Bipolar II Disorder

Modelling, Measuring and Managing

Edited by

GORDON PARKER

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Bipolar Disorder is now more commonly viewed as a spectrum of conditions rather than a single disease entity. Bipolar II Disorder exists on this spectrum as a condition where the depressive episodes are as severe as in Bipolar I Disorder, but where the mood elevation states are not as extreme, often leading to failure to detect a condition thought to affect up to 6% of the population.

This book reviews, for the first time, our knowledge of this debilitating disorder, covering its history, classification and neurobiology. In a unique section, fourteen internationally recognised experts debate management strategies, building to some consensus, and resulting in treatment guidelines where no such advice currently exists. It should be read by all health professionals managing mood disorders and will also be informative to those with Bipolar II who wish to learn more about the condition.

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Preface

Gordon Parker

This is, we believe, the first monograph focusing on Bipolar II Disorder by itself. 'By itself' raising an obvious question. If Bipolar II is a true mood disorder, is distinctly more common than Bipolar I (or manic depressive illness) but has comparable disability, sequelae and suicide rates, why has it not invited any previous definitive overview? The answer will be quickly apparent to readers.

Firstly, Bipolar II is a relatively 'new' condition, in the sense of it being defined and detailed only over the last few decades. Secondly, its status as a 'condition' is challenged by many. Thirdly, its detection by professionals is low and delayed. Fourthly, it is commonly viewed as a mild condition (e.g. 'bipolar lite'), and as therefore of little consequence in terms of its differentiation from unipolar depression. Fifthly, there are no treatment guidelines for its management, with clinical management – if conceding such a diagnosis – generally extrapolating strategies from the management of Bipolar I Disorder.

Most psychiatric monographs are written when there is a bank of knowledge. Not on this occasion. Here, author after author, all with expertise in the bipolar disorders, note the lack of a clear knowledge base and of any formalised clinical guidelines. This book was designed, however, to detail both what is currently known or debated, and what needs to be clarified. We aim to provide an advance on current clinical management, which has had to operate largely within a vacuum over the last decade – despite rapidly increasing interest in Bipolar II Disorder.

This book proceeds in two broad ways. To begin with, individual chapters review specific issues of relevance. All are informative but there is a predictable lack of integration as each writer addresses their specialist domain. Next, an unusual strategy, a set of international researchers turn from simply interpreting research studies, to considering the clinical nuances that *they* have observed. We learn what they actually do on a day-to-day basis, and their management recommendations. Personal views iterate with thoughtful interpretations of the literature. The tone is

consequently quite different to most clinical overviews. Rather than reference, rely on and often reify previously published treatment guidelines, here the writers bring freshness to their clinical observations – providing new knowledge rather than overviewing old information. Despite some disparate individual views, it is possible to observe integration emerging, but without the collective tone of a 'consensus conference' – which often reflects the majority lining up with the views articulated by the most dominant and charismatic members.

The two sections – respectively prioritising literature overviews and clinical observation – combine to provide management strategies that should assist clinicians. Such strategies are not 'black and white', nor beyond debate and challenge, and are not necessarily easy to assimilate – but it is rich material that provides as many hypotheses for clinicians as for researchers. Most importantly, most of the multiple treatment options considered and questioned by clinicians are examined – so that this monograph should prove of practical use to clinicians and many who suffer from this condition.

A brief overview of the book. We start with an introduction – a young man's essay captures the day-to-day oscillations experienced by those with Bipolar II Disorder. Of greater salience is the tone of the writing. The reader can detect the exuberant chords and cadences of an individual communicating during a 'high' – a quality which is sometimes palpable in patients during their first visit and which may alert the clinician to the possibility of a bipolar mood disorder. This personal story sets a scene in many ways.

The first six chapters overview historical, definitional, classification and measurement issues, consider epidemiological nuances, and identify the limited research examining neurobiological underpinnings to Bipolar II Disorder. The status of Bipolar II Disorder is considered, from its 'non-existence', to it being a discrete categorical type, or its lying within a spectrum, and that it may even exist in the absence of any elevated mood states. Such thoughtful considerations of its status (most evident in Chapter 2) help explain why Bipolar II Disorder has long resisted encapsulation. The chapters following on from these six provide contemporary overviews of a number of possible management strategies, including psychotropic drugs (i.e. antidepressants in general, SSRIs, mood stabilisers, and antipsychotics), fish oil, and psychological interventions, and two chapters consider wellbeing plans and survival strategies.

