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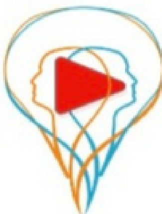

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YAYINDA

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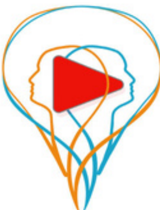

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Instructor's Manual

for

ASSESSMENT AND PSYCHOLOGICAL TREATMENT OF BIPOLAR DISORDER

with

KAY REDFIELD JAMISON, PHD

Manual by

Ali Miller, MFT

The *Instructor's Manual* accompanies the DVD *Assessment and Psychological Treatment of Bipolar Disorder with Kay Redfield Jamison, PhD* (Institutional/ Instructor's Version). Video available at www.psychotherapy.net.

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Teaching and Training: Instructors, training directors and facilitators

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Miller, Ali, MFT

Instructor's Manual for Assessment and Psychological Treatment of Bipolar Disorder with Kay Redfield Jamison, PhD

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Instructor's Manual for

ASSESSMENT AND PSYCHOLOGICAL TREATMENT OF BIPOLAR DISORDER WITH KAY REDFIELD JAMISON, PHD

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Tips for Making the Best Use of the DVD

1. USE THE TRANSCRIPTS

Make notes in the video **Transcript** for future reference; the next time you show the video you will have them available. Highlight or notate key moments in the video to better facilitate discussion during and after the video.

2. FACILITATE DISCUSSION

Pause the video at different points to elicit viewers' observations and reactions to the concepts presented. The **Discussion Questions** section provides ideas about key points that can stimulate rich discussions and learning. The **Role-Plays** section guides you through exercises you can assign to your students in the classroom or training session.

3.ENCOURAGE SHARING OF OPINIONS

Encourage viewers to voice their opinions. What are viewers' impressions of what is presented in the interview?

4. SUGGEST READINGS TO ENRICH VIDEO MATERIAL

Assign readings from **Related Websites, Videos and Further Reading** prior to or after viewing.

5. ASSIGN A REACTION PAPER

See suggestions in the **Reaction Paper** section.

Diagnostic Criteria for Bipolar I Disorder*

Bipolar Disorder is classified in the DSM-IV-TR as a Mood Disorder. The category of Bipolar Disorders includes Bipolar I Disorder, Bipolar II Disorder, Cyclothymia, and Bipolar Disorder Not Otherwise Specified. The following description applies only to Bipolar I Disorder. To learn more about Bipolar Disorder, refer to the DSM-IV-TR, pp. 382-401.

The essential feature of Bipolar I Disorder is a clinical course that is characterized by the occurrence of one or more Manic Episodes or Mixed Episodes. Often individuals have also had one or more Major Depressive Episode. There are six separate criteria sets for Bipolar I Disorder: Single Manic Episode, Most Recent Episode Hypomanic, Most Recent Episode Manic, Most Recent Episode Mixed, Most Recent Episode Depressed, and Most Recent Episode Unspecified. Since the essential feature of Bipolar I Disorder is a Manic Episode, the focus in this summary is exclusively on an abbreviated description of Manic Episode. Students are strongly encouraged to refer to the DSM-IV-TR for a complete description of Bipolar I Disorder.

What is a Manic Episode?

The elevated mood of a Manic Episode may be described as euphoric, unusually good, cheerful, or high. Although the person's mood may initially have an infectious quality for the uninvolved observer, it is recognized as excessive by those who know the person well. The expansive quality of the mood is characterized by unceasing and indiscriminate enthusiasm for interpersonal, sexual, or occupational interactions. For example, the person may spontaneously start extensive conversations with strangers in public places, or a salesperson may telephone strangers at home in the early morning hours to initiate sales. Although elevated mood is considered the prototypical symptom, the predominant mood disturbance may be irritability, particularly when the person's wishes are thwarted. Lability of mood (e.g., the alternation between euphoria and

irritability) is frequently seen.

Inflated self-esteem is typically present, ranging from uncritical self-confidence to marked grandiosity, and may reach delusional proportions. Individuals may give advice on matters about which they have no special knowledge (e.g., how to run the United Nations). Despite lack of any particular experience or talent, the individual may embark on writing a novel or composing a symphony or seek publicity for some impractical invention. Grandiose delusions are common (e.g., having a special relationship to God or to some public figure from the political, religious, or entertainment world).

Almost invariably, there is a decreased need for sleep. The person usually awakens several hours earlier than usual, feeling full of energy. When the sleep disturbance is severe, the person may go for days without sleep and yet not feel tired.

Manic speech is typically pressured, loud, rapid, and difficult to interrupt. Individuals may talk nonstop, sometimes for hours on end, and without regard for others' wishes to communicate. Speech is sometimes characterized by joking, punning, and amusing irrelevancies. The individual may become theatrical, with dramatic mannerisms and singing. Sounds rather than meaningful conceptual relationships may govern word choice (i.e., clanging). If the person's mood is more irritable than expansive, speech may be marked by complaints, hostile comments, or angry tirades.

The individual's thought may race, often at a rate faster than can be articulated. Some individuals with Manic Episodes report that this experience resembles watching tow or three television programs simultaneously. Frequently there is flight of ideas evidenced by a nearly continuous flow of accelerated speech, with abrupt changes from one topic to another. When flight of ideas is severe, speech may become disorganized and incoherent.

Distractibility is evidenced by an inability to screen out irrelevant external stimuli (e.g., the interviewer's tie, background noises or conversations, or furnishings in the room). There may be a reduced ability to differentiate between thoughts that are germane to the topic and thoughts that are only slightly relevant or clearly irrelevant.

The increase in goal-directed activity often involves excessive planning of, and excessive participation in, multiple activities (e.g., sexual, occupational, political, religious). Increased sexual drive, fantasies, and behavior are often present. The person may simultaneously take on multiple new business ventures without regard for the apparent risks or the need to complete each venture satisfactorily. Almost invariably, there is increased sociability (e.g., renewing old acquaintances or calling friends or even strangers at all hours of the day or night), without regard to the intrusive, domineering, and demanding nature of these interactions. Individuals often display psychomotor agitation or restlessness by pacing or by holding multiple conversations simultaneously. Some individuals write a torrent of letters on many different topics to friends, public figures, or the media.

Expansiveness, unwarranted optimism, grandiosity, and poor judgment often lead to an imprudent involvement in pleasurable activities such as buying sprees, reckless driving, foolish business investments, and sexual behavior unusual for the person, even though these activities are likely to have painful consequences. The individual may purchase many unneeded items (e.g., 20 pairs of shoes, expensive antiques) without the money to pay for them. Unusual sexual behavior may include infidelity or indiscriminate sexual encounters with strangers.

Associated descriptive features and mental disorders

Individuals with a Manic Episode frequently do not recognize that they are ill and resist efforts to be treated. They may travel impulsively to other cities, losing contact with relatives and caretakers. They may change their dress, makeup, or personal appearance to a more sexually suggestive or dramatically flamboyant style that is out of character for them. They may engage in activities that have a disorganized or bizarre quality (e.g., distributing candy, money, or advice to passing strangers). Gambling and antisocial behaviors may accompany the Manic Episode. Ethical concerns may be disregarded even by those who are typically very conscientious. The person may be hostile and physically threatening to others. Some individuals, especially those with psychotic features, may become physically assaultive or

suicidal. Adverse consequences of a Manic Episode (e.g., involuntary hospitalization, difficulties with the law, or serious financial difficulties) often result from poor judgment and hyperactivity. When no longer in the Manic Episode, most individuals are regretful for behaviors engaged in during the Manic Episode. Some individuals describe having a much sharper sense of smell, hearing, or vision (e.g., colors appear very bright).

