

MOODS

Serving people with depression and manic depression, their families and friends since 1981

**Out of the Pillbox:
Brain Stimulation for
Medication-Resistant Disorders**
Sarah Lisanby, MD
Director, New York State Psychiatric
Institute's Division of Brain Stimulation
and Therapeutic Modulation
March 13, 2007



Breakthrough treatments like transcranial magnetic stimulation, electroconvulsive therapy, vagus nerve stimulation, and deep brain stimulation are all emerging from the research lab as powerful and effective tools for treating depression and bipolar disorder. This is especially true in cases where medications work poorly or not at all. Few people know much about these techniques though, and without a basic understanding, they can sound like nothing more than science fiction. Come hear the latest evidence from one of the top experts in this fascinating field. Sarah Lisanby has been at the forefront of researching these cutting edge methods. Be sure to attend her informative lecture.

Bipolar II: What I've Learned from Treating 8,000 Cases Over Many Decades

Ronald Fieve, MD,
Eminent psychiatrist, renowned researcher, and
author of *Bipolar II* and *Moodswing*.
May 1, 2007



When it comes to treating bipolar disorder, Ronald Fieve is one of the giants in the field. He was among the pioneers in using lithium as a mood stabilizer and his best-selling book *Moodswing* introduced the concept of bipolar disorder into the mainstream. He was also instrumental in helping to establish this very organization, twenty-five years ago. Now he turns his attention to bipolar II, the frequently misunderstood subtype of the disease. His recent book explores the concept of "beneficial highs," and raises the question, "Is it possible to take advantage of these highly productive, positive states and still adequately treat the devastating depressive ones?" Don't miss this important lecture.

A Consumer's Guide to Impasse and Failure in Psychotherapy Recognizing and Resolving Problems in your Working Relationship with your Therapist

J. Christopher Muran, PhD
Chief psychologist, Beth Israel Medical Center,
Director, Brief Psychotherapy Research Program
April 10, 2007



Some days it can seem like your relationship with your therapist could use some therapy of its own. Anything from communication breakdown to mutual anxiety can often cause what should be a free-flowing, well-functioning working relationship to encounter troublesome gridlock. J. Christopher Muran is an expert on the therapeutic relationship.

He'll explain how to spot red flags and give valuable, practical advice on the best ways to address them.

T.V. in the Newsletter: Announcing Our Contest Winners

In our last issue, we asked you to come up with television titles that spoofed existing shows and used mood disorders as a theme. And the winners are...

First Prize:

The O.C.D.
-Abbe Jo Phillips

Second Prize:

Two and a Half Ativan
-Eileen Budd

Third Prize:

The Symptoms
-Barbara Staehle

Honorable Mention:

Depressed Housewives
-Jason Petree

Unhappy Days
-Trish Blodget

Dancing with the Buspars
-Eileen Budd

Top Shrink
-Ellisa Hamm

Let's Make a Diagnosis
-Joe Piscopia

Da MDSG Show
-Nathan Hirsch

Thanks to everyone who entered!



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New York
MOODS

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Ask the Doctors

Ivan Goldberg, Psychopharmacologist



What is the difference between a mixed episode and rapid cycling?

A mixed episode is a mood state in which an individual shows some symptoms characteristic of mania together with other symptoms found in depression, such as depressed mood, inability to experience pleasure, guilt, suicidal thinking or anxiety. For example, an individual may have the racing thoughts characteristic of mania, but the content of the racing thoughts may be related to themes of guilt, pessimism, or

suicide. The presence of a history of past suicide attempts and substance abuse increases the likelihood that someone in a mixed state will experience suicidal ideation.

People with mixed states are at increased risk for substance abuse and suicide attempts when compared to people with purely manic episodes. It has been estimated that over a lifetime, 40 percent of individuals with bipolar disorder will experience a mixed episode.

Rapid cycling is a form of bipolar

disorder in which there are four or more distinct episodes within a 12-month period. The episodes must either be separated by two months of wellness or by a switch in polarity. Rapid cycling occurs at some point in almost three quarters of women with bipolar disorder and in about a quarter of men with the disorder.

