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Chapter 1

Bipolar disorder in historical perspective

Edward Shorter

Psychiatric disorders are like children laughing and playing gaily in 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 do we know where they are.

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. It would be as idle to ask who was the first to describe this 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. Etienne Esquirol, director of the Charenton asylum outside of Paris and one of the founders of modern psychiatry, noted in 1819 (Esquirol, 1819, p. 169), 'sometimes melancholia passes into mania; indeed it is the ease with which this … transformation occurs that has led all the authors to confuse melancholia with mania.' There is no hint in Esquirol's writing that he considered the alternation of melancholia and mania to constitute a separate disorder.

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 writing 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-depressive insanity' 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 depression, mania and hypomania, each an independent illness entity in its own right? Conrad Swartz has suggested

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that, in this kind of alternation, the term ‘multipolar disorder’ might be more appropriate than ‘bipolar disorder’ (C. Swartz, personal communication, 24 October, 2006). When we find these syndromes occurring over the years in the same patient, is it one illness or several?

For psychiatrists of the past, it was quite consistent to see melancholia cede to mania. Vincenzo Chiarugi, psychiatrist at the Bonifazio mental hospital in Florence, Italy, at the end of the eighteenth century, described a female patient, aged 35, who switched from deep melancholia to mania. Chiarugi thought this a case of ‘true melancholy’ and by no means out of the ordinary. The clinicians of the day often used such terms as mania and melancholia in a sense quite different from ours, yet, on the basis of the case report (Chiarugi, 1794, pp. 95–96), Chiarugi was dealing with manic-depression.

In the world of patients as well, alternating mania and melancholia have been known since time out of mind. As Thomas Penrose, the curate of Newbury in Berkshire, England, penned (Penrose, 1775, p. 19) in the 1780s of a young woman disappointed in love:

Dim haggard looks, and clouded o'er with care,
Point out to Pity's tears, the poor distracted fair.
Dead to the world – her fondest wishes crossed
She mourns herself thus early lost.

Now, sadly gay, of sorrows past she sings,
Now, pensive, ruminates unutterable things.
She starts – she flies – who dares so rude
On her sequester'd steps intrude?

In the Voitsberg district of Austria early in the nineteenth century, such alternations of melancholia and mania were regarded by the valley dwellers as quite typical, and one of the features that distinguished them from the hill dwellers. Said a Dr Irschitzky in 1838, ‘We know from experience, that among the valley folk now and then melancholia occurs, mostly for religious reasons, and frequently acute insanity (mania). These mental illnesses follow in a quite natural manner from the constitution and the character of these people … whereby frequently mania serves as an interlude’ (Irschitzky, 1838, p. 243).

These authors regarded mania and melancholia as two illnesses succeeding each other. Among the first observers to see this alternation of mania and melancholia as parts of the same disease was Spanish court physician Andrés Piquer-Arrufat, who described in 1759 the mentally ill king Fernando VI has having ‘el afecto mélancolico-maniaco’, and penned a quite careful clinical description. Piquer regarded the illness as a unitary condition (‘son una misma enfermedad’) different from either melancholia or mania, in the broad sense in which those diagnoses were then understood (Piquer, 1759/1846, pp. 6, 27). Piquer's manuscript account was, however, not published until 1846, which makes his priority a bibliographic curiosity rather than a fundamental building stone in the history of psychiatric illness classification. Jésus Pérez and co-workers, who have studied the Piquer account carefully, point out that Piquer apparently launched the diagnosis in a 1764 textbook, yet without the careful characterisation of it that we find in the memoir published in 1846 (Pérez *et al.*, 2011, p. 72); nor do they mention the 1846 publication.

