DEPRESSION AND BIPOLAR DISORDER: EVIDENCE-BASED NATURAL TREATMENTS AND A NEW THEORY

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To Cheryl Mcky, dead of suicide at age 24.

Full many a gem of purest ray serene
The dark unfathomed caves of oceans bear:
Full many a flower is born to blush unseen
And waste its sweetness on the desert air.

(Thomas Gray “Elegy Written in a Country Churchyard”)

And to my father Roy V. Sherman, PhD
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INTRODUCTION

NOTHING IN THIS PUBLICATION SHOULD BE CONSTRUED AS OFFERING MEDICAL ADVICE. THIS INFORMATION IS NOT INTENDED AS A SUBSTITUTE FOR CONSULTATION WITH HEALTH CARE PROFESSIONALS. EACH INDIVIDUAL’S HEALTH CONCERNS SHOULD BE EVALUATED BY A QUALIFIED PROFESSIONAL.

According to the World Health Organization, depression is one of the world’s top health problems, yet its cause is unknown and its treatment is uncertain. These uncertainties also apply to bipolar disorder. Psychiatric drugs are often prescribed for depression or bipolar disorder, but many are frightened by the idea of drugs. Others have taken psychiatric drugs, and either they got no relief or troublesome and alarming side effects. If you’re pregnant, or want to get pregnant, or you’re nursing, you know that psychiatric drugs may be dangerous for your baby. Perhaps because of a mood disorder, you’ve been placed on drugs for the long term, even life, and you’re looking for an alternative. Or you may already be receiving psychotherapy or a drug treatment from a health care professional and some alternative methods may fit in well with your existing treatment. For all these reasons, effective, science-based natural treatments may be of interest to you.

On the other hand, major depression or bipolar disorder may run in your family and you’re concerned about the younger generation. You may have a problem child or grandchild, perhaps diagnosed with depression, bipolar disorder, or attention deficit-hyperactivity disorder.
(ADHD). Information in these pages will be vitally informative, and may even be of interest to those of you concerned about schizophrenia and autism spectrum disorders.

HOWEVER, IF YOU OR YOUR CHILD IS ON PSYCHIATRIC DRUGS AND YOU WANT TO DISCONTINUE THEM, DO IT GRADUALLY UNDER PROFESSIONAL SUPERVISION.

Psychiatric drugs help some people some of the time, but they are overprescribed, and prescribed when their safety and effectiveness aren’t known. Moreover, patients aren’t completely informed about side effects. For example, patients are told that their antidepressant isn’t addictive, which is technically correct, but they’re not told that they may experience serious withdrawal aftereffects that last for months.

The problem with psychiatric drugs is the bad news. The good news is that recent scientific research offers us a new theoretical understanding of how depression and bipolar disorder originated, what causes them, and how they can be managed without drugs, or with their minimal use. This book’s contents are solidly based in science and experience. Its theoretical explanation is called the “Evolutionary Origin of Bipolar Disorder (EOBD),” which I published in 2001 in *Psycoloquy*, an on-line journal sponsored by the American Psychological Association, and Princeton and Oxford Universities. This journal aimed to make science available to the worldwide public without charge, but, alas, they ran out of funds. The original article, however, can still be found on the Internet. The theory’s revised version (EOBD-R) was published in *Medical Hypotheses* in 2012 (see Resources). It explains the origin of depression and bipolar disorder and is briefly discussed in Chapter 9. The theory has its basis in ground-breaking DNA research and advances in paleoanthropology.
The new treatment ideas come from recent scientific findings about the effects of light on human behavior and how this knowledge can be used to manage mood disorders. Light orders our behavior and light can also disorder it. Light profoundly affects the chemistry of the brain. Drugs also affect brain chemistry, but managing the brain chemistry of moods with light is much more predictable, safer, quicker, and cheaper. The general name for treatments using light is chronotherapy. Chronotherapy means using the brightness or darkness of light and the timing of the light exposure as it enters the eye in order to influence the brain’s neurochemistry for healing purposes.

Chronotherapy is both old and new. Since the beginning of recorded history the activating power of sunlight has been known and doctors sent their patients for cures to sunny climes. It’s only since the advent of electric lighting, however, that we’ve been able to create a light strong enough to imitate the sun. This has made Bright Light Therapy for depression conveniently and cheaply available.

On the other hand, the advent of electricity has unnaturally exposed us to light during the night when our bodies are expecting near total darkness. This nighttime light has disruptive, adverse effects on everyone’s body function and mood stability, but these effects are more serious for individuals who carry genes that make them vulnerable to extreme mood swings.

Just as the activating effect of light has long been known, so has the calming effect of darkness. In Shakespeare’s time darkness was used to calm the mentally ill. Now it’s been rediscovered as a treatment for mania and rapid mood cycling.

Bright Light Therapy has been shown to prevent and treat major and bipolar depressions safely, cheaply and effectively. Even severe suicidal depressions can be quickly treated by a new combination treatment called Triple Chronotherapy or Wake Therapy. Other methods, such as
the new Ben Franklin Routine and Dark Therapy, help prevent and dampen manic mood swings. These treatments deserve to be better known and utilized.

**SPECIAL NOTE FOR YOUNG PEOPLE**

Mood disorders are especially tough for young people. If you don’t know whether or not you have a serious mood problem, read Chapter Two. Be especially concerned if mood disorders run in your family. Look for mental illnesses, hospitalizations, suicide, and substance abuse, which is correlated with mood disorders. Check out grandparents, aunts, uncles and cousins. Learn as much as you can about your illness; especially learn to recognize when your mood is going too high or too low, and what to do to keep your mood stable.

- Remember that your illness is not your fault; you have a genetic vulnerability you need to learn to manage.
- Realize that you may have been depressed off and on during your childhood. Childhood depression often goes unnoticed. Children don’t label their feelings as depressed. They just feel bad or grumpy, and don’t want to do anything. You may already have spent years being depressed off and on without understanding what was going on.
- You may have feelings and attitudes about yourself that are way off. “Are you really no good?” Seriously? Downer thoughts are the product of depression; depression colors your thoughts black. A habit of negative thinking can make you more depressed and hopeless. Through cognitive behavior therapy you can learn to recognize these distorted thoughts and get rid of them.
- Keep alcohol and illicit drug use to a minimum. They seriously complicate mood management. Be careful; a drug that makes someone else pleasantly high may make you bonkers.

- Resist the temptation to make a suicide attempt. It’s harder to kill yourself than you might think and a failed suicide attempt brings many complications you don’t want. Remember that moods go away, but suicide is forever. If you’re feeling suicidal, call the National Suicide Prevention Lifeline 1-800-273-TALK (8255), available 24-7. You can also call 911 or go to a hospital emergency room.

- **Warning:** Your doctor or therapist is required by law to make a report to authorities if you threaten violence. This is an exception to the rule of confidentiality during psychotherapy sessions. Watch what you say and write. If you appear to be an imminent danger to yourself or others you can be involuntarily confined. If this happens, you’re entitled to a free lawyer, and you should get one as soon as possible. After a few days a legal hearing must be held. If the authorities find that you are an imminent danger to yourself or others, you can continue to be held and you can be medicated against your will. If you enter a hospital voluntarily you cannot be held or medicated against your will unless you show signs of being an imminent danger to yourself or others while you’re in the hospital. In that case commitment procedures may be started.

- If you’re male, your first episode of illness is likely to be mania, which can get you locked up in a jail or prison in a hurry. If you’re going out of control, admit yourself to a hospital. It’s much better than jail. Again be really careful not to say or do anything that looks even remotely like violence. Don’t let anyone provoke
you into violent talk or actions. You don’t want to give the authorities a reason to initiate commitment proceedings. Again, if you have concerns, get a lawyer.

- If you’re female, your first episode of illness is likely to be depression. You need to learn to pay special attention to the times just before your menstrual period and just after childbirth when your symptoms are likely to get worse. You also need to recognize signs of mania in case that becomes a problem.

- Realize that the mood of the country is to make commitment easier and to force people to take medications. Yes, you have rights, but the rules are being bent. Be careful.

- Get some positive goals and work toward them. Lots of people with mood disorders are smart, talented and creative. Go for it.

SPECIAL NOTE TO PARENTS AND SPOUSES ABOUT PSYCHIATRIC DRUGS

This book is about evidence-based nondrug treatments, but you will probably be pressured to urge your family member to take drugs and take them on a regular basis. Here is a quick look at some of the problems with psychiatric medication.

As of late-2015, when you search the Internet and media and listen to medical opinion, you’ll find endless discussions of drugs and the search for new drugs. Antidepressants are popular despite their many side effects and addiction-like aftereffects. If you search far enough you’ll learn that antidepressants aren’t that effective and can cause violent and suicidal urges. Moreover, a depression may be part of a bipolar disorder, and among individuals given an antidepressant, a manic episode is triggered in up to 25% of cases. A manic episode usually ends up in the hospital (or jail) and more drugs. Although you’ll learn that the problem of switching to
mania when given an antidepressant can be avoided by also taking a mood stabilizer like lithium, valproic acid (Depakote), or one of several other drugs, these drugs also have serious side effects.

Doctors want to help and they don’t want to scare you or your loved one out of the treatment program they think best. You won’t easily learn how much is unknown about the effects of psychiatric drugs. You also may not learn that drug therapy is often expected to continue long-term, nor how hard it is to quit. Nor will you learn that little is known about the long-term effects of drugs even for adults. Instead you’ll hear, “There’s no evidence that, for example, lithium has significant negative effects on cognition.” What you won’t hear is that the appropriate studies haven’t even been done (Pachet & Wisniewski, 2003).

Here’s something to think about: Would you put an additive in your gas tank when you can’t be sure it won’t harm your car?

Treatment of major depression and bipolar disorder is tricky, and I’m certainly not suggesting that you ditch medical help. I am suggesting that there are effective nondrug treatments and that you need to become informed about drugs and insist on their careful and conservative use. Talk to your pharmacist; read the fine print, and find out about drugs. Finally, be sure to listen to your family member. Your role is extremely important.

**SPECIAL CONCERN: IF YOU DON’T BELIEVE IN EVOLUTION**

The theory of the evolutionary origin of major depression and bipolar disorder is only a small part of this book. About 29% of Americans don’t believe in evolution, but belief in evolution isn’t necessary to benefit from these new natural treatments. In any case, evolution isn’t that mysterious. Horse and dog breeders do something like it all the time. They breed the animals that
have the qualities they want. This process also occurs in nature when a particular environment favors certain traits, which then tend to survive while other traits die out. When our ancestors without modern conveniences had to survive during the Ice Ages, the ones who adapted to the severe environment survived while the others died out, which in theory is the source of bipolar traits.

CHAPTER CONTENT DESCRIPTIONS

Chapter 1 tells how necessity forced me to successfully pioneer these natural treatment methods as an experiment on myself. Chapter 2 provides information about the symptoms of depression and mood disorders, and how the sexes differ.

Chapter 3 is about Bright Light Therapy. It’s been in use since the 1980s and found effective not only for seasonal affective disorder, but also for treatment of major depression and bipolar depression. However, the value of Bright Light Therapy isn’t widely touted and it’s underutilized.

Chapter 4 explains the Ben Franklin Routine, which is a key management tool for mood disorders. The routine involves about eight hours of sleep or rest in the dark during the night. The name comes from Ben Franklin’s sage advice: “Early to bed, early to rise, makes a man healthy, wealthy, and wise.” New scientific findings are moving treatments like the Ben Franklin Routine out of the experimental and into the mainstream.

Chapter 5 discusses co-occurring conditions: addictions, PTSD, obesity, panic disorder, eating disorders, and problems specific to women such as premenstrual tension, postpartum depression, and menopause.
In the rest of the book, we’ll consider other topics relevant to maintaining mental health. Chapter 6 deals with the key issue of social support. Chapter 7 is about psychotherapies, while Chapter 8 discusses other alternative interventions.

Chapter 9 briefly presents the new EOBD-R theory which explains why we have mood swings and why light-based treatments work. It connects the dots. So far research results continue to be consistent with the theory, but new ideas take a while to be accepted. We need more research on the EOBD-R theory.

Chapter 10 discusses research needs, summarizes the top treatment options, and gives suggestions for political action. Finally there is a Resources section.
CHAPTER 1

WHY I WROTE THIS BOOK

The idea that major depression and bipolar disorder can be managed naturally without drugs sounds improbable, but there have been times in history when simple solutions were crucial to the solution of serious health problems. Think of the people saved from disease because doctors washed their hands, or the sailors who died of scurvy for lack of vitamin C. The methods I’ll explain are safe, simple, and effective. They have worked marvelously for me, and I’m betting they’ll help you.

Our culture has been subject to galloping changes, and we humans have a hard time keeping up. For millennia we spent most of our fair-weather days outside in the sunshine, and we slept or rested at night in the dark, exposed at most to the dim light of a camp fire. This is not the way we live today. Our bodies and brains, however, are built for the way we used to live.

Moreover, all of us outside of Africa carry the genes of peoples who lived through the Ice Ages when winters were times of near starvation. It’s theorized that about five percent of us have inherited specific genes that helped us adapt to the Ice Ages, although these behaviors are questionably adaptive today. These behaviors include a hibernation-like state we call depression, plus activity/mood upswings that we call hypomania and mania.

These ideas represent an important scientific breakthrough and indicate new, better ways to manage depression and bipolar disorder because switches in mood can be accomplished by manipulating light exposure based on this new understanding.

Scientists are only now beginning to appreciate the important ways in which light influences behavior. As late as the 1970s, most scientists thought that, unlike all other living
things, we humans are not influenced by the effects of light. In fact, early ideas about seasonal affective disorder (SAD) were ridiculed as “chipmunks in the sky,” referring to the fact that chipmunks hibernate while humans don’t. In genetically vulnerable people, however, a winter slow-down occurs, though not hibernation. (Hibernation involves complicated body changes such as extreme drops in body temperature that humans don’t experience.)

Science marches on and we now know that the behavior of all humans is ordered by light exposure through the eyes, which acts on the suprachiasmatic nucleus of the brain. This fact has profound implications: What can be ordered, can be disordered. Our eyes have a whole system of detecting light in order to regulate our behavior in response to daily and seasonal rhythms. These cells are intrinsically photosensitive retinal ganglion cells (ipRGCs) that have nothing to do with normal vision, but use light to set and reset our biological rhythms. As Paul Bogard reports in his book *The End of Night*, everyone suffers negative consequences from nighttime light exposure. But because a mutated biological clock is hypothesized to be central to the pathophysiology of major depression and bipolar disorders, clock stability and darkness at night are especially important for individuals with mood disorders.

Scientific evidence supports the view that managing light input helps correct and stabilize mood swings. Light deprivation has been experimentally shown to cause depression. Conversely, Bright Light Therapy is effective in relieving depression. Bright Light Therapy was originally a treatment for serious major depression and bipolar depression (seasonal affective disorder) occurring in the winter. For more detail and references on these points, see Sherman (2001). A review of the scientific literature published in the *American Journal of Psychiatry* found that Bright Light Therapy is an effective treatment for depression, including those depressions that don’t meet all the particular diagnostic criteria for seasonal affective disorder.
Research also suggests that it’s therapeutic for individuals with major depression or mood swings to maintain an early sleep schedule and avoid light exposure during the night. “Early to bed and early to rise makes a man (or woman) healthy, wealthy, and wise,” said our very healthy, wealthy, and wise founding father, Benjamin Franklin. This book explains the ins and outs of this truthful saying and how it applies to major depression and mood swings.

Although considerable scientific progress has been made, there are many questions for continuing research. Will the methods I’ve successfully used work as well for other people? At a deeper level, what happens when natural rhythms of light input are disrupted? Are these consequences different depending on age? We know that some biological functions are set for life at certain young ages. Could disruption of natural rhythms in young children have adverse lifetime consequences? Could this be a factor in the increasing number of children with mental illnesses? Are there epigenetic implications? Answers to these questions may revolutionize our understanding of mental illnesses.

EXPERIENCE WITH MENTAL ILLNESSES

I did not come to these ideas about major depression and mood disorders easily. They are well considered and the product of years of scholarly study, testing and personal experience. I received a PhD in clinical psychology from the State University of Iowa in Iowa City in 1957, and I began seeing severely ill patients during the 1950’s in an era before tranquilizers and antidepressants. At that time many patients were locked up; electroconvulsive therapy was the usual treatment for severe mental illnesses, and the American Psychiatric Association’s *Diagnostic and Statistical Manual* was less than one-half inch thick (now it’s over two inches). Psychoanalysis was influential and neurosis was a common diagnosis. However, my professors
at the University of Iowa strongly emphasized the scientific method, and I was required to take a graduate school minor in statistics and to demonstrate an understanding of research principles, in addition to learning the art and practice of clinical psychology.

Later I published ground-breaking scientific books and research articles in the area of the psychology of women, especially the question of whether women could master advanced mathematics. I was also active in various committees of the American Psychological Association dealing with women’s issues. As a clinician I cooperated with psychiatric colleagues pioneering psychotherapy in cases of severe depression, bipolar disorder, and schizophrenia. I became a Diplomate of the American Board of Examiners in Professional Psychology, and I was elected Fellow of both the American Psychological Association and the Association for Psychological Science.

As a young woman, I thought of myself and my family as healthy hard-working people, though I had some problems with anxiety and depression. However, bipolar disorder began popping up in my family, first in my younger sister and then in my older brother. My parents showed only milder forms of the disorder, but they constituted a particularly malignant genetic combination: All their children and half their grandchildren became ill (and many have had substance abuse problems). There is a strong genetic factor in bipolar disorder, even stronger than in the case of schizophrenia, the other severe and persistent mental illness.

For a long time, I seemed to be OK. I was married and had a fine son. Mine was a happy life of achievement and reward. Then in 1984 at age fifty, just at menopause, a major depression struck.

There are different kinds of depression. Everyone feels bad when they lose out or lose someone or something important to them, but this depression was different. It was a melancholic,
major depression characteristic of bipolar disorder. No bad event brought it on and sadness wasn’t even a major feature of the illness in the beginning, nor was suicidal thoughts. I was much too concerned about survival and recovery to want to kill myself. That came later as I experienced the negative social consequences of mental illness.

Of all the misfortunes that can befall a person, none will bring you less sympathy and help than a mental illness. So far as making you a social pariah, mental illness is right up there with HIV-positive. Social rejection and victimization are common experiences for the mentally ill, even for someone like me who was in a better situation than most. I had adequate money and access to medical care, but victimization, rejections, disappointments, and losses eventually brought on the other kind of depression that everyone experiences. This is a confusing feature of depression: There are at least two types. Major depression and bipolar depression run in families and involve a special genetic vulnerability to the disorder while ordinary depression is universal. That doesn’t make garden variety depression less painful, but its cause and management are different from that of major and bipolar depressions.

In contrast to ordinary depression, major and bipolar depressions produce distinct physical effects. In my case I was slowed in movement and thinking, and I lost my appetite and interest in the things I usually liked to do. I had trouble sleeping. My face acquired a seemingly permanent sour puss expression that no makeup could correct. My concentration was poor and my memory began to fail. None of these symptoms was under my voluntary control. I was in a partial shut-down state. I couldn’t hurry up; I couldn’t laugh, and at one point food tasted like ashes in my mouth, an affliction known since Biblical times (more about the diagnosis of depression in Chapter 2).
Medical science has made great strides in the treatment of heart disease, cancer and AIDs, but we still don’t know what causes severe mental illnesses or how to treat them safely and effectively. So many advances have been made that we thought a cure was just around the corner, but hundreds of new drugs and millions of dollars later we still have no cure. The drugs alleviate some symptoms some of the time, but they can also cause many, many terrible side effects. At the time I first got sick, I thought that by co-operating with my doctors, I would be able to lead a near-normal life, but that was not to be.

**PSYCHIATRIC DRUGS A PROBLEM**

There have been serious problems with the testing and marketing of psychiatric drugs; they have been carelessly prescribed and their use insufficiently monitored. Dr. E. Fuller Torrey is a proponent of medications, especially for schizophrenia, but he has urged that psychiatric drugs be used as little as possible and for the shortest time possible. I couldn’t agree more.

