Over-diagnosing Bipolar Disorder; History, Causes and Forensic Consequences

Roberto Flores de Apodaca
Bekah Burza
Concordia University / Irvine
Psychology Department

Abstract

What was once classified some 60 years ago as a "Manic-Depressive Psychosis" and considered a rare disorder affecting only adults has come to represent one point along a broad spectrum of presumptively kindred conditions ranging from the mild to the severe, afflicting infants to adults. The formal definitions have expanded over the various editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM). Along with a number of earlier authors, we maintain that there has been an overexpansion of this diagnosis on the basis of theory rather than scientific findings. The reasons for this overexpansion have included; the advent of managed care (with its economic incentives to certain remunerable conditions, and pressure to treat conditions with medications whenever possible), the development of effective medications for use with genuine Bipolar Disorders, and an unconscious collusion between therapists and patients for the over-diagnosing of Bipolar Disorder, which ostensibly (but actually does not) serve the needs of both groups. This phenomenon of over-diagnosing can have adverse consequences in the forensic arena when individuals are given a Bipolar Disorder diagnosis they do not warrant. Two case examples from the criminal arena are provided; both confounded the legal process with one "favoring" Defense and the other the Prosecution.

Key Words: Over-diagnosing Bipolar Disorder

Introduction

Since the publication of the first edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) by the American Psychiatric Association (APA) in 1952, the definition and diagnostic criteria for what is now known as Bipolar Disorder have expanded several times. What was classified some 60 years ago as a "Manic-Depressive Psychosis" and considered a rare disorder affecting only adults has come to represent a broad spectrum of conditions ranging from the mild to the severe, afflicting infants to adults(Shulman, Tohen& Kutcher, 1996). The expansion in definition and corresponding increase in prevalence rates has led oneclinical observer to ask in the title of his article; *Does almost everybody suffer from a Bipolar Disorder?* (Patten, 2006).

The current study examined the history of this observed expansion and offered a number of hypotheses as to its causes. It is our contention that the broadened definition has resulted in psychiatric patients being given serious diagnoses when a lesser one or none at all wasprobably warranted. We also offer two case studiesfrom the forensic psychology practice of the senior author to illustrate the unintended ways in which this expansion can distort the legal process incriminal cases.

Diagnostic and Statistical Manuals

Bipolar disorder has always been defined as an affliction in which a person's mood cycles between maladaptive highs and lows; i.e. mania and depression. Theseepisodic symptoms have remained the defining components of Bipolar disorders through itsexpansive revisions in the six editions of the DSMs. The criteria for a manic episode have typically included; inflated self-esteem or grandiosity, decreased need for sleep, extreme talkativeness, flight of ideas, distractibility, increase in goal-directed activity and a reckless, impulsive involvement in pleasurable activities that leave the individual at a high risk for harmful consequences. In turn, the criteria for a depressive episode include; a depressed mood most of the day, nearly every day, markedly diminished interest in pleasurable activities, significant weight loss or gain, insomnia or hypersomnia, fatigue or loss of energy, feelings of worthlessness or guilt, and recurrent thoughts of death or suicide.

Since the time the condition was originally defined by Emil Kraepelin, and separated from other psychotic disorders,it has been understood that the patient cycles between episodes of mania and depression of varying duration, which are distinctly displayed in time, and result in periods of dysfunction for its sufferers. The singular experience of mania is what distinguished this condition from any of the other mood or psychotic disorders. Once the patient showed the symptoms of mania, it was understood that the symptoms of depression would eventually surface and alternate again with the mania in unpredictable but distinct episodes.

DSM-I: In the first edition of the DSM (DSM-I), the condition was called a "manic-depressive reaction", thought to represent a psychotic disorder in which the patient experienced a break with reality (AMA, 1952). The full text on "manic-depressive reaction" took up less than 180 words and was in keeping with Kraepelin's original formulation of this condition as a severe disorder. The most reliable prevalence data from the time indicated that well under 1% of the population would meet the diagnostic criteria for this condition.

