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This book is dedicated to everyone touched by bipolar disorder. Whether you, or someone you care about, have bipolar disorder, your strength and courage is an inspiration to us all. We dedicate this book to you and wish you the best of health. A special thanks to the children who inspired us to found this organization, Chris, Court, Lauren and Sam.
Acknowledgments

The International Bipolar Foundation was founded in 2006 by four mothers with children affected with bipolar disorder. Their desire to ensure a better future for their children and others affected by this illness resulted in an organization dedicated to finding the cure for bipolar disorder.

In this manual, we are so fortunate to receive the support and input from many experts in the field of bipolar disorder, practitioners, and those who have been touched firsthand by the illness. They came together with the common goal of presenting a book that would help anyone who has a connection to this disease. We extend a special thanks to the four founding members of the International Bipolar Foundation - Lynn Hart-Muto, Karen Sheffres, Muffy Walker, and Lisa Selbst Weinreb - whose love for their children and their desire to make a better future for them and others with the disease never waned. The International Bipolar Foundation came into being through their tireless work, vision and dedication. The foundation has awarded over $210,000 in research grants to assist in finding a cure for bipolar disorder.

In addition, we wish to thank our scientific advisory, honorary and consumer advisory boards who have continued to support the foundation.

Lastly, a resounding thank you to all who support the International Bipolar Foundation by providing encouragement, guidance, and love to those affected by this disease.

To your health,

The Founding Board

Lynn Hart-Muto         Karen Sheffres         Muffy Walker         Lisa Selbst Weinreb
Founded by four parents with children affected with bipolar disorder, the International Bipolar Foundation is a not for profit organization whose mission is to eliminate bipolar disorder through the advancement of research; to promote and enhance care and support services; and to erase associated stigma through public education.

www.InternationalBipolarFoundation.org

We are proud to offer these programs and services free of charge to our global community:

Research

- **Research Partner Program**: Research Partner Program offers donors the opportunity to personally select and sponsor scientists based on specific research aims, their affiliated institutions, or a combination thereof.

Care & Support

- **Buddy Program**: If you are new to the diagnosis of bipolar disorder and need a helping hand, or if you are willing to lend a helping hand to a newly diagnosed person or family, then the Buddy Program is for you. This program matches new members with more experienced members/families.

- **Outreach & Referral**: If you need a referral or feedback on a provider, we will send you the comments from our supporters

- **Ambassador Program**: Ambassadors surpass barriers of stigma, help others with bipolar disorder (or other mental illnesses), and further the mission of educating the public and erasing stigma

- **International bloggers**

- **Awards**: HOPE Award is given to an individual or organization whose public efforts improve care, support and access to mental health treatment &/or champions to erase the stigma of mental illness and instills hope in families, communities and the nation. IMAGINE Award is given to a person who has bipolar disorder who sees beyond the illness and can imagine a future free of barriers, stigma, and discrimination. The recipient empowers others by sharing their story instilling hope and inspiration.

- **Memory Wall**: Leave a comment of hope or dedication on our website memory wall

Education

- Healthy Living with Bipolar Disorder book
- Girl Scouts of the United States Mental Health Awareness patch
- My Support e-newsletter
- High school essay contest
- Speakers’ Bureau
- Webinars
- Monthly lectures
- Say it Forward anti-stigma campaign
- FaceBook, Twitter, ShareCare
- Educational videos and brochures
- Conferences
How To Use This Manual

This book was created to assist anyone touched by bipolar disorder. It contains helpful information on a variety of topics that arise in everyday life, as well as resources for dealing with specific issues facing those affected by this illness. It is our goal to provide new perspectives and helpful guides to healthy living, while recognizing the stigma and challenges of bipolar disorder.

The binder format allows you to continue to add any additional information so that this may become your ultimate reference book. Periodic updates will be posted at www.InternationalBipolarFoundation.org which you can download and print for free.
Ashley Aleem, B.A. graduated from San Diego State University in 2008 with a Bachelor of Arts in Psychology. While an undergraduate student she volunteered as a peer advocate at San Diego Center for Children where she worked alongside severely emotionally disturbed youth. She also worked with San Diego County Independent Living as a residential supervisor to former foster females and as a case manager and daily living skills educator to transitioning and former foster youth within the community. She is currently pursuing a Master’s degree in Clinical Mental Health Counseling at the University of San Diego. In July 2010, Ashley presented a proposal on a screening process for psychopathic violent offenders at the American Mental Health Counseling Association’s national conference in Boston, Massachusetts. Since its inception in January of 2010, Ashley has been working with Exodus Central Connections, the treatment sector of the San Diego Behavioral Health Court Calendar, where she provide case management and rehabilitative services to severely mentally ill individuals involved in the criminal justice system.
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Karen Freeman, MS, RD, CSSD

Karen Freeman is a Registered Dietitian and Certified Specialist in Sports Dietetics, and has been applying her nutritional expertise in academic, clinical and private practice settings for the past thirty years. She specializes in weight management, eating disorders and sports nutrition for all age groups. In addition to her full time private practice, she is the Sports Dietitian for the San Diego Chargers football team. She has also worked with the San Diego Padres, San Diego Spirit women’s soccer team, Los Angeles Raiders, New York Rangers hockey team, as well as high school, college and Olympic athletes.

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Ellen Frudakis was born in Northern California and raised in the foothills of Nevada County California. In 2004 she co-founded Impact Young Adults (IYA), a nonprofit organization that provides social activities and leadership development for young adults with mental illness. Since that time she has held the role of Co-president, helping to build the organization along with its next round of young leaders. A previous member of the Consumer Advisory Board, Ellen now serves on the Executive Board of the International Bipolar Foundation. Ellen is also the recipient of the International Bipolar Foundation’s prestigious Imagine award.

Ellen received her Bachelor of Science degree in Human Services from Springfield College in 2005, graduating with honors and earning the Student Humanics award for representing the very principles of this degree program. She is currently in graduate school, working towards a Master of Arts Degree in Nonprofit Leadership and Management at the University of San Diego.
Reverand Susan Gregg-Schroeder of California founded Mental Health Ministries in 2001 to provide media and print educational resources to help erase the stigma of mental illness in our faith communities. Susan’s DVD set, Mental Illness and Families of Faith: How Congregations Can Respond, offers eight shows on a variety of mental health issues. There is also a downloadable resource/study guide and other print resources available in English and Spanish at www.MentalHealthMinistries.net. Susan’s shares her personal journey with clinical depression in her book, In the Shadow of God’s Wings: Grace in the Midst of Depression. Susan works with several national groups including serving on the Advisory Committee for NAMI FaithNet, the American Association of Pastoral Counselors and the Board of Directors for Pathways to Promise.
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Christi Huff was diagnosed with Bipolar II in 2005 after experiencing eating disorders and struggling with anorexia, bulimia and depression in college. Christi has worked on understanding her own illness and how to manage it by turning to social media sites for more information and support. In addition to holding a full-time job as a paralegal, she is a partner and author of the website Ask A Bipolar and is a monthly blogger for International Bipolar Foundation. Her goal is to use her writing and support to help others. Christi wants others to know they are not alone and hopes her work can help break the stigmas.
Dr. Jensen is a psychiatrist in private practice in San Diego. He specializes in general and neuropsychiatry treating children, adolescents and adults, but is especially esteemed for his work with patients with bipolar disorder. Dr. Jensen is the Medical Director for International Bipolar Foundation.

