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Ghosting Behaviors in Respect to Diagnostic Criteria of Bipolar and Post Traumatic Stress Disorder: Clinical Review and Treatment Implications

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Abstract

This article aims to identify gaps in literature pertaining to individuals formally diagnosed with Bipolar Disorder (BD) and comorbid Post Traumatic Stress Disorder (PTSD) exhibiting isolation type behaviors. In this article, I will define ghosting as an isolative behavior and outline the diagnostic criteria and clinical symptomology of BD and PTSD that align with ghosting behaviors. Ghosting behaviors have strong implications for mental health treatment regarding preventative and management strategies. I will review additional factors to conceptualize ghosting and address implications for mental health treatment.

Keywords: Ghosting; Bipolar; Post-traumatic stress disorder; Behavioral; Symptomology

Introduction

Bipolar disorder and PTSD: The ghosting factor

The DSM 5 outlines the symptomology inclusion, and exclusion criteria of the often-comorbid diagnoses of Bipolar Disorder (BD) and Post Traumatic Stress Disorder (PTSD) [1]. BD and PTSD overlap in aspects of symptomology and behavior indicating an interdependent relationship [2-4]. One feature of each diagnosis is decrease in social interaction and/or increase in social isolation. Both BD and PTSD diagnoses indicate the vanishing or exiting of the individual from social or familial interaction. In this article I define these socially isolative behaviors as ghosting. In BD, for example, regarding clinical implications, I have found that family members and therapists will report this ghosting that occurs without warning and providing no leads or access to the individual to confirm wellness or other aspects of the individual's life.

Individuals diagnosed with both PTSD and BD tend to exhibit similar patterns regarding the uninformed ghosting that occurs within their social circles [3]. I will outline the symptomology of BD and PTSD and how they align with ghosting. I will identify gaps between what is already known about the two-diagnosis comorbidity and what is not indicated regarding these vanishing or isolation type behaviors. Lastly, I will review factors to conceptualize ghosting, and address implications for treatment with clients experiencing this complex diagnosis.

Literature Review

Ghosting

Ghosting is historically a buzz word used to describe an abrupt ending to a romantic relationship. (e.g. "He ghosted me after one date"). This statement usually signifies discontentment with the person making the complaint without gracing the individual with at minimum an explanation for their absence. Clinically, I define ghosting as an avoidant-type behavior and/or symptom where the client is no longer actively seeking and interacting with family or friends as evidenced by a lack of communication for several days to several months.

The isolating behaviors or symptoms are not representative of one diagnosis, but rather a feature of various diagnosis especially BD and PTSD. Ghosting occurs within the clinical setting as well where clients no longer attend sessions within outpatient therapy pre-emptive of termination. The main feature of the ghosting factor is not providing warning to others that the individual will no longer reach out or engage in interaction by phone computer, or in person. Causes of this behavior are not identified in research [1-4].

Bipolar disorder comorbidity with PTSD

Bipolar disorder is a multi-dimensional mental illness comprising of several facets of symptomology [2]. Making connections between possible risk factors in individuals diagnosed with BD is under research Marwaha, et al. Furthermore, individuals with BD are more likely to experience post-traumatic stress symptoms comorbidly [4,5]. Individuals diagnosed with bipolar disorder and co-morbid PTSD have a higher frequency of suicide attempts [6]. Additionally, individuals with BD and co-morbid PTSD are reportedly experiencing more manic/hypomanic episodes, reduced quality of life, intermittently higher rates of depressive episodic cycles, and impaired functioning. In the national comorbidity replication study, researchers reported a 16%-39% likelihood of comorbid PTSD in BD patients [7].

PTSD in terms of its criteria overlap many symptoms categorically of BD. For example, avoidance as one category of the PTSD diagnosis closely mirrors depressive symptoms. Individuals may isolate due to avolition and decrease their communication with others due to a loss of interest in activities once deemed as important or beneficial. An example of ghosting in this context occurs when an individual does not reach out to others to confirm their existence or to address problems due to severe lack of motivation to engage with others [8].