DSM-II: The first noticeable expansion in the definition and understanding of the manic-depressive condition came with the publication of the second edition of DSM (DSM-II), in 1968. The disorder title was changed from a "manic-depressive reaction" to a "manic-depressive illness". The very change in the title indicated that what was once conceptualized as an "episode" that may have been short-lived, was then conceptualized as an invariant illness, implying something more serious and ongoing. The descriptions of each of the three types of "manic depressive illness" offered in this edition of the DSM were relatively brief and lacking in detailed criteria. Nonetheless, the prevalence estimates remained largely unchanged from the first DSM and the disorder was still considered rare.

DSM-III: Bipolar Disorder made its largest and most significant expansion with the third edition of DSM (DSM III), published in 1980.It was at that point that the "manic-depressive illness" became a "Bipolar Disorder" and presumably came to encompass not just a given condition, but to actually constitute a spectrum of phylogentically linked conditions that ranged from a mild disturbance to a severe psychosis. For the first time, clinicians were given multiple pages describing the symptoms and explicit diagnostic criteria for what was then understood to be a full spectrum of Bipolar Disorders. A full, detailed description of what constituted both a manic and a depressive episode was provided, so the appearance of objectivity was asserted. In DSM-III, it was asserted that this disorder might be more common than was once thought. "This disorder was previously assumed to be rare. Recent evidence suggests that among outpatients the disorder may be relatively common…" (DSM-III, 1980).

It is important to note that the "recent evidence" referred to did not come from controlled clinical trials or laboratory findings, but mainly from the observations and opinions of clinicians, who could be presumed to have a vested self-interest in the expansion of this condition, in the form of added patients which comes with the broadening of any clinical category (Baldessarini**,** 2000). Once a Bipolar condition was no longer considered a rare, psychotic disorder, more patients came to be included under the expanding classification and its assumed prevalence rate went up accordingly. It is important to note that this expansion was justified and undertaken without any breakthroughs in the biomedical understandings of the condition or demonstration of different therapeutic rates for the various subtypes that had been adopted officially in the new edition of the Manual (Baldessarini, 2000, van Praag, 1993).

DSM-III-R: The 1987 revision of the DSM Manual (DSM-III-R) furthered this expansion by adding more differentiations among the hypothesized disorders in the middle end of the severity spectrum. It is arguably fair to characterize this expansion as hypothetical since the new conditions introduced were again not the result of empirical findings, but the success of theoretical arguments in favor of a more nuanced understanding and yet another expansion in the presumed reality of this clinical phenomenon.

DSM-IV and DSM-IV-TR: These are the 1994 and 1996 editions of the DSM Manuals, respectively, currently employed in professional mental health settings; i.e. clinics, hospitals, research settings, insurance carriers, etc. The expansion of the Bipolar spectrum disorders in these editions of DSM progressed more modestly from its immediate predecessors with yet greater articulations of the milder versions of these disorders; i.e. Bipolar II, Cyclothymia. Again, no definitive research of a biological or experimentally controlled nature was offered for this growing endorsement (Patten, 2006). Indeed, there has yet to be professional consensus on just what a bipolar spectrum phenomenon is. Nonetheless, we have the fully expanded versions of the Bipolar conditions officially enshrined in the current version of the DSM Manual.

Bipolar Disorder Prevalence Increase

As the definition of Bipolar Disorder came to encompass a broader range of symptoms from severe mania to mild disturbances in mood, there was an entirely expectable increase in the prevalence rates of what came to be known as the Bipolar "spectrum" disorders (Carta& Angst, 2005;Patten, 2006). Because symptoms are mainly self-reported, diagnosing the disorder has always been fraught with questions of validity. Patients may often be inaccurate in reporting their experiences to clinicians, and this inaccuracy is likely to be in the direction of *over*-reporting symptoms and their severity (Berk& Dodd, 2005).

The patient is likely to believe, consciously andunconsciously, that their interests are best served if they are diagnosed with a more serious condition, particularly if this condition, as is presumably the case with Bipolar Disorder, is biologically based and not their "fault." There is the added psychological benefit to having this diagnosis that medication treatments for it have shown moderate success. So, the promise of experiencing psychological relief comes along with the belief that one has such a condition.