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Throughout his career, Dr. Jensen has been a department chair, written several medical articles, been interviewed by news and radio, spoken to over 100 different organizations, been President of the San Diego Chapter of the American Academy of Child and Adolescent Psychiatry, held positions as both assistant and associate professor and has received several awards including the American Psychiatric Association (APA) Distinguished Fellow and a Special Presidential Commendation from the APA.
Wendy McNeill is a Los Angeles native who moved to San Diego to attend the University of California, San Diego, where she graduated with a B.A. in literature/writing in 1995. Ever since, her professional and personal pursuits have been as an educator, writer, and mental health advocate. She currently is a tutor at San Diego Mesa College’s Writing Center, where she has worked with students one-on-one for over ten years. Prior to her work at the college, Ms. McNeill was a recruiter and assistant to the clinic manager at the medical research study, the Women’s Health Initiative at UCSD. Later, she worked in marketing for Prudential. In the non-profit world, Ms. McNeill served as the Editor-In-Chief of The Advocate, the NAMI (National Alliance on Mental Illness) newsletter, for four years. Ms. McNeill continued to serve NAMI as a Peer Mentor, an In Our Own Voice public speaker, and as a trainer for PERT, the Psychiatric Emergency Response Team with the SDPD. In addition, Ms. McNeill served on the NAMI Board for four years and is currently on the Board of MHA (Mental Health America.) Ms. McNeill continues to advocate for people with mental illness in her blog, Wendy’s Whirl’d. She has been published in Our Stories: Things We Knew Now We Wish We Knew Then and bp magazine.
Dr. Thomson is a board certified staff psychiatrist at Counseling and Psychological Services at the University of Virginia Student Health Services as well as a private practitioner in Charlottesville, Virginia. His work with Paul Andrews on an evolutionary view of depression was featured in the New York Times Magazine in 2010. He is the co-author of the 2010 book – Facing Bipolar: The Young Adults Guide to Dealing with Bipolar Disorder (New Harbinger Publications) as well as the author of Why We Believe In Gods: A Concise Guide to the Science of Faith (Pitchstone Publishing, 2011).
Muffy Walker was born and raised outside of Philadelphia, PA. She currently resides in Rancho Santa Fe with her husband John C. Reed and their three sons. In 1983, Walker graduated with a Master's of Science in Psychiatric Nursing from the University of Pennsylvania. She worked in the mental health field for over 18 years until she moved to California when she obtained her MBA with a focus in marketing from the University of California-Irvine.

Walker has owned several companies both for and not for profit and is the founder and President of International Bipolar Foundation (IBPF). After learning that her youngest son had Bipolar Disorder, Walker joined other mental health boards and ultimately started IBPF. She has served on a plethora of boards including Children's Hospital, Kids Korps USA, NeighborHelp, ChildHelp USA, and has dedicated the past 10 years of her life championing the education of the public about mental illness. Walker's interests include travel, tap dancing, community theatre, and Thai cooking.
Lisa Weinreb is a Deputy District Attorney in San Diego County and has been a prosecutor for 19 years. Ms. Weinreb is an adjunct Professor at California Western School of Law where she teaches Trial Practice, White Collar Crime, Culture and the Criminal Justice System and Advanced Criminal Prosecution. She has also been an instructor for the California District Attorneys Association, the National Institute for Trial Advocacy and the National District Attorneys Association. Ms. Weinreb received her Bachelors degree from the University of Texas at Austin and her Juris Doctor from California Western School of Law.

She is a co-founder and the Vice President for the International Bipolar Foundation.
What is Bipolar Disorder?

By Lisa Selbst Weinreb, J.D.

Bipolar disorder, formerly referred to as manic-depressive illness, is a brain illness that causes unusual fluctuations in a person’s mood. These fluctuations are very different from the normal mood changes most people experience. Those with bipolar disorder commonly have very severe mood changes that can impact all aspects of their lives, including work, relationships, school, and may involve substance abuse and suicide attempts. However, bipolar disorder is treatable, and most people diagnosed with bipolar disorder lead healthy, active and very successful lives.

There are 27 million people worldwide who have bipolar disorder, according to National Institute of Mental Health. (NIMH) The numbers are actually higher since statistics for children are not yet included. Bipolar disorder typically develops in late adolescence or early adulthood, with many people experiencing their first symptoms in childhood. Bipolar disorder is often either not recognized or is misdiagnosed, resulting in unnecessary suffering for years before being properly diagnosed and treated. Bipolar disorder is a lifelong illness that must be addressed and treated throughout a person’s life, just like any other chronic disease, such as diabetes and heart disease.

Symptoms of Bipolar Disorder

According to NIMH, “people with bipolar disorder experience unusually intense emotional states that occur in distinct periods called “mood episodes.” NIMH describes a mood episode as an overly joyful or overly excited state or manic episode, and an extremely sad or hopeless state is called a depressive episode. Sometimes, a mood episode includes symptoms of both mania and depression resulting in a mixed state. People with bipolar disorder also may be explosive and irritable during a mood episode.

<table>
<thead>
<tr>
<th>Mood Changes</th>
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<td><strong>Symptoms of mania or a manic episode include:</strong></td>
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<tr>
<td>• A long period of feeling “high” or an overly happy mood</td>
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<tr>
<td>• Extremely irritable mood or agitation</td>
</tr>
<tr>
<td><strong>Symptoms of depression or a depressive episode include:</strong></td>
</tr>
<tr>
<td>• A long period of feeling worried or empty</td>
</tr>
<tr>
<td>• Loss of interest in activities once enjoyed</td>
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</tbody>
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Symptoms of mania or a manic episode include:
- Easily distracted
- Rapid speech, racing thoughts
- Increasing goal-directed activities, such as taking on new projects
- Decreased need for sleep
- Having an unrealistic belief in one’s abilities
- Behaving impulsively and engaging in high risk behaviors such as spending sprees or impulsive sexual activity

Symptoms of depression or a depressive episode include:
- Feeling tired or “slowed down”
- Having problems concentrating, remembering, and making decisions
- Being restless or irritable
- Change in eating, sleeping or other habits
- Thinking of death or suicide, or attempting suicide*

* Thoughts of suicide can occur in manic, depressive and mixed state episodes
If you are a parent and have suspected or been told that your child may be suffering from bipolar disorder, no doubt, you are somewhere in the process of trying to understand what that means for you, your child and the rest of your family, now and in the future. Not every child with a mood swing or tantrum however, has bipolar disorder.

The entire topic of bipolar disorder in children and adolescents is a confusing one, even within the medical community. It is understandable then, that as a parent, you may be confused as well. Skepticism and disbelief are common initial reactions, sometimes with good reason. On the other hand, it is important for parents to not allow their own confusion and fears to interfere with finding the proper help for one’s child. With so much information readily accessible from the reliable resources referred to elsewhere in this guide, a little self-education can go a long way in helping your child and family. In this chapter, we will examine why there is so much confusion about bipolar disorder in children and adolescents, help clarify some of the issues surrounding this confusion, and attempt to provide some guidance for you and your family. With the correct information, you will be prepared to seek and obtain the most appropriate intervention and treatment for your child and family. With proper guidance and proper treatment, you will be providing your child with the best chance of living a happy, healthy, fulfilling, and successful life.

