



Depression Center



Bright Nights – Understanding Bipolar Disorder

Q & A

March 29, 2006

Do you have any comments on the use of calcium channel blockers?

Calcium Channel blockers have been evaluated as treatments for acute mania and maintenance treatments in bipolar disorder for over 20 years. There were some preliminary positive findings, however better and more recent studies have not shown these agents to be effective. Verapamil has properties that suggest it may not travel easily from blood to brain tissue whereas nimodipine is more likely to cross into the brain. One relatively recent study (1998) suggested a modest effect of nimodipine in acute mania, the effect in depression was minimal. Calcium channel blockers are not considered first line therapy and the reader is advised that the evidence supporting their use is at best, mixed.

During my last hospitalization for bipolar disorder the doctors wanted to use E.C.T. Is this a therapy that is commonly used?

Yes, ECT is a treatment that is commonly used. ECT is effective in depressions that are severe and life threatening. Generally the more severe the depression, the more likely that ECT will be considered. Some people have depression that does not respond to medication and ECT may help. In certain situations, psychiatrists may be concerned that using an antidepressant medication will cause or induce mania, ECT is particularly helpful (although ECT can sometimes induce mania). Life threatening depressions are those wherein the patient has serious suicidality, and the nursing staff are concerned that the patient may attempt suicide even on the nursing unit (such patients require 1:1 nursing). The second serious life threatening depression is one wherein the patient may become so depressed that they are unable to eat or drink and are stuporous from their depression. Finally ECT may be used in manias that have not responded to medications, although this is generally a rare use of ECT.

ECT is a safe and effective treatment. Modern anesthesiology allows for the patient to be briefly asleep for the procedure and muscle relaxants prevent serious seizures.

What is the difference between a nervous breakdown and bipolar disorder?

A nervous breakdown is a term frequently heard in conversation and suggests in general terms that the individual referred has experienced overwhelming mental

symptoms or experiences that have resulted in them not being able to perform their regular social, family, or occupational duties. It can refer to any number of psychiatric disorders and is not specific to Bipolar disorder.

What effect does seroquel have on weight gain?!

Seroquel, like several medications in the class of atypical antipsychotic medications, can increase appetite and result in weight gain. It works through a central brain mechanism and not directly on metabolism of food. Not everyone who takes Seroquel experiences the increase in appetite, this increase occurs in approximately 1/3 of patients who take Seroquel and is more common in younger people.

If one individual in a marriage is bipolar, what percentage of children will be bipolar?

The risk of a child of person with BP disorder is roughly 5%.

Does depressive disorder lead to bipolar disorder through time?

It is generally thought that the younger the onset of depression, the greater the risk of developing BP disorder at some time during the life of the individual. Possibly up to 40 or 50% of people who experience significant depression in their teens may later develop BP disorder. Depressions that are later in onset (over 30 years age) are much less likely to develop BP disorder.

Is there a correlation between increased triglycerides (300+) for increased cholesterol (esp. LDL) and bipolar symptoms? What are treatments?

There is no specific correlation between increased triglycerides or cholesterol and bipolar symptoms. Recently researchers have identified that patients taking some of the “atypical antipsychotic” medications are at risk for increasing both their triglycerides and cholesterol. The cause of these increases is related primarily to the medication. Patients with BP disorder are more likely to be overweight compared to the general population, being overweight can also be associated with elevations in triglycerides and cholesterol.

The treatment should focus on weight reduction that can be achieved by diet and exercise (with appreciation that this is often difficult when medicines are causing ravenous increases in appetite, and that when one is depressed, it is just very difficult to exercise). Medications that cause increase in weight through an increased appetite should be discussed with your doctor to see if there are substitutions that can be made that do not increase appetite. Finally, using the cholesterol lowering medications are effective (the so-called “statins”).

In what way is hoarding related to bipolar disorder?

