



The Entertainment Industries Council, Inc. (EIC)

First Draft Service



presents...

a series of "tip sheet" emails with information and depiction suggestions on **BIPOLAR DISORDER**. Hopefully, these will not only be the impetus for fresh story ideas, but will also imbue scripts with a realistic and accurate portrayal of bipolar disorder. They are designed to enhance the creative process -- not limit it.

To the Creative Community:

As a supplement to the first tip sheet about bipolar disorder sent out last month, this tip sheet will feature excerpts from an in-depth interview about bipolar disorder between *CBS Cares* and Dr. Maria Oquendo, M.D., a professor of Clinical Psychiatry at Columbia University and director of the Clinical Evaluation Core of the Silvio O. Conte Center for the Neurobiology of Mental Disorders at the New York State Psychiatric Institute.

This interview is formatted in such a way that depiction suggestions can be taken straight out of Dr. Oquendo's answers, as she touches on various aspects of bipolar disorder. The excerpts are grouped into categories that deal with these aspects and we hope that this will assist you in the creative process. For more information and depiction suggestions, check out www.eiconline.org.

Regards,

A handwritten signature in black ink, appearing to read 'Brian Dyak'.

Brian Dyak
President and CEO

CBS Cares Interview

CBS CARES: What exactly is "**bipolar disorder**" and how does it differ from depression?

DR. OQUENDO: Bipolar disorder, as currently defined in the Diagnostic and Statistical Manual (DSM) of Mental Disorders, consists of three subsets:

First, there is "**bipolar disorder one**." This is a disorder that has been recognized since the turn of the last century and is also known as manic depression. It's characterized by episodes of major depression, for example; depressed mood, difficulty enjoying oneself, difficulty in sleeping and eating, low energy, problems with concentration, suicidal ideation, et cetera. But in addition to having episodes of depression, people with manic depression, or bipolar disorder one, also have episodes of mania or up-swings in mood. In mania, the presentation is one of either euphoria or extreme irritability.

Then, there is "**bipolar disorder two**." This is a more subtle form of the illness, in that the person still has episodes of major depression, but on the other side of the coin, there is **hypomania**. The up-swings never reach the same magnitude as they do in full mania, so that patients with bipolar disorder two have episodes of what we refer to as hypo-manic episodes, where they have some of the symptoms for mania, but in a much more attenuated fashion. One of the difficulties of this disorder is that the subtlety of those symptoms can often make it hard to diagnose.

The third type of bipolar disorder, which is what's being included in so-called "bipolar spectrum disorder," is "**bipolar disorder NOS**" ("Not Otherwise Specified"). This is a diagnostic criterion that's available when the clinician sees a patient who he or she believes has a bipolar condition, but doesn't strictly meet the criteria of either bipolar disorder one or bipolar disorder two. So that's where the word "spectrum" is utilized, to refer to this type of problem.

So it is the episodes of either manic or hypo-manic episodes that separate bipolar from depression.

CBS CARES: Earlier when you described the third category of "**bipolar disorder NOS**" it sounded very fluid ...doesn't that leave room for some psychiatrists to subjectively, but wrongly, diagnose someone as "bipolar"?

DR. OQUENDO: It allows flexibility for the clinician to use their judgment about whether the patient has some features consistent with a bipolar spectrum. It is possible that less definitive criteria such as the ones in bipolar NOS can lead to misdiagnosis, but having this kind of diagnosis available is a *good way to try to deal with the reality that psychiatric conditions are not easy to put into neat little boxes.*

CBS CARES: Can you further describe **manic episodes**?