In Chapter 15, one model for managing Bipolar II Disorder is presented – as a template for consideration and debate by a number of international experts – with their astute independent observations allowing some integration. By close, I suggest that we can no longer view ourselves as having little understanding of the condition. Consensus may not have been achieved, but that is rarely truly achievable in psychiatry. Agreement on many issues is clearly evident. While

ambiguities remain, many have now been defined and their parameters are marked out for resolution by researchers and sharp clinical observations. The hope then is that this book will not only be helpful to clinicians in their daily practice but also to the research community in highlighting key questions that remain to be answered.

I would like to express my appreciation to a number of people. My particular thanks to the many authors who willingly responded to the demands involved in preparing this book, and who provided thoughtful, comprehensive and informative chapters. Then to Kerrie Eyers, who, as in-house editor, has rigorously and precisely edited the volume; and to my secretary Yvonne Foy, who has addressed the multiple administrative demands responsively and smoothly. Many thanks to Black Dog Institute colleagues (Kathryn Fletcher, Dusan Hadzi-Pavlovic, Gin Malhi, Vijaya Manicavasagar, Philip Mitchell, Amanda Olley, Anne-Marie Rees, Meg Smith, Lucy Tully) who contributed to the research underpinning my chapters and to independent chapters. My gratitude to the editors and publishers of the *American Journal of Psychiatry* and *Journal of Affective Disorders* for permission to republish from papers published in their journal, and to Allen & Unwin publishers for permission to republish the 'D club' essay. Sincere appreciation to Richard Marley, Alison Evans and Lesley Bennun of Cambridge University Press for their professional excellence at every stage of this production. Finally, I salute my wife Heather, for her support and graciousness in allowing me the time to write.

Introduction

Gordon Parker

In 2005, the Black Dog Institute held an essay competition, inviting those who had experienced the 'black dog' to describe how they lived with and mastered their depression. Most individuals portrayed depressive episodes with classic melancholic features – with a number of these individuals also depicting 'highs' indicative of bipolar disorder. One such essay is published here. There are several reasons for its reproduction in this forum. Firstly, it is delightfully written. Secondly, its writ large tone is informative. Its author bursts into print with the energy, exuberance and creativity of a 'high', followed shortly by a sombre description of the anergia and enervating blackness of depression. In essence, the essay's structure depicts the roller coaster ride experienced by so many with bipolar disorder. Thirdly, while the author was aware of his depression – his membership of the 'D Club' – he was not aware (raised in subsequent discussion) of the possibility of having bipolar disorder. As detailed through this book, many individuals experience Bipolar II Disorder for decades before receiving an accurate diagnosis – while many others never receive such a diagnosis. It is the depression (the big 'D') that perturbs their lives and drives them to present for treatment of the lows. But bipolar disorder missed is bipolar disorder mis-managed. Fourthly, this essay is beautifully multi-layered. The author captures the enormity of depression but, in being quintessentially upbeat, he demonstrates true resilience, and is touchingly devoid of self-pity.

While this essay captures the factual day-to-day existence of the Bipolar II world, the tone provides the signature chord heard in the conversational style of many who experience Bipolar II Disorder. My gratitude to this Australian writer for allowing his essay to be published anonymously below.

The 'D' Club

I'm the perfect party guest. Put me anywhere and I'll energise. Sit me next to the nerd and we'll be digitising computers and code, saddle me up to an artist and it'll

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be all art house and film noir, introduce me to a mum and we'll be gushing over the newborn. Well, until baby needs a nappy change. Yep, I'm an energetic kind of guy. I'm into things. All things. Passion is my mantra. Be passionate – be proud. T'is cool. T'is sexy. What's more, people respond. I ask questions. They give me answers. It's like I have a truth serum aura or something. My intuition is strong, it is real, it is Instinct . . . it is David Beckham.

