Treatment of Bipolar Disorder: A Guide for Patients and Families

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Bipolar disorder (also known as manic-depressive illness) is a severe biological disorder that affects approximately 1.2% of the adult population (more than 2.2 million people in the United States). Although the symptoms and severity vary, bipolar disorder almost always has a powerful impact on those who have the illness as well as on their family members, partners, and friends. If you or someone you care about has been diagnosed with bipolar disorder, you may have many questions about the nature of the illness, its causes, and the treatments that are available. This guide is intended to answer some of the most commonly asked questions about bipolar disorder.

WHAT IS BIPOLAR DISORDER?

As human beings, we all experience a variety of moods—happiness, sadness, anger, to name a few. Unpleasant moods and changes in mood are normal reactions in everyday life, and we can often identify the events that caused our mood to change. However, when we experience changes in mood—or extremes of mood—that are out of proportion to events or come "out of the blue" and make it hard for us to function, these changes are often the result of a *mood disorder*.

Mood disorders are biological illnesses that affect our ability to experience normal mood states. There are 2 general groups of mood disorders: *unipolar depressive disorders*, in which all abnormal mood changes involve a lowering of mood, and *bipolar disorders*, in which at least some of the mood changes involve abnormal elevation of mood. All mood disorders are caused by changes in brain chemistry. They are not the fault of the person suffering from them. They are not the result of a "weak" or unstable personality. Rather, mood disorders are treatable medical illnesses for which there are specific medications that help most people.

How is the diagnosis made?

Although bipolar disorder is clearly a biological disease, there are no laboratory tests or other procedures that a doctor can use to make a definitive diagnosis. Instead, the doctor diagnoses the illness based on a group of symptoms that occur together. To make an accurate diagnosis, the doctor will need to take a careful history of the symptoms the person is currently experiencing as well as any symptoms he or she has had in the past.

What are the symptoms of bipolar disorder?

Bipolar disorder is a disease in which the person's mood changes in *cycles* over time. Over the course of the illness, the person experiences periods of elevated mood, periods of depressed mood, and times when mood is normal. There are 4 different kinds of mood episodes that occur in bipolar disorder:

Mania (manic episode). Mania often begins with a pleasurable sense of heightened energy, creativity, and social ease. However, these feelings quickly progress to full-blown euphoria (extremely elevated mood) or severe irritability. People with mania typically lack insight, deny that anything is wrong, and angrily blame anyone who points out a problem. In a manic episode, the following symptoms are present for at least 1 week and make it very difficult for the person to function:

- Feeling unusually "high," euphoric, or irritable

Plus at least 4 of the following symptoms:

- Needing little sleep yet having great amounts of energy
- Talking so fast that others cannot follow you
- Having racing thoughts
- Being so easily distracted that your attention shifts between many topics in just a few minutes
- Having an inflated feeling of power, greatness, or importance
- Doing reckless things without concern about possible bad consequences (e.g., spending too much money, inappropriate sexual activity, or making foolish business investments)

In severe cases, the person may also experience psychotic symptoms such as hallucinations (hearing or seeing things that are not there) or delusions (firmly believing things that are not true).

Hypomania (hypomanic episode). Hypomania is a milder form of mania that has similar but less severe symptoms and causes less impairment. During a hypomanic episode, the person may have an elevated mood, feel better than usual, and be more productive. These episodes often feel good and the quest for hypomania may even cause some individuals with bipolar disorder to stop their medication. However, hypomania can rarely be maintained indefinitely, and is often followed by an escalation to mania or a crash to depression.

Depression (major depressive episode). In a major depressive episode, the following symptoms are present for at least 2 weeks and make it difficult for the person to function:

- Feeling sad, blue, or down in the dumps or losing interest in the things one normally enjoys

Plus at least 4 of the following symptoms:

- Difficulty sleeping or sleeping too much
- Loss of appetite or eating too much
- Problems concentrating or making decisions
- Feeling slowed down or feeling too agitated to sit still
- Feeling worthless or guilty or having very low self-esteem
- Thoughts of suicide or death

Severe depressions may also include hallucinations or delusions.

Mixed Episode. Perhaps the most disabling episodes are those that involve symptoms of both mania and depression occurring at the same time or alternating frequently during the day. Individuals are excitable or agitated as in mania but also feel irritable and depressed. Owing to the combination of high energy and depression, mixed episodes present the greatest risk of suicide.

What are the different patterns of bipolar disorder?

People with bipolar disorder vary in the types of episodes they usually have and how often they become ill. Some individuals have equal numbers of manic and depressive episodes; others have mostly one type or the other. The average person with bipolar disorder has 4 episodes during the first 10 years of the illness. Men are more likely to start with a manic episode, women with a depressive episode. While a number of years can elapse between the first 2 or 3 episodes

of mania or depression, without treatment most people eventually have more frequent episodes. Sometimes these follow a seasonal pattern (for example, becoming hypomanic in the summer and depressed in the winter). A small number of people cycle frequently or even continuously throughout the year (termed "rapid-cycling" bipolar disorder).

Episodes can last days, months, or sometimes even years. On average, without treatment, manic or hypomanic episodes last a few months, while depressions often last well over 6 months. Some individuals recover completely between episodes and may go many years without any symptoms, while others continue to have low-grade but troubling depression or mild swings up and down.