DR. OQUENDO: Manic episodes are episodes in which the person finds him or herself feeling *very euphoric and exuberant, often times accompanied by significant irritability.* The person shows difficulty with impulse control, acting in ways that are uncharacteristic in terms of sexual activity, or spending money. They also often do not require very much sleep, they might be feeling especially creative, be very energetic, they might speak very quickly and they may move around very quickly. They may have feelings to such an extent that they believe that they have supernatural powers or that they are a special human being, but not in the way that we would ordinarily think of that word. They might think that, for example, they have been sent by God to save the world or something of that nature. In other words, it is a very dramatic presentation and often times this type of illness is extremely disruptive to this person's life, particularly because they do things that are impulsive and often times in a public kind of way that later can be quite embarrassing to them.

CBS CARES: And "**hypo-manic episodes**" are subtler?

DR. OQUENDO: Exactly, hypo-manic episodes are much more subtle than manic episodes. Often times they have very similar symptoms, but by definition they cannot be as impairing. In other words, the person often times is functioning at their work or at home, but people around them notice that there's something markedly different about them.

DEPICTION SUGGESTION: Consider developing a character who might struggle with both manic and depressive episodes over an extended period—weeks, months, perhaps even a season or two. Try to show the subtleties between the three subsets of bipolar disorder and the potential difficulty of diagnosing them by portraying the intensity and/or frequency of either manic or hypo-manic episodes in one character.

CBS CARES: How many **people in the United States** have been diagnosed with any of these forms of **bipolar disorder** and how many new cases are there in a typical year?

DR. OQUENDO: It's estimated that *about 11.5 million Americans suffer from bipolar disorder and about 55,000 new cases are diagnosed each year.*

For more facts and statistics, [click here.](#)

CBS CARES: Is it accurate to say that a **misdiagnosis of depression**, when someone in fact has bipolar disorder, can be a very serious mistake, because the treatment for bipolar disorder is very different than for depression alone?

DR. OQUENDO: This is a critical point. *In bipolar disorder, it is absolutely critical that the person be treated with a mood stabilizer even if they are currently depressed.* The standard of treatment, even in depressed bipolar patients, is for them to be on a mood stabilizer and if necessary, which it often is, also on an anti-depressant. The reason for this is that *if you put a patient with bipolar disorder on an anti-depressant alone, there is a risk for triggering a manic episode or a hypo-manic episode.* If it's hypo-manic, it's not so bad. But if the person is manic, they may require hospitalization and/or do things that are self-destructive.

CBS CARES: What are the other **obstacles to proper diagnosis and treatment**?

DR. OQUENDO: The main roadblock to diagnosis has to do with two things. One is the problem with the patient not necessarily recognizing the pathology that is linked to hypo-manic or even manic states. The patient often doesn't think there's anything wrong with him or her, so they might not report it spontaneously. And secondly, it is sometimes the case that the patient presents to treatment when they're depressed, and the therapist or psychiatrist forgets to ask, not about whether the person has ever been manic, but about the particular symptoms.

Things that, for example, a patient might report without prejudice involve sleep. So, I often ask people, "*Have you ever had a period of time when you didn't need to sleep very much, but you were still really, really energetic and you felt fine?*" And that's often a very good way to get the person talking about the illness because it's almost always the case that the person has problems with decreased sleep. They don't perceive it as a problem, but they know that they have decreased sleep. And it opens the door to asking about other symptoms. If you ask the patient, "Have you ever had a point in your life when you felt especially good or euphoric," they may not consider that abnormal, and they wouldn't report it as a symptom.

DEPICTION SUGGESTION: Consider showing a conversation between a psychiatrist or therapist and a patient with bipolar disorder, revealing the types of questions (i.e., such as asking about sleeping patterns) that a therapist must ask that to determine the proper diagnosis of bipolar disorder.

CBS CARES: So to increase the chance of accurately diagnosing whether it's bipolar disorder or depression, does the **role of the family** become important in that they can give a perspective on the patient's mood swings that the patient may not always realize?

DR. OQUENDO: In my opinion, it's *absolutely critical to speak to family members about symptoms*, in particular in these types of disorders where some symptoms may not be apparent to the patient, him or herself.

CBS CARES: Are people with bipolar disorder especially difficult to convince about getting treatment? In the sense that grandiosity, for example, which accompanies the manic phase, could make them feel powerful, willful and manipulative?

