

Picture This:

**Bipolar
Disorder**

Picture This

A resource for creators...



Photo © Anselm Skogstad

Picture This is a guide to the key issues within the realm of bipolar disorder affecting different populations today, as identified by mental health experts, advocates, policy-makers, and others working to improve public awareness about and reduce stigma surrounding bipolar disorder and other mental illnesses.



Entertainment
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www.eiconline.org

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2 Acknowledgements

Researching health issues can be as basic as finding research papers on the Internet or as complex as delving into public policy and the philosophical positions of interest groups. Most important is the perspective of people who, for one reason or another, make a deep commitment and dedicate their time to a cause.

This document is a publication resulting from a formal meeting of mental health and bipolar disorder experts as well as three entertainment writers at the National Association of Broadcasters in Washington, D.C. Numerous individuals and organizations provided insight into the complex issues surrounding bipolar disorder and related mental illnesses as we created *Picture This: Bipolar Disorder*.

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James Kearns, Writer/Co-Producer, *JOHN Q*

PICTURE THIS! Fade In: A large room at the National Association of Broadcasters in Washington, D.C. Three Hollywood writers sit at a rectangular table. WIDEN TO REVEAL forty or fifty mental health professionals, psychotherapists, members of advocacy groups, research scientists, journalists; and most importantly, individuals who have or continue to struggle with bipolar disorder.

CUT TO: A very attractive moderator, let's call her Sarah Peterson, who for the next two hours, will oversee a stimulating, bi-lateral discussion on bipolar disorder.

"As a Hollywood writer, access to research is the single most critical component to my work. In order for there to be dramatic truth, a writer worth his or her salt must have access to as much factual, or in this case, psychological truth as possible.

The Entertainment Industries Council (EIC) is to be commended for opening the doors of perception and sponsoring this timely debate. As a screenwriter and a father of a 22 year-old daughter who is bipolar, I can't tell you how liberating it was to openly discuss this much misunderstood, highly stigmatized illness.

What did I learn? That bipolar disease, true to the American spirit, is very democratic. It does not discriminate. On the contrary, it affects people from every walk of life, across all racial, social and economic strata. That we probably all know someone who suffers and struggles from it. That despite firmly entrenched taboos surrounding mental illness, they are not and should not be treated as second class citizens.

And that, as a person and a writer, it is incumbent upon me to understand this affliction from the inside out, so that if I one day decide to write a bipolar character, I will endow that person with all the grace, humanity and dignity I can muster."

Karen Maser, Staff Writer, *ER*

"The EIC's 'Picture This' event was a wonderful collaborative and thought-provoking experience. The knowledge, dedication and enthusiasm of all the attendees was truly inspiring. I came away with a greater understanding of bipolar disease and, as a writer, was reminded that showing the humanity of people with this disease is not only a responsibility, but an absolute obligation."

Lawrence Kaplow, Producer-Writer, *HOUSE, M.D.*

"The problem with incorporating content from health and political organizations is that as storytellers we tell stories, not messages. But in this type of roundtable discussion, competing messages gave rise to controversy, which was when I started to pay attention, as participants began substantiating their opinions with their own experience. And since whenever there's conflict, there's story, I probably walked away with four or five pretty good story/character ideas. Plus they fed me."

The *Picture This: Bipolar Disorder* panel of writers included *HOUSE* Producer-Writer Lawrence Kaplow, *ER* Staff Writer Karen Maser and *JOHN Q* Writer James Kearns



4 Special Message to the Creative Community

Recently the Entertainment Industries Council, Inc. (EIC) hosted the national leadership of organizations working to encourage awareness about, reduce stigma surrounding, and treat bipolar disorder and other mental illnesses. The meeting, called *Picture This*, was held at the National Association of Broadcasters headquarters in Washington, D.C. *Picture This* is an ongoing EIC project seeking to find new and innovative ways to address important health and social issues by way of entertainment.

This document provides an understanding of the many landscapes of bipolar disorder, and hopefully it will spark new, creative ways of addressing mental illness within the storylines and characterizations you develop. As a creator, you will be armed with the most current information available and a stronger sense of how your audiences respond to the myriad peripheral concerns surrounding the central issue of bipolar disorder.

The purpose of the most recent *Picture This* meeting was to ascertain the top three issues related to bipolar disorder that various populations across the country are experiencing today. The issues discussed ranged from stigma surrounding mental illness in general to specific treatments, concerns among different demographics and, above all, the importance of recognizing that people with bipolar disorder suffer from a chronic illness in exactly the same way that people with heart disease or cancer do. The results of the discussions are detailed in this document. On the following pages you will find well-researched facts as well as personal anecdotal stories from people who live with bipolar disorder.

EIC's mission and operating principles uncompromisingly protect the creative freedom of the entertainment community, while recognizing and promoting those productions that accurately depict and proactively address mental illness. Visit eiconline.org for more information about bipolar disorder and how to identify and treat it.

As always, please let us know if EIC and our technical assistance service, *First Draft* (firstdraft@eiconline.org), can provide you with any additional information and resources for depicting bipolar disorder, mental illness, or any other health or social issue. Accurate depiction yields powerful entertainment, and we salute your contributions to "the art of making a difference."



Sincerely,

A handwritten signature in black ink that reads "Brian Dyak". The signature is written in a cursive, flowing style.

Brian Dyak
President and CEO
Entertainment Industries Council, Inc.

National Association of Broadcasters
President and CEO David Rehr with
EIC President and CEO Brian Dyak

First Priority: Recognizing Bipolar Disorder

During EIC's *Picture This* meeting, the importance of **recognizing that bipolar disorder is a real disease was the number one priority**. Our mental health experts and people living with bipolar disorder agreed that there are many misconceptions about bipolar disorder, perhaps the most deceiving of which is that a person living with bipolar disorder can "fix it with will power."

