Bipolar II Disorder
Modelling, Measuring and Managing
Second Edition
Bipolar II Disorder

Modelling, Measuring and Managing

Second Edition

Edited by

Gordon Parker

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To Heather Brotchie – my wife for more than four decades – ever modest about her many talents but who has provided the highlight to my life
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Introduction to the second edition

The first edition of this book was published in 2008 and it was – as far as we can establish – the first monograph to focus on Bipolar II (BP II) disorder for the academic community. This reflected the condition having only been defined and detailed since the 1970s, having its very diagnostic status challenged by many, being viewed as a minor condition (e.g. ‘bipolar lite’) and with the absence of treatment guidelines. The book was designed to detail what is known, what needs to be clarified and what issues should be debated – especially the extent to which the condition’s management should be simply extrapolated from the management of Bipolar I disorder or modified to reflect disorder-specific differences.

It is therefore encouraging that the book’s success led to Cambridge University Press inviting a second early edition. Clearly, because the information about BP II is expanding rapidly, and argued for the chapter list to be reviewed and chapters updated. In addition, it was an opportunity to amalgamate some chapters and introduce new ones, particularly addressing personality issues, comorbidity and the personal experience and trajectory as detailed by those diagnosed with a BP II episode. The appeal of the first edition appeared to very much reflect the debate format in the second half of the book – where instead of a ‘consensus’ of views, we found that bipolar experts are in two minds about many aspects of definition and management. The appeal came less from observing experts argue and more from observing the strength of their arguments and their clinical observations. Reviewer John Gottlieb observed that the book was ‘… the first publication out of the gate on this important area’ and went on to observe that ‘Eschewing the standard … format of blandly compiling the accumulated data … and striving for a deadening impartiality … [and] draining the lifeblood out of the subject … [the book] makes room for the full cacophony of opinion, debate, agreement and conflict that constitutes the field of research at this time … The result is less a compilation than a real-time, street fight amongst respected colleagues’ (John Gottlieb, 2008). This shared view encouraged inviting a second clinical model to spark multiple management commentaries.

There is still a clear need to improve detection and diagnosis. In relation to the ‘binary model’ the observation by the humourist Robert Benchley is cogent: ‘There are two classes of people in the world: those who divide the people in the world into two classes and those who do not’. The bipolar disorders can be divided into Bipolar I (BP I) and BP II sub-sets, but the other relevant binary issue is that BP II seemingly attracts two positions – ‘over-diagnosis’ (often by expanding the spectrum concept into domains of personality and temperament) and ‘under-diagnosis’. The latter concern is worthy of extension. As noted throughout the book, very high percentages of individuals with a BP II disorder never receive that diagnosis or, alternatively, are only so diagnosed after an extensive period and often after experiencing considerable ‘collateral damage’ from the condition (in terms of disruption to work and relationships in particular). Over the last decade I have been somewhat critical of colleagues who have failed to diagnose a seemingly characteristic BP II condition and been perplexed by their monocular vision. I now suspect that one of the principal explanations is training – or, in this instance, the lack of it. Most psychiatrists train in facilities where they observe psychotic or BP I (manic-depressive) states. Few mental health professionals have ever received a lecture on the topic during their training course. Most professionals who have developed an interest in this diagnostic condition over the last few decades have
Introduction to the second edition

generally 'learned on the job' and in the absence of clear evidence and clear management guidelines.

Detection is not possible without awareness. While BP II was only formally classified some 30 years ago, it is not a 'new' condition. For example, Davidson (2010) has compiled psychological evaluations of the first 51 British Prime Ministers, from Walpole to Blair. His descriptions suggest that eight (16%) had a likely BP II condition – including Pitt the Elder, Gladstone, Grey, Disraeli, Lloyd George, Churchill, Canning and Macmillan. He judged that bipolar highs might have fired their ambition and ability to reach the top, and that Prime Ministers with a bipolar disorder may have therefore provided a 'greater service' to the country (particularly in wartime) than provided by those with cautious and self-doubting traits. Neither they – nor those around them – would have 'known' that they had a 'BP II condition' as it had no formal classificatory status. It would have gone 'under the radar' as still commonly occurs. To repeat the point – detection is not possible without awareness.

Such observations argue for much greater professional and community awareness, which can be acquired incrementally or advanced via seminal events. One exemplar of the latter occurred recently in Australia. In 2008, the well-respected television newreader Charmaine Dragun committed suicide. Her life and her death were overviewed in an award-winning documentary titled 'Friday's child'. The coronial inquest sought to examine the reasons that had caused her to take her life and to 'try to prevent similar tragedies in the future'. Charmaine had received treatment for depression from general practitioners, psychiatrists and psychologists for over a decade. The coronial inquiry identified clear evidence of a previously unidentified BP II condition, with 'highs' observed by numerous work colleagues and friends, with Charmaine's diary recording 'manic mood swings' and with her mother also asking Charmaine whether a bipolar disorder had been considered. The Coroner was highly critical of the health professionals who had failed to pursue such a diagnosis and made a number of recommendations. Two are noted. Firstly, that there should be 'increased awareness by health professionals of the need to exclude a bipolar disorder in all patients presenting with signs and symptoms of depression', and secondly, the 'need' for readily available assessment tools. An overview of the issues raised in the coronial inquest (Parker, 2011) – and some of the medico-legal implications (Freckelton and Mendelson, 2011) have been recently detailed.

Her story is salutary. While this book focusses on the 'outside in' views of many experts, it is complemented by many 'inside out' stories, of those who have lived with a BP II disorder. Their stories enrich our understanding of nuances of the condition, both here with the 'D Club' story and in Chapter 16, which focusses on the narrated nuanced experiences of a number of individuals with the condition.

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 unaware that he might
have a bipolar disorder – until I sought his permission to publish this exemplar essay. As detailed through this book, many individuals experience BP II 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 mismanaged. 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 BP II world, the tone provides the signature chord heard in the conversational style of many who experience BP II. 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 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 6 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 2-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 well-being, 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 well-being. 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.

Gordon Parker

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References


