On Being and Bipolar Disorder: Addressing existential concerns in newly diagnosed clients

“There is but one truly serious philosophical problem, and that is suicide. Judging whether life is or is not worth living amounts to answering the fundamental question of philosophy. All the rest—whether or not the world has three dimensions, whether the mind has nine or twelve categories—comes afterwards.”

-Albert Camus

If we agree with Albert Camus’s claim that suicide is the single most important philosophical question, then it becomes of concern to study bipolar disorder. I say this because of the global prevalence of Bipolar disorder 0.3-1.2% (Ritchie & Roser, 2018) and the alarming suicide rate in the population experiencing this illness. A person diagnosed with Bipolar disorder is 5.7 times more vulnerable to death by suicide as compared to the general population (Ritchie & Roser, 2018). If we see this not as a statistic but as 46 million individuals along with their families and friends, impacted by a debilitating mental health experience (Ritchie & Roser, 2018), we attribute a new meaning to the global burden of the disease—not just an economic loss, but distress experienced by an incomprehensible number of people.

Bipolar disorder is genetically and biologically determined and developed. It is characterized by alternating periods of euthymia with episodes of depression and mania. But most often the disorder lies not in clearly demarcated states or categories, but in mixed states (Kemner et al., 2015) and can impact anyone. However, those with a family history of Bipolar disorder have the highest chance of developing the disorder, and stressful life events are also predictors of recurrent episodes (Kemner et al., 2015). The prevalence rate is higher in women (52.3%) than in men (27.7%) and highest in those aged 20-24 years (0.8%) (Ritchie & Roser, 2018). The most

common treatment is long-term medication usage (Proudfoot et al., 2009), in conjunction with psychotherapy, however with heavy reliance on the former.

The need to study manic-depressive illness rises from a personal quest to better understand this illness in young women. They are more likely to receive a delayed diagnosis, which further delays treatment (Arnold, 2003). Young adults go through a series of psychological and physical transitions and have a higher propensity to develop poor psychological functioning owing to developmental stressors. These include but are not limited to autonomy and decision making related to career, sex-role identity, and economic, social and intimate relationship roles (Deshpande, 2019). While already encumbered by the tribulations of building an identity like the rest of the population, this demographic experiences the additional challenge of having a mental illness that is known to drastically impact their social relationships, employment, health, etc. This is exacerbated by the fact that cognitive impairment seems to be correlated to a worse clinical course and poor functional outcome, leading to weariness, interpersonal difficulties, unemployment and poor academic achievements (Goldner-Vukov et al., 2007). In addition to this, they also have to deal with the alienation that the stigma of experiencing mental illness and encounter side-effects in the process of finding a suitable medication combination (Proudfoot et al., 2009). Further, given the newly acquired label of the illness, the questions of identity, especially finding the distinction between their manic or depressed states from their ‘self’, becomes a salient struggle (Ghaemi, 2013).

Bipolar disorder is genetically and biologically caused, and impacts one’s experience of life. However, since existential psychotherapy firmly attempts to avoid diagnosis, I will not conceptualize the etiology of the illness, but the subjective experience of its early manifestation from a phenomenological point of view. If diagnosis a selective, but representative, way of operationalizing distress, and a mental illness as pervading into one’s existence, I posit that

existential psychotherapy with its givens (death, isolation, freedom and meaninglessness) becomes pertinent in understanding one's experience of a diagnosis.

