


Understanding Bipolar Disorder and Recovery



What you
need to
know
about this
medical
illness



Bipolar disorder expresses itself in an irregular pattern of changes in mood, energy, and thinking.

■ Understanding Bipolar Disorder and Treatment

This brochure has two main purposes: First, to provide an introduction to bipolar disorder for those seeking to gain a basic understanding of the illness itself, its medical treatments, and coping strategies. Second, to update consumers and family members briefly on the recent scientific thinking about the causes and symptoms of bipolar disorder as well as some discussion of treatment options. You will find additional references at the end—including some technical, scientific summaries of the available treatments, and other resources for coping.

■ Introduction to Bipolar Disorder: What you need to know about this medical illness


Bipolar disorder is a complex medical illness of the brain. Over the life of a person who lives with bipolar disorder, the illness expresses itself in an irregular pattern of changes in mood, energy, and thinking. These changes may be subtle or dramatic and typically vary greatly over the course of a person's life as well as among individuals. This complexity and variability are a challenge for individuals, families, and care providers. Fortunately, treatment and understanding of bipolar disorder have steadily improved over the past two decades, and the pace of discoveries is accelerating. As our understanding of bipolar disorder, recommended treatments, and recovery are continuously improved by new research findings, it is increasingly important to maintain up-to-date knowledge.

Taking the time to read this information is an important first step toward understanding the illness, seeking proper medical care, and making the best choices for managing this challenging condition.

■ Recognizing Bipolar Disorder: What is it?

Bipolar disorder, also known as *manic depression*, is a common psychiatric disorder that includes periods of extremely elevated mood. Most people with bipolar disorder also experience periods of depression and periods of full or partial recovery. The cycles of high and low mood states and well periods may follow an irregular pattern.

Actual field tests of the *Diagnostic and Statistical Manual* (DSM-IV), used by psychiatrists for diagnosis, show that the



“It does come to a point of accepting the fact that you have a medical illness, very similar to high blood pressure or diabetes, and one in which over time you have to monitor shifts in mood, changes in behavior, and just be really observant of it.”

diagnostic criteria for mania (extreme episodes of mood elevation) are the most reliable of any common psychiatric condition.

However, it is important to understand a few of the many reasons why bipolar disorder can be hard to diagnose:

- Although diagnosis of bipolar disorder requires the occurrence of at least one episode of unusual mood elevation (see hypomania and mania below), most people living with bipolar disorder experience depression more frequently than mania or hypomania.
- Diagnosis can be delayed or made difficult when the first episode is depression; episodes of mood elevation are subtle, infrequent, or brief; symptoms of other disorders are present; or professionals use words without providing appropriate definitions.
- Bipolar disorder is classified as a mood disorder, but nearly all people living with bipolar disorder also experience a wide variety of non-mood symptoms which are frequently as prominent as the mood episodes. The most common problems are anxiety disorders, substance misuse, attention problems, and medical problems like asthma and obesity.

Thoughtful professional evaluation is needed to distinguish bipolar disorder from conditions that produce symptoms which can overlap with bipolar disorder, both psychiatric (unipolar mood disorder, attention deficit hyperactivity disorder, panic disorder, borderline personality disorder, psychoactive substance abuse) and medical (hyperthyroidism, lupus, multiple sclerosis, drug withdrawal states). Therefore, getting a good medical check-up as part of the diagnostic work-up is an absolute must.

These issues make talking about conditions like “bipolar disorder” or even “mood disorders” confusing. The confusion can be reduced, however, if everyone involved in the person’s treatment plan has the same basic understanding of the terms used by clinicians.

■ What is Hypomania?

The term *hypomania* refers to a clearly altered mood state with mild to severe symptoms of mania that may last for a few days or may persist for many months. Thus, the key difference between mania and hypomania is not so much the severity or duration of symptoms, but the impact the symptoms have on the person's social or occupational function (see Table 1 for more details). Mania typically causes obvious problems in daily functioning and often leads to serious problems with a person's relationships or work functioning. By definition, hypomania does not cause problems to the same extent as mania.

While for some people the hypomania is a pleasant state of good humor and high productivity, for most people even hypomania can be problematic. Things said and done during a hypomanic episode often have negative long-term consequences. For example, people learn that jokes told during a hypomanic episode may have met with roaring approval when made at an office party, but are later cited as an obstacle to promotion at the time of their annual performance review. Individual purchases that may seem like irresistible good deals turn out to be pointless expenditures costing a person and his or her family significant, if not catastrophic, financial strain.

Hypomania is seldom stable. It may occur as a phase in an evolving full manic episode, or it may precede a severe depression. In other words, a hypomanic episode may be a sign that a more severe manic episode is on the way, or it may be a sign that a person is going to "crash" and become depressed.

■ The Experience of Mania and Hypomania

Mania is the word that describes the activated phase of bipolar disorder. When it is less severe, it is called *hypomania*. The symptoms of mania may take a variety of forms.

People on the "high" side of bipolar disorder may feel on top of things, productive, sociable, and self-confident. Many people have described the "high" of hypomania as feeling better than at any other time in their lives, but the feelings are exaggerated. They cannot understand why anyone would call their experience abnormal or part of a disorder.

They feel excited, have surges of energy, and describe feeling more creative, attractive, active, intelligent, important, and sexual. They may take on a tremendous amount of work, and most times accomplish only a fraction of it. For some people, the experience of elevated mood consists mostly of irritability and hostility. Hypomania is often very appealing to individuals who have

recently come out of an extended episode of the depression so common in bipolar II disorder. (More information on the different types of bipolar disorder is below).

Unfortunately, the “high” frequently does not stop with hypomania. The mood becomes more elevated or irritable, behavior more unpredictable, and judgment more impaired as mania develops. People often make reckless decisions during periods of mania and put stress on their relationships; more often than not, the person is unaware of the negative consequences of these extreme actions.

Spending sprees, alcohol and drug abuse, and hypersexuality are common. These periods of perceived self-importance and uncritical self-confidence can advance into a state of psychosis, with delusions and loss of contact with reality. People with bipolar disorder rarely seek treatment during a manic episode, because they may not recognize that anything is wrong.

