders*, vol. 17, no. 7, 2015, pp. 715–728., https://doi.org/10.1111/bdi.12332

Franssen, G. (2020). The celebritization of self-care: The celebrity health narrative of Demi Lovato and the sickscape of mental illness. *European Journal of Cultural Studies*, *23*(1), 89–111. https://doi.org/10.1177/1367549419861636

Goodwin G. M. (2012). Bipolar depression and treatment with antidepressants. *The British journal of psychiatry : the journal of mental science*, *200*(1), 5–6. https://doi.org/10.1192/bjp.bp.111.095349

Jaggers, J. A., & Gruber, J. (2020). Mixed mood states and emotion-related urgency in bipolar spectrum disorders: A call for greater investigation. *International Journal of Bipolar Disorders*, *8*(1), 12–12.

Karanti, A., Kardell, M., Joas, E., Runeson, B., Pålsson, E., & Landén, M. (2019). Characteristics of bipolar I and II disorder: A study of 8766 individuals. *Bipolar Disorders*, *22*(4), 392–400. https://doi.org/10.1111/bdi.12867

Kishi, N., Taro; Sakuma, Kenji; Okuya, Makoto; Matsuda, Yuki; Esumi, Satoru; Hashimoto, Yasuhiko; Hatano, Masakazu; Miyake, Nobumi; Miura, Itaru; Mishima, Kazuo; Iwata. (2021). Effects of a conventional mood stabilizer alone or in combination with second-generation antipsychotics on recurrence rate and discontinuation rate in bipolar I disorder in the maintenance phase: A systematic review and meta-analysis of randomized, placebo-controlled trials. *Bipolar Disorders*, *23*(8), 789–800. https://doi.org/10.1111/bdi.13053

Kreisman, J. J., & Straus, H. (2021). *I hate you, don't leave me: Understanding the borderline personality*. Perigee Books.

Kusumakar, V. (2002). Antidepressants and antipsychotics in the long-term treatment of bipolar disorder. *Journal of clinical psychiatry*, *63 Suppl 10*, 23-28

Latalova K, Ociskova M, Prasko J, Kamaradova D, Jelenova D, Sedlackova Z. Self-stigmatization in patients with bipolar disorder. Neuro Endocrinol Lett. 2013;34(4):265-72. PMID: 23803872.

Malhi, G.S., Hamilton, A., Morris, G., & Bell, E. (2021). What does it mean to be bipolar? *Bipolar Disorders*, *23*(6), 537–540. https://doi.org/10.1111/bdi.13131

Marks, T., M.D. (2018, May 9.) *Bipolar Disorder vs Depression – 5 Signs You're Likely Bipolar.* YouTube. Retrieved February 28, 2022, from https://youtu.be/AM7vf5HJxaQ

Marks, T., M.D. (2019, April 24.) *Bipolar Disorder vs ADHD – How to Tell the Difference.* YouTube. Retrieved March 7, 2022, from https://youtu.be/pGUvXPL57as

Marks, T., M.D. (2020, August 5.) *Bipolar Disorder – Why One Medication May not Work* YouTube. Retrieved March 7, 2022, from https://youtu.be/KDMbRW_fEwM

Miklowitz, D., (2019). *The Bipolar Disorder Survival Guide, Third Edition: What You and Your Family Need to Know*. The Guilford Press.

Nelson, A. (2019). Ups and Downs: Social Media Advocacy of Bipolar Disorder on World Mental Health Day. *Frontiers in Communication,* 4, 24. https://doi.org/10.3389/fcomm.2019.00024

Palmier-Claus, J., Lobban, F., Mansell, W., Jones, S., Tyler, E., Lodge, C., Bowe, S., Dodd, A., & Wright, K. (2021). Mood monitoring in bipolar disorder: Is it always helpful? *Bipolar Disorders, 23*(4), 429–431. https://doi.org/10.1111/bdi.13057

Perlis, R. H., Smoller, J. W., Fava, M., Rosenbaum, J. F., Nierenberg, A. A., & Sachs, G. S. (2004). The prevalence and clinical correlates of anger attacks during depressive episodes in bipolar disorder. *Journal of Affective Disorders, 79*(1), 291–295. https://doi.org/10.1016/S0165-0327(02)00451-2