This paper addresses clients' perception of having newly received a diagnosis for Bipolar disorder, and their experience of the disorder and the diagnosis from an existential perspective. The differences in the efficacy of psychotherapy and antidepressant medication are insignificant and the two modes of treatment work best in conjunction with one another (Cuijpers et al., 2013). Given this, the paper finally addresses treatment and advocates for existential group therapy with elements of narrative therapy. Existential psychotherapy works on the principle that all individuals struggle with four major ultimate concerns in life. According to Tillich (Moore & Goldner-Vukov, 2009), human beings:

“1) are centred in themselves, 2) strive to preserve and affirm their true being, 3) need and the choice of extending themselves to others, 4) have the capacity for self-awareness, 5) can know themselves as subjects who have a world and 6) have an ontological foundation for consciousness based on freedom”

Human beings therefore unconsciously or consciously avoid thinking about their inevitable mortality and strive to live as authentically as possible. This is done by attempting to find and create meaning, harness their creative life force, take responsibility for their free will to act and make a decision, and finally, to realize that while they are alone in the world, they need to meaningfully connect with those around them while accepting the aloneness.

As conceptualized by Jaspers, existence is characterized by the awareness of the knowledge that one exists, which he terms as a 'limit situation.' He proposes that the mental illness is a 'limit situation' which makes those who are mentally ill acutely aware of the givens of existence, exacerbating the distress (Fuchs, 2013). This then makes them vulnerable to an inauthentic

experience. While patients report social, financial and interpersonal outcomes, a significant number also experience positive spirituality, creativity, empathy, realism, sensitivity, alertness, productivity, and positive sexuality (Galvez et al., 2011). I report this because existential psychotherapy is a salutogenic approach, and despite having a propensity to a more intense existential struggle, they also by virtue of their disorder have the tools to experience 'limit situations' affirmatively. The etiology section expands on what this means for people diagnosed with Bipolar disorder.

As my professor from my undergraduate abnormal psychology class would say, "Nature does not read the DSM." This stands out to me because there seems to be a gap between what the diagnostic features are and what clients experience. Diagnosis can be liberating or discouraging, but despite similar biological origins and marking features of the disorder, each person experiences it differently. This subjective experience is the focus of existential psychotherapy. The duality of experience across the spectrum and the resulting challenges in euthymic phases results in painful losses for individuals resulting in despair. This suffering expands beyond the mundane plane to the existential plane where duality of the experience and the challenges merge. Experiences are magnified with a specific intensity and complexity that neurotypical clients may not experience given that the illness, often lasting a lifetime is entwined with life (Rusner et al., 2009). Clients report a certain sense of unpredictability in their rhythm of life, and it is characterized not by polarity but by an intense and complex experience of both mania and depression. It is then no wonder that the disorder becomes a part of one's identity and the self is often difficult to discern from the illness. Existential despair is characterized by hopelessness and a loss of meaning, and manifests itself as low self-esteem, and identity issues (Ghaemi, 2007).

Identities that are based on emotional disorder labels tend to induce confusion (Howard, 2008), when it comes to connectedness and meaning making, especially when it comes to ambivalence about one's ability to satisfactorily follow through with commitments. Authenticity becomes of concern as one is uncertain as to which the real self is—the manic or despairing self—is it the person's personality or simply a function of one's age. As we can see in Kay Jamison's (1995) seminal work, *An Unquiet Mind*, she asks

“Which of my feelings are real? Which of the mes is me? The wild, impulsive, chaotic, energetic, and crazy one? Or the shy, withdrawn, desperate, suicidal, doomed, and tired one? Probably a bit of both, hopefully, much that is neither.”

There is difficulty separating the illness from the self and there is increased anxiety, hopelessness, identity confusion and the fear of living an inauthentic life marked by intense and complex despair.

Existential therapists reject pathology and diagnosis, and meet clients for their problem rather than the diagnosis itself, though without discarding it (Havens & Ghaemi, 2005). Treatment in existential psychotherapy is marked by unconditional positive regard where the therapist brings their whole self to meet the client's whole self to form a successful alliance, a real relationship meant to lead to healing. It is essential to maintain that both are equals and that there is no hierarchy or power imbalance in the relationship, as is the case in most medical provider patient relationships. If clients fail to accept their diagnosis, this leads to poorer healing outcomes for them (Proudfoot et al., 2009). One then must accept the client for all their states and deny neither the mania, the depression, nor the client's subjective experiences.