Table 1. Modified Summary of DSM-IV Episodes

Acute Episodes with Elevated Mood			
Episode Type	Predominant Mood State	Symptom Threshold	Requires \geq three associated features in presence of euphoric or expansive mood. If only irritable, \geq four associated features are required
Mania	High, euphoric, expansive, irritable	Present to a significant degree through at least one week, or any duration if hospitalized	<ol style="list-style-type: none"> 1. Increased self-esteem/grandiosity 2. Decreased need for sleep 3. More talkative 4. Racing thoughts/flight of ideas 5. Distractible 6. Increased goal-directed activities/psychomotor agitation 7. Risk taking
Hypomania	High, euphoric, expansive, irritable	Present to a significant degree through at least four days	<ol style="list-style-type: none"> 1. Increased self-esteem/grandiosity 2. Decreased need for sleep 3. More talkative 4. Racing thoughts/flight of ideas 5. Distractible 6. Increased goal-directed activities/psychomotor agitation 7. Risk taking

Acute Episodes with Depressed Mood

Episode Type	Predominant Mood State	Symptom Threshold	In presence of depressed mood, requires four additional symptoms; in absence of depressed mood, requires diminished interest/anhedonia and four additional symptoms
Depression	Low, dysphoric, sad, disinterested	Present most of the day/nearly every day through at least two weeks	<ol style="list-style-type: none"> 1. Sleep disturbance 2. Diminished interest/capacity for pleasure 3. Inappropriate guilt/low self-esteem 4. Decreased energy; fatigue 5. Inability to concentrate/make simple decisions 6. Appetite disturbance 7. Psychomotor retardation/agitation 8. Suicidal ideation/morbid preoccupation

Acute Episodes with Elevated and Depressed Mood

Episode Type	Predominant Mood State	Symptom Threshold
Mixed	Both states above	At least one week during which symptoms satisfying criteria for depression are present most of the day/nearly every day and symptoms meeting criteria for mania are present to a significant degree

What Is Depression?

Depression is more than just the sad mood that most people might experience when they have had a bad day. Major depression is a medical disorder that lasts at least two weeks and that produces a combination of physical and emotional symptoms that makes it very difficult to function in life (see Table 1). At the heart of clinical depression is a loss of pleasure in activities that used to be fun or exciting. Also, people often have feelings of sadness, hopelessness, and pessimism. These symptoms are accompanied by a wide variety of physical symptoms, such as difficulties sleeping, poor concentration and memory, low energy, and changes in appetite.

Not everyone will experience all of these physical symptoms. For example, someone may have problems with his or her sleep and feel low in energy, but find that appetite remains normal. Depression also changes the way a person thinks about the world. For example, people who are depressed typically feel helpless and hopeless about their life situation and may feel that suicide is a rational alternative to their current situation. Over time, pessimism can become so pervasive that people living with this illness can see no possibility that their depression is treatable. This extremely negative attitude or loss of hope can frustrate even the staunchest supports and may encourage distress among family members and health care providers.

■ The Experience of Depression

Clinical or major depression goes far beyond a normal sense of sadness. When they are depressed, people who live with bipolar disorder are often in a profoundly sad, irritable, or “flat” mood. The inner pain may be intense and result in feelings that life is totally without pleasure and not worth living. When depressed, people who live with bipolar disorder lose interest in their usual activities. Even eating and sex are no longer enjoyable. Former interests seem boring or unrewarding, and the ability to feel and offer love may be diminished or lost.

The lows of depression are often so physically debilitating that people in this phase of the illness may even be unable to get out of bed. Sleep is disrupted. Typically, depressed individuals have difficulty falling asleep, awaken throughout the night, and awaken an hour to several hours earlier than they’d like to. However, about 20 percent of depressed people sleep more than usual.

A frightening part of bipolar disorder for people in the depressive phase is their inability to concentrate, remember, and make decisions. Even minor decisions such as what to have for dinner can seem overwhelming. Self-esteem usually plummets, and the mind often becomes obsessed with losses and personal failures, guilt, and helplessness. “I am not worth much” and “the world is a terrible place” are examples of common negative thoughts.

Such negative thinking can lead to a wish to die, or thoughts of suicide, or actual suicide. In this illness, suicide is an ever-present danger on both sides of mood swings: a subgroup of people can become severely suicidal in manic or mixed (high and low together) states. Use of drugs and alcohol can be fatal, as these substances lower whatever protective inhibitions may still be in place.

What Is the Difference Between Unipolar and Bipolar Mood Disorders?

There are many types of mood disorders, depending on the symptoms that an individual experiences. Certain sets of symptoms are referred to as an “episode.” So, a person who is living with a mood disorder can have an episode of *depression*, an episode of *hypomania*, an episode of *mania*, or a *mixed* episode.

Not only are mood disorders divided into episodes, they are divided into two large groups: unipolar and bipolar disorders. People who have unipolar disorders experience episodes of depressed mood, but never experience the manic or hypomanic symptoms of bipolar disorder. Even though unipolar and bipolar disorders are classified as mood disorders, they are considered different illnesses.



What Are the Subtypes of Bipolar Disorder?

People who are diagnosed with bipolar disorder have different types of mood episodes from people who are diagnosed with unipolar disorders. In fact, bipolar disorder has several subtypes: *bipolar I*, *bipolar II*, *cyclothymia*, and *bipolar NOS*.

Bipolar I refers to a condition in which people have experienced one or more episodes of mania. (See Tables 1 and 2 for more details.) Though an episode of depression is not necessary for a diagnosis of bipolar I, most people who have bipolar I will have episodes of both mania and depression. In other words, although most people who have bipolar I will have episodes of both depression and mania, a few people will have episodes of mania alone.

Bipolar II is another bipolar disorder, but it is different from bipolar I. *Bipolar II* refers to a condition in which people have had at least one hypomanic episode (see Tables 1 and 2 for more

details), but never a full manic episode. To meet the criteria for bipolar II, a person also must have had at least one episode of depression. Thus, there is one major difference between bipolar I and bipolar II disorders: for a diagnosis of bipolar I, there must have been at least one manic episode, whereas in bipolar II there may have been only hypomanic episodes and never a full-blown manic episode. (Tables 1 and 2 may help you understand further these distinctions.)