Mood may shift rapidly to anger or depression. Depressive symptoms may last moments, hours, or, more rarely, days. Not uncommonly, the depressive symptoms and manic symptoms occur simultaneously. As the Manic Episode develops, there is often a substantial increase in the use of alcohol or stimulants, which may exacerbate or prolong the episode.

Differential Diagnosis

Manic Episodes should be distinguished from Hypomanic Episodes. Although Manic Episodes and Hypomanic Episodes have an identical list of characteristic symptoms, the disturbance in Hypomanic Episodes is not sufficiently severe to cause marked impairment in social or occupational functioning or to require hospitalization. Some Hypomanic Episodes may evolve into full Manic Episodes.

Attention-Deficit/Hyperactivity Disorder and a Manic Episode are both characterized by excessive activity, impulsive behavior, poor judgment, and denial of problems. ADHD is distinguished from a Manic Episode by its characteristic early onset (i.e., before age 7 years); chronic rather than episodic course; lack of relatively clear onsets and offsets; and the absence of abnormally expansive or elevated mood or psychotic features.

Full Criteria for Manic Episode

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary).

B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only

irritable) and have been present to a significant degree:

1. inflated self-esteem or grandiosity
2. decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
3. more talkative than usual or pressure to keep talking
4. flight of ideas or subjective experience that thoughts are racing
5. distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)
6. increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
7. excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

C. The symptoms do not meet criteria for a Mixed Episode (see below).

D. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

E. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).

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Reaction Paper for Classes and Training

Video: *Assessment and Psychological Treatment of Bipolar Disorder with Kay Redfield Jamison, PhD*

- **Assignment:** Complete this reaction paper and return it by the date noted by the facilitator.
- **Suggestions for Viewers:** Take notes on these questions while viewing the video and complete the reaction paper afterwards. Respond to each question below.
- **Length and Style:** 2-4 pages double-spaced. Be brief and concise. Do NOT provide a full synopsis of the video. This is meant to be a brief reaction paper that you write soon after watching the video—we want your ideas and reactions.

What to Write: Respond to the following questions in your reaction paper:

1. Key points: What important points did you learn about Bipolar Disorder? What stands out to you about Jamison's approach to assessing and treating Bipolar Disorder?

2. What I found most helpful: As a therapist, what was most beneficial to you about the material presented? What tools or perspectives did you find helpful and might you use in your own work? What challenged you to think about something in a new way?

3. What does not make sense: What principles/techniques/interventions did not make sense to you? Did anything push your buttons or bring about a sense of resistance in you, or just not fit with your own style of working?

4. How I would do it differently: What might you do differently than Jamison when working with people with Bipolar Disorder? Be specific about what different approaches, interventions and techniques you would apply.

5. Other questions/reactions: What questions or reactions did you have as you viewed the interview with Jamison? Other comments, thoughts or feelings?

Related Websites, Videos and Further Reading

WEB RESOURCES

Dr. Jamison's faculty page at Johns Hopkins

www.hopkinsmedicine.org/psychiatry/expert_team/faculty/J/Jamison.html

Mood Disorders Center at Johns Hopkins

www.hopkinsmedicine.org/psychiatry/specialty_areas/moods/

National Network of Depression Centers

www.nndc.org

Depression and Bipolar Support Alliance

www.dbsalliance.org

National Institute of Mental Health's publication on Bipolar Disorder

www.nimh.nih.gov/health/publications/bipolar-disorder/complete-index.shtml

The American Psychiatric Association practice guidelines, *Guideline Watch: Practice Guideline for the Treatment of Patients with Bipolar Disorder, 2nd Edition*

www.psychiatryonline.com/content.aspx?aID=148434

RELATED VIDEOS AVAILABLE AT WWW.PSYCHOTHERAPY.NET

Suicide & Self-Harm: Helping People at Risk by Linda Gask
Voices of Suicide: Learning from those who lived by The Glendon Association Understanding and Preventing Suicide by The Glendon Association Depression: A Cognitive Therapy Approach by Arthur Freeman
Gender Differences in Depression: A Marital Therapy Approach by The Ack- erman Institute, Peggy Papp

RECOMMENDED READINGS

Goodwin, F. K. and Jamison, K. R. (2007). *Manic-depressive illness: Bipolar disorders and recurrent depression (Second edition)*. New York: Oxford University Press.

Jamison, K. R. (2009). *Nothing was the same: A memoir.* New York: Alfred A. Knopf.

Jamison, K. R. (2004). *Exuberance: The passion for life.* New York: Alfred A. Knopf.

Jamison, K. R. (2000). Suicide and bipolar disorder. *Journal of clinical psychiatry*, 61:1-5.

Jamision, K. R. (1999). *Night falls fast: Understanding suicide.* New York: Alfred A. Knopf.

Jamison, K. R. (1995). *An unquiet mind.* New York: Alfred A. Knopf.

Jamison, K. R. (1993). *Touched with fire: Manic-depressive illness and the Artistic Temperament.* New York: Free Press (Macmillan).

Jamison, K. R. (1990). The role of psychotherapy in the management of bipolar disorder. In P. J. Cowen & K. Hawton (Eds.) *Dilemmas and difficulties in the management of psychiatric patients.* Oxford: Oxford University Press.

Discussion Questions

Professors, training directors and facilitators may use some or all of these discussion questions, depending on what aspects of the video are most relevant to the audience.

WHAT IS BIPOLAR DISORDER?

1. **Challenges and rewards:** Have you had experiences working with clients with bipolar disorder? If so, what have been some of the challenges you have faced? What has been rewarding about working with people with this diagnosis?

2. **The medical model:** What was your reaction when Dr. Jamison said she thinks it is "pretty much malpractice" not to assume that medication is the central treatment for bipolar illenss? Do you agree or disagree with her? Why? She also makes the point that she considers bipolar disorder to be an illness, a medical disease. Is that how you see it? Why or why not?

CRITICAL TASKS FOR THERAPISTS

3. **Medication compliance:** In your work with clients with bipolar disorder, have you ever come across clients who don't want to take medication? How have you worked with this? What have you found helpful and unhelpful in supporting your clients to "come to deal with their qualms and disquietudes about taking medication"? What came up for you when Dr. Jamison said that the therapist has to be persuasive, to convince someone that they have a destructive illness that needs treatment? Have you ever been in the position of having to convince someone of this? How was that for you?

SUICIDALITY

4. **Death rates:** What reactions did you have when Dr. Jamison stated that psychotherapists working with people with bipolar illness need to know that bipolar disorder has a very high suicide rate, higher than a lot forms of heart disease and cancer? Was this something you were aware of? Do you keep the high possibility of suicide in the forefront of your mind when you work with people with bipolar disorder? Did you already know that bipolar

illness puts someone at a greater risk for suicide than any other illness? Do you think this information will change how you work with any of your current or future clients? How so?

