

Treatment of Bipolar Disorder: A Guide for Patients and Families

David A. Kahn, M.D., Paul E. Keck, Jr., M.D., Roy H. Perlis, M.D., Michael W. Otto, Ph.D., Ruth Ross, M.A.

Bipolar disorder (also known as manic-depressive illness) is a severe biological disorder that affects slightly more than 1% of the adult population (more than 2.2 million people in the United States). Although symptoms and severity vary, bipolar disorder almost always has a powerful impact on those who have the illness and on their family, partners, and friends. If you or someone you care about has been diagnosed with bipolar disorder, you probably have many questions about the illness, its causes, and treatments that are available. This guide is intended to answer commonly asked questions about bipolar disorder. The treatment information given here is based on research findings and a recent survey of approximately 50 leading experts on 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 to everyday life, and we can often identify events that caused our mood to change. However, when we experience mood changes—or extremes—that are out of proportion to events or come “out of the blue” and make it hard to function, these changes may be due to a mood disorder. *Mood disorders* are medical illnesses that affect our moods and how we feel. There are 2 main types of mood disorders. In *unipolar* (1 pole) disorders, such as major depressive disorder, the mood changes all involve a lowering of mood. In *bipolar* (2 pole) disorders, at least some of the changes involve an excessive elevation in mood. All mood disorders are associated with changes in brain chemistry. They are not the fault of the person suffering from them. Mood disorders are treatable medical illnesses for which there are specific interventions that help.

How is the diagnosis made?

Although bipolar disorder is a biological disease, there are no laboratory tests or other procedures a clinician can use to make a firm diagnosis. Instead, the clinician makes the diagnosis based on a group of symptoms that occur together. To make an accurate diagnosis, the clinician needs to take a careful history from the person who is ill and, if possible, from family members. The clinician will want to know about symptoms the person is currently having as well as any symptoms he or she had in the past.

What are the symptoms of bipolar disorder?

Bipolar disorder is a disease in which mood changes in cycles. At different times, the person experiences periods of elevated mood, periods of depressed mood, and times when mood is normal. Four kinds of mood episodes can 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—they often deny anything is wrong and may angrily blame anyone who points out a problem. In a full manic episode, the following symptoms are present for at least 1 week and make it very hard for the person to function:

- Feeling unusually “high,” euphoric, or irritable

Plus at least 3 of the following symptoms:

- Needing little sleep but 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, making foolish business investments)

In severe cases, the person may also have 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 person may not recognize that anything is wrong. The desire to experience hypomania may even cause some people with bipolar disorder to stop their medication. However, hypomania can rarely be maintained indefinitely, and it 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 hard 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:

- Trouble 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. The person feels excitable or agitated but also irritable and depressed.

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 people have equal numbers of manic and depressive episodes; others have

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mostly 1 type or the other. The average person with bipolar disorder has 4 episodes during the first 10 years of the illness. 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, the person may become hypomanic in summer and depressed in winter). A small number of people cycle frequently or even continuously throughout the year. 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 people recover completely between episodes and may go years without any symptoms. Others continue to have low-grade but troubling depression or mild up-and-down mood swings. Some 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 a depression has not yet occurred. It is very 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 of bipolar disorder can be 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 an antidepressant is prescribed alone, without a mood stabilizer, for unrecognized bipolar II disorder, it may trigger a “high” or set off more frequent cycles.
- Both bipolar I and bipolar II disorder can be **rapid-cycling**. 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 pattern occurs at times in about 5%–15% of patients with bipolar disorder. Rapid cycling can sometimes be triggered by taking antidepressants without mood stabilizers. For unknown reasons, rapid-cycling 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 anxiety disorders and psychotic disorders such as schizophrenia and schizoaffective disorder. This is because anxiety and psychotic symptoms may also occur at times in bipolar disorder. People with bipolar disorder also frequently suffer from other psychiatric disorders in addition to bipolar illness. The most common of these are substance abuse, obsessive-compulsive disorder, and panic disorder. If you have concerns about whether your diagnosis is correct, feel comfortable asking your clinician 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 another medical problem that is imitating bipolar disorder, such as a neurological illness or the effects of drugs, alcohol, or some prescription medicines.

