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Bipolar Affective Disorder: Socio-Psychiatric And Clinical Phenomenology In The Post-Truth Period

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Abstract: *This study examines the clinical-phenomenological and socio-psychiatric features of bipolar affective disorder (BD) in the post-truth period. The aim is to describe the clinical picture of BD while accounting for diagnostic contradictions, comorbidity, and patients' narrative identity. Materials and methods: 1,397 outpatient visits to a private psychiatric center were analyzed (male:female 1:3; age 18–55; BD:monopolar depressive and anxiety disorders 1:3); MDQ, HCL-33, and psychiatric interview were used. Results: the study identified hereditary loading with emotional instability, changes in adolescence, antidepressant inefficacy, addictive realizations, ADHD symptoms, and instability of the "self"; socio-psychiatric features include assortative mating and stigmatizing labels. Mixed states, ego-dystonic mania/hypomania, and diagnosis acceptance as a pathway to recovery are discussed. Conclusion: the clinical picture of BD in the post-truth era requires a combination of evidence-based diagnosis, longitudinal assessment, and destigmatizing psychotherapeutic work with identity and informational influences.*

Keywords: *bipolar affective disorder; mixed states; identity; post-truth; diagnosis acceptance*

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I. INTRODUCTION

The bipolar spectrum includes not only classic bipolar disorder (BD) types I and II. It also encompasses cyclothymia, "double depression" (a depressive episode superimposed on dysthymia), other specified and unspecified bipolar disorders, and mood disorders with bipolar features for which the evidence may be incomplete in chronic cyclothymic mood disorder. The healthy pole of the spectrum comprises personality traits with signs of emotional instability and cyclothymic temperament, where these do not cause any problems for the patient or those around them.

Diagnosis of BD relies on ICD-11 criteria (6A60–6A62) and DSM-5-TR, as well as clinical assessment of the longitudinal course: it is the dynamics of phases, rather than a single episode, that distinguishes BD from recurrent depression.

We, for our part, identify the following contradictions surrounding BD, which this work aims to address. According to our arguments and preliminary data, this diagnosis is made predominantly by exclusion in favour of depressive-neurotic and personality disorders, although the neurotic spectrum should imply a "negative" diagnosis; as a result, patients receive ineffective antidepressant treatment for long periods.

A large systematic review and meta-analysis (114 studies) (Léda-Rêgo, G., et al., 2024) showed that the lifetime prevalence of at least one psychiatric comorbidity in BD was 38.91%. The most common were anxiety disorders (40.4%), substance use disorders (30.7%), ADHD (18.6%), and impulse control disorders (15%) (Léda-Rêgo, G., et al., 2024). A biobank-based study (n = 53,386) showed that a diagnosis of BD was associated with increased rates of psychiatric conditions, injuries and poisonings, endocrine-metabolic and neurological disorders, viral hepatitis C, and asthma (Sanchez-Ruiz, J. A., et al., 2024). At the same time, genetic risk for BD was associated only with psychiatric comorbidities but not with general medical conditions, indicating a key role of environmental factors (Sanchez-Ruiz, J. A., et al., 2024).

Comparison of patients from an outpatient clinic with cohort study participants and the general population revealed important differences. In particular, in one cohort, comorbidity rates for alcohol and anxiety disorders were significantly lower than in the real outpatient sample, whereas in the population study they were higher. This highlights the risk of selection bias when extrapolating research data to routine practice (Renes, J. W., et al., 2025). Among 1,897 outpatients with BD, 48.9% reported pain (Chabert, J., et al., 2025). Higher pain levels were associated exclusively with a history of alcohol use disorder (AUD). This association was partly mediated by current levels of depression, anxiety, and affective lability (Chabert, J., et al., 2025).