**Bipolar Disorder is a Brain Disorder**

It is very difficult for us to think of the brain in the way we think about any other organ in our body, like the heart, skin, pancreas or lungs. When one of these organs malfunctions as the result of illness, there is no negative stigma attached to it. If someone suffers from high blood pressure, friends and relatives do not suggest that he or she simply lower one’s blood pressure by using his or her mind. If one suffers from skin cancer, no one expects that he or she make the cancer go away by willpower. If someone suffers from diabetes, we don’t suggest that the person just use their brain to get their pancreas to regulate the levels of sugar in their blood. If someone has pneumonia, no one expects that he or she use their mind to fight off the virus or bacteria causing the pneumonia. Of course, there are things
we can do to help the situation. For high blood pressure, we can decrease our salt intake. For diabetes, one can modify one’s diet, exercise and sugar intake. When one’s body needs to fight cancer or an infection, one needs to rest, so the body can use its resources for healing.

When one suffers from an illness of the brain, instead of resulting in measurable changes in blood pressure or blood sugar, it often results in less easy to measure changes in one’s thoughts, feelings and behaviors. Just like in the examples above, these alterations in one’s thoughts, feelings and behaviors, are often beyond one’s control. We are raised however, to believe that we have the power and ability to exercise control over our own thoughts, feelings and behaviors. When we don’t, we are held accountable and there are consequences. This is reasonable in the absence of a brain illness. When there is an illness of the brain however, there are chemical, cellular and structural changes caused by the illness that, up until very recently, have been difficult to observe and measure. Since these changes are difficult to observe and measure, people have traditionally had a difficult time believing such changes were real. The belief that we should be able to control our thoughts, feelings and behaviors, coupled with the lack of evidence that anything was physically altered in the brains of people with disordered thoughts, feelings and behaviors, resulted in the bias and stigma that people with a brain or mental illness should somehow be able to have control over the abnormal thoughts feelings and behaviors from which they suffer. This stigma becomes fueled by our own fears of not being able to control our own thoughts, feelings or behaviors while failing to make the distinction between a normally functioning brain, and a brain suffering from an illness.

During the last two decades, however, with advances in technology and the development of sophisticated brain imaging techniques, the changes in the brains of people who suffer from mental illnesses are more able to be observed, measured and studied. While such scientific techniques are used in researching brain illnesses, in most cases, these techniques are not yet available for examining the brains of individuals for the purposes of assessing, diagnosing and treating individual people who suffer from some form of mental, or brain illness.

After years of research, although we still probably know relatively little about the functioning of the brain, there are some things we have learned about illnesses of
the brain, such as bipolar disorder. We know that in bipolar disorder, there are often underlying genetic determinants found in the DNA inherited from one’s ancestors that modulate the production and release of chemicals within and between our brain cells, which have an impact upon how the brain works. Depending upon which areas of the brain are affected, changes in one’s thoughts, feelings and behaviors can be the result. While there are likely many other chemicals involved, some of these chemicals are called “neurotransmitters.” Some of the commonly known neurotransmitters include Serotonin, Dopamine, Acetylcholine and Norepinephrine. Whether caused completely by genetics, or by an interaction between something in the environment and our genetically inherited DNA, the result can be structural and chemical changes in the brain that can change the way we think, feel and behave. When these altered thoughts, feeling and behaviors are recognized as abnormal, they are called “symptoms.” When there is a collection of symptoms that have a negative impact on one’s successful functioning, we call it an illness, a disease or a disorder. In the past, before we had a way to link these symptoms of impaired thoughts, feelings and behavior to the physical structure of the brain, we attributed them to the “mind” and understood them to be a result of a “mental disorder.” It would seem that much of the confusion and stigma surrounding these illnesses could be resolved if we began to understand these illnesses for what they are: illnesses of the brain, or Brain Disorders.

### Genetics and the Environment

Bipolar disorder is understood as a genetically determined disorder of the brain that results in an alteration in one’s thoughts, feelings and behaviors that are not readily controlled by an individual’s will or desire to control them. According to the American Academy of Child and Adolescent Psychiatry, identical twin studies have demonstrated that if one twin has bipolar disorder, there is a seventy percent chance that the other twin will develop it as well. There is a four to six times increased risk of a child developing bipolar disorder if that child has a parent or sibling with bipolar disorder. Even though a child may be at a four to six times increased risk of developing bipolar disorder when their parent or sibling has bipolar disorder when compared to the general population, most children whose parents or sibling have bipolar disorder will not develop bipolar disorder. Proper nutrition, exercise, an adequate amount of sleep, avoiding overly stressful life situations, the absence of trauma, and avoiding substances that can be toxic to the brain such as drugs of abuse and alcohol, may possibly prevent, help delay the onset or minimize the impact of bipolar disorder in some genetically vulnerable people.

It is difficult to argue against the idea that people are responsible and accountable for their behavior. However, if we can understand that the child or adolescent whose behaviors are the result of, or at least influenced by an illness affecting his or her brain, through no fault of his or her own, it can help parents, siblings,
Diagnosing Bipolar Disorder in Children and Adolescents

As is true for medical conditions of any kind, an understanding of that condition, how to treat it, and what to expect in the future begins with a proper diagnosis. This is where most of the confusion regarding bipolar disorder in children and adolescents begins. Thirty years ago, bipolar disorder in children and adolescents was a rarity. In the past ten years, there has been a fortyfold increase in the diagnosis of bipolar disorder in children and adolescents, with one percent, or approximately one million children and adolescents in the United States currently diagnosed with bipolar disorder. (Bipolar Disorders: A Guide to Helping Children and Adolescents by Mitzi Walt) There is some controversy as to whether these statistics reflect better recognition of a disorder that has always been there, an actual increase in incidence of the disorder, an over inclusiveness with regard to what we define as bipolar disorder in children and adolescents, or some combination of these three factors.

Nevertheless, it is very difficult for a parent to hear, and accept that their child’s mood or behavior may be the result of a serious psychiatric condition. As parents, we want our children to be “normal,” and we struggle with accepting the news that our child’s behavior may fall outside of the range of what is considered “normal,” regardless of whatever the diagnosis may be. Suddenly, our hopes, dreams and wishes for our child are being threatened. Making matters worse, as is true for much of the world of medical science and research, the more we learn, the more we realize how much we don’t know. It is important that one’s child be assessed by a qualified, up to date clinician whom you feel comfortable with and have confidence in.

In the past, bipolar disorder was called “Manic Depression” or “Manic Depressive Disorder.” These terms are synonymous, but today, we refer to the condition as “bipolar disorder.” Bipolar disorder is suspected when there are symptoms...
suggestive of a “manic episode” or “mania.” as well as “depressive episodes,” or “depression.” These episodes can be mild, moderate or severe. When very severe, the depressive or manic episodes may be accompanied by misperceptions of reality, or “psychotic symptoms,” such as delusional beliefs or hallucinations. One of the problems with recognizing and diagnosing bipolar disorder is that for some period of time, a person appears to be manic, while at other times, that same person may appear to be depressed for a period of time, and at other times, that same person may have a normal, or “euthymic” mood for a period of time. This pattern is called Bipolar Disorder, Type I. If the manic episode is on the mild side, sometimes it is referred to as “hypomaniac” as it may not have quite reached the diagnostic threshold of a full blown “manic” episode. Instead of being diagnosed with Bipolar Type I Disorder, one may therefore be diagnosed with Bipolar Type II Disorder. When there are mild depressive episodes alternating with hypomaniac episodes, this is sometimes called “Cyclothymia.” When someone has symptoms suggestive of a bipolar disorder, but the symptoms do not fit any of the above subtypes, it may be categorized as Bipolar Disorder Not Otherwise Specified (NOS).