Special terms are used to describe these common patterns:

- In **Bipolar I Disorder**, a person has manic or mixed episodes and almost always has depressions as well. If someone becomes ill for the first time with a manic episode, the illness is still considered bipolar even though depressions have not yet occurred. It is highly likely that future episodes will involve depression as well as mania unless effective treatment is received.

- In **Bipolar II Disorder**, a person has only hypomanic and depressive episodes, not full manic or mixed episodes. This type is often hard to recognize because hypomania may seem normal if the person is very productive and avoids getting into serious trouble. Individuals with bipolar II disorder frequently overlook episodes of hypomania and seek treatment only for depression. Unfortunately, if a mood stabilizer is not prescribed with an antidepressant for unrecognized bipolar II disorder, the antidepressant may trigger a "high" or set off more frequent cycles.

- In **Rapid-Cycling Bipolar Disorder**, a person has at least 4 episodes per year, in any combination of manic, hypomanic, mixed, or depressive episodes. This course pattern is seen in approximately 5% to 15% of patients with bipolar disorder. It is sometimes associated with use of antidepressants without mood stabilizers, which may increase cycling. For unknown reasons, the rapid-cycling subtype of bipolar disorder is more common in women.

Are there other psychiatric conditions that may be confused with, or coexist with, bipolar disorder?

Bipolar disorder can be confused with other disorders, including a variety of anxiety disorders and psychotic disorders (such as schizophrenia and schizoaffective disorder). This is because anxiety and psychotic symptoms often occur during the course of bipolar disorder. Individuals with bipolar disorder also frequently suffer from psychiatric disorders that are "comorbid" with (are present in addition to) the bipolar illness. The most common of these comorbid conditions are substance abuse disorders, obsessive-compulsive disorder, and panic disorder. If you have any concerns about whether your diagnosis is correct, you should feel comfortable asking the doctor to explain how he or she arrived at a diagnosis of bipolar disorder.

When does bipolar disorder begin?

Bipolar disorder usually begins in adolescence or early adulthood, although it can sometimes start in early childhood or as late as the 40s or 50s. When someone over 50 has a manic episode for the first time, the cause is more likely to be a problem imitating bipolar disorder, such as a neurological illness or the effects of drugs, alcohol, or some prescription medications.

Why is it important to diagnose and treat bipolar disorder as early as possible?

On average, people with bipolar disorder see 3 to 4 doctors and spend over 8 years seeking treatment before they receive a correct diagnosis. Earlier diagnosis, proper treatment, and finding the right medications can help people avoid the following:

- ***Suicide.*** The risk is highest in the initial years of the illness. Over the course of the illness nearly 1 out of 5 individuals with bipolar disorder will die from suicide, making it one of the most lethal psychiatric illnesses.
- ***Alcohol/substance abuse.*** More than 50% of those with bipolar disorder abuse alcohol or drugs during their illness. While some individuals may use substances in an attempt to "self-medicate" symptoms of bipolar illness, individuals with a combination of substance abuse and bipolar illness have a worse outcome.
- ***Marital and work problems.*** Prompt treatment improves the prospects for a stable marriage and productive work.
- ***Treatment difficulties.*** In some individuals, it appears that episodes become more frequent and harder to treat over time. This is sometimes referred to as "kindling."
- ***Incorrect, inappropriate, or partial treatment.*** A person misdiagnosed as having depression alone instead of bipolar disorder may incorrectly receive antidepressants alone without a mood stabilizing medication. This can trigger manic episodes and make the overall course of the illness worse.

What causes bipolar disorder?

There is no single, proven cause of bipolar disorder, but research suggests that it is the result of abnormalities in the way some nerve cells in the brain function or communicate. Whatever the precise nature of the biochemical problem underlying bipolar illness, it clearly makes people with the disorder more vulnerable to emotional and physical stresses. As a result, upsetting life experiences, substance use, lack of sleep, or other stresses can trigger episodes of illness, even though these stresses do not actually cause the disorder.

This theory of an inborn vulnerability interacting with an environmental trigger is similar to theories proposed for many other medical conditions. In heart disease, for example, a person might inherit a tendency to have high cholesterol or high blood pressure, which can cause gradual damage to the heart's supply of oxygen. During stress, such as physical exertion or emotional tension, the person might suddenly develop chest pain or have a heart attack if the oxygen supply becomes too low. The treatment in this case is to take medication to lower the cholesterol or blood pressure (treating the underlying illness) and make changes in lifestyle (e.g., exercise, diet, reducing stresses that can trigger acute episodes). Similarly, in bipolar disorder, we use mood stabilizers to treat the underlying biological disorder while at the same time recommending changes in lifestyle (e.g., reducing stress, good sleep habits, avoiding substances of abuse) to lower the risk of relapse.

Is bipolar disorder inherited?

Bipolar disorder tends to run in families. Researchers have identified a number of genes that may be linked to the disorder, suggesting that several different biochemical problems may occur in bipolar disorder. Like other complex inherited disorders, bipolar disorder only occurs in a fraction of the individuals at genetic risk. For

example, if an individual has bipolar disorder and his or her spouse does not, there is only a 1 in 7 chance that their child will develop it. The chance may be greater if you have a greater number of relatives with bipolar disorder or depression.