Some people experience ultra-fast rapid cycling or ultradian cycling in which they cycle within a single day. Antidepressant use and undetected hypothyroidism are frequent causes of rapid cycling.

Joe Nieder, Pediatric Psychiatrist

My wife has cyclothymia and is being successfully treated with a mood stabilizer. We have teenage children—a son and a daughter. What are the chance that they too might have cyclothymia or other mood disorders?

Your son and daughter would be at increased risk for a mood disorder, because like many medical conditions, mood disorders tend to run in families. This tendency of occurring in biologic relatives is seen with lots of conditions including heart disease, allergies, and asthma. However, just because there could be a genetic component, that does not mean

that the condition will occur in all offspring, or even in a major proportion of the children who have a parent with the condition. It simply means that the chance of developing a cyclothymia or another mood disorder would be somewhat greater than in a family with no history of mood disorders.

Early symptoms of cyclothymia in a teenager might include sleep problems, anger, irritability, declining school performance, difficulties with friends and peers, major conflicts with parents or siblings. This is a difficult diagnosis to make because we see many of these symptoms in teenagers without mood problems.

In the child with a mood disorder, though, the symptoms would be

exaggerated and more severe than in the typical teenager. One might also see more clearly defined episodes of depression or mood swings, or even suicidal ideas or acts. In addition, there is an increased risk of substance abuse, with alcohol and marijuana being the most common. In boys there is a greater incidence of aggressive or violent behavior; in girls, more mood instability or self-destructive ideas or acts.

With a history of cyclothymia in a parent, one would look for any symptoms that suggest an illness in a teenager, especially in early to mid-adolescence. If possible, antidepressants would be avoided as they could increase mood cycling.



The Reader's Corner with Betsy Naylor

Bipolar II: Enhance Your Highs, Boost your Creativity, and Escape the Cycles of Recurrent Depression—The Essential Guide to Recognize and Treat the Mood Swings of this Increasingly Common Disorder.

by Ronald Fieve, MD

275 pages.

Rodale, Inc.

\$22.95

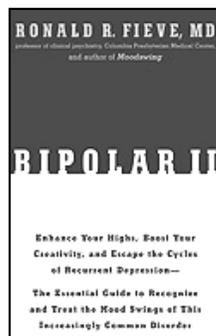
Does it sometimes seem that our most energetic, productive people are actually hypomanic? Dr. Ronald Fieve, a leader in the field of bipolar disorder, has just published *Bipolar II*, the first major book on this elusive, often misdiagnosed bipolar subtype.

Decades ago Dr. Fieve was one of the pioneers in using lithium to treat bipolar disorder, but he is best-known for his 1975 book *Moodswing*, the landmark volume on bipolar disorder that first helped the general public to understand mood disorders. My sister, like so many family members who seek insight into this illness, read *Moodswing* and it helped her grasp what was going on with me. In his latest work, Fieve delves into bipolar II, a subtype that's much less known and is often described as a milder form of the disease. The main difference between I and II is the intensity of the high phases. In contrast to bipolar I's, in which mania tends to take the form of explosive highs, distorted

and dangerous thoughts and, self-destructive behavior, bipolar IIs experience hypomania, which is often a period of exuberant mood, creative thoughts, and increased productivity. (According to Fieve, about half of bipolar II's experience these sorts of "beneficial highs" whereas the other half will have a lot of irritability.)

As Fieve explains, mood disordered people tend to seek out a psychiatrist when they are depressed, not when they are manic or hypomanic. Therefore, when he takes a case history, he asks about happier times in order to gain insight into possible periods of mania. He also looks into a patient's family history for clues: alcoholism, antisocial behavior, remarkable accomplishments, drug addiction, and mood disorders. Fieve includes several vignettes to illustrate his theme and describes patients who, with the right diagnosis and treatment, are able to avoid debilitating depression and experience some periods of beneficial hypomania. He also includes a chapter on proper diagnosis and treatment.