Because bipolar disorder is a disease of the brain, rather than of another organ such as the heart or liver, some

Continues on Page 7

Signs and Symptoms of Bipolar Disorder¹

People with bipolar disorder have episodes of both depression and mania. The depressive phase of bipolar disorder has the same symptoms as major depressive disorder—what people commonly call "depression". However, because people with bipolar disorder, but not those with major depression, also have manic episodes, these are *two different illnesses that require different treatments*.

The symptoms of both major depression and bipolar depression include overwhelming feelings of sadness, worthlessness and hopelessness, as well as physical changes such as difficulty concentrating and problems with appetite and sleep. Bipolar disorder also involves episodes of mania—symptoms of which can include excessive energy, extreme irritability or "out of control" behavior.

Depressive Symptoms vs. Manic Symptoms

Depressive Symptoms	Manic Symptoms
<ul style="list-style-type: none">• Sadness• Excessive crying• Loss of pleasure• Sleeping too much or too little• Low energy• Restlessness• Difficulty concentrating• Irritability• Loss of appetite or overeating• Feelings of worthlessness and hopelessness• Ongoing physical problems that are not caused by physical illness or injury (e.g., headaches, digestive problems, pain)• Thoughts of death or suicide	<ul style="list-style-type: none">• Inappropriate sense of euphoria (excitement)• Reckless behavior• Little sleep needed• Excessive energy• Racing thoughts; talking too much and too fast• Out of control spending• Difficulty concentrating• Irritability• Abnormally increased activity, including sexual activity• Poor judgment

¹ Is It Really Depression? Available at: http://www.isitreallydepression.com/mini_c/isitreallydepression/depvsbipolar.asp. Accessed August 16, 2006.



Sally Field's 'Maggie' Finds Her Way on ER

FLASHBACK:

In 2001, EIC hosted a meeting with then-Surgeon General Dr. David Satcher and leaders of the entertainment industry. Held at the Beverly Hills Hotel, the event also featured former *ER* Executive Producer and current *Law and Order: SVU* Executive Producer Dr. Neal Baer, Academy Award-winning actress Sally Field, best-selling author and Johns Hopkins University Professor of Psychiatry Dr. Kay Jamison, and Dr. David Litts, Special Advisor to the Surgeon General.

A primary focus of the conference, attended by producers, directors, writers and both network and studio executives, was the pervasive stigma confronting people living with mental illness. Dr. Satcher encouraged the entertainment industry to create sympathetic and accurate portrayals of mentally ill people as people who have problems rather than people who cause problems, being more troubled than troublesome and—as in true life—more frightened than frightening.

Dr. Neal Baer spoke about his role in shaping a mentally ill character on TV. He scripted an *ER* episode featuring Maggie (who lives with bipolar disorder), the mother of medical student (now a doctor on the show), Abby Lockhart, played by Maura Tierney. EIC wrote, in a publication reporting on the event, “Though it’s far from an airbrushed characterization—she is exasperating, irrational and intrusive—it unfolds with insight, sympathy and a faithfulness to reality, thanks in part to Dr. Baer and to Sally Field, who portrayed her.”

CUT TO PRESENT:

Maggie has been a recurring character since EIC’s 2001 briefing, and she made another appearance in the second episode of the fall 2006 *ER* season, in an episode titled “Graduation Day.” In keeping with real life, Maggie’s struggles with her mental illness have been laborious—but she is finally beginning to live a productive life by adhering to treatment.

Ms. Field spoke about the considerable research she did to imbue Maggie with depth and realism—interviewing patients, reading books, and meeting with psychiatrists. Gathering this information, she used her artist’s mind to take her where she would go if she had the disorder.

“My task was to let this fire that I live with, a kind of on-edge place, to allow that part of reaching not only for other people’s emotions, but my own to create this complex character. I was allowed to go with the colors that came to me even though they weren’t in the script. Some of the fire and difficulty Maggie has weren’t written. I knew that’s where she lived. I knew it went further than what’s put on a page.”

Though Ms. Field may not have bipolar disorder, she makes an important statement when she says that she lives with some of the same emotions as a person who lives with mental illness. The truth is, Maggie resonates as a character because she is written accurately and with compassion—and also because Sally Field’s acting imbues her character with a humanity that is sometimes glossed over in portrayals of mental illness—or any illness for that matter. *ER*’s Maggie is evidence of the hard work that entertainment creators invest in creating quality work. We are moved by her because we see her as a real person with real problems—we see her as human, just like us.



Continued from Page 5

people think that it's an imagined illness. Some people think that if a person with bipolar disorder wanted to put an end to his or her symptoms, she or he could do so by sheer will and go back to his or her daily routine. The truth is that bipolar disorder is a real physical illness—a brain-based illness.

Bipolar Disorder, which until recently was commonly referred to as manic depression, is a disorder in which a person experiences severe mood swings that may range from deep depression and suicidal tendencies to extreme elation, or mania. The mood swings are associated with physical symptoms, such as changes in sleep, appetite, and activity level.

Bipolar disorder is not a new disease. In Julia Pesek's *The History of Bipolar Mood Disorder*, the author notes that mania and depression occurring together were first described in the second century.

Studies on bipolar disorder have found that it affects approximately 2% of the population. Men and women are equally affected by bipolar disorder. The disease usually surfaces in late adolescence or early adulthood.



Difficult Diagnosis

Misdiagnosis is a major concern among consumers, mental health practitioners and advocates. Bipolar disorder cannot be determined by a laboratory test, and instead must be diagnosed by a highly trained professional who evaluates a person for a confluence of co-occurring symptoms (See sidebar for symptoms of bipolar disorder). Bipolar disorder shares some symptoms with other mental illnesses, making it difficult to diagnose with accuracy. In fact, the National Alliance on Mental Illness (NAMI) states that it often takes as long as ten years to diagnose bipolar disorder in a patient correctly. Because of the difficulty of diagnosing the disorder, many people have been misdiagnosed by their physicians as having depression, schizophrenia, or another mental illness. Misdiagnoses of bipolar disorder occur often because, for example, a person may visit his or her doctor during a depressive episode, and may not disclose (or realize) that he or she also experiences manic episodes. Incorrect diagnoses can lead to inappropriate treatment, such as prescription of the wrong medication, which can adversely affect a person with bipolar disorder, sometimes even making symptoms of the disorder worse and cause prolonged suffering.