II. EXPERIMENTAL PROCEDURE: OBJECTIVE-PSYCHIC MECHANISMS OF BD

2.1. Exploratory review: general psychopathology of BD.

We consider it meaningful to review the general psychopathology of BD as the fundamental clinical phenomenology of this disorder. Classical affective syndromes are described through "triads." Their description goes back to the works of the German psychiatrist Emil Kraepelin (Kraepelin, 2004) and Russian psychopathologists (Nuller, Mikhalenko, 1988; Zhmurov, 2010). The depressive triad: lowered mood (affect of anguish), psychic (ideational) retardation: slowed thinking, difficulties with concentration, "depressive monoideism" as fixation on negative thoughts, motor retardation: slowed movements, poverty of facial expression, up to depressive stupor. The manic triad: hyperthymia: pathologically elevated, euphoric mood, ideational acceleration (tachyphrenia): accelerated rate of thinking, "flight of ideas," hyperbulia: increased drive for activity, heightened motor activity. Mixed states: the most complex and dangerous in BD, when symptoms of depression and mania coexist simultaneously. They were first described by E. Kraepelin (Kraepelin, 2004), and they may manifest in various combinations.

Depressive or anxious mania: dysphoric (irritable) affect, disordered thinking, increased activity. As a rule, this is a case where anxiety becomes not merely a background but part of the manic pole. Agitated depression: sad, anguished affect, but with pressure of speech and verbigeration, and increased activity, when retardation from the depressive triad paradoxically combines with manic acceleration. Depression with "flight of ideas": anguished affect, accelerated thinking, reduced activity, when ideational acceleration from the manic triad is superimposed on anguished affect (usually experienced as vividly felt obsessions in the depressive plot). Manic stupor: cheerful, euphoric affect, retarded thinking, sharply reduced activity up to stupor (the opposite combination: hyperthymia present against the background of motor retardation from the depressive triad). Dysphoric mania is also distinguished, when irritability and anger are combined with elevated mood. Mixed states often run more severely than "pure" phases and are associated with a high risk of suicidal thoughts.

2.2. Neurotransmitters and neuroimmunology in BD

From the standpoint of neuroimmunology, manic, hypomanic, and mixed phases of bipolar disorder are characterized by combined hyperactivity of the catecholamine system (dopamine, norepinephrine) and activation of innate immunity with elevated IL-6, TNF-α, IL-18, and CRP. According to Brunoni et al. (2020), bipolar depression differs from unipolar depression by higher levels of IL-6, sTNFR2, IL-18, and IL-33, whereas in unipolar depression TNF-α, IL-1β, and IL-12 predominate. Poletti et al. (2024) emphasize that elevated IL-6 and TNF-α are common to affective disorders, but in bipolar disorder chemokines and markers of innate immunity are involved to a greater extent. Munkholm et al. (2013) in a meta-analysis confirmed elevation of TNF-α, sTNFR1, sIL-2R, and IL-4 in bipolar disorder compared with healthy controls. Proinflammatory cytokines, as Rosenblat et al. (2018) indicate, reduce the activity of tetrahydrobiopterin (BH4) — a cofactor for the synthesis of dopamine, norepinephrine, and serotonin — which aggravates neurotransmitter imbalance. Clinically, this means that in bipolar depression antidepressants may be ineffective and dangerous in terms of phase inversion, and therapeutic strategies aimed at modulating IL-6 and microglia are theoretically more relevant for the bipolar spectrum than for unipolar depression. In minor (subclinical) depression, the proinflammatory profile is milder: baseline levels of IL-6 and TNF-α may not correlate with symptoms, whereas the functional response of monocytes to lipopolysaccharide shows stronger associations, which is important to consider in differential diagnosis.

2.3 Empirical data

A total of 1,397 cases of visits to a private outpatient center licensed for psychiatry and psychotherapy were analyzed. The male-to-female ratio was 1:3. Age ranged from 18 to 55 years. The ratio of patients with monopolar depressive and anxiety-spectrum disorders to patients with bipolar-spectrum disorders was 1:3. Patients gave informed voluntary consent; the necessary data were coded before being obtained by the researcher.

Each patient necessarily underwent experimental psychological testing using MDQ, HCL-33, and a psychiatric interview. In a quarter of cases, the patient was referred by a clinical psychologist who had conducted a screening examination for severe mental pathology.

