Word Count (excluding references and notes): 3,929

**Abstract**

In this paper, I examine the connections between bipolar disorder and consent. I defend the view that many (although far from all) individuals with bipolar disorder are competent to consent to a wide variety of things when they are in a manic state.

**Key Words**

Consent; Bipolar Disorder; Competence

**Bipolar Disorder and Competence**

Josh is a typical 27-year-old in a career that he enjoys and a successful marriage.[[1]](#footnote-1) Josh begins to exhibit the symptoms of a manic episode. He is soon diagnosed with bipolar disorder. While non-manic, Josh’s preferences are typical. While manic, his preferences change dramatically. He quits his job, cheats on his partner, and squanders his savings. These are behaviors that Josh, when non-manic (euthymic), would never agree to. When Josh returns to a euthymic state, he regrets these decisions. Should those close to Josh have prevented him from making these decisions, or does his competence to decide persist despite his acute mania?[[2]](#footnote-2) In this paper, I examine the connections between bipolar disorder and consent. I defend the view that many (although far from all) individuals with bipolar disorder are competent to consent to a wide variety of things when they are in a manic state. This means that mania should not be presumed to undermine competence in clinical settings.

I have several goals in this paper. I want to bring philosophy to bear on the connection between consent and bipolar disorder. Additionally, I intend this paper to contribute to the general debate about the conditions of informed consent. Bipolar disorder presents novel challenges to existing conceptions of competence to consent which require stable core of values for an agent to be competent. For example, Buchanan and Brock endorse such a view [1]. In showing that shifting values do not undermine the competence of a person experiencing acute mania ], I show that the aforementioned views of competence are false. Overall, this paper makes substantive contributions to the debate about competence to consent and presents the first sustained philosophical treatment of consent among people with bipolar disorder.[[3]](#footnote-3)

In section I, I discuss the background of bipolar disorder. In section II, I argue that many manic individuals are competent to consent. In section III, I consider objections.

**I. The Background of Bipolar Disorder:**

For the purposes of this paper, I am focusing on Bipolar I, Bipolar II, and Cyclothymic Disorder. Although there are differences between all three, they are all characterized by “unusual shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks” [2]. Individuals with bipolar disorder experience extreme fluctuations of mood, going between states of mania and/or hypomania, major depression (or more mild depression for cyclothymia), mixed mood states, and remission (also called euthymia). The length and severity of these periods depends on the type of bipolar disorder. As Misra et al. say, “the disorder is characterized by recurrent episodes of mania or major depression with variable lengths of remission” [3]. While in a manic state, individuals with bipolar disorder “have an elevated, expansive, or irritable mood that is distinctly different than their usual mood,” and this mood “may lead to grandiose self-concept, inflated self-esteem, and unrealistic confidence and optimism, all resulting in a sense of personal invulnerability” [3].While manic, people with bipolar disorder “often pursue impulsive, imprudent, pleasurable, and dangerous activities that they may later regret,” including “unwise business ventures, unlawful conduct, exorbitant purchases, and promiscuous sexual encounters” [3]. Furthermore, “individuals with mania experience an alteration in their usual balancing of risks and benefits,” which prompts the “concern that individuals experiencing a manic episode may substantially depart from their characteristic assessment of risk and benefits and potentially choose to participate in yet another activity…that they will later regret” [3]. Although the duration of cycles can vary, Hindley et al. note “a median of 1 episode every 2.5 and 3 years for BP I and II patients respectively” [4]. Risk of recurring incidents remains constant throughout one’s life [5]. Even with treatment, the chance of relapse is fairly high.[[4]](#footnote-4)

Because my argument is pitched at the level of an individual who is experiencing mania at a level strong enough for their behavior to be self-destructive, if I’m successful in arguing that individuals with symptoms this strong can give valid consent, then I have also shown that individuals with more mild symptoms can give valid consent. This means that my argument would apply to hypomania and other cases of less severe impairment.

**II. Why Some Manic Individuals Are Competent to Consent**

I argue that many, although far from all, manic individuals are competent to consent to a wide variety of things. Because the common-sense burden of proof is on the side of paternalistic intervention, not on the side of autonomy, I defend this conclusion by arguing against what I take to be the best reasons to regard Josh (henceforth J) as incompetent. I am working from a generally (but not universally) agreed upon view in bioethics that anti-paternalism is the default, common-sense view. Settling the debate between paternalism and anti-paternalism is too large for this paper to resolve, so I assume anti-paternalism.