Rashid, Mohammad Harunur, et al. “Substance Abuse among Bipolar Mood Disorder Patients.” *Delta Medical College Journal*, vol. 7, no. 1, 2019, pp. 31–34., https://doi.org/10.3329/dmcj.v7i1.40618

Saunders, K., Jones, T., Perry, A., Florio, A., Craddock, N., Jones, I., Gordon-Smith, K., & Jones, L. (2020) The influence of borderline personality traits on clinical outcomes in bipolar disorder. *Bipolar Disorders*, *23*(4), 368-375. https://doi.org/10.1111/bdi.12978

Scheffer R. E. (2007). Concurrent ADHD and bipolar disorder. *Current psychiatry reports*, *9*(5), 415–419. https://doi.org/10.1007/s11920-007-0054-2

Serra, F., Gordon-Smith, K., Perry, A., Fraser, C., di Florio, A., Craddock, N., Jones, I., & Jones, L. (2019). Agitated depression in bipolar disorder. *Bipolar Disorders*, *21*(6), 547–555. https://doi.org/10.1111/bdi.12778

Simon, N. M., Otto, M. W., Wisniewski, S. R., Fossey, M., Sagduyu, K., Frank, E., Sachs, G. S., Nierenberg, A. A., Thase, M. E., & Pollack, M. H. and. (2004). Anxiety Disorder Comorbidity in Bipolar Disorder Patients: Data From the First 500 Participants in the Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD). *American Journal of Psychiatry*, *161*(12), 2222–2229. https://doi.org/10.1176/appi.ajp.161.12.2222

Stahl, D. A., Stephen M. ;. Morrissette. (2019). Mixed mood states: Baffled, bewildered, befuddled and bemused. *Bipolar Disorders*, *21*(6), 560–561. https://doi.org/10.1111/bdi.12787

Suto, Melinda, et al. “What Works for People with Bipolar Disorder? Tips from the Experts.” *Journal of Affective Disorders*, vol. 124, no. 1-2, 2010, pp. 76–84., https://doi.org/10.1016/j.jad.2009.11.004

Swartz, H. A., & Swanson, J. (2014). Psychotherapy for bipolar disorder in adults: A review of the evidence. *FOCUS*, *12*(3), 251–266. https://doi.org/10.1176/appi.focus.12.3.251

Tamam, L., Karakus, G., & Ozpoyraz, N. (2008). Comorbidity of adult attention-deficit hyperactivity disorder and bipolar disorder: Prevalence and clinical correlates. *European Archives of Psychiatry and Clinical Neuroscience*, *258*(7), 385–393. https://doi.org/10.1007/s00406-008-0807-x

Valiente-Gómez, A., Moreno-Alcázar, A., Treen, D., Cedrón, C., Colom, F., Pérez, V., & Amann, B. L. (2017). EMDR beyond PTSD: A Systematic Literature Review. *Frontiers in Psychology*, *8*. https://doi.org/10.3389/fpsyg.2017.01668

Valiente-Gómez, A., Moreno-Alcázar, A., Gardoki-Souto, I., Masferrer, C., Porta, S., Royuela, O., Hogg, B., Lupo, W., & Amann, B. L. (2019). Theoretical Background and Clinical Aspects of the Use of EMDR in Patients With Bipolar Disorder. *Journal of EMDR Practice and Research*, *13*(4), 307–312. https://doi.org/10.1891/1933-3196.13.4.307

Wilkowska, A., Szałach, Ł., & Cubała, W. J. (2020). Ketamine in Bipolar Disorder: A Review. *Neuropsychiatric disease and treatment*, 16, 2707–2717. https://doi.org/10.2147/NDT.S282208

Wingård, L., Taipale, H., Reutfors, J., Westerlund, A., Bodén, R., Tiihonen, J., Tanskanen, A., & Andersen, M. (2018). Initiation and long-term use of benzodiazepines and Z-drugs in bipolar disorder. *Bipolar Disorders*, *20*(7), 634–646.