In 2006 Harvard psychiatrist Joseph Glenmullen published *Coming off Antidepressants* (now titled *The Antidepressant Solution: A Step-by-Step Guide to Safely Overcoming Antidepressant Withdrawal Dependence and Addiction*). Glenmullen revealed that although patients aren’t technically addicted to antidepressants, they may suffer serious withdrawal effects that last for months. The nasty truth about psychiatric drugs is that they’re much easier to get on than off. Most patients have no idea what they’re getting into when they start antidepressants. When the newer antidepressants drugs, such as Prozac, Paxil, Celexa, Luvox, or Zoloft, are stopped, serious withdrawal effects can occur for months. (Glenmullen lists 58 symptoms.) Many mistakenly think that these symptoms represent a return of the depression, but they are the effect of withdrawal, and include suicidal impulses and violence. Remember this the next time
someone implies that everything would have been OK if the patient had just stayed on their medications. The evidence is that the antidepressant drugs don’t work well to relieve major/bipolar depression (Saunders & Goodwin, 2013; Sidor & Macqueen, 2012), and they can backfire and trigger violence in the form of suicide or aggression toward others especially among teens, which has prompted an FDA warning. These adverse reactions can also occur as a withdrawal symptom when the antidepressants are stopped.

In 2009 psychologist Irving Kirsch raised many questions about antidepressants in his controversial book, *The Emperor’s New Drugs: Exploding the Antidepressant Myth*. Kirsch essentially maintained that antidepressants don’t work much better than placebos (sugar pills). They certainly don’t work well. The United States Depression Guidelines Panel reported that at least 40% of patients treated for depression don’t respond to the first antidepressant, and at least half of these don’t get an effective response after several more treatment trials.

In 2010 investigative journalist Robert Whitaker starkly laid bare more problems with psychiatric drugs in his controversial book, *Anatomy of an Epidemic*. He reported that the millions of dollars to be made from psychiatric drugs have corrupted the pharmaceutical industry and the medical profession itself. This theme was continued in a 2015 book co-authored with Lisa Cosgrove, *Psychiatry under the Influence: Institutional Corruption, Social Injury, and Prescriptions for Reform*.

These reports make clear that thousands of people have been harmed by the unscientific and unethical marketing of psychiatric drugs, and that, as a result, there has been a huge increase in the number of people disabled by mood disorders. Many have been permanently damaged by psychiatric drugs. They lose their ability to think, concentrate and remember, and they can no longer experience normal emotions. They are worse off than if they’d received no treatment at
all. This is what happened to me. Some of us have been able to recover, but as Whitaker reported in *Anatomy of an Epidemic*, others remain dysfunctional and will never recover. You may hear that lithium, for example, doesn’t cause serious intellectual impairment, but that opinion needs to be reexamined because it’s based on relatively short-term studies. Plenty of us have been kept on lithium for years, even life. This book is about how I managed to recover and stay well (fifteen years so far) without the use of psychiatric drugs.

Although many people suffer medication side effects, I suddenly developed symptoms of life-endangering proportions: my ability to speak and breathe was dramatically affected. I went to my doctors, but no one took my complaints seriously. Thoroughly alarmed and suspecting drugs as the cause, good patient though I was, I stopped all my medications. For me it was the right decision, but don’t do it yourself. If at all possible, go off meds gradually under medical supervision.

Abruptly stopping lithium can cause rebound mania. Like a sapling held down by the weight of winter snow, I sprang into my first (and only) manic episode. However, stopping the medications was the right thing to do because it turned out that I have a rare neurological disease (Charcot-Marie-Tooth) that is intolerant of medications. In fact people with CMT have died from toxic medication effects. Moreover, had I not stopped the drugs, I never would have learned that I didn’t need them.

However, I was scared. What was I going to do? Medical authorities insisted that I must take the drugs. At the Mayo hospital in Rochester, Minnesota I was repeatedly warned that if I didn’t take the psychiatric medications, I would spend the rest of my life in a mental institution. It was terrifying.
My body was experiencing a vast array of side effects plus withdrawal symptoms. Two of my worse symptoms were caused by the use of lithium for fifteen years: I ached all over and my memory was shot. I couldn’t remember anything beyond my own phone number. It took over two years off the medications for my body to clear their effects, and then I was amazed. Misery after misery disappeared. It wasn’t until then that I understood the full extent of the toxic effect of the medications. I feel extremely lucky to have lived to tell the tale.

TOWARD NEW SOLUTIONS: THE POWER OF LIGHT

It was an improbable and fortunate set of circumstances that led me to reject the medications but nonetheless find effective ways to manage my illness. In 1990 my friend Harriet Shetler, co-founder of the National Alliance on Mental Illness (NAMI), asked me to review the book *Manic-Depressive Illness* (the old name for bipolar disorder) by Frederick K. Goodwin and Kay Redfield Jamison (who also has bipolar disorder). I ploughed into this dense tome and became fascinated by the illness and its causes. It was known to be a genetic disorder, but where did the genes come from? I devoted myself to understanding the illness, and at the time of my psychiatric crisis, I’d already spent ten years in intensive study of major depression and bipolar disorder. Despite my impairments, I knew a great deal about the illness and possible modes of alternative treatment. As a result I was able to develop an experimental drug-free treatment that worked.

I based my treatment program on research pursued by a group of scientists at the National Institute of Mental Health including Tom Wehr, Frederick K. Goodwin, Norman Rosenthal, and Anna Wirz-Justice. Key information was the finding that Bright Light Therapy is effective in treating winter major depression and bipolar depression. I’d also heard that local psychiatrist, Dr.
Wanda Bincer, used it to treat her own bipolar depression. Although it wasn’t yet accepted as a sole treatment for major depression not necessarily related to the season, I was desperate to find a nondrug way to avert depression, and decided to use Bright Light Therapy. It worked.

One NIMH report showed that rest or sleep in the dark for fourteen hours during the night stabilized the mood swings of a severely ill hospitalized bipolar patient who had been untreatable. NIMH researchers also found that individuals with major depression wake up early, which apparently is a biologically set characteristic. Violating biologically set rhythms is known to disrupt body functions. The most common way we experience this effect is jet lag, when we change time zones. However, repeated violations of a biologically set rhythm may result in mental disruption more serious than jet lag. Based on these ideas, I reasoned that I should go to bed early and get up early, which is what Ben Franklin advised. Of course at the time of Ben Franklin there was no electricity so the night would by necessity be spent in the dark. This is what I call the Ben Franklin Routine.

CORRECTING CHEMICAL IMBALANCES

But what about the chemical imbalance theory? Many Americans (including me) bought in big-time to the idea that drugs are the answer to managing depression and bipolar disorder. The idea is that since mood disorders are chemical imbalances of the brain, chemicals could logically correct them. However, the theory is inadequate, incorrect, and misleading.

Of course, brain chemistry is involved in serious mental illnesses. For example, there is some evidence that the brain chemical (neurotransmitter) serotonin is low during depression and the neurotransmitter dopamine is high during mania, and that the levels of these neurotransmitters may be altered by drugs, but this doesn’t mean that adding chemicals to the
brain is a good idea. There are big problems: Normal brain functioning can be easily disrupted by artificially adding chemicals to the brain, wreaking havoc in many ways. As mentioned before, antidepressants can backfire causing suicide and violence. How can this happen? How can an antidepressant backfire? To understand this, it’s necessary to look at how the brain works. When, for example, an antidepressant increases serotonin in the brain, the brain decreases its own natural production of serotonin. Now the brain may have less serotonin than before. Also, when the antidepressant is stopped, the brain doesn’t start producing serotonin right away. This is how an antidepressant can cause depression, suicide, and violence.

By way of contrast, light therapy and the Ben Franklin Routine correctly alter (and stabilize) brain chemistry more safely and less expensively because light itself naturally affects the neurochemistry of the brain.

**BUT MY ANTIDEPRESSANT SEEMED TO WORK**

Maybe it did and maybe it didn’t. That is, maybe your depression went away because of the chemicals in the drug, but maybe it went away for some other reason.

Despite the fact that it’s been known since the 1980’s that ambient light has a powerful antidepressant effect, few studies of the effectiveness of antidepressant drugs have controlled for light exposure or even for season of the year. Incredibly, millions of dollars spent on research left a major variable uncontrolled. Patients may be led to falsely believe that an antidepressant works. They’re told, “Don’t worry. If this antidepressant doesn’t work, we’ll try another.” And another and another; different drugs are tried and different combinations are used until the “correct” drugs are found. The patient is made to feel as though a unique solution has been
identified for his/her individual problem. However, by this time months have passed and the mood might well be going away by itself because spring has arrived.

Moreover, Irving Kirsch emphasizes the possibility that you may have gotten better because of the power of the placebo effect. It’s part of our human condition that when we believe a treatment will work, often it will work even if it’s just a sugar pill. Amazing though it may seem, it’s normal for us to be suggestible in this way, and that’s the basis of many a con.

Some people say, “Oh well, what’s the difference? They got better, didn’t they?” It does make a difference. First of all, many didn’t and don’t get better. Moreover, there are a lot of problems with drugs: expense, risk of serious side effects, and problems with withdrawal. What if you could get a good antidepressant response from Bright Light Therapy, which is cheaper and safer?

Belief in the efficacy of drugs dies hard, and it’s tricky to know whether or not an antidepressant works. Both Kirsch and Glenmullen point out that when some antidepressant drugs are stopped, “withdrawal” effects can occur that are like the symptoms of the depression itself (or worse). This may lead the individual and/or others to think that the drug worked and that stopping it made the symptoms return. This misinterpretation of the effects of drug discontinuation also happens in the case of other psychiatric drugs, especially antipsychotics.

The strong drumbeat pressuring individuals with bipolar disorder to stay on drugs indefinitely needs to be reevaluated and adjusted. Families and the public need to become more sophisticated about psychiatric medications. Many media accounts give the impression that if only the individual had stayed on medications, all would have been well. The public naively supposes that effective, safe treatments are available for the mentally ill, if only they would take
their medicine. Nothing could be further from the truth. To repeat, drugs help sometimes with some patients, but there are just too many ways they can do more harm than good.

With regard specifically to antidepressant drugs, mounting evidence of problems has led medical authorities in Great Britain and the United States to back away from recommending antidepressants as a first choice for treatment of depression.

Using Bright Light Therapy and the Ben Franklin Routine, I have had no significant mood swings for over fifteen years. So far as I know, my experience is the first report of drug-free methods that maintained mood stability over such a long span. This result is especially notable, since psychiatrists at Mayo told me repeatedly that I would spend the rest of my life in a mental institution if I didn’t take the psychiatric drugs they recommended. They were wrong. My excellent health outcome is entirely against expert medical opinion.

At first I couldn’t be sure that my recovery and continued good health were not unique to me, perhaps even a placebo effect. However, now that scientific evidence has accumulated supporting the effectiveness of Bright Light Therapy and other chronotherapies, I feel comfortable presenting these ideas to the general public. Of course more research is needed: Will further research confirm that individuals with major depression or bipolar disorder tend to have a biologically set early waking time? How early do you need to go to bed? How long do you need to spend in the dark? Will these methods work for the individuals, mostly men, who have a major problem with mania?

Although I managed my own therapeutic interventions using light, it wasn’t by choice. It’s highly advisable to get professional advice. Bright Light Therapy and the Ben Franklin Routine may not work as well for you as for me, but my experience demonstrates the possibilities of nondrug treatments.
CHAPTER 2

DIAGNOSIS OF DEPRESSION AND BIPOLAR DISORDER

Psychiatric diagnosis is a controversial and uncertain process. A major part of my work as a clinical psychologist was to help psychiatrists and physicians make an accurate diagnosis using my special expertise in psychological testing. For diagnosis, and for the best psychiatric care, a team approach worked best. Medical, psychological, personal and family history information would be integrated by a team consisting of a psychiatrist, psychologist, and social worker. The team provided perspective from three different disciplines as well as valuable checks and balances for individual biases and blind spots.

Objective, biological tests for mental illnesses have long been sought. Scientists at Northwestern University are working on a genetic test for depression, and a genetic test for bipolar disorder is being sold on the Internet. However, Dr. Tom Insel, head of NIMH, commented that the bipolar test isn’t “ready for prime time,” and that you’re better off getting a diagnosis from a qualified professional and taking a careful look at your family tree.

The current psychiatric diagnostic manual is called DSM-V. Its material is lengthy and confusing, and according to Dr. Insel it lacks validity for research purposes, a view I share. NIMH is developing a new framework for defining mental illnesses called Research Domain Criteria (RDoC). This system is organized around specific symptoms and the characteristics correlated with them. This radical empirical approach is an advance, but it’s different from the suggestion presented here that, in the case of major depression and bipolar disorder, progress could be accelerated through guidance from the EOBD-R theory.
IMPORTANCE OF DIAGNOSIS

If even the head of NIMH questions the validity of DSM-V, why then should you pay any attention to the question of diagnosis? A diagnosis has too much legal, financial, and social importance to be ignored. Beyond that, it’s vital to know if you have major depression or bipolar disorder so you can take steps to learn about the illness and how to manage it because episodes of illness are likely to recur throughout your lifetime. When you’re feeling awful and can’t get anything done, it’s a great relief to learn that you’re experiencing a known illness that will go away. Moreover, if you’ve received a diagnosis of bipolar disorder, you can be on guard to avoid out-of-bounds behavior that can get you in trouble.

You also need to learn about your diagnosis because misdiagnosis can have serious consequences. If misdiagnosed with schizophrenia instead of bipolar disorder, you’ll be given the wrong medications (with even worse side effects), and you and your family will be given the wrong expectations about your illness.

Take the example of Bob. (In the case of examples, all names and details are changed to protect privacy.) He was misdiagnosed as schizophrenic, and finally recovered after a year in an expensive hospital. When I learned about him, he was in prison because of financial indiscretions. He soon fell into a depression. He had been disowned by his wealthy parents who thought he was simply a bad person. Neither he nor his parents realized that he actually had bipolar disorder, not schizophrenia, and that his out-of-bounds behavior was a product of his illness. Because they lacked a proper understanding of his illness, he didn’t have a chance to guard against a potential weakness and was denied the opportunity for proper treatment and a better legal defense.
Sue is another case in point. Her experience illustrates what can happen when a patient is diagnosed with major depression, but not warned it could be part of a bipolar illness. Although she had been successfully treated for a major depression, she didn’t know that the depression could be part of a bipolar disorder and that her mood might take a drastic upward swing. She was happily engaged to be married and totally panicked when her sexual urges got out of control. She’d gone for a drink at the local bar and brought home a complete stranger to bed with her. She had shifted to mania. No one had warned her that depression and mania can be part of the same illness.

Getting the wrong medications because of a misdiagnosis of schizophrenia can have dire consequences. Jim, a bipolar patient, was mistakenly diagnosed as schizophrenic and given antipsychotic drugs, with the result that he developed tardive dyskinesia, a disfiguring and debilitating side effect. His body jerked and his face and arms twitched involuntarily; he also sometimes made involuntary noises. This kept up almost continuously. You’d think that stopping the drug would end the problem, but this is not the case. Stopping the drug makes tardive dyskinesia worse. There is no treatment for it and one can only hope that the symptoms will eventually go away. (They mostly did after many months.) In Jim’s case, he was told that he had Tourette’s syndrome, a diagnosis that obscured the true source of the symptoms. However, Jim was lucky. Many who have taken antipsychotic drugs spend the rest of their lives afflicted with tardive dyskinesia.

YOUR FAMILY TREE: A DIAGNOSTIC KEY

One of the solid facts about major depression and bipolar disorder is that they have a strong genetic component. In the scientific and mental health community, there is no dispute about this
point. If you’re having symptoms, one of the best clues as to whether or not they’re a serious
sign of major depression or bipolar disorder lies in your family tree. Look at parents,
grandparents, siblings, aunts and uncles, cousins. Look for suicides, hospitalizations, reports of
illness, or substance abuse. At least thirty percent of individuals with a mood disorder also have a
substance abuse problem; other addictive behaviors, like gambling, are also common. A mood
disorder is often hidden behind addictive behavior. Many people would rather have a drunk for a
relative than a “crazy” person. Because of the stigma attached to mental illness, it may be hard to
get an accurate report, but the information is extremely valuable, if you can get it. Forewarned is
forearmed. However, all this emphasis on heredity doesn’t mean that if one of your parents was
ill, you’re going to be ill. On the other hand, if you or your children develop suspicious
symptoms, this information can lead you to a correct diagnosis sooner rather than later.

Unfortunately in recent years, there’s been an emphasis on making a psychiatric
diagnosis on the basis of observable behavior that health care providers can see right in front of
them. It was thought that this would make diagnosis more reliable. However, as a result, family
history is sometimes not adequately considered, even though heredity is known to be an
important etiological factor. The diagnostic criteria in DSM-V reflect this problem. If you know
your family history is negative for major depression and bipolar disorder, question a mood
disorder diagnosis. On the other hand, if it’s positive for mood disorder, be skeptical of a
schizophrenic diagnosis.

RULE OUT MEDICAL PROBLEMS

A caution: If you think you may have a depression or mood disorder, don’t jump to conclusions.
Be sure to share this concern with your physician and rule out medical problems that may be
causing your symptoms, including side effects of medications. During the course of my practice, I discovered several instances of physical disease mistaken for a psychiatric problem: underactive and overactive thyroid, lupus, and porphyria, even cancer and brain tumor. Sometimes missing the diagnosis of a medical disease had serious consequences. Sally’s erratic behavior due to untreated porphyria nearly caused her to lose custody of her children. Jane’s case was even more serious. She became my patient after repeated suicide attempts. Her depression was secondary to lupus and cleared up once that disease was treated. Sometimes medications like steroids or birth control pills can upset your system. Toxins can be a problem. Mabel was treated for mania when she actually had mercury poisoning. Be sure to rule out physical diseases before embarking on treatment for a mood disorder.

ORDINARY DEPRESSION AND MAJOR/BIPOLAR DEPRESSION

When people talk about depression they often think of “being down.” They don’t realize that major/bipolar depression is very different and much more serious. The word “depression” is confusing since it’s used to describe everything from a gloomy mood to a life-threatening illness. In the case of an ordinary depression something bad has happened. This is disaster depression, blow-to-the ego depression, status-loss depression. I’ve called it ordinary depression, but it used to be called reactive depression, which is also descriptive.

In ordinary depression, sadness is obvious, and physical symptoms aren’t a prominent part of the problem. Helen is an example of an ordinary depression. Her long-time boyfriend and fiancé broke off their engagement. She was heartbroken and frequently burst into tears. Everyone felt sorry for her and people made allowances when she was off-kilter. Her depression was completely understandable. Time and psychotherapy usually resolve this type of depression.
Sue (mentioned earlier) is an example of major depression later recognized as part of a bipolar illness. Sue took to her bed and refused to get up. Her mother became angry with her and called her lazy. It wasn’t until her mother realized that Sue had lost a lot of weight and wasn’t even getting up to eat that she took her to the doctor. In major/bipolar depression, loss of appetite, energy, interest, and concentration are common, as well as social withdrawal and sleep problems (too much or too little). Irritability and psychotic thinking can also be part of the picture. Nothing bad precipitated Sue’s depression. However, this is not to say that stressful events can’t help push genetically vulnerable individuals over the edge into a major/bipolar depression.

Here is a summary of the diagnostic criteria for major depressive disorder according to DSM-V. For at least two weeks, the individual must show a depressed mood and loss of pleasure as well as most of the following symptoms: significant loss or gain of weight or appetite, insomnia or hypersomnia, psychomotor slowing or agitation, decreased concentration, and recurrent thoughts of death or suicidal ideation. (The prevalence of major depressive disorder is given as 7% in the United States.)

Notice that the criteria for major depressive disorder don’t include family history, which is a serious omission according to many experts. Also notice that the symptoms are contradictory: weight loss or gain; too much sleep or too little; slowing or agitation. These contradictions don’t make sense as part of a single diagnosis. Are these symptoms part of one illness or somewhat different illnesses? Do they respond to the same treatments? Are the differences related to age and sex, or to the severity of the illness? The new RDoC research initiative hopes to finally make sense of this.
A further confusion is added by the fact that a major depressive episode can be characterized by what are called melancholic features: extreme loss of pleasure and reactivity, empty mood, depression worse in the morning, early morning awakening, agitation or slowing, weight loss, and irrational feelings of guilt. These symptoms occur more often among older patients and among bipolar patients. Many experts think that studies of the treatment effectiveness of drugs and psychotherapies should report results separately for these patients.

