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Hallucinations in Bipolar Disorder: A Spectrum Between Psychotic Features and Affective Intensification

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ABSTRACT: Hallucinations, while traditionally associated with schizophrenia spectrum disorders, are increasingly recognized in individuals with bipolar disorder, particularly in rapid cycling forms. Such manifestations complicate diagnosis and, if overlooked, may lead to poorer prognoses. This case report describes the clinical course and management of a 30-year-old female with bipolar I disorder, rapid cycling subtype (≥6 episodes/year), presenting with impulsivity, emotional instability, and mild auditory hallucinations. Her history included childhood emotional and physical abuse. Assessments involved DSM-5 structured interviews, the Young Mania Rating Scale (YMRS), Hamilton Depression Rating Scale (HAM-D), and Difficulties in Emotion Regulation Scale (DERS). Findings indicated pronounced affective lability, trauma-related personality traits overlapping with borderline personality disorder, and partial resistance to prior pharmacological treatment. During inpatient care, she was treated with valproate and low-dose quetiapine, complemented by psychoeducation and trauma-focused psychotherapy, producing notable improvement despite residual mood instability. This case underscores the interaction between trauma, affective dysregulation, and psychotic-like features in rapid cycling bipolar disorder (RCBD). Hallucinations here may reflect affective intensification rather than primary psychosis, stressing the need for careful differential diagnosis and trauma screening. The implications advocate routine trauma-informed assessments in bipolar disorder and highlight the efficacy of multimodal strategies combining pharmacological stabilization with targeted psychotherapy. Integrating trauma-focused care with mood management can enhance long-term outcomes in RCBD, particularly where conventional treatment shows partial resistance.

Keywords: Bipolar Disorder, Rapid Cycling, Hallucinations, Trauma, Emotion Dysregulation, Trauma-Informed Care.

INTRODUCTION

Bipolar disorder is a complex psychiatric condition characterized by recurrent episodes of mania, hypomania, and depression. Among its subtypes, rapid cycling bipolar disorder (RCBD)—defined as four or more mood episodes within one year represents one of the most severe and

diagnostically challenging forms. RCBD is associated with early onset, higher comorbidity rates, treatment resistance, and poorer functional outcomes compared with non-rapid cycling presentations (Baldessarini et al., 2023; Miola et al., 2023).

Hallucinations, although traditionally associated with schizophrenia spectrum disorders, are increasingly reported in patients with bipolar disorder, particularly during severe or rapid cycling episodes. Up to one-third of individuals with bipolar disorder experience auditory hallucinations, either mood-congruent or incongruent, with the latter predicting worse prognosis (Santoso & Wijaya, 2022). Such features often complicate diagnostic clarity, increasing the risk of misdiagnosis as schizophrenia or borderline personality disorder (BPD).

Early-life trauma, including emotional and physical abuse, has been identified as a major vulnerability factor in the onset and course of bipolar disorder. Neurobiological evidence indicates that trauma may lead to persistent amygdala hyperactivation, hypothalamic–pituitary–adrenal (HPA) axis dysregulation, and epigenetic alterations, all of which contribute to affective instability, impulsivity, and partial treatment resistance (Heim & Binder, 2012). Early adversity has also been linked to vulnerability for other mood-related conditions such as prolonged grief disorder and early-onset depression in children (Prameswari et al., 2024), reinforcing the developmental impact of trauma on affective dysregulation.

Despite growing evidence, trauma-related hallucinatory phenomena in bipolar disorder remain underrecognized, particularly in low- and middle-income countries where psychiatric resources are limited and cultural or religious interpretations of symptoms may delay treatment.

This case report describes a 30-year-old female with RCBD and a history of childhood trauma who presented with auditory hallucinations. The aim is to highlight how hallucinations in this context may reflect affective intensification rather than primary psychosis, and to underscore the importance of trauma-informed assessment and integrative treatment approaches in bipolar disorder.

METHOD

Case Presentation

The patient was a 30-year-old female admitted to the psychiatric inpatient unit of a tertiary care hospital in Surabaya, Indonesia. She met DSM-5 criteria for bipolar I disorder with rapid cycling, defined as at least four mood episodes within a 12-month period.