Another type of bipolar disorder, *cyclothymia*, refers to a more chronic unstable mood state. This diagnosis is given when, over the course of one year for children and adolescents, or two years for an adult, a person experiences moods that are abnormally high or low for at least half of the days. During this time of unstable mood, there will be hypomania, but no full manic or depressive episodes. (See Tables 1 and 2.)

In other words, in order to be diagnosed with cyclothymia, a person must have hypomanic symptoms and some depressive symptoms for at least half of the time, over a period of one to two years. Though a person with cyclothymia has hypomanic episodes, he or she has never experienced a full-blown depressive episode, only periods of feeling sad or down. A person with cyclothymia may have periods of normal mood, but these periods are brief and last less than eight weeks.

Bipolar NOS (“not otherwise specified”) refers to a condition in which people have experienced periods of elevated mood, but do not meet criteria for any of the other three defined subtypes of bipolar disorder. For example, a person can have some symptoms of hypomania followed by an episode of depression. Because the symptoms of hypomania never lasted that long, the person would not qualify for a diagnosis of bipolar II, since he or she did not have a full-blown hypomanic episode, but he or she would qualify for a diagnosis of bipolar NOS. Some health care providers giving this diagnosis also may call bipolar NOS “atypical bipolar” disorder. (See Tables 1 and 2.)

In summary, what distinguishes bipolar disorders from unipolar disorders is the occurrence of episodes of extremely expansive or irritable mood (e.g., hypomania or mania). Episodes of depression (low mood) are also a common feature of bipolar disorder. A person with bipolar disorder may experience mood swings from excessive highs (mania) to profound hopelessness (depression), usually with periods of normal mood in between. Some individuals experience mixed episodes in which symptoms of both mania and depression occur at the same time.

Table 2. Summary of Unipolar and Bipolar Disorders

Acute Episodes with Depressed Mood			
	Mania	Hypomania	Depression
Unipolar Disorders			
Major Depression	No	No	Yes
Dysthymic Disorder	No	No	No, but person feels chronically sad or down
Bipolar Disorders			
Bipolar I	Yes	Yes	Usually
Bipolar II	No	Yes	Yes
Cyclothymia	No	Yes	No, but person has periods of feeling sad or down
Bipolar NOS	No	Yes	Person has some symptoms of depression
Or			
Bipolar NOS	No	Person has some symptoms of hypomania	Yes

■ How Common Is Bipolar Disorder?

Bipolar disorder is common. Approximately three percent of adults in the population have bipolar disorder. In the United States alone, approximately 10 million people have bipolar disorder. Overall, the disorder affects both women and men equally.

■ What Is the Course of the Illness?

Bipolar disorder can occur at any time, but usually begins before age 35. People between the ages of 15 and 25 years have the highest risk of developing this disorder. However, the delay between the first signs and symptoms of the disorder and proper diagnosis and treatment is often 10 years. There is increasing recognition that bipolar disorder can begin in childhood.

The type, severity, and duration of mood episodes can vary. For example, some individuals may have more manic episodes or more depressed episodes, while others may have an equal number of depressive and manic episodes. The length of time that someone is in a normal mood state after an episode also

can vary greatly. Without treatment, people living with bipolar disorder frequently experience shorter periods of normal mood and more periods of depression, hypomania, and mania. For most people, this increase in mood episodes ends after three to five episodes. Over a 10-year period, the average person living with bipolar disorder will have about four mood episodes.

Even among people who have frequent severe episodes, there may be long periods with normal mood states. Some doctors, consumers, and family members may be tempted to interpret these periods of wellness as evidence that the diagnosis of bipolar disorder was incorrect. Unfortunately, this is seldom the case. Bipolar disorder often has natural periods of remission, but those who meet criteria for bipolar disorder will almost always relapse without treatment.

■ Course Specifiers

Approximately one out of eight individuals with bipolar disorder suffers from the “rapid cycling” form of the disorder (i.e., four or more mood episodes per year). Rapid cycling tends to be more common in women than in men. Some women also experience bipolar disorder after childbirth. This type is called *postpartum onset* bipolar disorder. Some people also experience a seasonal pattern to bipolar disorder, where most episodes start and end around the same time each year.

■ What Causes Bipolar Disorder?

While no one knows the exact cause of bipolar disorder, most scientists believe that bipolar disorder is likely caused by multiple factors that interact with each other to produce a chemical imbalance affecting certain parts of the brain. Bipolar disorder often runs in families, and studies suggest a genetic component to the disorder. For example, your chances of getting bipolar disorder are higher if your parents or siblings have this disorder. However, even though someone may have inherited the genes for bipolar disorder, it does not guarantee that this person will develop the disorder. A stressful environment or negative life events may interact with an underlying genetic or biological vulnerability to produce the disorder. In other words, some people are born with genes that make it more likely that they will experience the symptoms of bipolar disorder.

It is not known why some people with these genes develop bipolar disorder and others do not. Often a stressful event, such as unexpected loss, chronic illness, difficult relationship or

financial problems, or any major change in life, seems to trigger the first episode. Therefore, an individual's coping skills or style of handling stress also may play a role in the development of symptoms. In some cases, drug abuse (for example, alcohol, amphetamines, LSD, cocaine, etc.) can trigger the disorder. Stressful life events also may lead to a loss of sleep or a change in usual routines. Such changes in one's schedule can contribute to the onset and recurrence of depression and mania. Recognizing, and having a plan to control, the earliest symptoms for a given person (such as waking up at 3 a.m., or feeling "high" every spring) offers a chance to reduce distress associated with the condition. For some people, however, triggers are not identifiable or become harder to identify as they experience more episodes.

"If something bad happens, I catch my breath after getting knocked down, and I say to myself, the first thing is I've got to be able to sleep, and I've got to be able to keep myself safe."

■ Co-morbidity

Co-morbidity is a term that is used in psychiatry when a person has two or more psychiatric disorders that often occur at the same time. The DSM-IV lists more than 330 different types of psychiatric disorders. A person living with bipolar disorder is very likely to meet criteria for one or more additional DSM-IV disorders. No one knows why, but having bipolar disorder appears to make people more vulnerable to anxiety disorders, alcoholism, substance abuse, bulimia, attention deficit hyperactivity disorder, and migraine headaches. Successful treatment of bipolar disorder almost always improves these other conditions.