Apart from ensuring medication adherence, preventing relapse, establishing rhythm and providing psychoeducation, the goal is to help clients reshape their perspective of their experience (Havens & Ghaemi, 2005) and to create and sustain hope! An existential therapist accepts their

patient and helps them construct a valid portrayal of the givens of existence and take life forward from there (Ghaemi, 2007). It is important to pay attention to the client's personal triggers and narratives about themselves and their experience of the disorder and what it means for them 'to be bipolar' (I contend that one is not their disorder, but rather, suffers from it), how they understand mental illness and experience Bipolar disorder as themselves.

The paper advocates for group existential therapy for newly diagnosed individuals. The reason being that the group serves as a means to combat stigma and the intense isolation that a diagnosis can bring with it. I propose a closed support group for 8 to 10 members that meets fortnightly for a year. A licensed therapist or clinical social worker and a seasoned individual with Bipolar disorder who has been managing their disorder for a few years will co-facilitate the group. The facilitators will recruit the participants by reaching out to clinics, hospitals and private practitioners who are to recommend suitable young adults who will voluntarily choose to participate for two hours, twice a month. Research affirms the effectiveness of such groups, especially in relapse prevention. When members address their ultimate concerns apart from their everyday problems, coping mechanisms and interpersonal relationships, personal change and growth are ultimately facilitated (Goldner-Vukov, et al., 2007).

Secondly, existential therapy does not rely on specific techniques but rather a way of moulding and giving direction to the therapeutic journey. However, given that the focus is on phenomenological concerns, narrative therapy techniques will be utilized in the spirit of constructivism—to help the group reauthor their narratives and gain control over them. The rationale for doing this is that both focus on the meaning making, address psychological dysfunction and despair, and focus on one's relationship to the self and others (Richert, 2002). The group will begin by individuals sharing their anxieties and concerns and end with psychoeducation in each

session. To orient the group to existential themes, the facilitators will explicitly discuss the givens as they arise in the clients' content. Another focus will be to emphasize that clients are not alone in their experience without diminishing their unique, individual trysts with the four givens of therapy. As interaction and trust increases, the hope is that self-knowledge increases, and leads to acting on choices, and taking responsibility for them with support from the group. Facilitators will encourage members to share their experiences, perceptions of their illness, and the group together will try to reframe their narratives for each of them.

Psychiatric problems such as Bipolar disorder are but a reflection of existential issues beyond one's choosing (Moore & Goldner-Vukov, 2009). The experience can be isolating and can lead to struggles in making meaning, lead to close brushes with death, and anxiety about life which can manifest as mania or depression. Clients struggle with establishing one's identity with an illness, leading to ambivalence as one tries to decide authentic courses of life. It is unequivocally essential that mental health care providers need to understand Bipolar disorder from a more holistic perspective beyond what the DSM has to offer, and to shift focus to client experience and their inner tensions and processes (Rusner et al., 2009). To provide better therapy for clients with Bipolar Disorder, clinicians need to shift focus from symptom reduction to truly understanding and addressing what a being with Bipolar disorder is like for individuals.