In 1818, the German psychiatrist Johann Christian August Heinroth in Leipzig proposed four versions of ‘mixed mood disorders’ (gemischte Gemüthsstörungen), in each of which insanity of some kind alternated with melancholia. One form, for example, Heinroth described as the alternation of ‘madness’ (Wahnsinn) and melancholia. Calling the disorder ‘quiet madness (ecstasis melancholica)’, Heinroth said that in the illness, madness ‘loses

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its monstrousness', and melancholia loses its 'lifelessness, and the whole illness proceeds in alternating exaltation and depression'. Heinroth also threw in a dollop of German romanticism, and had the patient spending the melancholic phase 'dragging about the fields and woods or isolated mountain tops giving full expression to his still sobs and sighs, or weaving in quiet contemplation wreaths of white flowers…' (Heinroth, 1818, pp. 355–356).

By the 1840s such accounts were numerous. In 1844, Carl Friedrich Flemming, director of the Sachsenberg mental hospital in Germany, described '*Dysthymia mutabilis*', the kind of mood disorder that arises when *Dysthymia atra* (black depression) and *Dysthymia candida* (low-level mania) alternate. 'Between both of them (atra and candida) there is a not infrequent connection, *Dysthymia mutabilis*, which sometimes shows the character of one, sometimes the character of the other.' Flemming saw other kinds of depression too, such as *melancholia attonita*, or retarded melancholia (Flemming, 1844, pp. 114, 129)

Flemming's proposed coinage, appearing in a then obscure German-language journal, was soon forgotten in an era when Paris was the centre of the enlightened world. And it was in Paris that bipolar disorder as a separate entity was famously announced a few years later. In 1850, Jean-Pierre Falret, a staff psychiatrist of the Salpêtrière Hospice in Paris gave a lecture to the Psychiatric Society in which he briefly mentioned 'circular insanity' (*la folie circulaire*), thus giving the alternation of mania and melancholia a separate name. He incorporated the idea into the clinical lectures he offered at the hospital in the early 1850s, and published those lectures in 1854. Whatever Falret might have said in the early lectures, by the 1854 book, the alternation of mania and melancholia in *la folie circulaire* had become a disease of its own, not just the succession of two separate illnesses. Falret: '[La folie circulaire] is generally neither mania nor melancholia as such, with their customary characteristics; it is, in some manner, the core of these two kinds of mental disease without their depth [sans leur relief]' (Falret, 1854a, pp. 249–250). He went on to explain how bipolar mania and melancholia differed from the regular versions. (There was in 1854 a vigorous exchange between Jules Baillarger, who claimed to have described the same disease under another label (*la folie à double forme*), claiming priority, and Falret, who insisted on his own priority of *la folie circulaire* (Baillarger, 1854a, 1854b; Falret, 1854b.)

In 1864, Falret attempted to strangle the entire debate by insisting that neither mania nor melancholia existed as separate diseases and the only natural entity was *la folie circulaire*, in which these phases alternated, sometimes at prolonged intervals (Falret, 1864). The issue of which of these squabbling clinicians has priority is secondary. But it would be fair to say that in Paris in the early 1850s bipolar disorder was born for an international audience, yet without the careful apparatus of psychopathology and nosology that came later.

The baton now passed to the Germans, and for the next 100 years the principal contributions to bipolar disorder would be made by German professors. In 1878, Ludwig Kirn, a psychiatry resident who had trained at the Illenau asylum, published a postdoctoral thesis on 'the periodic psychoses' in which he gave a detailed psychopathological account of bipolar disorder, something the French clinicians had omitted in favour of grand generalisations (Kirn, 1878). German nationalists, with their dislike of the French, considered this the first description of the disorder *tout court*, but in fact it was not (Kirchhoff, 1924, p. 167)

In these years many German psychiatrists such as Wilhelm Griesinger and Heinrich Neumann described bipolar disorder in one form or another. For most, the usual course was switching from melancholia into mania, and then into terminal dementia, more or less as Falret had first described. But in 1882, Karl Kahlbaum, one of the great names in the history of German psychiatry – because of his insistence on using the 'clinical method'

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to study psychopathology – proposed the term 'cyclothymia' for recoverable alternations of melancholia and mania, but – in not tipping into dementia (as in Heinrich Neumann's 'typical insanity') – instead the patients get better. Another such cyclical episode might then occur, and so forth. Also, the 'mania' that Kahlbaum described was not a full-blast onslaught affecting all mental functions but a kind of exaggerated elation without psychosis (Kahlbaum, 1882). It corresponded roughly to what Berlin psychiatrist Emanuel Ernst Mendel had called a year previously 'hypomania'. (Mendel, 1881), and – in essence – the ancestor of 'Bipolar II disorder'.