One pattern of major depression, which is more common among the young, results in lethargy, sleeping a lot, and eating too much, especially carbohydrates. Despite hours in bed, in such cases patients don’t feel rested and alert and they have trouble getting things done. This is often a seasonal pattern that begins in the fall and carries on through the winter. Such winter slow-down behavior is much more common in women. Its link to reproduction is demonstrated by the fact that the sex difference in depression doesn’t appear until puberty. The EOBD-R theory suggests that winter depression occurs more often in women because in the past, winters were times of food scarcity, and these behaviors helped women keep the necessary body fat for the reproductive needs of ovulation, pregnancy, childbirth, and breast feeding. While winter depression may have been adaptive long ago, it’s a serious problem for modern women and can lead to progressive weight gain over the years. Bright Light Therapy helps not only depression, but also obesity.

In Winter Blues, Rosenthal reports that about a third of the people in the northern half of the United States notice a significant downward mood shift in the winter. Because it’s so common, many people think of seasonal affective disorder as a mild problem. However, people differ genetically and some are much more sensitive to seasonal light deprivation than others. Many major/bipolar depressions are seasonal. I first became severely depressed in the dead of
winter. I couldn’t figure it out. Nothing bad had happened. The depression seemed to come out of nowhere. At that time information about seasonal affective disorder wasn’t widespread and instead of Bright Light Therapy, I was started on a heavy regime of antidepressants, lithium and other drugs that continued for years.

Common symptoms of depression are that you don’t want to get up. You don’t want to do anything. You lose interest in everything, including sex. You have a hard time meeting your work, social, and family responsibilities. You have difficulty concentrating. Some individuals (especially young women) overeat and oversleep, while others lose their appetite and have trouble sleeping. Irritability can be a problem. Psychosis such as delusions of poverty can occur. According to DSM-V, major depression is 1.5-3 times as common in women as men. Women are likely to experience a major depressive episode first, before a manic episode, if there ever is one.

In the past, an episode of major depression was considered part of bipolarity and would have received a diagnosis of manic depression, the old name for bipolar disorder, but this is no longer the case. The change was controversial, and experts on bipolar disorder, Frederick K. Goodwin and Kay Redfield Jamison, strongly objected. Obscuring the relationship between major depression and mood swings helped cause the kind of problem Sue experienced, and there’s yet another difficulty: When individuals diagnosed with major depression are given an antidepressant, up to 25% of them will switch to mania. The consequences of a switch to mania aren’t trivial because it usually means hospitalization and heavy-duty treatments. (Bright Light Therapy is much less likely to set off mania.) Again the best way to tell if a major depression is part of a bipolar disorder is to examine your family tree. The criteria for major depression and bipolar depression are the same. The only difference is that the bipolar depression occurs in a
person who has also been diagnosed with hypomania or mania. The term major/bipolar
depression is meant to bridge this diagnostic confusion.

**HYPOMANIA**

Hypomania is enjoyable. If you’re in this state you’re out-going, feel good, optimistic, and
accomplish a lot. You’re often obsessed with accomplishment, figuring something out, working
toward a goal. The problem is to keep behavior from getting out of bounds (for example,
speeding, mouthing off, sexual indiscretions, spending, or becoming so absorbed in your
interests that you neglect other responsibilities).

Considerable psychiatric opinion is of the view that hypomanic individuals should be
given anti-manic drugs to prevent mania, but a conservative approach suggests that you should
be taught how to recognize mood upswings and how to deescalate them. When people around
you begin to comment or complain about your behavior, it’s time to take notice. Here are some
typical symptoms of mania: Your mood changes and you feel unusually good or else irritable.
You start sleeping less. You’re distractible and your thoughts race. You’re impulsive and go
overboard doing things you wouldn’t ordinarily do. (See Chapter 4 for information about
maintaining mood stability.)

Hypomania is one of the main features of the bipolar II diagnosis. Individuals with this
diagnosis (mostly women) experience episodes of major depression (often in the winter) with
hypomania often occurring in the summer. Since this is a disorder characterized by life-long
episodes of depression and hypomania, medicating the hypomania is likely to mean a lifetime of
medications and their side effects. Since women of reproductive age often have this disorder,
such a prospect is worrisome and bleak, given the contraindications of psychiatric medications for reproduction. These facts underscore the need for nondrug therapies.

**MANIA**

Mania is hypomania to the extreme. But where is the line? People who go non-stop without sleep or think they’re Napoleon are obviously manic, but what about people who make you laugh? Maybe they’re bragging, indiscreet, or over the top, but you like them. The fact is that these people (mostly men) aren’t going to get a psychiatric label unless they go too far and get in trouble. A high status person can get away with a lot in this regard. DSM-V draws the line between hypomania and mania at the point at which the behavior causes definite “impairment in social or occupational functioning.” What it boils down to is that behavior gets the psychiatric label of mania when it gets a person in trouble they can’t get out of.

Here are some examples of behavior during a manic episode, but during mania even more extreme behavior may occur such as acts of violence, delusions, or hallucinations:

Lydia, a seventy-year-old widow, fell into a deep depression, which was successfully treated, but later she had a manic episode. Her daughter came home from work to find their belongings piled in the middle of the living room floor. Lydia was planning to sell them. Workmen had been busy around the house installing several new phones that were unnecessary. Lydia cheerfully greeted her daughter and announced that she was going dancing. Her manic speeded behavior had accomplished a surprising amount during the hours her daughter had been at work, but her actions made no sense.
Wanderlust and confusion are common during a manic episode. Alice told me that she came to herself in Denver, a thousand miles from home, and found herself living with a strange man. She couldn’t account for how all this had come about.

Doug decided to start a new business in a distant city. He rented an enormous amount of space and bought equipment, none of which he could afford. His brother, who also had bipolar disorder, talked him into going to a hospital, but Doug escaped from the hospital and celebrated by throwing a party for the neighborhood. The police finally arrested him for nonsupport and put him back in a hospital. This high mood, expansive behavior, poor judgment, and overspending are typical of manic behavior.

Depressed people tend to be quiet and withdrawn and they may not get diagnosed for months. The excessive, in-your-face manic behavior, however, is likely to result in confinement in a jail or mental institution quickly, in less than a month. The jails and prisons are full of mentally ill individuals, especially men. As mentioned before, although the first episode of a mood disorder is likely to be depression for females, it’s likely to be mania for males.

Mood swing episodes are commonly first diagnosed in young adults, but, more and more frequently, they are being diagnosed among teens and children. In the 1950s, we were taught that the onset of manic-depression (former name for bipolar disorder) took place in middle-age, contrasted with an earlier onset for schizophrenia. This is certainly not the picture today. Both are showing up at much younger ages (plus a startling number of autism-related diagnoses).

**BIPOLAR DISORDER OR SCHIZOPHRENIA?**

As difficult as it may be to understand bipolar disorder, schizophrenia is an even more diverse group of disorders. However, schizophrenia is always a severe brain disorder showing abnormal
interpretation of reality, which may include hallucinations and delusions. A psychotic disorder, it results in noticeable deterioration in the level of functioning in everyday life. In this respect, it is different from bipolar disorder in that, among all the individuals diagnosed with a bipolar disorder, a small minority is ever psychotic.

The two disorders can often be differentiated by their speech. The schizophrenic individual’s speech generally doesn’t make sense and has even been described as a “word salad.” In response to the question, “How are you?” an individual suffering from a schizophrenic episode might respond, “The bird is in the heaven. Bless the little ants.” An individual suffering from a major/bipolar depression might say, after a long pause, “Depressed.” The manic person might say while pacing about, “I’m great. When am I getting out of this dump?” Sometimes you can’t tell whether the person is schizophrenic or manic because manic individuals can show a “flight of ideas,” jumping around from subject to subject. Differential diagnosis has to await more information such as personal and family history.

Another difference between schizophrenia and mood disorders is the course of the illness. Mood disorders are episodic, showing repeat mood swings with periods of normal behavior in between. Schizophrenia doesn’t show the swings of mood characteristic of bipolar disorder. A schizophrenic individual may also be depressed, but depression isn’t the dominant symptom. The prognosis for mood disorders is much better than for schizophrenia. Within the first five years following a schizophrenic episode only about 15% show a sustained recovery according to DSM-V.

Bipolar disorder has historically been considered a different illness from schizophrenia, but that idea is now debated. Some individuals show a mix of symptoms and receive a diagnosis of schizoaffective disorder. However, in Psychiatry under the Influence, Whitaker and Cosgrove
report that bipolar disorder is beginning to look more like schizophrenia in the sense that people become permanently disabled instead of having episodes of illness with normal periods in between. Whitaker and Cosgrove think this is the result of inappropriate drug treatment.

ATTENTION DEFICIT-HYPERACTIVITY DISORDER OR BIPOLAR DISORDER
Diagnosis is even more difficult for children than adults, and the differential diagnosis of attention deficit-hyperactivity disorder (ADHD) versus bipolar disorder is problematic. One way to tell them apart is that ADHD children are persistently restless and easily distracted, while these symptoms are episodic in the case of bipolar disorder. Family history is also an important guide.

The integrity of the diagnosis and treatment of ADHD has been sharply criticized. In Psychiatry under the Influence, Whitaker and Cosgrove suggest that the ADHD diagnosis was hyped for financial advantage and that the public was misled to believe that the medications to treat it are effective although this is not the case. Moreover 8 % of the children receiving the stimulants used to treat ADHD experience a manic or hypomanic episode, which is likely to lead to a bipolar diagnosis and more medications. These authors think that children and teens are being seriously harmed by psychiatric drugs. In 2008 the US Governmental Accountability Office reported that 1 in 15 young adults, 18-26 years old, were “seriously mentally ill,” an alarming statistic.

If you are responsible for a troubled child or teen, or one who may carry bipolar heredity, consider the natural treatment alternatives suggested in this book. Bright Light Therapy is effective to treat depression in children and teens, and how can you go wrong with exercise? Here is a bit of encouragement from the research literature in support of the Ben Franklin
Routine: A 2010 report in the journal *Sleep* found that the teenage children of parents who set bedtime at ten pm or earlier were 24% less likely to suffer from depression. (But was it the early bedtime or another factor, firm parenting? We need more research.)

**DIAGNOSTIC LABELS**

Individuals who show only episodes of major depression receive that diagnosis. Those with chronic depression are diagnosed dysthymic. Individuals who have both episodes of major depression and hypomania receive a bipolar II diagnosis. (Milder swings of mood are diagnosed as cyclothymia.) Individuals showing episodes of both major depression and mania, or mania alone receive a bipolar I diagnosis, which occurs about 1% worldwide while all bipolar diagnoses together are about 5% of the world’s population. Individuals with what I’ve called ordinary depression receive a diagnosis of adjustment disorder with depression. Seasonal affective disorder is diagnosed when depressions regularly occur in the fall/winter. Grief reactions are considered normal.

A symptom pattern that’s grown is rapid cycling, such as four extreme mood shifts in a year. This condition was almost unheard of in the 1950s, and is three times more frequent in women. It causes enormous suffering and is difficult to treat. Some experts such as Dr. Goodwin believe rapid cycling is caused by stimulants such as antidepressant drugs, which trigger mania in as many as 1 in 4 cases.

**POSITIVE QUALITIES ASSOCIATED WITH BIPOLAR DISORDER**

Although bipolar behaviors are often maladaptive in today’s world, bipolar disorder is correlated with achievement and creativity. In his book, *Bipolar Breakthrough*, New York-based pioneer
expert on bipolar disorder, Ronald R. Fieve, says that 50% of his bipolar II patients are among the most successful high achievers in the city. (Fieve describes Donald Trump as a hyperthymic, hypomanic personality.) Examples of contemporary high achievers with bipolar disorder include the late Robin Williams, famous for his acting and comedic talents, and perhaps the best known living American with bipolar disorder, Ted Turner.

John Hopkins professor, John Gartner, in his book, *The Hypomanic: The Link between (A Little) Craziness and (A Lot) of Success in America*, makes the argument that America’s success partly derives from the fact that immigrants are genetic risk takers, and it is a fact that there are more people with bipolar disorder here than anywhere else. (New Zealand and Canada are runner-ups.)

Gartner has also published *In Search of Bill Clinton*, which suggests that Clinton is a hypomanic personality. He certainly seems to fit the description. Intriguingly, Clinton reports that he has 4% Neandertal genes, which is at the high end for Neandertal inheritance, a fact weakly consistent with the idea that the vulnerability genes for bipolar disorder descend from Neandertal.

Many famous people have had bipolar disorder, including leaders like Abraham Lincoln, William Tecumseh Sherman, Teddy Roosevelt, and Winston Churchill. In fact, psychiatrist Nassir Ghaemi in his book, *A First-Rate Madness*, makes the case that bipolarity provides the best qualities for first-rate leadership in times of crisis. Individuals in a manic state can go without felt need for sleep or food. Their thought and behavior are speeded and they are described as possessing superhuman strength. These attributes are great qualities during an emergency and may be one of the reasons for the genetic persistence of the bipolar vulnerability genes.
Creativity in music, art and literature is also associated with bipolar disorder. Examples include: George Frederic Handel, Peter Tchaikovsky, Vincent van Gogh, Georgia O’Keeffe, Ernest Hemingway, Tennessee Williams, Mary Shelly, Virginia Woolf, Louisa May Alcott. Kay Redfield Jamison brought these ideas to the fore in her book, *Touched with Fire: Manic-Depressive Illness and the Artistic Temperament*. Expert Robert R. Fieve goes so far as to say, “I’d wager that without some form of bipolar II hypomania, there is no genius!” (*Bipolar Breakthrough*, 2006, p. 32).

During hypomania and mania, individuals are described as being obsessed with pursuing an idea, a goal, or solution to a problem. This characteristic is probably crucial to the link between bipolarity and achievement. It is also logically linked to neurochemistry. It’s known that dopamine levels increase with mania and that dopamine has a rewarding effect. It’s as though an accomplishment is accompanied by a little drop of dopamine that rewards achievement and spurs further effort. (See Fred Previc’s book *The Dopaminergic Mind in Human Evolution and History.*)

**SOME THOUGHTS ABOUT STIGMA**

Today many people with depression or bipolar disorder prefer to keep this information to themselves or even develop a cover story. In the past, sometimes attitudes toward depression were more accepting. Reading *Lincoln’s Melancholy: How Depression Challenged a President and Fueled his Greatness*, by Joshua Wolf Shenk, I was struck by the lack of stigma attached to Lincoln’s depressions. His friends accepted his problem and lovingly cared for him until he recovered.
I gained a similar impression of societal tolerance when I read James Boswell’s, *London Journal*, about life in England a century before Lincoln’s time. Boswell had spells of depression and showed out-of-bounds behavior such as excessive drinking and whoring. All the same he was accepted in society. He was a close friend of Samuel Johnson and ultimately became famous as Johnson’s biographer. Boswell medicated himself with alcohol, which often happens today. Samuel Johnson, who also suffered from depression, advised the younger Boswell “to have constant occupation of mind; to take a great deal of exercise and to live moderately, especially to shun drinking at night.” All this is excellent advice.

**CHAPTER CONCLUSION**

Whether you like it or not, you (or your loved one) may receive a psychiatric diagnosis. You must find out what it is and try to determine if it is correct. Also be alert to the fact your symptoms may be caused by a medication, a physical disease, or a different psychiatric illness. The information I’ve given you in this chapter will help you decide if the diagnosis is correct.
CHAPTER 3

BRIGHT LIGHT THERAPY AND TRIPLE CHRONOTHERAPY

We humans are activated by light and deactivated by darkness. This has been understood for centuries, but what we didn’t realize is that a minority of us can be more strongly affected, undergoing behavior changes outside the norm. Moreover, because the effects of light occur without an accompanying awareness, we may not understand that our behavior is changing because of a reduction in light exposure.

As a result of scientific advances and the advent of electricity, we now have lights strong enough to simulate the sun and relieve this kind of depression. The sun’s light is powerful. To give you some idea, the daytime average home or office has a light intensity of 50-300 lux while at sunrise outdoor illumination is 10,000 lux; at noon it is 100,000 lux. (Lux is a measure of light intensity.) In order to be effective to relieve depression, therapeutic bright lights provide 10,000 lux of light, at a specified distance between the light and your eyes.

You may think that turning on all the lights in the house or adding more lights will do the trick, but it won’t. These measures fall far short. Going out into the sunshine will boost your mood, but to treat a major depression, daily use of a therapeutic lamp each morning guarantees that you’ll get a shot of light when it’ll do the most good, in the morning. The sun rises early in the summer. It’s theorized that major/bipolar depression originated as a hibernation-like adaptation to a severe winter climate. Thus the reason light therapy works is that early light tricks the body that it’s not winter. Whether or not the theory is correct, research demonstrates that early light exposure works best. Terman has shown that the effectiveness of light therapy is 40-80% more effective if it is begun between 6 and 8 am. Light therapy has been found to work
even if the depression doesn’t meet all the criteria for seasonal affective disorder. Aside from seasonal affective disorder, many people are simply light deprived, spending less than an hour a day outside even in summer.

A bright light can be ordered by phone or on the Internet; it usually costs about $200 and lasts years. With the newer 10,000 lux lights, twenty minutes to ninety minutes daily in front of the light will usually do the trick within a few days. (An antidepressant, if it works, takes effect in two to four weeks.) Keep the light about a foot away (not more than two feet), and don’t stare at the light. Have it a little above eye level. You can do other things while you’re in front of the light. For example, I eat breakfast and read the paper (about a half hour). The light will not hurt your eyes. (However, if you’re nursing a baby, shield the baby’s eyes from the direct light.)

In the northern temperate zone, the biggest single drop in ambient light occurs August 15. Dr. Tom Wehr found that individuals with seasonal affective disorder, like hibernating animals, respond to this precipitate drop in ambient light as a signal to begin fattening up for winter. This research importantly demonstrates the link between human mood disorders (major/bipolar depression, seasonal affective disorder) and the neurophysiological responses to light of hibernating animals. Light therapy could appropriately begin in late August, but most people wait till they see the first signs of depression: low energy and difficulty getting out of bed.

Symptoms of depression can easily go unnoticed. I didn’t catch on that I was depressed until I realized I was spending a lot of time reading the newspapers without remembering what I’d read. Even in summer, if it’s gloomy or you’re inside, you’ll benefit from your bright light. Winter slow-down behavior is common in Scandinavia and among peoples of the far north where it’s regarded as a natural reaction to the season.
In *Winter Blues*, Dr. Norman Rosenthal gives a detailed account of Bright Light Therapy. If you’re starting light therapy in the fall, he recommends a twenty minute exposure to a therapeutic lamp in the early morning for a week or so. If this works, stay with this routine until your body tells you that you need more or less light. If necessary, add more light especially early. A second session can be added in the afternoon, but be careful not to use light late in the day as it may interfere with sleep.

Bright Light Therapy is safe for the eyes and has minimal side effects (headache, jitters), but it can elevate mood too far. Anything that lifts the mood can set off a manic episode. This includes antidepressants, drugs like cocaine, meth and amphetamine, and even the bright lights of a TV studio. The chance of triggering a manic episode is only 1 in 20 for Bright Light Therapy, but up to 1 in 4 for antidepressants. Most people don’t understand that this is a problem, and they don’t know whether, in addition to depression, they also have bipolar disorder and are subject to upward mood swings. Although Bright Light Therapy could trigger a manic episode, light therapy is more flexible. If you’re feeling low, you can increase your dose. If you’re getting high, irritable or jittery, you can decrease it. Since exposure to the light is under your control, you can avert a manic episode by cutting your light exposure. Once you swallow a pill, you don’t have the choice to unswallow it. Although this problem with antidepressants can be side-stepped by the addition of a mood leveler like lithium or Depakote to your medication regimen, then you’re taking more medications, with possible additional complications.

You can get more or less activated by adjusting the dosage of light, which is affected by four factors: the brightness of the light, the duration of exposure to the light, distance from the light, and time of day—earlier is more stimulating. You may find that you need to increase your dosage of light in the dead of winter while you can probably discontinue treatment over the
summer unless it’s gloomy, you’re not out much, or you’re older (old eyes don’t let in as much light). Keeping track of your mood and concentration level will help you know whether you need to return to treatment or increase your dosage. I’ve found that a sensitive indicator of the need for more light is instances of forgetting and lack of concentration. If I start making mistakes, I pay attention to increasing my dosage of light.