III. RESULTS AND DISCUSSIONS

3.1. Results of psychiatric observation: clinical features in BD

On the basis of empirical data, we identify particular semiological phenomena that are noticeable in the narratives of patients with BD and to which we further draw attention:

1) heredity: the patients' parents had signs of emotional instability and/or abuse of substances or actions;

2) changes since adolescence: the patient admits and realizes that he or she noticeably changed in mental life during this period;

3) inefficacy of antidepressants: SSRIs (and SNRIs) did not help with symptoms of anxiety (panic attacks, persistent "pervasive" generalized anxiety, fears, unpleasant ideas that are difficult to get rid of), depression, or changed their course, based on the history before treatment and during treatment in empirical cases;

4) abuse: not all patients with BD have addictions and dependencies, but in all patients with addictions and dependencies we detected BD;

5) ADHD symptoms: observed from an early age in all patients with BD;

6) instability of the "self": patients could admit that their identity (the self) is unstable or was so for some time.

The question of diagnosis acceptance, however, is contradictory: positive acceptance was found both when benefit from such a diagnosis was admitted and gradually, after denial, but we also found stable narratives of non-acceptance expressed by verbal disagreement.

3.2. Socio-psychiatric givens of patients with BD

People with BD phenomenally attract people with a similar disorder (Kolosov, 2026). Data on the patients' parents may serve as an example: during the appointment, the subject evaluates parental behavior from the outside, when the mother and father could have lived with this disorder without knowing about it, while the child already suspected it.

It is difficult to call this a coincidence. The phenomenon of assortative mating is distinguished as a tendency to choose partners with a similar phenotype. The meta-analysis by Mathews & Reus (2001) confirmed that assortative mating occurs in both bipolar disorder and major depression, with the degree of assortativeness being higher specifically in BD than in major depression. A national cohort study (Hsieh et al., 2022) showed that BD is the second most frequent disorder among married couples after substance use disorders. This, in turn, clearly reflects the generally recognized anthropobiological tendency that humanity in general is inclined toward assortative marriages. It is important to remember that when both partners are on active treatment, this significantly improves the mental health of both.

Our observations also show that in the mental-health community, people with BD may be called "barsiks." We believe this can significantly reduce stigma. Playful self-names — "bipolars," "barsiks" — are recorded in the neologistic lexicon of Russian precisely as neutral and humorous alternatives to the clinical label. In the "Bipolar Family" community, "barsik" is not a diagnosis but a way of saying "one of us," a marker of belonging to those in the know..

3.3. Conclusion

The clinical-semiological phenomenon of adolescence that we discovered, when the patient admits and realizes that he or she noticeably changed in mental life during this period, is open to considerable doubt as a nosological phenomenon. Such changes, when the client expresses awareness on this issue, may be a psychological manifestation of growing up as-is (Dasein) of the normal spectrum of crisis experiences, in particular age-related crises, and we did not conduct a comparison specifically with psychological studies unrelated to pathology on conscious changes of adolescence.

Regarding the question of accepting the BD diagnosis in the subject's mental life, the difficulty and even torment of this acceptance is beyond doubt. For historical reasons, BD was long called "manic-depressive psychosis," and this label left a deep trace in cultural memory. In these cases, we used and recommended the rational psychotherapeutic principle of reframing: "not 'to reconcile oneself with the illness,' but [to accept the disorder] to admit that the disorder exists and that the main thing is that it is treatable, especially against the background of improvement from psychopharmacotherapy."

Studies show that acceptance of the BD diagnosis is not a one-time act but a process that patients describe as a "path to recovery." In the qualitative study by Pereira et al. (2024), participants directly say: acceptance of the diagnosis and the search for meaning in life are essential to their recovery. Another study (Mizock et al., 2020) emphasizes the significance of the "client–clinician" relationship in forming hope and accepting the diagnosis. Meta-analyses confirm that lithium, lamotrigine, valproate, and olanzapine reliably reduce the risk of relapse of any affective episode compared with placebo (Smith et al., 2007). The network meta-analysis by Kishi et al. (2021) confirms these data at the level of 56 RCTs.