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 early years of the illness.
- **Alcohol or substance abuse.** More than half of those with bipolar disorder abuse alcohol or drugs during their illness. While some individuals may use substances in an attempt to “self-medicate” their symptoms, individuals with bipolar disorder who abuse substances have a worse outcome.
- **Marital and work problems.** Prompt treatment improves the prospects for a stable marriage and productive work.
- **Incorrect, inappropriate, or partial treatment.** A person who is misdiagnosed with depression alone instead of bipolar disorder may incorrectly receive antidepressants alone without a mood stabilizing medication. This can trigger manic episodes and make the course of the illness worse.

What causes bipolar disorder?

Bipolar disorder has no single proven cause, but research suggests the illness is due to abnormalities in the way some nerve cells in the brain function or communicate. Whatever the precise nature of the biochemical problem, the disorder makes people more vulnerable to emotional and physical stress. As a result, stresses such as upsetting experiences, substance use, or lack of sleep can trigger episodes of illness, even though they do not actually cause the disorder.

This theory of an inborn vulnerability that interacts with an environmental trigger is similar to theories proposed for many other medical conditions. For example, in heart disease, a person might inherit a tendency to have high cholesterol or 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 may suddenly develop chest pain or have a heart attack if the oxygen supply gets 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 could trigger an attack). Similarly, in bipolar disorder, we use medications to correct imbalances in brain chemistry, while at the same time recommending psychotherapy and changes in lifestyle (e.g., reducing stress, good sleep habits, avoiding substances of abuse) to further reduce symptoms and 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 relatively small 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 to manage bipolar disorder and prevent complications.
- *Psychotherapy* helps patients and families deal with disturbing thoughts, feelings, and behaviors in a constructive manner. It emphasizes early detection of and treatment for mood episodes; managing activity and stress levels; and training in problem-solving skills.
- *Support* groups provide help and understanding that can be useful in promoting longer-term mood stability. Participants say support groups help them feel safe and accepted, motivate them to follow their treatment plans, and give them a chance to share experiences with others who have “been there.”

TYPES OF MEDICATION

The most important medications used to treat bipolar disorder are mood stabilizing agents (including lithium, anticonvulsants, and atypical antipsychotics) and antidepressants. Your doctor may also prescribe other medications for insomnia, anxiety, or restlessness. While we do not understand exactly how these medications work, they all affect chemicals in the brain called neurotransmitters that are involved in the functioning of nerve cells.

What are mood stabilizers?

Medications are considered mood stabilizers if 1) they provide relief from acute episodes of mania and depression and help prevent such episodes from occurring; and 2) they do not make depression or mania worse or lead to increased mood cycling. Medications that are generally considered mood stabilizers are lithium, divalproex, carbamazepine, and the atypical antipsychotics. Lithium was the first mood stabilizer that was introduced and has been used for many years. Divalproex and carbamazepine were originally developed as anticonvulsants to control epilepsy, another brain disorder, but were also found effective for bipolar disorder. Atypical antipsychotics have also been found to be effective in stabilizing mood. Medications that have been approved by the Food and Drug Administration (FDA) for the treatment of different phases of bipolar disorder are shown in Table 1. Electroconvulsive therapy (ECT) is also considered a mood stabilizing treatment and may be used for severe depression or mania.

Lithium (brand names Eskalith, Lithobid)

The first known mood stabilizer, lithium, is an element rather than a compound (a substance synthesized by a laboratory).

Table 1. Medications with FDA indications for treatment of bipolar disorder as of November 1, 2004 (updated 8/1/2010 by Dr. Aiken)

Medication Generic	(Product)	Acute bipolar depression	Acute bipolar mania	Maintenance treatment of bipolar I disorder
Aripiprazole	(Abilify)		●	●
Chlorpromazine	(Thorazine)		●	
Divalproex	(Depakote)	+/-	●	+
Lamotrigine	(Lamictal)	+/-		●
Lithium	(Eskalith)	+	●	●
Olanzapine	(Zyprexa)		●	●
Quetiapine	(Seroquel)	●	●	●
Risperidone	(Risperdal)		●	+
Ziprasidone	(Geodon)		●	●
Olanzapine/fluoxetine combination	(Symbyax)	●		

Carbamazepine (Equetro), Invega and Saphris were FDA-approved to treat mania after 2004

+/- means scientific studies show likely benefit but not FDA approved
 + means scientific studies show clear benefit but not FDA approved

Non-FDA options with scientific studies for bipolar...