DR. OQUENDO: I think that, *during the manic and hypo-manic phase*, it is almost always all but impossible to convince patients that they need treatment because they feel good for the most part. And *that's where the family is instrumental*. At times, hospitalization becomes necessary. *In some cases, treatment has to occur against the person's will*.

CBS CARES: It must be very hard from the therapist's perspective. So how do you deal with that?

DR. OQUENDO: Well, *one of the best ways to do it is to try to have the family engaged, so that they can help bring about some pressure to have the person stick with their treatment*. And often times, it's just after experience that people really understand that they need the treatment and that they have to go through a couple of cycles to see this.

We've also told the patients things like, "Let's write up a contract now that you're aware of your illness. There's going to be a time when you want stop the treatment, but you agree that you will continue to work with me on reasonable approaches to your condition." But that doesn't seem to work very well because often the insight just goes right out the window.

DEPICTION SUGGESTION: Consider showing the importance of how a family can help or hinder a character's willingness to seek treatment and stay in treatment. For instance, you might show how a character seeks a proper mental health evaluation or treatment only after a family member or friend persistently encourages them to go.

CBS CARES: How do you accurately diagnose **bipolar disorder in children**, when they may not understand all the diagnostic questions and when fantasies, delusions and boundless energy are a natural part of being a child?

DR. OQUENDO: Well, I have to say that I would defer to a *child psychiatrist* on this. However, I think that one of the critical things, in terms of our being able to adequately treat patients is to *make sure that they meet criteria in terms of duration and symptoms clustered together*. So, one of the things that's happening, for example, is that at times children may be diagnosed without meeting the length of time required in a manic episode. If somebody has a manic episode that lasts more than four hours, they might be diagnosed as bipolar, whereas that is not typically the way the diagnosis is made. In terms of making a distinction between normal fantasy and delusions or the natural ebullience of childhood and pathologically increased energy, *one key is that if there is a manic episode going on, the symptoms will be an obvious change from the child's usual behavior*. Furthermore, children over the age of about 6 or 7 can distinguish between what is real and what is not.

CBS CARES: Does depression in teen years indicate a strong possibility of bipolar disorder later in life?

DR. OQUENDO: That's a really important question. In fact, *20% to 30% of all teens diagnosed with depression will go on to develop bipolar disorder*. So parents of these teens should be especially vigilant for later signs of bipolar disorder.

CBS CARES: Are the children of bipolar parents more likely to be bipolar?

DR. OQUENDO: *There does seem to be familial transmission of this disease, or inheritability of this disease*. It's interesting. So, studies of children and adolescents, who have parents who have bipolar disorder, show that psychiatric symptoms occur in anywhere between twenty-four and ninety-two percent of the kids. Most of the studies find that the range is between forty and sixty percent. And of that forty and sixty percent, about a third of them can be expected to develop bipolar disorder. So that leaves you with anywhere between say thirteen and twenty percent.

CBS CARES: What **signs** should parents look for in terms of a child with possible bipolar condition? Obviously the mood swings, but what specific day-to-day activities or behavior of a young child or adolescent provide warning signs for parents?

DR. OQUENDO: Well, I think that the most reliable thing to observe has to do with *sleep patterns*. **Sleep is sort of the lynch pin of mood stability**. We know that the less you sleep, the more euphoric or manic you become. If you've ever had to work late into the night and not get very much sleep, you may have noticed that even though you're tired, you might feel giddy or elevated the next day. And you can imagine what that does in someone who has a predisposition towards mania or hypo-mania. So sleeping regularly and sleeping a serious six to eight hours a night is absolutely critical for adults, and for children it would be more, of course.

DEPICTION SUGGESTION: People with family histories of bipolar disorder are at a greater risk of suffering from the illness. Consider showing how a parent's journey through a child's diagnosis and treatment actually might lead to questioning his or her own behavioral patterns—perhaps even discovering that he or she is bipolar.