History and Clinical Presentation:

The patient reported more than six mood episodes during the past year, alternating between depressive and hypomanic states. Symptoms included irritability, impulsivity, affective lability, and

disturbed sleep. She also reported experiencing mild auditory hallucinations, described as voices commenting on her behavior, particularly during depressive phases.

Trauma Background:

Her personal history revealed childhood emotional and physical abuse, without evidence of substance use disorders. There was no family history of psychotic disorders.

Assessment:

Clinical evaluation was performed using a structured DSM-5 interview, supplemented with collateral information from family members. Symptom severity was measured with standardized instruments: the Young Mania Rating Scale (YMRS), the Hamilton, (1960) Depression Rating Scale (HAM-D), and the Difficulties in Emotion Regulation Scale (DERS). Daily mental status examinations were conducted throughout hospitalization.

Treatment:

Pharmacological management consisted of valproate (1,000 mg/day) and low-dose quetiapine (100 mg/night), with dosage adjustments according to clinical response. Psychoeducation sessions focused on illness awareness, treatment adherence, and early recognition of mood changes. Trauma-focused psychotherapy sessions were delivered using cognitive-behavioral techniques, emphasizing maladaptive belief restructuring and coping strategy development.

Ethical Considerations:

Written informed consent was obtained from the patient for the use of anonymized clinical information in this report. All potentially identifying details were altered to preserve confidentiality.

RESULT AND DISCUSSION

The patient experienced more than six mood episodes within a one-year period, alternating between depressive and hypomanic states. Clinical symptoms included irritability, impulsivity, affective lability, disturbed sleep, and mild auditory hallucinations described as voices commenting on her behavior, particularly during depressive phases.

Standardized assessments confirmed the severity of her condition. Scores indicated moderate mania on the Young Mania Rating Scale (YMRS), severe depression on the Hamilton Depression Rating Scale (HAM-D), and significant emotion regulation difficulties on the Difficulties in Emotion Regulation Scale (DERS). Mental status examinations during hospitalization consistently revealed affective instability, heightened reactivity to stressors, and intermittent hallucinatory experiences.

Following treatment with valproate (1,000 mg/day) and low-dose quetiapine (100 mg/night), alongside psychoeducation and trauma-focused psychotherapy, the patient demonstrated substantial clinical improvement. Mood stabilization was achieved to a moderate degree, hallucinations diminished, and insight into illness improved, although residual affective lability persisted.

This case highlights the complex interplay between RCBD, trauma history, and hallucinatory phenomena. The occurrence of auditory hallucinations during affective instability supports the view that such experiences may represent an intensification of mood dysregulation rather than a distinct psychotic disorder. Prior studies have reported similar findings, noting that up to one-third of bipolar patients experience hallucinations, with mood-incongruent hallucinations predicting a more severe clinical trajectory (Elowe et al., 2022; Sommer et al., 2012).

Childhood trauma emerged as a critical factor in this presentation. Evidence suggests that trauma contributes to persistent amygdala hyperactivation, HPA axis dysregulation, and epigenetic changes that increase vulnerability to unstable mood states and treatment resistance (Nemeroff, 2016) Goodman et al., 2022). These mechanisms likely underlie the patient's affective instability and partial resistance to previous pharmacological interventions. Early-life adversity is often implicated in shaping maladaptive coping strategies, with compulsive behaviors such as substance use or hypersexuality serving as emotion regulation substitutes (Shafly et al., 2025).

Recent neurobiological studies have further clarified the mechanisms linking early adversity to the development of affective and psychotic-like symptoms in bipolar disorder. Beyond HPA axis dysregulation, trauma has been associated with chronic low-grade inflammation, altered microglial activation, and disrupted connectivity in fronto-limbic networks that regulate emotion and cognition (Goodman et al., 2022). These processes may sensitize the individual to environmental stressors, creating a state of allostatic overload that predisposes to rapid mood shifts and perceptual disturbances. Such findings support the conceptualization of hallucinations in bipolar disorder as not merely secondary to psychosis but as emergent phenomena of affective and neurobiological dysregulation.