References

- Arnold, L. M. (2003). Gender differences in bipolar disorder. *Psychiatric Clinics of North America*, 26(3), 595–620. [https://doi.org/10.1016/s0193-953x\(03\)00036-4](https://doi.org/10.1016/s0193-953x(03)00036-4)
- Cuijpers, P., Sijbrandij, M., Koole, S. L., Andersson, G., Beekman, A. T., & Reynolds, C. F. (2013). The efficacy of psychotherapy and pharmacotherapy in treating depressive and anxiety disorders: a meta-analysis of direct comparisons. *World Psychiatry*, 12(2), 137–148. <https://doi.org/10.1002/wps.20038>
- Deshpande, A. (2019). *Relationships and Resilience in Young adults from Fragmented and Discordant Households in India*. <https://doi.org/10.31234/osf.io/ey3w8>
- Darian Leader. (2013). *Strictly bipolar*. Penguin Books Ltd.
- Fuchs, T. (2013). Existential Vulnerability: Toward a Psychopathology of Limit Situations. *Psychopathology*, 46(5), 301–308. <https://doi.org/10.1159/000351838>
- Galvez, J. F., Thommi, S., & Ghaemi, S. N. (2011). Positive aspects of mental illness: A review in bipolar disorder. *Journal of Affective Disorders*, 128(3), 185–190. <https://doi.org/10.1016/j.jad.2010.03.017>
- Ghaemi, N. (2013). What is Me? What is Bipolar. *Philosophy, Psychiatry, & Psychology*, 20(1). Project Muse. <https://muse.jhu.edu/article/511271>
- Ghaemi, S. N. (2006). Feeling and Time: The Phenomenology of Mood Disorders, Depressive Realism, and Existential Psychotherapy. *Schizophrenia Bulletin*, 33(1), 122–130. <https://doi.org/10.1093/schbul/sbl061>
- Gitlin, M., & Malhi, G. S. (2020). The existential crisis of bipolar II disorder. *International Journal of Bipolar Disorders*, 8(1). <https://doi.org/10.1186/s40345-019-0175-7>

- Goldner-Vukov, M., Moore, L.-J., & Cupina, D. (2007). Bipolar Disorder: From Psychoeducational to Existential Group Therapy. *Australasian Psychiatry*, 15(1), 30–34.
<https://doi.org/10.1080/10398560601083100>
- Goodwin, F. K., Jamison, K. R., & S Nassir Ghaemi. (2007). *Manic-depressive illness : bipolar disorders and recurrent depression*. Oxford University Press.
- Havens, L. L., & Ghaemi, S. N. (2007). Existential Despair and Bipolar Disorder: The Therapeutic Alliance as a Mood Stabilizer. *FOCUS*, 5(1), 111–116.
<https://doi.org/10.1176/foc.5.1.111>
- Howard, J. (2008). Negotiating an Exit: Existential, Interactional, and Cultural Obstacles to Disorder Disidentification. *Social Psychology Quarterly*, 71(2), 177–192.
<https://doi.org/10.1177/019027250807100206>
- Jamison, K. R. (1995). *An unquiet mind : a memoir of moods and madness*. Picador.
- Kemner, S. M., Mesman, E., Nolen, W. A., Eijckmans, M. J. C., & Hillegers, M. H. J. (2015). The role of life events and psychological factors in the onset of first and recurrent mood episodes in bipolar offspring: results from the Dutch Bipolar Offspring Study. *Psychological Medicine*, 45(12), 2571–2581.
<https://doi.org/10.1017/s0033291715000495>
- Lanzoni, S. (2005). The enigma of subjectivity: Ludwig Binswanger's existential anthropology of mania. *History of the Human Sciences*, 18(2), 23–41.
<https://doi.org/10.1177/0952695105054180>
- Moore, L. J., & Goldner-Vukov, M. (2009). The Existential Way to Recovery. *Psychiatria Danubina*, 21(4), 453–462.

Richert, A. J. (2002). The self-narrative therapy: Thoughts from a humanistic/existential perspective. *Journal of Psychotherapy Integration*, 12(1), 77–104.

<https://doi.org/10.1037/1053-0479.12.1.77>

Ritchie, H., & Roser, M. (2018). *Mental Health*. Our World in Data.

<https://ourworldindata.org/mental-health#bipolar-disorder>

Rusner, M., Carlsson, G., Brunt, D., & Nyström, M. (2009). Extra dimensions in all aspects of life—the meaning of life with bipolar disorder. *International Journal of Qualitative Studies on Health and Well-Being*, 4(3), 159–169.

<https://doi.org/10.1080/17482620902864194>