SPEAKER NOTES

Bipolar Disorder and Other Depressive Disorders

Summarized by Thomas T. Thomas

Many types of mental illness have depression as a component, including bipolar disorder– formerly and still sometimes called "manic depression"– and simple depression. All of them require treatment. **W. Douglas Moorhead, MD,** medical and clinical director of Berkeley Mental Health, discussed bipolar, depression, and similar diseases, and some of the newer medications and therapies for treating them at our March 26 meeting.

W. DOUGLAS MOORHEAD, MD

"Bipolar disorder was only recognized as an illness separate from schizophrenia at the turn of the century– the 1900s, that is," Dr. Moorhead said. "A study by the German psychiatrist Emil Kraepelin identified *dementia praecox*, or schizophrenia, as occurring early in life and *la folie circulaire*, or circular illness– manic depression– as something that came on somewhat later. It was noted at the time that, while people with schizophrenia tended to deteriorate over the course of the illness, manic depression was marked by episodes of illness followed by apparent recovery.

"However, we since have learned that, with schizophrenia, deterioration occurs in only about 30 percent of cases."

The next big advance in the study of bipolar disorder came in the 1940s. Doctors in Australia were prescribing lithium chloride as a substitute for table salt to help people with kidney and heart conditions. The practice became so widespread that the new salt was even used in cooking, and then its toxic side effects, including tremors and some deaths, became known. But the doctors also found that people with manic depression experienced improvement. A decade later, lithium became the first big medical breakthrough in treating mental illness.

The other breakthrough was Thorazine (generic: chlorpromazine), one of the typical antipsychotic medications. "They were called typical," Dr. Moorhead noted, "because they commonly caused movement disorders as a side effect. Doctors used this as a sign that the medication was working and would prescribe dosing up until these 'typical' disorders developed. The newer 'atypical' antipsychotic medications affect a different track in the brain and so have no movement disorders associated with them."

After Thorazine, the mood stabilizers Depakene (valproic acid) and Depakote (divalproex sodium) were developed and used in treating manic depression.

"One of the newest waves in medication," the doctor said, "has been the discovery that the antipsychotic Zyprexa [olanzapine] is more effective in treating bipolar disorder than either lithium or valproic acid and has fewer side effects.

"The other wave is research on mental illness in children and adolescents. Back in 1975, the psychiatric dogma was that depression did not occur in children. They might be hyperactive or autistic, but they were not schizophrenic or depressed, because children were supposed to be happy.

"This changed," Dr. Moorhead said, "with the first research into the dissociative disorders in children, which range from sleep walking to multiple personality. These studies suggested that the disorders we see in adults often have precursors in children and adolescents, but they are not completely formed, as the child's body and mind are not completely formed. And now we have indications of schizophrenia and bipolar in children."

Some psychiatrists, he said, want to treat these illnesses aggressively with medication in childhood, arguing that the child's mind is malleable and will recover. Others hesitate because they don't want to alter the developmental process.

Dr. Moorhead said that the *Diagnostic and Statistical Manual of Mental Disorders*, which is the bible for treatment, identifies the following types of bipolar disorder, in descending order of severity:

- Bipolar 1, marked by major depression and at least one major manic episode where the patient loses touch with reality (i.e., becomes psychotic) for at least four days.
- Bipolar 2, marked by depression and hypomania (i.e., mania without the psychosis), but neither set of symptoms is considered major.
- Cyclothymia, a cycling of the "feeling states" (in Greek, *thymia*) with no psychotic experiences.
- Bipolar NOS (for Not Otherwise Specified), which covers bipolarlike symptoms that don't appear to fit into other categories.

What may be added soon is a category Bipolar 3, in which the patient sees the doctor for depression and experiences the first manic episode while under— and perhaps as a cause of— treatment.

"Seventy percent of the people who receive antidepressants," Dr. Moorhead said, "get them from a general practitioner, nor a psychiatrist. It has just come out in the journals that the older antidepressants, the tricyclics like Elavil [amitriptyline], can flip a bipolar person into a manic episode.

"So the physician must check for any history of bipolar before prescribing these medications. If the patient is resistant to treatment for depression— that is, has failed to respond to three antidepressants of different classes— he or she may indeed be bipolar. Better yet, start with a mood stabilizer like Lithane [lithium carbonate], Tegretol [carbamazepine], or Depakote [divalproex sodium]."