A compelling reason to think that J is incompetent when manic comes from the fact that bipolar disorder causes cognitive impairments for manic individuals. Often, people who are manic are not as good at reasoning as people who are euthymic. It’s not just that their values shift; it’s also that they become impulsive and irrational. The objector might argue that manic individuals are sufficiently irrational to render them incompetent.

It is clear that manic individuals are less rational. As Robinson et al. say, “a consensus is emerging that patients with bipolar disorder show cognitive deficits both during the acute phase of illness and during remission” [6]. The question is whether the cognitive impairment present in manic individuals is sufficient to make them incompetent. Clearly, not all impairments make one incompetent. Unfortunately, as Misra et al. say, “until recently [writing in 2010] there has been a paucity of information about the decisional capacity of individuals with bipolar mania” [3]. And, in the literature that does exist, there is disagreement. I believe that there is sufficient evidence to regard many manic individuals as competent.

The likely explanation for the paucity of empirical evidence is that studying people undergoing acute mania is difficult. Acutely manic people are unlikely to seek out research trials to participate in. Unfortunately, most of the empirical evidence available is on patients who are hospitalized while in acute mania. So, there is reason to think that the existing data is strongly skewed in one direction, because the only people studied are those whose manic episode was sufficient to require hospital care.

The impairments in mania include: diminished ability to engage in cost-benefit analysis [7], “inattention,” “distractibility,” “compromised ability to process and retain pertinent information about the activities in which she or he is involved,” “deficits on measures of insight, memory and executive function, including the ability to plan, organize, sequence tasks, and think abstractly” [3]. Additionally, manic individuals often lack insight and appreciation of their conditions; as Misra et al. says, manic individuals “at times even deny that they are mentally ill” [3]. As one patient says, “when you’re under [mania] you don’t know the difference…because everything seems so real you think that you are well and that everybody else is making a wrong diagnosis” [8].

In a study that included 36 manic patients currently in psychiatric wards, researchers administered a modified version of the MacArthur Competence exam (which is considered the gold-standard of competence exams), finding that of the 36 patients, 97% (with a confidence interval of 86-100) were not competent [9]. An additional study that included 23 manic individuals and which also administered the MacArthur exam found that 22 of 23 patients were deemed to lack capacity [10].[[5]](#footnote-5)

In the face of this list of impairments, it may seem obvious that manic individuals are not rational enough to be competent. Yet, there is evidence of competence among manic individuals. Here are some considerations in favor of competence.

First, studies have shown the contrary result, namely that manic people can be competent. In the aforementioned study, although 97% of manic individuals were found to be incompetent, 3% were found to be competent. Although this is the minority, it shows that manic people can be competent. In a study of 131 acute patients with bipolar disorder who were *involuntarily* hospitalized in Italy, “the percentage of patients with high treatment DMC [decision making capacity] reached 32% [as measured by the MacArthur exam]among BD [bipolar disorder] patients,” and “such patients presented an almost complete understanding and appreciating of their clinical condition, as well as of the risks and benefits of their treatment” [11].[[6]](#footnote-6) Furthermore, these manic patients showed “an adequate capacity to reason about their therapy and to express a choice…in a clear and consistent way” [11]. The lesson to draw from this study is that while less than half of the manic individuals were deemed competent, this still means that being manic does not *necessarily* render one incompetent. Thus, it is an open question whether a particular manic individual is competent, and medical health professionals should make a case-by-case judgment of capacity among manic individuals. This result is further supported by Beckett and Chaplin, who used an interview method to assess the competence of currently manic individuals; of the 50 people in their study, they note that 19 (38%) “were found to have overall capacity” [12].[[7]](#footnote-7) Again, all of the participants were currently receiving in-patient care at a psychiatric hospital. While there are certainly differences across the studied populations, were we to add up all of this data, approximately 26% of manic patients were deemed competent across all of the studies.

Second, the previously mentioned study conducted in Italy administered the Mini Mental State Exam (MMSE) to manic patients and found that, from 47 patients, their average MMSE score was 26.7/30 [11]. An MMSE score of 27-30 correlates to very little impairment, while a score of 23-26 correlates to mild impairment [13]. Although the MMSE is by no means a perfect measure of competence, it is at least a relevant piece of evidence.