Adding further to the confusion, sometimes these mood shifts can last for weeks or months, but at other times, these mood shifts can occur with a greater frequency, and are referred to as “rapid cycling” bipolar disorder. When the mood shifts happen very frequently, such as several times per day for several days in a row, it is called “ultra rapid cycling” bipolar disorder. If that isn’t confusing enough sometimes, people can have both manic and depressive mood states overlapping and present at the same time. This is called a “mixed” episode of bipolar disorder.

To shed some light on this confusion, it appears that there is a developmental trajectory of the symptoms of bipolar disorder from childhood to adulthood. In early childhood, it is more common to have mixed states and ultra-rapidly cycling symptoms. As children with bipolar disorder become a little older, the pattern is likely to shift to a rapid cycling pattern. As age increases toward late childhood and early adolescence, there is likely to be some separation of the mixed states toward the more classic manic and depressive episodic pattern of hypomaniac or manic episodes alternating with normal mood and depressive episodes, the pattern which continues to be more common in adulthood.
Let’s take a closer look at the symptoms of both manic and depressive episodes.

**The symptoms of mania or manic episodes include:**
- an elevated, expansive, overly joyful, overly silly or irritable mood
- a decreased need for sleep
- racing thoughts
- rapid speech
- inflated self-esteem or “grandiosity”
- excessive involvement in pleasurable but risky activities
- increased physical or mental activity and energy
- an increase in sexual ideation or interest
- a decrease in the ability to concentrate and stay focused.

**The symptoms of depression or a depressive episode include:**
- frequent sadness, tearfulness, crying or persistent irritability
- a decrease in interest in activities that used to be interesting, or an inability to enjoy those activities
- a sense of boredom, feelings of hopelessness, feeling worthless or feeling inappropriately guilty
- decreased energy
- social isolation and withdrawal from others
- feeling sensitive to perceived or real rejection or failure
- low self esteem, anger, or hostility
- trouble concentrating
- poor school performance
- changes in eating habits with an increase or decrease in weight
- changes in sleeping habits, with an increase or decrease in sleep duration, headaches, stomachaches or other physical complaints
- thoughts of death and/or suicide.

In order to accurately diagnose bipolar disorder in children and adolescents, one must take all of the above information into account and put it into the context of the degree, duration and frequency of symptoms. It is important to differentiate whether or not the moods and behaviors being reported or experienced fall within the normal range of a child’s behaviors or cross the threshold into the realm of abnormality. Medical conditions, supplement or medication side effects that could mimic the symptoms of bipolar disorder must be considered. Other mood or psychiatric disorders as well as illicit drug and alcohol use may also have symptoms that can be confused with, or co-occur with the symptoms of bipolar disorder in children and adolescents.

Many of the symptoms of ADHD, another disorder common in childhood, for example, overlap with the symptoms of bipolar disorder in children and adolescents. Impulsivity, hyperactivity and distractibility, the hallmark symptoms of ADHD, are a subset of the symptoms found in bipolar disorder. Irritability, as well as oppositional and defiant behaviors, is commonly present in children with ADHD as well as bipolar disorder. It is helpful to recognize that mood elevation,
grandiosity, a decreased need for sleep and an increase in sexual interest or behavior, are features strongly suggestive of bipolar disorder, as they are not generally part of the presentation of ADHD. Another clue is that the symptoms of ADHD are generally always present, while the symptoms of inattention, distractibility, hyperactivity and impulsivity, when present in Bipolar Disorder tend to fluctuate as the episodes of mania and depression fluctuate. However, since eighty five percent of children and adolescents with bipolar disorder are likely to also suffer from ADHD, this distinction is not always helpful.

Another dilemma that causes confusion in diagnosis involves drug and alcohol use, especially in adolescents. Sometimes the effects of drugs and alcohol can mimic the symptoms of the manic or depressive episodes of bipolar disorder. Other times, when a teenager is in the midst of a manic or depressive episode, they may be more likely to experiment with or use drugs or alcohol, adding yet another layer to the difficulty in accurately diagnosing bipolar disorder in adolescents as well as young adults. One thing is very clear. The use of any illicit drugs and alcohol in the presence of bipolar disorder must be completely prohibited. Not only do they complicate the diagnostic picture, but their use is like adding “fuel to the fire” of a brain already impaired by a severe illness, and will undoubtedly worsen the symptoms and outcome of the illness. Anxiety Disorders, Major Depressive Disorder, Schizophrenia, Autism Spectrum Disorders, Post Traumatic Stress Disorder, and ADHD are some of the other common psychiatric conditions that can present with symptoms that may be confused with, or co-occur with bipolar disorder in children and adolescents.

A thorough and complete diagnostic assessment, including a physical examination, blood tests, drug screens, a thorough medical history, supplement and medication history, a thorough psychosocial and behavioral history of functioning at home, school and the community throughout the lifecycle, with special attention paid to fluctuations in moods, behaviors, feelings, performance, sleep, appetite, energy and activity level across the lifespan, are essential parts of arriving at a proper and accurate diagnosis. Interviewing the child, as well as his or her parents, with collateral input from teachers, friends and other relatives are also likely to prove helpful.

Finally, if the above diagnostic challenges are not enough, the diagnosis of bipolar disorder in children and adolescents is not without further controversy. As mentioned above, in the last decade, there has been a dramatic increase in the diagnosis of childhood onset bipolar disorder. While some parents resist the identification of bipolar disorder in their children, other parents may seek such a diagnosis as a means of explaining their child’s behavior, when the issues may have more to do with behavior problems and parenting issues as opposed to bipolar...
disorder. Still, other children may be diagnosed with bipolar disorder because of the presence of severe tantrums and outbursts along with other disruptive behaviors that warrant intervention, but there is no other diagnostic category that is a better fit in categorizing their symptoms. Researchers have recently begun examining the subset of children who may be given a diagnosis of bipolar disorder, but who lack clearly defined episodes of mania and depression. Perhaps some of these children overlap with ultra-rapid and rapid cycling presentations of bipolar disorder in children and adolescents, while others may present differently. There are some children who present with persistent and continuous severe irritability along with a low frustration tolerance, leading to frequent and severe emotional outbursts that are no longer developmentally appropriate for their age, and may be accompanied by additional symptoms of sadness, anxiety, distractibility, racing thoughts, insomnia and agitation. These children may be on a different developmental trajectory than children with classic bipolar disorder. They may be at risk for developing Depressive and Anxiety Disorders and not bipolar disorder when they reach adulthood. A new diagnostic entity called Disruptive Mood Dysregulation Disorder to identify and describe these children may be forthcoming. Regardless of the label, the children who manifest these symptoms, as well as their parents, siblings and others around them suffer greatly, and the impairments from which these children suffer are serious. A better understanding of these children, as well as effective interventions and treatments to improve the symptoms from which they suffer are clearly needed.