BE INFORMED

5. **Being informed:** Dr. Jamison talked about how important it is for therapists to be informed about bipolar illness and that “there’s no reason not to be informed” because “this is a very well-studied illness.” Would you consider yourself to be informed? If so, how did you learn about bipolar disorder? Why do you think many psychotherapists are not informed about this illness? Do you agree with Dr. Jamison that the severity of the illness is underappreciated by many therapists? If so, why do you think that is?

INVOLVE THE FAMILY

6. **Family involvement:** What are your thoughts about Dr. Jamison’s advice to, whenever possible, involve the family of a person diagnosed with bipolar disorder? In your work with people with this illness, have you involved their family members? What are some experiences you’ve had with family involvement?

7. **A sobering disease:** What came up for you when Dr. Jamison spoke about her own personal plan for treatment if she becomes manic or severely depressed again? How did you react when she said she wants to be hospitalized against her will because otherwise she could ruin everything in her life? Given how healthy and high-functioning she appears in the interview, were you surprised to hear her say this? Why or why not?

8. **Forever:** What did you think of Dr. Jamison’s statement about bipolar disorder that, “You got it forever”? Have you thought about bipolar disorder as a recurrent illness or a curable disorder? Do you agree with her that bipolar disorder is an illness that one has forever? Why or why not?

EFFECTIVE STRATEGIES

9. **Psychiatrists:** What kinds of experiences have you had collaborating with psychiatrists who are prescribing medications

to your psychotherapy clients? Dr. Jamison said, “don’t just assume the other person is accurate.” Have you ever disagreed with the medicating psychiatrist about your client’s diagnosis or treatment recommendations? How did you handle that?

DIAGNOSIS

10. **Misdiagnosis:** What are some of the challenges you’ve faced in diagnosing clients with bipolar disorder? Has it been clear cut for you, or have you had some cases where you were uncertain about the diagnosis? After watching this interview, do any clients come to mind whom you may have misdiagnosed?

CHILDHOOD BIPOLAR DISORDER

11. **Childhood bipolar illness:** What are your thoughts on diagnosing children with bipolar disorder? If you work with children, have you come across any children who you would consider as having bipolar disorder? Do you agree with Dr. Jamison that childhood bipolar illness exists, but is an unusual occurrence? Why or why not? What are your thoughts on medicating children diagnosed with bipolar disorder?

THE ULTIMATE SELF-DISCLOSURE

12. **Going public:** What do you think of Dr. Jamison’s decision to give up her clinical practice after she published An Unquiet Mind? Do you agree with her that it would have been self-absorbed of her to continue seeing patients after making her own issues so public? Why or why not? In general, what are your thoughts on therapists going public about their own mental illnesses? How do you think it impacts clients when they know that their therapist has a mental illness? If you wrote a very self-revealing book about your own life struggles, do you think you would stop seeing clients? Why or why not?

13. **The approach:** What are your overall thoughts about Jamison’s approach to assessing and treating bipolar disorder? What aspects of her approach can you see yourself incorporating into your work? Are there some components of her approach that seem incompatible with how you work? What in

particular would you do differently from Jamison?

14. **Personal Reaction:** How would you feel about having Jamison as your therapist? Do you think she could build a solid therapeutic alliance with you? Would she be effective with you? Why or why not?

Role-Plays

After watching the video and reviewing the ***Diagnostic Criteria for Bipolar I Disorder*** in this manual, break participants into groups of two and have them role-play a diagnostic interview with a client displaying or describing symptoms of ***Bipolar I Disorder, Most Recent Episode Manic***.

One person will start out as the therapist and the other person will be the client, and then invite participants to switch roles. Clients may pull from actual experiences in their own lives, or may role-play a friend, acquaintance, a client of their own, or they can completely make it up. They can either be in the midst of manic episode, or else reporting on a past episode. If clients are displaying a current manic episode, caution them not to overact it, to prevent the role-play from becoming too theatrical or comical. The client should display or describe symptoms of a **Manic Episode**, including three or more of the following symptoms:

1. Inflated self-esteem or grandiosity
2. Decreased need for sleep
3. More talkative than usual or pressure to keep talking
4. Flight of ideas or subjective experience that thoughts are racing
5. Distractibility
6. Increase in goal-directed activity
7. Excessive involvement in pleasurable activities that have a high potential for painful consequences

In addition to validating the client's experiences, the therapist should focus primarily on making a diagnosis of Bipolar I Disorder, Most Recent Episode Manic, by asking first about family history of: suicide, alcohol and drug use, depression, mania, and psychiatric hospitalizations. Secondly, ask about symptoms and the duration and severity of symptoms. Do the symptoms disrupt the client's life? Do they disrupt the lives of other people? Do they disrupt the client's

ability to form relationships, to keep a job?

Once the therapist has determined that the client fits the criteria for Bipolar I Disorder, Most Recent Episode Manic, the therapist should practice discussing this diagnosis with the client and engaging the client in a conversation about the necessity of medication. Clients should initially resist the therapist's advice, so therapists have an opportunity to practice convincing the client a) that they have a serious disease that's going to come back if they don't treat it and, b) that there is the potential for major destruction (including suicide) if they don't get medical treatment. Therapists should use Jamison's medical terminology, such as referring to the disorder as an illness. Therapists should also practice letting the client know that they'd like to involve family members in the treatment.

After the role-plays, have the groups come together to discuss their experiences. What did participants learn about Bipolar I Disorder? Invite the clients to talk about what it was like to role-play someone with Bipolar I Disorder and how they felt about the diagnostic interview. Was the client convinced that they have an illness and that they need to take medication? Did they feel understood and validated? Then, invite the therapists to talk about their experiences: How did it feel to focus on assessment and diagnosis? What feelings came up for them when they were trying to convince their client that they have a lethal disease and need medical treatment? What was it like to talk about involving the family? Finally, open up a general discussion of what participants learned about the assessment and treatment of Bipolar I Disorder.

An alternative is to do this role-play in front of the whole group with one therapist and one client; the rest of the group can observe, acting as the advising team to the therapist. Before the end of the session, have the therapist take a break, get feedback from the observation team, and bring it back into the session with the client. Other observers might jump in if the therapist gets stuck. Follow up with a discussion on what participants learned about the assessment and treatment of Bipolar Disorder.

Complete Session Transcript of Assessment and Psychological Treatment of Bipolar Disorder with Kay Redfield Jamison, PhD

Victor Yalom: Hello, I'm Victor Yalom, and I'm delighted to be here today with Dr. Kay Redfield Jamison. She's a leading expert on bipolar and mood disorders, as well as a most talented and lyrical writer. She's co-authored the definitive text on bipolar disorders, as well as written books on such diverse subjects as suicide, exuberance, manic depression, and the artistic temperament, as well as two unflinchingly candid memoirs. The first, An Unquiet Mind, chronicles her own personal struggles with bipolar disorder. And most recently, Nothing Was the Same, which relates the healing powers of love in marriage with her late husband, Richard Wyatt, and her grief in coping with his illness and death.

Welcome, Dr. Jamison.

Kay Redfield Jamison: Thank you.