**BUYING A BRIGHT LIGHT THERAPY LAMP**

Therapeutic lamps are widely available, but scams are out there; don’t buy an inferior product that doesn’t work. According to Rosenthal, the light need not be full-spectrum or blue light in order to be effective (despite what you may hear or read). Insurance will sometimes cover the cost of a lamp.

Although lamps and light boxes of all kinds are available, most people want something small, and lamps weighing as little as two pounds are now available. It’s not advisable to make your own light box. They’re more complex than just light bulbs. A proper lamp has a plastic diffuser and a UV filter to protect your eyes and skin from harmful UV rays.

In today’s society many people find it difficult to start light therapy early in the morning. As a result light therapists invented the dawn simulator. This device allows you to stay in bed while the light turns on mimicking an early dawn, gradually getting brighter. Roughly the same effect may be obtained (more cheaply) by putting a regular therapeutic lamp on a timer.

Travel lamps and other devices are available. Dr. Norman Rosenthal, who suffers from depression himself, has even used a bright light visor, but he’s also skipped a day or two of light therapy without ill effect.
I intended to refer you to a list of recommended dealers that the Center for Environmental Therapeutics had online last fall, but it was gone last time I checked. Dr. Jim Phelps has some advice about buying on his web site. From my personal experience I can recommend Northern Lights Technologies based in Canada. (I have no financial connection with the company.)

WHAT ABOUT TANNING SALONS OR A VACATION IN THE SOUTH?
Going to a tanning salon isn’t a good idea. It may make you feel better because it raises endorphin levels, but it heightens your risk for cancer and it’s not a treatment for major depression. To effectively relieve depression, light must be received through the eye.

A winter vacation can be helpful, but it’s not a substitute for light therapy. In fact, the contrast in lighting between south and north may bring the depression back when you return north if you don’t resume light therapy. Some people relocate in the south permanently or during the winters. However, remember to get in the light. We moderns are so divorced from natural conditions that we sometimes wilt away in our darkened interiors. My friend Jack moved from the state of Washington to Tucson, Arizona but he couldn’t shake his depression. Why? He spent his time inside a dark gloomy apartment. Once inactivation set in, he felt less and less like venturing outside or doing anything. People living in southern areas are much less likely to experience winter major depression, but it can occur.

WHAT IF BRIGHT LIGHT THERAPY DOESN’T WORK?
One of the great advantages of Bright Light Therapy is that it works quickly. In Winter Blues, Rosenthal suggests giving the treatment two weeks, making adjustments if there’s been no relief in a few days. To increase its effectiveness, you can move the treatment earlier or increase the
amount of time exposed to the light. If the treatment still doesn’t work, another type of therapeutic intervention can be tried.

**CAVEAT**

Several studies have shown that major depression and bipolar depression can be successfully treated with Bright Light Therapy. And it’s been a completely satisfactory treatment for me in the sense that, although I was supposed to have repeated episodes of bipolar depression, I haven’t been depressed for fifteen years. However, a study published recently suggested that Bright Light Therapy doesn’t work for bipolar depression. I have a research background and was an editor of a psychology research journal. As a result I was extremely surprised that this study was accepted for publication. It can be criticized in many ways, but the fact that there are only nine subjects is a deal-breaker in itself. Nonetheless, the study is being cited, which is also a surprise. Clearly more research will be needed to make obvious the effectiveness of Bright Light Therapy as a treatment for bipolar depression without the additional use of psychiatric drugs.

**TRIPLE CHRONOTHERAPY**

Triple Chronotherapy is the name of a package of chronotherapeutic techniques that offer fast, safe relief from severe depression. The treatment developed from research done by the NIMH group that discovered seasonal affective disorder and Bright Light Therapy. It is described by Michael Terman and Ian McMahan (in New York City) in their book for the general public entitled *Chronotherapy (Reset your Inner Clock)* in paperback). Anna Wirz-Justice (in Switzerland), Francesco Benedetti (in Italy), and Terman describe more or less the same therapy in *Chronotherapeutics for Affective Disorders*, written for clinical practitioners.
Bright Light Therapy alone without psychiatric drugs is usually effective to manage depression, but these clinician/researchers have developed Triple Chronotherapy as a technique that can be used to manage severe suicidal depressions quickly, without necessarily using psychiatric drugs. To do this, they take advantage of the amazing fact that sleep deprivation will abort even severe depression. Terman and McMahon reported that Triple Chronotherapy is especially useful for those individuals in deep depression who were first put on one antidepressant that didn’t work and then on another that didn’t work, until months later they become acutely suicidal. In the past, when these patients entered the treatment center at the Columbia University hospital, treatment choices were limited. Either they spent weeks in the hospital in order to wash out the previous antidepressant medication and then try a new antidepressant to see if it would work, or the only other alternative was electroconvulsive therapy (discussed in Chapter 8).

Triple Chronotherapy takes advantage of a quirk in the neurophysiology of individuals with major/bipolar depression: the ability to switch out of a depression when deprived of sleep (more about this in Chapter 9). For years clinicians have been startled to see a profoundly depressed patient suddenly change to mania. This is what was historically called the switch response. The switch may be to euthymia (neutral mood), hypomania, or mania, but it is short-lived. However, recovery can be sustained by daily early morning Bright Light Therapy.

The first step is called wake therapy. Patients are kept awake all night and all the next day. The second step is going to bed early for eight hours of sleep in the dark, which Terman and McMahon describe as “recovery sleep with phase advance,” meaning getting them to an earlier wake-up time. Finally a half hour of Bright Light Therapy is given early each morning, and continued for maintenance treatment. On the first try, the procedure works in about sixty percent
of cases and the response rate goes up with additional repetitions of the procedure. Positive results are usually achieved within a couple of weeks.

Triple Chronotherapy may be a God-send for suicidal, severely depressed individuals who aren’t responding to antidepressants or who don’t want to take them. It’s quicker and safer than the alternatives, but it may be expensive if it isn’t covered by insurance. If you need Triple Chronotherapy, talk to your doctor, contact Terman’s treatment center in New York City, the chronotherapy treatment center in Chicago, or treatment centers in Italy or Switzerland (see Resources). In the best case scenario, your local health care providers will help you figure out a way to make this treatment possible. Although Triple Chronotherapy may currently be expensive, it could be made a very inexpensive treatment and greatly reduce the cost of treating depressions.

Sleep deprivation is not recommended as a self-help treatment for depression because it sometimes precipitates a manic state. Suicidal tendencies and mania are most safely managed in a hospital setting. If your urges to commit suicide are getting out of control, seek help. Call the National Suicide Prevention Lifeline 1-800-273-TALK (8255), available 24-7. You can also dial 911 or go to a hospital emergency room.

CHAPTER CONCLUSION
The effect of light on human behavior is a break-through area of research promising great improvements in our understanding and management of human illnesses. Many serious depressions can be quickly, effectively, and cheaply treated by Bright Light Therapy and Triple Chronotherapy; more advances await further research.
CHAPTER 4

BEN FRANKLIN ROUTINE AND DARK THERAPY

In addition to Bright Light Therapy during the wintry months, I’ve used another variant of chronotherapy to keep me well. The procedure is based on research demonstrating that early rising and darkness during the night are stabilizing for those of us with mood disorders. NIMH researchers found that extended periods (up to fourteen hours) of continuous sleep/rest in the dark was effective in stabilizing manic and difficult-to-treat rapid cycling patients, resulting in the recovery of previously untreatable bipolar patients. When I started this routine, I wasn’t manic, depressed or rapid cycling, but I reasoned that if this routine worked in such severe cases, a modified version (eight hours of darkness) would probably keep me well. The method had been demonstrated to be effective on only one or two patients, but I desperately needed preventive measures and adopted the procedures. They worked.

The Ben Franklin Routine is simple. Go to bed early; stay continuously in the dark, sleeping or resting for about eight hours during the night, and then get up early. (Resting provides about 70% of the renewal of sleep.) Keep the room as dark as possible by using darkening window shades and/or drapes over the windows (or a blindfold). It’s best to experience as much darkness as possible, but a small amount of light like a night light is OK. Do not turn on an overhead light. The reason to avoid light exposure during nighttime sleep is that it upsets the body’s neurochemistry. Light stops the pineal gland from secreting melatonin, a hormone that keeps the body and brain functioning in an orderly way. Light exposure during the night disrupts normal functioning. Use a flashlight when you get up. If you’re getting up to care
for a child, realize that nighttime exposure to light isn’t good for children either, so keep light conditions as dark as possible.

My routine has been to go to bed about 9, rarely as late as 10, and to get up about 4:30, almost never later than 5:30. I get up whenever I wake up after about eight hours of sleep or rest. I feel very well, alert, and rested when I get up. However, I am older and early schedules are typical of older people. It may be that you can successfully use a later schedule. This is something you can experiment with, but try to maintain a consistent bedtime and as much darkness as possible during the night (and use early exposure to Bright Light Therapy during wintry months).

Fieve describes hypomanic personalities who thrive on just four hours sleep. If this works for you, you’re probably not reading this book. The Ben Franklin Routine is for people concerned that their mood may swing too high.

At the time that I adopted the Ben Franklin Routine, it was my understanding that NIMH researchers had found that individuals with major depression have a biologically set early waking time, as early as 4:30 am. Although this may strike you as incredibly early, I didn’t find it unreasonable since I often awakened at this hour. Farmers have routinely gotten up at this time. Moreover, when I considered that waking times are biologically set and part of our genetic heritage, this waking time made sense. Early peoples followed animal herds and they would need to be awake before dawn in order to follow the herd. Such an early schedule is contrary to current social habits, but what if our bodies were built for the conditions of the past millennia, not for contemporary society? (The problems caused by late and erratic hours are being increasingly recognized and popularly labeled social jet lag.) The Ben Franklin Routine can be socially problematic until you and those you know get used to it. It may necessitate some
negotiations with a spouse, roommate or partner. However, the routine promotes not only better mood, but also better sleep, alertness and a slimmer figure. (And remember Ben Franklin said that it’ll also make you wealthy and wise!)

Dark Therapy, written about on the Internet by Dr. Jim Phelps, is similar to the Ben Franklin Routine. It uses the deactivating qualities of darkness to calm mood elevations. Terman and McMahan point out that staying in the dark for up to fourteen hours can stop a manic episode just as fast as powerful psychiatric drugs. Here is an example of how knowing about your illness is invaluable. Contrary to common belief, even a person labeled psychotic has plenty of sense left, especially when it comes to self-preservation. If you think you’re going manic, get yourself in the dark. (Get some food, CDs with unemotional content, sleep, rest, and chill out.)

Yet human beings don’t like being out of action for very long. Phelps has had trouble getting patients to stay in the dark for extended periods. He has experimented with the use of amber colored glasses that filter out blue light, which is the most activating. Wearing the glasses has the effect of simulating darkness, allowing patients to stay up longer without being in actual darkness. Phelps reports a fifty percent improvement in his patients using the glasses.

I think the Ben Franklin Routine (with seasonal Bright Light Therapy) will work well to keep moods stable if you have only major depression or major depression and mild upward mood swings (Bipolar II disorder). I also think it will work as a maintenance routine for individuals with Bipolar I disorder (like myself), but if you’re in a full-blown psychotic manic state, you’re better off in a hospital. There’s just too much chance that you’ll do something you’ll seriously regret or that you’ll land in jail. Go to a hospital or allow yourself to be taken there.

Once you’re in the hospital the doctors in charge will want you to take medications. What to do? First of all don’t be combative, don’t fight, don’t threaten, and don’t even mouth off.
Cause as little trouble as possible. Otherwise you’re likely to be put in physical restraints, and/or commitment proceedings will be started. Get a lawyer, because if the authorities think you may be troublesome or not cooperative enough, they may start legal proceedings to commit you.

You can try to bargain with the psychiatrists to give you Dark Therapy and as few drugs as possible. You can request to be put in a dark room during the night to see if you can calm down without drugs. They may or may not allow you to do this. (You can create your own darkness by using a blindfold.) If you can sleep or rest quietly in the dark for up to 14 hours each night, you probably will be able to calm down.

I’m no fan of psychiatric drugs, but the worst effects come from long-term use. Lithium, anti-manic, and other drugs are effective in calming mania, but they do have side effects. For example, Depakote can make you suicidal; Lamictal can kill you; so can lithium or it can damage your kidneys, but these extreme adverse effects are unlikely. In the short-term, rather than being involuntarily committed under a court order, you’ll probably be better off taking the drugs. Once the psychosis clears, you should be able to get out of the hospital and work with your health care professional to move toward a drug free, chronotherapeutic management of your disorder, avoiding a dangerous long-term exposure to psychiatric drugs. You can cooperate with your doctor to take as few drugs as possible and transition off them to the use of chronotherapeutic techniques to see if, along with psychoeducation and psychotherapy, you can manage without psychiatric drugs.

On the other hand, if you flatly refuse to take any medications, they will probably start legal proceedings for a commitment hearing. This will happen in a few days, and they must legally provide you with a free lawyer. By this time you will hopefully be sufficiently in charge of yourself that you can convince the sanity hearing board that you aren’t a danger to yourself or
anyone else. My sister had been through this more than once. Her advice to me: “Say you realize you were sick, but you’re all better now.” Actually even though it’d been only a few days, the psychosis was gone. So much for my need for life-long institutionalization.

However, if you are judged a danger to yourself or others, you can be held in a locked ward and medicated with any drugs the authorities think are appropriate. You will have no choice. (Even if this happens, try to get as much nightly darkness as possible.)

If you refuse to take medications, another possibility is that the hospital will decide that they don’t want to bother with you and discharge you, even though you have no money or place to go, and even though they know you’re not able to think clearly. This is illegal, but it happens. In making your decision to refuse medications, this is another possibility to be considered. Since it’s illegal to throw you out, if you refuse to go, you may be allowed to stay even though you don’t take medications. On the other hand, you may be threatened that if you refuse medications, insurance won’t cover your hospital stay, or that you will be transferred to a state mental institution. In these circumstances you need accurate practical information, advice, and a lawyer.

Ironically people take recreational drugs to have a trip, but a manic psychosis is a trip with an uncertain outcome. It’s not a trip you take at a party; it’s a trip you take essentially alone.

SLEEP PROBLEMS?
When I first started using the Ben Franklin Routine, I was frightened and miserable with all kinds of worries, aches and pains from drug withdrawal and side effects. I had trouble sleeping and used either Benadryl or a short-acting benzodiazepine as a sleep aid (15 mg. Serax), but even that light dose of Serax was addicting. Now I rarely use a sleep aid. Most sleep aids can’t be used for more than a couple weeks without becoming addictive, and they have a negative effect on
cognitive function. I particularly don’t recommend Ambien and similar drugs. Not only are they addictive, but they have a bizarre side effect: You can end up doing things without your conscious awareness, even driving a car. Some antidepressants (e.g. Elavil, Trazodone) have been used as sleep aids because of their sedative effect, but of course they run the risk of setting off a manic episode. I’ve sometimes used the Relaxation Response (meditation) to help me get to sleep (Chapter 7), but the best solution I’ve found for a sleep aid is to listen to factual material like lectures or biographies on CD. The material needs to be interesting enough to be diverting, but not emotionally arousing.

RESEARCH NEEDS

More research is needed to establish the effectiveness of Dark Therapy and the Ben Franklin Routine in order to legitimize their use and bring them into the mainstream of treatment. How late can the schedule be and still work? A push from the public and from individuals willing to volunteer for chronotherapy research studies is needed.

CHAPTER CONCLUSION

Three facts are well established: 1) A stable routine, including a regular time to go to bed and get up, is beneficial in the treatment of mood disorders. 2) Darkness at night benefits sound sleep. 3) Staying up all night triggers mood elevation, even mania, in bipolar individuals. These facts all support the usefulness of the Ben Franklin Routine. However, it’s unclear whether a “normal” schedule of 11-7 sleep time is adequate or if it needs to be set earlier (9-5?). Moreover, will this routine work as well for others as it has for me?
CHAPTER 5

CO-OCCURRING CONDITIONS, INCLUDING OBESITY

A significant number of individuals with major depression or bipolar disorder also receive an additional psychiatric diagnosis. This may be confusing. “Do I have a mood disorder or do I really have an addiction problem? panic disorder? PTSD?”

If a qualified professional has diagnosed you with major depression or bipolar disorder (or it runs in your family), consider this your primary diagnosis. However, you may also have another problem, and it will also need to be managed. This is especially the case with addiction problems which have a strong potential for seriously negative life and legal consequences.

This chapter will briefly consider the most common co-occurring problems: ordinary depression, substance abuse, PTSD, panic disorder, and eating disorders. We’ll also discuss problems specific to women: premenstrual tension (PMS) and depressions occurring after childbirth and at menopause. Physical problems like obesity and type 2 diabetes also frequently co-occur. Obesity is facilitated by a seasonal biologically programmed eating frenzy, designed to fatten you up for an expected winter of food scarcity. Moreover, many psychiatric drugs have weight gain as one of their side effects. Obesity often leads to type 2 diabetes.

ORDINARY DEPRESSION

As mentioned in Chapter 2, in contrast to major depression and bipolar disorder, which have a strong hereditary component, everyone is subject to ordinary depression. The inherited variety is linked to light input and a mutated clock gene. Ordinary depression, however, is a reaction to losing out socially. We humans tend to develop depressive symptoms when we lose out.
Unfortunately, major depression and bipolar disorder usually cause multiple real-life problems: rejections, disappointments, victimizations, and educational, job and financial setbacks of a kind that bring on ordinary depression, though individuals with major/bipolar depression don’t get a second depression diagnosis. Ordinary depression responds to social support and psychotherapy. To combat the social wreckage of bipolar disorder, people also often need vocational rehabilitation in order to restore their earning power and a sense of usefulness and belonging.

ADDITIONS

Substance abuse affects up to a third of individuals with major depression or bipolar disorder, and it seriously complicates the management of these disorders. Many experts think that the co-occurrence of substance abuse and mood disorders has a genetic basis, and all agree that many self-medicate. Alcohol and drugs provide temporary relief from psychiatric problems, even though they make them worse in the long run.

Minimize your substance abuse. If necessary, get into a professionally run treatment program. These are now covered by insurance. If you’re taking psychiatric drugs, make sure that they won’t be abruptly discontinued. Many substance abuse treatment programs don’t want their patients on any drugs whatsoever. This is fine, but there is a right way and a wrong way to stop drugs. Abruptly and arbitrarily taking away all your medications is not the right way. It shouldn’t happen, but it does.

Aside from professionally run treatment centers, there are lots of different support groups. Many people have greatly benefitted from these groups, but it may take some trial and error to find a suitable one. In any case be careful with Step 4 of Alcoholics Anonymous which requires you to review and make amends for past misdeeds. This can be overwhelming for
someone already depressed. Some people cure their own addictions to drugs or alcohol, but remember that gradual withdrawal is essential. It’s a tough way to go, but it can be done.

However, alcohol and drugs are not the only addiction problems. Up to two thirds of individuals with a bipolar diagnosis meet the criteria for an addiction disorder including buying sprees, sex, gambling, wild bets on the stock market, and kleptomania (compulsive stealing).

**PTSD**

PTSD stands for post-traumatic stress disorder and it’s not limited to veterans of war. Many individuals are abused as children. Rape and domestic abuse are common experiences for women (20-30%), and people who are mentally ill are especially vulnerable and often victimized. The main problems with PTSD are anxiety and maladaptive, inappropriate behaviors. Even mild forms of PTSD can be problematic. I was surprised to discover that I was riddled with mild forms of PTSD, both from childhood and from traumatic events that occurred when I was ill.

For example, as a result of the callous treatment I received from physicians, on the morning of my appointment with a new highly recommended doctor, I had such a severe anxiety attack that I didn’t think I’d be able to keep the appointment. I called a volunteer help line and was able to calm down. In this case it was obvious to me what brought on the anxiety attack. In other instances, I was able to use free association techniques to uncover and deal with the causes of more subtle expressions of PTSD. (Although psychoanalysis has correctly been discounted as an overall treatment and theory, free association, a technique typical of psychoanalysis, is useful in these situations.)

A special victimization problem is that of therapist sexual misconduct. I was asked to serve on a task force of the American Psychological Association dealing with this issue, and I
was shocked to learn that as many as 20% of practitioners have sex with their patients. These aren’t love affairs. Nearly all these instances involve male practitioners taking advantage of female patients. Usually these men are serial abusers, seducing woman after woman. Some of them are truly scary though they usually appear entirely respectable. For example, one eminent psychiatrist abused several women, tried to blackmail a therapist, and made threatening phone calls to those of us trying to help victims. He threatened his bipolar patient that if she didn’t co-operate, he’d see to it that she would be put in an institution and never get out. He also blackmailed her with threats to tell her husband. This man was a professor in a medical school, the top forensic psychiatrist in the state, and a prominent churchgoer.

