Spring, 2007 On the Internet at www.leeheymd.com Volume 11, No. 2

MEDICAL MEMO

Kevin Leehey, M.D. Child, Adolescent, and Adult Psychiatry; Board Certified

Bipolar Disorder

Bipolar Disorder is present in at least 1% (1 person 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 experienced enough and knowledgeable enough about the disorder to recognize it. Others with Bipolar Disorder have hard to recognize forms of it or don't ask for help when the recognizable signs are present. Only about 25% of people with any mental illness or disorder ever see a psychiatrist, psychologist or clinical social worker.

Bipolar Disorder is sometimes over diagnosed partly because it is so hard to recognize some forms of Bipolar Disorder and when the person is not in a classic manic stage (see below). There is debate in the field about whether some forms of Bipolar even exist and about their frequency. This debate revolves around 1) making the diagnosis in children, 2) whether "soft Bipolar II and Bipolar III exist, and 3) the frequency of "Mixed", "Rapid Cycling" and Bipolar II types. The debate is made more important by the question of whether currently available Bipolar treatments are even effective in these atypical cases. There hasn't been enough time and research to settle this debate yet.

Let me next briefly summarize the types of Bipolar Disorder. Our current diagnostic manual, DSM IV-TR, contains 7 bipolar related categories; Type I (the classic manic depression with separate clear depressed and fully manic episodes), Type II (episodes of depression alternating with less than full manic periods but clearly "higher" than normal periods referred to as hypomania), NOS (Not Otherwise Specified - which is essentially "atypical" or "other"); Rapid Cycling (the severe ups and downs cycle occur **at least** 4 times a year and may be much more frequent); Mixed (in which episodes have mixed features of mania and depression simultaneously); Schizoaffective-Bipolar (schizophrenia and Bipolar intermingle or overlap); and Cyclothymia (less severe but troubling mood irregularities that cycle). Some more aggressive diagnosers of Bipolar Disorder now argue for the addition of even less clear cut categories such as "soft" Bipolar type II and Bipolar Type III or lump these and other subtypes into the imprecise category of Bipolar NOS.

There are important reasons to be careful with this diagnosis. Although there are, and have been, many successful and even very successful and very admirable people with Bipolar Disorder, it is frequently 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 negatively affects one's life, including employment, licenses, and obtaining insurance coverage. Bipolar Disorder is strongly inherited 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), are "big

guns" that often require blood levels, at least twice daily dosing, and have a longer list of potential minor and even (uncommon) major side effects than other simpler medicines for depression, anxiety, and ADHD. The "atypical antipsychotics (see my medication chart) are also complex as well as often helpful. Treatment results for the more controversial ("soft" Bipolar II and Bipolar III) and less clear forms of the disorder (Mixed or Rapid Cycling) is often less satisfactory than for the more accepted forms. Thus one can question the usefulness of a diagnosis that doesn't clearly lead to effective treatment. Although this should improve with research, some believe this disparity is the case because the person really has some other condition like a personality disorder, substance abuse, anxiety disorder, or another form of depression; not Bipolar Disorder. This type of diagnostic error may be more likely when the doctor's knowledge of the patient is limited by a short time of working together, seeing the patient only at their worst (like a brief hospital stay or brief clinic contact), or little history is available about the person and family background.

How to make the diagnosis of Bipolar Disorder in children, especially before puberty, is a very big controversy currently. There is no doubt Bipolar exists in children 12 and under, but how does it show itself? Some see it hidden in severe ADHD, some see it in "rage attacks", "affective storms", etc. Bipolar in kids is seen as more chronic, less episodic, and more mixed than it appears in teens and adults. The newer views of how Bipolar shows in kids often does not fit the criteria in DSM IV. Thus there is more room for mistake, disagreement, and confusion. Additionally, there is uncertainty about treatment efficacy; more so than with adults. The field of Child Psychiatry is making substantial progress in the diagnosis and treatment of Bipolar Disorder in children, but we have quite a ways to go. New ideas about how Bipolar Disorder shows in children include that it is often more chronic and continuous, less episodic, more often mixed and rapid cycling, with little or no periods of normal function in between, and little or no separation between the depressed and manic times. To separate Bipolar in children from severe ADHD we look for **grandiosity, elated mood, racing thoughts, flight of ideas, and much increased inappropriate behavior (silly laughing, daredevil, less sleep, hypersexuality) and even hallucinations and delusions which all point to Bipolar** while irritablity, rapid speech, high energy, and distractibilty often occur in both.

Since the unique feature of of Bipolar Disorder is mania, **what is Mania**? The pure and clear form of classic mania is typified by **at least a week** of 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 dramatic 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, and is less severe than mania. These criteria are available for review in the DSM IV.

For too 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. Bipolar Depression is often hard to diagnose and thus treat effectively because the manic or hypomanic phases can be rare, hidden, enjoyed by the patient, 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 the classic mood stabilizers lithium, the AED's (anti-epileptic drugs) valproic acid (Depakote), and carbamazepine (Tegretol). Newer AED's include Lamictal, Trileptal, the "atypical antipsychotics" like Zyprexa, Risperdal, Seroquel, Abilify, and Geodon are often helpful options. A strong family history of Bipolar Disorder is one of the better guides 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 and milder medication and other 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.

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 hard 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 straight forward and simple 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. 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.

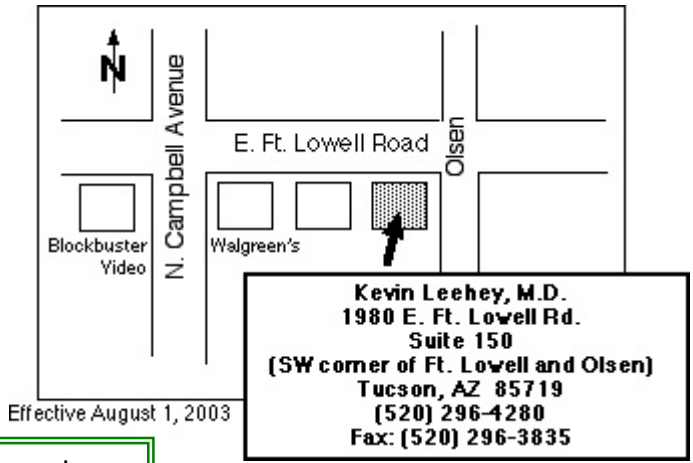
Many people are surprised to learn that SAD occurs in places as sunny and clear in the fall and winter as Arizona. The incidence of SAD is much less here but not rare. Even we have less sun, cooler weather, and shorter days such that many people have less opportunity to get outside in bright sunshine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

Light Therapy is an increasingly accepted and 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 a lot more than seasonal depressions.

Kevin Leehey, M.D.
Child, Adolescent and Adult Psychiatry

Find this issue of Medical Memo, past issues, and other helpful information at Dr. Leehey's web site:
www.leeheymd.com



This newsletter is for information only and does not substitute for talking with your psychiatrist, medical doctor, and/or therapist.