CBS CARES: Would you say that **bipolar disorder**, as with depression, is usually **treatable through medication**?

DR. OQUENDO: *It's very treatable*.

CBS CARES: *And people with bipolar disorder on the medication are capable of leading happy and high quality lives?*

DR. OQUENDO: **Yes**.

CBS CARES: How can **alcohol or drug abuse interact with bipolar disorder** and your ability to treat it effectively?

DR. OQUENDO: That's a great question. *Alcohol and drug abuse are extremely common complications of bipolar disorder*. And it's not well understood whether people use these substances to try to regulate their mood or manage their mood, or if the use of substances somehow makes the emergence of bipolar disorder more likely. However, the presence of substance abuse, and especially alcohol abuse, *makes the treatment of bipolar disorder very, very difficult*.

In particular, just as an example, when people are using a lot of alcohol, it disrupts sleep architecture. And as I mentioned before, sleep architecture or preserved sleep is a lynch pin to mood stability. So, if in addition to being manic or hypo-manic or depressed, you're also disrupting sleep by using alcohol, *the ability to get the illness into a remission is going to be much more challenging*.

For more information on how alcohol and drug abuse and addiction might co-occur with mental disorders, [click here](#).

CBS CARES: Why is it so high, compared to depression alone? **Bipolar suicide rates** seem to compare with the mortality rate for many forms of cancer!

DR. OQUENDO: It's a very interesting question, and we're trying to understand it. It appears that at least one of the problems is the frequency with which patients with bipolar disorder become depressed. One of the things that's worth clarifying is that there's a lot of controversy about what the actual suicide rate is in bipolar disorder. So, you'll read anything between eight and nineteen percent.

The same is true for depression. You'll read anything between two percent and fifteen percent. And this depends on a variety of things. It depends on whether, for example, you're looking at mortality rates on people who are ill enough

to need hospitalization, because then you'll see the higher rates. If you're looking at milder forms of the illness, the rates may not be as high. *The suicidal behavior seems to correlate with the frequency of depressive episodes. Rapid cycling bipolar disorder appears to be especially associated with suicidal behavior.* And anywhere between thirty and fifty percent of all patients with bipolar disorder, living in the community, will acknowledge having tried to kill themselves at least once.

DEPICTION SUGGESTION: When four or more episodes of illness occur within a 12-month period, a person is said to have rapid-cycling bipolar disorder. Some people experience multiple episodes within a single week, or even within a single day. Rapid cycling is more common among women than among men (National Institute of Mental Health). You might consider showing a female character self-diagnosing with "depression," when in fact she is actually dealing with rapid cycling bipolar disorder.

CBS CARES: What is the **most common misperception about bipolar disorder** and can you please clarify it for readers of this interview?

DR. OQUENDO: I think the most common misperception is that the *most difficult part of dealing with a bipolar disorder has to do with manic or hypo-manic episodes.* Those are certainly extremely disruptive, but in general they tend to be less common, and we have much more effective treatments than for the depression. *The depression tends to be more difficult to treat, and is associated with terrible morbidity and of course mortality from suicide.*

CBS CARES: What is the most important piece of advice you can give to someone who suffers from bipolar disorder and to their loved ones?

DR. OQUENDO: I would say that *aiming for mood stability at all costs.* For example, *sticking with the treatment and working with the doctor to find a medication or a combination of medications that works and is tolerable is absolutely key.* Early identification of emerging symptoms also can prevent worsening.

FOR THE FULL LENGTH INTERVIEW AT CBSCARES.COM, [CLICK HERE.](#)

Bipolar disorder is treatable, and recovery is possible.
- National Mental Health Association

For more expert consultation on bipolar disorder: [First Draft Service](#)

For more information on bipolar disorder: www.isitreallydepression.com



If you do not wish to receive further depiction tip sheets, please email jkim@eiconline.org, with "remove tip sheet list" in the subject of your email.