

'I want to be bipolar' ... a new phenomenon

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Summary There has been renewed interest in the concept and diagnosis of bipolar affective disorder in recent years. Previous epidemiological studies have reported the prevalence of the disorder in the USA at 1–2% but further studies have shown that the disorder is underdiagnosed and the true prevalence may be as high as 11%. Despite the stigma attached to mental illness, we have noticed in our clinical practice a new and unusual phenomenon, where patients present to psychiatrists with self-diagnosed bipolar disorder. Here, we explore the background to this phenomenon, the diagnostic challenges and the implications for our patients and practice.

Declaration of interest None.

Bipolar disorder in the media

In recent times, a public awareness of bipolar disorder has spread through the internet, radio and television shows such as MTV's 'True Life: I'm Bipolar', and BBC's 'The Secret Life of the Manic Depressive'. The latter was first shown in 2006 and repeated in 2007. It presented the public with an honest portrayal of what it is like to have bipolar disorder.

Actor and comedian Stephen Fry, himself diagnosed with bipolar disorder, gave an insightful personal account and interviewed many celebrities diagnosed with mood disorders, including British pop-singer Robbie Williams, Hollywood actress Carrie Fisher, and comedian Tony Slattery. He also interviewed lay people with bipolar disorder and enquired about the positives and negatives of having a mood disorder. Given the impact of mood instability on their lives and careers, they were asked, that if they had a choice, whether they would rather have or not have the illness. Most of those interviewed chose to 'keep' the illness. They commented on the enjoyable experience of having new ideas with increased activity, the excitement of feeling high in mood, and powerful, and how these experiences would be difficult to relinquish. Clearly experienced as advantageous by the interviewees, evidence has shown that bipolar disorder is strongly correlated with creativity and literacy.¹ Only one person on the programme reported a strong desire never to have had the illness. This appears to contrast the findings of a qualitative study by Michalak *et al*, where the majority of individuals with bipolar disorder reported a profoundly negative effect upon their quality of life and the minority reported that the illness had opened up new doors of opportunity.²

Comments on the BBC website indicate that the series was well received by both psychiatrists and the public. It appears to have portrayed mental illness from a fairly benign perspective, noticeably without the strong associations of risk and violence that are often reported in the media.

New attitudes to bipolar disorder?

Lay people appear able to distinguish between different mental illnesses, and the labelling of different illnesses may in turn provoke changes in attitude. Negativity, perceived dangerousness and fear are associated with schizophrenia, whereas labelling people with major depression appears to have no effect on public attitudes.³ A comparison of attitudes in young people showed that significantly more negative attitudes were held towards a person with mania than a person with depression.⁴ There has been little further research on the public opinion of different mood disorders, in particular bipolar disorder.⁵ Extrapolation of the above evidence suggests that labelling someone with mania or bipolar disorder might be viewed by a lay person as better (more positive) than schizophrenia, but worse (less positive) than depression.

Over the years, stigma attached to mental illness may have lessened following changes to the vocabulary of psychiatric taxonomy. For example, the term 'manic-depression' originated from German psychiatrist Emil Kraepelin in the late 19th century.⁶ As knowledge of the illness evolved, Leonhard in 1957 used the word 'bipolar' to distinguish between people who experienced mania and depression, and 'unipolar' for those with depression only.⁷ The terminology was adopted into modern psychiatric practice and bipolar disorder has replaced 'manic-depression' over the past two decades. To some, 'manic' is thought to have a pejorative flavour⁸ and therefore 'bipolar' is the preferred term. Others might view being manic favourably, as defined in the *Collins New English Dictionary*, 'extremely excited, energetic; frenzied', believing it to have the same meaning in a psychiatric setting.

The increasing popularity of bipolar disorder as a self-diagnosis may be attributed to the media coverage coupled with the willingness of celebrities such as Stephen Fry to talk about their own personal experiences of mental illness. This appears to have promoted the disorder as less stigmatising, and acceptable to the public. Evolutionary

psychiatrists might postulate that the self-diagnosis of bipolar disorder may also reflect the lay person's aspirations for higher social status, as illustrated by the implicit association of bipolar disorder with celebrity status and creativity. Could the cumulative effect of these factors account for bipolar disorder as a favourable and even desirable diagnosis?