In terms of coping strategies, while compulsive sexual behavior may serve as one maladaptive attempt to regulate negative affect, other patterns are also frequently observed. Substance use, binge eating, and deliberate self-harm have been reported in bipolar patients with significant trauma histories. These behaviors provide transient relief but ultimately exacerbate mood instability, increase relapse risk, and complicate treatment adherence. Recognition of such maladaptive coping patterns is clinically important, as they often coexist with residual affective symptoms even when pharmacological stabilization has been partially achieved. Integrating trauma-focused psychotherapy with skills training in adaptive emotion regulation may therefore improve long-term prognosis.

From a diagnostic perspective, the overlap between RCBD and borderline personality disorder remains a considerable challenge. Both disorders share affective instability, impulsivity, and heightened interpersonal sensitivity, but differ in course, treatment response, and underlying

neurobiology (Phillips & Kupfer, 2013). Misdiagnosis may result in inappropriate use of long-term antipsychotic or mood stabilizer therapy in BPD, or conversely, inadequate pharmacological treatment in RCBD misclassified as personality pathology. In this regard, the presence of cyclicity, family history of mood disorders, and response to mood stabilizers serve as important clinical clues favoring bipolar disorder. Nevertheless, trauma-informed assessments are indispensable, as early adversity contributes to phenotypic overlap and increases diagnostic uncertainty. The present case underscores the necessity of comprehensive evaluation that incorporates both dimensional (e.g., RDoC framework) and categorical approaches to improve diagnostic precision and treatment planning.

Clinically, the overlap between trauma-related traits and borderline personality disorder (BPD) complicates diagnosis. The diagnostic complexity observed in this case is consistent with broader concerns regarding the challenges of distinguishing bipolar disorder from schizophrenia spectrum and personality disorders (Phillips & Kupfer, 2013). Both conditions share affective instability and impulsivity, raising the risk of misdiagnosis and inappropriate treatment. Moreover, patients with BPD and histories of severe depression often present with heightened suicidality, underscoring the clinical urgency of accurate differential diagnosis (Faisal et al., 2022). Systematic trauma screening is therefore essential in bipolar patients, particularly those with rapid cycling or atypical features (Janiri et al., 2023).

From a therapeutic perspective, the multimodal approach combining mood stabilizers, antipsychotic augmentation, psychoeducation, and trauma-focused psychotherapy produced meaningful improvement. This aligns with emerging recommendations for integrated treatment strategies that address both biological and psychosocial vulnerabilities. However, residual symptoms in this case emphasize the need for long-term, trauma-informed, and recovery-oriented care.

Beyond individual treatment, the findings carry public health relevance, particularly in low- and middle-income countries such as Indonesia. Cultural interpretations of hallucinations through religious or mystical frameworks may delay psychiatric care (Kohrt et al., 2016). Culturally sensitive psychoeducation, combined with accessible community-based services, is crucial to reduce stigma, improve help-seeking, and align with Sustainable Development Goal (SDG) 3 on health and well-being.

In summary, this case demonstrates that hallucinations in RCBD may arise from affective intensification rather than primary psychosis, and that trauma exposure plays a pivotal role in shaping clinical course and treatment response. Routine trauma-informed assessments and integrative therapeutic approaches are essential for improving outcomes in such complex presentations.

Public Health Relevance and Sustainable Development Goals (SDGs)

Bipolar disorder with psychotic features represents a substantial public health burden, particularly in low- and middle-income countries (LMICs) where access to mental health services remains limited. The (Organization, 2022) has emphasized that neuropsychiatric conditions contribute significantly to global disability-adjusted life years (DALYs), and untreated mood disorders are among the leading causes of years lived with disability (YLDs). Within this context, managing hallucinations in bipolar disorder is not only a clinical imperative but also a public health priority aligned with Sustainable Development Goal 3 (Good Health and Well-being).

Global estimates indicate that around 40 million people live with bipolar disorder, underscoring its substantial contribution to disability worldwide. In Indonesia, national surveys suggest that as many as one in five people experience some form of mental disorder, yet treatment coverage for severe conditions such as bipolar disorder remains very limited and varies widely across regions. Barriers include a shortage of mental health professionals, limited financing, and cultural interpretations of symptoms that delay appropriate treatment. Addressing these gaps requires integration of mental health services into primary care and the adoption of task-shifting approaches, such as training nurses and community health cadres to provide psychoeducation, early screening, relapse monitoring, and referral. Evidence from Indonesian pilot programs indicates that well-supervised cadres can help reduce stigma, improve help-seeking, and bridge the treatment gap in underserved communities, aligning with SDG targets 3.4 and 3.8 on mental health and universal health coverage.