WHAT IS BIPOLAR DISORDER?

Yalom: Let's start with the basics. What is bipolar disorder and what's our latest current understanding of what the causes of it are?

Jamison: Bipolar disorder is a genetic illness—it runs in families. And it varies tremendously in severity, from mild forms where people just have swings in moods, but mood swings that don't cause too much damage, to severe psychotic forms where people are psychotically manic or suicidally depressed. And it's really characterized by not just changes in mood, but changes in energy and sleep patterns and the capacity to think clearly, use judgment well.

Yalom: And the DSM now has several subtypes of those.

Jamison: Yes.

Yalom: Can you say a little bit about that?

Jamison: Well, traditional manic depressive illness or bipolar illness—bipolar I is the severe form, and it's really a severe form of mania, which is characterized by speaking rapidly, thinking very rapidly, extremely irritable, paranoid mood, or a very forward and expansive mood, a tendency to use exceedingly bad judgment, to spend a lot of money, get involved in sexual relationships, to do a variety of things that are not generally regarded as "good for you." And it's also characterized in many people by hallucinations and delusions. So it's a psychotic illness in many people.

In depression, the symptoms are very much the opposite, where people really slow down. The irritability may be significant, but people have a very flat, disinterested mood—occasionally sad, but generally flat and disinterested—and sleep too much or sleep too little, have very little energy and, again, can be psychotic and have delusions and hallucinate.

Yalom: In the depressive cycle?

Jamison: In the depressive cycle, though that's less frequent than in mania.

Yalom: Yeah. So you say it's a genetic illness.

Jamison: Right.

Yalom: So people often talk about genetic vulnerabilities or disposition. How do we know it's a genetic disorder? Does everyone who has... Have genes been identified, or what's the evidence for this?

Jamison: Generally with a genetic illness you look to see, in the ideal case, identical twins raised apart.

Yalom: Yes.

Jamison: So if one twin is raised in Los Angeles, and another twin is raised in Copenhagen, and they both have bipolar disorder then that's evidence—some evidence.

Yalom: If there's a high correlation.

Jamison: That's right. There's a concordance between those two. So what we know about bipolar illness is that if one twin has bipolar illness, it's very, very likely that the other one will as well.

Yalom: How strong is the correlation?

Jamison: 60 to 80 percent.

Yalom: Wow.

Jamison: So it's pretty high, particularly if you add into that just depression alone, major depression, as opposed to bipolar illness and suicide. So, it's a very heritable illness. That's been known. It's been know this runs in families. That doesn't necessarily make it genetic, of course. And there a lot of studies going on now in labs across the world looking for the genes, isolating some of the genes, and making very real progress on that.

Yalom: Yeah. Now, in terms of that, I assume there are some other factors that contribute to how likely that predisposition manifests into a full-blown mania versus a milder form. Is that the case?

Jamison: We don't know. The severity of the illness does seem to have a heritable quality as well. So bipolar II, which tends to have full-blown depressions but much milder manias, seems to actually to clump in families—go together in families. So it seems to be,that particular form seems to have a particular genetic pattern to it.

Yalom: Uh-huh.

Jamison: We know that there are certain things that certainly trigger an initial episode in somebody who's vulnerable.

Yalom: Such as?

Jamison: Alcohol, drugs, sleep deprivation. Probably the single easiest way to make somebody manic who has the genetic predisposition is deprive them of sleep.

Yalom: Now, if they never have these triggers, are there some people you'd say are manic, but never manifested? Or how that does—

Jamison: Well, I guess it would be a little "trees falling in the forest" kind of philosophy. If somebody doesn't have—has never shown symptoms of mania, no, they don't have the illness. So you don't know whether that's because they haven't had things that trigger it, or that they don't have that particular form the illness, or that they don't have certain other protective genes.

Yalom: Now, you know I've read some of your books and I know your stance on this, but I'm sure you also know there are critics of the medical model in general, and critics of the medical model as applied to this disorder or anxiety or depression. And there are certainly gray areas of social anxieties. So what convinces you that this a medical order or disease, and what's your stance in general about that?

Jamison: Well, I would limit… I, in general, take the medical model. Not in all instances, but certainly with respect to bipolar illness.

Yalom: Yeah.

Jamison: I think it's pretty much malpractice not to assume that medication is the central treatment. And I say that on the basis of hundreds and hundreds of studies.

Yalom: Sure.

Dr. Jamison: And a lot of people who disagree with the medical model of bipolar illness don't read the literature. At some point science does have something to say about the practice of psychology.

Yalom: Right.

Jamison: And I think that evidence is overwhelming. I mean, it's an illness. It's a progressive illness. We know that it gets worse every time if it's not treated medically. The central treatment is a medical treatment. Now, I'm also a great believer in the value of psychotherapy, and I think that psychotherapy saves the lives of many people with bipolar illness. I don't see these as incompatible philosophies of treatment. I just think that it is malpractice, essentially, not to treat, certainly, bipolar I with medication in almost all cases. It's the sort of thing that people show up in court and win cases, all on the basis of the science.

CRITICAL TASKS FOR THERAPISTS

Yalom: All right. So, since our audience is primary psychotherapists, my understanding is, from your point of view there are benefits from psychotherapy, both in terms on helping the patient accept and work with taking Lithium, because there's often a lot of resistance to that, as well as some other supportive issues in psychotherapy that can be

quite helpful.

Jamison: Right. I think that psychotherapy is, as I said, life saving in many people who have bipolar illness. I think that one of the things most psychotherapists tend to focus on is quality of life, and enhancement of life, and mindfulness, and all these kinds of things. And these are terribly important things.

But, unfortunately, what doesn't tend to get focused on is that it saves lives—I mean literal lives. And I think, as a result, the very serious psychiatric illnesses, such as bipolar I, the severe forms of bipolar illness, and schizophrenia, tend not to get the attention from psychotherapists that other illnesses or other anxiety disorders—

Yalom: Because it's considered a medical disorder?

Jamison: Because they're considered so medical. I mean, I believe completely that bipolar illness is a medical disease.

Yalom: Right.

Jamison: But it doesn't keep it from... The central fact of the illness is that it also has huge psychological ramifications. The manifestations of the illness are largely psychological, they're behavioral, they're cognitive. The consequences in people's lives are in the ruining of relationships, the ruining of finances or jobs, and all those things that kind of give people their identity.

So it's a devastating illness. It's a completely devastating illness. And I think that psychotherapy is the only thing that I know of that can really come and make some difference in the way people pick up the wreckage and deal with it, and learn to recognize the early symptoms of mania, the early symptoms of depression, come to deal with their qualms and disquietudes about taking medication.

Yalom: Let's start with that first, because I know that that's a big issue, and I know that was for you in your life and you've written quite honestly about it.

Jamison: A little too honestly.

Yalom: Well, refreshingly so and poignantly so. But I know that was a big issue in your life and you having strong feelings about that. And

one of the problems, I understand, is that you wrote another book about exuberance, which is often for people who are not—before they're manic, they have exuberance. And other very creative and artistic people who are not bipolar have a great deal of exuberance, and it's a wonderful thing, and it's a creative quality.

