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Misdiagnosing Narcissism – The Bipolar I Disorder

By Sam Vaknin

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(The use of gender pronouns in this article reflects the clinical facts: most narcissists are men.)

The manic phase of Bipolar I Disorder is often misdiagnosed as Narcissistic Personality Disorder (NPD).

Bipolar patients in the manic phase exhibit many of the signs and symptoms of pathological narcissism – hyperactivity, self-centeredness, lack of empathy, and control freakery. During this recurring chapter of the disease, the patient is euphoric, has grandiose fantasies, spins unrealistic schemes, and has frequent rage attacks (is irritable) if her or his wishes and plans are (inevitably) frustrated.

The manic phases of the bipolar disorder, however, are limited in time – NPD is not. Furthermore, the mania is followed by – usually protracted – depressive episodes. The narcissist is also frequently dysphoric. But whereas the bipolar sinks into deep self-deprecation, self-devaluation, unbounded pessimism, all-pervasive guilt and anhedonia – the narcissist, even when depressed, never forgoes his narcissism: his grandiosity, sense of entitlement, haughtiness, and lack of empathy.

Narcissistic dysphorias are much shorter and reactive – they constitute a response to the Grandiosity Gap. In plain words, the narcissist is dejected when confronted with the abyss between his inflated self-image and grandiose fantasies – and the drab reality of his life: his failures, lack of accomplishments, disintegrating interpersonal relationships, and low status. Yet, one dose of Narcissistic Supply is enough to elevate the narcissists from the depth of misery to the heights of manic euphoria.

Not so with the bipolar. The source of her or his mood swings is assumed to be brain biochemistry – not the availability of Narcissistic Supply. Whereas the narcissist is in full control of his faculties, even when maximally agitated, the bipolar often feels that s/he has lost control of his/her brain ("flight of ideas"), his/her speech, his/her attention span (distractibility), and his/her motor functions.

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The bipolar is prone to reckless behaviors and substance abuse only during the manic phase. The narcissist does drugs, drinks, gambles, shops on credit, indulges in unsafe sex or in other compulsive behaviors both when elated and when deflated.

As a rule, the bipolar's manic phase interferes with his/her social and occupational functioning. Many narcissists, in contrast, reach the highest rungs of their community, church, firm, or voluntary organization. Most of the time, they function flawlessly – though the inevitable blowups and the grating extortion of Narcissistic Supply usually put an end to the narcissist's career and social liaisons.

The manic phase of bipolar sometimes requires hospitalization and – more frequently than admitted – involves psychotic features. Narcissists are never hospitalized as the risk for self-harm is minute. Moreover, psychotic microepisodes in narcissism are decompensatory in nature and appear only under unendurable stress (e.g., in intensive therapy).

The bipolar's mania provokes discomfort in both strangers and in the patient's nearest and dearest. His/her constant cheer and compulsive insistence on interpersonal, sexual, and occupational, or professional interactions engenders unease and repulsion. Her/his lability of mood – rapid shifts between uncontrollable rage and unnatural good spirits – is downright intimidating. The narcissist's gregariousness, by comparison, is calculated, "cold", controlled, and goal-orientated (the extraction of Narcissistic Supply). His cycles of mood and affect are far less pronounced and less rapid.

The bipolar's swollen self-esteem, overstated self-confidence, obvious grandiosity, and delusional fantasies are akin to the narcissist's and are the source of the diagnostic confusion. Both types of patients purport to give advice, carry out an assignment, accomplish a mission, or embark on an enterprise for which they are uniquely unqualified and lack the talents, skills, knowledge, or experience required.

But the bipolar's bombast is far more delusional than the narcissist's. Ideas of reference and magical thinking are common and, in this sense, the bipolar is closer to the schizotypal than to the narcissistic.

There are other differentiating symptoms:

Sleep disorders – notably acute insomnia – are common in the manic phase of bipolar and uncommon in narcissism. So is "manic speech" – pressured, uninterruptible, loud, rapid, dramatic (includes singing and humorous asides), sometimes incomprehensible, incoherent, chaotic, and lasts for hours. It reflects the bipolar's inner turmoil and his/her inability to control his/her racing and kaleidoscopic thoughts.