All of this helps to lay the groundwork for a deeper understanding of bipolar II, and his examples do shed light on how, in certain patients, hypomania has its pluses. However, there is still that central philosophical question many of us with mood disorders have: Do we have to give up all the benefits of our highs to have a positive outcome? Fieve opens up an important discussion about the nature of this complex illness.



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Mood Disorders Support Groups and Lectures

Spring 2007

Support Groups

Manhattan – West Side/Columbus Circle
Every Wednesday

Doors open at 7:00pm, groups begin at 7:30pm
St. Luke's/Roosevelt Adult Outpatient Psychiatric Clinic
910 Ninth Ave (between 58th and 59th Sts)

Manhattan – East Side/Downtown
Every Friday

Doors open at 7:00pm, groups begin at 7:30pm,
Beth Israel Medical Center, Bernstein Pavilion,
2nd floor, Enter on Nathan Perlman Place
(between 15th & 16th Sts and 1st & 2nd Avenues)

Support groups enable participants to share personal experiences, thoughts, and feelings in small confidential gatherings. Separate groups are available for newcomers, unipolar (depressive), bipolar (manic depressive), family members, and friends. At *both* locations, all groups meet at the same time, including the Under-30 Group. The support groups are free for members. A \$5 contribution is suggested for non-members.

Tuesday Lectures

March 13, 2007
Tuesday
7:30 p.m.

Sarah Lisanby, MD
Director, New York State
Psychiatric Institute's Division
of Brain Stimulation and
Therapeutic Modulation

Out of the Pillbox: Brain Stimulation for Medication Resistant Disorders. Come hear the latest on electromagnetic therapies from ECT to vagus nerve stimulation to TCM.

April 10 2007
Tuesday
7:30 p.m.

J. Christopher Muran, MD
Chief psychologist, Beth Israel
Medical Center; Director, Brief
Psychotherapy Research Pro-
gram

A Consumer's Guide to Impasse and Failure in Psychotherapy: Recognizing and Resolving Problems in your Working Relationships with you Therapist. Learn how to spot problems and improve your therapeutic relationship.

May 1, 2007
Tuesday
7:30 p.m.

Ronald Fieve, MD
Eminent researcher, pioneer
in the use of lithium, author of
Moodswing and *Bipolar II*.

Bipolar II: What I've learned from Treating 800 Cases over Many Decades.* A giant in the field of treating bipolar disorder explores this often misunderstood subtype.

Lectures are *usually* held on **Tuesdays** (call and listen to message for last minute changes). Doors open at 7:00 pm; lectures begin at 7:30 p.m. in Podell Auditorium, Dazion Pavillion, Beth Israel Medical Center (enter at northwest corner of 1st Avenue and 16th Street). Lectures are free for members. A \$5 contribution is suggested for non-members.

**Fundraiser: \$10 non-members, \$6 members.*

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Diagnosing Personality Disorders

By Michael Craig Miller, MD

The Austrian-Jewish philosopher Martin Buber once wrote, "Every person born into this world represents something new, something that never existed before, something original and unique." This attractive sentiment seems to make the notion of a personality diagnosis pointless. Why typecast people, if everyone is different?

Individualists are especially troubled by a cookbook approach to codifying personality and many mental health professionals believe that's what the American Psychiatric Association's *Diagnostic and Statistical Manual* (DSM) does. In its third edition, published in 1980, that volume introduced diagnostic criteria for all psychiatric disorders. It provided researchers and clinicians with reliable definitions to replace the previously vague descriptions.

The DSM system favors categories (like subtypes of depression or schizophrenia) over dimensions of illness (such as the intensity of sadness or the degree of isolation a person feels). Symptoms can be found in multiple categories, and a person may end up carrying multiple diagnoses. Of course, there are no sharp divisions between *any* of the mental disorders, but personality disorders are hardest to reduce to a defining checklist. Many researchers have therefore advocated a dimensional approach to diagnosing personality disorders, focusing on the extent to which various traits are expressed and abandoning categories altogether.

