Misdiagnosis of Bipolar Disorder and the Effect on Treatment

**Abstract**

 Bipolar disorder was initially understood to be two distinct disorders, depression and mania. Throughout the past two centuries, the field of psychology has grown and the understanding of mental disorders like bipolar has greatly improved. Today, bipolar is classified into four types: Bipolar I, Bipolar II, Cyclothymic, and a fourth unspecified bipolar disorder. Although, the knowledge of bipolar has evolved, it is still one of the most misdiagnosed disorders. Oftentimes it is mistaken for depression and the patient is prescribed antidepressants alone for treatment. Incorrect treatment can in turn be detrimental to a person so it is important to further define our classifications of bipolar and depression.

**Introduction**

Psychology officially emerged as a medical field in the 19th century, however the basic principles can be traced back to ancient Greek philosophy (Lumen). The ancient Greek physician Hippocrates, who was commonly referred to as “the father of medicine,” (WebMD 2020) was among the first to recognize that a mental disorder was the result of imbalances in the body. (Hardy 2015). He was also the first to note two extreme moods known as “melancholia,” known as depression now, and mania. However, another physician established the idea of the mood spectrum of which depression and mania were on opposite ends. For centuries, depression and mania were thought to be two individual disorders until a French psychiatrist in the mid-1800s connected the two in a single disorder, referred to as “folie circulaire,” which characterized the cycle between mania, depression, and a mix of the two. Currently, bipolar is categorized into four different disorders (WebMD 2020). Karl Kahlbaum attempted to characterize all mood dysfunctions “dementia praecox” and “manic depressive insanity,” which is currently known as schizophrenia and bipolar disorder. Although it was found that his definition of manic-depressive insanity is broad and is believed to include more than bipolar disorder (Mason 2016).

**Bipolar Disorder**

Bipolar disorder is considered one of the most investigated disorders. The National Institute of Mental Health (NMH) estimates that approximately 4.5% of adults in the United States are affected. Among those, over 80% have what is considered a “severe” case. (Krans 2019). The World Health Organization (WHO) approximates that around 45 million people have this disorder worldwide. (WebMD) Despite the common reoccurrence through history, the prognosis is typically poor. (Angst 2000).

Today there are four diagnosed types of bipolar disorder: Bipolar I, Bipolar II, Cyclothymic disorder, and an unspecified bipolar disorder. (WebMD). Bipolar I is diagnosed through severe manic episodes that last at least a week and depressive episodes that tend to last a few weeks. Bipolar II is typically diagnosed after at least one depressive episode and one hypomanic episode, which is a milder form of mania. Cyclothymic is an overall milder form. It still involves the cycle of emotions, but the highs and lows are not quite as severe as mania or major depression. The fourth bipolar disorder covers those with the disorder who do not meet the criterion for the other three, but they are still subject to atypical mood changes (Hayes 2019).

**Diagnosis and Misdiagnosis**

The field of psychology itself has fluctuated over the decades due to the unpredictable nature of human behavior. Psychologists have theorized how to predict patterns in behavior, so it can be noted when there are abnormalities. However, diagnosing a mental illness is not as straightforward as finding a physical medical abnormality. MRI’s and other tests cannot determine if there is an issue with an individual’s brain chemistry

The development of the Diagnostic and Statistical Manual of Mental Disorders (DSM) has helped health care professionals navigate through symptoms to find the appropriate diagnosis. The original DSM was created in the 1950s as health experts attempted to categorize different illnesses (WebMD 2020) Throughout the years, there have been five editions as experts’ understanding of mental disorders evolved and new disorders were established or defined. There were 106 disorders listed in the DSM-I, while there were 297 in the DSM-IV. (Rosenburg 2013). Terminology has also evolved with each edition. In the first edition, bipolar disorder was classified as a psychotic disorder, divided into three types: depressed, manic, and other, and was referred to as manic-depressive insanity. This shifted to manic-depressive illness for the second edition and was classified as a mood disorder (Mason 2016). The third edition was the first to officially label it as bipolar disorder, separating it as a condition apart from depression (WebMD).

Every known disorder is categorized with a criterion for diagnosis, but this is not infallible. Certain behaviors and symptoms can be applied to multiple disorders, so misdiagnosis is possible. Bipolar disorder is most commonly misdiagnosed. Bipolar I patients were sometimes mistaken for having schizophrenia or other psychotic disorders and many patients with bipolar II were misdiagnosed with depression. (Shen 2018). Approximately 70% of patients are initially misdiagnosed and over 33% are still misdiagnosed for over a decade. A study done in Europe found that it took on average 5.7 years for people with bipolar disorder to receive a proper diagnosis (Singh 2006).

A factor contributing to this is that bipolar disorder is not a linear disorder. While it may be considered life-long, it is diagnostically unstable due to a change in how the symptoms present over time (Baca-Garcia 2007). People with bipolar disorder also find it hard to classify their symptoms. Majority of them initially seek treatment for their depressive symptoms, not noticing manic or hypomanic episodes. Studies done in 1999 and 2000 found that nearly 40% of patients are initially diagnosed with depression. Bipolar disorder also has a high comorbidity rate with obsessive compulsive disorder (OCD), eating disorders, panic disorders, and attention deficit hyperactivity disorder (ADHD), contributing to the rate of misdiagnosis (Singh 2006).

**Course of Treatment and the Detrimental Effects of Misdiagnosis**

 The primary goal of treatment is to manage symptoms. Treatment varies and usually includes a balanced combination of medications, psychotherapy, hospitalization, and day treatment programs and recreational activities. (WebMD). These can include a mixture of anti-seizure medications, antipsychotics, antidepressants, mood stabilizers, anti-anxiety, and an antidepressant-antipsychotic combination medication (Mayo Clinic). Lithium was considered one of the first treatments and can be effective at stabilizing a person’s mood (Purse 2020). However, determining what medications to use can be a long process. Every medication comes with its own list of potential side effects and each person can react differently. Patients typically have to test multiple medications over the course of weeks or months to find the best treatment for their symptoms (Mayo Clinic).

 A misdiagnosis can affect the course of treatment. The treatment for depression with the use of antidepressants only can trigger manic episodes and result in rapid cycling between mania and depression. A study found that approximately 55% of people with bipolar who were initially diagnosed with depression developed mania. Another study on people with rapid cycling bipolar found that there was a correlation between rapid cycling and the use of antidepressants in over half of the cases. Nearly 73% of them were on antidepressants when their cycling first presented itself. A misdiagnosis can also result in a delay in the use of mood stabilizers. This delay has been associated with an increase in suicide attempts. The risk of suicide attempts is between 25% and 50%, much higher than the 15% in people with depression (Singh 2006).

Delayed or incorrect treatment of bipolar disorder resulting from a misdiagnosis can be detrimental to a patient. A misdiagnosis can possibly be avoided by taking a detailed patient history documenting each manic or depressive episode, screening using a Mood Disorder Questionnaire, and noting the behaviors that distinguish bipolar disorder from depression (Singh 2006). Many therapists have also advocated for early intervention. Bipolar symptoms commonly present during a person’s youth. Prodromal symptoms can be an indicator before a person has a full depressive or manic episode. The recognition of these symptoms can aid with an early correct diagnosis. Treatments can begin and hopefully maintain the severity of the symptoms (Vieta 2018).

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