So one of the reasons people with bipolar disorder are reluctant to get on Lithium or stay on Lithium is because it dampens some of that exuberance, which is a positive quality.

Jamison: Right. I think that's true—Lithium or any of the other medications that are used to treat bipolar illness in this day and age. But there's no question that in the 50 percent who have bipolar illness who also have expansive and grandiose manias, as opposed to just the irritable paranoid forms of mania, in that 50 percent there is a reluctance in some people to take medication. And again, all the more reason for psychotherapy.

Because the illness may be a medical one, but the treatment is a psychological one, as well as a medical one, and you have to be persuasive. You have to be able to convince someone who's young that, A, they have illness that's going to come back if they don't treat it and, B, that there is real damage, potentially, to the brain if they don't do this—that they could die by suicide, drug overdose or alcoholism, and that it's basically a very destructive disease. And you have to convince them of this in the midst of them feeling better than they've ever felt in their life.

Yalom: Yes.

Jamison: It is not an easy to thing to do. And I don't know any therapist on the planet who's treated bipolar illness who would say that that's an easy thing to do. Or if they have, they haven't been treating bipolar illness.

Yalom: Okay. So, that's the first and biggest challenge at hand, is to help convince the patient to—

Jamison: That it's a serious disease and it can well kill them, and each manic episode takes a hit on your brain, every depressive episode takes hit on your brain.

SUICIDALITY

Jamison: So I think in order for psychotherapists to work effectively with patients who have bipolar illness, they have to know what they're talking about, in terms of the devastating nature of this illness. It has a very high suicide rate. And one of the problems in psychology and psychiatry is that we don't... In cardiology or in oncology you talk about mortality rates, you talk about death rates. We don't talk about those in psychology. Death rates are real. The death rates are higher than a lot of forms of heart disease and cancer. So people, I think, need to keep that in the forefront, that suicide is a very real possibility. There's a big comorbidity between bipolar illness and cardiovascular disease. So if people don't get their bipolar illness treated, there are really increased risks for heart disease, significant heart disease.

Yalom: Wow.

Jamison: So, there are all sort of reasons. Dementias. There are all sort of reasons for trying to persuade.

Yalom: Suicide is a big one. How big is the comorbidity, and why is it so high for bipolar disorder?

Jamison: Well, bipolar illness puts you at a greater risk for suicide than any other illness.

Yalom: Yes.

Jamison: And one reason is that people get profoundly despairing, really suicidally depressed, when they get depressed. They get hopeless, they see no point in living, everything's flat and despairing. But they also, many of them get agitated and perturbed, because it's in the nature of the illness to have a highly irritable, perturbed quality. So if you combine that perturbance with tremendous despair and hopelessness, that is a particularly lethal combination for suicide.

Yalom: We were always told in grad school that coming out of the depression can be a particularly lethal time.

Jamison: That's true. And one reason is that, oddly enough, when you're really deeply, profoundly suicidally depressed, you are perhaps less ambivalent about dying than when you begin to get a bit well. You

also have less energy. You have less psychological energy. When people begin to move into getting normal, they're much more likely to have mixed states, where they have a combination of a high energy states along with depression. Again, a very high risk factor for suicide. There are all sorts of things.

And also, with antidepressants, for instance, the time course for response on antidepressants, the first things that clear up are energy. People who tend to get more energetic and they tend to sleep better on antidepressants. The last thing to clear up is mood.

So patients should be told. They should be simply informed that "you may get more energy, but you may not feel better." It's really important to know that in advance so it isn't so demoralizing and so concerning.

Yalom: So you think that it's the demoralization?

Jamison: And agitation.

Yalom: Because another thing that we've heard is that having that... If you need a certain amount of energy to commit suicide, having increased energy or agitation, as you put it, might increase the likelihood of acting upon those thoughts?

Jamison: Yeah, I think that's true.

BE INFORMED

Yalom: So it sounds like one thing is that, in terms of helping therapists be more effective and persuading clients who have bipolar to take their Lithium, whether you're a prescribing psychiatrist or you're a therapist and there's meds elsewhere, one prerequisite for being able to persuade them is to be highly informed yourself.

Jamison: Absolutely. And there's no reason not to be informed. This is a very well-studied illness. This illness has been around for a long time, described beautifully by Hippocrates 2500 years ago, been described over the centuries in great detail. We know an enormous amount about this illness.

And just as you wouldn't want to be going to a cardiologist that didn't know the basic structure of the heart and what causes arrhythmias

and how to diagnose this kind of problem, that kind of problem, what the consequences are, you for sure don't want to be going to a psychologist or psychiatrist who doesn't understand those things about bipolar illness.

Yalom: So the implication is that there a lot of therapists, psychologists, master's-level therapists, and even psychiatrists, that are not highly informed about this?

Jamison: Sure.

Yalom: What are some of the biggest gaps we'd see in understanding, or misconceptions?

Jamison: One, what a serious illness it is in terms of lethality, in terms of cost to personal happiness, in cost to families, society, in terms of drug and alcohol abuse, violence, suicide, all those things. That is something that's, I think, underappreciated about bipolar illness. And I think also that the course of the illness, that it will tend to progress, that it will tend to get worse if it's not treated, will tend to get more frequent or more severe. I think many people don't focus on that enough.

Yalom: Is one of the reasons you think the severity is underappreciated that when they're not in their most depressed state or the most manic state, bipolars can be very high functioning? In fact, if they're a little hypo-manic they can seem very charming and energetic?

Jamison: Yes. I think that's true, but that not really a reason not to read and understand the illness. Because you could say the same things about, again, certain kinds of heart disease, right? People are happy as clams, they wander around.

Yalom: No. Of course, I'm not justifying why therapists should not be informed. But, is that—

Jamison: But that's what I'm saying, is that that's why... You're saying a lot of it's because they're normal in between. Well, most people who have a lot of very bad illnesses are quite normal.

Yalom: If you have a heart attack, you're normal before you have the

heart attack.

Jamison: And normal afterwards. So, that doesn't take away from the problem of the potential of dying from it. So I think that that side of things needs perhaps more emphasis. And again, the course of the illness, that it's going to get worse, that these drugs work by reversing some of the damages that's in the brain.

Yalom: Really?

Jamison: That they're neuro-regenerative. They seem to be neuro-protective. So those are also very important things for therapists to talk with patients about. They also, I think, need to know really how uncomfortable the side effects are, of the drug.

I mean, I'm a great believer of medication, but I'm also a great believer that the side effects are really, really problematic. I mean, there's not just side effects, it's not just a side effect checklist. These are things that people live with day in and day out.

Yalom: Yeah.

Jamison: Very serious.

Yalom: And you described them personally—

Jamison: Yes, in great detail.

Yalom: —the level of the discomfort and physical comfort and—

Jamison: Cognitive discomfort.

Yalom: And also the dampening of that some of that exuberance and creativity.

Jamison: Right, although I think it's very different in this day and age. Most people who prescribed Lithium when I was first prescribed it prescribed at very high levels. People are kept at lower levels of virtually all the major psychiatric drugs now. So I think it's less of a problem.

Yalom: Easier to tolerate.

Jamison: Right.

Yalom: So, going back to the first step of therapists at helping their

patients accept the idea of being on Lithium and actually be on it and to maintain it, understanding it is the first thing, and understanding the side effects. What are the other skills and challenges of the therapist just to establish that first task of helping the clients stabilize on their medication?