Given that experts can easily overlook or misidentify bipolar symptoms, **a writer or actor depicting the disorder may have a “diagnostic advantage” over the medical community** in that he or she can start backward, creating the profile of a person with bipolar disorder whose behavior does not at first appear unusual, or who only has isolated symptoms in the beginning. Since a writer can purposefully create a character with bipolar disorder, the writer can be sure of the diagnosis while leaving other characters in the dark about it; with such an approach, it would be easy to show that only through the recognition of specific overlapping symptoms would other characters, perhaps including medical professionals, ultimately be able to identify the disorder. This is how people usually become aware of bipolar disorder in real life—after finally “connecting the dots” and making sense of co-occurring symptoms.

Depiction Suggestion

Remember that people with bipolar disorder are *people* living with a disease—just like those who have cancer, heart disease or any other illness. However, bipolar disorder has a distinct entertainment advantage over some other physical illnesses in that drama and even comedy can express/depict the ups and downs that result from mania and depression. Several people at our *Picture This: Bipolar Disorder* meeting were adamant that comedy should not be avoided when showing people with bipolar disorder. In fact, people with bipolar disorder often have great senses of humor and comic timing during manic states. Additionally, a good sense of humor might help a person and his or her loved ones cope with living with and recovering from an illness—and perhaps especially with a mental illness about which little is known by many people.

Individuals involved in the criminal justice system may not be well trained in identifying mental illness and may incarcerate someone who needs, and would benefit from, treatment.

Types of Bipolar Disorder²

There are several different types of bipolar disorder, including bipolar I, bipolar II, and rapid-cycling bipolar disorder and cyclothymia.

According to the National Institute of Mental Health (NIMH), “The classic form of the illness, which involves recurrent episodes of mania and depression, is called **bipolar I disorder**.¹ Some people, however, never develop severe mania but instead experience milder episodes of *hypomania* that alternate with depression; this form of the illness is called **bipolar II disorder**. When 4 or more episodes of illness occur within a 12-month period, a person is said to have **rapid-cycling bipolar disorder**.”

Another variant of bipolar disorder is **cyclothymia**, a milder form of bipolar disorder with chronic, low level mood swings lasting at least two years. Those with bipolar I disorder also have the possibility of having a *psychotic episode*, in which one loses touch with reality, when either manic or depressed. *Psychosis* can affect all five senses; one can experience “auditory hallucinations, visual hallucinations, or sensory hallucinations: hearing, seeing, feeling, even smelling or tasting things that are not there” (Waltz, 13). Among these sensory hallucinations, auditory are by far the most common, followed somewhat distantly by visual hallucinations; the others are so rare that most physicians would want to be sure there isn’t a neurological illness present.

The news media tend to focus on the manic and psychotic aspects of bipolar disorder. (See depiction suggestion.) However, it is important to recognize that people with bipolar disorder cycle through depression and elation. Also, at times their abnormal moods may be relatively mild, and at other times their mood might be completely normal. Showing only the most severe characteristics of bipolar disorder does not show the *humanity* of people living with bipolar disorder.

² <http://www.nimh.nih.gov/healthinformation/bipolarmenu.cfm>

Depiction Suggestion

While headlines having to do with bipolar disorder often are negative or show the troubling aspects of the disorder, most often, people with bipolar disorder are the victims of crimes and violence rather than the perpetrators. Most people would not think twice if they read a newspaper headline stating, “BIPO-LAR MAN INVOLVED IN ROBBERY.” But given that most people with bipolar disorder are not perpetrators of crimes, the headline, “DIABETIC WOMAN BURGLES BANK,” makes just as much sense—that is to say, it doesn’t make much sense at all. While criminals may suffer from various diseases, in most cases the person’s illness has nothing to do with the crime he or she commits. Consider showing the erroneous-ness of such headlines in scenes depicting such crimes; these headlines may attribute violence or acci-dents to health problems that are simply coincidental, not the cause of such violent activity.

Second Priority: Addressing Stigma

A 2001 study published in *Health Affairs* (a bimonthly, peer-reviewed journal that explores health policy) indicated that most people get their information about health from the media, including news and entertainment. If this is the case, then it is reasonable to presume that public perception of mental illness is guided in large part by media depictions. Most news headlines that feature bipolar disorder focus on negative events resulting from manic or psychotic states of bipolar disorder. Showing bipolar disorder to be wholly negative contributes to and reinforces stigma about the illness and about people who live with it. Often, bipolar disorder is associated with violence and crime. People with bipolar disorder might be perceived as dangerous, or even as villainous. **But the truth is, people with bipolar disorder are in fact more likely to be victims of violent crimes than the perpetrator of a violent crime.** The entertainment industry—television, feature films, music videos, comic books and other forms of storytelling—has a great opportunity to show the many sides of bipolar disorder. This includes the ups and downs, and the often overlooked or unrecognized fact that during manic states, people sometimes are much more trusting and adventurous than other people, and might therefore put themselves at immediate risk, or put their safety in the hands of people who seek to take advantage of their vulnerability.

Stigma Hurts

Stigma, for the most part, is created and perpetuated by a lack of knowledge. The best way to combat stigma is through education. People with bipolar disorder are ordinary people living in extraordinary circumstances. It may be helpful to think about it like this: **A person lives with bipolar disorder; he or she is not “bipolar” or “manic.”** Suffering should not be the expectation. Contrary to disasters and accidents often seen in headlines, it is possible to lead a fulfilling, productive life as a person diagnosed with bipolar disorder. Just because they don’t make headlines doesn’t mean they aren’t dramatically compelling.