Bipolar disorder and ghosting

Distinguishing bipolar I and bipolar II: Kemberg and Yeomans 2013, there is debate on the range of presentation regarding bipolar disorder. Bipolar I disorder is the more severe of the two diagnoses. Bipolar I disorder consists of manic, depressive, and mixed episodes. Mixed episodes seem to manifest with the presence of features of both

episodes at the same time. The rapid cycling gives impressions of this simultaneous demonstration with mania being the predominant exhibited episode [9].

The depressive side in Bipolar I can manifest quickly and in extreme intensity resulting in suicidal ideation, suicide attempts, or homicidal ideation [10]. The attitudes or perceptions are distorted within the manic episode. Fears and paranoid thoughts around mistrust are pre-emptive components creating the perfect storm for these highly impulsive behaviors.

Bipolar II structure and patterns are the same as bipolar I apart from manic episodes manifesting with less intensity. Manic episodes are characterized as mild and less detectible. The less intense or hypomanic episodes are usually an indication of lack of appropriate treatment. The manic episodes go untreated due to most likely being misread or minimized by the client. Further concern arises when untreated bipolar II can then evolve into bipolar I [9].

Ghosting or isolating behaviors

Whether an individual is diagnosed with bipolar I or II, there are implications for why he, she, or they would go into hiding. A milder form of manic episode indicating less activity in the limbic system, does not negate hyper-focus on other areas of interest [11]. The absence of an individual once present and responsive to significant others, for example, can count for less severe manic episodes. The buildup of distrust and anger can lead to suicidal thoughts further necessitating a need for isolation and covert planning undisclosed to family or friends [9].

Depressive symptoms include having avolition or low to no interest in engaging in activities, eating, or socializing with natural supports. Also, the person feels worthless, hopeless and at times barely alive. The fear and anxiety associated with depressive episodes also can lead to deep paranoia and avoidance of human contact [9]. Depression in severe formulations can lead to suicidality related to attempts or completed [1]. Depressive symptoms are not the more dominant feature of BD; however, BD I can quickly escalate into more behaviors presenting more imminent risk of harm to self or others due to the lack of pre-emptive indications of more severe pathology. The spontaneity of manic states can lead to intense depression resulting in suicidality [12,9].

Functional impairment

BD impairs individual functioning significantly reducing one's quality of life [1]. Authors emphasize how impairment caused by bipolar disorder is also categorized as a disability [2]. With the consideration of disabled individuals, daily functioning can be compromised, which implicates having limited access to individuals or other means in which to communicate. Limitations in communication, transportation, and socialization can propagate a possible lack in willingness to obtain or implement these basic human needs perpetuating symptomology of BD. Additionally, individuals suffering from BD reportedly are more likely to have poorer perceptions of life further limiting the individual [12]. Similarly, PTSD contains criteria reflective of being stifled in human interaction due to the complexity of the aftermath of traumatic experiences.

This "exiting" from reality, social interaction, and overall, lack of responsiveness appears to be related to cases where there has been a formal diagnosis of bipolar I [12,13]. However, PTSD criteria includes avoidance, and this element can take many forms including excessive drug usage, isolation, avoidance of persons or places associated with past trauma, and social interactions mandatory to maintain good standing in work environments [14].

Neurological considerations

As stated in the DSM 5, bipolar I's signature episodic changes are categorized as manic or depressive. A manic episode historically manifests as hypersexual behavior, extreme impulsivity, excessive spending or use of substances, rapid speech, flight of ideas, and thoughts of grandeur. Counter intuitive to the idea that isolation-type or exiting behaviors would manifest during a manic episode, the element of distraction emerges. The implication is that an individual experiencing a manic episode will be in that cycle anywhere from days, weeks, or months impairing his or her ability to focus on daily expected tasks more relevant to the maintenance of daily functioning [9].