Depression:

- Mirapex
- Provigil
- Nuvigil
- NAC
- Omega-3
- Inositol
- Psychotherapy

Mania:

- Trileptal
- Ca-channel-blockers
- Allopurinol

Lithium was first found to have effects on behavior in the 1950s and has been used as a mood stabilizer in the United States for 30 years. Lithium appears most effective for “pure” or euphoric mania (little depression mixed with the elevated mood). It is also helpful for depression, especially when added to other medications. Lithium appears less effective for mixed manic episodes and rapid-cycling bipolar disorder. The doctor must monitor lithium blood levels to reduce the risk of side effects and ensure an adequate dose to produce the best response. Common side effects of lithium include weight gain, tremor, nausea, and increased urination. Lithium may affect the thyroid gland and 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 studied as a mood stabilizer in bipolar illness. Divalproex is equally effective for both euphoric and mixed manic episodes. It is also effective in rapid-cycling bipolar disorder and bipolar illness complicated by substance abuse or anxiety disorders. Unlike other mood stabilizers, divalproex can be given in relatively large initial doses which may produce a more rapid response in acute mania. Common side effects of divalproex are sedation, weight gain, tremor, and gastrointestinal problems. Blood level monitoring and dose adjustments may help minimize side effects. Divalproex may cause mild liver inflammation and may affect production of a type of blood cell called platelets. Although it is quite rare for there to be any serious complications from these possible effects, it is important to monitor liver function tests and platelet counts periodically.

Other anticonvulsants used as mood stabilizers

- *Carbamazepine* (Tegretol). Although fewer studies support the use of carbamazepine, its effects appear similar to divalproex. It has also been available for many years and is effective in a broad range of bipolar subtypes 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. Carbamazepine can interact in complicated ways with many other medications, so

that careful monitoring is needed when it is combined with other medications.

- **Lamotrigine** (Lamictal) may be especially useful for the depressed phase of bipolar disorder and in maintenance treatment. It is sometimes considered an antidepressant agent (see below). One serious risk of lamotrigine is that 3/1,000 individuals (0.3%) taking the medication develop a serious rash. The risk of rash can be reduced by increasing doses very slowly. Aside from the risk of rash, lamotrigine tends to have fewer troublesome side effects, but can cause dizziness, headaches, and vision difficulties.

Antipsychotic medications

A number of antipsychotic medications have been approved by the FDA to treat bipolar disorder. These medications are called antipsychotics because they were first approved for the treatment of psychotic symptoms, such as hallucinations and delusions, that may occur in disorders such as schizophrenia or severe depression or mania. There are 2 kinds of antipsychotics: older antipsychotics (called *typical* or *conventional antipsychotics*) and newer antipsychotics (called *atypical* or *second-generation antipsychotics*). Older antipsychotics, such as haloperidol (Haldol), perphenazine (Trilafon), and chlorpromazine (Thorazine), can cause a permanent movement disorder called tardive dyskinesia (TD) and may also cause muscle stiffness, restlessness, and tremors. For this reason, the older antipsychotics are not usually a first-choice treatment, but they can sometimes be helpful for patients who do not respond to or have troublesome side effects with the newer atypical antipsychotics. The atypical antipsychotics have a much lower risk of causing TD (roughly 1% per year) and movement and muscle side effects. Because of this, they are usually the first choice in any situation when an antipsychotic is needed.

The *atypical antipsychotic medications* have been found to be effective in treating bipolar mania even when no psychotic symptoms are present, so that they are now considered mood stabilizers as well as antipsychotics. Five of these agents are currently approved by the FDA for use in bipolar mania:

- **aripiprazole** (Abilify)
- **olanzapine** (Zyprexa)
- **quetiapine** (Seroquel)
- **risperidone** (Risperdal)
- **ziprasidone** (Geodon)

Another atypical antipsychotic, clozapine (Clozaril), is also available. However, it can cause a rare and serious blood side effect, requiring weekly or biweekly blood tests, so that it is only used when patients have not responded to other antipsychotics.