To summarize, not everyone who has “mood swings” suffers from bipolar disorder. Although challenging, a thorough assessment performed by a qualified and competent clinician can help clarify the issues related to the mood swings, and facilitate the establishment of the correct diagnosis or diagnoses, which will lead to recommendations for appropriate interventions and treatment. If it turns out that your child is correctly diagnosed with bipolar disorder, it is very important that your child be treated effectively and appropriately. Untreated or incompletely treated bipolar disorder can lead to terrible consequences. There are very effective treatments available that may improve or control the symptoms of bipolar disorder and allow your child every opportunity to lead a full, productive and successful life.

Course and Outcome of Children and Adolescents with Bipolar Disorder

New and ongoing research about bipolar disorder in children and adolescents is taking place and new information is being learned all the time. As of 2005, studies
suggest that 40% to 100% of children and adolescents who suffer from a manic episode will usually recover from that episode within one to two years. However, according to the Journal of American Academy of Child and Adolescent Psychiatry, of those who do not recover, up to 60-70% will experience a recurrence of an episode within 10-12 months (Journal of the American Academy of Child & Adolescent Psychiatry, Volume 44, Issue 9, Pages 846-871). In addition, many of these young people will experience frequent fluctuations in their moods, most often with depressed or mixed episodes, on an ongoing basis, aside from the recurrent episodes. The factors associated with a worse outcome over time for these children and adolescents include an early age of onset, a long duration of the illness, mixed episodes, rapid cycling, the presence of psychotic symptoms, a lack of treatment, and poor compliance with medication treatment. About 20-25% of children and adolescents with Bipolar Disorder NOS and Bipolar Type II are likely to progress to the Bipolar Type I Disorder in adulthood. Between episodes, many of these young people experience what are called “subsyndromal” symptoms of bipolar disorder, or mood and behavioral symptoms that are beyond what would be considered normal, but not severe enough to reach the level of a full blown episode. For children and adolescents, 30% of the time, full blown mood shifts between mania and depression will likely occur one time or less per year, while 50% of the time, the mood shifts will likely occur more than five times per year. Almost 40% of the time, the mood shifts between depression and mania will occur more than 10 times per year, and in 24%, they will occur more than twenty times per year ("Four-Year Longitudinal Course of Children and Adolescents with Bipolar Spectrum Disorders: The Course and Outcome of Bipolar Youth (COBY) Study, American Journal of Psychiatry, Volume 166, Pages 795-804).

Bipolar disorder in children and adolescents is best understood as characterized by shifting episodes between mania and depression, while between these episodes, symptoms of depression, mixed symptoms of depression and mania, as well as rapidly changing moods are common. The challenge for parents and clinicians is to be able to differentiate what may be a normally moody child from a child who has symptoms of a disorder that warrants treatment. Although not easy, this is an important task, as each year of untreated bipolar disorder in children and adolescents goes by, effective treatments becomes more difficult, and full recovery from symptoms becomes more difficult to achieve. Left untreated, many children with bipolar disorder grow up to become adults with bipolar disorder. Left untreated, this brain illness

As each year of untreated bipolar disorder in children and adolescents goes by, effective treatments becomes more difficult.
can lead to serious impairments in school functioning, work functioning, interpersonal relationships, one’s physical health and lifespan, as well as wreak havoc upon families, other loved ones and friends. It is not surprising that many people with bipolar disorder end up in jail. Bipolar disorder can result in premature death due to high risk behaviors, including the use of drugs and alcohol, as well as accidents, suicide, and the medical complications of poor physical health. One out of four people with bipolar disorder will attempt suicide, sometimes resulting in debilitating injuries, while one out of ten people with bipolar disorder will succeed in committing suicide.

**Treatment of Children and Adolescents with Bipolar Disorder**

Various forms of psychotherapy, or “talk” therapy, to include the child or adolescent and his or her parents and other members of the family are valuable and important. It is important that everyone in the family become educated about bipolar disorder and be kept up to date with current understanding and new findings, as research is ongoing in many countries throughout the world. Counseling and guidance for parents and siblings is essential. One must keep in mind that although it may appear that the child is in control of his or her behavior, much of his or her behavior is a manifestation of an illness of the brain, over which the child may have little or no control. The child may already blame him or herself for difficult and disappointing behavior. To experience the anger, frustration, disappointment and rejection of those people that the child is closest to and relies on for emotional and physical safety and security, may contribute negatively to the outcome of an already challenging course of life. While it is reasonable to expect family members to experience many of these feelings, working together as a family, with the guidance of skilled professional counselors or therapists, can help modulate those feelings and facilitate their expression in a positive and helpful manner.

Although not something parents like to hear and often experience some resistance to, prescribed medications are the mainstay of treatment for stabilizing the moods in children and adolescents with bipolar disorder. There are several medications approved by the Food and Drug Administration for the treatment of bipolar disorder in children and adolescents. They include lithium, and the second generation antipsychotics (SGAs) Risperdal, Abilify, Seroquel, and Zyprexa. However, it is important to keep in mind that many medications used to treat childhood illnesses, including childhood cancers, may be FDA approved for use in adults, but not for use in children. Often times, we extrapolate the use of these medications from adults to children and adolescents. There are several other medications that have been or are used to treat bipolar disorder in children and adolescents with varying degrees of success. They include the anticonvulsants Depakote, Tegretol, Trileptal, Topamax, Neurontin and Lamictal, as well as other SGAs’, such as Geodon and Clozaril. Many of these medications are used alone or in combination, depending upon each individual’s unique circumstances.

The use of antidepressant medications, such as the SSRIs’, including Prozac, Paxil, Zoloft, Celexa and Lexapro, while often helpful in treating depressive symptoms in children and adolescents, pose serious risks when used in attempting to treat
depressive symptoms in the context of bipolar disorder in children and adolescents. Activation, disinhibition, the triggering of a manic episode and the worsening of mood symptoms are not uncommon results. If these medications are to be used, caution and careful monitoring are required (see section on medication treatment).

Since it is not unusual for bipolar disorder to be present along with other psychiatric disorders most commonly ADHD or Anxiety Disorders sometimes, combinations of medications to treat more than one disorder is indicated. Treatment can be very challenging, as the symptoms of one disorder may worsen when trying to treat the symptoms of a co-occurring disorder with medication.

Each medication or combination of medications has its pros and cons, upsides and downsides, risks and benefits. Different medications or combinations of medications may be warranted in different circumstances at different times. Each medication may have an unwanted effect on some other area of the brain or other parts of the body than intended, with the potential for causing unwanted side effects. These side effects can range from short-term temporary annoyances, to long-term and permanent problems. However, just because there is a risk of developing a certain side effect, does not mean that one will develop that side effect. One must also keep in mind that there are serious potential risks in not using medications to treat the symptoms of bipolar disorder. Becoming educated about these medications and discussing the various treatment options and alternatives with a child and adolescent psychiatrist in whom you have trust and confidence are the first steps. If medications are prescribed, participating in regular medical follow up visits with the child and adolescent psychiatrist in order to monitor the symptoms and treatment response, as well as for the potential of unwanted side effects is essential in ensuring that your child receives every opportunity to obtain the best treatment available.