Women with mental illness are especially vulnerable to abuse because of the great power disparity in the doctor-patient relationship. For example, a psychiatrist accused of sexual misconduct changed the patient’s diagnosis from depression to borderline personality disorder. He then got a fellow psychiatrist to testify that individuals diagnosed with borderline personality disorders are habitual liars. Although this is a doubtful statement, it had the effect of discrediting the patient. He also blackmailed her by threatening to publicly reveal confidential information he learned while acting as her therapist. The Medical Examining Board found this man innocent.

It’s illegal and unethical to have sexual contact with a patient and the practitioner can lose his license and/or go to jail. However, most of them don’t suffer such dire consequences. If your therapist comes on to you, the best thing to do is to get out quick. Many women get a crush on their therapists, but what may seem to be a mutual love affair probably is sexual exploitation. If you’re having a problem, consult your state Medical (or Psychology) Examining Board or a lawyer.
PANIC DISORDER

Increased anxiety is almost inevitable for anyone with a severe mood disorder. What is happening to me? What will I do? How long is this going to last? Will I be able to keep my job? Am I going to screw up? Will my husband still love me? Can I keep my friends? Do people know I’m sick? Am I thinking right? Being mentally ill is a terrifying experience.

Sometimes the anxiety mounts into the form of a panic attack, an experience of extreme overwhelming anxiety so severe you think you’re going to die. You aren’t. I was lucky to know about panic attacks and when one occurred I simply waited for it to go away. But some individuals develop a fear of the attacks themselves and become unable to go out of the house (agoraphobia), which is a severe handicap. There are effective anti-anxiety pills, but they are addicting and have other problems. In any case, agoraphobia can be managed without pills.

Phyllis was a young woman who had been home taking care of her three year old daughter. Now she wanted to get a job, but she found herself unable to leave the house. She didn’t want to take medications and she wanted to get well in three months, which was the limit of her insurance coverage. Phyllis’s primary diagnosis was panic disorder. She didn’t have major depression or bipolar disorder, but her experience is a good example of nondrug treatment of agoraphobia, which is quite simple once you know how.

The crucial strategy is to be exposed to the feared object just to the point that you become scared and then back off, but continue to repeat the exposure for gradually longer and longer periods. Over time the irrational fear wears off.

The first thing I had Phyllis do was to make a list of scary things, so we could rank them. For example, going out alone was scarier than going with someone. Going someplace where she...
couldn’t get out easily was scarier than some place with a quick escape. After ranking the items, we began with the easiest one.

Phyllis started out walking from her home until she became fearful. Then she went back, but repeated the experience, each time going a bit farther. The plan worked well. Each week she’d try a more difficult task. However, at one point she went out to dinner with her husband only to have a panic attack during the meal. She now knew that, unpleasant as it was, it would go away. She toughed it out and continued to make progress. Near the end of the three month period, she walked into our session and proudly announced that she had a job and was going to work.

Many people with major depression or bipolar disorder avoid social contact because they fear they can’t act appropriately. This avoidance may be prudent at times, but don’t let it get out of hand.

**EATING DISORDERS**

Eating disorders are also associated with mood disorders, occurring much more often in women. If there is a family history of mood disorder, the appearance of an eating disorder is best considered in that context. Of my parents’ nine children and grandchildren, at least three showed anorexia. Anorexia and bulimia were almost unknown in the 1950s. My hunch is that part of the reason for the increase is an enhanced feeling of sexual threat among young women. At an unconscious level, being skinny means no big belly and no baby, and in fact skinniness stops menstruation and the chance for pregnancy. The common explanation for anorexia and bulimia is that girls want to be fashionable, but this deeper explanation bears examination.
PREMENSTRUAL TENSION

Premenstrual tension, known as PMS, also has a fancy psychiatric diagnostic label. PMS refers to anxiety, depression and irritability that occur in the days before the menstrual period and during its first couple days. It occurs more frequently in women with vulnerability to major depression or bipolar disorder and it can be severe.

Many women don’t experience PMS and feminists tend to regard attention to the topic as an effort to denigrate women. However, PMS is real. For me, it was more than a nuisance. Once I recognized what it was, I was able to avoid some of its worst consequences. Luckily, while doing research on the psychology of women, I ran across a paper demonstrating that a high protein diet low in simple carbohydrates (for example, low in pastries, bread, potatoes, rice, bananas) lessened symptoms of PMS. In my own experience, I found this to be the case. The diet involved three regular meals a day with mid-morning and mid-afternoon protein snacks. The idea is to keep blood sugar levels steady. Many people don’t realize that eating sugar and simple carbohydrates raises blood sugar levels that then crash, negatively affecting emotional stability. The high protein/low simple carbohydrate diet helps keep sugar levels and emotions stable. For example, orange juice, a doughnut and coffee is a bad start for the day. This breakfast has lots of sugar, a stimulant and no protein. It’s bad for emotional control and bad for weight management. The high protein/low simple carbohydrate diet doesn’t eliminate the PMS problem, but helps make it manageable. (I got type 2 diabetes when I went off this healthy diet.)
POSTPARTUM DEPRESSION

If you are a woman vulnerable to major depression or bipolar disorder, it’s helpful to know that you’re at heightened risk for postpartum depression. It’s always wise to plan for adequate rest and help after childbirth, but doubly necessary if you’re liable to postpartum depression. There is some evidence that Omega-3 fatty acids can prevent postpartum depression and may also be beneficial for your newborn. It’s thought that the mother’s supply of this vital nutrient may become depleted during pregnancy, which causes postpartum depression. Furthermore it’s thought that an Omega-3 deficiency may predispose the newborn to a mood disorder. Omega-3 fatty acids (fish oils) have been found beneficial in the treatment of major depression and bipolar disorder (see Chapter 8).

Estrogen has a strong antidepressant action and a recent study found it effective in treatment of postpartum depression because estrogen levels may be depleted after childbirth. (However, taking estrogen may affect breastfeeding.) Light is a general antidepressant and Bright Light Therapy has been found useful in the treatment of postpartum depression.

In any case, it’s important for you and your family to understand that your depression doesn’t mean that you don’t want or love your baby. Postpartum depression is a neurophysiological disorder, not an expression of feelings. Sudden weeping spells, called Baby Blues, is different from postpartum depression and goes away in a few days.

MENOPAUSAL DEPRESSION

Menopause is a time of adjustment and discomfort for many women, but women with a genetic vulnerability to major depression or bipolar disorder are at increased risk for depression. Aside from the usual treatments, taking estrogen is also a possibility, but it is rarely prescribed because
of health risks, especially cancer. Nonetheless, I have found it helpful and I’m willing to assume the risk. However, cancer doesn’t run in my family and I no longer have either ovaries or a uterus. Each woman will have to make her own risk/benefit analysis and decision.

**OBESITY**

There are important relationships between major depression/bipolar disorder and obesity, build, diet, and type 2 diabetes. Seasonal neurophysiological changes prompt individuals with major depression/bipolar disorder, especially women, to eat more as winter comes on. Weight gain can lead to type 2 diabetes, and a recent *Lancet* article reported that depression is twice as common in those of us with type 2 diabetes (Moulton et al., 2015).

Moreover, there is a particular type of physique (called pyknic) associated with bipolar disorder. A relatively short, thick build is modestly correlated at a statistically significant level (.30) with bipolar disorder and includes a tendency for fat to collect especially around the middle. The legs are relatively short compared to the trunk, and the length of the lower leg is short compared to the thigh (crural index). Scientists describe this as a cold-adapted build because it retains heat better than a long skinny build. Think of Shakespeare’s character Falstaff. German psychiatrist Ernst Kretschmer, who first observed the link between this kind of physique and bipolar disorder, described Falstaff as typical of the bipolar build. Although the correlation between this kind of physique and bipolar disorder isn’t strong enough to be diagnostic in itself, if you have this type of build, it may be a clue to your heritage.

Researchers studying the effectiveness of Bright Light Therapy showed that it helps obesity. The therapy interrupts signals to the body to fatten up for a winter of food scarcity. Although the treatment is more crucial for women, it’s also helpful to prevent obesity in men. Of
course, exercise is also important to manage weight (and depression), but the whole process of weight management becomes a lot easier when the body isn’t hell bent on gaining weight.

Loren Cordain, author of *The Paleo Answer*, thinks that humans are genetically designed to eat meat, fish, fresh fruits, vegetables and nuts, a diet aligned with that of our hunter-gatherer Paleolithic ancestors (including Neandertal). He also claims that we should not eat dairy, legumes (which includes beans, peanuts, and cashews), potatoes, corn, and whole grains because these foods were not available to hunter-gatherers. Although the Paleo diet is extreme, Cordain says that only an 85% adherence is necessary in order to reap its benefits.

Cordain’s ideas are backed by some research, but they fly in the face of the many diets and recommendations that ban red meat and push whole grains, or that advocate completely vegetarian diets. However, Cordain is on solid ground when he observes that the health risk of saturated fats has been greatly exaggerated.

The Paleo diet may be especially relevant for individuals with bipolar disorder, since it’s suggested that the genes for bipolar disorder developed among the Neandertal during Paleolithic times. As mentioned earlier in discussing premenstrual tension, I’ve found that the best diet for me is a high protein/low carbohydrate diet with three regular meals and two daily protein snacks. I have found that this type of diet is the only one that can keep my weight down and control my type 2 diabetes without using drugs. It’s similar to the Paleo diet, but not as extreme. I eat a little dairy, especially butter, aged cheese, and ice cream as a treat. Hunter-gatherers never maintained flocks of cattle, sheep, or goats; as a consequence they never developed the ability to digest milk-based products, a condition known as lactose intolerance, in which milk products induce stomach cramps and diarrhea. Although I have lactose intolerance, butter and
aged cheese don’t contain lactose and can be enjoyed. I also eat small amounts of other non-Paleo foods.

The simple way to start following a high protein diet is to severely limit the white foods, which include bread, pasta, potatoes, bananas, rice, and anything containing sugar. I have found that by following this type of diet, I can eat a surprising amount of meat, fish, nuts, eggs, aged cheese, fruits and vegetables and not gain weight, or raise my sugar level or my cholesterol reading.

CHAPTER CONCLUSION

Some of these co-occurring illnesses are probably genetically related to major depression and bipolar disorder. In any case, it’s helpful to know what else to expect and what the primary disorder is. On the other hand, some disorders naturally follow from having a serious illness. It’s often not realized that anxiety and some depression symptoms can be simply a reaction to having the illness itself. Everyone understands an individual’s upset, anxiety, and depression when confronted with other major illnesses, but people fail to recognize that a diagnosis of major depression or bipolar disorder can be extremely upsetting for good reason.

Drug and alcohol addictions are probably the most common serious co-occurring conditions. Hard as it may be, addictions must be tackled. Recent favorable changes in health care insurance laws make treatment much more feasible.
Social support is extremely important. We all need to feel accepted and useful. If this is not the case at present, at least we need hope that life will be better in the future. No man or woman is an island; we are social creatures and need a sense of belonging. When we lose out, are slighted, rejected, or fail to meet responsibilities or expectations, our social relationships are damaged, and such experiences tend to depress everyone. They are part and parcel of ordinary depressions, yet these downer experiences inevitably descend more frequently on those of us with a major/bipolar depression or manic episode, and they add another layer of ordinary depression. The sense of exclusion from society is intensified by the stigma attached to mental illness. Not only are those of us with depression or bipolar illnesses and our families not accorded the sympathy and help given to individuals with other illnesses, we tend to be viewed with a jaundiced eye.

To counter this lethal sense of failure and rejection, we need social support from a therapist, family, and friends. Evidence shows that individuals with family support have a much better outcome than those without, and the suicide rate among patients with therapists is greatly reduced. There is nothing like not feeling alone. In his book, *American Psychosis*, psychiatrist E. Fuller Torrey stresses the importance of the therapist and the necessity of continuity of care. Patients benefit from a sense of steadfast support. A monthly fifteen minute medication check is wholly inadequate.

There is a high rate of suicide (20-30%) among individuals with major depressions and bipolar disorder, but I don’t think that suicide is endemic to the disorders themselves. Instead, I think suicide is often secondary to the life damaging negative social consequences of the
illnesses. With regard to suicide, remember that the people who are most likely to commit suicide are those who are impulsive, who feel hopeless, and who have ready means to kill themselves. Substance abuse is also a factor. A simple way to help prevent suicide is to put guns away.

I was greatly helped by a National Alliance for the Mentally Ill (NAMI) support group that ironically I had already been leading at the time of my psychiatric crisis. The members of the group rallied around and I don’t know how I would have managed without them. At that point I was almost totally without family support and had lost nearly all my friends. It was extremely difficult to find support from a qualified therapist because they insisted that I take medications.

NAMI runs many support groups and so does the Depression and Bipolar Support Alliance, and there are also many support groups available for addictions, a problem I luckily escaped. If you’re in a good spot, you may even want to start a support group yourself. The Depression and Bipolar Support Alliance provides training on how to become a group leader. If there is a clubhouse for the mentally ill in your community, that may also be a valuable resource. You may need to shop around for a group that is suitable for you (see Resources).

**A WORD OF SYMPATHY FOR FAMILY AND FRIENDS**

It’s a terrible experience to see a loved one suffer yet not know what to do to help, and financial problems can be acute. It’s really difficult to deal day to day with a depressed/bipolar person. If you’re the spouse, this isn’t the person you married and your partner isn’t holding up his or her end of the deal. However, moods are episodic and this mood will pass. Do you really want to give up on such a special person? Do the best you can, so that if you do have to get out of the relationship, you won’t feel guilty if things don’t work out well. I’ve heard a lot of advice that
the mentally ill person has to hit bottom, but don’t think you need to take that kind of advice. Keep your sense of compassion. There is a big difference between enabling people’s irresponsibility, such as substance abuse, and turning your back on them.

**FAMILY THERAPY**

Support from the family is extremely important for individuals with a mood disorder. However, be sure that family therapy isn’t going to be an occasion for heavy-handed pressure to use drugs and abandon conservative nondrug treatments. NAMI offers excellent family education and support groups, which may be a better option.

**WHAT WE CAN DO FOR OURSELVES**

Depressed and bipolar people need to retain the expectation of positive social relationships. But how can we do that? One of the best pieces of advice I’ve heard was at a meeting of a support group called Recovery. Their advice was, “Be ordinary.” In other words, try to fit in. Curiously enough, dress is extremely important. People make a lot of judgments just looking at how you’re dressed and groomed. Keep it clean and appropriate. In terms of your behavior, when depressed avoid spreading doom and gloom. If you have a substance abuse problem, be especially careful about social gatherings because with alcohol or drugs you may go beyond the pale.

The advice to be ordinary is especially hard for individuals in an upward mood swing because they’re biologically primed to an out-going, attention-getting course. Just be careful. Don’t carry it too far. Don’t talk too much. Don’t interrupt other people. Don’t swear or talk dirty in the wrong places. Don’t do outlandish things. Don’t have the last word. Don’t be afraid
to back down. Be especially careful with policemen and people in authority. If you screw up, apologize, try to make amends, and let people know you will try to do better.

If you’re on the upswing and liable to go overboard, stay home. Even put yourself in dark treatment till you calm down, and watch the substance abuse. A powerful trigger for mania is loss of sleep, especially combined with a sense of emergency. According to Proudfoot et al. (2012), other triggers found to set off mania include falling in love, late night partying, and starting a creative project. The project may seem all important at the time, but in the long run your health, family and friends are more important. In any case, be sure to spend about eight hours sleeping or resting in the dark each night. Simple advice may sound obvious, but I’ve found that remembering good advice is extremely helpful. Here are two more gems: “Don’t take things personally,” and “Don’t jump to conclusions.”

This brings us to an important point: You need to learn about yourself and your illness, especially when you’re going up and when you’re going down and what to do about it. You will doubtless get feedback from family, friends and health care professionals, but you need to learn for yourself. You can and should learn from books, the Internet, and your health care provider. Unfortunately most educational material stresses the value of drugs and the importance of staying on drugs. This is an area where you’ll have to make your own decision, taking into account what you’ve learned here.

In my opinion, a face-to-face peer support group is invaluable. There is no better source of feedback. They’re not professionals, but they know your illness in a way no professional does and they’re much more likely to give you the straight scoop. No one should have to go through a major depression or bipolar disorder alone.
CHAPTER 7

EVIDENCE-BASED PSYCHOTHERAPIES

Because of the serious side effects of antidepressant drugs and the lack of evidence supporting their effectiveness, government-sponsored best practice standards in the United States and Great Britain now advise that depressed individuals first try certain psychotherapies found effective. If patients are already taking antidepressants, it’s recommended that they also receive psychotherapy. These recommendations have largely ignored chronotherapies. It’s hoped that in the future they will include Bright Light Therapy, Triple Chronotherapy, and the Ben Franklin Routine as first-line treatments for major/bipolar depressions.

While it’s refreshing that nondrug treatments are being recommended, there are problems with the research supporting the efficacy of these psychotherapies. The research implies that they are effective for all depressions, but is this true? Some of the measures of depression that researchers used to demonstrate therapeutic effectiveness didn’t even include two of the most serious symptoms of major/bipolar depression: poor concentration and slowing. (This is true of the depression test in Burns’s book, *Feeling Good.*)

Investigators have failed to differentiate between types of depression. For example, melancholia, a type of depression correlated with bipolar disorder, is characterized by slowed action and thought, poor concentration, and severe problems with sleep and appetite. It’s more of a shut-down than sadness, an emotion that is often missing. However, because melancholic depression is lumped with other depressions, it’s not possible to know from research studies if psychotherapy helps bipolar melancholic depression or if it really only helps other depressions. Many experts agree that DSM-V should be revised to include melancholia as a clearly separate
diagnosis. In this way future research can better establish the effectiveness of treatments for severe depressions, such as melancholia.

A second major problem is that, despite clear evidence of the effects of light on human mood, there has been a failure to control for light exposure. From a scientific point of view, this is a gaping error. Psychotherapy goes on for months. Patients may feel better because spring arrived, rather than as a result of psychotherapy. (This criticism was also made of the research on the efficacy of antidepressant drugs.)

Reviewing the evidence as a whole, I’m doubtful that psychotherapies are effective as a sole treatment for major/bipolar depressions or melancholia, but the evidence supports the view that they are effective at least for many depressions.

**ACCEPTED PSYCHOTHERAPIES**

The two types of psychotherapy that have found acceptance as effective in the treatment of depression are Interpersonal Therapy (IPT) and Cognitive Behavioral Therapy (CBT). A third, Mindfulness Based Cognitive Therapy (MBCT) is said to prevent reoccurrence of depression. IPT concentrates on improving relationships with other people. It’s a short-term therapy conducted from a manual. CBT has a different focus. In his book, *Feeling Good*, which sold four million copies, Dr. David D. Burns states that the first principle of cognitive therapy is that your moods are created by your “cognitions” or thoughts, which includes how you interpret things. According to CBT, you feel the way you do because of your thoughts. CBT teaches you to recognize and correct irrational depressive thoughts.

The idea that depression is created by our own thoughts is counter factual when applied to major/bipolar depressions, which have a genetic basis. There is solid scientific evidence that
some depressions are caused by light deprivation and seasonal drops in ambient light. These depressions are logically treated by Bright Light Therapy, not psychotherapy.

While it’s true that what you think can be depressing, it’s also true that what you think is affected by the physiological state of your brain. Here is a commonplace example: When you’re drunk, you don’t think and act the same as when you’re sober. People become drunk when they drink too much alcohol. In a similar way mood swings are influenced by chemical changes in the brain, despite the fact that these changes aren’t obvious. Unlike the case of the drunk, for example, without psychoeducation neither individuals with bipolar disorder (nor their family and friends) have any idea that a seasonal change in light has triggered depressive behaviors.

Granted, depression can be made worse by dwelling on irrational depressive thoughts. However, for those of us well acquainted with major/bipolar depression, the CBT viewpoint, suggesting that depression is caused only by faulty thinking, is inaccurate and fails to validate our experience of depression.