All of this leads me to the conclusion that although many manic individuals are incompetent, a good number are competent. We have compelling empirical evidence that this is the case. Given that the empirical evidence draws almost solely from hospitalized patients (who likely have more severe impairments), we can infer that many competent manic individuals are left out of the evidence due to not seeking hospitalization and that, the existing data thatsupports the competence of many manic individuals is likely skewed to only include patients with the most severe impairments, suggesting that even more manic people are competent. I do not know the exact percentage of manic individuals who are competent,but it is clear that being manic does not rule out competence a priori. Each manic individual’s competence should be assessed on a case-by-case basis.

One might argue that, even if manic individuals are ruled sufficiently rational by tests of competence, they are incompetent for reasons not captured in those tests. On some views, J is not competent to consent when manic, because J’s values shift drastically and rapidly when manic, J’s manic values are alienated from him, not his own, or inauthentic in some way that makes him unable to competently choose. Yet, J’s non-manic desires are a reflection of his authentic self, are not alienated from him, and so forth. Thus, J can consent while euthymic but not while manic. Although they do not defend this view specifically in the context of bipolar disorder, several philosophers have defended the idea that stable values are a necessary condition of competence. Buchanan and Brock argue that, as a condition of being competent, an agent needs “a set of values or conception of what is good that is at least minimally consistent, stable, and affirmed” [1]. Charland and Elliot endorse similar views [14, 15].

The most plausible version of this objection has to do with the shifting nature of a manic individual’s values. One might argue that manic J cannot consent because his values have shifted rapidly, which is taken to be evidence that they are inauthentic, alienated, etc. The defender of this view might appeal to this case:

**Rapid Conversion**: S is a conservative Christian who believes that sex outside of wedlock is morally impermissible. After the death of a close friend, S undergoes a rapid loss of faith and ceases to be a Christian. Now, S believes that casual sex is permissible. S decides to have sex with several partners. In a matter of weeks, S has a religious experience and returns to his Christian faith and its sexual morality.[[8]](#footnote-8)

In this case, S underwent a rapid, unstable, and drastic shift in values. Despite this, it seems implausible to say that the people he had sex with during the period in which he was not a Christian engaged in a seriously wrong and impermissible sexual act without his valid consent, even if they knew that he had undergone this rapid and potentially unstable conversion. So, this version of the objection does not succeed.

To make Rapid Conversion more like bipolar disorder, we must take into account the empirical facts about how often an individual with bipolar disorder experiences value shifts. As Solomon et al. say, “the median duration of bipolar I mood episodes was 13 weeks” [16]. Hindley et al. note that “a median of 1 episode every 2.5 and 3 years for BP I and II patients respectively” [4].[[9]](#footnote-9) Given this information, we should revise the case to be as follows:

**Bipolar Conversion**: S is a conservative Christian who believes that sex outside of wedlock is morally impermissible. After the death of a close friend, S undergoes a rapid loss of faith and ceases to be a Christian. Now, S believes that casual sex is permissible. S decides to have sex with several partners. *After 13 weeks*, S has a religious experience and returns to his Christian faith and its sexual morality. *But, this pattern repeats at least once every few years.*

In this case, it is far less clear that S’s consent is valid. What is at issue is whether a decision based on a value shift that will flip-flop in a short period of time is consensual. So, the objector might endorse the following principle:

**Fickle Consent Principle**: S cannot consent on the basis of values that are shifting and which will last for only a short period of time.

This principle seems false on its face. It amounts to saying that one’s consent should be honored only if one’s preferences last a long time and that one’s consent should not be honored if one’s preferences are short-lived. If this were true, no impulsive decisions would be consensual. Of course, the person who acts on S’s consent in Bipolar Conversion is not acting virtuously. This person knows that S’s consent would not have been given if their interaction happened a few weeks later. However, the question of whether an interaction was consensual and whether it was virtuous are distinct.

The objector might reformulate the objection to focus not on the shifting nature of J’s values but instead on the fact that J’s value shifts are not within his control. For J, the shift in values that occurs when he is manic is not voluntary. Perhaps this involuntary shift undermines his ability to consent.