In practice, clinicians don't necessarily think about categories *or* dimensions of illness, nor do they dwell on distinct traits and behaviors. Rather, they try to understand a complete picture — that is, what comprises an individual's development, experiences, aspirations, and ways of relating to others. Now researchers are considering new ways to diagnose personality disorders that they hope will add subtlety and complexity to established definitions.

One of the most interesting proposals is a suggestion that clinicians compare their patients to composite descriptions called prototypes that are developed from questionnaires answered by experienced clinicians [Westen D, et al., *American Journal of Psychiatry*, May 2006]. In one set of questionnaires, clinicians described the features they thought were typical of various personality disorders. In another set of questionnaires, they described actual patients. Researchers developed prototypes from this set by

determining statistically which personality traits tended to go together. The resulting prototype descriptions, each about a paragraph long, included much more information than current DSM definitions.

The results were encouraging. The diagnoses based on prototypes were at least as good as the current system for predicting a person's functioning and guiding decisions about treatment. Patients were less likely to be given comorbid (multiple or redundant) diagnoses. And clinicians preferred the prototype method. They found it more meaningful and easier to use than a checklist of criteria, partly because it corresponded more closely to what many, if not most, of them were already doing in practice.

Although this new system still needs refinement, it looks promising. With its help, clinicians can quickly develop a broader picture of a patient's or client's problems. They can also determine when a patient fits none of the prototypes and therefore may require blended approaches to treatment.

Clinicians and researchers alike might embrace such a system, because they know that a diagnosis of personality disorder is only a starting point. At best, it provides a framework for doing what Martin Buber's saying implies is necessary — understanding what is original and unique about a person who has asked for help.

Michael Craig Miller, M.D. is editor-in-chief of the Harvard Mental Health Letter. This article originally appeared in the August 2006 issue. © 2006 President and Fellows Harvard College Reprinted with permission. For more information visit www.harvard.edu_harvard_mental_health_letter.

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<u>Lecture #</u>	<u>Date</u>	<u>Presenter</u>	<u>Subject</u>
63	2/6/07	Maria Oquendo, MD	Antidepressants for Bipolar Disorder
62	1/9/07	Dennis Charney, MD	Advances in the Diagnosis and Treatment of Depression
61	12/5/06	Gianni Faedda, MD	Mood Disorders and Development: From Childhood to Adulthood
60	11/7/06	Jeffrey Borenstein, MD	Dual Diagnosis: Alcohol, Drugs, and Mood Disorders
59	10/10/06	Richard O'Connor, PhD	Making the Best of Depression
58	9/12/06	David Hellerstein, MD	Healing Your Brain
57	6/6/06	Psychologist panel	Therapists Discuss Therapy
55	4/4/06	Facilitator panel	Coping with Depression and Bipolar Disorder: Expert Advice
54	3/7/06	Joshua Wolf Shenk	Lincoln's Melancholy
53	12/6/05	Ivan Goldberg, MD	Ask the Doctor: All Your Questions Answered
52	11/7/05	John F. Clarkin, PhD	Talk Therapy for Mood Disorders
51	10/10/05	James C.-Y. Chou MD	What is Standard Care, Best Care for Bipolar Disease!
50	9/12/05	Richard O'Connor, PhD	Self Destructive Behavior, Mood Disorders, and Stress
49	6/13/05	Peter Kramer, MD	At Last—Confronting Depression
48	5/2/05	Lois Kroplick, MD	Fresh Insights into Mood Disorders in Women
47	4/4/05	Issie Greenberg, PhD	Obesity, Weight Control, and Psychiatric Meds
46	3/7/05	Jack M. Gorman, MD	New Meds, Best Meds and What's in the Pipeline
45	1/10/05	Michael Terman, PhD	Light and Negative Air Ion Therapy for SAD, sub-SAD, Depression
44	12/6/04	Joseph Nieder, MD (moderator)	Panel: Antidepressant Medications for Children and Adolescents
43	11/1/04	Richard Rosenthal, MD	Mood Disorders and Substance Abuse

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