the misdiagnosis of bipolar II

As many personality and mood disorders share characteristics, they also share criteria for diagnosis. The thin lines dividing these diagnoses in the Diagnostic and Statistical Manual of Mental Disorders (DSM) lead to inconsistent and oftentimes substandard treatment. In recent years, bipolar disorder — specifically, bipolar II — has become grossly misdiagnosed and, in turn, mistreated.

In an article found in the journal of Innovations in Clinical Neuroscience, *Misdiagnosis of Bipolar Disorder,* scholars recognize how clients are often incorrectly diagnosed with bipolar disorder "because of overlap of symptoms between mania/hypomania and many psychiatric diagnoses, [especially] if DSM-IV criteria is loosely applied." As the DSM criteria surrounding mood and personality is largely general and open to interpretation, incorrect diagnoses are extremely prevalent. These misdiagnoses, of course, "result in delay of appropriate treatment, which in turn increases the risk of recurrence and chronicity of episodes [and] results in further treatment complications."

In order to better determine how frequently these misdiagnoses occur, researchers completed a study, *Analysis of Misdiagnosis of Bipolar Disorder in An Outpatient Setting,* in the Shanghai Archives of Psychiatry, reporting a shocking misdiagnosis rate of 76.8%. According to this study, bipolar disorder is routinely misdiagnosed when "there is not sufficient attention paid to medical history, or through overly restrictive use of the diagnostic criteria." These findings draw further attention to the importance behind and shortcomings of effectively comparing the DSM's criteria against mood and personality.

To further complicate these misinterpretations, researchers go on to identify how comorbidity, the simultaneous presence of two chronic conditions, contributes to the increase of clinical misdiagnosis as comorbidity "results in complex or atypical clinical symptoms," which lead to treatment difficulties. By better identifying comorbidity, "clinicians should [be able to] reduce the misdiagnosis and missed diagnosis of bipolar disorder so as to give timely and standardized treatment."

Most often, bipolar II co-occurs with borderline personality disorder (BPD) because they can present similar symptoms. In the journal Comprehensive Psychiatry, educators discuss this relationship between these disorders in their article, *The Interface between Borderline Personality Disorder and Bipolar Spectrum Disorders*. They offer, "borderline personality disorder and bipolar disorder co-occur, but their relationship is not consistent or specific." The variability of how these symptoms present and, therefore, how they're diagnosed leads to inconsistent and potentially harmful treatment for those improperly medicated due to

misdiagnosis. When comparing the two diagnoses, scholars write, “there are overlaps but important differences in phenomenology and in medication response.”

According to clinicians in The Lancet, primary treatment for BPD remains “psychosocial intervention [...] to reduce acute life-threatening symptoms and improve distressing mental state symptoms.” In their article, *Treatment of Personality Disorder*, they cite, “pharmacotherapy is only advised as an adjunctive treatment [as] drug treatment only focuses on specific aspects of personality disorder’s pathological effects, such as affective instability and cognitive–perceptual disturbances.”

Where medication for BPD is solely supplementary, and focus must be placed on psychological intervention, drug treatment is essential in treating the chemical imbalances involved with bipolar disorder. When pharmacotherapy is misused as the main source of treatment for BPD, focus is diverted from psychosocial interventions essential for advancing the progress of treatment. Even further, people with misdiagnosed BPD then find themselves on high doses of mood stabilizers and antipsychotics for chemical imbalances they don’t have.

In his article in the Expert Review of Neurotherapeutics, *Problems Diagnosing Bipolar Disorder in Clinical Practice,* Mark Zimmerman, MD, a researcher from Brown University, offers potential reasons as to why these misdiagnoses are so common. For one, “because clinicians are probably inclined to diagnose disorders that they feel more comfortable treating, we hypothesized that in patients with mood instability who do not meet criteria for a hypomanic episode, physicians are nonetheless inclined to diagnose a potentially medication-responsive disorder, such as bipolar disorder, than a disorder such as borderline personality disorder that is less medication-responsive.”

“We believe that the increased availability of medications to treat bipolar disorder, and the accompanying marketing efforts, are chiefly responsible,” cites Zimmerman. He recognizes the chokehold both pharmaceutical and insurance companies have on mental health treatment in offering another explanation for misdiagnosing these disorders: “clinicians are frequently reluctant to give patients a diagnosis of borderline personality disorder because it is viewed negatively and is treated most effectively when specialized services that may not qualify for full reimbursement are used.”

With this, he touches on another reason clinicians may avoid diagnosing BPD, which is the stigma surrounding the diagnosis. In order to properly treat a diagnosis, one must have respect for it — not fear. In the current world of mental health, BPD and other personality disorders [link to article: *the validity of the diagnosis “personality disorder”*] are largely stigmatized, and those who receive a diagnosis are often shamed. This, of course, thoroughly detracts from quality of

care.

In addressing complications surrounding mood and personality, we as a treatment center aim to reduce the stress of treatment as much as possible. We work with every client toward finding a correct, individualized treatment plan, and we recognize just how much work doing so really is. With this, we're not concerned with labeling specific diagnoses until totally necessary, because we're focused on addressing the person in front of us instead of the checklist in the DSM.

By sifting through the richness that makes someone a person, instead of breaking that person up into handfuls of criteria, we're able to pinpoint disordered thoughts and behaviors instead of throwing around disorders and diagnoses. From there, we can work together to better understand personality and mood and all of their intricacies.

Works Referenced

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

Bateman, A. W., Gunderson, J., & Mulder, R. (2015). Treatment of personality disorder. *Lancet (London, England)*.

"Bipolar Disorder." *National Institute of Mental Health*, U.S. Department of Health and Human Services.

"Borderline Personality Disorder." *NAMI*.

Mark Zimmerman (2010). Problems diagnosing bipolar disorder in clinical practice. *Expert Review of Neurotherapeutics.*

Paris, J., Gunderson, J., & Weinberg, I. (2007). The interface between borderline personality disorder and bipolar spectrum disorders. *Comprehensive psychiatry*.

Shen, H., Zhang, L., Xu, C., Zhu, J., Chen, M., & Fang, Y. (2018). Analysis of Misdiagnosis of Bipolar Disorder in An Outpatient Setting. *Shanghai archives of psychiatry*.

Singh, T., & Rajput, M. (2006). Misdiagnosis of bipolar disorder. *Innovations in Clinical Neuroscience (Edgmont (Pa. : Township))*.