INVOLVE THE FAMILY

Jamison: I think some of it is simply like you would with any patient, I suppose, but particularly with somebody who has got a chronic illness—to ask them what it feels like. For two reasons. The most important reason is that it's important clinically, but also to inform yourself, to learn yourself. It's a variable illness, and the manifestations of mania in people are very different. Manifestations of depression are very different. So, while you don't want to spend inordinate amounts of time going into individual episodes, you do want to ask about what were the most concerning things, what were the most frightening things? What were the things that you might miss along the way? Those kinds of things.

But I think, in other words, you want to learn about the illness in general from a scientific point of view, from a clinical point of view. But you also want to learn about the illness from the patient's perspective, from the family perspective. You want to, almost whenever you possibly can, have the family involved. Get as much information as you can from the husband—

Yalom: Why?

Jamison: Why? For a lot of reasons. One is it's an illness that's not going to go away, and it has tremendous implications on family lives. Secondly, family members will have information that patients will not have. I mean, you could have somebody in your office and you ask them, "Have you ever been hospitalized for mania?" And they say, "Yeah, yeah."

Yalom: And actually no?

Jamison: No, and then you see their charts and their charts are this long. They, in fact, have been hospitalized 20 times. So it's not

necessarily lying about it. It's that people forget, don't remember. When people are depressed they don't remember they've been manic, or when people are manic they won't remember they've been depressed.

Cognitive functioning is very, very, very bad in a severe depression, and it's very, very, very bad in mania. So you want other perspectives. You want somebody to say, you know, patient says, "Yeah, I was just feeling kind of good," and the husband says, "Oh, well, actually she racked up $7,000 on the credit card. She was out in the gardens in the nude singing and dancing with the fairies." That kind of thing gives you information that you don't necessarily get from patient. And that's particularly true with mood disorders.

Yalom: So it seems like both of these are stepping outside of some comfort zones that a lot of therapists stay in. In other words—

Jamison: Get used to it.

Yalom: No, no. It sounds important, but often times if you're not a psychiatrist or medically trained, if it's something medical you may want to know a little about it, but you kind of think, "Well, that's not my area of expertise." Likewise, a lot of therapists that are not family therapists, which are most therapists these days, don't typically involve the family. So, it sounds like effective treatment.

Jamison: Well, that's fine as long as you're not treating something like bipolar illness.

Yalom: Right.

Jamison: I think that that's perfectly—

Yalom: No. And I'm talking about—

Jamison: —legitimate. But when you're talking about bipolar illness or schizophrenia, where there's such potentially lethal and other severe consequences to the illness, it's very hard to treat it effectively without involving... It doesn't mean that you have a family in your office with you all the time. But you have to have them available. You have to have to certain ground rules about confidentiality—and the same kind of rules in general—that if somebody is talking seriously about suicide or

violence to someone else, that these are things that need to reported. Confidentiality doesn't hold under those circumstances.

I think there are a lot of things that you do perhaps with bipolar illness and schizophrenia that you wouldn't do with other illnesses. You make advance directives. You encourage people to figure out what they want to do when they're sick, when they're feeling their best. So you want people to be actively engaged in decision making about their lives when they're at their top of their form, rather than when they're in the middle of being manic and being hospitalized against their will, or whatever. You want these decisions to be made, and to the advantage of the patient.

Yalom: So that sounds really important, to negotiate with them when they're in a lucid state, about the ability—to make some contact with the family, and to have clear agreements, signed consent forms that you can—

Jamison: And to make it clear to the therapist what they want done. I've made it very clear that if I get manic again or I get severely depressed again, that I want to be treated at Johns Hopkins. I want to the following doctor working with my psychiatrist. I wanted E.C.T. shock treatment for severe depression. I don't want certain other medications. And I want to be hospitalized against my will.

Yalom: You want to be?

Jamison: Yeah, and I want to be treated against my will, and I leave it in the hands of my doctor to make those decisions for me and my family, a designated member of my family. That means that I make those decisions when I'm thinking best about what I want done, rather than in the middle of being manic, in which case I would of course say, "No, I don't need to be in the hospital," and I would ruin everything in my life.

Yalom: You feel that that's still possible for you?

Jamison: It's always possible.

Yalom: Yeah.

Jamison: Absolutely.

Yalom: Yeah. Sobering.

Jamison: It's very sobering. This is a sobering disease. **Yalom:** Yeah.

Jamison: For sure.

Yalom: So—

Jamison: It doesn't just traipse off into the wilderness. **Yalom:** Right.

Jamison: You've got it forever.

EFFECTIVE STRATEGIES

Yalom: Yeah. So getting back to skills therapists need, and pitfalls?

Jamison: Humor.

Yalom: Humor.

Jamison: Being not too obsessive. I think the people who tend to do well as therapists with people with bipolar illness tend to have a certain long-lead approach. Not just calling somebody up on every possible therapeutic transgression, but just allowing a large, wide range.

Yalom: Say more about that.

Jamison: Well, I mean, to the extent that psychotherapy can occasionally become a power struggle—and not infrequently with mood disorders that's the case—you want somebody with latitude and flexibility being the therapist, particularly with people in mania. Because otherwise you're just going to be left behind. People who are manic tend to think real fast. And you want to keep people... You want their respect and you want to have some flexibility, or you will lose them.

Yalom: So does that mean not to overreact on any exuberant behavior and you think that they're manic, but at the same time to—

Jamison: Right. I think you have to assume a great deal of independence and latitude, all while being actively involved. It's also

a place where you have to be a lot more proactive than people usually are as therapists. Anytime you're dealing with someone who has the potential to kill themselves, you want to be very much more proactive. You want to, if necessary, call that person, to have a simple way of reaching out to that person. You can't just assume that the patient's always going to come to you, because the last thing you do when you're depressed is pick up the phone and call anybody.

Yalom: So, stepping outside that comfort zone, I know that since you wrote An Unquiet Mind you gave up your clinical practice, so that's been awhile. But can you give some examples of ways that the therapist might step out or reach out that come to mind, or things that you've done or has been done to you?

Yalom: Yes. So I know when you wrote An Unquiet Mind some time ago you gave up your clinical practice, so it's been awhile since you've worked with patients. But can you think of some examples of ways that you've worked with clients that might not come firsthand to some therapists?

Jamison: I think one is ask, ask, ask. Inquire about people's concerns repeatedly. Take them very, very seriously.

Yalom: Such as?

Jamison: Concerns about medication, so that that doesn't just drift off into being a non-discussed issue.

Yalom: So if they express concerns about side effects, follow up.

Jamison: To say, "Well, that's concerning. Let's see what can be done about it." And work on that very comprehensively. Get people actively engaged in reading their moods so that they can begin to see patterns in their moods—everything from seasonal patterns to premenstrual patterns, to patterns in response to things that go on their lives.

Yalom: Are there scales or measurement devices you recommend?

Jamison: Oh, there are a lot of them. Some of them are just very simple 100-millimeter line scale, having people do it the same time every day to avoid diurnal variations. And just put a line across it and then rate and see how that varies as a function of treatment,

medications, psychotherapy, all of the things that you might do. But that does two things. One is it gives you information that you can use that's helpful—often helpful. And the second is to get people involved in their own treatment. Encourage not only patients but family members to read a lot about the illness.

