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MEDICAL MEMO

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Bipolar Disorder, DMDD, and SAD

Bipolar Disorder is present in at least 1 to 2% (1 to 2 persons out of every 100) of adults. It is definitely not rare; many cases are in fact being misdiagnosed or being missed completely. Many people with Bipolar Disorder never seek help, end up in jail, cover it up with substance abuse, or never see a clinician long enough or experienced enough and knowledgeable enough about the disorder to recognize it. Others with Bipolar Disorder have hard to recognize forms of it, enjoy the up phases and don't ask for or want help when the recognizable signs are present. Bipolar Disorder is sometimes over diagnosed when people are in crisis for other reasons. It is often difficult to recognize Bipolar Disorder unless the person is in a classic manic stage (see below). Only about 25% of people with any mental illness or disorder ever see a psychiatrist, psychologist, counselor, or therapist.

DSM-5 addressed, simplified, and at least partially resolved major debates in mental health: 1) it reduced the 7 types of Bipolar in DSM-IV to three (plus subtypes), and 2) regarding diagnosing Bipolar in children and adolescents.

DSM-5 now has only two main types of Bipolar Disorder, Bipolar I Disorder (the classic manic depression with separate clear depressed and at least a week of fully manic episodes), and Bipolar II Disorder (episodes of depression alternating with less than full manic periods but clearly "higher" than normal periods referred to as hypomania lasting at least 4 days). Subtypes of Bipolar I and II (for all ages), rather than separate types of Bipolar, are now specified including rapid cycling, mixed (in which episodes have mixed features of mania and depression simultaneously), anxious distress, seasonal, peripartum onset, melancholia, psychosis, etc. Cyclothymia (less severe but troubling mood irregularities that cycle) continues as a third member of the Bipolar and Related Disorders group. Schizoaffective Disorder is now part of the updated Schizophrenia Spectrum.

The diagnostic criteria for prepubertal children and teens are now generally accepted to be the same as for adults. The much broader (less restricted than DSM-5 and DSM-IV) methods to diagnose such as in the book The Bipolar Child which did not require episodes, focused on temper outbursts, over-emphasized multiple ultra rapid "cycles" such as hourly within one day, and essentially said the more problems the child has, the more likely it's Bipolar has been mostly discredited (eg., roughly 75% of prepubertal children diagnosed Bipolar by the broad Bipolar Child type criteria do not have Bipolar as adults).

What is Disruptive Mood Dysregulation Disorder (DMDD)? So how do we understand the many children between age 6 and 18 who have severe recurrent temper outbursts at least 3 times a week occurring in multiple settings, with their mood between outbursts being persistently irritable or angry most of the day nearly every day, for at least the last year, and has never had mania or hypomania. These kids are a substantial portion of those who used to be called Bipolar under the looser and broader Bipolar Child perspective. This new diagnosis was

created in DSM-5 based on research and a better clinical understanding showing that the chances of a child with severe non-episodic irritability becoming Bipolar are very low. Typically, unlike kids with Bipolar, they do not have a strong family history for Bipolar and they do not exhibit DSM-5 mania. Rather, they tend to show depression (DSM-5 includes DMDD in the group of Depressive Disorders), anxiety, Oppositional Disorder, family problems, trauma history, learning disorder, and/or ADHD. Notice that with a top age of 18 this is a developmental disorder that resolves or, more often, becomes something else by adulthood.

The DSM-5 emphasis on the presence of episodes of mania or hypomania has also lessened the chance of confusing severe ADHD with Bipolar Disorder. **To separate Bipolar Disorder in children from severe ADHD** we look for episodes, grandiosity, elated mood, racing thoughts, flight of ideas, and much increased inappropriate behavior (silly laughing, daredevil behavior, much less sleep need, hyper-sexuality) and even hallucinations and delusions which all point to Bipolar while irritablity, rapid speech, high energy, and distractibilty often occur in both.

There are important reasons to be careful with the diagnosis of Bipolar Disorder. Although there are, and have been, many successful and even very successful and very admirable people with Bipolar Disorder, it is too often a disabling chronic and recurrent life long disorder with a worrisome prognosis. There is reason to believe that early life onset is even more of a concern. The label of Bipolar Disorder too often complicates one's life, potentially including employment, professional licenses, and obtaining insurance coverage. Bipolar Disorder runs in families and thus may have an impact on family planning. Treatment response is sometimes quite good, although patient compliance with the needed long-term maintenance treatment is too often a problem. The standard medications, mood stabilizers (see my medication chart) and atypical antipsychotics (see my medication chart) often have a longer list of potential minor and even (uncommon) major side effects than other simpler medicines for depression, anxiety, and ADHD.

Since the unique feature of Bipolar Disorder is mania, **WHAT IS MANIA?** The pure and clear form of classic mania is typified by **at least a week** of the person **not being their usual self**, experiencing **all or most of** the following symptoms **at the same time**: dramatically decreased need for sleep, decreased need for eating, being too energized with fabulous new ideas or creative projects to pursue to have time to waste on such mundane tasks as eating or sleeping, thoughts that come so fast ("racing") that the mouth or writing can't keep up, talking so fast ("pressured") others can't get a word in edgewise, the ideas though seeming logical to the manic are expressed and change so quickly that others can't follow the "flight of ideas", the manic is so overwhelmed by urges and thoughts that he or she is very easily distracted, social judgment is lost, the person becomes overly sexual, spends money excessively and unwisely, the manic's mood is euphoric and elated "happier than happy" or very very irritable, the view of self is now "grandiose" such that he or she believe the normal rules of life no longer apply to him or her. The character change in an episode of classic mania is typically dramatically different and severe enough to cause marked impairment in work, relationships, activities of life, and/or endanger the person or others. Severe forms of mania may include hallucinations or delusions and is then called psychotic. **"Hypomania"** is between normal mood ("euthymia") and mania, is less severe than mania and typically lasts at least four days. It is similar to but milder than mania. These criteria are available for review in DSM 5.