This seems too strong. Most shifts in values are involuntary. In a (in)famous example, Bertrand Russell describes riding his bicycle and suddenly realizing that he did not love his wife.[[10]](#footnote-10) This was not volitional. Yet, his decision to get divorced seems autonomous. Of course, J’s value shift is caused by a chemical issue in his brain, while Russell’s was not. However, I see no reason to treat the influence of a chemical issue or anything else differently, so long as both are not within the control of the agent.

One might object that value shifts in most cases are in response to reasons (perhaps Russell had reasons for falling out of love), while value shifts in people with bipolar disorder are not caused by being reasons-responsive. While I agree that value shifts are more praiseworthy if they are responsive to reasons, this seems like an overly intellectualized view of autonomy. For many people, value shifts occur in a way that is not reasons-responsive. To fill this in more, the reason that we should not prefer an overly intellectualized view of autonomy is that our theory of autonomy should be able to count everyday behaviors of non-philosophers as being autonomous.[[11]](#footnote-11) Most people make many decisions each day that are not responsive to reasons. If we were to make reasons-responsiveness a necessary condition of autonomy, we would have to say that the folk are not acting autonomously when they do simple actions like daydreaming, unconsciously petting their dog, or any other decision made on a whim.

The objector might shift her position to claim that J cannot consent when manic because of a combination of two previous factors; J’s value shifts are short-lived *and* out of his control. There are counter-examples to this view. Consider this case:

**Steak Regret**: S cares about saving money and rarely buys expensive things. To celebrate his birthday, he goes to a nice restaurant, intending to buy a $30 entrée. When he gets to the restaurant, he sees the steak served at a neighboring table, and is overcome by how appealing it seems. He checks the menu and sees that it costs $500. Something comes over him, he orders and eats the steak, and he regrets it when he gets the bill.

In this case, S’s values shifted temporarily and in a way that was not volitional. Specifically, he temporarily valued the deliciousness of the steak over his desire to save money. But, it doesn’t seem plausible to say that the waiter (even if they knew of his state of mind) robbed him or that he could demand a refund. If his behavior were not consensual, then he would be entitled to a refund, and the restaurant would have taken his money without his valid consent, which is theft.

Consider this case:

**No Steak Regret**: S cares about saving money and rarely buys expensive things. To celebrate his birthday, he goes to a nice restaurant, intending to buy a $30 entrée. When he gets to the restaurant, he sees the steak served at a neighboring table, and is overcome by how appealing it seems. He checks the menu and sees that it costs $500. Something comes over him, and he orders and eats the steak. When he sees the bill, he decides that his frugal ways have been cutting him off from good experiences and decides to become a lavish spender for several years.

Let’s stipulate that S’s value shift was not reasons-responsive; it was outside of his control, but it was long-lived. According to the proposed view (that people are not competent if their value shifts are dramatic, non-volitional, and short-lived), this decision is autonomous. Why should it matter that the preference is short in Steak Regret but long in No Steak Regret? According to the view under discussion, the amount of time a preference is held makes the difference between competence and incompetence. That seems implausible.

Overall, many manic individuals are competent, and considerations of irrationality or defective values do not necessarily undermine their competence.

Given that some non-trivial number of manic individuals are competent, one might wonder about what this looks like in practice. Suppose that J is manic but competent for the next month. Those around J know that, when manic, he will want to give away all of his money, have sex with any willing partner, etc. On my view, if J is genuinely competent, and if those around him justifiably believe that he is competent, then there are no consent-based reasons against them accepting money from J, having sex with J, etc. There may be non-consent-based reasons against these behaviors. If the individuals in question are J’s friends, they have obligations to him that go beyond merely respecting his consent; they have duties of beneficence toward him which would make these actions impermissible. Or, in just the way that bartenders cut off people who are drunk out of concern for harm to others, a gun store ought to not sell J a gun if the owner has reason to believe that his manic state makes him more likely to use it for harm, even though J is competent. However, I am committed to the view that if a stranger with no special obligations were to encounter J, this stranger can act on his manic consent (provided others are not harmed).

Overall, medical professionals should assess the competence of people with bipolar disorder on a case-by-case basis and not see being manic as necessarily entailing incompetence.

Before concluding, two more variations of bipolar disorder must be discussed.