Likewise, successful treatment of these conditions usually improves the symptoms of bipolar disorder. Unfortunately for some people, the treatments for other disorders can worsen symptoms of bipolar disorder. For example, the medicines used to treat obsessive-compulsive disorder (antidepressants) and attention deficit hyperactivity disorder (stimulants) may worsen symptoms of bipolar disorder and may even cause a manic episode. When this happens, it is usually possible to find other treatments which help these conditions.

It is also important to note that in all forms of bipolar disorder, psychiatric co-morbidity is very common. In a recent study of 1,000 people living with this disorder, 32 percent had anxiety and panic disorder, and almost half of this group reported abusing substances over the life of their illness. The use of drugs and alcohol adds an enormous and dangerous risk factor to bipolar illness, leading to more frequent relapse, increased suicide attempts, and death. Prompt, comprehensive, and aggressive treatment of co-morbid conditions in bipolar disorder is now recommended.

However, getting to a diagnosis in this illness can prove difficult. Even when others see signs of trouble, it may be very hard to get the person with symptoms to seek help. During hypomania or mania, mood is typically elevated, and judgment impaired. People often deny their changed mood and behaviors are symptoms of illness. During depression, despair and lack of energy may be so profound that seeking help seems useless or impossible. People typically seek help more often in the depressed phase. In the manic phase, friends and family members may be the first to notice changes.

■ The Risks of Not Getting Treatment

The greatest risk in bipolar disorder is not getting treatment, or refusing treatment because of lack of insight into, or inability to resist, the lure of mania. Untreated people not only experience more frequent or more severe episodes, but also suffer higher death rates from medical conditions such as cancer, heart disease, and stroke. One's career, marriage, friendships, and financial stability can be compromised or lost in the face of repeated bouts of depression, recklessness, irrational behavior, drinking, or drugging. The risk of suicide during depressive episodes looms large in the wake of life setbacks experienced as a consequence of repeated episodes. Sadly, one-half of the people who develop manic-depressive illness receive no treatment—a terrible loss, when you consider that treatment for this illness is generally safe and effective, and getting better all the time.

Bipolar disorder is a chronic condition, much like diabetes. Because periods of remission are sometimes complete, but are often complicated by persistent symptoms, bipolar illness requires preventive maintenance treatment as well as acute treatment, ongoing medication management, and close monitoring during periods of remission. Left untreated, it tends to get worse, and the symptoms can become more

pronounced. Recognition and diagnosis of the disorder in its earliest stages is important, so that the ill person can receive effective treatment and avoid the potentially harmful consequences of repeated episodes. Although bipolar disorder is described primarily as a mood disorder, episodes of illness produce significant changes in a wide range of areas, including thinking and judgment, speech, activity, energy, sleep, and ability to maintain relationships with others. The use of alcohol and other drugs is common during an episode and can complicate recovery between episodes.



■ Getting Treatment

From an earlier focus on the optimum treatment of acute manic and depressive episodes, the field is now investigating treatments geared to achieving long-term goals of durable recovery from symptoms and maximum functional recovery. This is a most encouraging development for individuals coping with this illness, and offers the eventual possibility of a level of sustained wellness only imagined in the past.

Following these developments over time will help to maximize one's options for managing the condition. Devising the best plan to live with bipolar disorder is an important goal for consumers as well as family members. The illness can be devastating if left unaddressed. Your management plan should include attention to lifestyle, stress management, supports, and also medication options. There is no one-size-fits-all approach in the field—it is essential to put together a care plan with elements individualized for your needs.

“I try to structure my life so I know where I’m going and I don’t have free time. And that’s not saying that everybody should do that, but for me, free time is dangerous.”

■ How Is Bipolar Disorder Treated?

Many of the recent advances in the treatment of bipolar disorder reflect what researchers are learning about the nature and courses of this illness.

If repeated episodes cause greater severity over the lifetime of the illness, then acute episodes of the illness must be treated effectively to halt its progress. Given that half of those developing bipolar illness start with depressive episodes, and that most experience depressive symptoms much more than they experience the “high” mood state of mania, placing them at increased risk of suicide, effective treatment for bipolar depression is a top priority. The ideal course of research is to identify medication that, used alone or in combination, effectively prevents episodes and offers maximum periods of symptom-free maintenance coverage during periods of remission.

It is also important that these medications are tolerable enough for people to take, so that they will stick with a daily dose (adherence) as the cornerstone of being well and staying well.

While medication is one key element in successful treatment of bipolar disorder, psychotherapy, support groups, and education about the illness are also essential components of the treatment process. The most useful psychotherapies generally focus on understanding the illness, learning how to cope with it, and changing ineffective patterns of thinking or interacting. Each of these components serves a critical role in helping people recognize the specific factors that can trigger their episodes. It is important for individuals with bipolar disorder, and their families, to play active roles in learning about the illness, and in developing and carrying out a treatment plan of the person’s choosing.

Mood Stabilizers

During an acute manic or depressive episode of bipolar disorder, the primary goal is to end the distressing mood state. There is a group of medications commonly used for this purpose; they are often referred to as *mood stabilizers*, to indicate that they are effective in shortening the acute episodes and returning the person to usual levels of psychosocial functioning. The Food and Drug Administration (FDA) and regulatory authorities do not recognize the term “mood stabilizer,” and definitions of this term can vary. Therefore, doctors and pharmaceutical companies may use the term in an inconsistent manner.