Social stigma can lead to loneliness and alienation. Someone suffering from bipolar disorder may hesitate to tell family members or close friends about his or her illness for fear of being labeled “crazy.” **Words such as “crazy” or “maniac” reinforce stigma.** In turn, people with stigma-bearing illnesses may try to stifle their symptoms and not want to admit that they may have bipolar disorder, therefore avoiding diagnosis and treat-ment. They might even become agoraphobic (that is, they might become reclusive and fearful of public spaces) because they fear being around other people who might judge them.

Lack of Mental Health Insurance Increases Stigma & Prevents Treatment

Getting treatment for bipolar disorder can be a real feat. Most people's health insurance policies do not cover treatment for psychiatric illnesses as much as they do treatment for non-psychiatric illnesses, and often there is no provision for mental health care at all. The ability to pay for treatment can be difficult in itself. Not being able to get the proper treatment can lead to self-medicating and/or substance abuse. "In the United States, for every dollar spent on serious physical illness, only twenty cents is spent on serious emotional disorders" (Edward, 154).

Stigma at Work

Unfortunately, there is also a risk of discrimination in the workplace. Those not educated about bipolar disorder may see an employee or coworker with bipolar disorder as a liability, or assume that the person's work will not be up to par because of their psychiatric illness. For this reason, many people with bipolar disorder will not disclose their illness to others, and may feel persecuted, misunderstood or underappreciated at work. At the same time, many people will never seek care for bipolar disorder because they fear being "outed" at work or having to deal with other people's judgments. The truth is, people who do seek and receive treatment may be better employees than those who do not, and their performance will probably improve on the job simply because they do not have to harbor a secret or worry about other people's speculation about their behaviors.

The most reasonable way to understand any psychiatric illness in the workplace is to view it as any other major health concern: **Just as we do not look down upon people who live with cancer, diabetes or any other physical illness, we should be able to view people with psychiatric disorders the same way—as ill, not "crazy."** New science indicates major differences in brain function between people with psychiatric disorders versus those without; this knowledge may help people understand that psychiatric illnesses including bipolar disorder are, in fact, legitimate health crises just like diabetes or cancer, and people living with such illnesses should be accorded the same respect, consideration and treatment.

Third Priority: Recovery and Hope

Recovery and hope often are overlooked in favor of more sensational stories about the suffering involved in dealing with a major life problem. However, the recovery and treatment processes offer plenty of opportunity for drama and comedy alike. Showing an ongoing recovery process in storylines and characterizations would offer viewers something entirely new to watch.

Depiction Suggestion

Consider the opportunities to depict recovery and treatment: You might share the story of a person seeking treatment, undergoing misdiagnoses, finding treatment, coping with the side-effects of medications that do work for them, and so on. Try to represent the whole person and the strides that can be made, showing that it is possible to regain control in life and live with bipolar disorder. *The fact that bipolar disorder is treatable is overlooked and needs to be depicted.* Bipolar disorder presents itself in many ways, and the accurate depiction of symptoms is essential to showing the disorder realistically. Reversing stereotypes in characters with bipolar disorder would be powerful and unexpected to viewers. Consider provoking new public perceptions of bipolar disorder by showing a hero or highly productive and functional person living with bipolar disorder, as often is the case in reality.

There are also many misconceptions about treatment for bipolar disorder. For example, many people think that treatment for the disease is uniform—that one treatment works for everyone. Treating bipolar disorder may be just as difficult as diagnosing it; every person’s body chemistry is different and one person’s symptoms may respond differently to various treatments than another’s. Some people with bipolar disorder may even avoid treatment purposefully in the mistaken belief that their manic states bring about creativity—and in the case of people with creative jobs, such as artists, writers, et al., they may have the mistaken idea that their professional lives may suffer from being treated. But mania for many people compromises their safety. People with bipolar disorder must realize that their illness may put their life on the line, and sacrificing the bursts of energy that mania gives them may be the only option to keep them healthy, or even alive. Also, when people experience mania, they can be very easily distracted and therefore might not be very productive in a creative (or other) enterprise.

Humor and Healing

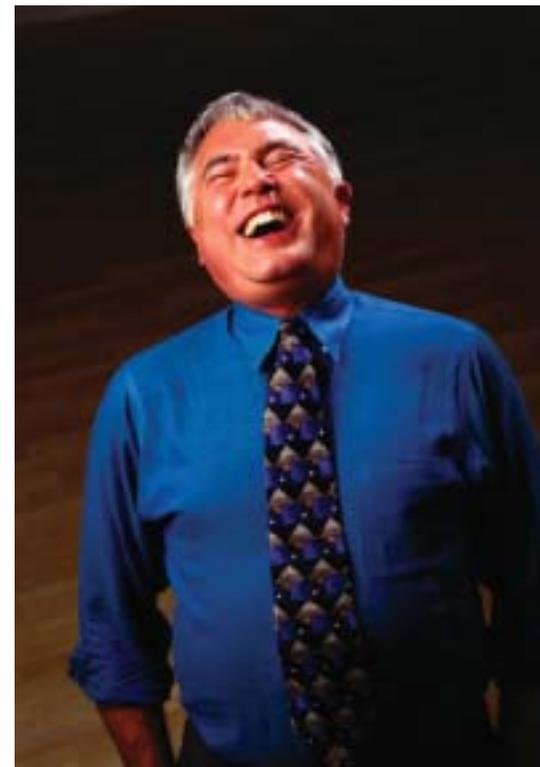
When addressing sensitive health and social issues such as bipolar disorder, many people have a natural inclination to become “politically correct” and always treat a matter seriously. The fact is, though, that bipolar disorder is a health issue that involves a variety of moods, including ups and downs, that can cause tragedy, but also a great deal of laughter and elation. In direct opposition to the ultra-serious route, many of the experts and people living with bipolar disorder participating in our *Picture This* meeting strongly encouraged depictions of bipolar disorder that are comic and lighthearted. Several people also pointed out that dark comedy is a natural tone by which to set a bipolar-themed storyline or character, as many people with bipolar disorder are able to laugh at dark situations they encounter in life. Humor, in fact, can help make recovery easier, or at least less stressful. There is a possibility that when people see bipolar disorder depicted with sensitive humor, they will feel more comfortable discussing the disorder.