Some of the atypical antipsychotics can cause side effects such as drowsiness and weight gain. Weight gain is most often associated with clozapine and olanzapine, followed by risperidone and quetiapine, while ziprasidone and aripiprazole have the lowest risk of weight gain. Because substantial weight gain can increase the risk for type II diabetes mellitus, the American Diabetes Association recommends that weight, blood sugar, and cholesterol levels be monitored in patients taking atypical antipsychotics.

What are antidepressants?

Antidepressants treat symptoms of depression. In bipolar disorder,

antidepressants must be used together with a mood stabilizing medication. If used alone, antidepressants can cause a person's mood to "overshoot" and switch from depression to hypomania or mania. Many types of antidepressants are available with different mechanisms of action and side effects. Most antidepressant studies have been done in unipolar depression—in people who have never had a manic episode. In unipolar depression, the available antidepressants appear to be about equally effective. Only limited research has been done with antidepressants in bipolar disorder, but most doctors would consider using one of the following:

- **Lamotrigine** (Lamictal)
- **Bupropion** (Wellbutrin)
- **Selective serotonin reuptake inhibitors:** citalopram (Celexa), escitalopram (Lexapro), fluoxetine (Prozac), fluvoxamine (Luvox), paroxetine (Paxil), sertraline (Zoloft)
- **Venlafaxine** (Effexor)
- **Duloxetine** (Cymbalta)
- **Olanzapine/fluoxetine combination** (Symbyax)

TREATMENT OF DIFFERENT PHASES OF ILLNESS

Treatments for acute mania

In choosing among the different medications that are available, your doctor will consider your treatment history (whether any of the medicines has worked well for you in the past), the subtype of bipolar disorder you have (e.g., whether you have rapid-cycling illness), your current mood state (euphoric or mixed mania), and the particular side effects you are most concerned about.

Manic episodes can be treated with a traditional mood stabilizer (lithium or divalproex) alone, an atypical antipsychotic alone, or a combination of the 2. Patients with more severe symptoms may do best taking a combination of lithium or divalproex and an atypical antipsychotic. It is also sometimes helpful to combine lithium and divalproex. Carbamazepine is sometimes used as an alternative or in addition to lithium or divalproex.

Less is known about the treatment of hypomanic episodes in bipolar II disorder. They can be treated with lithium or divalproex. It is also often helpful to combine medication with psychotherapy in hypomania. While psychotherapy is not usually particularly helpful during acute mania, it is highly recommended for phases of illness when the person is more able to take in and use new information, such as hypomanic or depressive episodes and during maintenance treatment.

How quickly do treatments for acute mania work?

It can take a few weeks to see a full response to medications used to treat acute mania. For this reason, doctors sometimes find it helpful to add a sedative called a benzodiazepine, such as lorazepam (Ativan) or clonazepam (Klonopin), to provide immediate, short-term relief from the insomnia, anxiety, and agitation that often occur during a manic episode. However, these medicines should be carefully supervised or avoided in patients who have a history of drug addiction or alcoholism, due to their addictive potential. Although benzodiazepines can cause drowsiness, doses can generally be lowered as the person recovers. However, some people need to continue taking a sedative for longer to control symptoms such as insomnia or anxiety.

Treatments for acute depression

A combination of medication and psychotherapy is recommended for bipolar depression. The doctor may also use medication alone at first, especially if the person has severe or psychotic depression and finds it hard to participate in therapy. Milder depression can usually be treated with lamotrigine or lithium alone. Combination treatment with lithium plus an antidepressant or lamotrigine may be needed for more severe depression. For psychotic depression, an atypical antipsychotic is usually combined with an antidepressant, lithium, or lamotrigine. Antidepressants should always be given with a mood stabilizing agent in bipolar disorder to avoid triggering a manic episode and should be avoided if possible in rapid cycling patients.

Antidepressants usually take several weeks to show effects. Although many patients will respond to the first antidepressant they try, some people may have to try 2 or 3 different antidepressants before finding one that is fully effective and doesn't cause troublesome side effects. While waiting for the antidepressant to work, the doctor may prescribe a sedative to help relieve insomnia, anxiety, or agitation. If depression persists, the doctor may suggest adding another medication (lamotrigine, lithium, an antidepressant, an atypical antipsychotic) or switching to a different medication.