For example, if an individual diagnosed with BD and experiencing a manic episode is having racing thoughts, focusing on a possible business venture, other necessary tasks such as visiting a relative during a holiday, paying vital bills to sustain operation of their domicile, or medication management will be disregarded or forgotten to "make room" for this new influx of ideas [9].

Whatever the manifestation of the mania, the idea is that an individual simply has no ability to balance executive functioning, self-awareness, or skill implementation when the brain is hijacked by the limbic system including neural amygdala responsiveness [11]. The amygdala is responsible for processing emotions and fights or flight responses. Hyper arousal of the amygdala may be associated with impulsivity related to survival mechanisms such as safety being threatened. Additionally, the prefrontal cortex also part of the limbic system, is responsible for planning, reasoning, and judgment. An over-active limbic system indicates the impairment of making sound decisions supporting why impulsive behaviors are inevitable.

Post-traumatic stress disorder and ghosting

The DSM 5 designates PTSD by four distinctive categories including arousal, intrusion, avoidance, and mood disturbance. In regard to ghosting, isolating tendencies are listed within the diagnostic category of avoidance. According to the 17 symptoms associated with PTSD, avoidance takes the form of avoiding people, places, or things an individual relates to past trauma. Trauma takes many forms and the most highly researched area when addressing PTSD and BD comorbidity is childhood abuse [2,4].

Avoidance can also manifest in the form of alcohol or drug abuse. An individual heavily intoxicated and/or out of touch with the world can mimic the brain chemistry of someone always in a heightened state of awareness or amplified in deep depression finding minimal comfort in the interaction of others. Avoidance as a self-explanatory term, refers to not engaging others as result of association with past traumatic event(s). For example, a police officer might not drive by a neighborhood where a traumatic event occurred to not be triggered and force to revisit the disturbing elements of the event.

Avoidance is not the only category that can shed light on the propensity towards ghosting (e.g., isolating or exiting from social support interaction). An individual who is hyper aroused might avoid connection with others inadvertently. For example, if someone is

experiencing a flight of ideas or thoughts of grandeur associated with manic states, regardless of the source or cause, the aroused person is unable to concentrate and have full range of access to executive functioning. If the limbic system is in overdrive, flight might be the option for the individual opposed to fight [11]. The perceived threat of an event or individual causing distress in a compromising situation would exasperate all available neurological resources preventing the person from feeling safe. The individual not experiencing a basic need of safety is an ample driving force to prevent social interaction, reaching out to or responding to concerned family or peers.

Another category comprising of the PTSD diagnosis refers to unwanted or uninhibited thoughts or feelings manifested inadvertently within the brain due to an accumulation of unwanted traumatic experiences. Having nightmares, flashbacks, or intrusive thoughts after revisiting a location or individual associated with the trauma can manifest stressful symptoms not premeditated by the individual. The backlash created by this powerful neurological response serves as a coping strategy leading to avoidant behaviors. This, the categories of PTSD have an overlap or causative nature as well.

Discussion

Medication (non) compliance

According to Aksoy and Kelleci, the risk factors impacting medication compliance with individuals formally diagnosed with BD and PTSD are limited. Medication noncompliance in individuals diagnosed with BD are associated with lower life satisfaction, increase in costs for care, and higher rates of inpatient hospitalization [15]. Medication compliance is important when investigating this ghosting factor in that symptoms may exasperate in such forms as rapid cycling or increased suicidality leading to possible mortality. One factor associated with challenges in medication compliance is the level of access to social support. Deficiencies in these areas can cause issues with compliance with medications.

Aksoy and Kelleci aimed to analyze variables related to medication compliance and coping strategies of individuals formally diagnosed with BD. Authors used the Morisky Compliance Scale (MCS), Scale of Ways of Coping with Stress, and the Multidimensional Scale of Perceived Social Support (MSPSS) to analyze descriptive characteristics of the participants. Results determined that most participants were over 40 years old, unemployed, single, female, and have been taking medications for over 10 years. More than half of their data set reported noncompliance. In comparing compliant to noncompliant individuals regarding levels of social support, there was no statistical significance [15].