Also, let’s not forget that bipolar disorder is also referred to as the “genius disease.” Many great people, past and present, have lived with bipolar disorder and were able to accomplish great things. The only way the disease can get the best of you is if you give up on diagnosis and treatment.

Bipolar Doesn’t Discriminate

An intriguing topic that came up during EIC’s *Picture This* meeting was the universality of bipolar disorder. In the past it had been referred to as a disease that only affected Caucasians, and many people also thought that bipolar disorder was a “middle-class illness,” meaning only well-to-do people were susceptible because it was thought by some to be a psychosomatic disease brought about by boredom or not having enough to do. The truth is, when it comes to bipolar disorder, no one is immune. Bipolar disorder is a disease that affects the brain, and it affects all populations equally.

“The analysis of 134,523 mentally ill patients in the VA registry is by far the largest national sample to show broad ethnic disparities in the diagnosis of serious mental disorders in the United States. The data confirm the fears of experts who have warned for years that minorities are more likely to be misdiagnosed as having serious psychiatric problems. ‘Bias is a real issue,’ said



Francis Lu, a psychiatrist at the University of California at San Francisco. ‘We don’t talk about it—it’s upsetting. We see ourselves as unbiased and rational and scientific’” (Washington Post).

The bias described above is a bias that many people feel the medical community has toward diagnosing schizophrenia in minorities, whereas bipolar disorder is more frequently diagnosed in non-minorities and affluent people. Schizophrenia is a more severe illness with a generally worse prognosis than bipolar disorder, though both are considered serious (major) psychiatric illnesses.

Bipolar Disorder is Not “Black and White”

Because a large part of diagnosing bipolar disorder is observational, cultural differences and language barriers come into play.

Picture This experts from the Asian American community noted that some minorities—particularly Asian Americans—sometimes have difficulty coming to terms with bipolar disorder because of being pigeonholed as the “model minority.” Many Asian Americans feel pressure to be successful and productive, and might view bipolar disorder as an obstacle that might get in the way of their success; therefore, many people who feel such social pressures may ignore warning signs and symptoms of bipolar disorder, or even reject the idea that they or their loved ones may be susceptible to it, and as a result never seek treatment. A related social concern for Asian Americans is that “because of stigma and cultural differences, Asians tend to view depression as a personal weakness or moral failing” (Chen, et al., 2002). The social pressures and stigmas against mental illness within certain communities can be detrimental to people who suffer from bipolar disorder and other mental illnesses.

Conversely, many African Americans who recognize symptoms of bipolar disorder and seek treatment face another problem: They are mistakenly diagnosed with schizophrenia. According to William B. Lawson, MD, PhD, chair of the department of psychiatry at Howard University, there is “a tendency of many [health care] providers to fail to recognize that there may be cultural differences [for the ways people act].” Since many African Americans are culturally unlikely to discuss their personal lives with doctors, some physicians interpret their secretive behavior as indicative of schizophrenia. Lawson notes that perhaps 90 percent of African Americans seeking treatment are misdiagnosed for schizophrenia or other mental illnesses instead of bipolar disorder.

In other cultures, it is disrespectful to give out family history, which may be of use to the doctor when trying to determine a diagnosis. “Advocates for cultural competence say both clinicians and patients are unwilling to

acknowledge that race might matter: ‘In a cross-cultural situation, race or ethnicity is the white elephant in the room,’ said Lillian Comas-Diaz, a psychotherapist in Washington, who added that she always brings up the subject with patients as a way to get hidden issues into the open—and increase trust” (Washington Post). In terms of ethnic minorities, getting information about bipolar disorder from peers is helpful because there is a level of comfort and more of a willingness to open up thoughts and feelings.



Further, *bp Magazine* for bipolar disorder notes that “minorities with bipolar disorder can run into a twofold problem. First, for reasons that are unclear, minorities tend to be prescribed older-generation drugs. African Americans are less likely than Caucasians and Latinos to be prescribed new-generation drugs [...] the older drugs have uncomfortable side effects and the risk of tardive dyskinesia (TD—repetitive, involuntary movements of the face, trunk, arms, fingers, and legs, which may be irreversible in some people) is higher in African Americans than in whites.”

Another concern for minorities includes the effects of differing metabolic rates: some ethnic minority groups metabolize drugs more slowly than Caucasian people, and end up absorbing more of the drug because physicians are accustomed to treating Caucasian patients and may not know how to regulate doses for people of varying ethnic and racial backgrounds. Improper dosages can lead to increased or heightened side effects. Because of this, some people with bipolar disorder limit how often they take their medications, decreasing the effectiveness of treatment regimens and *increasing* the risk of side effects.

About Bipolar Episodes

Bipolar disorder causes both depressive episodes and manic episodes at different times during the illness. A common misperception is that bipolar mood changes are usually quick and drastic. In reality, the shift from one extreme to the other is often quite gradual. And an episode—either depressive or manic—can last for days, weeks, months or even years.

Moreover, people with bipolar disorder are not always depressed or manic; they can go for long stretches of time in a “normal,” balanced mood. The typical person with bipolar disorder has an average of four episodes during the first 10 years of the illness.

When Signs Are Missed

Sadly, some people are diagnosed and treated for major depressive disorder when they really have bipolar disorder. It is easy to understand how misdiagnosis can occur. Some individuals (especially if they are unaware of bipolar disorder) may not recognize their manic symptoms—and therefore don’t report them to their doctor. They may seek a doctor’s help only when they are immersed in a depressive episode.