The prevalence of Bipolar Disorder has grown far more in the United States than in the rest of the world (Parry, Furber& Allison, 2009). These authors noted while rates have increased slightly in various Western nations, there has been about a five-fold increase in the rates of Bipolar disorders in the United States since the advent of DSM-III. Has this increase come about because of an actual increase in the prevalence of the disorder, or has the definition merely changed over time?

Akiskal, Bourgeois, Angst, Post, Moller&Hirschfeld(2000) noted that the 1% of the United States population that was diagnosed with Bipolar Disorder under DSM-I and DSM-II had risen to 5% with DSM-III. A number of investigators have noted that this dramatic increase is probably the result of a broadening of the definition of Bipolar Disorder, rather than an actual increase in the incidence of this condition. A "softer" clinical definition has been allowing doctors to diagnose this disorder in patients more freely (Akiskal et al., 2000). This 5% estimate is explicable by the fact that the higher prevalence rates encompass disorders across the Bipolar spectrum, including cyclothymia and hypomania (Berk& Dodd, 2005).

Relative to other nations, the United States is the leading country when it comes to the prevalence of Bipolar disorders in the population (Parry et al. 2009). These authors noted that Bipolar Disorder is the most common disorder given to children under 12 admitted to inpatient, psychiatric facilities in the United States. In contrast, New Zealand and Australia consider the disorder to be very rare in the general population and particularly among children (Parry et al., 2009).

What accounts for the enthusiasm and support for this expanded definition and resulting prevalence rates for Bipolar disorders? In our judgment, this comes mostly from the intermingling influences of managed care, advances in the use of psychotropic medications, and an unwitting collusion of therapist and patient self-interests.

Causes of the Expansion

Managed Care: The current business environment in which independent practice psychologists operate is known as the era of "Managed Care" (Gasqoine, 2010). Managed care is a system of health care that flourished after the passage of the Health Maintenance Organization Act of 1973, with the principal purpose of reducing the high and rising costs of medical services (including psychological treatment). Essentially, under managed care, insurance companies pay clinicians on the basis of what one of their employees determines to be the proper and necessary services for that clinician's services to their given patients (Gray, Brody & Johnson, 2005). The intent has been to limit waste and ensure efficiency by disallowing unnecessary or excessive prices. The necessity for given services is decided largely on the basis of what the proper diagnosis is for every given patient (Gray et al., 2005).

Under this system, some psychiatric conditions (usually the more serious ones) qualify for greater care, while others (namely, personality disorders and adjustment reactions) do not (Gray et al., 2005). Bipolar conditions have generally been covered by most insurance plans, while disorders of personality and other kindred conditions have not. It therefore became in the economic interests of both patients and therapists for more and more people to be given the diagnosis of any of the Bipolar spectrum disorders.

One does not have to infer that there was always conscious corruption in order to understand how this situation provided the economic incentives for both parties to agree to assume the Bipolar diagnosis (Cantor & Fuentes, 2008). This preference fordiagnostically questionable treatments with psychotropic medications has given rise to the practice of "up and down coding"; i.e. giving a reimbursable diagnoses, like Bipolar disorders, to allow a client to receive therapy (Gasquoine, 2010).

Effectiveness of Medications: There have undoubtedly been magnificent advances in the efficacy of drugs developed in the last 50 years to treat a number of psychiatric conditions. Among these have been medications to treat schizophrenia andattention deficit-hyperactivity (Thase&Kupfer, 1996). A recurring clinical phenomenon has been that whenever a medication is proven successful in treating a given disorder, the incidence rate for that condition rises immediately afterward, and tends to stay high. This has happened with each of the aforementioned disorders and it is our contention that is likely to have been the case with Bipolar disorders, as well. Lithium Carbonate, and other medications, has proven quite successful in the management (not the cure) of Bipolar disorders (Thase&Kupfer, 1996). There are therefore, conscious and unconscious incentives for diagnosing a patient with an illness for which there are effective treatments / medications, and if the criteria are broad and reliant at least in part on the self-report of the patients, the stage is set for over-diagnosing this condition.