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 people have varying responses to different medications, the types of side effects 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 one 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. The doctor may start with a low dose and adjust the medication to higher doses very slowly. Although this may mean waiting longer to see if the medication will help, it reduces the chances of side effects. With lithium or divalproex, blood level monitoring is important to be sure you are receiving enough medication to help, but not more than is needed. If side effects occur, the dose can often be lowered to eliminate side effects or another medication can be added to help. *Be sure to discuss your concerns about side effects and any problems you may be having with your doctor, so that these can be taken into account in planning your treatment.*

Psychotherapy

Over the last decade, great progress has been made in developing effective psychotherapy treatments for bipolar disorder. These are almost always used together with medication, but can sometimes be useful alternatives for patients whose ability to take medication is limited by conditions such as heart or liver disease, obesity, renal problems, or pregnancy. Psychotherapy can also be very helpful for other problems people with bipolar disorder may have, such as anxiety, eating disorders, or substance abuse.

Psychotherapy is more likely to be used during acute depressive episodes than during manic episodes. This is because people may find it hard to listen to a therapist during a manic episode. Psychotherapy can help a person cope with life problems, come to terms with changes in self-image and goals, and understand

the effects of the illness on significant relationships. It may also help prevent future manic and depressive episodes by reducing the stresses that trigger episodes and by helping patients continue taking their medication.

Studies have found the following types of therapy to be effective in improving depressive symptoms and preventing relapse:

- **Cognitive-behavioral therapy** focuses on education about the illness, taking medication as prescribed, changing negative thoughts and beliefs that can lead to depression, problem solving, and setting goals.
- **Family-focused therapy** focuses on educating family members about the illness and improving communication and problem solving within the family.
- **Interpersonal therapy** focuses on improving relationships and ability to interact with other people and reducing the strain that a mood disorder can place on relationships. It may include social rhythms therapy, which focuses on restoring and maintaining personal and social routines to stabilize body rhythms, especially the 24-hour sleep-wake cycle.

Psychotherapy can be done individually (just you and a therapist), in a group (with other people with similar problems), or with the 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.

Psychotherapy usually works more gradually than medication and may take 2 months or more to show its full effects, but the benefits may be long lasting. Remember that psychotherapy, like medication, works differently for different people.

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 delusions or hallucinations are 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 generally 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) will be hospitalized at some point in their illness. Because both mania and depression affect insight and judgment, individuals with bipolar disorder are often hospitalized over their objections, which can be upsetting for both patients and their loved ones. However, most people with bipolar disorder 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:

- When safety is in question because of 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 continue to provide for a long period of time)
- To prevent access to drugs, when there is ongoing substance abuse
- When the patient has an unstable medical condition
- When the reaction to medication needs to be closely observed

Preventive (maintenance) treatment

Mood stabilizing medications are the cornerstones of preventive or maintenance treatment. Some people with bipolar disorder remain completely free of symptoms just by taking mood stabilizing medication for life. Most people experience a great reduction in the frequency and severity of episodes by continuing medication on a maintenance basis. Psychotherapy can also help prevent mania and depression by reducing stresses that trigger episodes and by helping patients continue to take their medication.

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).

It is hard to continue taking medication as prescribed on a long-term basis whether you are being treated for a medical condition, such as high blood pressure or diabetes, or for bipolar disorder. Individuals with bipolar disorder may be tempted to stop 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 side effects too hard to deal with. Or they may miss the mild euphoria they experienced during hypomanic episodes. However, research clearly shows that stopping maintenance medication almost always results in relapse, usually in weeks to months after stopping. It has been found that, when lithium is stopped, the rate of suicide rises dangerously. There is some evidence that stopping lithium abruptly (rather than slowly tapering off) carries a much greater risk of relapse. Therefore, if you must stop medication, it should be done gradually under the close medical supervision of your doctor.

If someone has had just 1 episode of mania, the doctor may consider tapering the medication after about a year; however, if the person has a strong family history of bipolar disorder or it was a particularly severe episode, the doctor may consider longer term maintenance treatment. If someone has had 2 or more manic or depressive episodes, experts strongly recommended taking preventive medication indefinitely. The only times to consider stopping preventive medication that is working well are if a medical condition or severe side effects prevent 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. Discuss each of these situations carefully with your doctor.