People may experience depression as their very first episode, and they will not have a manic episode until some time in the future.

An incorrect diagnosis can lead to inappropriate treatment. In fact, antidepressant medications can bring about a manic episode in someone who really has bipolar disorder.

Awareness about bipolar disorder is the first step to recognizing possible signs. There are excellent treatments for both depression and bipolar disorder. The key is to get a correct diagnosis.

Bipolar Disorder Misconceptions and Stigma

The following list of misconceptions and stigma about people with bipolar disorder were defined by experts and people living with bipolar disorder participating in EIC's *Picture This* meeting in Washington, D.C. This list is not comprehensive, but it does provide an idea of the need for a better understanding of bipolar disorder and other mental illnesses.

INACCURACIES:

- People with bipolar disorder are “crazy” or “out of control.”
- They need constant supervision.
- They have no discretion or use poor judgment.
- People with bipolar disorder are dangerous criminals.
- Only Caucasians have bipolar disorder.
- Everyone with bipolar disorder is middle class.
- Bipolar disorder is not a real illness.
- Having bipolar disorder is a choice—anyone with will power can control symptoms.
- Suffering is the expectation.
- Bipolar disorder is associated with violence and crime.
- Treatment is uniform; treatment is the same for everyone.
- Bipolar disorder is a sign of failure.
- Bipolar disorder is a character flaw.
- The illness defines the person.
- If a person does not get better, it is because he or she is not actively engaged in the recovery process.
- The person is to blame for their mental illness.

Other Misconceptions and Stigma*

- Mental illness has no physical basis.
- We all get depressed from time to time. Positive thinking should be enough to turn things around.
- Lots of people think about suicide at times but don't actually attempt it. Those who say they want to kill themselves are just seeking sympathy.
- The mentally ill are eccentrics who crave attention. They aren't sick, and many of them don't want treatment.
- Psychiatric diagnoses involve a lot of guesswork. They're not made scientifically. “Shrinks” are quacks/incompetent.
- Lots of people with “mental illness” have some unrelated physical illness. When that gets treated, the “mental illness” should go away.
- The mentally ill have warped personalities.
- People with mental illness come from bad families.

*From the book *Bipolar Disorder Demystified* by Lana R. Castle

- The mentally ill are weak. They're just overreacting to stress.
- The mentally ill just won't take responsibility and help themselves.
- If "imbalanced brain chemistry" causes mental illness, then medication alone should rebalance it and cure the problem.
- Talking about problems won't solve them. It only makes you dwell on them more. Instead of yammering endlessly in therapy, these people should take action.
- The mentally ill can do nothing to help themselves other than find good mental health professionals, take the right medications, and undergo lengthy hospitalizations.
- The mentally ill are immature and self-absorbed. They just need to grow up and become responsible.
- Those people are sick because they have no faith in God. All they really need is religious commitment and prayer.
- Friends and relatives often overreact and push those who "march to a different drummer" into unnecessary treatment.
- The mentally ill are too undependable, weird, or violent to function well in society.



Moderate Exercise = Improved Feelings

A study conducted by scientists from the University of Texas' Exercise Psychology Laboratory in the department of kinesiology and health education, have shown that moderate exercise, for example, thirty minutes on a treadmill can elevate the moods of people who have major depressive disorder. The best part is the benefits of exercise are immediate. The exercise group in the study reported an improved sense of vigor and well-being.

Wired for Creativity?

“Men have called me mad, but the question is not yet settled whether madness is or is not the loftiest intelligence—whether all that is profound—does not spring from disease of thought, from moods of mind exalted at the expenses of the general intellect.”

—Edgar Allan Poe

Ups and Downs of a Creativity Link

Many people have wondered whether or not there is a link between creativity and mental illness. We have all heard stories of the tortured artist or the depressed writer. Looking back, there have been many great artists, writers, musicians and other artists who have or had some form of mental illness. Some of the greatest artists, including Vincent van Gogh, Sylvia Plath, and Virginia Woolf, lived with mental illness and possibly died as a result of not having had access to treatments that are available today.

Bipolar disorder is sometimes called “the genius disease.” Certainly, not everyone with bipolar disorder is highly creative or a genius; however, given that so many great artists and other creative people suffered from symptoms related to bipolar disorder, it is worthy of investigation to find out if some link does exist. Current studies are being performed to find out if creative people are more susceptible to mental illness, as well as if mental illness may contribute to creativity in some way.

University of Iowa psychiatrist **Nancy C. Andreasen** completed one of the first controlled studies of the creativity/mood disorder link. She compared 30 creative writers at the University of Iowa with 30 people holding jobs that were not inherently creative. She found that 80% of the writers said they had experienced either manic-depressive illness or major depression, while only 30% of the people in noncreative jobs said they had. Andreasen published her results in the October 1987 issue of the *American Journal of Psychiatry*.

In the late 1980s, Johns Hopkins University psychiatrist and leading bipolar disorder expert **Kay Redfield Jamison** also examined the link. She studied 47 painters, sculptors, playwrights and poets, all of who had received high honors in their respective fields. Jamison found that 38% of the artists had been treated for a mood disorder. That percentage



is extremely high compared with only about 1% of people in the general population who report manic-depressive episodes and about 5% who report major depression at some point.

For 10 years, **Arnold M. Ludwig** studied the lives of 1,004 men and women who are prominent in a variety of fields, including art, music, science, sports, politics and business. He studied these people by reading 2,200 biographies. Ludwig argued that biographers were less likely than psychiatrists to believe in evidence that a person has a mental illness. This would make biographies less biased than psychiatric interviews. Biographers also typically draw information about their subjects from a variety of sources, which would make misrepresentations of mental state more difficult.