Along with the unintended influences of managed care, then, there are financial and psychological incentives for the use of prescription drugs over psychological therapies in the treatment of mental disorders (Frank & Garfield, 2007). Treatment with medications is simply cheaper than traditional "talking" therapies. That has resulted in family physicians armed with psychotropic medications who assume the role of mental health specialists. More effective medications, in our judgment, have likely led to the over-diagnosing of those conditions for which those medications have proven effective.

Unconscious collusion between therapists and patients: Principally, patients want to get better and therapists want to believe they have been helpful to their patients. These interests are perfectly natural, salutary and complementary in a psychotherapeutic alliance. The benefits from diagnosing a Bipolar Disorder are different but powerful for each member of the therapeutic dyad. By diagnosing the patient as Bipolar, the therapist addresses a condition whose treatment is likely to be authorized and compensated for under managed care guidelines. In the use of a mood stabilizing drug, the therapist is also employing a treatment modality that is likely to be helpful if the patient is genuinely Bipolar, and essentially benign if the patient is not. His benefits from the over-diagnosing Bipolar disorder are therefore economic and professional in nature, and carry little risk.

Patients are also likely to be unconsciously invested in the Bipolar diagnosis because of the promise that having this condition renders them eligible for treatment with a form of therapy (medications) which have the promise of being helpful. There is an added, likely to be unconscious benefit to this diagnosis in that the assumption is that the disorder is caused by some manner of biologically-based malady. In other words, there is no personal or character flaw inherent in this condition if it is biologically based. That makes the Bipolar diagnosis less ego-threatening and more psychologically palatable to accept.

All of these, and other, influences have intermingled in creating and promoting the over-diagnosing of Bipolar disorders, in our judgment. While this five-fold increase in the prevalence rate of this disorder seems to have had at least an inadvertently favorable impact for patients and therapists in the clinical arena, we contend, theconsequences in the forensic arena are likely to have been largely unfavorable.

Forensic Consequences

Forensic psychology involves the use of clinical knowledge and expertise in legal cases where a person's mental state is one of the issues being adjudicated (Huss, 2009). In criminal cases, a forensic psychologist is often called on to serve as an expert witness to the Court and opine if at the time of a crime the defendant had the requisite mental capacity to be held legally accountable for his actions; i.e. if the defendant possessed the requisite *Mens Rea* to be considered morally and legally responsible for his actions. This is what is known as Not Guilty by Reason of Insanity (NGRI) evaluations.

The following case histories were taken from the forensic practice of the senior author and illustratewhat we consider to be the confusion and inefficiencies that result from the over-diagnosing of Bipolar disorders.

> **Case History 1:** *This case involved a 25-year-old Defendant who faced First Degree Murder charges in the homicide of his mother and filed an NGRI defense. He had a long psychiatric history dating back to his early teens. Some of his troubled behaviors and symptoms as an adolescent included his disruptiveness in the classroom, disinterest in academics and difficulties getting along with peers. He began abusing various drugs at about 13 years of age, and under-performed academically until he discontinued school altogether in the 10th grade, at about the age of 16. He had engaged in numerous fights with other boys in school and seemed to have a mercurial temper. He attempted and talked about suicide on a number of occasions. After dropping out of school, he lived with his mother, with whom he had a hostile-dependent relationship. He worked erratically with his jobs lasting on the order of a few weeks. They ended typically when he lost his temper and got into verbal confrontations with either his co-workers or his immediate supervisor. The Defendant worried about his sexual identity and frequently voiced the fear that he did not know if he was hetero or homosexual in orientation. He would respond with great despair and self-injuriousness behavior whenever he felt one of his friends or acquaintances ended their relationship or abandoned him. He had several diagnoses in his voluminous mental health records, with Bipolar Disorder as one that recurred with, by far, the most frequency.*

Forensic Evaluations: The examining expert for the Defense diagnosedthe Defendant as having a BipolarDisorder, principally on the basis of what he saw as hissteep fluctuations in mood. He interpreted his irritability and temper outbursts as signs of mania; which indeed, the current DSM Manual lists as one of its *ancillary* indicators of a manic state. On the basis of that diagnosis, the Defendant and his Attorney entered a plea of NGRI on the homicide charges and proceeded to trial.