As opposed to narcissists, bipolar in the manic phase are often distracted by the slightest stimuli, are unable to focus on relevant data, or to maintain the thread of conversation. They are "all over the place" – simultaneously initiating numerous business ventures, joining a myriad organization, writing umpteen letters, contacting hundreds of friends and perfect strangers, acting in a domineering, demanding, and intrusive manner, totally disregarding the needs and emotions of the unfortunate recipients of their unwanted attentions. They rarely follow up on their projects.

The transformation is so marked that the bipolar is often described by his/her closest as "not himself/herself". Indeed, some bipolars relocate, change name and appearance, and lose contact with their "former life". Antisocial or even criminal behavior is not uncommon and aggression is marked, directed at both others (assault) and oneself (suicide). Some bipolars describe an acuteness of the senses, akin to experiences recounted by drug users: smells, sounds, and sights are accentuated and attain an unearthly quality.

As opposed to narcissists, bipolars regret their misdeeds following the manic phase and try to atone for their actions. They realize and accept that "something is wrong with them" and seek help. During the depressive phase they are ego-dystonic and their defenses are autoplatic (they blame themselves for their defeats, failures, and mishaps).

Finally, pathological narcissism is already discernible in early adolescence. The full-fledged bipolar disorder – including a manic phase – rarely occurs before the age of 20. The narcissist is consistent in his pathology – not so the bipolar. The onset of the manic episode is fast and furious and results in a conspicuous metamorphosis of the patient.

More about this topic here:

Stormberg, D., Roningstam, E., Gunderson, J., & Tohen, M. (1998) Pathological Narcissism in Bipolar Disorder Patients. *Journal of Personality Disorders*, 12, 179–185

Roningstam, E. (1996), Pathological Narcissism and Narcissistic Personality Disorder in Axis I Disorders. *Harvard Review of Psychiatry*, 3, 326–340

Sam Vaknin (<http://samvak.tripod.com>) is the author of *Malignant Self Love – Narcissism Revisited* and *After the Rain – How the West Lost the East*. He served as a columnist for *Central Europe Review*, *PopMatters*, and *eBookWeb* , and *Bellaonline*, and as a United Press International (UPI) Senior Business Correspondent. He is the the editor of mental health and Central East Europe categories in *The Open Directory* and *Suite101*.

My Experience With Bipolar

By Triston Huntsmin

As a counseling psychologist, I enjoy a variety of clients each day with a variety of needs. I see couples who are on the edge of divorce yet still want to save their marriage and I see young children who are struggling after the loss of a parent or sibling. Some of my most interesting clients are those that deal with bipolar. I was never trained to specifically deal with bipolar, so I had to dive in with my first bipolar client and learn as I went.

I'll never forget meeting with my first (of many) client who was struggling with bipolar. I was a little bit afraid because I only had a basic knowledge of the problem and even less understanding of effective treatment plans for the disorder. The first three sessions I had with this bipolar client I simply let her

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talk. I asked questions as a method of gaining information, but I barely gave any tidbit of counsel or direction. Why? Because I didn't know what to say. I had never experienced someone in my years of preparation and internship for counseling who was so clearly up and down and almost living two different lives.

Each day after I met with my first bipolar client I shut myself in my office and spent the day pouring over books and other credible resources that would help me learn about the disorder. I called up a few friends that were specialists on the topic and I did ever possible proactive thing to be more prepared for my client by the next week.

The things I have learned in the fifteen years since that first close encounter with someone struggling with bipolar are things I never expected to learn. I have become so intrigued with the subject that I have conducted a series of clinical research studies aimed at bringing further understanding of bipolar into the medical and psychological communities. Studying and aiding people with bipolar truly has become my life's work and passion. In the strangest way it snuck up on me and became all I could focus on. It has been my privilege to receive certification as a "bipolar needs specialist" and to begin teaching other counselors how to aptly deal with the problems of bipolar.

If you or someone you know struggles with bipolar disorder, then my advice is simple: learn more. Educating yourself on this important topic is the most important thing you can do. There is much to be learned and much victory to be gained in this area as more people learn the truth.

Triston Huntsmin is a counseling psychologist who now specializes in the diagnosis and treatment of bipolar patients. See

for more information on the disorder.



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