There are a lot of good things that have been written out there. There are great advocacy groups nationalized for the mentally ill—The Depression and Bipolar Support Alliance. There are many groups out there that do terrific jobs on giving information to patients—supports groups, family groups and those kinds of things I think people should be very proactive about.

Yalom: Those are helpful.

Jamison: And reading firsthand accounts. There are a lot of people that have written about their experiences with different illnesses. But also encourage people to learn about, again, some of the science of their illness, to learn about the age of onset, what the symptom patterns typically are, learn about the different medications. And if a therapist is working with a psychiatrist who is a prescribing doctor for the medications, be actively involved. Or try and ask as many questions as possible, try and get it in writing. "Why is it that you think this patient has bipolar illness? What are the symptoms? What are the things that you see, family history," and so forth.

In other words, don't just assume that the other person is accurate—again, because the more engaged you are, the better it is generally for patients. "Why are you prescribing this drug?" Not in an adversarial sort of way, but just in an informational sort of way. "Had you thought about this," or, "What would you think of doing that?" But I always encourage people to get as much information in writing from the people who are prescribing, just for everyone's clarity.

Yalom: You said before, psychotherapy can be very helpful in dealing with the psychological fallout of it. What are some other ways psychotherapy is helpful in that regard?

Jamison: I think that it's... Psychotherapy, among many other things, gives a legitimacy to the devastation of an illness. If you are hit when

you're 18 years old by psychosis or suicidal depression, there's no one who can understand that better than a well-informed therapist or someone who's been there.

But I think that's a tremendously important aspect of psychotherapy, is that it can validate how awful it was, how traumatic—genuinely traumatic in the therapeutic sense—it is to lose your mind. I think that's very important for people. And for people to learn techniques, in whatever kinds of psychotherapy that you're using. I mean, the ones that have obviously been tested the most are cognitive therapy or cognitive behavioral therapy. And those give specific tools. And I think those are very important to a lot of people, and a lot of patients don't want them. A lot of people benefit from them enormously.

But I think psychotherapy, in general, gives people a place where they say, "This is what I'm going through. This is my terror." This is an illness that is a recurrent illness. And under the best of circumstances, medications and psychotherapy will keep it well in check. And there a lot of people for whom that's true. And there are a lot of people for whom that isn't true.

Yalom: So psychotherapy can help keep in check by—

Jamison: I think so—I think from the most concrete thing, keeping your sleep patterns in check, which is the single easiest way to keep your mind in check if you've got mania.

Yalom: So the factors contributing to a recurrence, or maybe not a recurrence.

Jamison: Or stopping your medication.

Yalom: Right, that's number one.

Jamison: The stress or anything else that can lead to a disruption in sleep. Learning to fill your life with great relationships. Now, that's true of any kind of psychotherapy. But I think it's particularly true with bipolar illness, where people can really go through a lot of friendships pretty quickly, and marriages pretty quickly, and employers pretty quickly. And one of the great things that psychotherapy can do is begin to try and understand that and put that wreckage in some order.

DIAGNOSIS

Yalom: It's pretty clear that the greatest risk from your perspective is under-diagnosis, people that are not diagnosed or treated as bipolar disorders.

Jamison: Yeah, I would say misdiagnosis.

Yalom: Okay.

Jamison: I wouldn't limit it to underdiagnosis.

Yalom: Okay.

Jamison: I mean, I see a lot of people who have been diagnosed with bipolar illness who don't seem to have bipolar illness.

Yalom: I see, so there are false positives as well.

Jamison: Yeah, for sure.

Yalom: What are the telltale symptoms, or what are the criteria

that can be missed? What are that factors that are contributing to misdiagnoses?

Jamison: I think for most people with bipolar illness it's a reasonably straightforward diagnosis.

Yalom: They've had to have one full-blown manic episode.

Jamison: Yeah, but making that diagnosis of mania can be relatively straightforward. That's not true for everybody. But it's a genetic illness, okay? So before getting into the diagnostic criteria you really want to ask about family history. You really want to ask about family history of suicide, family history of alcohol and drug use, family history of depression, psychiatric hospitalizations, mania. And go as deep as you can into a family tree on that, because that is enormously important information in any genetic illness.

Yalom: Because if someone has a strong family component then that makes it more likely—

Jamison: Well, it makes it more likely in conjunction. You don't make

a diagnosis on the basis.

Yalom: Of course, right.

Jamison: In conjunction with a pattern of symptoms, the knowledge that it does run strongly in someone's family certainly adds information that is useful to making a diagnosis. But the diagnosis at the moment does not take into account—

Yalom: Right. It's based on—

Jamison: —the symptoms and duration and severity of symptoms. You want to know about the course of the illness. This, too, is not asked about in the DSM-IV.

Yalom: Before we get to that, I've had clients who've had some form of manic or hypo-manic episode in their late teens or early 20s, have had nothing since then. They may have been in an extreme situational stressor. They may have been diagnosed as bipolar at that time and may have been put on medication or may have discontinued it.

Are there cases where people have what is a full-blown manic episode in terms of behavior, or close to that, that do not have a lifelong illness?

Jamison: Well, in the case of full-blown mania, it's rare. And it's rare to the point that, you know, once somebody's had a full-blown manic episode, the assumption is that that diagnosis is bipolar, manic episode. Are there people who have episodes of mood disorders that are tied very closely to certain disruptive events in their lives? And they never really quite met all the diagnostic criteria and then they don't have something again? Yes, of course that happens. Once somebody's been manic, that's one thing. People being hypo-manic, it depends on what you mean by hypo-manic. It depends on how strict the diagnostic criteria.

But, by definition, the more rigid the diagnostic criteria, the less likely you are to have people that just go on and don't have something else. So that's one of the arguments for having pretty strict diagnostic criteria for mania and for depression.

But you diagnose on the basis of not one or two symptoms, but many symptoms and patterns of symptoms, how they go together, the age of onset, and how severe they are with how long they lasted. So anyone who's been alive will have been depressed or high for a period of time.

That's not the point. The point is pathology. Does it disrupt a life? Does it disrupt the lives of other people? Does it disrupt the ability to form relationships, keep a job, and not to be terribly miserable, in terms of depression?

So, in the case of depression and mania, actually, the diagnosis criteria are reasonably clear cut. They include changes of mood. They include changes in thinking. In depression, people tend to focus on mood, and so overdiagnose depression when, in fact, equally important are the changes in the capacity to think. I mean ruminative thinking, obsessive thinking, inability to run with things, inability to carry on a conversation, suicidal thinking. These things are part and parcel of major depression. It's not enough that somebody's just kind of depressed, or they've just been kind of depressed for six months. That's not what we mean by major depressive disorder. It does mean that there are disruptions in energy and sleep. So these are fundamental to diagnosis. And I think part of the problem in this day and age is that children who, for example, have temper tantrums and scream and holler for a while, in some parts of country are now diagnosed as bipolar just because they have attentional problems or they have problems with impulsiveness.