At trial, the senior author served as a rebuttal testimony for the prosecution and testified that the Defendant's constellation of symptoms was more parsimoniously explained by a diagnosis of Borderline Personality Disorder. His identity confusion over his sexuality, his self-injurious reactions to perceived abandonment, and his volatile temper were all cardinal symptoms of Borderline Personality Disorder, but at most, only secondary ones of any of the conditions listed among the spectrum of Bipolar disorders. After what was essentially a crash course in DSM diagnoses, and Bipolar disorders in particular, the jury agreed with the testimony of the prosecution's expert that a Bipolar Disorder was not defensible and that the Defendant was legally and morally responsible for killing his mother. Nonetheless, a great deal of time and money in the form of deliberation by the court process, was squandered. It is the authors' contention that over-diagnosing Bipolar Disorder to such an extent (arguably five-fold), lends itself to frequent misapplications of the sort experienced in this Defendant's case.

> **Case History 2:** *This case involved a 32-year-old male who had filed to have his Sanity restored. His original crime consisted of a first degree Burglary in an inhabited dwelling. He had He had originally been found NGRI when the Court found that as a result of a Bipolar Disorder he had been delusional and disoriented at the time of his arrest. His adjustment in forensic custody had been very poor with numerous infractions showing a poor ability to modulate his feelings of anger, irritability, impulsivity and hostility toward others; including staff. He showed little to no insight about his condition and had trouble accepting responsibility for his outbursts.*

Similarly to Case 1, the principal set of symptoms associated with the Bipolar Diagnosis for the Defendant was the irritability, anger and violent outburst. This is a common diagnostic decision the senior author has seen in many criminal cases that feature the diagnosis of Bipolar Disorder. In this case, a Court trial, the Judge agreed that the Bipolar Disorder diagnosis was probably not warranted and that there had not been a frank episode of mania documented in the Defendant's psychiatric history. His behavior could more parsimoniously be understood as borderline features of personality that was consistent with a tumultuous developmental history.

Summary and Discussion

Bipolar disorders have a long, well-established clinical legacy dating back professionally to the time of Emil Kraepelin, in the late 1800's. As the professions of psychiatry and clinical psychology have grown and matured, the definition for this condition has steadily expanded across the four editions of the DSM Manuals and come to include a growing number of patients in the population. This increase has been conservatively established as being 5-fold over the last few decades, particularly in the United States(Alloy, Urosevic,Abramson,Jager-Hyman, Nusslock, Whitehouse & Hogan, 2011).

This expansion has taken place not only horizontally across a greater segment of the adult population, but also vertically in that more children than ever, particularly in the United States,are receiving the diagnosis (Reddy &Atamanoff, 2006).

For reasons discussed above (i.e. the institution of managed care, the advent of effective medications and the largely unconscious collusion of therapists and patients), this expansion has continued steadily. Long with others, we argued in this paper that there is likely to have been an over-diagnosing and not an actual increase in the incidence rate for this disorder. The expanded definitions have not been based on biomedical findings showing an anatomical substrate in this condition which is growing in the population. Rather, the forces influencing this phenomenon are seemingly all too human and subjective.

The result for the practice of forensic psychology, as the given case studies illustrated, is that more cases are likely to be going to trial that should not and more criminal defendants are being given diagnoses that untimely obfuscate their legal status, either advancing or impeding their apparent best interests, falsely. There is no particular reason to expect that either the defense or prosecution is being affected systematically by the over-diagnosing of Bipolar disorder in criminal cases.

Ultimately, no one benefits in the long-run from a condition being over-diagnosed relative to its actual prevalence rates in the population (Patten, 2006). Over-diagnosing Bipolar Disorders results in the wrong treatment approaches being taken with those whose conditions are being misdiagnosed. Patients will experience avoidable delay and effectiveness in the treatments they receive, when they are treated for a condition they actually do not have. Therapistswill experience frustration and disillusionment if their diagnoses prove ineffectual in treating their patients. As shown in the case examples above, the legal system will conduct needless trials and run the risk of handling defendants in ways that are not warranted by their actual, clinical conditions.