He noted that a person who goes into mania after taking an antidepressant can become "rapid cycling." Instead of building gradually, the episodes quickly grow intense and come closer together. Normally, a person with bipolar might have one manic episode in his or her teens, two in the twenties, and so on. In the common progression, the manic episodes stop being euphoric, characterized by

grandiosity, and instead become a grinding experience, a mixed state, like the depression but with energy. Less commonly, the episodes become longer and milder.

After the mania comes shame and guilt at the excesses the patient has experienced. By itself, this reaction can trigger the onset of depression. "Psychotherapy can help the patient understand the nature of the illness, learn about and deal with it, and understand the medications and course of treatment," Dr. Moorhead said.

During the presentation, the doctor addressed many questions from the audience.

Where does schizo-affective disorder fall between schizophrenia and bipolar?

A person who meets the criteria for both may have schizo-affective disorder. Hallucinations and delusions, the symptoms of psychosis, can happen to anyone under sufficient stress. In the Korean War it was shown that everyone who spent 72 hours under fire in a foxhole became psychotic. One hundred percent. So it's not surprising that bipolar patients, under the stress of their mania, have psychotic symptoms.

Does manic depression start in childhood?

People, including children, may have depression but are not diagnosed as bipolar until they have a manic episode. We now see that childhood depression and mania are different, as children are different from adults. The onset of a bipolar disorder may have been in childhood, and in retrospect you may see that there were signals before the person's twenties. But this is not something you should watch for, because normal childhood and adolescence are also characterized by mood swings.

Is the diagnosis based solely on behavior?

At this point, diagnosis is based on "phenomenology." That is, a history of behavior over time. You cannot judge from behavior in the moment. Over the years there has been a lot of experimental work on imaging mental illnesses with things like PET scans, but as yet no X-ray will diagnose bipolar.

My daughter has bipolar and the episodes seem to be linked to her menstrual cycle. Would hormonal therapy work on mental illness?

We have not seen this. Some women with premenstrual anxiety and pain who are not helped by hormonal therapy can be helped by psychiatric medications. So perhaps your daughter's psychiatric illness could benefit from hormone treatment.

What percentage of people in the population have bipolar disorder?

Under the old diagnostic standards, we used to say one percent. But with the "Not Otherwise Specified" category, that's risen to 15 percent. And 30 percent of people with depression have had some bipolar incidents. We now think of these illnesses like a wagon wheel, with everyday moods in the center and the spokes radiating outward in progressions from normal feelings to cyclothymia to bipolar disorder

What is the response time to medications?

Don't expect to see results right away. Some medications take up to six weeks for effect. If a patient reports an immediate "miracle cure"— wow, I feel better already!— it may be a sign of mania flipped on by the antidepressant.

And, by the way, the older antidepressants are just as effective as the newer ones. Don't switch because you think they will work better. The newer ones just have fewer side effects.

It's not surprising that stomach aches, nausea, and diarrhea are common side effects of these medications, because one-quarter of the nerves in the body's central nervous system are in the gastrointestinal tract. If we give medicines for the brain, they are going to have an effect on digestion.

Why do psychiatrists tend to exclude family members when it comes to diagnosis and treatment?

This is unfortunate, because bipolar patients tend to underreport their manic episodes, either because they don't remember them or because they are shamed by the excesses. So it's important for the psychiatrist to have information from family members to get the whole picture.

However, psychiatry derives from psychoanalysis, which depends on the patient being involved with the treatment and has issues with confidentiality. And then, laws regarding the handing of mentally ill patients and their records are written by lawyers, who may not have experienced the illness themselves or imagined themselves working with an ill family member.

Is there some protocol for medication— some way of knowing what medications will work?

Not in California at present. In Texas they have a statewide algorithm, in which medications are applied in a particular order. A person from Austin can walk into a doctor's office in Amarillo and the doctor can know where he is in the medication cycle. California psychiatrists don't do this yet. Each doctor here has his or her own favorite medications and algorithms.

We are still at the stage of empirical medicine. Doctors don't really know how the brain's mood system operates, why we feel well or poorly. But we are learning that mood may be directly related to a person's sense of meaning and his or her sense of place in life.