Then came the great earthquake in German nosology: Emil Kraepelin and his historic classification of psychiatric illnesses, the basic outlines of which have endured more or less intact until the present. The classification, based on course and outcome, became the first real conceptualisation of manic-depressive illness, a disease having an undulating course rather than an irreversible downhill slide as in chronic psychosis (which Kraepelin called '*dementia praecox*'). Building on the work of Karl Kahlbaum in 1863 – who was the first psychiatrist to have classified mental illnesses on the basis of clinical course (Kahlbaum, 1863) – Kraepelin spelled out the importance of course in detail for mania and melancholia. Thomas Ban once observed, 'Many people described what was to become manic-depressive illness but it was Emil Kraepelin who conceptualised it as a class of illness because of his adoption of temporality as an organizing principle of psychiatric nosology.' (T. Ban, personal communication, 9 November, 2006).

In 1899, in the sixth edition of his textbook, Kraepelin lumped together all depression (except that beginning in middle age) and all mania under the category manic-depression (Kraepelin, 1899). For him, it was the sole mood disorder. There was no 'unipolar' depression. Kraepelin thought it a matter of indifference whether the illnesses recurred periodically, or whether mania and melancholia were linked together or not. Thus, with Kraepelin's work what we most emphatically call 'bipolar disorder' ceased to be a separate disease. The concept of alternating mania and melancholia as a disease of its own became lost from sight because Kraepelin considered *all* mood disorders to be part of 'manic-depressive insanity' (*das manisch-depressive Irresein*). Although we commonly say that bipolar disorder is the successor of Kraepelin's manic-depressive insanity, this is erroneous: Kraepelin made all cases of depression and mania, alternating or not, into manic-depression. Our use of the term 'bipolar disorder' implies that there is a separate class of unipolar depression.

Two further comments about Kraepelin's manic-depressive illness should be made. Firstly, in later editions, he popularised Wilhelm Weygandt's concept of the existence of 'mixed psychoses', that is, manic and depressive symptoms appearing simultaneously. Weygandt had ventured the notion in a post-doctoral thesis, which was not an automatic guarantee of international acceptance (Weygandt, 1899; Kraepelin, 1904). Secondly, Kraepelin doubted that Kahlbaum's cyclothymia represented a separate illness but rather just a form of manic-depressive insanity in which there might be long lucid intervals between episodes. Today's *Diagnostic and Statistical Manual* (DSM) sees cyclothymic disorder as 'bipolar', yet as separate from the main bipolar disorders (I and II) because the mania and depression of cyclothymia both fall below the threshold of a full episode of mania or of major depression (American Psychiatric Association, 2000).

The main problem with Kraepelin's manic-depressive illness was not its nosological adequacy – there is really no reason why the concept would not serve us quite well today – but its prognostic desperateness: Kraepelin had a dim view of the prognosis of most illnesses. He believed that dementia praecox went relentlessly downhill, but that lifetime

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prospects for 'MDI' were those of unceasing recidivism. Oswald Bumke, soon to succeed Kraepelin as Professor of Psychiatry in Munich, wrote in 1908, 'Many physicians today view the chances of recovery of a patient who once falls ill with mania or melancholia as far too unfavourably – because a relapse is possible but certainly not necessary' (Bumke, 1908, p. 39). Of treatment in those days there was, with the exception of opium for melancholia, very little talk.