For many people the depressed phase of Bipolar disorder, known as Bipolar Depression, is the worst. Bipolar Depression too often lasts many months, is very severe (Major), and may be masked by unusual features like disabling anxiety, cognitive (thinking) dysfunction, and even psychotic symptoms like hallucinations or delusions. Furthermore, Bipolar Depression may not respond to typical depression treatments or even be worsened by antidepressants used without a mood stabilizing medication at the same time. Bipolar Depression is often hard to diagnose and thus treat effectively because the manic or hypomanic phases can be few, hidden, enjoyed by the patient and thus not reported as a problem, or unseen by the therapist and/or psychiatrist. Suspicion of underlying Bipolar Disorder is raised in such hard to treat or diagnose situations.

In summary, for many people with Bipolar Disorder there is no doubt of the diagnosis. Once a clear episode of mania has occurred the diagnosis is definite. Many people respond very well to mood stabilizers such as lithium, the AED's (anti-epileptic drugs) valproic acid (Depakote), lamotrigine (Lamictal), the "atypical antipsychotics" like olanzapine (Zyprexa), risperidone (Risperdal), quetiapine (Seroquel), Abilify, ziprasidone (Geodon), lurasidone (Latuda), and others. **A strong family history** of Bipolar Disorder is a helpful guide in clarifying the diagnosis. **If Bipolar Disorder is definite** or clearly the most likely condition, a treatment plan including mood stabilizers is often advised. **If Bipolar Disorder is only suspected or not definite** the more conservative treatment, in my view, is to proceed with easier to use and milder medication and/or other non-medicine interventions while watching for more clear signs of Bipolar (mania or hypomania) to emerge. With time, the correct diagnosis for an individual patient will generally become more clear due to higher rates of onset as youth grow into adults.

What Is Seasonal Affective Disorder (SAD)?

The term **"Affective"** refers to mood or feelings. Generally this refers to the various forms of depression but includes mania as well. **"Seasonal"** means that the depression or mania seems to vary with the season of the year. Most often this occurs as the beginning or return or worsening of depression in the fall and winter followed by improvement in the spring and summer. Some people have a yearly or almost yearly pattern where a worsening or onset of symptoms at a certain time may be predictable. This is different from or may overlap with a tendency to difficult emotional times at certain sad anniversaries, return to school, other stressors, loss of or change in life structure, or "holiday blues". SAD is believed to be a biologically, not life event, based disorder and pattern. The most frequently cited biological mechanism causing the cycles or pattern of SAD is exposure to amount (time) and intensity (brightness) of **daylight!** Why or how this occurs is not fully understood but clearly melatonin and the Pineal gland have a role. The key point is that we all need (some of us far more than others) an adequate amount of sunlight exposure all year round or we are vulnerable to moodiness or even a full blown Major Depression.

The depression form of SAD is more common in northern (or far south in the southern hemisphere) latitudes and climates that have shorter or excessively cloudy days and thereby less hours of bright sunshine. If the weather is cold or rainy so that people do not go out in the sun this also increases the risk. This helps to partially explain the phenomenon of "cabin fever" many people experience when cooped up inside for long periods. The manic form of SAD usually occurs in summer in persons who have winter depressions but can be reversed. The psychological effects of various weather patterns

is a bigger and fascinating topic which also includes some people being sensitive to the ionization and pressure changes of weather fronts, and even certain winds like the Santa Ana in California, the Chinook in Alaska and Yukon, and the Foehn in central Europe. The amount of windows, skylights and orientation to the sun of our buildings also is quite important in determining the amount and intensity of sunlight.

Many people are surprised to learn that SAD occurs in places as sunny and clear in the fall and winter as Arizona. The incidence of SAD is much less here but not rare. Even we have less sun, cooler weather, and shorter days such that many people have less opportunity to get outside in bright sunshine each day.

So what do you do if you suspect you have SAD? You do what you should always do when you suspect you have an illness: go see your doctor, learn about it and other possibilities, make sure it isn't some other health problem, and see a mental health professional knowledgeable about the condition, related conditions, and **treatments**. Psychotherapies used for depression, life style adjustments and medication used in other forms of depression are also often helpful for SAD. Increasing healthy light exposure is often desirable as well for SAD. Neither the use of melatonin for SAD nor light therapy for non SAD depressions are often effective. **Light Therapy** is a proven treatment for some or many people with SAD. Bright diffuse fluorescent light of 10,000 lux for 30 minutes daily is best for most people. The light is best full spectrum but without ultraviolet (UV) light. The light can be given in the early evening or during the day, but morning light, mimicking sunrise, is best. If living patterns cannot be adjusted to achieve this, commercially sold Light Boxes can be purchased for around $300 to $400. Light boxes typically come with filters to screen out ultraviolet light. Light therapy is reportedly free of significant or lasting side effects. A useful source of information is the Society For Light Treatment and Biological Rhythms. Lifestyle adjustments include various ways to ensure appropriate levels of light exposure. This may include making choices about where you live and work, the hours you keep, and how you spend free time. Exercise outdoors in the morning such as a morning walk, hike, jog, or bike ride are obvious good choices. Getting outside in the light for at least 30 to 60 minutes regardless of the weather, keeping the blinds or curtains open in the house, choosing to be in a sunny room at home or work, and avoiding winter "hibernating" indoors or living and working in a "cave-like" existence are wise. Of course, many of these lifestyle choices will help other problems as well as seasonal depressions.

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