**Knowledge is Power**

Although it may not be obvious, children and adolescents with unstable moods as the result of bipolar disorder are often frightened about how out of control they feel. Although challenging, it is important for parents to do all that they can to stay in the role of the adult. Staying calm in the face of upsetting situations and reacting to your child’s out of control behavior in a thoughtful and rational way that models being “in control” is not always easy. However, such a stance can have a significant impact on increasing the chances of a positive outcome for your child and your family. Your child needs you and is relying on you to make the right choices and decisions while shepherding your child through childhood and into adulthood. Learn as much as you can from the reliable resources available, and make the best decisions you can for the health, safety and future of your child.
References:


www.nimh.nih.gov

www.aacap.org
Medication Treatment Of Bipolar Disorder
By Tom Jensen M.D.

Medications form the cornerstone for building a comprehensive and effective treatment plan for individuals with bipolar disorder. While medications alone are not sufficient treatment, it is difficult for the other elements of treatment to work effectively if the patient is struggling regularly with rapid mood swings, manias, depressions, mixed states, or severe anxiety.

This chapter is not intended to be a prescribing guide, but rather to describe general principles of medication treatment and to inform the consumer of the most relevant issues with each medication that they or a family member might be taking. As most consumers are more familiar with the brand names of these medications, I have elected to use brand names in the chapter, but have provided a table that also shows the generic name of each medication. Additionally, I have not restricted myself to simply discussing “FDA approved” indications for each medication. The reason for this is that, while FDA approval does indicate that the manufacturer funded and produced studies to show effectiveness in a given condition (for example acute mania or depression), which manufacturers seek FDA approval is as much a business decision as a medical one. It is expensive to fund the studies for a specific FDA indication, and therefore only newer drugs tend to receive such funding to get approval. That the FDA has not given approval for a specific indication does not in any way mean the drug is ineffective for that condition; it simply means that the drug company that made it did not produce studies to earn the FDA endorsement for the specific condition. At times, the drugs that don’t have the indication are basically the same as the drug that did get the indication. For example, Seroquel XR got the indication for bipolar depression. This happened as Seroquel was going off patent, and therefore a generic form would become available. The manufacturer came up with a slow release version of Seroquel, called it “XR” and funded the study for bipolar depression. With that study in hand, Seroquel XR can be marketed for bipolar depression, but Seroquel, the same drug in an immediate release formula, cannot.

I will discuss side effects commonly seen with each medication in this chapter. That said, it is impossible in a chapter of this nature to list every side effect for every medication. I have focused on the more common ones and the more serious ones. As a general rule, any of the medications discussed here can cause nausea, vomiting, headache, allergic reactions, sleepiness, or sleeplessness. I will not list these side effects repeatedly for every medication.

With respect to the interactions of each of these medications, it is not possible to go into all interactions in this chapter. What I advise consumers and family
members to do is to use a “drug interaction” computer program any time a new medication is added, whether it is another psychiatric medication, an over the counter medication, or an antibiotic. There are many such programs online. People seem to find the one at www.drugs.com to be quite easy to use, so I typically recommend it. If computers are not available, discuss all medicines, prescribed and over the counter, with your doctor and pharmacist.

In order to discuss and understand the medication treatment of bipolar disorder, one must understand the different mood states or “phases” of the illness. For many years, I have explained to my patients that had I named this illness I would have called it “Quatripolar Disorder” because there are really four mood states that people with the illness experience. The mood state that we want to spend as much time as possible in is the euthymic state, which translates from Latin into “true mood” or normal mood. A stable and consistent normal mood is desirable and when we track mood states during the course of treatment it is important to note how much of the time the patient is feeling normal, not just how long they are in the altered mood states.

To begin, let’s look at the different categories of bipolar disorder as well as what defines each mood state. There are currently four types of bipolar disorder defined in the DSM IV. I will describe them below, but must emphasize that there is strong genetic evidence that these are artificial distinctions and that, in fact, this is a spectrum illness.

Bipolar Type I is characterized by one or more manic episodes. A depressive or hypomanic episode is not required to fall into this category, but often occurs. Bipolar Type II is characterized by no manic episodes, but hypomanic episodes and at least one Major Depressive Episode. Hypomanias are essentially manias that don’t cause severe life impairment, but the distinction is often quite gray in real life.

Cyclothymic Disorder is a history of one more more hypomanias, and periods of depression that do not meet criteria for a Major Depressive Disorder.

Bipolar Not Otherwise Specified (NOS) is a rather ill-defined category that essentially includes the people who don’t quite fit into the above categories.

While not yet a diagnostic category, Bipolar Type III has been considered for inclusion as well. This would reference people who have only had a mania that was medication induced (for example, by an antidepressant).

Rapid cycling is added to the diagnostic label if four or more episodes occur per year.

A Manic episode is defined as a period of unusually elevated, expansive, or irritable mood lasting at least one week plus three or more of the following symptoms:
- inflated sense of self-esteem or grandiosity
- reduced sleep
• pressured speech
• flight of ideas
• distractibility
• increased involvement in goal directed activities
• physical agitation or “psychomotor agitation”
• excessive involvement in pleasurable activities that have a high potential for painful consequences.

If the mood is just irritable, then four of these symptoms are required rather than just three.

A Hypomaniac episode is similar to a mania, but less severe and without substantial life impairment.

A Major Depressive episode is a period of two or more weeks of low or irritable mood associated with at least five of these nine symptoms:
• sleep disturbance
• loss of interest in one’s usual activities
• guilty or negative thoughts
• loss of energy; poor concentration
• change in appetite
• a physically slowed appearance called “psychomotor slowing”
• loss of libido

The symptoms have to be severe enough to impair life functioning to fall into this category.

A definition of a Mixed State is a hybrid condition with simultaneous features of mania and depression. For example, one may experience the irritable low mood of a depression, but greatly amplified by racing thoughts and high energy of a mania. Other combinations of manic and depressed symptoms also occur. What is important to know is that this is probably the most uncomfortable psychological experience a person can suffer. Often the person in the mixed state does not recognize it, and concludes that the people around them or circumstances they are in are intolerably irritating rather than concluding that the problem lies within their own irritability. The degree to which they feel agitated and irritated is often extraordinary and often associated with profound suicidal thinking. I believe that a high percentage of suicide completions in bipolar patients occur in the mixed state, and addressing these states effectively is critical to prevent the worst outcome of all in this illness: suicide. Antidepressant medications have a strong tendency to induce or worsen mixed states. Some clinicians believe that this is the most common reason that people commit suicide a few days or weeks into an antidepressant trial. The official DSM criteria require that one simultaneously meet the diagnostic criteria for mania and depression. This stricter definition sets the bar extremely high and in my view misses the fact that milder mixed states characterized by depression with a few manic symptoms or mania with a few depressive symptoms is extremely common. This state is often under-recognized by doctors and patients. Failure to recognize the state can result in incorrect medication decisions which then worsen the mixed state.
Typically patients initially present for treatment in the Manic, Depressed, or Mixed Phases of the illness, though some will seek treatment at a time of normal mood (euthymia). Optimal results are obtained by setting therapeutic priorities and introducing medications in the order dictated by those priorities. The acutely manic patient needs to be rapidly brought down to a normal, or at a minimum, mildly hypomanic state so that they are not making decisions or engaging in behaviors that can be destructive. Patients who are in an extremely irritable mixed state need to be rapidly stabilized such that they do not act on or inappropriately express the rage that so often characterizes this mood state, or commit suicide. Depressed patients need to have their depression treated, but without triggering a manic or mixed state as antidepressants so often do.