The next development was elaborating the 'two depressions', the depression of unipolar disorder and the depression of bipolar disorder. Kraepelin taught in Heidelberg and Munich. But the charge back towards bipolar disorder as a disease of its own, *à la Française*, began in a different academic fortress entirely: Karl Kleist's university clinic in Frankfurt. Kleist saw his own nosological thinking in general to be beyond that of Kraepelin, and more identified with the intensely biological approach to psychiatry of Carl Wernicke. It was actually Wernicke (1900) who adumbrated in part 3 of his textbook, published in 1900, the first of these new bipolar entities: hyperkinetic and akinetic motility psychosis.

For Wernicke, bipolarity was not a big deal. But for Kleist it was. Kleist's ambition was to continue the series of independent disease entities between manic-depressive illness and dementia praecox, which were the two great diseases that Kraepelin had established. Between these bookends, Kleist (1911) started to insert a number of diagnoses, some unipolar and some bipolar. It is thus Kleist who restored bipolar thinking to psychiatry in 1911, without challenging the existence of Kraepelin's manic-depressive illness (which was, of course, not a bipolar illness because Kraepelin did not conceptualise a separate unipolar depression).

In the following years Kleist identified several other cyclical psychoses, including 'confusional psychoses' that alternate between 'agitated confusion' and 'stupor' (Kleist, 1926, 1928). The point was, for Kleist and other investigators in these years, to open up space in-between Kraepelin's two great diseases, which were manic-depression and dementia praecox, to find room in the middle for diagnoses with prognoses that were perhaps more benign than Kraepelin's terrible dementia praecox. Yet, against the great Kraepelinian 'two-disease' tide, Kleist's ideas made little headway at this point.

Kleist had two very productive students, Edda Neele and Karl Leonhard, who after the Second World War carried forward Kleist's teachings about bipolarity. In a 1949 study of all 'cyclical psychoses' admitted to the Frankfurt university clinic between 1938 and 1942, Neele (1949, p.6) introduced the terms 'unipolar disorder' and 'bipolar disorder' (*einpolige und zweipolige Erkrankungen*). Kleist must have used these previously in a teaching setting but Neele's post-doctoral thesis (*Habilitation*) is their first major public airing.

Throughout the 1940s and 1950s Leonhard burrowed away at the periodic and the cyclical psychoses – at Frankfurt until 1955, then at Erfurt and Berlin – trying to insert them in the larger scheme of psychiatric illness. In 1957, Leonhard's magisterial study – *The Classification of the Endogenous Psychoses* – appeared and definitively separated what we call bipolar affective disorder from 'pure depression'. This separation of depressive illness by polarity remains in force in most circles today. 'Undoubtedly there is a manic-depressive illness', wrote Leonhard (1957, pp. 4–5) 'having in its very nature the tendency to mania and melancholia alike. But next to this there are also periodically appearing euphoric and depressive states that show no disposition at all to change to the opposite form. Thus, there exists this basic and very important distinction between bipolar and monopolar psychoses.' This is the true birth, or rebirth if one will, of bipolar disorder in contemporary psychiatry. This is the part of Leonhard's work that went into the DSM of the American Psychiatric Association in 1980 (see below).

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Yet for the most part, Leonhard did not use the terms unipolar or bipolar in describing manic-depressive illness or the 'pure' depressions and manias, even though they correspond nicely to our concepts of bipolar and unipolar today. Instead, in his detailed discussions he reserved bipolar and unipolar for the 'cyclic psychoses', such as 'anxiety-euphoria psychosis' and Wernicke's 'hyperkinetic-akinetic motility psychosis'. He stated that the 'cyclic psychoses are related to the phasic psychoses – indeed directly linked to them. [These are] are the psychoses that Kleist brought together as cyclic. They are bipolar and multiform and never result in lasting disability' (Leonhard, 1957, p. 120).

Leonhard's cyclic psychoses did not make it into the DSM system. He differentiated them from the 'periodic psychoses' (phasic psychoses) such as manic-depressive illness and pure depression and pure euphoria. Yet manic-depression is also cyclical, while pure depression and pure euphoria are not. These refinements would be almost too trivial to mention were it not for the fact that Leonhard's schema as a whole deserves a well-informed second look. The main point here is that Leonhard is the first author to separate depressions by polarity (though generally he reserved the polarity terms for other illnesses).

