

THROUGH THE AGES

IT'S BEEN THERE

By Stephanie Stephens


There's no time like the present to be diagnosed with bipolar disorder. Comparisons between what we know *now* versus what we knew *then* reveal that, indeed, our understanding of the disorder has come a long way. Though it's impossible to trace the first case of bipolar depression or mania, much is known about the evolution of its identification and subsequent classification and naming as manic depression—now known generally as bipolar—and about those specialists whose breakthroughs have contributed so much to our present-day treatment expertise.

IN THE BEGINNING

As might be expected, the early history of bipolar and other mental disorders is not pretty, but rather a testimony to ignorance, misunderstanding, and fear. Consider that in 300 to 500 AD, some people with bipolar disorder were euthanized, according to Cara Gardenswartz, PhD, who is in private practice in Beverly Hills, California, with specific expertise in bipolar disorder and in its history.



“In the earliest days of documentation, these people were viewed as ‘crazy,’ possessed by the devil or demons,” Dr. Gardenswartz says. Their treatment or punishment, she explains, included restraint or chaining; their blood was let out; they were given different potions, or electric eels were applied to the skull—“much in the way witches have been treated in various cultures. In fact, witchcraft was often used to try and ‘cure’ them,” Gardenswartz says.

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Spas were recommended treatments early on for agitated or euphoric patients. It was thought that lithium salts were absorbed into the body as a naturally occurring mineral.

Above: The Baths of Caracalla, Alma-Tadema, Sir Lawrence (1836-1912) Private Collection, Bridgeman Art Library

“Less is known about bipolar disorder from 1000 to 1700 AD, but in the 18th and 19th centuries, we adopted a healthier overall approach to mental disorders.”

Consider these developments in the evolution of bipolar disorder, which was observed and studied in the second century by physician Aretaeus of Cappadocia—a city in ancient Turkey. In his scholarly work, *On Etiology and Symptomatology of Chronic Illnesses*, Aretaeus identified mania and depression; he felt they shared a common link and were two forms of the same disease. The ancient Greeks and Romans coined the terms “mania” and “melancholia” and used waters of northern Italian spas to treat agitated or euphoric patients—and in a forecast of things to come—believed that lithium salts were absorbed into the body as a naturally occurring mineral. In 300–400 BC, the ancient Greek philosopher Aristotle had thanked “melancholia” for the gifts of artists, poets, and writers, the creative minds of his time. Conversely, in the Middle Ages, those afflicted with mental illness were thought to be guilty of wrongdoing; their illness was surely a manifestation of bad deeds, it was thought.

In 1621, Robert Burton—English scholar, writer, and Anglican clergyman—wrote what many deem a classic of its time, a review of 2,000 years of medical and philosophical “wisdom”: *The Anatomy of Melancholia*, a treatise on depression that defined it as a mental illness in its own right. In 1686, Swiss physician Théophile Bonet named “manico-melancolicus” and linked mania and melancholia.

Measurable progress was made in the early 1850s when Jean-Pierre Falret, a French psychiatrist, identified *folie circulaire* or circular insanity—manic and melancholic

episodes that were separated by symptom-free intervals. He broke substantial new academic ground when he chronicled distinct differences between simple depression and heightened moods. In 1875, because of his work, the term “manic-depressive psychosis,” a psychiatric disorder, was coined. Scientists also credit Falret with recognizing a genetic link associated with this disease.

“We owe the categorization of bipolar disorder as an illness to Falret,” write Jules Angst, MD, and Robert Sellaro, BSc, of Zurich University Hospital in Switzerland, in their September 2000 paper, “Historical Perspectives and the Natural History of Bipolar Disorder,” published in *Biological Psychiatry*.

“It is remarkable how Falret’s description of symptoms and hereditary factors are so similar to descriptions found in present-day books and journals,” writes Erika Bukkfalvi Hillard, MSW, RSW, of Royal Columbian Hospital in New Westminster, British Columbia, in her 1992 book *Bipolar Disorder, Manic-Depressive Illness*. “Falret even encouraged physicians to diversify medications used in the treatment of manic-depressive illness in the hopes that one of them might one day discover an effective drug therapy.”

Dr. Angst and Sellaro note that concurrently in 1854 French neurologist and psychiatrist Jules-Gabriel-François Baillarger used the term *folie à double forme* to describe cyclic (manic-melancholic) episodes. Baillarger apparently also recognized a distinct difference between what we now know as bipolar and schizophrenia.

In their treatise, the Swiss specialists detail more specifics about the face of an emerging illness, particularly as it relates to “mixed states.” They write, “The history of the concept of mixed states [symptoms of

mania and depression occurring simultaneously] ... were probably already known at the beginning of the 19th century and named ‘mixtures’ ... and ‘middle forms.’” A 1995 paper by French psychiatrist T. Haugsten, “Historical Aspects of Bipolar Disorders in French Psychiatry,” also traces the term “mixed states” to J. P. Falret’s son, Jules Falret.

“At the end of the 19th century, in spite of the contributions of Falret, Baillarger, and [German psychiatrist Karl Ludwig] Kahlbaum (among others), most clinicians continued to consider mania and melancholia as distinct and chronic entities with a deteriorating course,” José Alberto Del Porto, Paulista School of Medicine of the Federal University of São Paulo, states in an October 2004 research paper published in *Revista Brasileira de Psiquiatria*. However, the acceptance of this theory would not prevail forever.