CBT is of doubtful immediate value for patients in the throes of severe depression because of the overwhelming amount of required written homework. Unable to concentrate well enough to do the homework, patients may become discouraged and hopeless. However, CBT may be useful when patients are well enough to engage effectively with it. By this time, weeks of dysfunction with a stigmatizing illness may have undermined self-confidence and self-esteem, feelings appropriately addressed by psychotherapy.

Depression is much more common than mania, and most psychotherapies have concentrated on depression. However, the problem of elevated mood swings is beginning to receive more attention as a focus of behavioral forms of psychotherapy.
PSYCHOTHERAPY ESSENTIALS FOR MAJOR DEPRESSION/BIPOLAR DISORDER

Mood disorders are expensive, debilitating and hard to treat. Psychotherapies are a valuable component of their successful management. Here are the essential elements of mood disorder psychotherapeutic treatment:

- Sustain hope.
- Provide an enhanced sense of security.
- Give accurate information.
- Increase patients’ self-knowledge about when they’re swinging up or down.
- Teach patients how to cope with mood swings and support their efforts.
- Help patients identify and correct mood-distorted thinking and accurately assess reality.
- Improve patients’ emotional control of anger, hostility, and violence.
- Emphasize keeping a regular schedule of eating and sleeping (in the dark), with planned activities every day, including at least one pleasant activity.
- Of course from my point of view, any treatment program should include early morning Bright Light Therapy for depression and the Ben Franklin Routine.

SUSTAINING HOPE

All psychotherapies should sustain hope because hopelessness is one of the antecedents of suicide. A recent major idea in psychiatry is the kindling theory which holds that, like epilepsy, the more episodes of depression or mania a person has, the more they’ll have in the future. Upon hearing this news, a bipolar friend called me, suicidal. Fortunately I was able to reassure her that this theory is incorrect and unsupported by evidence.
PROVIDING A SENSE OF ENHANCED SECURITY

During an episode of severe illness, you need your therapist to provide a positive relationship that is calming and gives you emotional support. This is not the time for a therapist to fish for early-life traumas. Your therapist needs to be supportive, flexible, and practical. You may need advice or referral for difficulties such as substance abuse, legal, or financial problems. The therapist’s role in treating patients with severe mood disorders is different from that of the psychoanalyst or psychodynamic therapist.

In order to promote a sense of security, it’s important that you have continuity of care. You should be seen weekly long term or more often if you’re suicidal, and the therapist should be available for phone calls. A reliable link to the therapist is not only humane, but it’s also likely to be cost effective by preventing expensive suicide attempts and hospitalizations. However, remember: If your therapist isn’t available, it’s not the end of the world; you can call a crisis line.

ACCURATE INFORMATION

You need accurate information about what to expect from the therapist, especially with regard to confidentiality, accessibility, and financial arrangements. Therapists need to be upfront. You need straight information regarding treatment options, and the opportunity to decide for yourself. Incomplete or misleading information because of a doctor-knows-best attitude is disrespectful as well as a betrayal of trust. The biggest problem in this regard is not the psychotherapist per se, but health care providers who don’t provide full information about drug side effects, or who deny that you have side effects because they think you should stay on the drug. Seek reliable
information on your own. Trust but verify. Use the Internet, a pharmacist, or a reference librarian to get more extensive, accurate information.

**KNOWLEDGE ABOUT MOOD SWINGS AND HOW TO COPE**

Psychoeducation is an essential part of the management of severe mood disorders. You need to know about the effects of seasonal light changes, that light deprivation facilitates depression, and that sleep deprivation may trigger mania. You need to stabilize the biological clock by rest or sleep in the dark for about eight hours each night. If depressed, you need to know that in the future you may be subject to an episode of mania. If you have hypomanic or manic mood swings, you need to recognize when your mood rises: you talk too much, speed, gamble, overspend, go overboard sexually. When you’re getting high, you can choose to drop the level of stimulation. You can try to stop a manic episode with Dark Therapy: spending up to fourteen hours in darkness. This choice is a whole lot better than being in trouble and possibly locked up.

In your search for information, don’t forget your pharmacist, and check out the Resources section in this book. Talk to the reference librarians at your local library or state medical school library. If you need a book or article not at your local library, they may be able to get it for you. If you need help searching the web for information, or if you don’t have a computer, they can help you. Libraries have become hangouts for the mentally ill, so be sure to be on your best behavior. Most libraries now have security personnel; be careful.

**CORRECTING MOOD-DISTORTED THINKING**

If depressed, it’s important to learn about your negative thinking: how you’re putting yourself down and viewing the world in a negative light. Depressed thinking can become habitual.
Exaggerated negative thinking is unrealistic and undermines positive actions and hope. Moreover, sour puss attitudes are socially unattractive. For individuals in a high mood, it’s equally important to realize that your thinking may be distorted in an unrealistic positive direction. Self-confidence is good; grandiosity is a recipe for disaster.

**EMOTIONAL CONTROL OF ANGER AND VIOLENCE**

The jails and prisons are full of mentally ill people, mostly men. Control of anger and violence is vitally important. Mental illness is stigmatized and someone labeled mentally ill doesn’t necessarily get the benefit of a doubt. However, not even “respectable” white women are free from excessive coercive police action.

Linda was a white bipolar professional woman with school-age children whose husband left her so he could live with another woman. Linda needed help with the children, but her husband wouldn’t answer the phone so she went to his apartment and knocked on the door. When he didn’t respond, she pounded on the door, yelling at him. She wasn’t psychotic; she had no weapon and made no threats, but her husband called the police. Instead of immediately obeying the police order to quietly leave, Linda argued with them. They handcuffed her, sent her to a locked ward, and she had to pay for the ambulance.

**SCHEDULING**

Experts agree that the biological clock is unstable in mood disorders and that keeping a regular schedule of eating, sleeping and activities helps stabilize the clock. Considerable research was done by Dr. Ellen Frank on Social Zeitgeber Therapy (or Social Rhythm Therapy). A zeitgeber is a cue that helps to set and regulate the biological clock. The therapy stabilizes the biological
clock by using a set schedule. It isn’t effective as a sole treatment, but it’s been found helpful. Keeping busy also helps override hibernation-like tendencies of slowing and inactivity.

Unfortunately the Social Zeitgeber Therapy failed to use the most powerful zeitgebers: seasonal early morning Bright Light Therapy and several hours of complete darkness in rest or sleep during the night. It’s likely that inclusion of these powerful zeitgebers would have greatly boosted the effectiveness of the intervention. The treatment of depression isn’t just a matter of stabilizing the clock. In the case of depressions influenced by light deprivation, it’s a matter of fooling the body that it’s not winter. Exposure to early morning bright light typical of a summer sunrise tends to do the trick, averting the slowdown we call depression.

However, scheduling is definitely helpful, and the scheduling for each day should involve a plan of what’s to be done, even on an hourly basis. Left to our own devices, the depressed person is likely to lie around, do nothing, and think morbid thoughts. Each daily plan should include something fun, something pleasant that involves social interaction, if possible. The more dysfunctional you are, the more detailed the schedule needs to be. Scheduling helps you get done what needs to be done, like keeping appointments and being on time, having dental care, paying bills and taxes. Meeting your responsibilities to yourself and others helps reduce the negative consequences of depressive dysfunction. Set times for going to sleep and getting up also help, because sleeping too much facilitates depression, while sleep deprivation may trigger mania. A schedule, however, should only be a guide to be kept as well as possible. It should not be something to be slavishly adhered to for its own sake, nor a focus for self-blame.
MINDFULNESS

Mindfulness is a popular new psychotherapy with implications for the treatment of depression. It has its roots in Buddha’s idea, dating to the 5th century B.C.E., that suffering is lessened by emotional detachment. The mindfulness movement has three main parts: 1) meditation that leads to a transcendent, blissful state; 2) an emphasis on love and compassion, including self-compassion, and 3) mindfulness teachings that develop focus and a kind of Teflon mind that detaches thoughts from excessive emotion. Mindfulness teaches you to become more aware of your thoughts, feelings, and bodily sensations, and to relate to them differently. You’re encouraged to view thoughts and feelings as passing events in the mind, rather than to take them seriously as accurate representations of reality. A possible side-effect of meditation practices is an absorption in these procedures to the neglect of the practical aspects of life.

My own introduction to meditation began in the 1980s with Dr. Herbert Benson’s book, *The Relaxation Response*. The book was recommended by a former therapist, the late Dr. Paul Meehl, Regents Professor of Psychology at the University of Minnesota. He mastered this technique in two weeks simply by reading the book, and I challenged myself to do the same.

Benson was intrigued by the meditation feats of Tibetan monks and undertook a study of their practices. His research suggested that meditation is valuable as a method of stress reduction, and he refined meditation to its scientifically necessary and nonreligious core. Some may enjoy the accoutrements and rituals of elaborate teachings, gurus and mantras, but Benson stripped all this away, leaving a surprisingly simple, easy procedure—once you know what it is. He labeled meditation as the Relaxation Response and characterized it as a state of unusual well-being and bliss. I followed the directions and I too was soon experiencing my own delightful state of bliss.
The procedure involves two twenty-minute sessions a day (not more). Lie in a quiet darkened room with the eyes closed and clothing loosened at the waist. Breathe in slowly in such a way that the belly rises, meanwhile repeating a phrase to yourself as you exhale, the same phrase every time. That’s it. You’ll have trouble just focusing on your breathing and the phrase, but bring your mind back to the task each time it wanders. Gradually you’ll get better at it. The Relaxation Response is basically the same as Transcendental Meditation and some practices of mindfulness, but framed in a much simpler way.

The Relaxation Response is useful to treat stress-related health problems. I found it improved concentration and reduced anxiety and excessive emotionality. It helped me relax to get to sleep and was useful in alleviating pain. After I became proficient, I was able to put myself in a relaxation state, sitting up, eyes open, which was useful in boring meetings. Neither this type of meditation nor the emphasis on loving and compassion are directly relevant to treatment of major/bipolar depression, but they’re helpful for the stress and anxiety which everyone experiences.

The book, *The Mindful Way through Depression: Freeing Yourself from Chronic Unhappiness*, by Mark Williams, John Teasdale, Zindel Segal and Jon-Kabat Zinn, claims their therapy relieves depression. However, as with other psychotherapies, research studies of the effectiveness of mindfulness-based cognitive therapy (MBCT) didn’t control for light exposure; the studies don’t separate melancholic bipolar depressions from other depressions, and MBCT also has the incorrect idea that only thoughts cause depression. But, to their credit, Williams and his colleagues caution people not to start the MCBT program if they’re in a “clinical” depression. They recognize that the concentration and homework required by MCBT are beyond the capacity of someone in a deep depression.
Although research suggests that MCBT helps prevent the occurrence of future episodes of depression in individuals who have already experienced three or more previous episodes of depression, the results didn’t demonstrate a statistically significant effect at the usual level of scientific acceptance.

**DIALECTICAL BEHAVIOR THERAPY (DBT)**

Dialectical behavior therapy (DBT) was developed by Marsha Linehan as the first ever successful treatment of borderline personality disorder. (This condition involves self-harming and extreme, unpredictable shifts of emotion.) Linehan developed DBT because CBT annoyed these patients, and they either refused to do the exercises or left therapy. DBT combines cognitive behavior therapy with the calming, mindfulness-acceptance techniques from Buddhism. It should be noted that Linehan allows her patients to call her when they need help, which may partly account for the therapy’s success. Kudos to Linehan.

CBT concentrates on correcting negative self-messages (irrational thoughts) while mindfulness-acceptance therapy aims to create some distance between a problematic situation and reaction. It strives to create a habit of thinking and reaction that realistically recognizes a negative situation, without overly engaging an emotional response. “Acceptance” means acknowledging reality calmly and factually, while “compassion” typically means compassion to the self, but in the context of a generally benign non-judgmental attitude toward other people. DBT’s emphasis on enhancing control of emotions may make it of special value for individuals with bipolar disorder, though its usefulness for this group has yet to be explored.
CHAPTER CONCLUSION

Efforts by NIMH to move toward evidence-based treatments have been hindered by lack of clearly defined depressive diagnoses and failure to control for light exposure in psychotherapy clinical trials. As a result, the evidence supporting the value of IPT and CBT is not convincing.

In my opinion, the bottom line is that to prevent or treat an episode of serious major/bipolar depression, Bright Light Therapy is more likely to be a safe, effective treatment than drugs or psychotherapy. If you need quick relief from a suicidal depression requiring hospitalization, Triple Chronotherapy is your best bet for a quick, safe treatment. In order to prevent mood swings, the Ben Franklin Routine should be a regular part of your life, but more research is needed.

However, you shouldn’t be alone going through this experience. I agree with Dr. E. Fuller Torrey that all mentally ill individuals should have at least weekly contact with the same mental health professional on an indefinite basis (with provision for emergency contact). Continuity of care is essential.

Although I’m skeptical about the effectiveness of psychotherapy as a sole treatment for an acute episode of major/bipolar depression, IPT, CBT, and MCBT are useful when the worst is over. CBT is effective in ridding individuals of habits of negative thinking, a guaranteed gloom producer. Mindfulness therapies improve mental focus, reduce stress, and may help prevent further depressive episodes.

Individuals in a psychotic manic episode aren’t amenable to psychotherapy. However, when they calm down, psychotherapies that provide psychoeducation and increased emotional control can make valuable contributions to management of severe mood swings.
CHAPTER 8

OTHER INTERVENTIONS

Did you ever think of coffee as an anti-depressant? Well, it is. How about exercise? This is another proven antidepressant. Estrogen is effective for women’s depressions when there is a deficiency, but it’s rarely used because of health concerns. Omega-3 fatty acids is a newer intervention and there is evidence of its effectiveness in preventing and treating major/bipolar depression, postpartum depression and mood swings. Research is needed to establish it as a first-line treatment recommendation. Electroconvulsive therapy, a scary but effective treatment, has a new cousin, transmagnetic cranial stimulation. Finally, we’ll discuss a few other treatments of interest and the problem of quack therapies.

CAFFEINE

Caffeine is probably the world’s most common and cheap antidepressant: Tea for the Brits; coffee for the Swedes. Caffeine is such a part of our lives that we don’t think of it as a drug, but it has medicinal antidepressant effects. The suicide rate among coffee drinkers is half that of non-coffee drinkers, according to a 2013 Harvard study published in *The World Journal of Biological Psychiatry*. Coffee enhances production of antidepressant neurotransmitters in the brain including serotonin, dopamine, and noradrenaline. However, the antidepressant effect doesn’t increase with more than two or three cups of coffee a day, and more coffee brings other problems such as jitters and stomach upset. Presumably equivalent caffeine drinks would have similar beneficial effects, but watch out for the new “super-caffeine” high-energy drinks.
EXERCISE

Exercise is now scientifically established as an antidepressant (Rethorst, Wipfli & Parker, 2009; Stanton & Happell, 2014.) Exercise is great for health, weight control, and depression. The problem is to get people to do it. I began regular exercise because of overweight and diabetes, but it was hard. A bipolar friend gave me this advice: Start your day with the thing that is hardest to do. What wonderful advice. I started doing my stretches before I got out of bed and gave exercise my first morning priority, no ifs, ands, or buts. Between psychiatric drugs and the fact that I had stopped my high protein/low carbohydrate diet, I put on weight which led to diabetes. I spent a summer losing forty pounds by walking 45 minutes a day and staying on a high protein/low carbohydrate diet. Exercise and diet allow me to control my diabetes without drugs.

In order to exercise, it’s not necessary to join a gym that you don’t go to, or buy a bike you don’t use, and you don’t have to run. Walking is fine and there are plenty of home exercise programs. My physicians insisted that I get a trainer because of the neurological disorder and I finally settled on Pilates. I do specialized exercises for various maladies and walk or use a stationary bike for a total of an hour exercise a day. However, you probably don’t need that much exercise for a therapeutic effect. If you become hypomanic or manic, be careful not to overdo exercise. People have died from a non-stop, no-need-for-food routine. Moreover, women shouldn’t lose too much weight because it can damage their ability ever to have children.

ESTROGEN

Estrogen is an effective antidepressant for women with estrogen deficiency, typically at menopause or possibly in the case of a postpartum depression. However, estrogen is now rarely prescribed for its antidepressant action because of health risks, especially cancer. For women
whose uterus and ovaries have been removed and without a family history of breast cancer, estrogen treatment may be a viable option. I am in a low-risk cancer group and have taken 1 mg. of estradiol every day for many years.

**OMEGA-3 FATTY ACIDS**

Omega-3 is the name of a type of fat that has been shown to have considerable value for many maladies, especially heart health, but also for depression and bipolar disorder. As mentioned earlier, a recent study showed that Omega-3 has promise in preventing postpartum depression, which occurs more frequently in women with a history of major depression or bipolar disorder. Advocates of Omega-3 fatty acids point out that we contemporary humans don’t get nearly as much Omega-3 from our ordinary diets as we did in our evolutionary past. They suggest that we suffer from a Omega-3 deficiency that may even be passed down from mother to child.

In 2001 Harvard psychiatrist Dr. Andrew L. Stoll published *The Omega-3 Connection*, showing that Omega-3 alone, without psychiatric drugs, resulted in significant improvement for bipolar patients. The next year Dr. Barry Sears published *The Omega Rx Zone* that agreed with Stoll about the value of Omega-3 for depression and other problems. Since then numerous studies have confirmed the value of Omega-3 for the treatment of mood disorders, but the studies have used Omega-3 of varying formulations and in addition to “treatment as usual” drug therapies, which makes the results hard to evaluate.

There is need for better research. Given the adverse side effects of psychiatric drugs, it’s possible that Omega-3 alone would show more benefit than when used with “as usual” psychiatric drugs. There’s also a problem about the formulation of the Omega-3 fatty acids used in the studies. Both Stoll and Sears provide complex discussions on this point. There are two
Omega-3 fatty acids, EPA and DHA, and, according to them, the ratio of these two must be correct in order to get a therapeutic result. Most of the studies, however, don’t address the question of the formulation.

After reading Stoll’s book, I started using Omega-Brite, the formulation of Omega-3 fatty acids that Stoll used in his original study. I was euthymic (normal mood) at the time, but I was made miserable with side effects, poor memory and anxiety. I noticed a definite increase in a sense of well-being and I have taken a gram or more of Omega-Brite every day since. I tried other Omega-3 formulations, but got a fishy taste. In the end I decided to pay the extra money and stick to a formulation that had been demonstrated to be effective for mood disorders. (I have no financial connection with the company.)

The largest natural sources of Omega-3 are fishes, such as salmon, tuna, white fish, mackerel, and sardines. However, obtaining therapeutic levels of Omega-3 from fishes is impossible because of the large amount of fish you’d have to eat and the fact that many fish are contaminated with mercury. In fact, women pregnant or planning to get pregnant are warned about fish consumption because of mercury contamination. (The capsule forms of Omega-3 can be refined to eliminate the mercury.)

**ELECTROCONVULSIVE THERAPY (ECT)**

This is an unpopular, invasive treatment. It is effective, though with potential side effects. In its 2012 *Clinical Practices Guidelines*, the American Psychiatric Association recommended ECT for patients with moderate to severe symptoms who haven’t responded to antidepressants or psychotherapy. During ECT electric currents are passed through the brain, inducing a brief seizure. ECT seems to cause changes in brain chemistry that often reverse symptoms of severe
depression or mania within a relatively short time. ECT is safer today than it used to be, but the procedure is stigmatized and feared. It causes short-term confusion and memory loss, and sometimes patients never quite get all their memory back.

TRANSCRANIAL MAGNETIC STIMULATION (TMS)

This is a new treatment that has been FDA approved, but it’s not completely established as an effective treatment for depression. Nonetheless, recently there was a full page ad for this treatment in my Sunday newspaper. It’s being used when patients don’t respond to antidepressants. Transcranial magnetic stimulation of the brain (TMS) is similar to ECT in that it works by producing an electric current in the brain. However, with TMS the patient remains conscious and is treated in an outpatient setting. Highly focused magnetic pulses induce an electrical current two to three centimeters deep in the left prefrontal section of the cerebral cortex, which is thought to alter brain chemistry. Treatments typically occur five days a week for four to six weeks. They’re expensive and often not covered by insurance. Among the possible side effects of the treatment is grand mal seizure.