It is useful to know whether the “mood stabilizing medication” prescribed for you has been approved by the FDA for use in bipolar disorder:

Medications for mania

Currently FDA-approved: lithium (Eskalith or Lithobid), divalproex sodium (Depakote), carbamazepine (Tegretol), olanzapine (Zyprexa), risperidone (Risperdal), quetiapine (Seroquel), ziprasidone (Geodon), aripiprazole (Abilify)

At least one adequate, well-controlled study with positive data: haloperidol (Haldol)

Medications for bipolar depression

Currently FDA-approved: combination of olanzapine, fluoxetine (Symbyax), and quetiapine (Seroquel)

At least one adequate, well-controlled study with positive data: lamotrigine (Lamictal)

Medications for use in adolescents with bipolar disorder, ages 10-17

Currently FDA approved: risperidone (Risperdal), aripiprazole (Abilify), lithium (Eskalith or Lithobid)

Medications for preventing (or delaying) recurrence

Currently FDA-approved: lithium (Eskalith or Lithobid), lamotrigine (Lamictal), olanzapine (Zyprexa), and aripiprazole (Abilify)

Frequently a combination of two or more medications is used, especially during severe episodes of acute mania or depression.

Lithium has been used for more than 50 years for stabilization and maintenance treatment of bipolar disorder. It generally has more positive impact when used earlier, rather than later, in the course of bipolar disorder. Research shows it is most effective in those individuals with a family history of the illness, and in those experiencing the bipolar I sequence of swings between mania and depression with return to normal function between episodes.

Lithium has proved to be effective in acute relapse prevention and maintenance coverage for bipolar depression. It is the only mood stabilizer to have demonstrated a reduction in suicide among people with bipolar disorder. Some observers feel that lithium is underprescribed, given its evidence-based success in treatment over many years of use.

The therapeutic dose (how much medication is required to control the bipolar disorder symptoms) for lithium varies substantially from person to person. Because it is important to maintain a therapeutic level of lithium in the blood within a certain range, the lithium levels must be monitored with blood tests. Factors that can change lithium blood levels, even when the medication is taken as prescribed, include kidney function and fluid and salt intake.

Like all medications, lithium treatment produces side effects. The most common ones are dose-related and can be effectively managed, but for about 30 percent of people who try it, lithium is not tolerable. Lithium side effects may include frequent urination, excessive thirst, weight gain, memory problems, hand tremors, gastrointestinal problems, hair loss, acne, and water retention. There are two important lithium side effects that can be effectively monitored by a simple blood test: 1) hypothyroidism, which mimics depression and can be easily treated, and 2) less commonly, damage to kidney functions.

Anti-convulsants: The FDA approved divalproex sodium (Depakote) in 1995 for treating bipolar episodes. Originally approved in 1983 as a drug to treat epilepsy, Depakote was found to be as effective as lithium for treating acute mania, and appears to be better than lithium in treating the more complex bipolar subtypes of rapid cycling and dysphoric mania, as well as co-morbid substance abuse. In addition, Depakote may be safely given in larger doses to treat acute episodes, and works faster in this situation than lithium. The generic version of this drug is valproic acid. Some people find that the generic version produces more gastrointestinal distress than Depakote.

Depakote may also produce sedation and gastrointestinal distress, but these side effects often resolve during the first six months of treatment, or with dose adjustment. Another dose-related side effect is weight gain, and rare liver and pancreatic function problems may develop while taking Depakote. However, Depakote is generally well-tolerated, and is now prescribed far more often than lithium. Recent controlled trials indicate that the combination of Depakote and lithium is more effective in preventing relapse and

recurrence than treatment with lithium alone. Because Depakote can affect the level of other drugs taken, it is important to be mindful of possible drug interactions.

Lamictal (lamotrigine), another anti-convulsant, has received FDA approval for maintenance treatment in bipolar I disorder. It is effective in the treatment of acute depression in bipolar I and II and in promoting remissions between episodes. For most people, Lamictal has a very tolerable side effect profile. Rarely, this medication can cause a rash serious enough to cause a medical emergency. The risk of this one potentially serious side effect can be reduced by starting with a low dose and going slowly in increasing the dose. In one study, Lamictal was also demonstrated to be useful in treating bipolar depression. This is important, as it appears to be better than lithium as a preventive for bipolar depression. It appears to have a modest benefit in preventing or delaying recurrence of mania, but appears to be less beneficial than lithium for this purpose.

Use of Antidepressants

Standard antidepressant medications (those approved for the treatment of unipolar depression) have not yet been proven effective for bipolar depression. Although the evidence supporting their use for bipolar depression is limited to small or less rigorous studies, these medications remain the most commonly used treatment for bipolar depression. The data from larger studies finds neither evidence of benefit nor evidence that these agents cause large numbers of depressed people to switch into mania. There likely are, however, individuals for whom standard antidepressants do increase the risk of manic episodes. In 2006, a study from the Stanley Foundation Bipolar Research Network found that bipolar depressed people who were treated with venlafaxine (Effexor) had a higher rate of switch to hypomania and mania than those treated with bupropion (Wellbutrin) or sertraline (Zoloft).



Use of Antipsychotic Medications as Mood Stabilizers

To control acute episodes, antipsychotic medications may be used alone (monotherapy), or added to anti-convulsant medications (combination therapy). Medication guidelines now recommend the combination of these two medications as most effective for acute manic episodes. Because the older typical antipsychotic medications run the risk of causing permanent movement disorder, and have been associated with depression when used over the long term, the new atypical antipsychotics are now preferred for this purpose. All the new atypicals are effective in the treatment of acute and mixed mania. Olanzapine (Zyprexa) and risperidone (Risperdal) are FDA-approved for this purpose.

Finding the right preventive/maintenance medicine is an art informed by science and your own observations. Not all medicines that work in the acute phase of mania are as strong in preventing the next episode, so this is an area to explore.

Side effects of the atypicals are different from those of the first-generation antipsychotics (such as Haldol), although sedation, weight gain, and risk of diabetes are problems associated with many of the new antipsychotics. Clozapine and olanzapine, both effective antipsychotics and mood stabilizers, offer the most risk in this area. Weight gain is a serious clinical concern related to all atypical antipsychotics, and to anti-convulsants as well. Not only can weight gain lead to diabetes II and cardiovascular diseases, but being overweight is also now the leading cause of medication non-adherence. Doctors advise weekly monitoring of weight in the early stages of taking these medications, along with regular exercise and healthy diets, and people must be willing

“I was scared [that when taking medications] I was going to be like a zombie, you know, that I was going to be walking around like you see in ‘One Flew over the Cuckoo’s Nest’ or something.”

to make lifestyle changes to maintain optimal health. The FDA has noted an association between all atypical antipsychotics and the risk of diabetes. As the science develops in this area, it will continue to inform medicine choices for the person that best reflect their risks and benefits.