The disproportionate treatment gap in LMICs is exacerbated by stigma, shortage of trained personnel, and lack of culturally responsive care models. In Indonesia, for example, psychiatric symptoms such as hallucinations are often interpreted through religious or mystical lenses, delaying appropriate treatment and increasing the risk of chronicity or institutionalization. Addressing this requires integration of mental health services into primary care and community-based interventions that respect local belief systems.

Efforts to reduce stigma and improve help-seeking behavior must include educational outreach, early screening, and psychoeducation that is linguistically and culturally tailored. Incorporating these approaches into national health frameworks also aligns with SDG Target 3.4, which aims to reduce premature mortality from non-communicable diseases, including mental illness, through prevention and treatment.

Moreover, promoting equity in access to psychotropic medications, digital mental health tools, and professional supervision for community health workers are critical steps toward SDG Target 3.8, which focuses on achieving universal health coverage, including mental health care.

In conclusion, the complex interplay between biological vulnerability, psychosocial stressors, and cultural perception of hallucinations in bipolar disorder must be viewed through a public health lens. Strengthening the system-level response is vital for ensuring that mental health care is inclusive, sustainable, and effective in preventing disability and improving recovery outcomes.

Digital Interventions and Recovery-Oriented Models

The integration of digital technologies into mental health care has transformed the management of bipolar disorder, especially in individuals with psychotic features. Mobile applications for mood tracking, speech analysis, and behavioral monitoring have shown promise in predicting mood episodes, including manic and psychotic shifts (Shatte et al., 2019). These tools, often powered by machine learning algorithms, can detect subtle behavioral changes, offering real-time alerts for clinicians or caregivers and enabling proactive intervention.

Telepsychiatry and online counseling platforms have also expanded access to care, particularly in remote or underserved areas. In LMICs such as Indonesia, digital delivery of psychoeducation and cognitive behavioral therapy (CBT) modules has reduced stigma and bridged the urban-rural treatment divide (Naslund et al., 2020). These innovations are not meant to replace traditional care but to complement in-person services, especially for patients with mobility issues, high relapse risk, or low insight during psychotic episodes.

Complementing the technological shift is the rise of recovery-oriented models of care. These models prioritize not only symptom reduction but also functional recovery, autonomy, and meaning-making in daily life (Fc et al., 2020; Slade et al., 2014). For individuals with hallucinations in bipolar disorder, recovery is not linear and often involves navigating fluctuating insight, affective dysregulation, and the residual effects of trauma. Supportive therapy, peer support groups, and structured community involvement have been shown to foster resilience and reduce rehospitalization rates.

Moreover, the use of digital platforms to facilitate peer support such as moderated forums or group video sessions has demonstrated benefits in reducing social isolation and enhancing self-efficacy. Integration of spiritual or culturally adapted content in digital CBT tools has also shown promise in Southeast Asian populations, where personal meaning and belief systems deeply influence the recovery trajectory.

In this context, future mental health strategies must include both high-tech and high-touch approaches leveraging technology without compromising human connection. A blended care model that incorporates evidence-based digital tools within a recovery framework holds significant potential for improving outcomes in bipolar disorder with psychotic features.

Recommendations for Future Research and Clinical Practice

Given the complexity of hallucinations in bipolar disorder, future research should prioritize longitudinal and neurobiologically informed studies that examine the trajectory and predictors of psychotic symptoms across various mood phases. Neuroimaging techniques such as fMRI and diffusion tensor imaging (DTI) may provide further insight into how affective dysregulation interacts with perceptual processing and auditory hallucinations in the brain (Phillips & Swartz, 2014; Reilly, 2014). Future research should also incorporate dimensional approaches such as the Research Domain Criteria (RDoC) framework, which aims to capture transdiagnostic mechanisms underlying mental disorders (Insel, 2010). Moreover, there is a growing need to distinguish

between mood-congruent and incongruent hallucinations in clinical settings to better guide diagnostic clarity and treatment algorithms.