HOW IS BIPOLAR DISORDER TREATED?

Stages of Treatment

- ***Acute phase:*** treatment is aimed at ending the current manic, hypomanic, depressive, or mixed episode
- ***Preventive or maintenance phase:*** treatment is continued on a long-term basis to prevent future episodes

Components of Treatment

- ***Medication*** is necessary for nearly all patients during acute and preventive phases.
- ***Education*** is crucial in helping patients and families learn how best to manage bipolar disorder and prevent its complications.
- ***Psychotherapy*** helps patients and families affected by bipolar disorder deal with disturbing thoughts, feelings, and behaviors in a constructive manner.

TYPES OF MEDICATION

The 3 most important types of medication used to control the symptoms of bipolar disorder are ***mood stabilizers***, ***antidepressants***, and ***antipsychotics***. Your doctor may also prescribe other medications to help with insomnia, anxiety, or restlessness. While we do not understand how some of these medications work, we do know that all of them affect chemicals in the brain called neurotransmitters, which are involved in the functioning of nerve cells.

What are mood stabilizers?

Medications are considered mood stabilizers if they have 2 properties: 1) they provide relief from acute episodes of mania or depression, or prevent them from occurring; and 2) they do not worsen depression or mania or lead to increased cycling.

Lithium, divalproex and carbamazepine have been shown to meet this definition; the first 2 are the best established and most widely used. Divalproex and carbamazepine were originally developed as anticonvulsants for the control of epilepsy, another brain disorder. Other available medications that are undergoing research as promising mood stabilizers include several new anticonvulsants and the newer "atypical" antipsychotics. Electroconvulsive therapy (ECT), discussed later, is also considered a mood stabilizing treatment.

Lithium (brand names Eskalith, Lithobid, Lithonate)

The first known mood stabilizer, lithium, is actually an element rather than a compound (a substance synthesized by a laboratory). Lithium was first found to have behavioral effects in the 1950s and has been used as a mood stabilizer in the United States for 30 years. Lithium appears to be most effective for individuals with more "pure" or euphoric mania (where there is little depression mixed in with the elevated mood). It is also helpful for depression, especially when added to other medications. Lithium appears to be less effective in mixed manic episodes and in rapid-cycling bipolar disorder. Monitoring blood levels of lithium can reduce side effects and ensure that the patient is receiving an adequate dose to help produce the best response. Common side effects of lithium include weight gain, tremor, nausea, and increased urination. Lithium may affect the thyroid gland and the kidneys, so that periodic blood tests are needed to be sure they are functioning properly.

Divalproex (brand name Depakote)

Divalproex has been used as an anticonvulsant—to treat seizures—for several decades. It has also been extensively researched as a mood stabilizer in bipolar illness. Divalproex is equally effective in both euphoric and mixed manic episodes. It is also effective in rapid cycling bipolar disorder and for individuals whose illness is complicated by substance abuse or anxiety disorders. Unlike other mood stabilizers, divalproex can be given in relatively large initial doses for acute mania, which may produce a more rapid response. Common side effects of divalproex include sedation, weight gain, tremor, and gastrointestinal problems. Blood level monitoring and dose adjustments may help minimize side effects. Divalproex may cause a mild liver inflammation and may affect the production of a type of blood cell called platelets. Although it is quite rare for there to be any serious complications from these potential effects, it is important to monitor liver function tests and platelet counts periodically.

Other anticonvulsants used as mood stabilizers

- ***Carbamazepine*** (Tegretol, Carbatrol). Although fewer clinical studies support the use of carbamazepine, it appears to have a profile similar to divalproex. It, too, has been available for many years, and is effective in a broad range of subtypes of bipolar illness and in both euphoric and mixed manic episodes. Carbamazepine commonly causes sedation and gastrointestinal side effects. Because of a rare risk of bone marrow suppression and liver inflammation, periodic blood testing is also needed during carbamazepine treatment, just as during treatment with divalproex. Because carbamazepine has complicated interactions with many other medications, careful monitoring is needed when it is combined with other medications.
- ***Lamotrigine*** (Lamictal). Lamotrigine is a relatively new medication. Recent research suggests that it can act as a mood stabilizer, and may be especially useful for the depressed phase of bipolar disorder. One serious risk of lamotrigine use is that 3 out of every 1,000 individuals (0.3%) taking the medication develop a serious rash. The risk of rash can be lowered by increasing the dosage very slowly. Aside from the risk of rash, lamotrigine tends to have fewer troublesome side effects overall, but can cause dizziness, headaches, and difficulties with vision.
- ***Gabapentin*** (Neurontin). Gabapentin has become popular as a mood stabilizer, although there has been relatively little research on its use in bipolar disorder. It appears especially helpful in reducing anxiety. One strength of gabapentin is that it is unlikely to interact with other medications, so that it can be easily added to other mood stabilizers to augment their effect. Side effects of gabapentin can include fatigue, sedation, and dizziness.
- ***Topiramate*** (Topomax). Preliminary research suggests that this new anticonvulsant may be helpful in mania. One side effect of topiramate may actually be an advantage. Unlike many of the other mood stabilizers, topiramate does not appear to cause weight gain and may actually help people lose weight. Other side effects may include sedation, dizziness, and cognitive slowing or memory difficulties. It should avoided by people who have had kidney stones.