NAMI's *Hearts and Minds* program, launched in April 2004 and available at www.nami.org/heartsandminds, is a video and consumer presentation containing information on physical health concerns and accessible, affordable lifestyles designed to reduce cardiac risk among people with mental illness. A lifestyle of weight prevention, nutrition, and exercise to offset these side effects for those who are vulnerable but still benefit greatly from these medicines is good for everyone.

Treatment of Bipolar Depression

Finding a way to control acute depressive episodes and prevent breakthrough depressive symptoms in remission has been the most elusive problem to date in treating bipolar disorder. A principle risk is activating a person with bipolar disorder into a manic episode with an antidepressant, also referred to as “switching.” A common strategy is to have one or even more mood stabilizers on board before initiating antidepressant therapy. This is an area in which to work actively with the health care provider.

The multicenter, NIMH-funded STEP-BD study showed that several psychotherapy interventions were more useful than brief collaborative care visits to reduce episodes of bipolar depression. The three types of psychotherapy that were studied focused on cognitive strategies, family involvement, and schedule and stress regulation. Antidepressant medications were not effective for bipolar depression in this study.

Treatment for an episode of depression initially restores energy and initiative well before the improvement in the depressive mood occurs. This can place the individual in an energized state of despair, and therefore at greater risk of acting on suicidal thoughts. The danger in this two-stage response cannot be overstated. Close monitoring and a good clinical alliance with your health care provider at this critical point are essential. If an individual is considered dangerously suicidal, is unresponsive to, or can't take antidepressant medication, electroconvulsive therapy (ECT) may be recommended to treat depressive episodes in bipolar disorder.

There are a number of clinical trials underway in the STEP-BD studies to find ways to improve the treatment of

bipolar depression. Lamictal has done well in bipolar depression in the STEP-BD project, and may be useful for rapid cycling. Zyprexa has been shown to prolong the period between episodes. A compound combining the antipsychotic Zyprexa and the antidepressant Prozac, called Symbyax, has demonstrated a significantly better response than Zyprexa alone. In addition, every effort is being made to find the compounds that will reliably prolong remission in bipolar disorder. Close monitoring of medication during periods of remission is a critical part of successful maintenance therapy.

The initially promising small study suggesting that omega-3 fatty acids were beneficial for bipolar illness has not been replicated by the original researchers, nor other investigators who have attempted to study omega-3 fatty acids for any aspect of bipolar disorder. In test tubes, omega-3 fatty acids do appear to have activity in some of the same systems as lithium and valproate, but more science is needed to determine their effectiveness before these agents can be recommended as first-line treatments.

It takes courage and determination to stay with medications that don't work, to see oneself through the medication changes that are necessary in order to find the ones that do work, and to tolerate the side effects and risks that come with treating such a serious illness as bipolar disorder. People coping with any form of bipolar illness deserve understanding and appreciation of the difficult path they must navigate to achieve wellness.

In addition to the risks that side effects carry for the individual with the illness, these medications can also produce significant risks for a developing fetus. These risks need to be discussed directly, as bipolar illness itself can offer risks if left untreated. Women who are, or plan to become, pregnant should discuss fully the risks and benefits of various treatments with their doctors.

■ **Managing and Coping with Bipolar Disorder**

As people become familiar with their illness, they recognize their own unique patterns of behavior. If individuals recognize these signs and seek effective and timely care, they can often prevent relapses.

Individuals who live with bipolar disorder also benefit tremendously from taking responsibility for their own recovery. Once the illness is adequately managed, they must monitor side effects, changes in mood, and changes in lifestyle. The health care provider and consumer should be able to discuss, with respect

for each other, changes in medication, dose, or any other aspect of fine-tuning treatment.

■ Acceptance

Recovery is an ongoing, daily process. No one can manage an illness as well as the person who is living it. Every day, give yourself credit for having the courage to make the necessary changes in your life. Acknowledge that this process is hard. The changes you may have to make, and the changes to your external life you may have to accept, are major ones. These changes are the necessary price for living well. Celebrating successes you claim, learning from any setbacks, and refusing guilt or frustration about mistakes are all part of the recovery process.

Bipolar disorder presents a special challenge, because its manic or hypomania stages can be seductive. People with the illness may be afraid that they will feel flat, less capable, or less creative if they seek treatment; however, these fears must be judged against the benefits of getting and staying well. A person living with bipolar disorder may feel good while manic, but may make choices that could seriously damage his or her relationships, finances, health, home life, or job prospects. In this illness, a mixed or depressive state is also possible and can cause a great deal of subjective distress.

Many people who are advanced in their recovery for bipolar disorder are leaders of industry, entertainers, artists, craftsmen, and politicians, successful men and women in any line of work. Treatment is not the end of the possibility for achievement; it is the beginning. It is very common for people living with bipolar disorder to want to discontinue their medication, a thought that may be appealing because side effects may be uncomfortable or because it has been a long time since the last episode of illness. People living with bipolar disorder should remember, however, that the recovery they attain usually depends in large part on the medications they are taking and their other health and wellness strategies. A discussion of all options with a health care provider is essential before any treatment changes should be made.

■ Coping Strategies

Developing a balanced lifestyle will help make living with bipolar disorder easier. Incorporating strategies that promote wellness will help people take control of their illness. Many people living with bipolar disorder have said the following strategies are helpful:



Be an expert on the disorder

There are many excellent sources of information about bipolar disorder. Being well informed includes knowing about medications by reading medication inserts in packaging or fact sheets, or by consulting a health care provider. Keep up with current research and treatment options by reading publications such as the NAMI *Advocate* or those published by other reputable groups, attending conferences, subscribing to credible listserves, and networking with other consumers at meetings of support groups.

Become aware of your earliest symptoms

Learning your pattern of symptom development is a key to prevention. Certain stresses, times of the year, or feedback from others may help identify an emerging episode. This can prompt more aggressive intervention to prevent difficulty. There are several mood-monitoring self-assessments which can help structure one's self-awareness. Be aware that the people closest to you may be the first to see signs.