EDUCATION AND SUPPORT: LEARNING TO COPE WITH BIPOLAR DISORDER

Education and support are also important parts of treatment. The 2003 report of the President's New Freedom Commission on Mental Health stressed the importance of patient- and family-centered treatment that focuses on recovery. They noted that patients and families need to have access to up-to-date and accurate information about mental illness and its treatment and take an active role in making decisions about the care they receive.

Is there anything I can do to help my treatment?

Absolutely, yes. First, become an expert on your illness. Since bipolar disorder is a lifetime condition, you and your family, and others who are close to you, should try to learn as much as you can about the illness and its treatment. Read books, attend lectures, talk to your doctor or therapist, and consider joining a chapter of the Depression and Bipolar Support Alliance (DBSA) or NAMI 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.

The following techniques may help you reduce mood swings and stresses that sometimes lead to more severe episodes:

- **Maintain a stable sleep pattern.** Go to bed about 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 over busy 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 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 a self-help group such as Alcoholics Anonymous. Be 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 to 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.** Learning as much as you can about bipolar disorder will help reduce the inevitable stress on relationships that the illness can cause. Remember it is not always easy to live with someone who has mood swings and even the "calmest" family sometimes needs outside help to deal with the stress of a loved one who has a mood disorder. Ask your doctor or therapist to help you and your family learn more about bipolar disorder. It can also help to participate in family therapy or join a support group.
- **Try to reduce stress at work.** Of course, you want to do your best at work, but keep in mind that avoiding relapses is very important and, in the long run, will increase your overall productivity. If mood symptoms interfere with your ability to work, talk to your doctor about whether it is better to "tough it out" or take some time off. How much you tell your employers

and coworkers about your illness is ultimately up to you. If you are unable to work, you might have a family member tell your employer you are not feeling well, are under a doctor's care, and will return to work as soon as possible.

- **Learn to recognize “early warning signs” of a new episode.** Early signs of a mood episode vary from one person to another and are different for mania and depression. 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 changes in your sleep pattern*, because this is a common clue that trouble is brewing. Since loss of judgment may be an early sign of a coming episode, ask your family to watch for early warnings you may be missing.
- **Join a support group.** Support groups, such as those sponsored by DBSA or NAMI, give you the chance to share experiences with others who are facing many of the same problems and learn more about your illness and ways to cope with it.
- **Consider entering a clinical study.** Patients in clinical trials have thorough medical and psychiatric evaluations and sometimes have the chance to try medications that are not yet generally available.

What if I feel like quitting treatment?

It is normal to have occasional doubts about continuing treatment. If you feel your 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 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, you will see your doctor less often; 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
- Need for over-the-counter medication (cold or pain medicine)
- An acute medical illness or need for surgery, extensive dental care, or changes in other medicines you take
- A change in your medical situation, such as pregnancy

How can I monitor my own progress in treatment?

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. Many people use a simple, visual scale on which they note their mood on a line from the “most depressed” to the “most manic” they have ever felt, with “normal” in the middle (Your doctor can give you a

sample chart to use.) Often a quick daily entry about your mood is all that is needed. Noticing changes in sleep and stresses in your life may help you identify 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 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 illness, its causes, and treatments. Talk to the person's doctor if possible. Learn to recognize the person's particular warning signs of coming mania or depression. Talk to your loved one or friend, while he or she is well, about how you should respond if you see symptoms starting to come back.

- Encourage the person to stick with treatment, to see the doctor, and to avoid alcohol and drugs. If the person 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 an episode of depression or mania and suddenly views your concern as interference, remember this is not a rejection of you but is 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, discussing methods of suicide, or exhibiting increased feelings of despair, seek help from the doctor or other family members or friends. Privacy is a secondary concern when the person is at risk for suicide. Call 911 or a hospital emergency room if the situation becomes desperate.
- If the person is prone to mania, take advantage of stable periods to arrange “advance directives”—plans and agreements you make with the person when stable to avoid problems during future episodes of illness. Discuss when to institute safeguards, such as withholding credit cards, banking privileges, and car keys, and when to go to the hospital.
- Share responsibility for caring for the patient with other loved ones. This reduces stressful effects the illness has on caregivers and helps 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 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 warning symptoms. If there is a recurrence of illness, you may notice it before the person does. Point out the early symptoms in a caring manner and suggest talking with the doctor.
- Demonstrate hope. If you continue to believe your loved one will get better, you send a powerful message to your loved one.
- 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 and bad days like everyone else. With experience and awareness, you will be able to tell the difference between the two.
- Work with your family member or friend to find healthcare providers who 1) build on patients' strengths instead of focusing on the illness 2) seek full recovery, not merely a lessening of symptoms and 3) believe in patients' ability to recover.
- Take advantage of the help available from support groups.