On the clinical front, personalized medicine approaches should be expanded to include genetic, psychosocial, and digital phenotyping markers. Stratifying patients based on their risk for psychosis, medication sensitivity, environmental adversity, and treatment response can improve therapeutic precision and patient-centered outcomes. As hallucinations in bipolar disorder are often transient and linked to fluctuating mood states, over-reliance on antipsychotics should be avoided unless clinically justified. Instead, treatment strategies should emphasize mood stabilization using agents such as lithium, valproate, or lamotrigine, supplemented with time-limited antipsychotic therapy as needed (Geddes & Miklowitz, 2013; Goodwin et al., 2016).

Future research should also prioritize the identification of biological and psychosocial markers that can guide personalized treatment in rapid cycling bipolar disorder. In recent years, polygenic risk scores and genome-wide Association, (2013) studies have highlighted specific genetic variants associated with mood instability and treatment resistance, suggesting that integration of genetic testing into clinical care may allow for more precise prognostication. In parallel, inflammatory markers such as C-reactive protein and interleukin-6 have been repeatedly linked to bipolar disorder and may serve as state-dependent biomarkers that help distinguish between affective intensification and primary psychotic processes. Combining these biological indices with digital phenotyping approaches, such as ecological momentary assessment of mood, speech analysis, and actigraphy, could provide a multidimensional framework for early detection of relapse.

Equally important are sociocultural factors that shape clinical expression and access to care. Cross-national studies involving LMICs, including Indonesia, are needed to examine how cultural narratives about hallucinations intersect with biological vulnerabilities, potentially influencing illness trajectory and help-seeking behavior. International collaborations and capacity-building initiatives can strengthen methodological rigor, promote equity in mental health research, and ensure that findings are globally relevant rather than skewed toward high-income populations. Such research directions not only promise to refine diagnostic clarity but also to inform public health strategies that reduce stigma and close the treatment gap for individuals with complex presentations of bipolar disorder.

Training for clinicians must include dedicated modules on differential diagnosis between schizophrenia spectrum and bipolar disorders, particularly in emergency psychiatric settings. Additionally, integrating trauma-informed care frameworks may uncover underlying vulnerabilities that contribute to psychotic features in bipolar patients, especially those with histories of early adversity, abuse, or neglect (Algristian et al., 2024; Chatterjee, 2017) .

Finally, clinical guidelines should promote recovery-oriented goals, emphasizing functional autonomy, social reintegration, and long-term quality of life. Incorporating culturally sensitive psychoeducation, spirituality-informed practices, community partnerships, and user-friendly digital tools into psychiatric care pathways can enhance treatment engagement, adherence, and recovery outcomes. These strategies will not only reduce the treatment gap but also align contemporary

psychiatric practice with public health values and the broader Sustainable Development Goals agenda.

CONCLUSION

This case demonstrates that hallucinations in rapid cycling bipolar disorder (RCBD) may represent an intensification of affective dysregulation rather than a distinct psychotic disorder. The presence of early-life trauma contributed to affective instability, impulsivity, and partial treatment resistance, underscoring the importance of trauma-informed assessment in bipolar patients. A multimodal treatment approach combining mood stabilizers, psychoeducation, and trauma-focused psychotherapy produced significant clinical improvement, although residual mood lability persisted.

Routine trauma screening and integrative care pathways are essential to improve diagnostic accuracy, guide personalized treatment, and enhance functional recovery in patients with bipolar disorder who present with hallucinations. These strategies may also reduce misdiagnosis, prevent relapse, and align mental health services with global priorities for holistic and sustainable care.

Routine trauma screening and integrative care pathways are essential to improve diagnostic accuracy, guide personalized treatment, and enhance functional recovery in patients with bipolar disorder who present with hallucinations. These strategies may also reduce misdiagnosis, prevent relapse, and align mental health services with global priorities for holistic and sustainable care. Importantly, as highlighted in cases of BPD with severe depression and suicidality, failure to recognize trauma-related vulnerabilities may increase risk of poor outcomes, reinforcing the need for trauma-informed and suicide-preventive approaches in bipolar care.

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