Become a partner in treatment

The consumer/provider relationship is fundamental to successful management of bipolar illness. To be partners, you both must develop a give-and-take relationship. Information needs to flow both ways. Provide the information your health care provider needs to help you recover, including complete and honest reports about reactions to medications, symptoms that are improving or worsening, and new stresses. Ask questions, and write them down before appointments. You and your health care provider should ideally work as a team to fine-tune doses, schedule appointments for monitoring, or make any other helpful changes. Ideally, your health care provider can support you best by staying up to date with the most current treatments available and providing information and support to aid you in your recovery.

Develop a plan for emergencies with people you trust

Know what to do in a crisis, no matter where or when it occurs—this will reduce uncertainty and stress. Though challenging to discuss for many, get your loved ones on your team. Almost all communities have crisis hotlines or emergency walk-in centers, even if they're housed in the local hospital's emergency room.

Join a support group

Emotional support from others living with this disorder is an important part of recovery. It is helpful to share thoughts, fears, and questions with others with the same illness.

Avoid alcohol and illicit mood- or mind-altering substances

These drugs destroy the emotional balance that can be so hard to maintain. They may also interact dangerously with medications. Both depression and mania make these drugs dangerously attractive as ways to “slow down,” “perk up,” or “forget it all,” but the damage they can do will seriously block your road to recovery.

Beware of interactions

Make sure that any food, additional prescription drugs, over-the-counter medications, or herbal supplements you consider taking or take will not interact adversely with either your disorder itself or the medications used to treat it. Discuss any additions to your daily regimen with a health care provider.

Eat for health

Many individuals find that eating a well-balanced diet, avoiding caffeine, and limiting sugar improves how they feel.

Stay on a regular sleep schedule

Lack of sleep can bring on symptoms, and sleeping much more than normal or being unable or unwilling to sleep can indicate the beginning of an episode of illness. Note that, where long east-west trips in airplanes may produce jet lag for others, they can worsen bipolar illness.

Identify and reduce sources of stress: Know when to seek help

Call your health care provider if symptoms become distressing, if it becomes impossible to sleep, or if emotions get out of control. For the longer term, assess stressors and supports to inform your decision making.

Develop a personal support system

Find people among your friends, family, and acquaintances who are willing to learn about bipolar disorder, accept that treatment is necessary, and support your recovery. Choose those who can be trusted to tell you the truth, even if it's unpleasant.

Regular exercise

Scheduled exercise has great emotional as well as physical benefits. Aerobic exercise in particular can reduce mild depression and anxiety, both of which can hasten difficulty for people living with bipolar illness.

Follow a regular schedule

A schedule adds much-needed structure to your life. Balance periods of activity with time for quiet and relaxation.

Consider volunteer work or hobbies

If paid employment is not an option now, both of these activities will enrich your life, teach you useful skills, add to your resume, and give you a sense of purpose, and—again—structure.

Set and respect your limits

When you must tell others about those limits, be friendly but firm.

Continue with life

Don't let your illness take control, but recognize that—as with any chronic illness—some plans may have to be changed, canceled, or postponed. Perhaps vacation or other leave time can be reserved for a “tune-up” hospitalization or time off, if needed.

What Are Risk—Versus Protective—Factors in Coping with Bipolar Disorder?

Some of the strategies that protect a person living with bipolar disorder from future episodes include:

- taking medication as prescribed
- using social, family, and community supports
- using communication or problem-solving skills
- gaining education and experience in mutual support
- using treatment resources like psychotherapy

Strategies using these protective factors while avoiding risk factors are cornerstones of recovery for most people.

Monitoring for Relapse: A Shared Task

Learn to recognize signs that symptoms are developing. Since the best intervention occurs early, before symptoms become severe, recognizing early signs of an episode is a major key to living successfully with bipolar disorder. On the one hand, early recognition is vital, but on the other, you can't constantly ask

Table 3. Protective and Risk Factors in Bipolar Disorder

Protective Factors	Risk Factors
<ul style="list-style-type: none">• Use of mood-stabilizing medications• Abstinence from alcohol• Abstinence from recreational drug use• Structured schedule<ul style="list-style-type: none">• Regular awakening and sleep times• Schedule of recurring social activity• Support system<ul style="list-style-type: none">• Professionals• Family• Friends• Peers• Psychotherapy• Self-help groups• Regular exercise	<ul style="list-style-type: none">• Alcohol• Recreational drugs• Abrupt discontinuation of medications<ul style="list-style-type: none">• Mood stabilizers• Antidepressants• Anxiolytics• Sleep disruption• Loss of supports• Cognitive distortions• Interpersonal conflict• Role transition• Negative expressed emotion• East-west travel• Stress

yourself how you are feeling or become totally focused on your behavior or emotions.

Individuals living with bipolar disorder and their families must work together and discuss past episodes, so they can clearly recognize the early signs of a developing episode. While people's symptoms vary, sleep is one of the best indicators of illness, because it is usually disturbed very early in an episode, easy to observe, and an objective activity to evaluate (in contrast to feelings). Sleep is also important to monitor because episodes can be triggered by sleep deprivation, even if caused simply by travel or work or social events. For many people, disturbance of sleep is the first tip-off of a developing episode.

Whatever the indicator of possible relapse, everyone should agree on what the objective signs of a possible episode are. When such signs appear, they should promptly place a call to the doctor, who may adjust medications.

■ What Can a Family Member or Friend Do to Cope?

Family members and close friends should be supportive and willing to listen to their loved one who is ill talk about his or her feelings. As caregivers, they too need support and the opportunity to talk to people who understand and can help. It is common

for both the person living with the illness and family members to experience grief because of the drastic changes in their lives and the trauma that previous episodes may have caused. Family and friends find it easier to handle this sometimes frustrating illness if they learn what is possible with good treatment, stay positive about the future, become partners in the process of recovery, and accept and respect whatever level of wellness their loved one attains.

Try some of these additional coping strategies:

Join NAMI support groups

To talk about your feelings, fears, and hopes. Talking about your own emotions and anxieties with others in similar situations is therapeutic.

Develop specific and realistic plans

Know exactly what you will do for the person with bipolar disorder in an emergency or during a relapse, but keep clearly in mind that everyone has good and bad days and that a change in mood is not necessarily the start of a new episode.