In my experience, treatment for most bipolar patients is best accomplished in four phases:

1. Rapidly stabilize Mania or Mixed States to avoid dangerous or inappropriate behaviors and the long-term consequences of such behaviors.
2. Introduce agents that are likely to dampen mood cycles and reduce their frequency over time, as opposed to just providing acute suppression of the symptoms of a mania or mixed state.
3. Address residual depression if it remains after phase 1 and 2.
4. Address coexisting conditions (anxiety or ADHD most commonly).

Prior to discussing how to carry out this four-phase treatment, it is important to first discuss the classes of medication, examples of each, and their general pros and cons. As there is no perfect “one size fits all” medication, we are continually making choices that balance risks, benefits, side effects, and the probability of success for each of the three altered mood states (Manic, Depressed, and Mixed). There is no such thing as a side effect free medication, or a medication without some risks. However, because of the devastating effects of untreated bipolar disorder, a decision not to medicate is typically ill-advised and leads to very poor outcomes. Indeed, it seems that in this illness, one cycle kindles another and that failure to stabilize mood is associated with a worsening of the illness over time. It is heartbreaking to see individuals with this illness who are quite treatable, but who focus so strongly on side effects and risks of medications that they do not accept effective and appropriate treatment. As a result, they become progressively more ill over the years.

Another important principle is that, unless safety dictates otherwise, medications should be introduced one at a time, adjusted carefully to optimize their effect, and given enough time to work prior to adding other medications. The reason for this is simple. If the physician is introducing multiple drugs quickly, he can’t tell which of them is working or which of them is causing any specific side effect.

The classes of medications we will discuss are as follows: antipsychotic mood stabilizers, mood stabilizers, medications that treat the depressed phase, anti-anxiety medications, and ADHD medications.
I believe that newer is not always better. When a new drug gets FDA approval for any condition, it is important for the manufacturer to get the word out about the drug. Marketing campaigns are well thought out and designed to be effective. Representatives of the manufacturing company have a tendency to accentuate the positive and not talk about a very important point: FDA approval of these medications does not require comparing them to existing drugs, only to a placebo (sugar pill). So, in fact, whether the new drug is superior to older drugs is a matter of conjecture. Further, it is the history of pharmacology that new drugs are introduced, and some long-term or low-frequency side effects are not noted until the drug has been out for many years. Because of this, a rule of thumb I follow is to use older drugs first, unless there is a compelling reason to try the newer ones with a given patient.

I have chosen to separate the antipsychotic mood stabilizers from the other mood stabilizers because they have different characteristics, advantages, and disadvantages from the more traditional mood stabilizers. Antipsychotic mood stabilizers are our “go to” drugs for acute mania or mixed states, particularly severe forms of these states that threaten safety or place the patient in the hospital or at risk of hospitalization. Their advantages include that they can be rapidly introduced, rapidly adjusted, and often can, at the cost of some annoying side effects, bring the acute mania or agitation of a mixed state under control in 24 to 72 hours. This rapid effect is not shared by the other mood stabilizers. Prior to the advent of antipsychotic mood stabilizers, an acutely manic patient was typically hospitalized for many weeks as the more traditional mood stabilizers slowly took hold. Another advantage is found in patients who experience hallucinations, paranoia, delusions (false beliefs that things are happening that in fact, are not happening), or other symptoms of the inability to distinguish that which is real from that which is not (the definition of psychosis). The antipsychotic mood stabilizers are the best agents for addressing these psychotic symptoms.

However, these antipsychotic mood stabilizers have some disadvantages as well. With the exception of Abilify and Saphris, the members of this class have a strong tendency to promote weight gain, and sometimes even Abilify or Saphris do so. At times this weight gain is marked and can lead to obesity and even Type II Diabetes. Many of the medications in this class are highly sedating. This is an advantage in that we can put the acutely manic patient to sleep and break the mania with them. This is a disadvantage in that daytime sedation can occur and this is not desirable. Another disadvantage is that, in contrast to the more traditional mood stabilizers, there is no evidence that the antipsychotic mood stabilizers lengthen the time between cycles, and therefore likely do not improve the long-term course of the illness. This is a point that is still debated, but in my 20-plus years of experience of treating thousands of bipolar patients, I have
developed the belief that the antipsychotic mood stabilizers lack this important characteristic.

Two important side effects of antipsychotics to consider are what are called EPS and a side effect called Akathisia. EPS stands for “Extrapyramidal Side Effects.” Extrapyramidal refers to the brain anatomy where these drugs work to cause this side effect (outside = extra; pyramids= a specific tract/area of the brain involved in regulating movement and muscle tone). The side effect is characterized by entirely reversible muscle stiffness. To the extent that it affects facial muscles, one can have the inexpressive or “masked” facial appearance that we associate with Parkinson’s disease. To the extent that it involves the neck, one can get a reaction that leaves the neck stuck and turned off to one side until the side effect is addressed or the medication wears off. Sometimes, more often in children, it can involve the muscles that move the eyes and the eyes can appear to have rolled up in the head (oculogyric crisis) and this is sometimes mistaken for a seizure. This side effect is usually easily reversed by medications that have drying or “anticholinergic” properties like Benadryl or Cogentin, and your doctor should discuss what to do if you have this side effect at the time that an antipsychotic is prescribed.

A much more subtle and often not properly recognized side effect is akathisia. Akathisia can be defined as a sense of restlessness: it can be physical and characterized by inability to sit still, constant fidgeting, or pacing. It can also be mental and characterized by marked mental restlessness, agitation, extreme discomfort, and rage outbursts. To the extent that it expresses itself primarily as mental restlessness, it is often mistaken for worsening mania or for a mixed state. One must carefully interview the patient to distinguish these two conditions, and even then it can sometimes be hard to tell. Sometimes if we can’t tell, we will use a medication that usually reverses akathisia as a test dose. The reason we need to tell is that the response to worsening hypomania or mixed states is usually an increase in the antipsychotic dose, which is the wrong approach to do if the patient is having akathisia. Medications typically used to treat akathisia include the anticholinergic drugs mentioned above under EPS, and also antianxiety drugs called benzodiazepines like Ativan or Klonopin. Additionally, drugs that stimulate dopamine can be used for this, such as the medication Amantadine, but these dopamine stimulating (dopaminergic) drugs are used for chronic akathisia, not for the sudden onset of akathisia.

Finally, the antipsychotic mood stabilizers have two serious albeit low frequency outcome risks. First, they can cause a disorder called “Tardive Dyskinesia” or “TD.” TD is a disorder in which involuntary movements can develop, most commonly involving the mouth, lips, or tongue, but can occur elsewhere in the body. It often begins with wiggling movements of the tongue, giving the appearance of a “bag of worms” when the patient sticks their tongue out. Lip smacking is also a common manifestation, and the movements can spread to other areas of the face and involve
the neck, shoulders, and other areas of the body. It is important that the prescribing physician monitor for this side effect when these medications are used, particularly on a long-term basis.