Well now that you have my RSVP profile and we're on intimate terms, I can tell you a little secret. A kind of friend for life, confidant, I trust you a whole lot, secret – I'm not always the bundle of kilowatts you see before you. I'm not always the interested, interesting persona that invigorates and epitomises the successful young professional – the man about town who's hip, happening, sporty and fashionable.

Yep, while I sit here typing this on my new ultra-portable, carbon-coated, wireless notebook, because looks are important, I am reminded of my darkest hours. 'My achey breaky heart' hours. And I hated that song from Billy Ray Cyrus and his mullet. Only a few months ago I finished Series 5 of 'Desperate Individuals'. It's my own spin-off from 'Desperate Housewives', except with a limited budget there were no major co-stars or Wysteria Lane . . . just a cast of two, with my sofa taking the supporting role.

Truth be known, my sofa deserves a Logie. A Logie for the best supporting furniture in a clinically depressed episode. Oh Logie schmogie. My sofa does what it always does when I'm alone in my depressive mindlessness. Cradles me, protects me and warms me. We've become quite acquainted over the years since my late teens. We hide from the phone together, cry together and starve together. Ain't that a shit! I have a relationship with a couple of cushions. At least they cushion me from a world I can no longer face, expectations I can no longer live up to, productivity that has left me behind. It makes for good television. Because my life as a depressive is today's cable. It's 100% reality. It's repetitive. It's boring. It's cheap. It's a mockumentary to everyone but the participant. My sofa doesn't eat, you can tell that from the crumbs under the cushions, and with clinical depression, I'm not hungry either so we're a perfect match. Food? My tongue is numb and I can't taste anything so why bother.

Looking back, it's hard to see when each period of depression started. That's because most depressive episodes end up being a blur; a juvenile alcoholic stupor forgetting the hours between midnight and 4 am, except in my mental state it's a whopping six months that are hazy and foreign. Seconds don't exist in my world of depressive dryness. Seconds have become hours. Hours are now days. Months are lost in a timeless void of nothingness. No sleep, no interest, no energy. And it is here that life becomes its most challenging. Don't get me wrong, I'm all for the comfortable picture theatre vicarious experience with stadium seating and popcorn. I just wish depression was a two-hour affair on a cold Sunday afternoon

instead of the rigor-mortic torture that makes it too painful to stay in bed, but even more painful to get up.

Depression is incoherence – the death of wellbeing, direction and life. Everything aches. Everything! Your head. Your eyes. Your heart. Your soul. Your skin aches. Can you smell it? Oh yeah, ache smells and I've reeked of it. My grandmother ached. She told me just before she died of cancer. From then on I saw the ache in her eyes. Sometimes in the middle of a depressive episode, I see it in mine. To look in the mirror and see your own total despair is . . . horrendous.

Now all of this is sounding downright pessimistic and I mustn't dwell on the pain of the past. After all, I'm here to tell my story when many others are not. For I write this not to recapitulate history but to shed a little light on an illness that will affect so many at some time in their life.

For those of you who have been or are currently clinically depressed, welcome to the club – the members-only D Club. Here's your card and welcome letter, and don't forget that we have a loyalty programme. You get points for seeking help, points for talking to friends and family, and points for looking after yourself.

Now news headlines would count the economic cost of depression, which is in the billions, but from a human perspective, it's simply a hell of a lot of agony.

The good news is that public perceptions, which not long ago relegated mental illness to that of social taboo, are slowly being broken. Courage, dignity and honesty can be used to describe former Western Australian Premier Dr Geoff Gallop's address detailing his depression at the start of 2006. Here's a small excerpt:

'It is my difficult duty to inform you today that I am currently being treated for depression. Living with depression is a very debilitating experience, which affects different people in different ways. It has certainly affected many aspects of my life. So much so, that I sought expert help last week. My doctors advised me that with treatment, time and rest this illness is very curable. However, I cannot be certain how long I will need. So in the interests of my health and my family I have decided to rethink my career. I now need that time to restore my health and wellbeing. Therefore I am announcing today my intention to resign as Premier of Western Australia.'