Hoarding is often part of an illness called obsessive compulsive disorder (OCD). In a well designed study (the Epidemiological catchment area survey, ECA) the frequency of OCD was found to as high as 21% in patients with BP disorder compared to around 2% in the general population. This relationship is not thought to be such that BP disorder causes OCD or vice versa, rather it is just an observation that these two illnesses can go along with each other, we do not know why this is.

How does one treat a BP-II patient that antidepressant leads to hypomania and mood stabilizer leads to depression (Wellbutrin/Lamictal)?

One of the most challenging therapeutic problems that we face in treatment of BP disorder precisely this problem. With regards to mood stabilizers: it is generally recognized that there are the so-called “therapeutic ranges” for lithium, Depakote, and Carbamazepine, however very often patients with levels in these ranges experience a flattening of mood very similar to a depressed state. One may consider using these medicines at lower blood levels, e.g. a lithium level of 0.3 Meq/L or a Depakote level in the 40’s or so. The medicines you mention – Wellbutrin and Lamictal are often successful in treating such depressions. Other options are the atypical antipsychotic medications, there is emerging evidence that medicines from this class are effective in treating bipolar depression. Olanzapine and quetiapine have been specifically studied with positive results, however it is likely that most of the medications in this class (ziprasidone, risperidone, aripiprazole) may have this effect.

Can you explain rapid cycling and is it harder to treat?

Rapid cycling technically refers to anyone who has 4 or more episodes of mania, depression, or hypomania in one year. It is a pattern that is often associated with difficulties in finding the right medicine or combination of medicines because of the recurrence of symptoms. As such it is harder to treat. Finding the right combination is dependent on a good therapeutic relationship with a prescribing clinician and treatment team (a good psychotherapist can be also very helpful). It is not unusual to see a patient go through a period of rapid cycling followed by a longer period of relative wellness, only to find the rapid cycling recur some years later. The mainstay of the treatment should be a mood stabilizer, or a combination of mood stabilizers; additional medications may include an antipsychotic medicine and possibly a benzodiazepine (we always advise caution using these medicines). One is most cautious in advising use of an antidepressant because they often cause or worsen rapid cycling.

Is there any information on what happens over time to people with untreated bipolar or interfering pervasive alcoholism?

Untreated bipolar disorder is associated with a substantially elevated risk of suicide. There is also a much greater risk of social, family, and occupational impairments in untreated bipolar disorder. The risk is much greater in the more severe form of bipolar disorder (BPI) and diminishes in general as the severity of the illness decreases. Alcoholism aggravates all of the above risks. We strongly recommend anyone that has bipolar disorder to seek an evaluation with a specialist in mood disorders and discuss treatment options with that specialist. Anyone with both bipolar disorder and alcoholism should be evaluated by a specialist with experience in treating both illnesses (dual diagnosis programs) because both should be treated at the same time, it is difficult to just treat one or the other.

Is it dangerous for BP woman to become pregnant if she is on medication?

It is generally wise to be able to minimize all medications in women that are pregnant. However as many young women are taking medications and become pregnant there is some data on the experience so far for the medications and pregnancy. One must weigh the evidence for continuing a pregnancy on medication and the risk of developing a mood episode while pregnant. Many of the antidepressants of the SSRI have been associated with a minimal risk during pregnancy. Several of the mood stabilizers have been associated with increased risk of problems. In general the anticonvulsants show a greater risk compared to lithium. Anyone considering a pregnancy and taking psychiatric medications is absolutely advised to discuss this with their physician.

How can family members help BP patients during high anxiety and stressful moments - seems like the medication doesn't seem to help all that much.

Family members are very important to people with BP disorder. During times of high anxiety and stress, having a confidant and someone who understands and can just “be there” for them is extremely valuable. However, often we try perhaps a bit too hard to be helpful and may seem to the patient to be intrusive or over-involved. Perhaps we see the suffering and want to help and fail by trying too hard. The most important support is the support that is meaningful to the patient. In less stressful times it is wise to ask the BP family member how they feel you could be supportive, and if they become panicked and anxious – what would be the most helpful for them. Sometimes just being there and listening is helpful, others may find that taking a “time out” and going for a walk together to be useful. There is no one approach that fits all. Supportive family and friends are very important.