OTHER INTERVENTIONS

Negative ion therapy is a new treatment suggested by Terman and McMahan (2012), but I haven’t seen much research on it. St. John’s Wort is an herb with some antidepressant qualities that hasn’t been shown to be effective. Melatonin also hasn’t been found effective as an antidepressant. Likewise, the effectiveness of acupuncture in the treatment of mood disorders has yet to be demonstrated.
MARIJUANA

Marijuana has been called the poor man’s lithium, but evidence of its effectiveness will have to wait until the present restrictions on research are lifted. The dangers of using marijuana are hard to evaluate because the issue is so politicized, but so far as I can tell heavy use is unwise, especially during adolescence. Major reported adverse effects are a lack of motivation, popularly known as being a “pot head,” and an increased tendency to develop psychosis.

QUACK TREATMENTS

When conventional medical treatments aren’t effective, people often turn to alternatives, but these can also not only waste your time and money and delay effective treatment, they can be positively harmful. Mentally ill individuals are easy prey for unscrupulous or unethical professionals. Here are some examples from my own experience.

One of the well-known side effects of lithium is muscle pain. Nonetheless, both my psychiatrist and my internist overlooked or wouldn’t acknowledge this possibility. Instead, my problem was diagnosed as myalgia, which is just a fancy name for muscle pain. As a result, after about two years on lithium, I suffered from continual muscle pain for years and wasted time and money on massage, physical therapy, and seeing a chiropractor. It was the latter that landed me in big-time trouble. (The pains went entirely away after I quit lithium.)

The chiropractor was highly respected and attentive, but of course she was unsuccessful in alleviating my muscle pain since it was due to lithium. However, she had a couple money-making scams going for her. She had a phony apparatus that was supposed to detect food allergies, and she also made money by using the results of a legitimate blood test to make a phony diagnosis of vitamin deficiencies so she could sell supplements. She was the source of the
mega doses of vitamin B6 that made me ill, but redress for her unethical behavior was difficult. By the time I realized what had happened, I was too sick to deal with the stress of complaining to authorities or mounting a law suit.

Here is another example: In my search for nondrug treatments after my psychiatric crisis, and at the recommendation of a mental health counselor, I went to an acupuncturist, a man with an excellent local reputation. He claimed that instead of bipolar disorder, I had mercury poisoning. He made this diagnosis on the basis of a questionable hair test. He wanted to give me chelation therapy, a lengthy, expensive procedure involving injections of a chelating agent. I was doubtful of this plan and sought confirmation of my supposed mercury poisoning from traditional medicine. Careful medical testing showed that I didn’t have mercury poisoning.

This same man also recommended that I have transcranial magnetic stimulation therapy for depression, using a machine he had just purchased, the latest thing. This was years before this therapy received FDA approval, and I wasn’t even depressed at the time. When I pointed out that I wasn’t depressed, he replied, undeterred, that it might do me good anyway. Be careful. Try not to get taken in. Alternative approaches may be a scam.

**CHAPTER CONCLUSION**

Everyone knows that caffeine “picks you up,” but we don’t think of caffeine as an antidepressant, probably because we think of depression as being sad rather than deactivated. Exercise is another cheap, safe, easily available antidepressant. Estrogen is effective, but with possible adverse physical effects. The effectiveness of Omega-3 fatty acids remains to be firmly established. ECT, while effective, is invasive and risks some memory loss. The effectiveness of its cousin, TMS is unclear.
CHAPTER 9

REVOLUTIONARY NEW THEORY: CONNECTING THE DOTS

What good is a theory? Theory helps us make sense of known facts. In the case of bipolar disorder, the theory of the evolutionary origin of bipolar disorder makes the illness less scary and crazy, and it explains how it works so that it can be better managed. It gives us confidence in light mood-management methods that are safe, cheap, and quick, and it helps us avoid methods that won’t work, waste our time and money, or worst of all—damage our health. A good theory also helps direct research into fruitful areas that yield useful results.

But what does theory have to do with science? Ever hear of Einstein’s theory? Theory is extremely important in science. It’s a way to boot-strap our way to the truth. Americans became familiar with the importance of connecting the dots when intelligence analysts failed to put two and two together to prevent the 9/11 terrorist attack. Lots of information isn’t useful unless its significance is understood. Let’s try to remedy that situation in the case of bipolar disorder. Let’s see if we can put the dots together so that the disorder makes sense. What we’ll do is look at the facts and try to put them together into a logical theory. Then we’ll use logic again to make predictions from the theory. Each time a prediction is confirmed (or a fact consistent with the theory is uncovered) we can be a little more certain that we are on the right track. In this chapter we will examine the facts and how they can be put together to form a new understanding of bipolar disorder. (When a finding occurs that is consistent with the theory, I’ll mark it ***.)

Briefly the EOBD-R theory hypothesizes that bipolar disorder evolved in the northern temperate zone in response to the selective pressures of severe Ice Age winters and that the genes for this disorder descend to us from Neandertal, a people who survived there for thousands of
years. Depression developed as a winter slowdown (hibernation-like response), while hypomania was adaptive as an out-going, speeded state that helped make up for time lost during the winter slowdown. It ensured that tasks necessary for group survival, such as gathering food, mating, and travel, could be accomplished during the short summers. The manic state seems to have evolved as an emergency response.

My first article, entitled, “Evolutionary Origin of Bipolar Disorder (EOBD),” was published in 2001 in *Psycoloquy*, an online journal published by Cambridge and Princeton Universities in cooperation with the American Psychological Association. A revised version of the theory (EOBD-R) was published in 2012 in *Medical Hypotheses*. Google the first article and you’ll find it in full on the Internet. I wasn’t able to arrange this kind of availability for the second article; only an abstract is available for free on the Internet. For a full copy, you need to pay or get it from a library.

**FACTS THE THEORY MUST EXPLAIN**

A valid scientific theory must explain all known facts, yet it must not be contradicted by any known fact. The EOBD-R theory meets these standards. In addition, as research uncovered more facts, these were also in line with the EOBD-R theory, further confirming the theory’s validity.

The facts I started with came from Goodwin and Jamison’s book *Manic-Depressive Illness*. Aside from the symptoms, which have been described since antiquity, the only accepted facts at that time (1990) were that the disorder is genetic, comes in episodes, and has a worldwide incidence of 1% for Bipolar I disorder and 5% including all types of bipolar disorder.

However, there was one additional fact that Goodwin and Jamison didn’t mention: Dr. Ernst Kretschmer demonstrated that individuals with bipolar disorder have a different physique
from those either without the illness or with schizophrenia. He described the bipolar physique as compact with the legs relatively short compared to a broad trunk, with fat accumulating around the middle in later years. He called this build a pyknic physique. In contrast, the typical build associated with schizophrenia tends to be linear with comparatively long legs.

Doubtless the reason Goodwin and Jamison didn’t include this fact in their book is that the research on Kretschmer’s work dates from the first half of the 20th century and his ideas had fallen out of favor. However, I remembered this research from the 1950s when I was a graduate student reading statistician Anne Anastasi’s review of the many studies testing Kretschmer’s findings. Hans Eysenck, an eminent statistician who immigrated to England as the Nazis came to power, also reviewed the evidence. Eventually they both agreed that Kretschmer’s observation is correct and valid. Anastasi concluded that there is a statistically significant correlation of about .30 between bipolar disorder and the pyknic physique. This correlation is of theoretical significance as a clue to the origin of the genetic vulnerability for bipolar disorder. However, the correlation isn’t high enough to be predictive. Today, many a six-footer has bipolar disorder.

Because of the importance of this finding to the development of the EOBD-R theory, I carefully reviewed the considerable amount of evidence on the topic and satisfied myself that their conclusion is correct. This difference in physique was confirmed once again in a recent Hungarian study. *** What does this mean? Why would people with bipolar disorder tend to have this kind of build? How is it to be explained?

As it happened, while I was on an archaeological tour of Ireland I visited the museum of natural history in Dublin. Still puzzling about these questions, I asked the curator what kind of people might have a thick trunk with relatively short legs. “Neandertal,” he said. Bingo.
The origin of bipolar disorder began to make sense. A compact build with relatively short legs is an adaptation to an extremely cold climate, a fact that wasn’t known in Kretschmer’s time. This kind of build tends to conserve heat while a linear form dissipates heat. (Think curling up versus stretching out.) If bipolar disorder is associated with a cold-adapted build, vulnerability genes for the disorder might have come from Neandertal, who developed bipolar behaviors as climatic adaptations. Neandertals (and their ancestors) are known to have lived a sufficient amount of time under the kind of extreme, primitive conditions that could have evolved these adaptations. Could bipolar disorder be a behavioral fossil from prehistoric times? Could bipolar vulnerability genes come from Neandertal?

This was a possibility. Many paleoanthropologists who carefully studied fossil remains found ample evidence of Neandertal characteristics in modern people. They were convinced that we carry Neandertal genes. Other paleoanthropologists vehemently disagreed that genes from Neandertal could be part of our heritage.

As I studied the facts, these ideas coalesced into a theory as more evidence became available. For example, major depression resembles hibernation behavior; less light depresses mood and more light elevates mood; episodes of depression are more common in northern latitudes during wintry months while hypomania is more common in the summer. Researchers experimentally demonstrated that bright light alleviates depression while absence of light produces depression. These conclusions are based on large amounts of research, which is detailed in Sherman (2001). The puzzle was fitting together.

The symptoms of depression and hypomania have many similarities to the behaviors of hibernating animals, a fact noted by many observers. Bears, for example, gorge during the late summer and fall and then go off to hibernate for the winter. Similarly, many people subject
to depression begin eating more as winter comes on; they find it harder and harder to get up, and they lose their gitty-up and go. They just don’t feel like doing anything. We call this depression, but it’s a slowdown different from ordinary depression.

At the other end of the spectrum, hypomania also fits with the behavior of hibernating animals. Extreme hypomanic behavior is called “squirrely” or “nutty” because it reminds people of squirrels frantically storing away nuts. However, unlike bears and squirrels we humans don’t actually hibernate nor did Neandertal.

Neandertals survived during the Ice Ages even though they didn’t know how to make clothing to protect themselves from cold, as do the modern-day Inuit in Alaska. Neandertals had knowledge of the controlled use of fire, but there is debate about the extent of this knowledge. In any case, their ancestors didn’t have such knowledge, and paleoanthropologists have puzzled how they managed to survive so far north. Under the circumstances, it isn’t unreasonable to suppose that these peoples evolved seasonal behavioral adaptations. Since vulnerability to bipolar disorder is genetic, the genes had to come from somewhere. Why not from Neandertal?

But some symptoms puzzled me. What was adaptive about social withdrawal, loss of sexual interest, lack of concentration, paralysis of the will? Then I realized that these symptoms help the shut-down, deactivation process. People holed up together in a small area needed to be deactivated or else they would get into conflict with each other. Withdrawal and lack of sexual interest would help prevent social conflict. Lack of concentration and paralysis of the will helped guarantee deactivation.

However, there was another problem. How could a people survive depressed like this for months in the winter? Of course, as is the case with hibernating animals, the intensity of the slowdown would depend on conditions. People might bestir themselves on a sunny day. Men
would be less depressed than women, but what if there was an emergency? Then I realized the role of what was called the switch response, a bipolar phenomenon that had puzzled and confounded clinicians. The switch response is the ability of individuals with bipolar disorder to switch spontaneously out of a profound depression even to mania within hours, an amazing thing to observe. Then it hit me: Mania evolved as an emergency response. This is logical when you think about the symptoms of mania. During mania, individuals can think and act faster than usual and they can go without felt need for food or sleep. They have superhuman strength. These are characteristics adapted for emergencies.

At the time I was thinking about this, I was involved in an email correspondence with Dr. Tom Wehr at NIMH, and I was gratified to learn that he had also arrived at the conclusion that mania is an emergency response, but by a different line of reasoning. Researchers at NIMH had observed that when bipolar depressed patients are deprived of sleep, they come out of their depressions. Wehr concluded that this remission of depression is hard-wired to sleep loss and is an emergency response, since during emergencies people reliably lose sleep. The fact that sleep loss quickly reverses depression is now being used with Bright Light Therapy as part of Triple Chronotherapy, which reverses even severe depressions within a few days up to a couple of weeks (Chapter 3).

I kept checking out the theory. I even took a course in physical anthropology to learn more about Neandertal. Just about the time when I thought I had everything figured out, what was called the Out of Africa theory became public and dominated the scientific news. New evidence suggested that all of us descended from a gal named Eve in Africa and Neandertal wasn’t part of our heritage. The evidence wasn’t based on our entire DNA, just the part called mitochondrial DNA, but it convinced most commentators. In any case, I couldn’t publish a paper
claiming that the genes for bipolar disorder descended from Neandertal, so I had to leave out that part in the first paper published in 2001.

NEW FACTS SUPPORT THE EOBD-R THEORY

As I was preparing the first theoretical publication, Dr. Daniel Wilson published a paper showing that bipolar disorder has the medical epidemiology of an adaptation: Bipolar disorder is too common to be the result of an aberrant gene here or there. I was elated. His paper provided independent confirmation of my view that bipolar disorder evolved as an adaptation. ***

Over the next few years, more and more evidence came out supporting the theory and none contradicted it. Then in a 2010 article in Science magazine, Svante Pääbo and his team at the Max Planck Institute published their findings that all of us outside Africa have 1-4 % Neandertal genes. Which genes we have varies regionally and from person to person. The Out of Africa theory was replaced. This new information supports the EOBD-R theory, and the percentage of people having Neandertal genes is consistent with the incidence of bipolar disorder. *** The EOBD-R line of reasoning was vindicated.

When I prepared the revised second article, I included more facts supporting the theory. For example, the theory helps explain why depression is about three times more common among women than men,*** This is because, if major/bipolar depression evolved as a result of the selective pressures of winter food scarcity, the EOBD-R theory predicts that these pressures would fall more heavily on women because of their reproductive role. Unless there is adequate fat, women don’t ovulate; they don’t menstruate; they can’t have babies, and they can’t breast feed. Also consistent with the theory is the fact that the difference between the sexes doesn’t appear until adolescence. ***
Evolution means survival of the fittest in terms of having viable offspring. The EOBD-R theory suggests that more women than men are biologically programmed to engage in a set of behaviors designed to ensure viable offspring. As winter approaches, they more often experience the urge to eat more and gain weight. During the Ice Ages, women needed to put on weight to counter winter food shortages and have enough fat for reproductive purposes. Half of the 400 Neandertal remains discovered by paleoanthropologists show evidence of a deficient diet. ***

Even in modern times peoples have found themselves short of food in the winter. Members of hunter-gatherer groups have been known to lose 10% of their body weight during harsh winters. It’s theorized that winters during the Ice Ages put tremendous selective stresses on the Neandertal people resulting in bipolar adaptations.

This line of thinking allows another test of the theory. If it is correct that depression, like hibernation, is an adaptation linked to reproduction, then among hibernating animals, hibernation should be more common among females than males. It is. ***

However, the EOBD-R theory doesn’t deny that women also tend to be more depressed than men because of their lower status and greater vulnerability to abuse, though these factors are more important for ordinary depression. Through my participation in women’s causes, I know well that discrimination, domestic abuse and sexual assault take a tremendous toll on female wellbeing. Women with a genetic vulnerability to major/bipolar depression simply add to the numbers.

After the 2001 paper was published, a reader offered this challenge to the theory: If vulnerability to bipolar disorder evolved as an adaptation to Ice Age winters, then African-Americans shouldn’t have bipolar disorder. But is this true? In 2001 I was unable to find adequate data to test this idea, but in the interim more research accumulated to show that
African-Americans are less likely to have a bipolar illness. Many African-Americans carry “white” genes, so they are not immune to acquiring the Neandertal genes that are hypothesized to result in bipolar vulnerability, but the theory predicts that they are less likely to have bipolar disorder and recent research confirms that prediction. ***

As I contemplated the theory, it was obvious that the clock gene had to be central to the pathogenesis of bipolar disorder because it adjusts behavior to conform to daily and seasonal rhythms. The expectation is that the bipolar clock gene is genetically different from about 95% of the rest of the population. Since that first article appeared, more and more evidence has emerged to validate this idea. ***

Telling research was provided by Dr. Tom Wehr and his colleagues (2001). They showed that individuals with seasonal affective disorder (closely related to bipolar disorder) generate a biological signal of change in season that is similar to one that other mammals use to regulate seasonal changes in their behavior. This result is consistent with the hypothesis that these neural circuits and the signals they produce mediate the pathogenesis of winter depression and its response to light treatment. ***

Additionally, there is an intriguing piece of evidence that supports the idea that Neandertal had a capacity for manic behavior. *** Unlike other hominins, Neandertal used a close-up method of hunting. Meat was Neandertal’s main diet, and hunting large animals was a dangerous enterprise that engaged manic capacities for risk taking and extraordinary strength. Compared to fossil finds of other hominins, Neandertal skeletons reveal an unusual number of broken bones, and these injuries resemble those found in present-day bull riders. Anthropologists have supposed that while one hunter enticed the bull to charge, a second leaped on the animal’s back, grabbing neck hair, which was present in the ancient beast, hanging on until the animal
could be killed. Thus the nature of Neandertal’s broken bones gives testimony to behaviors different from other hominins in a way that fits the personality characteristics associated with bipolar disorder.

Recently, more results consistent with the theory and its potential explanatory power have emerged in the publications of Dr. Jordy van Enkhuizen and his colleagues. In 2013 a research paper was published in *Behavioral Brain Research* that involved replacing the clock gene in mice with a mutated form that generated mouse equivalents of manic behavior. Since then, three other articles have been published that point out the need to focus on environmental stimuli (such as light) and genetic susceptibilities in order to develop an understanding of the neurochemistry of bipolar disorder. ***

**CRITICISMS OF THE THEORY**

A major criticism of the EOBD theory by Keller and Miller was published in 2006 in *Behavioral and Brain Science*. They contended that bipolar disorder couldn’t have evolved as an adaptation because it isn’t adaptive. There are several arguments against this view. It ignores the fact that Dr. Daniel Wilson found that bipolar disorder has the medical epidemiology of an adaptation. It also ignores the point that the theory states that bipolar disorder was adaptive at the time of its evolution, not at the current time.

Moreover, this criticism neglects less obvious current adaptive features of bipolar behaviors, such as its association with leadership and creativity discussed in Chapter Two. Tufts University psychiatrist Nassir Ghaemi points out in his book *A First-Rate Madness* that individuals with bipolar characteristics make good leaders in emergency situations. In fact, many
of our great wartime leaders had bipolar disorder, for example, Abraham Lincoln, William Tecumseh Sherman, Teddy Roosevelt, and Winston Churchill.

I have also encountered a more extreme version of the Keller and Miller critique in the form of indignant outbursts that the theory is nonsense because, “How could a psychosis be adaptive?” This response reflects a stereotypic, stigmatizing view of bipolar disorder, and fails to consider the complex realities of the inheritance of adaptive traits.

Granted that the zany behavior of a psychotic manic makes quite an impression, but the fact is that the vast majority of people with a bipolar disorder diagnosis, and who carry bipolar vulnerability genes, are never psychotic. Moreover, as Dr. Ghaemi points out, manic behaviors are adaptive in emergencies. Viewed historically, going berserk gave an advantage in hand-to-hand combat.

Now let’s consider complexities of adaptation. Take the case of sickle cell anemia, a fatal disease that nonetheless evolved as an adaptation. Sound crazy? Actually not. It turns out that you have to inherit two of the sickle cell anemia vulnerability genes to get the disease, in which case you die. However, if you inherit only one of the genes, a more likely event, you get immunity to malaria, a killer in the region of Africa where sickle cell anemia originated. Thus overall the gene was adaptive at the time and place it developed. In a similar way it’s likely that bipolar genes confer adaptive advantages not readily apparent.

Another point concerns the fact that, according to evolutionary biology, the effectiveness of an adaptation is judged by its ability to produce viable offspring. Individuals with schizophrenia do have fewer children than average, but a recent study showed that this is not the case for bipolar disorder. Some of the older research, based on public records, suggested that bipolarity is associated with having fewer children. Since both mental illness and illegitimacy
are stigmatized in our society, public records are likely to contain many inaccuracies. Bipolar disorder is associated with increased sexual activity, and it’s likely that the number of children with bipolar parents is underestimated in official records.

Fred Previc has criticized the theory because it doesn’t include an account of neurotransmitters. However, the data about neurotransmitters is consistent with the theory, and none of the data contradicts it.