Stories like Dr Gallop's allow more of us to talk about how depression can affect our health, jobs, families, partners and friends. It's not a sign of weakness to express our inability to function mentally. It is in fact a sign of courage, openness, sincerity and trust. It is not unusual for those of us who have or are suffering from depression to feel guilty as if we have somehow brought this illness on ourselves, that we are weak, it's all in our head, or that we're somehow protecting those around us by hiding our mental paralysis. Truth be known, so many of us are lost in today's frenetic lifestyle that we don't see the signs of unhappiness and helplessness in our loved ones. Sometimes it takes a meltdown to even see it in

ourselves. But it is only through acknowledging mental illness that we can get treatment and start to finally feel better. Who would've thought that asking for help would be so hard? For someone suffering from clinical depression, just to talk can be exhausting. During my last episode, I had repeating visions of falling asleep on my grandmother's lap because there I could forget the worries of my world. Memories of her gentle hand caressing the back of my neck are safe and warm. A simple gesture can mean so much.

Today, instead of my grandmother, I have dear friends who offer to cook, clean, wash and care for me. They fight my fierce independence and depression-induced silence with frequent visits and constant dialogue. Their lives haven't stopped, they don't feel burdened and they haven't moved in. They are now simply aware that I have a mental illness, and we are closer because of it. I too have taken responsibility to seek assistance from qualified medical practitioners. Don't get me wrong, taking the first, second and third steps to get help from a doctor can be traumatic. It's not easy admitting that you're not coping with life. And finding a physician who you feel comfortable with and antidepressants that work can take time. But I am testimony that you've got to stick with it.

And so as I sit here and start to daydream as I look out of the window, I am reminded of a recent time when I lost my ability to sing, to share in laughter, to swim, to eat, to talk, to enjoy; when waking up was just as difficult as going to bed. It's a frightful place that sends shivers up my spine. However it's a fleeting memory, because Mr Passion, that energetic kind of guy is back, and he doesn't have time to dwell on the past. This D Club member is in remission and it's time to party.

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REFERENCE

Dr Geoff Gallop (2006). Press release. Statement from the Premier of Western Australia. Content authorised by the Government Media Office, Department of the Premier and Cabinet, 16 January.

1

Bipolar disorder in historical perspective

Edward Shorter

Psychiatric disorders are like children laughing and playing gaily at the park, while behind a screen other children, dimly seen, cry out to us for help. We want to come to their aid but their shapes are like shadows. Nor can we locate them.

Bipolar disorder is like one of these children. We have it before us in the pharmaceutical advertising, the woman going up and down on the merry-go-round and helped with 'mood stabilizers'. Meanwhile, behind the screen there are other forms. Maybe a historical analysis will help us to see them more clearly.

Physicians have always known the alternation of melancholia and mania. The consistency of description across the ages gives the diagnosis a certain face validity, and it would be as idle to ask who was the first to describe their alternation as to ask who first described mumps. Aretaeus of Cappadocia, around 150 years after the birth of Christ, wrote of the succession of the two illnesses. It is clear from the context (Jackson, 1986, pp. 39–41) that he was using the two terms to describe what we today would consider mania and melancholia. Yet Aretaeus did not consider the alternation of mania and melancholia to be a separate disease.

For these remote centuries I use 'bipolar disorder' to mean the succession of melancholia and mania. A word of clarification: in the twentieth century, after the writings of Kleist and Leonhard, 'bipolar disorder' implies that there is a separate unipolar depressive disease. By contrast, the term 'manic-depression' suggests that there is only one depression, whether linked to mania or not. But the term manic-depression itself did not surface until 1899. To describe mania, melancholia and their alternation in previous centuries, I shall simply call it bipolar disorder and crave the reader's indulgence.

So the big question is not who first described bipolar disorder, but rather is it one disease or two? The decades and centuries of clinical experience that lie behind us constitute a mountain of evidence of some weight. And in this tremendous accumulation of practical learning, has bipolar disorder been considered one disease? Or two: the alternation of two separate diseases, mania and melancholia?

A third possibility: is bipolar disorder an alternation of several different kinds of mood disorder that includes episodes of catatonia, melancholia, psychotic

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