In another study investigating correlations between denial or acceptance of having BD and medication compliance, compliance rates were lower among individuals who denied having the diagnosis of BD [16]. Additionally, in another study, authors reported that individuals who implemented adaptive coping strategies learned in therapy were able to minimize frequency and intensity of their manic and depressive episodes. Thus, individuals willing and able to proactively utilize mental health interventions are more likely to comply with medication regiments.

Upon reviewing literature addressing medication compliance in BD, large gaps in research are present considering the vast presentation of symptoms including isolation behaviors [15]. The ghosting factor might be implied in the context of how an individual chooses to cope with their symptoms; however, further research would be necessary to investigate specific types and ranges of symptomology. For example, if a noncompliant individual diagnosed with BD is more likely to experience more intensified and frequent episodic changes, then how would ghosting behaviors manifest? Would an individual compliant with medication experience more isolation as a side effect to the medication? Some regimens are standardized in addressing the symptoms of BD. The implications for side effects of these regiments might provide connections with ghosting.

Holistic conceptualization of ghosting

Attachment styles: According to Bowlby the fore runner in attachment theory, children develop differently based on varying ways of interaction with their mothers. Bowlby posited that mother and baby are genetically programmed to be in proximity. Various conditions or barriers to their connection will determine the attachment style. Bowlby was commissioned by the World Health Organization (WHO) to study children wo have suffered maternal deprivation due to the aftermath of World War II. Within Bowlby's 1951 written work known as maternal care in mental health, he outlined his observations in child cognitive, behavioral, emotional, and social deficits because of prolonged neglect. Bowlby even found that persistent deprivation can result in "affectionless psychopathology". This coined term is defined as a child not being able to formulate strong meaningful relationships as an adult.

Ghosting behavior is defined by varying periods of time avoiding interaction with family or friends due to pathological implications of BD and PTSD [3,11]. In reference to the avoidant attachment style where isolation-type behaviors are present, the mental health ramifications can exist at the onset of the life span formulating additional pathology. Childhood attachment issues exasperated by additional environmental stressors or traumas such as child abuse can lead to the comorbid diagnosis of BD and PTSD as an adult [2,3,12]. This presentation couples a coping strategy (IE: avoiding individual or places associated with the past) while defaulting to the behavior learned at the onset of birth that threatened the attachment with the mother. The argument can be made that this threat to connection with a caregiver is separate and arguably innate alongside of other exhibited features of the two diagnoses. However, further investigation about why an individual defaults to ghosting behaviors would be necessary to make these causal distinctions.

Depersonalization and derealization

In the DSM5, the concept of depersonalization is characterized by being out of one's body as if watching another individual carrying out various functions or activities [14]. The dreamlike state would be perceived in almost slow motion with a sense of separation. This dissociative state would be an ideal pre-emptive preparation to follow through on the excessively focused activities which can cause destruction and pain. This detachment creates an environment for the individual to feel more impermeable, indestructible to carry out some of the high-risk behaviors typical in BD [9,13].

While personalization can be framed as an intrapersonal experience, the derealization aspect comprises of a fabricated interpersonal scenario. The background seemingly two-dimensional, the

environment in which the individual is now interpreting encompasses actors who do not perceive to be real [13].

Family history

Individuals who have been formally diagnosed with PTSD are more likely to experience marital instability and divorce [8]. Couples' counseling and other forms of family-based treatment have been successful in the reduction in the manifestation of certain aspects of PTSD. Familial support is pivotal in the application of intervention especially maritally where individuals experiencing symptoms of PTSD or BD have more tendencies towards avoidant symptoms and behaviors.