Diagnosing bipolar disorder in primary care mental health

According to DSM-IV⁹ and ICD-10¹⁰ criteria, bipolar affective disorder is a disorder of mood instability defined by recurrent periods of 'highs' (mania or hypomania) and 'lows' (depression). There has been a shift by experts in the field towards the concept of a 'softer' bipolar spectrum disorder rather than an illness defined by discrete episodes of extremes in mood.^{11,12} In addition, further arguments for the broadening of the DSM-IV diagnostic criteria of hypomania have developed. Key features are an increased emphasis on overactivity as the core symptom in hypomania rather than elation or irritability of mood, and a reduction in the duration of hypomanic symptoms to less than 4 days.¹¹ These changes have contributed to the emerging evidence that bipolar affective disorder may be under-diagnosed or misdiagnosed as depression or personality disorder.^{12,13} It is not uncommon for a delay of 10 years or more after the onset of symptoms before a diagnosis of bipolar disorder is made.¹³

In primary care mental health, we principally see new out-patient referrals from general practitioners (GP). Recently, we have noticed numerous GP referrals to our service where the primary request has been for a psychiatric opinion on whether the patient may have bipolar disorder, as suggested by the patient's own self-diagnosis. Also common, but less so in our experience, is the patient who attends reluctantly at the instigation of family members who are convinced that they have finally made the diagnosis that can explain the awkward or embarrassing behaviour of their relative. Both types of presentation were very uncommon until about 3 years ago. We will now discuss two cases of individuals presenting with 'mood swings' to illustrate the diagnostic difficulties and issues to consider before diagnosing bipolar disorder.

Our patients of interest are two single females. Ms A was in her thirties, referred by her GP and presented to our clinic as a member of a bipolar support group which she had joined after viewing the Stephen Fry programme. Ms B was in her twenties and an identical twin. Her twin sister had no history of psychiatric illness but their grandmother had died by suicide. Her family had suggested that she attend a national bipolar twin study. There, she was diagnosed with bipolar disorder and referred to us locally. Typically, neither patient had a history of hospital admissions that might be supportive of a past manic episode. Ms A had past diagnoses of depression and personality disorder, and Ms B had been treated for depression in the past. Both patients reported using alcohol and drugs to manage their mood swings and overactivity, and characteristically reported embarrassing, disinhibited and disorderly behaviour.

Descriptions of such behaviour are not uncommon, as bipolar disorder often presents with comorbid disorders of anxiety, alcohol and substance misuse.¹⁴ Here, though, the difficulty is in identifying whether it has been a mental illness that has resulted in alcohol and substance misuse, or vice versa. In addition, there will often be recall bias in the self-reported retrospective life events supplied by a patient who has knowledge of and wants a particular diagnosis. There is a risk of medicalising difficult behaviour that is personality driven rather than a symptom of illness. As doctors, we want to help our patients and the need to engage and build a good rapport is fundamental to psychiatric practice. The psychiatrist needs to remain objective, however tempting it is in a busy out-patient clinic to collude with the patient's self-diagnosis. We should act in the best interests of patients; listening to and respecting their opinion is very different to blind agreement.

Often unknown to patients who 'want to be bipolar' are the consequences of being diagnosed with the disorder. These range from less burdensome psychosocial issues such as obligatory declarations of mental illness to employers and medical insurance companies, to the medical risks of potential treatment with teratogenic mood stabilisers, genetic predisposition to other mental illness and a potentially increased risk of suicide. These medical risks are at the forefront of the psychiatrist's mind and to misdiagnose and hence burden a patient with these risks would be wrong. However, it could be considered equally harmful, if not more so, to miss a true bipolar diagnosis. Finding the correct diagnosis can therefore be paramount to the patient's health and provide an explanation for misunderstood behaviours and choices. The astute psychiatrist should also consider that some patients may seek the diagnosis of a mental illness in order to obtain additional financial benefits from the state and/or social support from voluntary mental health groups.