What are antidepressants?

Antidepressants treat the symptoms of depression. In bipolar disorder, antidepressants must be used together with a mood stabiliz-

ing medication. If used without a mood stabilizer, an antidepressant can push a person with bipolar disorder into a manic state. Many types of antidepressants are available with different chemical mechanisms of action and side effect profiles. Most research with antidepressants has been done in people with unipolar depression—people who have never had a manic episode. In unipolar depression, the available medications are about equally effective. There has been little research on the use of antidepressants in bipolar disorder, but most experts consider the following 3 types to be first choices:

- ***Bupropion*** (Wellbutrin)
- ***Selective serotonin reuptake inhibitors***: fluoxetine (Prozac), fluvoxamine (Luvox), paroxetine (Paxil), sertraline (Zoloft)
- ***Venlafaxine*** (Effexor).

If these do not work, or if they cause unpleasant side effects, the other choices are:

- Mirtazapine (Remeron)
- Nefazodone (Serzone)
- Monoamine oxidase inhibitors: phenelzine (Nardil), tranylcypromine (Parnate). These are very effective but also require you to stay on a special diet to avoid dangerous side effects.
- Tricyclic antidepressants: amitriptyline (Elavil), desipramine (Norpramin, Pertofrane), imipramine (Tofranil), nortriptyline (Pamelor). Tricyclics may be more likely to cause side effects or to set off manic episodes or rapid cycling.

What are antipsychotic medications?

Antipsychotic medications are used to control psychotic symptoms, such as hallucinations or delusions, that sometimes occur in very severe depressive or manic episodes.

Antipsychotics can be used in 2 additional ways in bipolar disorder, even if no psychotic symptoms are present. They may be used as sedatives, especially during early stages of treatment, for insomnia, anxiety, and agitation. Researchers also believe that the newer antipsychotic medications have mood stabilizing properties, and may help control depression and mania. Antipsychotic medications are therefore often added to mood stabilizers to improve the response in patients who have never had psychotic symptoms. Antipsychotics may also be used alone as mood stabilizers when patients cannot tolerate or do not respond to any of the mood stabilizers.

There are 2 kinds of antipsychotics: older antispychotics (often called "typical" or conventional antipsychotics) and newer antipsychotics (often called atypical antipsychotics). One serious problem with the older antipsychotics is the risk of a permanent movement disorder called tardive dyskinesia (TD). Older antipsychotic medicines may also cause muscle stiffness, restlessness, and tremors. The newer "atypical" antipsychotics have a much lower risk of causing TD (roughly 1% per year) and movement and muscle side effects. Because of this, the newer atypical antipsychotics are usually the first choice in any of the situations when an antipsychotic is needed.

Four atypical antipsychotics, are currently available:

- olanzapine (Zyprexa)
- quetiapine (Seroquel)
- risperidone (Risperdal)
- clozapine (Clozaril)

As mentioned earlier, research is beginning to show that these atypical antipsychotics have mood stabilizing properties. Common side effects of the atypical antipsychotics include drowsiness and weight gain. Although it is very effective, clozapine is not a first choice medication because it can cause a rare and serious blood side effect, requiring weekly or biweekly blood tests.

Examples of conventional antipsychotics include older medications such as haloperidol (Haldol), perphenazine (Trilafon), and chlorpromazine (Thorazine). Although they are not usually a first choice, the older medications can be helpful for patients who do not respond to or have troublesome side effects with the newer atypical antipsychotics.

ACUTE PHASE OF TREATMENT

Selecting a mood stabilizer for an acute manic episode

The first-line drugs for treating a manic episode during the acute phase are lithium and valproate. In choosing between these 2 medications, your doctor will consider your treatment history (whether either of these medicines has worked well for you in the past), the subtype of bipolar disorder you have (e.g., whether you have rapid-cycling bipolar disorder), your current mood state (euphoric or mixed mania), and the particular side effects that you are most concerned about.

Lithium and divalproex are each good choices for "pure" mania (euphoric mood without symptoms of depression), while divalproex is preferred for mixed episodes or for patients who have rapid-cycling bipolar disorder. It is not unusual to combine lithium and divalproex to obtain the best possible response. If this combination is still not fully effective, a third mood stabilizer is sometimes added.

Carbamazepine is a good alternative medication after lithium and divalproex. Like divalproex, carbamazepine may be particularly effective in mixed episodes and in the rapid-cycling subtype. It can be easily combined with lithium, although it is more complicated to combine it with divalproex.

The newer anticonvulsants (lamotrigine, gabapentin, and topiramate) are often best reserved as back-up medications to add to first-line medications for mania, or to use instead of the first-line group if there have been difficult side effects.

How quickly do mood stabilizers work?

It can take a few weeks for a good response to occur with mood stabilizers. However, it is often helpful to combine mood stabilizers with other medications that provide immediate, short-term relief from the insomnia, anxiety, and agitation that often occur during a manic episode. The choices for so-called "adjunctive" medication include:

- antipsychotic medicines, especially if the person is also having psychotic symptoms (see above).
- a sedative called a *benzodiazepine*. Benzodiazpeines include lorazepam (Ativan), clonazepam (Klonopin), and others. They should be carefully supervised, or avoided, in patients who have a history of drug addiction or alcoholism.