Literature supports a strong association among BD, PTSD, and childhood trauma. In schema theory, negative cognitions, memories, and emotions are associated with pathological implications and are related to childhood trauma. Debilitating intrusive thoughts containing themes of guilt and self-responsibility are some ramifications from early childhood trauma. Ghosting behavior can result from intrusive thoughts; the threats can be catastrophized paired with misinterpretation of the thoughts.

For example, an individual may feel estranged from family members who were the perpetrators of abuse. Some unintentional negative thoughts about the extent of which the person was threatened or abused prevents social connectivity leading to isolative behaviors. In a meta-analysis, BD was found to be more severe in individuals who have experienced childhood abuse. Additionally, there is a higher likelihood of co-morbidity of PTSD [2]. Due to the ambiguous nature of the development and risks of BD, new treatment options are needed especially since individuals who have experienced trauma as a child are more likely to have an early onset of BD and a comorbidity of PTSD. Again, early onset of BD and PTSD indicate a more profound development of symptomology such as derealization, depersonalization, psychosis, and other dissociative features related to ghosting symptoms and behaviors [6,13].

Identifying ghosting

As mentioned, the individual exhibiting the ghosting behaviors because of BD and/or comorbid PTSD must disclose this behavior to provide evidence of having a history of this tendency. However, the family members or friends are equally likely to indicate a lack of connection to key players such as doctors, therapists, or faculty [1]. As clinicians, the lack of attendance to a session would indicate a possibility of these ghosting behaviors by simply not showing up to scheduled appointments. The attrition issue might not be a direct cause of features associated with certain diagnosis. The evidence of ghosting is supported when the accumulation of key players, family members, or friends, all confirm the lack of communication with the individual exhibiting the behavior.

"Have you heard from Ron?" "No, I have not, have you?" The evidence is proven of something more pathological than simply taking a break when these behaviors start to formulate patterns. The pattern development might not be information made privy to the therapist due to barriers like confidentiality and not having an inner loop of exposure or access to the client's personal life and the people within their communicative circle. There is a strong implication in support of family and friends having the key to more longitudinal patterns of behavior not necessarily disclosed in the therapy sessions.

Clinical implications

Counseling individuals with BD and comorbid PTSD: Clinicians who have provided services to individuals meeting criteria for either BD, PTSD, or both might have experienced ghosting behaviors in one form or another. Pre-emptive termination where there is no warning or indication of terminating the therapeutic alliance might be one formation of ghosting. Having evidenced based support can assist clinicians in formulating treatment plans that do not necessarily fall in range of the presence of imminent risk of harming self or others [3,10].

The counselor might have concern for suicidal or homicidal ideation based on a lack of attrition; however, providing insight to other possibilities as to the cause of the client's absence can help manifest lower risk treatment options [12]. For example, if a client exhibiting ghosting behavior in the past is aware of this trend or behavioral patterns, the clinician can then factor in that as a possibility and ask for permission to confirm that possibility with approved natural supports to reduce the concern and need for further investigative pursuits encompassed under mandated reporter responsibilities. Communication with the client can assist in future planning and assign coping strategies suitable to manage the isolation-type symptoms.

People reportedly diagnosed with both BD and comorbid PTSD have a higher likelihood of attempting suicide [6]. Higher risk clients need more attention in terms of monitoring and acuteness of treatment. Treatment planning options might include safety planning incorporating prevention and management of crisis related to imminent risks.

Treatment planning

Unlike crisis intervention where the individual is knowingly at risk to harm or self in that moment, individuals with BD and/or PTSD can exhibit covert symptoms in reference to the ghosting factor. There is an unpredictable nature when, for example, cycling from manic to depressive episodes. The outcome especially with a history of self-harming is evident, can be fatal [10,12,15]. Furthermore, configurating the ideal treatment plan with a built-in safety plan can be helpful, but has not proven to be effective.

