Bipolar Disorder (Cultural Comparisons)

Bipolar Disorder

The term Bipolar Disorder refers to a family of disorders currently composed of two different disorders- Bipolar I and Bipolar II. The primary difference between the two disorders is the presence or absence of mania. Mania is a severe condition in which the person experiences elevated mood, non-stop activity, thoughts of grandiosity, lack of impulse control, and frequently engages in reckless behaviors such as compulsive sexual activity, binge buying, and compulsive gambling. In some cases, mania is accompanied by psychosis. Mania frequently requires hospitalization. Mania only occurs in Bipolar I. Bipolar I patients can also experience Mixed Episodes, in which symptoms of mania and depression are present concurrently. Suicide is a particular risk in mixed episodes. Instead of mania, Bipolar II patients and Bipolar I patients both experience hypomania, which is an attenuated version of mania. Both Bipolar I and II are marked by depressive episodes, in which suicide is a risk. Bipolar has gone from a very rare condition- .5% to 1.6% in the total population, to current estimates of nearly 20%. Robert Whitaker estimates that there has been a 100-fold increase in bipolar diagnoses, or 1 in 40 adults. This article reviews the cultural conditions by which this estimated occurrence has risen so dramatically.

History of Bipolar

Bipolar is rooted in conceptions of mania that go back to the ancient Greeks. Aretaeus of Cappadocia first recognized alternating patterns of depression and mania. His findings remained unknown until 1650 when Richard Burton wrote the first book on Bipolar, although it focused specifically on depression. Jules Falret first coined the term folie circulaire (circular insanity) in 1854. What all of these conceptions had in common is that Bipolar disorder was a very debilitating and serious illness. In 1913 Emil Kraepelin termed the disorder Manic-Depressive disorder in the first major nosology of mental illness in the western world. Initial classifications of Bipolar disorder, including Kraepelin's were used to classify an inpatient population. Manic-Depressive illness, in other words, did not exist in the outpatient population. In 1980 the term Bipolar disorder officially replaced the term manic-depression in the DSM-III. In this manual, it was classified as a mood disorder, which was the only mood disorder recognized in this manual. In the DSM-I and DSM-II Bipolar disorder was classified as a psychotic disorder, which was very different from the psychoneurosis that dominated those manuals.

In the 1990's, perception of bipolar disorder began to change. This is partially a result of the addition of Bipolar II in the DSM-IV, and partially a result of Kay Jamison Redfield's book, "An Unquiet Mind." In this book, she, a psychologist, reveals that she herself has bipolar disorder. As an attractive, well-spoken woman, this revelation began to erode previous stereotypes about Bipolar Disorder. Her revelations made it clear that people can be successful with Bipolar disorder, and they are not all destined to be permanently institutionalized.

The role of psychiatric research

Psychiatric researchers are one key to the rise of the estimated increase in bipolar prevalence. One way they do this is by lowering the threshold of the symptoms it takes to be considered for a diagnosis of Bipolar. For instance, Franco Benazzi and others have suggested that the qualification for a diagnosis of Bipolar II disorder (which currently requires the presence of hypomania for at least 4 days), be dropped to a two-day minimum length of hypomania. Lowering this requirement means that more and more people will qualify for a Bipolar II diagnosis. This research has led to a concrete change in the Diagnostic and Statistical Manual (DSM), which, in the newest edition, DSM-5, to be published in 2013, has a new entity called "Major Depressive Episode with Short (2-3 day) Hypomanic Episode." This new inclusion to the book that guides all psychiatric disorders will now allow for the diagnosis of people with only 2-3 day long hypomania as Bipolar II. This is an example of how psychiatric researchers influence the rate of bipolar occurrence. Bipolar researchers have also called to expand the "Bipolar Spectrum" to include Bipolar 1 ½, 2 ½, 3, 3 ½, 4, 5, and 6. If these researcher's suggestions appear in a future edition of the DSM, we will continue to see rises in the prevalence of Bipolar disorder, because more and more people will fit into expanded, and increasingly lenient, criteria.