Although both benzodiazepine sedatives and antipsychotic medicines can cause drowsiness, the dosages of these medications can generally be lowered as the person recovers from the acute episode. However, some individuals need to continue taking a sedative for a longer period to control certain symptoms such as insomnia or anxiety. Longer-term treatment with an antipsychotic is sometimes needed to prevent relapse.

Selecting an antidepressant for an acute depression

Although a mood stabilizer alone may treat milder depression, an antidepressant is usually needed for more severe depression. It is dangerous to give antidepressants alone in bipolar disorder, because they can trigger an increase in cycling or cause the person's mood to

"overshoot" and switch from depression to hypomania or mania. For this reason, antidepressants are always given in combination with a mood stabilizer in bipolar disorder.

Antidepressants usually take several weeks to show effects. Although the first antidepressant tried will work for the majority of patients, it is common for patients to go through 2 or 3 trials of antidepressants before finding one that is fully effective and doesn't cause troublesome side effects. While waiting for the antidepressant to work, it may be helpful to take a sedating medication to help relieve insomnia, anxiety, or agitation.

If depression persists despite use of an antidepressant with a mood stabilizer, adding lithium (if not already in use) or changing the mood stabilizer might help. Lamotrigine, in particular, may be helpful in depression.

Strategies to limit side effects

All of the medications that are used to treat bipolar disorder can produce bothersome side effects; there are also some serious but rare medical reactions. Just as different people have varying responses to different medications, the type of side effects different people develop can vary widely, and some people may not have any side effects at all. Also, if someone has problems with side effects on 1 medication, this does not mean that that person will develop troublesome side effects on another medication.

Certain strategies can help prevent or minimize side effects. For example, the doctor may want to start at a low dose and adjust the medication to higher doses very slowly. Although this may mean that you need to wait longer to see if the medication will help the symptoms, it does reduce the chances of side effects developing. In the case of lithium or divalproex, blood level monitoring is very important to insure that a patient is receiving enough medication to help, but not more than is necessary. If side effects do occur, the dosage can frequently be adjusted to eliminate the side effects or another medication can be added to help. It is important to discuss your concerns about side effects and any problems you may be experiencing with your doctor, so that he or she can take these into account in planning your treatment.

Electroconvulsive therapy

Electroconvulsive therapy (ECT) is often life-saving in severe depression and mania, but has received a lot of undeserved negative publicity. ECT is a critically important option if someone is very suicidal, if the person is severely ill and cannot wait for medications to work (e.g., the person is not eating or drinking), if there is a history of many unsuccessful medication trials, if medical conditions or pregnancy make medications unsafe, or if psychosis (delusions or hallucinations) is present. ECT is administered under anesthesia in a carefully monitored medical setting. Patients typically receive 6 to 10 treatments over a few weeks. The most common side effect of ECT is temporary memory problems, but memory returns quickly after a course of treatment.

About hospitalization

Many patients with bipolar I disorder (i.e., patients who have had at least 1 full manic episode) are hospitalized at some point in the course of their illness. Because acute mania affects insight and judgment, individuals with mania are often hospitalized over their objections, which can be upsetting for both patients and their loved ones. However, most individuals with mania are grateful for the help they received during the acute episode, even if it was given against their will at the time. Hospitalization should be considered under the following circumstances:

- When safety is in question due to suicidal, homicidal, or aggressive impulses or actions
- When severe distress or dysfunction requires round-the-clock care and support (which is difficult, if not impossible, for any family to sustain for a long period of time)
- Where there is ongoing substance abuse, to prevent access to drugs
- When the patient has an unstable medical condition
- When close observation of the patient's reaction to medications is required

PREVENTIVE TREATMENT

Mood stabilizers, especially lithium and divalproex, are the cornerstones of prevention or long-term maintenance treatment. About 1 in 3 people with bipolar disorder will remain completely free of symptoms just by taking mood stabilizing medication for life. Most other people experience a great reduction in the frequency and severity of episodes during maintenance treatment.

It is important not to become overly discouraged when episodes do occur and to recognize that the success of treatment can only be evaluated over the long term, by looking at the frequency and severity of episodes. Be sure to report changes in mood to your doctor immediately, because adjustments in your medicine at the first warning signs can often restore normal mood and head off a full-blown episode. Medication adjustments should be viewed as a routine part of treatment (just as insulin doses are changed from time to time in diabetes). Most patients with bipolar disorder do best on a combination or "cocktail" of medications. Often the best response is achieved with 1 or more mood stabilizers, supplemented from time to time with an antidepressant or possibly an antipsychotic medication.

Continuing to take medication correctly and as prescribed (which is called adherence) on a long-term basis is difficult whether you are being treated for a medical condition (such as high blood pressure or diabetes) or for bipolar disorder. Individuals with bipolar disorder are often tempted to stop taking their medication during maintenance treatment for several reasons. They may feel free of symptoms and think they don't need medication any more. They may find the side effects too hard to deal with. Or they may miss the mild euphoria they experience during hypomanic episodes. However, research clearly indicates that stopping maintenance medication almost always results in relapse, usually in weeks to months after stopping. In the case of lithium discontinuation, the rate of suicide rises precipitously after discontinuation. There is some evidence that stopping lithium in an abrupt fashion (rather than slowly tapering off) carries a much greater risk of relapse. Therefore, if you must discontinue medication, it should be done gradually under the close medical supervision of your doctor.