CHILDHOOD BIPOLAR DISORDER

Yalom: Right. This is a big area of controversy, is childhood diagnosis of this.

Jamison: Right. And it doesn't pay the rent to just say because a child has a problem with impulsiveness and rage attacks that that's bipolar illness.

Yalom: Right. So you're very obviously very well up on the research. What's your take on the validity of childhood bipolar disorder, and at what age do you think it's really possible even to make this diagnosis, if it exists?

Jamison: I think it's very clear that in adolescence the diagnosis is much easier to make than with childhood, and that the diagnostic criteria that obtain with adults are useful—

Yalom: At what age are you defining? 13, 14?

Jamison: Well, okay. I'd say 14, but particularly 15-, 16-, 17-year-olds. Those kids, the diagnostic criteria tend to be applicable. The course of the illness tends to be very much the same course as you see in adults. And the treatment response to various medications tends to be very similar.

It gets much more difficult the younger you get. Does childhood bipolar illness exist? Yes, it does. Does it exist as frequently as you would be led to believe in some school districts or households? No, not at all. It's a reasonably unusual occurrence to have childhood bipolar illness.

Yalom: But you think with a skilled clinician who really knows their stuff, it could be diagnosed as early as what age?

Jamison: I think that's questionable. I think that's up for grabs. I mean, I could cite case studies of very, very young children indeed. I don't want to do that just because I think that we don't know.

Yalom: Okay.

Jamison: I think that what's going to happen, hopefully, in the next ten years is science will be really much more deeply involved in these diagnoses. There are already interesting studies being done on brains, developing brains. One of the many things that makes it difficult to diagnosis bipolar illness in children is that the symptoms tend to be different. The moods tend to be much more rapid cycling, and it's much less clear what is... A child's brain is still developing. So all these kinds of things that are in there that we just don't know yet.

There are studies going on, for example, at Stanford and other places, looking at the brains of children with bipolar illness and with bipolar illness in their family—again, a family history being of particular interest in children.

Yalom: What are they finding?

Jamison: Well, they're finding differences. And I think the genetic research is going well. And I think some combination, ultimately, of genetics and brain imaging are going to be making lot of the diagnoses for bipolar illness in the years to come. And that's particularly important with children where it's harder to do it accurately, and

where it's very important, you really want to treat children who have bipolar disorder, you really want to treat them because you don't want their brains to go awry. You don't want them to lose years of learning and social capacities and so forth.

On the other hand, for sure you don't want to be giving them heavy-duty medications that they don't need, that have very serious medical consequences in their own right. So that's—

Yalom: It's a balancing act.

Jamison: It is a balancing act and it's where science, I think, is going to really be helpful.

Yalom: And what research are you involved in these days, if any?

Jamison: I am involved tangentially in some of the genetics work at Hopkins, where I teach. And I'm very involved, I co-directed The Mood Disorder Center there. And there's a lot of work going on in various fields of neural imaging and medication trials and so forth. But 15 or 16 medical schools and hospitals have formed an alliance, the National Network of Depression Centers—along the lines of the National Cancer Institute Centers—to try and increase the standard and quality of care for people who suffer from depression, to do research so that... Obviously it's a lot easier to get numbers of patients to look at if you've got 15 medical schools and 15 hospitals, rather than one.

So this is the three Harvard teaching hospitals, The University of Michigan, Hopkins, Stanford, U.C. San Francisco. A group of us have gotten together. But, the idea is also to be able to advocate for people to be able to say, "Look, these are really important illnesses. We need more public funding for research and for treatment facilities to try to establish very definitely the standards of care."

So, for example, one of the consequences of the cancer centers is the idea that no patient with in the United States should be more than 200 miles away from a really good treatment facility. So we're hoping to do that, as well, so people can get good care.

THE ULTIMATE SELF-DISCLOSURE

Yalom: Now, when you took the bold step of publishing An Unquiet Mind, revealing your own history and struggles and nightmares in dealing with this, you made the decision that when it was published you would have to give up your clinical practice.

Jamison: Right.

Yalom: Why did you make that decision? There are other people that are in recovery from alcoholism, say, that go on to become clinicians, even specializing in addictions.

Jamison: Well, I mean, I obviously didn't do it because I had the bipolar illness, because I had bipolar illness and I practiced for many, many years.

Yalom: Yeah.

Jamison: And I always told people that I practiced with that I had the illness.

Yalom: You did?

Jamison: Oh, absolutely, I mean, I think it's... You can't treat patients without some sort of backup, clinical backup. So, were I to become manic, which I didn't, but were I to become manic, the people who worked with me needed to know that I had that potential.

Yalom: Okay.

Jamison: They needed to be able to go to my doctor without talking to me. And that was our agreement. Sure. So, no, I don't think you can just keep these things to yourself. You don't have a right to practice. It's a privilege. Serious public health issues are impaired clinicians' issues.

Yalom: Okay.

Jamison: But, I feel very strongly that you want to keep as many people in the field who have these illnesses as possible and get them treated and well.

Yalom: So, but why did you decide when you publicly disclosed this—

Jamison: Because I'd written a terribly personal book.

Yalom: Yeah.

Jamison: And I think that patients have a right to come into your offices to deal with their issues, rather than what they perceive to be your issues. And I think it would've been self-absorbed, in a way, to do that. I do still see patients in consultation, but just for a couple times. And I think psychotherapy is something that is predicated on privacy. And certainly, as I say, I wrote a very private book, I mean, and made it very public. So I knew when I did that that I would give up my clinical practice. Which I miss.

Yalom: Yeah. In your last book, you detailed your very loving marriage and the tragic loss of your husband. And there's one statement I recall from that. You differentiated grief from depression.

Jamison: Right.

Yalom: And I recall you said, "There's no saving grace in depression, but there's a great saving grace in grief."

Jamison: Right, I think that's true. I think that one of the things when I wrote—my book I wrote is as elegy, Nothing Was the Same, to my husband and about my husband. But I was very interested, as someone who'd suffered from severe depression at times: would I get severely depressed again after his death, after he died?

Yalom: You were interested.

Jamison: Yeah. Not just—I was terrified.

Yalom: Yeah.

Jamison: And frightened. And I didn't get depressed at all. But I got very interested in the issues of what the differences are between grief and depression, because they're both very common. Everybody grieves, and depression's very common.

And I feel grief to be an exceedingly interesting thing. I thought it taught a lot. And it was very clever in the way it came and went in waves, and forced you to look at everything, and forced you into different kinds of relationship, in my case, with my husband and so forth. So I thought it was absolutely intriguing.

Yalom: That's great to be able to use your—

Jamison: Yeah, it's not something I—

Yalom: — curiosity to be interesting to yourself.

Jamison: After several years, yes.

Yalom: Well, thank you for sharing so much of yourself and your wisdom and your writings. I know that's had a huge impact for many people. And thank you for coming here and sharing your wisdom and knowledge with us.

Jamison: Well, thank you.

Yalom: It was my pleasure.

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Victor Yalom, PhD is the founder, president, and resident cartoonist of Psychotherapy.net. He also maintains a part-time psychotherapy practice in San Francisco and Mill Valley, CA. He has conducted workshops in existential-humanistic and group therapy in the U.S., Mexico, and China, and also leads ongoing consultation group for therapists.

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