Leonhard's separation of manic-depressive illness from depression was taken up by a handful of scholars outside of Germany, and 1966 became 'a very good year' for the study of bipolar illness (for this phrase see Winokur, 1991, p. 28). In 1966, three studies appeared that distinguished among depressions by polarity, meaning the depression of bipolar disorder (manic-depressive illness) vs. the unipolar depression termed 'melancholia' at that time. All three studies found greater family histories of mood disorder in bipolar patients than unipolar. However, as observed by Michael Alan Taylor: 'they and all others found that among the families of bipolar patients there was always more unipolar than bipolar illness' (M.A. Taylor, personal communication, 12 November, 2006).

In one of these studies, Jules Angst in Zurich compared patients with bipolar disorder to those with endogenous depression, involutional melancholia and mixed affective-schizophrenia. He ended up questioning 'the nosological unity of the (Kraepelinian) manic-depressive illness. The purely depressive monophasic and periodic psychoses are statistically differentiated from those that have a cyclic course' (Angst, 1966, p. 106).

Meanwhile, Carlo Perris in Sweden, adopting a specifically Leonhardian approach, compared bipolar and unipolar depressive patients at the Sidsjon Mental Hospital in Umea, arguing that 'they are two different nosographic entities' (Perris, 1966, p. 187). It is worth noting that some feel that Angst and Perris created a monster by permitting the use of terms such as bipolar depression and monopolar depression in suggesting the existence of fundamentally different entities, albeit of great commercial use in registering pharmaceutical agents for 'bipolar depression' and the like.

Finally, in 1966, Leonhard's distinction between monopolar and bipolar depression made its first American beachhead. In June 1966, at a meeting of the Society of Biological Psychiatry in Washington DC, George Winokur and Paula Clayton of Washington University in St Louis, the then premier American institution for biological approaches to psychiatry, showed that 'the family background for manic-depressive patients differed from that of patients who showed only depression' (Winokur and Clayton, 1967; Winokur, 1991, p. 29). Interestingly, despite Winokur's presence on the team, manic-depressive illness did not make it into the so-called 'Feighner criteria', the attempt to recast psychiatric diagnosis launched at Washington University in the early 1970s, by Feighner *et al.* (1972).

In the 1970s, the evolution of bipolar disorder became a primarily American rather than a German story. In a reaction to the diagnostic indifference of psychoanalysis, these years

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saw a new fervour in nosological thinking in the USA. Led by Robert Spitzer, a group of researchers at the New York State Psychiatric Institute – that also included Eli Robins of Washington University – set about defining 'Research Diagnostic Criteria' (the RDC) as a way of recasting American psychiatric diagnosis. A preliminary paper produced by the group in the mid-1970s (Spitzer *et al.*, 1975) included 'major depressive illness' (and 'minor depressive illness') but made no reference to bipolar disorder. Yet by the time a final version of RDC was published in 1978, 'bipolar depression with mania (bipolar I)' and 'bipolar depression with hypomania (bipolar II)' had been added to RDC, alongside 'major depressive disorder'. There were now two big depressions firmly fixed in American psychiatric nosology, one linked to mania as bipolar disorder and the other a unipolar depression called 'major depression', although the RDC system also included a host of other depressive subtypes and atypical forms of depression (Spitzer *et al.*, 1978).

The RDC became the template in 1978 for the dramatic reshaping of psychiatric diagnosis that took place 2 years later, also under the leadership of Robert Spitzer, in the American Psychiatric Association's DSM-III, the third edition of the APA's *Diagnostic and Statistical Manual* (American Psychiatric Association, 1980). DSM-III provided for a Leonhardian division between unipolar depression (called Major Depression), and bipolar manic-depression (called Bipolar Disorder). Although by this time everyone had forgotten who Leonhard was, DSM-III represented the international triumph of one of the core concepts of Leonhard's system. The distinction between major depression and bipolar disorder was preserved in subsequent editions of the DSM series. Both depressions were called 'major depression', but the latter was more severe in terms of chronicity and shorter length of time between episodes.