The core of suffering in BD, as our previous clinical analysis showed, is the ego-dystonicity of experiences in the manic or hypomanic phase — the experience of pathologically elevated mood as alien, "not one's own." This experience of shame, alienation, loss of control, and identity rupture ("it was not me," "as if I had been replaced") is the key suffering in BD and is often described by patients. Clinical examples may include admissions of intentional substance abuse "for oneself" during an elevated state in addiction-like presentations of BD, assumptions of meaning that "that one" is "as if I had been replaced," and admissions of the "uselessness" of purchases recognized as impulsively bought; these denials are usually accompanied by

dysthymic mood and attitude toward these actions. Two components can be noted here: first, having arisen from the inner world, the urge to use will be recognized only later through self-reflection and/or psychotherapy; second, being an impulsive phenomenon, it is accompanied by a narrowing of consciousness. This also explains the dysthymic reaction to others' accusations in the context of "you are bad" toward a bipolar user with addictive realization (Kolosov, 2025).

Identity in BD, as M. L. Ironside and co-authors showed, is the self, and since the self is goals and aspirations toward these goals, bipolar identity will consist of ambitious goals, recognition from others, and dependence of self-esteem on measurable success, and people with BD have to reconcile themselves with significant internal variability in forming the self-concept. A. M. Pedersen and co-authors (2024) established that people with BD rated their past chapters of life as more negative and less positive, and their chapters contained fewer themes related to agency and communication, compared with people with type 1 diabetes mellitus and the control group; differences regarding future chapters were smaller, but BD was associated with a lower level of self-rated positive emotional tone and connections with self-stability. M. N. Ponticiello and co-authors (2025), studying the "labeling" of BD for patients themselves, identified three dialectical vectors: "benefit or burden" as significance over time, "self or others" as an internal or external locus of BD perception, and "from inexpressibility to finding meaning" as the process of labeling, understanding, and incorporating BD into life as a whole. J. E. Siegel-Ramsay and co-authors (2023) identified three groups of problems: capability-related (difficulties maintaining identity, interruptions in full employment, loss of close relationships, unpredictability of the disorder), comfort-related (personal perception of the diagnosis, social stigmatization, medication problems), and peace-of-mind-related (working with doctors who do not give due attention, finding a suitable psychotherapist, overcoming financial difficulties). J. Jupille and co-authors (2023) identified specific determinants of well-being: formation of a positive identity through acceptance of the diagnosis, and the importance of self-awareness and self-control. S. Arase (2024) finds philosophical concepts of identity quite close to medical ones and asserts that an interdisciplinary approach to the study of BD and identity may lead to the development of therapeutic methods through addressing official and private concepts of identity.

3.4 Study limitations

We recognize that our study has substantial limitations: our sample is based on the outpatient practice of a single clinic, and no comparison with other treatment facilities was performed, nor was any comparison made between outpatient and inpatient diagnostic groups. These data may indicate incomplete reliability and finality of our statistical data, and for this reason our study data contained a substantial amount of qualitative methodology. Our conclusions point toward certain directions rather than constituting directive true givens.

IV. CONCLUSION

The analysis shows that the clinical picture of bipolar affective disorder (BD) in the post-truth period cannot be reduced to classical affective "triads." Contemporary diagnosis must hold together evidence-based psychopathology (ICD-11/DSM-5-TR, longitudinal course, mixed states, comorbidity, neuroimmune markers) and the patient's social-narrative reality (stigmatizing labels, self-diagnosis, contradictory information, microsocial myths). In the empirical sample of 1,397 outpatient cases, the difficulty of timely verification is confirmed: BD is often masked by depressive-neurotic and personality disorders, leading to ineffective antidepressant monotherapy and phase inversion risk. The clinical core includes ego-dystonic mania/hypomania, identity instability, mixed states with high suicide risk, and addictive/pain comorbidities. Post-truth intensifies these phenomena: patients bring ready-made explanatory models, self-labels, and contradictory narratives, so clinicians need not only MDQ/HCL-33 and psychiatric interview but also critical dialogue, psychoeducation, and destigmatization. Diagnosis acceptance is a process rather than a one-time act; it is linked to hope, restored agency, and treatment adherence. Conclusion: modern BD clinic requires an integrative model — phenomenological, socio-psychiatric, and evidence-based — combining mood treatment with work on identity, comorbidity, and the information environment..

Conflict of interest

There is no conflict to disclose.

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