Another possible criticism is that the theory doesn’t account for differences between the brains of individuals with bipolar disorder and controls, such as differences in the white matter of the brain. However, these differences may be related to the extensive drug treatments experienced by individuals with bipolar disorder. On the other hand, these differences may be non-causal correlates. By this I mean that, even if the brains are different, it doesn’t mean that this difference is the cause of bipolar disorder, as some imply. For example, there is a difference in physique between individuals with bipolar I disorder and the general population, but the difference doesn’t cause bipolar disorder. Instead, it’s a non-causal correlate.

A friend said, “I have bipolar disorder, but I’m six feet-two. How do you account for that?” This is one of the most common criticisms I’ve heard. As mentioned earlier, the correlation between bipolar I disorder and a compact, cold-adapted build is only .30. Many people with the disorder don’t have that kind of build. A great deal of people intermixing has happened since the Ice Ages when that adaptation theoretically developed. The compact, pyknic build remains only as a clue to the past.

One of the questions I have is about depression after age fifty, the typical age of menopause in women. Around this time there is a decline in sex hormones, which is dramatic for
women, but not for men. It seems to me that hormone loss introduces a different cause of depression, which isn’t necessarily accounted for by the EOBD-R theory.

There are many important questions for future research. At this point, scientists are only beginning to contemplate the meaning of the fact that most of us are a mixture of two groups thought to be different species. What are the consequences of this admixture?

In the 2012 article in *Medical Hypotheses*, I presented a rigorous way to test the validity of the EOBD-R theory, but so far to my knowledge no one has subjected the theory to this test. The EOBD-R theory is just beginning to be taken seriously, but the practical applications of light-based management of major depression and bipolar disorder need not await validation of the theory.

**CHAPTER CONCLUSION**

The EOBD-R theory and the treatments consistent with it deserve attention. The theory explains the known facts about bipolar disorder, and it is not contradicted by any known facts. Is there a better theory of bipolar disorder?
CHAPTER 10

AFTERTHOUGHTS AND CONCLUSIONS

Evidence-based information about therapeutic management of major depression and bipolar disorder, and the need for further research on these ideas, is the theme of this book. Research designs need to take into account the fact that all depressions are not the same. At a minimum there is ordinary depression and major/bipolar depression, often melancholic. These depressions respond to different treatments. Everyone experiences ordinary depressions when they lose out, but only people with specific genetic vulnerabilities experience major/bipolar depression.

Moreover, research designs on the effectiveness of therapies for depression (antidepressants and psychotherapy) must control for light exposure. Patients may get better simply because spring has arrived. Light has a well demonstrated effect on mood that must be taken into account in order to get an accurate measure of therapeutic efficacy.

More clinical trials of chronotherapies are needed, and these need to be conducted without the use of “treatment as usual” psychiatric drugs that may obscure their effectiveness. Bright Light Therapy and Triple Chronotherapy need more research to make plain their usefulness in treating major/bipolar depressions that don’t necessarily meet all the criteria for seasonal affective disorder. Further, we need clinical trials of seasonal Bright Light Therapy combined with the Ben Franklin Routine of early to bed, early to rise (with darkness during the night) to establish that these chronotherapies can prevent or reduce the incidence and severity of mood swings. Dark therapy needs more clinical trials to demonstrate further its effectiveness in stopping a manic episode.
Obesity is at epidemic levels in the United States, and Bright Light Therapy has been shown to be an effective weapon in the management of weight, but this topic hasn’t been a focus of recent research. Earlier studies need to be repeated. Advances in chronotherapy research may be particularly valuable for the American Indian population which has a higher incidence of mood disorders, obesity, and substance abuse.

We need to understand better the mechanisms of light influences on human behavior. Will studies confirm that individuals with major depression/bipolar disorder have a biologically-set early waking time? What are the effects of continual violations of a biologically-set waking time? Does it destabilize the biological clock? Experts agree that individuals with major depression/bipolar disorder have an unstable biological clock. Could repeated violations of a biologically-set waking time be the reason? Repeated instances of violating biologically-set rhythms, as in jet lag, have been known to cause psychosis. Do the same sorts of negative consequences occur in response to repeated violation of a biologically-set waking time?

Is it possible that early awakening is not a symptom, but an inborn characteristic? The two viewpoints have drastically different implications. If early awakening is viewed as a symptom, it’ll probably be treated with medications. On the other hand, if early awakening is a biologically-set characteristic, it needs to be accommodated. Indeed, persistent violation of biologically-set rhythms may be increasing disordered behaviors.

Major depression and bipolar disorder are becoming more common and at younger and younger ages. Why? We need to know a lot more about the effects of the intensity and timing of light on children. How serious are the effects of erratic exposure to light during the nighttime or failure to have adequate hours of sleep in the dark during the night? Does it disorder the child’s biological clock? Some characteristics, such as adjustment to ambient heat, are set at certain
young ages. Is it possible that disordering a child’s biological clock could keep it disordered and contribute to a lifetime of disordered behavior? Are adverse effects passed on epigenetically? Would children with familial risk for major depression/bipolar disorder who keep the Ben Franklin Routine (and seasonal use of Bright Light Therapy) show a lower incidence of mood disorder as they move into adolescence and adulthood?

We need to understand the consequences of the mixing of what had been considered two different species: Neandertal and Homo sapiens. On the one hand, we may find that the mixture has contributed to a useful neurodiversity. On the other hand, we know that the mixing of two species (or two nearly different species) usually has negative consequences. Are some of our problems caused by incompatible genetic combinations? It’s possible that other mental illnesses besides major depression and bipolar disorder are related to the introgression of Neandertal genes into the human genome.

Will further research continue to support the EOBD-R theory? We know that Neandertal was characterized by a stout, compact build developed as an adaptation to the harsh Ice Age climate. We know that half of the four hundred Neandertal skeletal remains we’ve discovered show evidence of inadequate diet. This was a group hard-pressed to survive. Given these circumstances, isn’t it reasonable to think that Neandertal could also have developed, as climatic adaptations, the behaviors that we call seasonal affective disorder, major depression and bipolar disorder?

We know that all of us outside Africa have 1-4% Neandertal genes and that some of us show evidence of a stout, compact, cold-adapted build (and other Neandertal traits according to research by paleoanthropologists). We know bipolar disorder is inherited. Isn’t it possible that the vulnerability genes came from Neandertal? One way a theory is judged is by its ability to
explain the known facts; the EOBD-R theory is the only one to do that. Mental illness is a serious problem facing our nation. It deserves some new thinking.

**BOTTOM LINE: TREATMENT ISSUES**

Although antidepressants have become a household name and a multi-billion dollar industry, mounting evidence shows that they help only some of the people some of the time. Moreover, they have serious side effects and aftereffects. For these reasons, the governments of both Great Britain and the United States no longer recommend antidepressants as the first choice treatment for depression. Psychiatric drugs are so popular, widely used, and prescribed, that it seems hard to believe that they can be inadequate or even dangerous. However, a doctor friend reminded me that for 2000 years bloodletting was a common treatment (well into the 19th century). Indeed, George Washington died of a bloodletting treatment.

The positive effects of Bright Light Therapy have been well known since the 1980s, but what the public hasn’t understood is that it’s a better first choice treatment than antidepressants. Bright Light Therapy is faster and safer than antidepressants. For severe depressions that require hospitalization, Triple Chronotherapy is a faster, potentially cheaper, safer, more effective option than prolonged hospitalization for repeated antidepressant drug trials or electrical treatments of the brain.

Chronotherapeutic management techniques will be helpful for most people with mood disorders. All of us were built to have about eight hours of sleep or rest in the dark every night, but the bad effects of ignoring this fact may be more serious for those of us with genetic vulnerability to major depression or bipolar disorder. Sleep patterns such as the Ben Franklin
Routine help stabilize mood swings. Scheduling, with consistent meal and bedtimes and planned daily activities, also contributes to the successful prevention and recovery from mood disorders.

Women are especially well advised to choose chronotherapies rather than psychiatric drugs as their first treatment choice. Chronotherapies are effective and don’t jeopardize a fetus or nursing baby. Furthermore, they help women deal with other problems such as obesity, premenstrual tension, menopausal depressions, and postpartum depression.

Psychoeducation and learning about your illness is of key importance, as is social support. Psychotherapies, such as cognitive behavior therapies and interpersonal therapy, have been shown to be effective in the treatment of some depressions, though cognitive behavior therapies are best started after the worst of a major/bipolar depression is over. Mindfulness and anger management classes can help you gain control of your emotions. Exercise is helpful, and possibly Omega-Brite. Avoid substance abuse.

If, despite your best efforts, you end up in a manic psychosis, your best bet is to get yourself in a hospital and cooperate with the doctors, even though you may have to take drugs you don’t want. The anti-manic drugs do work; they can have serious side effects, but these should be manageable in the short term. If you’re there on a voluntary basis, you may be able to bargain with your doctors to use Dark Therapy and the least amount of drugs. In any case, even if you’re there on an involuntary commitment, once the psychosis clears you can get out of the hospital, and then you can work with your health care professionals to transition to a treatment program acceptable to you.
ACTION ISSUES

Political action is needed in several areas: 1) We need better research. 2) We need to safeguard the mentally ill against victimization and violation of their civil rights. 3) Chronotherapy needs more acceptance, and insurance companies need to cover the cost of Bright Light Therapy lamps and Triple Chronotherapy. 4) We need health care providers to offer chronotherapy treatment especially across the north. 5) We need more healthy light conditions as a matter of public policy: more light during the day and darkness at night. Industries may want to explore increasing worker productivity and health by practicing more enlightened policies. This is the torch I pass to you.
RESOURCES

The resources emphasize inexpensive, practical readily available material. For more scholarly references, Google Sherman *PsychoLoquy*, Evolutionary Origin of Bipolar Disorder, or see the revised theory published in 2012 in *Medical Hypotheses*. I read many self-help books, but I had mixed feelings about them. Some weren’t directly relevant to relieving major depression or bipolar disorder. Others I’ve recommended, even though they push drug treatment or the false idea that all depression is caused by the way you think.

ON THE INTERNET

Material on the Internet comes and goes and its quality is variable. Nearly all the advice is biased toward presenting a favorable impression of drug therapies. Except for that drawback, information from government sources, the Mayo Clinic, and the major universities is the most reliable. Anything for sale is suspect. But you may need to buy a Therapeutic Bright Light lamp. Dr. Jim Phelps gives advice on buying a bright light on his web site. I’ve always bought mine from Northern Light Technologies (800-263-0066). I have no financial connection with them.

Google bipolar disorder

Select NIMH (National Institute of Mental Health) choices. These describe the illness and current conventional best practice views. You can click on the STEP-BD research program which showed that antidepressant drugs weren’t effective. They recommend long-term anti-manic medication and intensive psychotherapy (weekly for a few months). Medication side effects are mentioned and include strong warnings for pregnant women and nursing mothers. However, the discussion doesn’t include a full picture of side effects or the more scary ones. Unfortunately, this huge NIMH research project that included over 4,000 individuals with bipolar disorder makes no mention of Bright Light Therapy for depression, even though they acknowledge that depression is by far the biggest problem in bipolar disorder. Let’s hope that they include light management techniques in future research.
Google [www.cet.org](http://www.cet.org)
The nonprofit Center for Environmental Therapeutics offers reliable information about chronotherapies. (However, their book *Chronotherapeutics for Affective Disorders* is much more informative.)

**Google jim phelps md**
Jim is a practicing psychiatrist in Corvallis, OR. He offers light management therapies and has been pioneering Dark Therapy for mania. His web site offers an extensive collection of material on bipolar disorder.

**Google daniel f. kripke**
Kripke is an experienced doctor in San Diego and has a 2013 book online with a lot of interesting material entitled *Brighten Your Life: How Bright Light Therapy Helps with Low Mood, Sleep Problems and Jet Lag*.

**Organizations:**
National Alliance on Mental Illness: [www.nami.org](http://www.nami.org) This is a very active group. They offer family and consumer support and education as well as lobbying for political action.

Depression and Bipolar Support Alliance [www.dbsalliance.org](http://www.dbsalliance.org) They specialize in peer-led support groups. Extremely helpful.

**BOOKS**

**Bipolar Disorder**

*Bipolar Disorder: A Guide for the Newly Diagnosed* by Janell M. Caponigro et al. (2012) is an inexpensive paperback with clear practical information written by experienced practitioners. It’s within a traditional medication treatment model, but it emphasizes psychoeducation, psychotherapy, and exercise, and discusses Omega-3 fatty acids as supplementary treatments. It
also clearly discusses legal issues. It’s an excellent book for a person with major depression or bipolar disorder (or their family). Highly recommended.

**Light Management Treatments**

*Chronotherapeutics for Affective Disorders: A Clinician’s Manual on Light and Wake Therapy* by Anna Wirz-Justice, Francesco Benedetti & Michael Terman (2013) (2nd Rev. Edition – 1st edition in 2009) (Affective disorders means mood disorders.) This is an expensive book published by Karger in Switzerland, but it’s available cheaper on the Internet. It is a project of a nonprofit group: Center for Environmental Therapeutics. The authors voice frustration about the continued dominance of Big Pharma despite better, safer, more effective treatments based on light management. The book is thorough with many references, written for professionals. It covers Bright Light Therapy, Dark Therapy, and Triple Chronotherapy, which they call Wake Therapy. This is the best book on light-based treatments. It’s clearly written, has material not available elsewhere, and it sticks to light-based treatments. Despite being written for professionals, it is clear, well worth the effort, and you can skip the technical charts.

*Winter Blues: Everything You Need to Know to Beat Seasonal Affective Disorder* by Norman E. Rosenthal (2013) is the 4th edition (first published in 1993). It is aimed at the general public, and you can probably get it from the library. “Winter Blues” is a misleading term since it sounds like a minor problem; however these “blues” can represent major depression or bipolar depression. Light therapy has been shown to be effective for both these conditions and for obesity. It may also be useful in post-partum depressions and premenstrual tension. The book describes light treatment in great detail. It also discusses cognitive therapy, Transcendental Meditation, and Mindfulness, but it doesn’t mention *The Relaxation Response*. Rosenthal is a practicing psychiatrist with a big following. The book is outdated in the sense that it is incorrectly reassuring about antidepressant drugs.

*Chronotherapy: Resetting Your Inner Clock to Boost Mood, Alertness and Quality Sleep* by Michael Terman & Ian McMahan (2012) (paperback entitled *Reset Your Inner Clock*) is meant for the general public, but I found it hard to understand, and it contains a lot of material not
related to chronotherapeutic treatment of depression. On the positive side, the authors present Triple Chronotherapy, a new safer, quicker alternative to drugs and ECT for severe suicidal depression. Under the name Wake Therapy, this treatment is also described in *Chronotherapeutics for Affective Disorders*. It could be a life saver. Although patients have managed this treatment themselves, the authors recommend that the treatment be done under medical supervision, which is available at Columbia University in New York and in the Chicago area. (It is also available in Europe.) The treatment is not that complicated, and your local psychiatrist should be able to figure out how to manage it. Triple Chronotherapy has the potential to be very inexpensive, but at the present time, it may not be covered by insurance.

**Psychiatric Drugs** – Reading these books was a revelation.

*Anatomy of an Epidemic: Magic Bullets, Psychiatric Drugs, and the Astonishing Rise of Mental Illness in America* by Robert Whitaker (2013). This prize-winning investigative journalist lays bare problems with the testing and marketing of psychiatric drugs that many professionals didn’t (don’t) know about. This shocking book reveals widespread unethical practices, and horrendous, often permanent, damaging “side effects” of psychiatric drugs. The book is controversial, but, as far as I can tell, accurate except that he may have exaggerated the extent of recent increases in mental illness in the US. Extremely readable-recommended.

*The Emperor’s New Drugs: Exploding the Antidepressant Myth* by Irving Kirsch (2009) explains the important concept of the placebo response. Few people appreciate its power. The book was very controversial when it came out. Kirsch maintained that antidepressants are little more effective than placebos, and he seems to be correct. Since then, medical authorities in Britain and the US have stopped recommending antidepressants as a first choice of treatment for depression.

*The Antidepressant Solution: A Step-by-Step Guide to Safely Overcoming Antidepressant Withdrawal Dependence and Addiction* (Old title - *Coming Off Antidepressants*) by Joseph Glenmullen (2006) is a book especially for those on antidepressant drugs who want to get off of them. It’s a guide about how to best quit antidepressants to minimize the negative aftereffects.
The extent and seriousness of the aftereffects of antidepressant drugs is another unappreciated fact. The book is/was controversial and scary, but it’s solidly based, written by a clinical instructor in psychiatry at Harvard.

*Psychiatry under the Influence: Institutional Corruption, Social Injury, and Prescriptions for Reform* by Robert Whitaker & Lisa Cosgrove (2015) is a scholarly book that reveals a sickening betrayal of public trust by the psychiatric profession and the pharmaceutical industry. The authors document the sad fate of thousands of people with mood disorders who, not as lucky as me, have become disabled by psychiatric drugs. Moreover, their account of ADHD children reveals truly appalling facts of financial exploitation to the detriment of these children and their families. The book has not received nearly the publicity it deserves. It has been incorrectly suggested that the authors reject a biological basis for mental illnesses. Instead, their critique of the chemical imbalance account of depression is based on the fact that it was sold to the public to boost drug sales. They are rejecting the simplistic, misleading implication that drugs can safely and readily correct a chemical imbalance of the brain.

**Cognitive Therapy**

*Feeling Good: The New Mood Therapy* by David D. Burns was first published in 1980. This classic may still be the best book on the topic and is available in an updated edition. The therapy is now a recommended treatment and is called Cognitive Behavioral Therapy (CBT). The book is available in libraries or cheap from Amazon. A major insight of the therapy is that depressed people need to learn to counter unrealistically negative thinking. However, Burns’ discussion doesn’t allow for the fact that depressions can be caused by genetic vulnerability and light deprivation. CBT therapy programs and workbooks tend to be overwhelming for individuals in the depths of major/bipolar depression. The therapy is valuable later since it helps interrupt chronic habits of negative thinking that are both unrealistic and socially unattractive.
Meditation

*The Relaxation Response* by Herbert Benson was first published in 1974 and various versions are still in print. (Of these, the original is the most interesting because it recounts Benson’s experiences in Tibet.) The book is simple and teaches you how to reach a deep meditation state on your own, with a couple weeks of practice. Benson learned these methods directly from Tibetan Buddhist monks, boiled them down to their essentials, and translated them into scientific terms. Like Transcendental Meditation, it allows you to reach a state of bliss, which Mindfulness doesn’t emphasize. Compared to the Relaxation Response, Mindfulness and Transcendental Meditation are not so clearly separated from religious practice and both the latter are more involved and expensive, requiring classes and teachers, but that can be an enjoyment factor for some people. The relaxation response and meditation have established health and mental health benefits, but they are not primary treatments for mood disorders. A possible side effect of meditation practices is absorption to the neglect of practical concerns.

Association between Depression and Bipolar Disorder and Creativity and Leadership

*Touched with Fire: Manic-Depressive Illness and the Artistic Temperament* by Kay Redfield Jamison (1993) is a classic. Redfield has severe bipolar disorder herself and is a professor of psychiatry at Johns Hopkins. She discusses the lives of hundreds of artists, writers, and musicians and demonstrates that they suffered from mood disorders.

*Lincoln’s Melancholy: How Depression Challenged a President and Fueled his Greatness* by Joshua Wolf Shenk (2005) is a well-written, interesting book about Abraham Lincoln, how he handled his depression, and how depression was dealt with in 19th century America.

*A First-Rate Madness: Uncovering the Link between Leadership & Mental Illness* by Nassir Ghaemi (2011) is an excellent study showing the role of bipolar individuals in leadership positions in times of crisis, for example Churchill.
The Hypomanic: The Link between (A Little) Craziness and (A Lot of) Success in America by John D. Gartner (2005) presents the thesis that part of the reason for American success is that, as a nation of immigrants, we have a higher concentration of risk takers, a characteristic of bipolar disorder. In fact, the United States has the world’s highest percentage of bipolar disorder, followed by New Zealand and Canada. Gartner makes a good case and reminds us once again to appreciate the positive qualities of bipolar disorder.

In Search of Bill Clinton: A Psychological Biography by John D. Gartner (2008) diagnoses and analyzes Clinton as a hypomanic personality, an informative, entertaining book.

OTHER WORKS CITED

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