If someone has had only a single episode of mania, consideration may be given to tapering the medication after about a year. However, if the single episode occurs in someone with a strong family history of bipolar disorder or is particularly severe, longer-term maintenance treatment should be considered. If someone has had 2 or more manic or depressive episodes, experts strongly recommend taking preventive medication indefinitely. The only times to consider stopping a preventive medication that is working well is if a medical condition or severe side effect prevents its safe use, or when a woman is trying to become pregnant. Even these situations

may not be absolute reasons to stop, and substitute medications can often be found. You should discuss each of these situations carefully with your doctor.

EDUCATION: LEARNING TO COPE WITH BIPOLAR DISORDER

Another important part of treatment is education. The more you and your family and loved ones learn about bipolar disorder and its treatment, the better you will be able to cope with it.

Is there anything I can do to help my treatment?

Absolutely, yes. First, you should become an expert on your illness. Since bipolar disorder is a lifetime condition, it is essential that you and your family or others close to you learn all about it and its treatment. Read books, attend lectures, talk to your doctor or therapist, and consider joining a chapter of the National Depressive and Manic-Depressive Association (NDMDA) or the National Alliance for the Mentally Ill (NAMI) near you to stay up to date on medical and other developments, as well as to learn from others about managing the illness. Being an informed patient is the surest path to success.

You can often help reduce the minor mood swings and stresses that sometimes lead to more severe episodes by paying attention to the following:

- **Maintain a stable sleep pattern.** Go to bed around the same time each night and get up about the same time each morning. Disrupted sleep patterns appear to cause chemical changes in your body that can trigger mood episodes. If you have to take a trip where you will change time zones and might have jet lag, get advice from your doctor.
- **Maintain a regular pattern of activity.** Don't be frenetic or drive yourself impossibly hard.
- **Do not use alcohol or illicit drugs.** Drugs and alcohol can trigger mood episodes and interfere with the effectiveness of psychiatric medications. You may sometimes find it tempting to use alcohol or illicit drugs to "treat" your own mood or sleep problems—but this almost always makes matters worse. If you have a problem with substances, ask your doctor for help and consider self-help groups such as Alcoholics Anonymous. Be very careful about "everyday" use of small amounts of alcohol, caffeine, and some over-the-counter medications for colds, allergies, or pain. Even small amounts of these substances can interfere with sleep, mood, or your medicine. It may not seem fair that you have to deprive yourself of a cocktail before dinner or a morning cup of coffee, but for many people this can be the "straw that breaks the camel's back."
- **Enlist the support of family and friends.** However, remember that it is not always easy to live with someone who has mood swings. If all of you learn as much as possible about bipolar disorder, you will be better able to help reduce the inevitable stress on relationships that the disorder can cause. Even the "calmest" family will sometimes need outside help dealing with the stress of a loved one who has continued symptoms. Ask your doctor or therapist to help educate both you and your family about bipolar disorder. Family therapy or joining a support group can also be very helpful.
- **Try to reduce stress at work.** Of course, you want to do your very best at work. However, keep in mind that avoiding relapses is more important and will, in the long run, increase your overall productivity. Try to keep predictable hours that allow you to get to sleep at a reasonable time. If mood symptoms interfere with your ability to work, discuss with your doctor whether to "tough it out" or take time off. How much to discuss openly with employers and coworkers is ultimately up to you. If you are unable to work, you might have a family member tell your employer that you are not feeling well and that you are under a doctor's care and will return to work as soon as possible.
- **Learn to recognize the "early warning signs" of a new mood episode.** Early signs of a mood episode differ from person to person and are different for mood elevations and depressions. The better you are at spotting your own early warning signs, the faster you can get help. Slight changes in mood, sleep, energy, self-esteem, sexual interest, concentration, willingness to take on new projects, thoughts of death (or sudden optimism), and even changes in dress and grooming may be early warnings of an impending high or low. *Pay special attention to a change in your sleep pattern,* because this is a common clue that trouble is brewing. Since loss of insight may be an early sign of an impending mood episode, don't hesitate to ask your family to watch for early warnings that you may be missing.
- **Consider entering a clinical study.**

What if you feel like quitting treatment?

It is normal to have occasional doubts and discomfort with treatment. If you feel a treatment is not working or is causing unpleasant side effects, tell your doctor—don't stop or adjust your medication on your own. Symptoms that come back after stopping medication are sometimes much harder to treat. Don't be shy about asking your doctor to arrange for a second opinion if things are not going well. Consultations can be a great help.

How often should I talk with my doctor?

During acute mania or depression, most people talk with their doctor at least once a week, or even every day, to monitor symptoms, medication doses, and side effects. As you recover, contact becomes less frequent; once you are well, you might see your doctor for a quick review every few months.