In the following years, a large body of clinical and pharmacological opinion upheld the distinction between bipolar and unipolar mood disorders, in other words, the distinction between two kinds of serious depression (Ban, 1990). Bernard Carroll called bipolar disorder 'the most extreme case of mood instability' and said that any theory of brain function would have to come to terms with, quoting Donald Klein, 'this striking phenomenon'. Carroll argued that there were fundamental biological differences between bipolar and unipolar disorders, in that, although those with bipolar disorder had more lifetime episodes, the excess was: 'entirely accounted for by the manias … in other words, manic depressive patients are not just more unstable than unipolar patients in mood regulation in both directions' (Carroll, 1994, p. 304). Yet there must be a pendular movement between the view that depression and mania are separate illnesses and the view that linked depression-mania constitutes an illness of its own. For in the 1990s, the pendulum began to swing back from DSM-III and Leonhard to a more Kraepelinian view. This movement was initiated as early as 1980 by Michael Taylor and Richard Abrams, then at the Chicago Medical School, who wrote, after reviewing genetic and biological studies, 'These data suggest that the separation of affective disorders by polarity may have been premature' (Taylor and Abrams, 1980, p. 195). Unlike previous investigators, Taylor and Abrams based their work on well-defined rating scales and treatment response.

In 2006 Taylor, now at the University of Michigan, and Max Fink at SUNY's Stony Brook campus, in a major review of the diagnosis of melancholia, said of the bipolar versus unipolar dichotomy, 'The scientific evidence fails to distinguish unipolar and bipolar depressive disorders … bipolarity as a separate psychiatric disorder is not supported by psychopathology, family studies, laboratory tests, or treatment response' (Taylor and Fink, 2006, p. 24) What other people see as unipolar illness, Taylor and Fink consider to be non-melancholic depression and what is bipolar depression they consider melancholia.

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As a historian, it is not my place to comment on the scientific merits of the polarity debate. Subsequent research may well establish that bipolar disorder is an illness in its own right, requiring a distinctive therapeutic approach involving mood stabilisation. In the meantime, however, the frequency of bipolar disorders seems to be growing by leaps and bounds (Healy, 2006). It would be wise for patients and doctors to take with a grain of salt pharmaceutical claims of products having differential efficacy.

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References

American Psychiatric Association (1980). *Diagnostic and Statistical Manual of Mental Disorders*, 3rd edn. Washington, DC: APA.

American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders*, 4th edn: Text Revision, DSM-IV-TR. Washington, DC: APA.

Angst, J. (1966). *Zur Ätiologie und Nosologie endogener depressiver Psychosen: Eine genetische, soziologische und klinische Studie*. Berlin: Springer.

Baillarger, J. (1854a). De la folie à double forme. *Annales médico-psychologiques*, **6**, 369–391.

Baillarger, J. (1854b). (Response in discussion – no title). *Bulletin de l'Académie de Médecine*, **19**, 401–415.

Ban, T. (1990). Clinical pharmacology and Leonhard's classification of endogenous psychoses. *Psychopathology*, **23**, 331–338.

Bumke, O. (1908). *Landläufige Irrtümer in der Beurteilung von Geisteskrankheiten*. Wiesbaden: Bergmann.

Carroll, B (1994). Brain mechanisms in manic depression. *Clinical Chemistry*, **40**, 303–308.

Chiarugi, V. (1794). *Della Pazzia in Genere e in Specie. Trattato Medico-analitico*. Vol. 3. Florence: Carlieri.

Esquirol, J.E.D. (1819). Mélancholie. In *Dictionnaire des sciences médicales*, ed. L.J. Renauldin. Paris: Panckoucke, Vol 39, pp. 147–183.