The Guilford Press published the results of Ludwig's study in 1995, in a book called *The Price of Greatness: Resolving the Creativity and Madness Controversy*. Ludwig concluded that "members of the artistic professions or creative arts as a whole suffer from more types of mental difficulties and do so over longer periods of their lives than members of the other professions." He found that, as teen-agers, between 29% and 34% of future artists and musicians suffered from symptoms of mental illness. In comparison, only 3% to 9% of future scientists, athletes and businesspeople suffered similar symptoms. As adults, between 59% and 77% of artists, writers and musicians suffered mental illness, while only 18% to 29% of the other professionals did. Ludwig's findings seemed to confirm the link between mental illness and the artistic temperament.

The downside of these findings is that the idea of missing out on the rush of energy and thought that sometimes accompanies the manic state of bipolar disorder scares some people away from taking their medication out of fear it will take away or stifle their creativity. The truth is that with effective medications, one can control and maintain his or her creative bursts while reducing the likelihood of doing self-harm.

Further Reading on Creativity and Mental Illness:

Touched With Fire

By Kay Redfield Jamison

*The Price Of Greatness:
Resolving The Creativity and Madness Controversy*

By Arnold M. Ludwig

Bipolar Disorder Demystified

By Lana R. Castle



Personal Stories

April's Story

During her manic episodes April lost the ability to sleep. She stayed up for days at a time. Her mania set off many other symptoms such as lack of concentration and irritability. April's lack of good judgment and impulsive behavior took the form of huge impromptu shopping sprees. And alarmingly, during her depressive phase she lost her appetite and dropped to a dangerous 90 pounds.

Extremely fortunate that she didn't fall into debt, April found the help she needed and started taking medication. "Medications are what keep me stable, to be honest, followed by coping skills. The meds alleviate most of the symptoms. It is my medicine that stabilizes my moods and helps me balance out. I wouldn't make it without my medication." With medication April now has a healthy sleep cycle, she can concentrate better, and she has a restored appetite.

April says she feels that the news media have sometimes portrayed people with bipolar disorder as "crazy homicidal maniacs." Such portrayals, she says, reinforce negative stereotypes and perpetuate stigma. "Mental illness doesn't have to be as destructive as it is. **I was never violent; I never even had a single violent thought.** If people in the community would become more educated and provide more support, people with mental illness could lead better and more productive lives."

Proving that bipolar disorder is indeed "color blind," April is a young African American woman—and proving that people with bipolar disorder can lead normal, productive lives, she is now a medical researcher at a southern university.

April says her strongest sources of support have been her mother, brother, and grandmother. Family support often can be the saving grace for people with bipolar disorder or other mental illnesses, as stigma attached to such illnesses can lead to one of the last accepted types of discrimination—against the mentally ill.

Tom B's Story

Tom B. lived the high life: At one point, he flew from Atlanta to Tampa and rented a Porsche, then flew to Toronto and went on a \$27,000 shopping spree for new clothes. On a whim, Tom will hop a jet to New York, Ft. Lauderdale, St. Louis, or anywhere else that seems interesting. The problem is that Tom can't afford his jet-set lifestyle—and yet until recently he had no control over it.

Tom B. has been hospitalized seven times. He was diagnosed with bipolar disorder at age 40. At age 45, Tom moved in with his parents to avoid his only other option: homelessness. Only four years ago did doctors find the right combination of medications that works for him.

As a board director for a mental health center and an advisor to the Montana State Board of Visitors, Tom points out that his struggles with finding the right treatment were not the result of improper medical care; in fact, the psychiatrists and counselors he saw over the years tried as hard as they could to treat him.

Tom's case is not atypical and highlights the difficulty of treating bipolar disorder. Often, effective treatment today is identified only through trial and error—but treatment is possible and, when the right combination of medications is identified, can save lives.

Linda's Story

Linda M. owns and operates an Amish taxi service in Missouri. She was diagnosed with bipolar disorder at age 35. Her treatment includes a “cocktail” of seven psychiatric medications and visits to a counselor she started seeing 20 years ago who lives 200 miles away.

Mental illness isn't just Linda's problem. As with many cases of mental illness, she is only one of many generations in her family that suffers from a mental disorder. Linda's daughter has schizoaffective disorder, which includes many of the symptoms of bipolar disorder.

“We are still in the dark ages when it comes to social acceptance of mental illness,” Linda says. During one of her daughter's hospitalizations, Linda's coworkers confessed that they were uncomfortable with the situation and didn't know what to do. “Do what you do when someone breaks a leg,” she told them. “Send a card, call and say you care, take food to the family, offer to baby sit,” and do whatever you do when someone you know has a seriously ill child.

Despite the complications that bipolar disorder has caused Linda throughout her life, she runs a successful business and has been married for 42 years—and while she and her daughter have mental illness in common, they also have each other to depend on.

“I would without hesitation be willing to tell anyone I have a mental illness,” she says. “My real motivation for that is the fact that I have ended up having a very good life in spite of severe bipolar disorder...When I was diagnosed with a mental illness, I was both devastated and ashamed beyond measure, and greatly disappointed with myself because I had tried so hard to cope over the years.

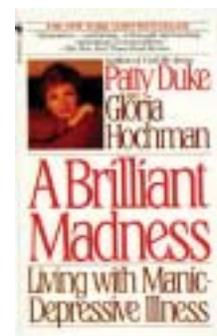
“...I finally knew why my life had been a living hell for [the majority] of 35 years. I have also been richly blessed with an extremely supportive family. It hasn't always been and still isn't always easy for them to live with my illness. I want people to know there is every reason to have hope that life can be rich and rewarding in spite of mental illness.”

Patty Duke

One of America's most beloved actresses, Patty Duke, disclosed in her best-seller *Call Me Anna* that she lives with bipolar disorder, which was at the time better known as manic depression. Like many people with bipolar disorder, it took a long time—almost 20 years—before she was correctly diagnosed with the disorder at age 35. During those years, Patty “careened between periods of extreme euphoria and debilitating depression, [was] prone to delusions and panic attacks, temper tantrums, spending sprees and suicide attempts,” according to her follow-up best-seller, *A Brilliant Madness*, which focuses almost exclusively on the Oscar-winning actress's bouts with mental illness.