Regardless of scheduled appointments or blood tests, call your doctor if you have:

- Suicidal or violent feelings
- Changes in mood, sleep, or energy
- Changes in medication side effects
- A need to use over-the-counter medications such as cold medicine or pain medicine
- Acute general medical illnesses or a need for surgery, extensive dental care, or changes in other medicines you take

How can I monitor my own treatment progress?

Keeping a mood chart is a good way to help you, your doctor, and your family manage your disorder. A mood chart is a diary in which you keep track of your daily feelings, activities, sleep patterns, medication and side effects, and important life events. (You can ask your doctor or the NDMDA for a sample chart.) Often just a quick daily entry about your mood is all that is needed. Many people like using a simple, visual scale—from the "most depressed" to the "most manic" you ever felt, with "normal" being in the middle. Noticing changes in sleep, stresses in your life, and so forth may help you identify what are the early warning signs of mania or depression and what types of triggers typically lead to

episodes for you. Keeping track of your medicines over many months or years will also help you figure out which ones work best for you.

What can families and friends do to help?

If you are a family member or friend of someone with bipolar disorder, become informed about the patient's illness, its causes, and its treatments. Talk to the patient's doctor if possible. Learn the particular warning signs for that person which indicate that he or she is becoming manic or depressed. Talk with the person, while he or she is well, about how you should respond when you see symptoms emerging.

- Encourage the patient to stick with treatment, to see the doctor, and to avoid alcohol and drugs. If the patient is not doing well or is having severe side effects, encourage the person to get a second opinion, but ***not*** to stop medication without advice.
- If your loved one becomes ill with a mood episode and suddenly views your concern as interference, remember that this is not a rejection of you but rather a symptom of the illness.
- Learn the warning signs of suicide and take any threats the person makes *very seriously*. If the person is "winding up" his or her affairs, talking about suicide, frequently discussing methods of suicide, or exhibiting increased feelings of despair, step in and seek help from the patient's doctor or other family members or friends. Privacy is a secondary concern when the person is at risk of committing suicide. Call 911 or a hospital emergency department if the situation becomes desperate.
- With someone prone to manic episodes, take advantage of periods of stable mood to arrange "advance directives"—plans and agreements you make with the person when he or she is stable to try to avoid problems during future episodes of illness. You should discuss when to institute safeguards, such as withholding credit cards, banking privileges, and car keys, and when to go to the hospital.
- Share the responsibility for taking care of the patient with other loved ones. This will help reduce the stressful effects that the illness has on caregivers and prevent you from "burning out" or feeling resentful.
- When patients are recovering from an episode, let them approach life at their own pace, and avoid the extremes of expecting too much or too little. Try to do things *with* them, rather than *for* them, so that they are able to regain their sense of self-confidence. Treat people normally once they have recovered, but be alert for telltale symptoms. If there is a recurrence of the illness, you may notice it before the person does. Indicate the early symptoms in a caring manner and suggest talking with the doctor.
- Both you and the patient need to learn to tell the difference between a good day and hypomania, and between a bad day and depression. Patients with bipolar disorder have good days and bad days just like everyone else. With experience and awareness, you will be able to tell the difference between the two.
- Take advantage of the help available from support groups.

PSYCHOTHERAPY

Psychotherapy for bipolar disorder helps a person cope with life problems, come to terms with changes in self-image and life goals, and understand the effects of the illness on significant relationships. As a treatment to relieve symptoms during an acute episode, psychotherapy is much more likely to help with depression than with mania—during a manic episode, patients may find it hard to listen to a therapist. Long-term psychotherapy may help prevent both mania and depression by reducing the stresses that trigger episodes and by increasing patients' acceptance of the need for medication.

Types of psychotherapy

Four specific types of psychotherapy have been studied by researchers. These approaches are particularly useful during acute depression and recovery:

- ***Behavioral therapy*** focuses on behaviors that can increase or decrease stress and ways to increase pleasurable experiences that may help improve depressive symptoms.
- ***Cognitive therapy*** focuses on identifying and changing the pessimistic thoughts and beliefs that can lead to depression.
- ***Interpersonal therapy*** focuses on reducing the strain that a mood disorder may place on relationships.
- ***Social rhythms therapy*** focuses on restoring and maintaining personal and social daily routines to stabilize body rhythms, especially the 24-hour sleep-wake cycle.

Psychotherapy can be individual (only you and a therapist), group (with other people with similar problems), or family. The person who provides therapy may be your doctor or another clinician, such as a social worker, psychologist, nurse, or counselor who works in partnership with your doctor.

How to get the most out of psychotherapy

- Keep your appointments.
- Be honest and open.
- Do the homework assigned to you as part of your therapy.
- Give the therapist feedback on how the treatment is working. Remember that psychotherapy usually works more gradually than medication and may take 2 months or more to show its full effects. However, the benefits may be long lasting. Remember that people can react differently to psychotherapy, just as they do to medicine.

INFORMATION, ADVOCACY, AND RESEARCH

Some of the major organizations that help people with bipolar disorder are listed below. The first 3 are advocacy groups— grassroots organizations founded by patients and families to improve care by providing educational material and support groups, helping with referrals, and working to eliminate stigma and to change laws and policies to benefit individuals with mental illness. The support groups they sponsor provide a forum for mutual acceptance and advice from others who have suffered from severe mood disorders—help that can be invaluable for some individuals. The last 3 organizations, headed by medical researchers, provide education and can help with referrals to programs and clinical studies that provide innovative and state-of-the-art treatment.