BIPOLAR ON ITS OWN

German psychiatrist Emil Kraepelin (1856–1926) is one of the most recognizable names in the history of bipolar. He is sometimes referred to as the founder of modern scientific psychiatry and psychopharmacology. He believed mental illness had a biological origin and he grouped diseases based on classification of common patterns of symptoms, rather than by simple similarity of major symptoms, as those who preceded him had done. This forward-thinking specialist postulated that a specific brain or other biological pathology was at the root of each of the major psychiatric disorders. Kraepelin felt that the classification system needed revising, and so he did just that.

In the early 1900s, after extremely detailed research, he formulated the separate terms “manic-depression” and “dementia praecox,” the latter later named “schizophrenia” by Eugène Bleuler (1857–1940). Widespread use of the term “manic depression” prevailed until the early 1930s—it was even used until the 1980s and 1990s. Also during the early 1900s, Sigmund Freud



broke new ground when he used psychoanalysis with his manic-depressive patients: biology then took a back seat. He implicated childhood trauma and unresolved developmental conflicts in bipolar disorder.

In the early 1950s, German psychiatrist Karl Leonhard and colleagues initiated the classification system that led to the term “bipolar,” differentiating between unipolar and bipolar depression. Dr. Gardenswartz notes that “once there was a difference between bipolar and other disorders, individuals suffering from mental illnesses were better understood, and in turn—along with the progress in psychopharmacology—were able to receive better treatment.”

The term “bipolar” logically emphasizes “the two poles,” according to Robert L. Spitzer, MD, professor of psychiatry at Columbia University. Specifically, it is known that people with unipolar depression experience drops in mood, and people with bipolar depression usually experience both depressed and elevated moods in a cyclical manner. In 1980, Dr. Spitzer and his team wrote the third version—an undeniably major revision—of the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders* (DSM) for classifying mental illnesses. The DSM is now in its fourth revision, published in 2000.

“DSM-II contained 150 disorders; DSM-III had 300, although some are ‘subtypes,’” explains Dr. Spitzer. DSM-III is considered a “bible” by specialists and others in the professions, having done away with a one-size-fits-all classification system. Among the monumental changes that occurred when the version DSM-III was published—demanding six years of painstaking work—was the changing of the term “manic-depression” to “bipolar,” which did away with descriptions of patients as “maniacs.” Until the book’s major overhaul, many professionals would say the book did not command much attention. *The New Yorker* wrote in a profile of him that Dr. Spitzer “established it [DSM-III] as a scientific instrument of enormous power,” a fact that few would challenge.

BEYOND FEAR, TO FACT

While names of mental disorders evolved and changed—as they have in medical disciplines in general—so did the range of treatments for those with bipolar disorder, says Dr. Gardenswartz. She points to the use of sedatives and barbiturates prior to the 1950s; patients were also institutionalized to separate them from others. Hot baths continued to be used through the ages, presumed to calm the person down. Electroconvulsive shock therapy and prefrontal lobotomies emerged as two more radical treatment options until new methods evolved and were accepted.

“Starting in the mid-1900s, with the advent of psychiatric and antipsychotic mood-stabilizing medications, patients were able to be viewed more as human beings suffering from illness that could be treated,” Dr. Gardenswartz affirms. Additionally, doctors and the public began to view various illnesses “as the separate entities that they were: schizophrenia, ongoing without breaks or relief from symptoms when untreated; or bipolar, in which people could typically function normally during periods between this cyclical illness.”

A discussion of medications to treat bipolar cannot be complete without acknowledging the work of John Cade, an Australian physician who introduced lithium to the practice of psychiatry in 1949 quite by accident when he observed that lithium urate appeared to calm guinea pigs. Lithium has since remained one of the most effective medications for those with mood disorders, providing a springboard for further research and discovery of biomedical treatments. It is not surprising that natural lithium is found in hot springs, which, as noted previously, were used historically as a treatment for bipolar disorder.

Inspired by Dr. Cade, Mogens Schou, MD (1918–2005), Prof. Med. Sci., continued

groundbreaking research into lithium. Dr. Schou was emeritus professor of the Psychiatric Hospital in Risskov, Denmark, and was named honorary president of the International Society for Bipolar Disorders.

Dr. Schou labeled manic-depression “the national illness” of his country and in the 1960s, Dr. Schou used lithium on an experimental basis with a group of his patients who suffered from mania. Schou’s work proved that when used properly with monitoring, it could be very effective in treating

bipolar depression. Understandably, pharmaceutical companies and academicians were not elated about a naturally occurring mineral salt that was “old news.” In no small part because of Dr. Schou’s efforts, the U. S. Food and Drug Administration (FDA) finally approved lithium as a treatment for mania in 1970, and in 1974, as a preventive treatment for manic-depressive illness.

Since the advent of lithium, the choices in medications (including antipsychotics, mood stabilizers, and antidepressants) combined with supportive, cognitive-behavioral and insight-oriented counseling and care, have provided new tools to confront bipolar disorder. “We have a lot to be grateful for,” says Dr. Gardenswartz, “and there’s much more to come. In the next several decades, we’ll see increased differentiation of symptoms and of treatment, and possibly, the ability to prevent and detect the onset of the disorder.” ●

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