The hope here is that this essay can serve as a reasoned argument in favor of further consideration of the way we have come to use the Bipolar spectrum disorder. We agree with Zimmerman et al. (2007) in concluding that there is likely to have been an over-diagnosing of these conditions, to the detriment of the practice of forensic psychology and the treatment of numerous patients. We urge forensic psychologists to be particularly aware of the likely phenomenon of over-diagnosing and to be especially wary of assuming that irritability and outbursts of anger are necessarily signs of manic episodes.

References

Akiskal, H., Bourgeois, M., Angst, J., Post, R., Moller, H., &Hirschfeld, R. (2000). Re-evaluating the prevalence of and diagnostic composition within the broad clinical spectrum of bipolar disorders. *Journal of Affective Disorders*.

Alloy, L. B., Urošević, S., Abramson, L. Y., Jager-Hyman, S., Nusslock, R., Whitehouse, W. G., & Hogan, M. (2011). Progression along the bipolar spectrum: A longitudinal study of predictors of conversion from bipolar spectrum conditions to bipolar I and II disorders. *Journal of Abnormal Psychology*.

American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. Editions I-IV-TR. (1952, 1964, 1973, 1980, 1994, 2000). Washington D.C.; American Psychiatric Press.

Baldessarini, R.J. (2000). APlea for Integrity of the Bipolar Disorder Concept. *Bipolar Disorder. 2, 3-7.*

Berk, M., & Dodd, S. (2005). Bipolar II disorder: A review. *Bipolar Disorders*, 7(1), 11- 21.

Cantor, D.W. & Fuentes, M.A. (2008). Psychology's Response to Managed Care. *Professional Psychology: Research and Practice,* 39, 638-645.

Carta, M.G. & Angst, J.(2005). Epidemiological and Clinical Aspects of Bipolar Disorders: Controversies or a Common Need to Redefine the Aims and Methodological Aspects of Surveys. *Clinical Practice and Epidemiological Mental Health*, 1, (4).

Frank, R.G. & Garfield, F.L. (2007). Managed Behavioral Health Care Carve-Outs: Past Performance and Future Prospects. *The Annual Review of Public Health*. *28*, 303-320.

Gasquoine, P. G. (2010) Comparison of public/private health care insurance parameters for independent psychological practice. *Professional Psychology: Research and Practice*, 41(4), 319-324.

Gray, G.V., Brody, D.S&Johnson, D. (2005). The Evolution of Behavioral Primary Care. *Professional Psychology; Research and Practice, 36,* (2), 123-129.

Huss, M.T. (2009). *ForensicPsychology: Research, ClinicalPractice and Applications.* Wile Blakck well Publishers, New York, N.Y.

Parry, P., Furber, G., & Allison, S. (2009). The pediatric bipolar hypothesis: The view from Australia and New Zealand. *Child and Adolescent Mental Health*, 14(3), 140-147.

Patten, S. B. (2006). Does Almost Everybody Suffer From a Bipolar Disorder?. *The Canadian Journal of Psychiatry / La Revue Canadienne de Psychiatrie*, 51(1), 6-8.

Reddy, L. A., &Atamanoff, T. (2006). From A to Z on child and adolescent bipolar disorder. *School Psychology Quarterly*, 21(1), 112-117.

Shulman, K.I, Tohen& Kutcher, S. (1996). Bi-Polar Disorder Through the Life-Cycle. New York, NY; John Wiley & Sons.

Thase, M.T&Kupfer, D.J. (1996). Recent Developments in the Pharmaco-Therapy of Mood Disorders. *Archives of General Psychiatry.* 64, 646-659.

Van Praag, H.M. (1993). "*Make-Believes" in Psychiatry: the Perils of Progress.* New York; Brunner / Mazel.

Zimmerman, M., Ruggero, C.J., Chelminski, I & Young, D. (2008). Is Bipolar Disorder Overdiagnosed? *Journal of Clinical Psychiatry.* 1-6.