First, some patients experience mixed-mood states, wherein an individual experiences both depressed and manic feelings. Insofar as being manic is covered by my argument, the question is whether experiencing depressive symptoms presents a new challenge for a patient’s competence. This is a complicated question, which has its own literature. My view is that depressive symptoms do not undermine competence to consent. Due to length requirements, I will assume this view for the sake of argument, meaning that my paper may be only persuasive to those who agree with me about depression and competence. However, this issue would only apply for cases of mixed-state bipolar disorder, which according to Persons et al. “are experienced by an estimated 20% of individuals with bipolar disorder” [17].[[12]](#footnote-12)

One might also wonder about rapid-cycling bipolar disorder, which involves patients that have at least 4 episodes per year [18]. I think that a modified version of the Bipolar Conversion case applies to rapid-cycling. Consider this case:

**Rapid-Cycling Bipolar Conversion**: S is a conservative Christian who believes that sex outside of wedlock is morally impermissible. After the death of a close friend, S undergoes a rapid loss of faith and ceases to be a Christian. Now, S believes that casual sex is permissible. S decides to have sex with several partners. *After 13 weeks*, S has a religious experience and returns to his Christian faith and its sexual morality. *This pattern repeats four times within a year.*

This case is not relevantly different in a way that would undermine competence. We’ve already seen that a desire being short-lived, involuntary, and not reasons-responsive is not sufficient to undermine competence. One might wonder about the case of ultra-ultra-rapid cycling bipolar disorder, wherein a person experiences 24-hour cycles. A similar version of the Bipolar Conversion case could be devised, except that S’s mind changes after 24 hours, and then the cycle repeats again the next day. On my view, there is no principled reason to view this pattern as competence undermining. But, if the reader finds this too strong, the blow can be softened by the fact that ultra-ultra-rapid cycling seems rare.

**Conclusion:**

In this paper, I have argued that many manic individuals are competent to consent. Although this paper mainly addresses bipolar disorder, the conclusions I make are more general. I have argued that (given the competence of some individuals experiencing mania) views of competence which require a stable set of values as necessary condition of competence are false. It is unfortunate that some individuals who are manic are competent to consent. Those individuals will likely make self-destructive decisions. In a separate, ongoing work, I propose a solution to this problem in the form of Ulysses Contracts for manic individuals, wherein a euthymic may sign a legally enforceable contract that binds their future, manic self away from self-destructive behaviors.

**References**

1. Buchanan, Alan and Dan Brock. *Deciding For Others: The Ethics of Surrogate Decision Making.* Cambridge: Cambridge University Press. 1989.

2. National Institutes of Mental Health. “Bipolar Disorder.” https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml#:~:text=Bipolar%20Disorder-,Overview,day%2Dto%2Dday%20tasks. Accessed October 2020.

3. Misra, Sahana., et al. “Bipolar Mania and Capacity to Consent: Recommendations for Investigators and IRBs.” *IRB: Ethics & Human Research* 32, no. 1 (2010): 7-15.

4. Hindley, Guy, et al. ““Why have I not been told about this?”: a survey of experiences of and attitudes to advance decision-making amongst people with bipolar.” *Wellcome Open Research* 4, no. 16 (2019): 1-38.

5. Angst, Jules, et al. “Recurrence of bipolar disorders and major depression: A life-long perspective.” *European Archives of Psychiatry and Clinical Neuroscience* 253 (2003): 236-240.

6. Robinson, Lucy J. “A meta-analysis of cognitive deficits in euthymic patients with bipolar disorder.” *Journal of Affective Disorders* 93 (2006): 105-115.

7. Adida, Marc. “Trait-Related Decision-Making Impairment in the Three Phases of Bipolar Disorder.” *Biological Psychiatry* 70 (2011): 357-365.

8. Gergel, Tania, and Gareth Owen. “Fluctuating capacity and advance decision-making in Bipolar Affective Disorder — Self-binding directives and self-determination.” *International Journal of Law and Psychiatry* 40 (2015): 92-101.

9. Owen, Gareth, et al. “Mental capacity to make decisions on treatment in people admitted to psychiatric hospitals: cross sectional study.” *British Medical Journal* 337 (2008): 1-4.

10. Owen, Gareth, et al. “Mental capacity, diagnosis and insight in psychiatric in-patients: a cross-sectional study.” *Psychological Medicine* 39 (2009): 1389-1398.

11. Mandarelli, G., et al. “Treatment decision-making capacity in nonconsensual psychiatric treatment: a multicentre study.” *Epidemiology and Psychiatric Science* 27 (2018): 492-499.

