

In Bipolar Disorder Beyond 10 Weeks of Treatment, the Term *Antidepressants* Is a Misnomer

To the Editor: In a January 2011 letter to the editor¹ commenting on the article by Ghaemi et al,² Dr Keith Rasmussen describes the finding of more depression in bipolar patients treated with antidepressants as if both new and surprising. In my opinion, it is neither. Two other recent studies^{3,4} have looked at rates of depression in bipolar disorder patients treated with and without antidepressants and found that those treated with antidepressants had twice as many depressed days,³ significantly higher CGI-BP depression scores ($P < .001$),⁴ and a significantly higher rate of depressive relapse ($P < .001$) at 12 weeks and 24 months.⁴

Since depression is by far the most commonly observed pathology after the first few years of bipolar disorder, it follows that if certain agents worsened cycling, they would be associated with more depression, mixed states, and cycling. Indeed, the recent study by Schneck et al⁵ of rapid-cycling bipolar patients found 2 to 4 times the rate of cycling in those treated with antidepressants.

Given all this, a more important question might be, Do these agents help beyond the initial 10 weeks of therapy? The best evidence in favor comes from the Stanley Foundation Bipolar Network (SFBN) studies, which showed continued benefit up to 1 year in 15%–20% of patients after initial response to the addition of an antidepressant to an average of 1.4 mood stabilizers.^{6,7} The perhaps methodologically more compelling Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD) studies, however, show “no statistically significant symptomatic benefit” of adjunctive antidepressants over 1 to 3 years after initial benefit in the randomized discontinuation study by Ghaemi et al,² and the adjunctive add-on antidepressant study by Sachs et al⁸ showed no benefit whatsoever up to 26 weeks.

As such, to continue to call these agents *antidepressants* in the context of the ongoing treatment of lifelong bipolar disorder serves merely to mislead ourselves, our colleagues, and especially our bipolar patients and their families, and to extend the use of these agents beyond 10 weeks, as observed in 50%–84% of bipolar patients.⁹ Beyond 10 weeks, the antidepressants appear to do more harm than good.^{2–5} I therefore propose instead the term *unipolar antidepressants*,¹⁰ as contrasted with the emerging class of bipolar antidepressants,¹⁰ such as lamotrigine, quetiapine, lithium, and possibly olanzapine, which have demonstrated long-term benefit without worsening of cycling or depression.

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Drs Rasmussen and Ghaemi were shown this letter and declined to comment.

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