Heed talk of suicide

Take any warning signs of suicide seriously and seek immediate help.

Accept reality and reach out to others

Learning to accept the illness (and how to adjust to the differences it makes in your life) and developing your own support systems will help with both everyday problems and major crises.

Find resources in your community

Seek out help with finding and taking advantage of everything you now need, from a good doctor or therapist to assistance programs to decent and safe housing for people with mental illnesses.

*—Written by Ken Duckworth, M.D.
with thanks to Gary Sachs, M.D.*

■ What Is NAMI?

The National Alliance on Mental Illness (NAMI) is the nation's largest grassroots mental health organization dedicated to improving the lives of individuals and families affected by mental illness. NAMI has over 1,100 affiliates in communities across the country who engage in advocacy, research, support, and education. Members of NAMI are families, friends, and people living with mental illnesses such as major depression, schizophrenia, bipolar disorder, obsessive-compulsive disorder (OCD), panic disorder, post-traumatic stress disorder (PTSD), and borderline personality disorder.

To learn more about your local affiliate:

Call your state's NAMI office

Write to: NAMI • 2107 Wilson Boulevard, Suite 300
Arlington, VA 22201-3042

Contact the NAMI Information Helpline at

1 (800) 950-NAMI (6264) or

Visit NAMI's Web site at www.nami.org

Many NAMI affiliates offer programs designed to assist individuals and families affected by mental illness:

NAMI Peer-to-Peer is a free 9-week education course on the topic of recovery for any person with a serious mental illness. Led by mentors who themselves have achieved recovery from mental illness, the course provides participants comprehensive information and teaches strategies for personal and interpersonal awareness, coping skills, and self-care.

NAMI Family-to-Family is a free 12-week course for family caregivers of adults with mental illness. Taught by trained NAMI family members who have relatives with mental illness, the course provides caregivers with communication and problem-solving techniques, coping mechanisms, and the self-care skills needed to deal with their loved ones and the impact on the family.

NAMI In Our Own Voice is a public education presentation. It enriches the audiences' understanding of how the over 58 million Americans contending with mental illness cope while also reclaiming rich and meaningful lives. Presented by two trained speakers who themselves live with mental illness, the presentation includes a brief video and personal testimonials, lasts 60-90 minutes, and is offered to a variety of audiences free of charge.

NAMI Connection is a recovery support group for adults with mental illness regardless of their diagnosis. Every group is offered free of charge and meets weekly for 90 minutes. NAMI Connection offers a casual and relaxed approach to

sharing the challenges and successes of coping with mental illness. The groups are led by trained individuals who are in recovery--people who understand the challenges others with mental illness face.

NAMI Basics is a free educational program for parents and other primary caregivers of children and adolescents with mental illness. The course is presented in 6 different classes, provides learning and practical insights for families, and is taught by trained parents and caregivers who have lived similar experiences with their own children.

■ Information Resources:

www.nami.org NAMI's Web site is visited by over half a million unique visitors each month and features the latest information on mental illness, medication and treatment, news, and resources promoting support, education, and advocacy. Special Web sections include resources for Veterans, college students, multicultural groups, and others. Additional features include online discussion groups and options for registration through **myNAMI**, which enables users to receive personalized information and e-mail updates on a variety of topics of their choosing.

1 (800) 950-NAMI, the NAMI Information HelpLine receives over 4,000 requests each month from individuals needing support, referral, and information. Over 60 fact sheets on a variety of topics are available along with referrals to NAMI's network of local affiliates in communities across the country.

Peer-to-Peer: www.nami.org/peertopeer

Family-to-Family: www.nami.org/familytofamily

In Our Own Voice: www.nami.org/IOOV

Connection: www.nami.org/connection

Basics: www.nami.org/basics

Star Center: www.consumerstar.org

The STAR Center provides Support, Technical Assistance, and Resources to assist consumer-operated and consumer-helper programs in meeting the needs of under-served populations. In pursuit of this mission, it offers leadership training, national teleconferences, listening sessions, forums, scholarships for consumers and consumer-operated organizations, as well as online resources.

National Institute of Mental Health (NIMH):

www.nimh.nih.gov

■ Books

The following books are a good place to start learning about bipolar disorder. They are available in libraries or can be ordered from booksellers, including a link to *Amazon.com* at www.nami.org/store. New books are also listed in the Advocate, the NAMI news magazine available to NAMI members.

A Brilliant Madness: Living with Manic-Depressive Illness (1993)
by Patty Duke and Gloria Hochman

An Unquiet Mind: A Memoir of Moods and Madness (1996)
by Kay Redfield Jamison, Ph.D.

The Bipolar Disorder Answer Book (2007) by Charles Atkins, M.D.

The Bipolar Disorder Survival Guide: What You and Your Family Need to Know (2002) by David J. Miklowitz, Ph.D.

The Bipolar Teen: What You Can Do to Help Your Child and Your Family (2008) by David J. Miklowitz, Ph.D. and Elizabeth L. George, Ph.D.

Break the Bipolar Cycle: A Day-to-Day Guide to Living with Bipolar Disorder (2008) by Elizabeth Brandolo and Xavier Amador, Ph.D.

New Hope for People with Bipolar Disorder (2000) by Jan Fawcett, M.D., Bernard Golden, Ph.D., and Nancy Rosenfeld

Surviving Manic Depression (2002) by E. Fuller Torrey and Michael B. Knable

■ Specific Informational Resources for Bipolar Disorder

Bipolar World: www.bipolarworld.net

bp magazine: www.bphope.com

A healthy living magazine for those with bipolar: hope and harmony for people with bipolar.

Children and Adolescent Bipolar Foundation: www.bpkids.org

Depression and Bipolar Support Alliance: www.dbsalliance.org

McMan's Depression and Bipolar Disorder Web:
www.mcmanweb.com

National Institute of Mental Health (NIMH): www.nimh.nih.gov



National Alliance on Mental Illness

August 2008

2107 Wilson Boulevard
Suite 300
Arlington, VA
22201-3042
Ph: (703) 524-7600

NAMI Information Helpline:
1 (800) 950-NAMI (6264)

www.nami.org