Falret, J.P. (1854a). *Leçons cliniques de Médecine Mentale Faites à l'Hospice de la Salpêtrière*. Paris: Baillière.

Falret, J.P. (1854b). Mémoire sur la folie circulaire. *Bulletin de l'Académie de Médecine*, **19**, 382–400.

Falret, J.P. (1864). *Des Maladies Mentales*. Paris: Baillière.

Feighner, J., Robins, E., Guze, S., Woodruff, R., Winokur, G. and Munoz, R. (1972). Diagnostic criteria for use in psychiatric research. *Archives of General Psychiatry*, **26**, 57–63.

Flemming, C. (1844) Über Classification der Seelenstörungen. *Allgemeine Zeitschrift für Psychiatrie*, **1**, 97–130.

Healy, D. (2006). The latest mania: selling bipolar disorder. *PLOS Medicine*, www.plosmedicine.org, **3**(4), e185.

Heinroth, J.C.A. (1818). *Lehrbuch der Störungen des Seelenlebens*. Leipzig: Vogel.

Irschitzky (1838). Über psychische Krankheiten im Districts-Physikate Voitsberg. *Medicinische Jahrbücher des k. k. Österreichischen Staates*, **17**, 233–247.

Jackson, S. (1986). *Melancholia and Depression From Hippocratic Times to Modern Times*. New Haven, CT: Yale.

Kahlbaum, K. (1863). *Die Gruppirung der psychischen Krankheiten und die Eintheilung der Seelenstörungen*. Danzig: Kafemann.

Kahlbaum, K. (1882). Über cyklisches Irresein. *Der Irrenfreund*, **24**, 145–157.

Kirchhoff, T. (1924). *Deutsche Irrenärzte*, Vol. 2. Berlin: Springer.

Kirn, L. (1878). *Die Periodischen Psychosen*. Stuttgart: Enke.

Kleist, K. (1911). Die klinische Stellung der Motilitätspsychosen. *Zeitschrift für die gesamte Neurologie und Psychiatrie*, **3**, 914–917.

Kleist, K. (1926). Über zykloide Degenerationspsychosen, besonders Verwirrtheits- und Motilitätspsychosen. *Archiv für Psychiatrie und Nervenkrankheiten*, **78**, 416–421.

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Kleist, K. (1928). Über zykloide, paranoide und epileptoide Psychosen und über die Frage der Degenerationspsychosen. *Schweizer Archiv für Neurologie und Psychiatrie*, **23**, 3–37.

Kraepelin, E. (1899). *Psychiatrie: ein Lehrbuch*, 6th edn, Vol. 2. Leipzig: Barth.

Kraepelin, E. (1904). *Psychiatrie: ein Lehrbuch*, 7th edn, Vol. 2. Leipzig: Barth.

Leonhard, K. (1957). *Aufteilung der Endogenen Psychosen*. Berlin: Akademie-Verlag.

Mendel, E. (1881). *Die Manie*. Vienna: Urban.

Neele, E. (1949). *Die phasischen Psychosen nach ihrem Erscheinungs- und Erbbild*. Leipzig: Barth.

Penrose, T. (1775). *Flights of Fancy*. London: Walter.

Pérez, J., Baldessarini, R., Cruz, N., Salvatore, P. and Vierta, E. (2011). Andrés Piquer-Arrufat (1711–1772): contributions of an eighteenth-century Spanish physician to the concept of manic-depressive illness. *Harvard Review of Psychiatry*, **19**, 68–77.

Perris, C. (1966). A study of bipolar (manic-depressive) and unipolar recurrent depressive psychoses. *Acta Psychiatrica Scandinavica*, **42** (Suppl.194), S1–S189.

Piquer, A. (1759/1846). Discurso sobre la enfermedad del rey nuestro señor D Fernando VI, (que Dios guarde), parte primera, Historia de la enfermedad, desdu su principio, hasta 20 de febrero de 1759. In *Anales Historicos de la Medicina en General, y Biografico-Bibliografico de la Española en Particular*, Vol. 4, ed. A. Chinchilla, pp. 3–34. Valencia: Cervera.