12. Beckett, Jonathan and Robert Chaplin. “Capacity to consent to treatment in patients with acute mania.” *Psychiatric Bulletin* 30 (2006): 419-422.

13. Clark, Patricia A, Shandra S. Tucke, Carol J. Whitlatch. “Consistency of Information from Persons with Dementia: An Analysis of Differences by Question Type.” *Dementia* 7, no. 3 (2008): 341-358.

14. Charland, Louis. “Cynthia’s Dilemma: Consenting to Heroin Prescription.” *The American Journal of Bioethics* 2, no. 2 (2002): 37-47.

15. Elliott, Carl. “Carking about risks: are severely depressed patients competent to consent to research?” *Archives of General Psychiatry* 54. (1997): 113-116.

16. Solomon, David, et al. “Longitudinal Course of Bipolar I Disorder: Duration of Mood Episodes.” *Archives of General Psychiatry* 67, no. 4 (2010): 339-347.

17. Persons, Jane, et al.  “Mixed state and suicide: Is the effect of mixed state on suicidal behavior more than the sum of its parts?” *Bipolar Disorders* 20, no. 1 (2018) 35–41.

18. Bauer, Michael, et al. “Rapid cycling bipolar disorder – diagnostic concepts.” *Bipolar Disorders* 10, no. 1 (2008): 153-162.

1. This is a hypothetical example and is not about a real patient. [↑](#footnote-ref-1)
2. Although depression is a feature of bipolar disorder, my focus will be mainly on mania, as depression has already been extensively analyzed in relation to competence. [↑](#footnote-ref-2)
3. I intend my view to be neutral on the debate regarding the metaphysical nature of consent. For a helpful summary of that debate, see Manson, Neil. “Permissive Consent: A Robust Reason-Changing Account.” *Philosophical Studies* 173 (2016): 3317-3334 [↑](#footnote-ref-3)
4. According to Geddes and Miklowitz, “even with treatment, about 37% of patients relapse into depression or mania within 1 year, and 60% within 2 years” (Geddes, John and David Miklowitz. “Treatment of bipolar disorder.” *The Lancet* 381, no. 9878 (2013): 1672-1682, 1672). [↑](#footnote-ref-4)
5. The MacArthur test is not a perfect guide to competence, but it is a useful heuristic. I intend my use of the MacArthur and MMSE exams to be relevant to the question of rationality, not the discussion of patients’ values. [↑](#footnote-ref-5)
6. This study did not say whether patients with bipolar disorder were currently manic or depressed while the study was conducted. But, all patients were in the acute stage (so either mania or depression) at the time of admission to the hospital. [↑](#footnote-ref-6)
7. This assessment was based on an interview that gauged the patients’ “ability to retain information,” “ability to understand the information disclosed to them,” “ability to reason,” and “ability to communicate a decision about treatment” (Beckett, Jonathan and Robert Chaplin. “Capacity to consent to treatment in patients with acute mania.” *Psychiatric Bulletin* 30 (2006): 419-422, 418-419). [↑](#footnote-ref-7)
8. In my view, it does not matter if the person receiving the consent in these cases is aware or unaware that the consent is only given based on short lived values. [↑](#footnote-ref-8)
9. Hindley is citing Angst et al, 2011. [↑](#footnote-ref-9)
10. See Clark (Clark, Ronald. *The Life of Bertrand Russell*. London. Bloomsbury. 2011) for a full account of the story. [↑](#footnote-ref-10)
11. Here, I agree with G. Dworkin (*The Theory and Practice of Autonomy*. Cambridge: Cambridge University Press. 1988, 17). [↑](#footnote-ref-11)
12. Persons et al. draw this information from the following three sources: Rihmer Annamaria, et al. “The importance of depressive mixed states in suicidal behaviour.” *Neuropsychopharmacologia* *Hungarica* (2008)1:45-49. Swann Alan, et al. “Bipolar mixed states: an international society for bipolar disorders task force report of symptom structure, course of illness, and diagnosis.” *American Journal of Psychiatry* 170, no. 1 (2013):31-42. Shim In Hee, Young Sup Woo & Won-Myong Bahk. “Prevalence rates and clinical implications of bipolar disorder ‘with mixed features’ as defined by DSM- 5.” *Journal of Affective Disorders* 173, no. 1 (2015):120-125. [↑](#footnote-ref-12)