What overlap do you see w/SAD? Is it BP if you're down Jan-April and hypomanic/ manic June-Sept? What do you think of Depakote as the mood stabilizer?

There can definitely be a seasonal pattern to BP disorder. It is not necessarily BP if one is down in Jan – April and hypomanic June to Sept, however one would be concerned if there was impairment in functioning either socially or occupationally. Keeping a mood log is useful to track and determine patterns in one's mood and going over this with your physician would be useful in determining if one should consider a mood stabilizer. Depakote is one of three of the primary medicines that are considered mood stabilizers (the remaining two are lithium and carbamazepine). Many, but not all, people have found Depakote to be helpful in stabilizing their moods. With all the medicines in the class of mood stabilizers the response rates are in the range of 50%. It takes time to evaluate the usefulness of mood stabilizers and we recommend that they be taken for several months (provided that one can tolerate them) in order to determine if they are helpful.

For depression, do you recommend high dose EPA fish oil supplements? And if so, what is the recommended dosage?

The data for fish oil supplements is not convincing and we don't recommend them as a matter of course. There was some data and interest a few years ago, especially in BP disorder, but this has not been born out by further studies. The doses that have been studied in depression range in the 1 – 2 grams per day, and have not been overly convincing, while in BP disorder have been substantially higher (8 – 9 grams/day). We generally do not recommend the high dose for depression, and suggest that sticking with the lower range of 1 –2 grams/day would be sufficient.

Please discuss the factors in deciding whether to prescribe lithium or a mood stabilizer like Depakote.

Firstly, lithium is a mood stabilizer and is the first one that was used for Bipolar disorder. Lithium is the drug of first choice for many psychiatrists in treating Bipolar disorder, when it works, it works very well, and it is associated with a decrease in suicidal behavior. Unfortunately many people experience side effects from lithium that are sufficiently distressing (tremor, nausea, diarrhea, etc) that they cannot continue. In such circumstances many psychiatrists would consider Depakote. There has been some data to suggest that patients with recurrent manias that have a high or euphoria to them respond better to lithium and that irritable manias respond better to Depakote, this is somewhat controversial. Lithium is likely to work well in patients with irritable mania. The important clinical point is that both of these medications can be monitored with blood levels.

What effect does alcohol have on a person's bipolar mania? Is it a catalyst? Magnify the episode? Extend it?

Alcohol tends to destabilize moods. It makes the manic episode more difficult to treat and ongoing alcohol use and abuse can cause significant fluctuations in the body fluids potentially leading to dehydration, this could result in fluctuations in lithium levels and toxicity. Alcohol is unlikely to be a catalyst to mania, by virtue of destabilizing moods it is possible that it could magnify it and subsequently extend the mania.

What treatments are available for the side effect "tardive dystonia" or torticollis?

By Tardive Dystonia you are probably referring to Tardive Dyskinesia (TD), which are automated movements that are long term side effects of antipsychotic medications. Unfortunately the treatment options for TD are very limited. When TD is identified, clinicians will often recommend decreasing the dose of the antipsychotic medication that is likely to have caused it. This may result in a worsening of symptoms, with TD related automated movements actually getting worse. Adding more antipsychotic medication will often improve the symptoms briefly, giving the incorrect impression that they are resolving. When TD is identified it is wise to gradually decrease the antipsychotic medication, with the expectation that over time, the less the exposure to the antipsychotic, the less the severity of TD. Often the psychosis is of such a severity that the medicine is required and the TD continues. There have been reports that vitamin E may be helpful for TD, however it was using a high dose (1200 IU daily) of Vitamin E, the long term effects of long term high dose vitamin E are unknown. In short, there is little effective treatment of TD.