National Depressive and Manic-Depressive Association (NDMDA)

- 35,000 members in 250 chapters
- For information:

  730 N. Franklin St., Suite 501
  Chicago IL, 60610-3526
  800-82-NDMDA (800-826-3632)
  www.ndmda.org

National Alliance for the Mentally Ill (NAMI)
- 140,000 members in 1,000 chapters
- For information:
  Colonial Place Three
  2107 Wilson Blvd., Suite 300
  Arlington, VA 22201-3042
  800-950-NAMI (800-950-6264)
  www.nami.org

National Mental Health Association (NMHA)
- 300 chapters
- For information:
  National Mental Health Information Center
  1021 Prince St.
  Alexandria, VA 22314-2971
  800-969-6642
  www.nmha.org

National Foundation for Depressive Illness, Inc. (NFDI)
PO Box 2257
New York, NY 10116-2257
800-248-4344

Madison Institute of Medicine
- Home of the *Lithium Information Center* and the *Stanley Center for the Innovative Treatment of Bipolar Disorder*
- Distributes very useful consumer guides to mood stabilizers
  7617 Mineral Point Rd., Suite 300
  Madison, WI 53717
  608-827-2470
  www. healthtechsys.com/mim.html

Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD)
- Project that is conducting studies involving 5,000 bipolar patients treated in different centers in the United States. The goal is to improve effectiveness of treatment for bipolar disorder. If you are interested in participating, visit:
  www.edc.gsph.pitt.edu/stepbd

FOR MORE INFORMATION

The NDMDA distributes free the booklet *A Guide to Depressive and Manic-Depressive Illness: Diagnosis, Treatment and Support*, along with a NDMDA bookstore catalog and chapter directory. The publications listed below also provide more information on bipolar disorder. Most are available from the NDMDA bookstore. To order these materials, call 800-82-NDMDA.

Medical information about bipolar disorder:

The Bipolar Child: the Definitive and Reassuring Guide to Childhood's Most Misunderstood Disorder. Demitri F. Papolos and Janice Papolos. Broadway Books, 1999.

Cognitive-Behavioral Therapy for Bipolar Disorder. MR Basco and AJ Rush. Guilford, 1996.

The Depression Workbook: a Guide for Living With Depression and Manic Depression. Mary Ellen Copeland, MS. Newharbinger Publications, 1992.

Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV). American Psychiatric Association, 1994.

Everyone Needs a Hand to Hold on to (18-minute video produced for NDMDA; comes with a discussion guide), 1995.

Living With Manic-Depressive Illness: a Guidebook for Patients, Families and Friends. NDMDA, 1997. Comprehensive, fully updated 60-page guide to the illness.

Manic-Depressive Illness. Frederick K. Goodwin, MD, and Kay Redfield Jamison, PhD. Oxford University Press, 1990.

A Mood Apart: Depression, Mania, and Other Afflictions of the Self. Peter C. Whybrow, MD. Basic Books, 1997.

Mood Genes: Hunting for Origins of Mania and Depression. Samuel H. Barondes, MD. W.H. Freeman and Co, 1998

Night Falls Fast: Understanding Suicide. Kay Redfield Jamison, PhD. Alfred A. Knopf, 1999.

Restoring Intimacy: the Patient's Guide to Maintaining Relationships During Depression. NDMDA developed this book to cover difficult and real issues for people living with depression. NDMDA, 1999.

Structured Group Psychotherapy for Bipolar Disorder: the Life Goals Program. M Bauer and L McBride. Springer, 1996.

Touched With Fire: Manic-Depressive Illness and the Artistic Temperament. Kay Redfield Jamison. Simon & Schuster, 1996.

When Someone You Love Is Depressed: How to Help Your Loved One Without Losing Yourself. Laura Epstein Rosen, PhD, and Xavier Francisco Amador, PhD. Simon & Schuster, revised 1997.

Outstanding books by people with bipolar disorder or depression:

The Beast: a Reckoning With Depression. Tracy Thompson. G.P. Putnam's Sons, 1995.

A Brilliant Madness: Living With Manic-Depressive Illness. Patty Duke and Gloria Hockman. Bantam Books, 1992.

Call Me Anna: the Autobiography of Patty Duke. Patty Duke and Kenneth Turan. Bantam, 1987.

Darkness Visible, a Memoir of Madness. William Styron. Random House, 1990.

On the Edge of Darkness: Conversations About Conquering Depression. Kathy Cronkite. Doubleday, 1994.

An Unquiet Mind, a Memoir of Moods and Madness. Kay Redfield Jamison, PhD. Random House, 1996.

Undercurrents: a Therapist's Reckoning With Her Own Depression. Martha Manning. Harper Collins, 1994.

FOR MORE INFORMATION

To request more copies of this handout, please contact NDMDA or NAMI (see above).

The recommendations in this article were based on a recent survey of experts on the medication treatment of bipolar disorder (published as A Postgraduate Medicine Special Report, April 2000). You can download an Adobe Acrobat file of this study and this guide for patients and families at our website:

www.psychguides.com

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