INFORMATION, ADVOCACY, AND RESEARCH*

Listed below are some of the major organizations that help people with bipolar disorder. The first 3 are advocacy groups—grass-roots 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 suffer from severe mood disorders. Such help can play an important role in promoting recovery. The other 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.

Depression and Bipolar Support Alliance (DBSA)

- Over 1,000 peer-run support groups
730 N. Franklin St., Suite 501
Chicago IL, 60610-7224
800-826-3632
www.DBSAlliance.org

NAMI

- More than 1,200 local affiliates
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)

- More than 340 affiliates
National Mental Health Information Center
2001 N. Beauregard St., 12th floor
Alexandria, VA 22314-2971
800-969-6642
www.nmha.org

American Foundation for Suicide Prevention

120 Wall Street, 22nd Floor
New York, New York 10005
888-333-AFSP (888-333-2377)
www.afsp.org

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.miminc.org

Massachusetts General Hospital Bipolar Clinic and Research Program

- Helpful information and resources for clinicians and patients
50 Staniford St., 5th floor
Boston, MA 02114
617-726-6188
www.manicdepressive.org

FOR MORE INFORMATION

The DBSA distributes educational booklets free of charge that can be downloaded or ordered from their Web site. The publications and Web sites listed below also provide more information.

Medical information about bipolar disorder

- The bipolar child: The definitive and reassuring guide to childhood's most misunderstood disorder. D. F. Papolos, J. Papolos. Broadway Books, 2002
- The bipolar disorder survival guide. D. J. Miklowitz. Guilford, 2002
- Cognitive-behavioral therapy for bipolar disorder. M.R. Basco, A.J. Rush. Guilford, 1996
- Coping with bipolar disorder: A guide to living with manic depression. S. Jones, P. Hayward, D. Lam. Oneworld Publications, 2002
- Diagnostic and statistical manual of mental disorders, 4th Ed, text revision (DSM-IV-TR). American Psychiatric Association, 2000
- Evidence-based practices: Shaping mental health services toward recovery. Project sponsored by U.S. Substance Abuse and Mental Health Administration (Center for Mental Health Services), the Robert Wood Johnson Foundation, and other public and private organizations to help consumers access effective services (www.mentalhealthpractices.org)
- Manic-depressive illness, 2nd edition. F. K. Goodwin, K. R. Jamison. Oxford University Press, in press
- A mood apart: The thinker's guide to emotion and its disorders. P. C. Whybrow. Perennial Currents, 1998
- Mood genes: Hunting for origins of mania and depression. S.H. Barondes. Oxford, 1998
- New hope for people with bipolar disorder. J. Fawcett, B. Golden, N. Rosenfeld. Three Rivers Press, 2000
- Night falls fast: Understanding suicide. K. R. Jamison. Vintage, 2000
- Report of the President's New Freedom Commission on Mental Health (www.mentalhealthcommission.gov)
- Touched with fire: Manic-depressive illness and the artistic temperament. K. R. Jamison. Free Press, 1996
- When someone you love is depressed. L. Rosen, X. Amador. Free Press, 1997

Outstanding books by people with bipolar disorder or depression:

- The beast: A reckoning with depression. T. Thompson. Diane Publishing, 2000
- A brilliant madness: Living with manic-depressive illness. P. Duke, G. Hockman. Bantam Books, 1992
- Call me Anna: The autobiography of Patty Duke. P. Duke. Bantam, 1988
- Darkness visible, a memoir of madness. W. Styron. Vintage, 1992
- On the edge of darkness: America's most celebrated actors, journalists and politicians chronicle their most arduous journey. K. Cronkite. Delta, 1995
- An unquiet mind, a memoir of moods and madness. K. R. Jamison. Vintage, 1997
- Undercurrents: A therapist's reckoning with her own depression. M. Manning. Harper Collins, 1994

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