Safety planning usually comprises of preventative and management strategies specifically indicated for the client to adhere to on a consistent basis until the imminent threat of harm to self or others has diminished or extinguished. The risk of harm becomes heightened when the client chooses to ghost in that concerned third parties have no access to intervene and assist in the implementation of the treatment recommended. Prevention would have to take an extra precautionary measure to provide the ultimate mental health service. For example, clients who have a history and knowledge of their tendency towards ghosting will have to communicate with individuals such as sponsors, or friend supports to address when feelings or thoughts are probable to a pre-emptive exiting behavior. Natural supports are one of the most effective and predominant interventions when addressing depression and PTSD.

Positive change and crisis prevention are associated with availability of family and friends. When addressing avoidant symptoms in reference to PTSD, ghosting behaviors and symptoms are found within the context of not allowing oneself to be subjected to further trauma in the mind of the individual. Individuals will avoid the

cognitions, memories, places, or even other individuals associated with that trauma. A study incorporating Strategic Approach Therapy (SAT) and a 10-session martial therapy was designed to target avoidant symptoms in PTSD [8].

The techniques involved partner-based interventions with anxiety-reduction elements to assist in reducing conscious efforts to avoid and the emotional numbing symptomology [8]. The aim of the study was to see a significant decrease in avoidant symptoms and behaviors, and an overall reduction in PTSD severity utilizing SAT. The main precaution when addressing a potential intervention such as SAT is the availability of a partner, or significant person whom the individual would trust enough to part take. The SAT model might not be malleable enough to alter or accommodate other populations including more severe cases where less natural supports are available or the pathological implications prevent compliance and attrition.

Limitations to researching the ghosting factor

Since the main premise of the ghosting factor is centered around the individual not communicating to confirm where about, research may entail barriers to acquiring data. As mentioned, individuals with a formal diagnosis of BD and/or PTSD experience various aspects of depersonalization, dissociation, psychosis, avoidant behaviors, and hyper-focus on activities preventing the individual from being present to self and others [8,13]. Ample barriers are present when connecting with a person when he, she, or they are experiencing dissociative symptoms.

Access to a general base of reality checking such as grounding techniques often used with trauma survivors, would allow facilitation for positive change in individuals with complex comorbidity. However, individuals must be willing to seek and obtain mental health treatment [9]. I outlined three main sources to provide evidence to the ghosting behavior or symptom. Family, the clinician, and the client are all sources to conform ghosting behaviors. If the clinical does not have permission to contact and confirm the whereabouts of the client, then further assessment and treatment are limited.

Conclusion

Ghosting as mentioned is a social and urban buzz word indicating disappearing specifically within the context of relationships. Disengaging with others is as concern in realms of risk factors associated with imminent risk to harm self or others. I addressed the complexity of BD and comorbid PTSD connected to the features and presentation of ghosting as both symptom (*i.e.,* avoidant due to intrusive thoughts or depersonalization and behavior (*i.e.,* Making the choice to avoid others to reduce exasperation of symptoms of overwhelming emotions). Additional aspects to assist in conceptualizing ghosting were addressed as well as implications for research and future treatment of individuals with complex diagnosis such as BD and comorbid PTSD.

Recognizing how BD and comorbid PTSD may contribute to heightened probability of ghosting symptoms or behaviors is imperative to preventative and management realms of treatment. Qualitative approaches may be best when gathering evidence to support both symptomology and behavioral aspects of ghosting.

Recommendations

Individuals diagnosed with BD and PTSD are encouraged to consider medication management to manage symptoms. Ideally, individuals must be monitored as efficiently as possible when introduced to a mental health setting providing services to review objectives of improving functionality. I have observed that monitoring is more plausible with verbal permission of the client to contact certain key players such as parents, siblings, or significant others through the signing of a release of information. Psychoeducation and awareness of symptomology related to ghosting can help initiate consideration for treatment. Mental health approaches such as mindfulness, emotional regulation, and distress tolerance can aid in positive treatment outcomes. Proactive theoretical approaches to therapy such as Dialectical Behavior Therapy (DBT), for example, may permit changes and enhance overall functioning.

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