Aids to the diagnosis

Life charts can be helpful to establish or rule out a bipolar disorder diagnosis and, if possible, should be drawn with a third person that has known the patient for years. A life chart is a diagram where significant life events (from birth) are plotted against a mood scale; the duration of each mood is also noted. Using this technique, affective episodes and possible predisposing/precipitating events can be identified and analysed.

The two patients described here each reported a history of suicidal thoughts and self-harm, in addition to problems in sustaining long-term employment and relationships. These are features that might be consistent with bipolar disorder, but they are also common to other psychiatric disorders. We constructed life charts for both our patients and in so doing, identified recurrent episodes of depression and hypomania. We confirmed to each patient that they had bipolar disorder. Ms A was pleased with the diagnosis and she already knew of the associated risks. Ms B appeared less informed and was reluctant to consider the diagnosis as a reality.

It was important for us to confirm the working diagnoses before treatment, given the patients' history of substance and alcohol misuse. We therefore also asked them

to keep a prospective mood diary to monitor their mood without the influence of illicit substances or alcohol for 6 months. Both patients responded to this request positively and produced mood diaries that fit with bipolar II disorder.¹¹ Some patients might conceivably misinterpret the delay in diagnosis as the psychiatrist disbelieving their self-reported history, or even consider the psychiatrist to be incompetent. This may in turn lead to the patient searching for someone else willing to give the desired diagnosis.

We know of no test that has well-defined cut-off points to reliably diagnose bipolar disorder routinely in clinical practice,¹⁵ be it a psychological questionnaire or brain scan. This point is of some importance and should therefore be communicated to patients. Although research questionnaire screening tools have been developed, clinical history-taking remains as the gold standard for detecting bipolar disorder in current practice, balanced with clinical experience and judgement.

Discussion

We recognise that other psychiatrists may have differing opinions on the diagnoses of our patients. Our colleagues considered the original diagnosis of personality disorder to be more suitable for Ms A, but doubts were raised in the case of Ms B. However, as the treating psychiatrists of both patients, we were optimally placed to confirm a diagnosis of bipolar disorder.

Treatment options

Due to the limited number and varying quality of available studies, the evidence for pharmacologically treating bipolar II disorder and other less significant mood changes appears weaker in comparison with bipolar I disorder. Prophylactic treatment in bipolar II disorder is less clear; whether a mood stabiliser, antidepressant or both should be tried remains an open question.¹⁶ Given their diagnosis and previous episodes of hypomania and depression, the issue for our patients is choosing which medication would be most suitable rather than whether to treat them or not.

It is more difficult to deal with those patients who want to be diagnosed with bipolar disorder in order to obtain treatment for 'mood swings' but fall short of any particular ICD-10 or DSM-IV diagnostic criteria. It is usual for such people also to have functional impairment. One might consider symptomatic treatment, but could this be justified without a diagnosis, ethically or medicolegally, especially in psychiatry where most medical treatments have potentially disabling side-effects? Should the primary care psychiatrist act as a 'gate-keeper', monitoring mood diaries and mental states where there is still uncertainty of diagnosis? This is an interesting concept as it is a role traditionally held by GPs. It would need further exploration by all stakeholders and consideration of resource allocation in view of the increasing number of referrals.

Conclusions

Historically, psychiatrists have diagnosed bipolar disorder with relative ease as patients present with clear manic symptoms requiring hospital admission. As bipolar disorder becomes recognised by the public and diagnostically accepted as a disorder with a continuum of mood changes, our dilemma is one that primary care psychiatrists may come to share. Current evidence suggests that bipolar disorder may be underdiagnosed in the community, with a significant delay to diagnosis. The challenge for the primary care psychiatrist is in either making or excluding the diagnosis of bipolar disorder, and then sensitively dealing with the patient who 'wants to be bipolar'.

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