By torticollis, you may be referring to a crisis in muscle tension called an "ocular gyric crisis", wherein there is a sudden onset of spasm in the neck muscles causing the head and eyes to move to one side. This acute condition is caused by antipsychotic medication. Spasmodic torticollis refers to a rare disorder characterized by repeated and sustained spasms of the head and neck musculature (this is not related to any medication use). The treatment of the ocular gyric crisis is medication similar to that used for parkinson's disease. Intramuscular cogentin (benztropine) rapidly relieves the spasm of this condition.

What treatments/drugs are available for BP people what aren't working and don't have medical insurance?

By this question you are asking about which medications and treatments would be the most inexpensive. Lithium is one of the most inexpensive medications. Drugstore.com lists 300 mg lithium tablets as costing around \$20 for 90 tablets.

This would be the average amount for one month. Unfortunately it is recommended that a blood test be performed a couple of times per year which would add to the cost. The second point is that the older antipsychotic, Thorazine, is also relatively inexpensive and is an effective medication in controlling mania. Drugstore.com indicates that 100 mg tablets (sixty) of generic Thorazine costs in the range of \$16. Be aware that Thorazine is associated with increased sun sensitivity, so be sure to use sunscreen with Thorazine.

Why are women more likely to experience manic depression? Have there been many studies on this disparity?

Women are more likely to experience depression. The rate for Bipolar I (classic form with severe manias) is similar for both sexes. There may be a somewhat higher rate for Bipolar II in females. The reasons for this are not known, but may be related to hormonal issues. There have been many studies that show the rate of depression is greater in females. There are fewer that address the underlying causal question.

Can you please comment on how and why anti-depressant medications can be problematic for someone with bipolar disorder?

Antidepressants can cause someone with Bipolar disorder to cycle into a manic or hypomanic episode. If a patient is depressed and it is considered necessary to use an antidepressant, they should be also taking a mood stabilizer such as lithium, valproate, or carbamazepine, alternatively they could be taking an antipsychotic medication, or both. This will ensure that the antidepressant does not cause the individual to become manic.

How do you differentiate between BP and ADHD in children/adolescents?

ADHD characteristically begins before the age of 7 (this is a required feature of the illness), with specific signs and symptoms relating to difficulties attending to the task at hand. BP disorder, on the other hand, may begin at any age. The difficulty in diagnosis is most pronounced when a child has a history of behavioral and attention problems beginning at an early age. Some researchers suggest that decreased need for sleep and grandiosity are necessary for a diagnosis of BP in children, others have suggested that in fact BP and ADHD frequently co-exist and both should be treated simultaneously. It is wise to establish a relationship with a good team of physicians, psychologists, social workers or other mental health professionals that can monitor a child over time to determine the most likely diagnosis.

What are the neurotransmitter abnormalities in BP? Are there any consistent patterns?

The neurotransmitter abnormalities in BP disorder are really not understood particularly well. Our hypotheses that bio-amines (dopamine, norepinephrine and serotonin) are involved comes, to a large degree, from studies of binding properties in cells from animal brains to the medications used to treat BP (this is a major over-simplification of years of neuroscience work). The hypotheses state that these bio-amines are over-active in mania and under-active in depression (again likely to be a gross over-simplification). There do not appear to be consistent patterns despite a lot of research, in other words, there are no characteristic patterns specific to depression or mania.

Do SSRIs raise the risk of suicide in bipolar disorder?

The risk of suicide is increased in the depressed and mixed phases of BP disorder, often the risk is increased paradoxically as the patient appears to be getting better from a depressed state. This has been observed for many years and is not specific to SSRIs. The increased risk of suicide related behaviors has been observed in some situations where patients have been taking SSRIs. On the other hand a large national registry based examination of 14,857 suicides (over a 9 year period) in Sweden found a lower relative rate of suicide in SSRIs compared to other antidepressant medications, suggesting that SSRIs themselves were not specifically increasing the risk of suicide. The study that proposed an increase in suicidal behaviors did not report completed suicides, rather increases in thoughts and less severe attempts.