Written with medical reporter Gloria Hochman, *A Brilliant Madness* gives an insightful look into bipolar disorder through Patty's story—a story that careens through extreme highs and lows but ultimately finds a healthy balance through treatment. The book is a must read for anyone who has bipolar disorder or knows someone who lives with it. Patty Duke is a well-known, well-spoken example of how, despite challenges, anyone with bipolar disorder can find success and thrive.



Stigma: The Name Game

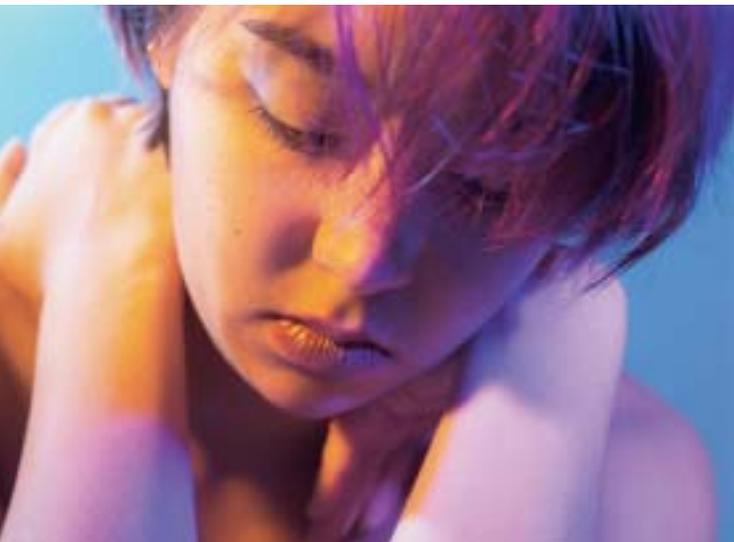
Stigma surrounding mental illness is not exclusive to bipolar disorder. In the spring 2006 issue of *Schizophrenia Digest*, Patricia Jane Teskey asks: “What’s in a name? A case for changing the ‘s’ word” (Teskey, 2006). The “S word” in this case is schizophrenia, but it may as well be *stigma*.

The article notes that “schizophrenia is a scary word. People on the receiving end of this diagnosis cringe and deny, and they are not alone.” It goes on to ask, “Have you noticed how we family supporters can talk about this illness for hours without saying its name? We are adept at avoiding the ‘s’ word.”

Rather than simply suffering with the stigma attached to the word (the article cites an entry from *Encarta Webster’s*

Dictionary of the English Language, 2004 edition, which has a second definition for “schizophrenia” that reads: “an offensive term for a state characterized by contradictory or conflicting attitudes, behavior or qualities (insult)”), it offers a radical idea: adopting a new common term to indicate what we currently know as schizophrenia. However, suggested names, such as “mind-split disease” (a Chinese translation of “schizophrenia”) may not be any less likely to harbor stigma.

Regardless, an official name change would have to be chosen “by committees of experts who refine and revise the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* published by the American Psychiatric Association (APA). The next *DSM* will be published in 2011; schizophrenia was first published in the *DSM* in 1911—a hundred years before any potential name change.



A Link Between Obesity and Bipolar Disorder?

Obesity Linked with Mood and Anxiety Disorders

Results of a National Institute of Mental Health (NIMH)-funded study show that nearly one out of four cases of obesity is associated with a mood or anxiety disorder, but the causal relationship and complex interplay between the two is still unclear. The study is based on data compiled from the National Comorbidity Survey Replication, a nationally representative, face-to-face household survey of 9,282 U.S. adults, conducted in 2001-2003. It was published in the July 3, 2006, issue of the *Archives of General Psychiatry*.

The results appear to support what other studies have found—that obesity, which is on the rise in the United States, is associated with increasing rates of major **depression, bipolar disorder, panic disorder** and other disorders. However, in contrast to other studies, this study found no significant differences in the rates between men and women. In addition, it found that obesity was associated with a 25 percent lower lifetime risk of having a substance abuse disorder. Obesity is defined as having a body mass index of 30 or more.

Social and cultural factors appear to influence the obesity connection with mood and anxiety disorders, according to the study. The association appeared to be strongest among non-Hispanic whites who are age 29 and younger, and college educated.

The causal relationship between obesity and mood and anxiety disorders continues to be debated and studied. Both likely contribute to the other, but they may be linked through a common environmental or biological factor as well. Lead author Gregory Simon, MD of the Center for Health Studies, Group Health Cooperative in Seattle, Wash., suggests further study into how the two conditions intersect. (Reported by the National Institute of Mental Health, July 3, 2006. Available at: http://www.nimh.nih.gov/press/obesity_mooddorders.cfm.)

Bipolar and the Brain

New imaging techniques (See *Spotlight on...Medical Technology*, available at: <http://www.eiconline.org/publications/spotlighton/medicaltech.pdf>) are helping researchers to examine how changes in brain function and structures might contribute to bipolar disorder. Research indicates that abnormalities in the structure and/or function of some brain circuits might be the cause of bipolar and other mood disorders, such as depression. Currently, researchers are investigating how neural circuits work to regulate moods. With better understanding of brain circuitry related to mood regulation, researchers anticipate the development of new and better treatments and a better ability to diagnose mood disorders.^{3,4}



³ Soares JC, Mann JJ. The anatomy of mood disorders-review of structural neuroimaging studies. *Biological Psychiatry*, 1997; 41(1): 86-106.

⁴ Soares JC, Mann JJ. The functional neuroanatomy of mood disorders. *Journal of Psychiatric Research*, 1997; 31(4): 393-432.

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