Psychiatric researchers and clinical psychiatrists and psychologists have also expanded the pool of potential patients to include children and adolescents. The current accepted age of onset of Bipolar disorder is late teens and early 20's. But more and more, teens and children as young as 3 years old are being diagnosed, and treated, for Bipolar disorder. This shift in diagnostic thinking increases the pool of people who are diagnosed with Bipolar. Childhood Bipolar is a relatively recent phenomenon, whereas adult Bipolar has been around for hundreds of years. The fact that it is recent suggests that it is psychiatrists who are actively seeking to increase the numbers of people who are diagnosed, rather than a change in America's children. The children have not changed, what is changed is how these children are treated and diagnosed by the psychiatric institution.

The role of the pharmaceutical industry

Psychiatric drugs first came to use in the 1950's, with the advent of Thorazine, and, in the 1960's, Haldol. The success of these drugs was partially responsible for the move from institutionalization to the mentally ill living in the community. More and more psychiatric drugs were introduced. The older antipsychotics, of which Thorazine and Haldol are two, cause serious side effects, such as permanent movement disorders. Because of this, atypical anti-psychotics were first developed in the 1970's. Development of atypical antipsychotics surged in the 1980's and 1990's, and there are now more than 8 atypical antipsychotics on the market. Atypical antipsychotics are commonly given to bipolar patients to combat psychosis and mania. People with bipolar also use mood-stabilizing medications. These medications are intended to stabilize the mood and eliminate the wide mood swings that are common in Bipolar. There are currently nine medications in this category. Anti-depressants are contraindicated in Bipolar because it is believed that anti-depressants can cause a manic episode in a bipolar patient. All drugs can have serious side effects for patients, however, including weight gain, thyroid dysfunction, diabetes, problems with memory, and movement disorders.

In 2008, the psychopharmaceutical industry earned $24.2 billion in the sales of anti-psychotics and anti depressants. It is obviously to their benefit when more people are diagnosed with a mental illness, especially Bipolar, which often requires the administration

of anti-psychotic medications, which are particularly expensive. Bipolar patients also frequently take multiple drugs at once, which is also beneficial to the psychopharmaceutical industry. One month of a single anti-psychotic medication can run over $1200 a month. The more people who are diagnosed with Bipolar, the more people who will start taking psychopharmaceutical drugs. Drug companies give samples to psychiatrists, hoping that the psychiatrist will chose to prescribe that drug over another competing drug.

Most importantly, the patents on SSRIs (Selective Serotonin Reuptake Inhibitors), which are used for depression, began to expire in the early 1980s. When these patents expired, drug companies needed new markets. So they began to develop anti-psychotics and advertise them widely. This advertising began to normalize Bipolar disorder, by showing normal, successful people in television and magazine advertisements taking anti-psychotics. These advertisements emphasized the normality of bipolar symptoms. The result of these advertisements were to re-label normal mood swings as pathological to appeal to the broadest possible market. By doing two things at once- normalizing behavior and pathologizing it at the same time, they broadened their market and redefined normal behavior as disorder, but at the same time, normalized that disorder by showing normal healthy people in the advertisements taking the medications. The goal of these advertisements is to motivate people to go to their doctor and seek help for mood swings that had been pathologized by the drug companies, but, contradictorily, seeking help through psychopharmacology was normalized.

Cultural trends

All of this points to broad cultural trends that result in the increasing numbers of people who are diagnosed with Bipolar disorder. These processes weaken the boundaries of what is considered bipolar disorder by lowering thresholds, and increasing the numbers of who can be considered Bipolar, as in the case of childhood Bipolar. This has largely not been a coercive process, because in today's therapeutic culture, people are more and more willing to adopt a bipolar label. This is partially a result of the inclusion of Bipolar II as a "less severe" version of Bipolar. In effect, Bipolar has become less stigmatized, because there is a less severe version of it. This process will continue with the onset of the DSM-5, in which the thresholds for bipolar are lowered.

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See Also: An Unquiet Mind (Jamison); Diagnosis and Culture; DSM-5 Classifications; Grandiosity; Hypersexuality; Lithium; Mania; Mood Disorders; Thorazine and First-Generation Anti-Psychotics;

Further Readings

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