Shorter, E. (2005). *Historical Dictionary of Psychiatry*. New York: Oxford University Press.

Spitzer, R., Endicott, J., Robins, E., Kuriansky, J. and Gurland, B. (1975). Preliminary report of the reliability of Research Diagnostic Criteria applied to psychiatric case records. In *Predictability in Psychopharmacology: Preclinical and Clinical Correlations*, ed. A. Sudilovsky, S. Gershon & B. Beer, pp. 1–47. New York: Raven.

Spitzer, R., Endicott, J. and Robins, E. (1978). Research Diagnostic Criteria. *Archives of General Psychiatry*, **35**, 773–782.

Taylor, M. and Abrams, R. (1980). Reassessing the bipolar-unipolar dichotomy. *Journal of Affective Disorders*, **2**, 195–217.

Taylor, M. and Fink, M. (2006). *Melancholia: the Diagnosis, Pathophysiology, and Treatment of Depressive Illness*. New York: Cambridge University Press.

Wernicke, C. (1900). *Grundriss der Psychiatrie*, part 3. Leipzig: Thieme.

Weygandt, W. (1899). *Über die Mischzustände des manisch-depressiven Irreseins*. Munich: Lehmann.

Winokur, G. (1991). *Mania and Depression: A Classification of Syndrome and Disease*. Baltimore, MD: Johns Hopkins University Press.

Winokur, G. and Clayton, P. (1967). Family history studies I. Two types of affective disorders separated according to genetic and clinical factors. In *Recent Advances in Biological Psychiatry*, ed. J. Wortis, pp. 25–30. New York: Plenum.

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Chapter 2

The bipolar spectrum

James Phelps

Introduction

An experienced host prepares to serve a ceremonial fowl. The guests look on with anticipation. The knife is sharpened. After he identifies the gap between thigh and body, the carving proceeds neatly. This image is often invoked in discussions of diagnostic systems, speaking of 'carving nature at its joints'. But what if the entity in question does not have joints? This is the essence of the bipolar spectrum perspective.

Most diagnostic systems – and many clinicians – categorise illnesses as discrete entities. This monograph has a similar orientation. In focussing on Bipolar II disorder (BP II), it assumes that this is a distinct condition or entity able to be distinguished from other putatively categorical mood disorders (particularly Bipolar I disorder or BP I and unipolar depression). But what if BP II is not an entity but rather a point on a continuous spectrum of mood disorders? This chapter examines such a proposition.

At least eight reviews have been written on the bipolar spectrum concept – including a chapter by the chairman of the International Society for Bipolar Disorder (ISBD) *Diagnostic Guidelines Task Force* (Ghaemi *et al.*, 2008); and a review with recommendations for changes to the DSM-IV, prepared for that Task Force by this author and colleagues (Phelps *et al.*, 2008); as well as six other cogent overviews (Dunner, 2003; Katzow *et al.*, 2003; Moller and Curtis, 2004; Angst and Cassano, 2005; Mondimore, 2005; Skeppar and Adolfsson, 2006). Rather than repeat arguments from that literature, this chapter will consider the utility of a spectrum approach to the diagnosis of bipolar disorder from the author's perspective. This approach presumes the existence of intermediate cases *between* DSM bipolar disorder and major depression conditions. While the model is also apposite for the World Health Organization's *International Classification of Diseases* (ICD), for simplicity, the DSM system will be used as the reference categorical system for model consideration.

After a brief description of the spectrum view, and an overview of the data supporting it, we will look at the implications of the spectrum approach for the diagnostic process, and for treatment selection.

The bipolar spectrum as a diagnostic perspective

In the Linnaean classification system of biology, species are recognised as distinctly different from one another, and identifiable by characteristic field markings and behaviours. Psychiatric diagnosis is currently based on a similar system of *categories*. But a parallel

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