Good Mood Bad Mood: Bipolar Disorder

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Introduction: Bipolar Disorder started the Journey.

I. Surge in Diagnosis since 1980.
   A. Epidemic?
   B. Changing criteria?
   C. Root of the problem is in diagnosis and treatment of depression.
   D. Similar subjective criteria method used to diagnose BPD as is in depression.
   E. Criteria for BPD 1 (old Manic Depression):
      1. Period of more than 1 week of improved mood.
      2. Irritable, inflated sense of self-esteem with decreased need for sleep.
      3. Easily distracted with a pressing need to get things done.
      4. Spending money they do not have. Disastrous sexual or moral choices.
      5. Mania is followed by depression. Diagnosis of depression required for BPD1.
   F. Tom's story fits.

II. Moving from Manic Depression to Bipolar Disorder.
   A. Starts with the Birth of Modern Medicine.
      1. William Perkin in 1900, discovery of purple dye.
      2. Paul Ehrlich used it to stain tissue samples.
         a. "It should be possible to find artificial substances which are really curative for certain diseases, not merely palliatives acting favorably on one or another symptom."
         b. Ehrlich found that nearly half of the patients at the Charite mental hospital (asylum) in Berlin had an infectious disease that caused their insanity.

c. Truth is never an enemy in the pursuit of understanding and curing disease.

3. Freud turned psychiatry away from the kind of pathology-based medicine of Ehrlich and towards theory based explanations

B. Psychiatry was in disarray by 1950. Out of it came the drive to standardize psychiatric terms and descriptions of disease.
   1. Diagnostic Statistical Manual of Mental Disorders first published in 1950 tried to bring order.
   2. In the 3rd revision of the DSM in 1980, bipolar disorder was added in the place of manic depression.
   3. Prozac was launched in January 1988.

C. Bipolar disorder categories.
   1. BPD1, the old manic depression
   2. BPD2
   3. Cyclothymia
   4. Depression with family history of BPD
   5. Mania alone.
   6. BPD NOS. Old trucking term: not otherwise specified.

D. With the DSM3, came a couple of important changes in the diagnosis of BPD:
   1. You no longer had to have a week long episode of mania requiring hospitalization.
   2. The criteria for BPD2 is less restricted.
      a. Presence of one or more major depressive episodes.
      b. Presence (or history) of a least one hypomanic episode.
      c. There never has been a manic episode or mixed episode.

d. Symptoms are not better accounted for by other disorder.
e. The symptoms cause significant clinical distress or social impairment in social, occupational or other areas of function.

3. The key difference is between mania and hypomania, which makes it much less difficult to apply the diagnosis.
    a. A distinct period of persistently elevated, expansive, or irritable mood, lasting at least 4 days, that is clearly different from the usual non-depressed mood.
    b. During the period of mood disturbance, 3 or 4 of the following symptoms have persisted (4 if only irritable) and have been present to a significant degree.
        1. Inflated self-esteem or grandiosity.
        2. Decreased need for sleep. (feels rested after 3 or 4 hours)
        3. More talkative than usual or feels pressure to keep talking.
        4. Flight of ideas or subjective experience that thoughts are racing.
        5. Distractibility
        6. Increase in goal directed activity (social, work, school, sexually) or psychomotor agitation.
        7. Excessive involvement in pleasurable activities that have a high potential for painful consequences (buying sprees, sexual indiscretion, or foolish business investments).

E. Represents change in function level, observed by others.

F. Not severe enough to cause marked impairment in social or occupational functioning and does not have psychotic features.
    1. This is the important dividing line.

2. “Hypomanic-like episodes that are clearly caused by somatic antidepressant treatment (medication, ECT, light therapy) should not count toward a diagnosis of bipolar II disorder.
3. The problem is that most people labeled with depression are on antidepressant medication when labeled with BPD2.

    “Instead of treating a new disease, we may simply be treating the side effects of a drug used to treat an old one.”

III. How can we help? Example: the case of the struggling young mother.

A. “The solution is the same as it always has been in medicine. We need to make a better diagnosis based on the most solid factual evidence we can get.”

1. It starts by recognizing that the diagnosis of bipolar disorder is just as confused today as is the diagnosis of depression. The labels offer us no pathological certainty or validation.
2. As disordered/normal sadness is the key to understanding depression, so mania/hypomania is the dividing line in BPD.
3. In the absence of mania, the bipolar 2 label has no more validity than the label of depression in the absence of disordered sadness.
4. The first important thing to do is to deal with normal sadness/grieving due to loss.
5. All of the aspects of Biblical counseling come to bear on this issue and the problems that grow from it. Sadness, sorrow, loss, anger, fear, worry, bitterness, self-orientation, idolatry, grace, hope, confidence, repentance, faith, sanctification, salvation, or perseverance, are all areas that will need to be explored.
6. Responsibility for behavior. Example: Dr. Welch’s patient.

"(the) scriptures tell us that our sin comes out of our own hearts and that mania could not cause him to sin." Ed Welch, CCEF Conference, Lecture Fall 2011.

B. Medication

1. BPD1: If patient has had 2 or more episodes of mania, it is likely to be in their best interest to continue the best and most tolerable medication that controls their symptoms.
2. BPD2: The benefit of medication in these cases is subject to question.
3. In either case, the use of medication is not a primary issue in Biblical counseling!
4. Primary goal of Biblical counseling starts in 2 Corinthians 5:9:

   "I want to glorify God with my life more than I want to breathe!"
5. The greatest benefit to those with mood disorders is to be found in discerning between normal and disorder sadness due to loss and then dealing with them biblically.