A second, very rare but very serious side effect is called Neuroleptic Malignant Syndrome, or NMS. NMS is a life threatening medical emergency. It is characterized by a rising body temperature to the point of being dangerous (it can climb above 104 degrees Fahrenheit). The muscles at the same time become very stiff, which probably generates some of the heat leading to the high temperature, though most of this heat is likely caused by the temperature regulating mechanism in the brain not working well. The prolonged muscle contractions can lead to popping of muscle cells which then release proteins called muscle enzymes into the blood. In sufficient quantities, these enzymes can more or less clog up the filtering elements of the kidneys and lead to kidney failure. The patient often becomes confused, and the blood pressure can begin to vary widely. Lest one interpret this side effect as a reason to never accept treatment with an antipsychotic, the side effect is extremely rare. Solid statistics are hard to come by and vary greatly, but 0.2% of those treated with antipsychotics is a number that is often quoted. That said, this number includes the older antipsychotics, which we don’t typically use. Those older medications are far more likely to cause NMS than the agents described in this chapter. NMS is a serious medical emergency requiring immediate treatment at the nearest hospital emergency room.

So what makes a medication an antipsychotic? The answer is both straightforward and complex. One of the earliest hypotheses involving brain chemicals and mental illness was the “Dopamine Hypothesis.” This hypothesis, which has stood the test of time, is that excessive activity of a neurotransmitter called dopamine leads to psychotic symptoms. The hypothesis has been bolstered by the fact that drugs which block dopamine reduce psychosis (the antipsychotics), while drugs that stimulate dopamine can induce psychosis (cocaine and amphetamines). Psychotic symptoms include hallucinations (seeing, hearing, feeling, or smelling things that are not there); delusions (false ideas that things are occurring despite ample evidence they are not, for example that the CIA has implanted a monitoring device in one’s brain); thought broadcasting (the notion that the TV or radio are broadcasting one’s thoughts and that others can perceive them); paranoia (the fixed idea that others harbor malintent towards one despite evidence to the contrary, and other cases where fantasy or unreality cannot be distinguished from that which is real.)

Over time, various protein receptors involved in the transmission of signals triggered by dopamine have been identified. One of those receptors, called the D2 receptor was named most important in the development of psychosis.

Antipsychotics block dopamine receptors, and thereby address the overstimulation of the dopamine neurons which create psychosis.
create psychosis. The older antipsychotics, which we don’t use very much these
days, blocked more of the types of dopamine receptors besides D2, whereas the
newer ones discussed in this chapter are more selective for the D2 receptor. As a
result of this selectiveness, the newer ones have a lower incidence of certain side
effects including Tardive Dyskinesia and NMS. Examples of the older medications,
which we will not discuss in this chapter, include Haldol, Thorazine, Trilafon, Mellaril,
and Prolixin.

The antipsychotics discussed here are sometimes referred to as “atypical”

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<th>BRAND NAME</th>
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antipsychotics or “D2 blockers.” The charts shown below demonstrate the degree
to which each medication causes the listed effects and are indicated by plus signs.
The number of plus signs indicate increased chances of the listed effects occurring.
Each of these medications will be discussed briefly with respect to the relevant
characteristics that can impact our choice of one agent over another: sedating
properties; tendency to cause EPS and akathisia; weight gain properties; and
antidepressant properties.

Zyprexa is my “go-to” drug for acute mania or acute agitated mixed states. It is
highly sedating, and therefore can be used to get the manic patient sleeping. This
usually breaks the mania quickly. In my experience, it has a low incidence of EPS or
akathisia. However, it has a strong propensity toward promoting weight gain. Not
all patients gain weight on it, but those who are likely to experience this side effect
usually declare themselves in the early weeks of treatment by showing an
astonishing rate of weight gain. While it does not have the FDA approval for the
depressed phase of bipolar disorder, my experience is that it often treats the
symptoms of depression or of mixed states quite effectively. The dosage of Zyprexa
in adults can vary from as little as 5 mg at bedtime to 10 mg twice a day, or even
higher.

Risperdal is less sedating than Zyprexa. It is therefore a good choice for those
people with Schizoaffective Disorder (a working definition for individuals who meet
criteria for bipolar disorder and are psychotic even when neither manic or
depressed) or bipolar disorder with psychotic features who may require
antipsychotic dosing in the daytime and don’t want to be sedated. Since it is less
sedating, I don’t usually start with this in acutely manic patients who I wish to be
put to sleep rapidly. Risperdal is more likely to cause EPS or akathisia than Zyprexa,
as it is, generally speaking, a more potent dopamine blocker. Risperdal can certainly
promote weight gain, but in my experience it is less likely to do this than Zyprexa.
Risperdal does not have the FDA approval for the depressed phase of Bipolar
Disorder, and in my experience with the drug it seems less likely to treat the
depressed phase than Zyprexa, Abilify, Seroquel, or Geodon.

**Geodon** is a medication that is more sedating than Risperdal, but less sedating
than Zyprexa. Geodon has a fairly low incidence of EPS or akathisia. It can promote
weight gain, but seems much less likely than Zyprexa to do so. It is often sedating
enough to treat acute manias, and since it seems less likely to promote weight gain,
may be a good choice for people who require long term treatment with
antipsychotics. Geodon does not have FDA approval for the depressed phase of
bipolar disorder, but it seems similar in effectiveness to Zyprexa and Seroquel for
depression. It is worth noting that Geodon can slow the speed at which the
electrical impulse from the pacemaker travels through the heart. If certain
preexisting conditions are present, or if one is on certain other medications, this
can be dangerous. An EKG should be performed prior to starting Geodon to be
sure it is safe to begin the drug.

**Seroquel** is an antipsychotic which is almost as sedating as Zyprexa. It is a good
choice, therefore, for treating acute mania. Its tendency to cause EPS or akathisia
is similar to that of Zyprexa. It can cause weight gain, and in my experience its
propensity to do so is somewhere between that of Zyprexa and that of Risperdal.
The newer slow release version of Seroquel called Seroquel XR received the FDA
approval for the depressed phase of bipolar disorder. That said, there is no logical
reason to presume that the XR version would be better for depression than the
much less expensive regular version. The XR version hits its peak blood level about
3.5 hours after taken, and that peak is going to be lower than the peak of the regular
version, which is all absorbed quickly. This can be a reason to use the extended
release formulation in people who require a daytime dose. The lower peak
concentration may result in less daytime sedation. However, if the goal is treatment
of acute mania and getting the person to sleep, the regular Seroquel with its faster
onset of sedation seems a better choice and is much less expensive.

**Abilify** is an antipsychotic mood stabilizer which for most people, is not very
sedating. It has the interesting property of activating dopamine receptors at low
doses and blocking them at high doses. This property can actually lead to it
showing amphetamine-like activation at low doses which can be a real problem if
someone is manic or mixed. Its tendency to cause EPS in my experience is low,
similar to that of Zyprexa. However, it has been my experience that it has a
remarkably higher incidence of akathisia than the other antipsychotic mood
stabilizers. Not infrequently I see cases where akathisia was confused with mania.
and the Abilify dose was pushed higher, resulting in profound agitation and discomfort. Abilify has one of the lowest likelihoods in its class for causing weight gain, and is therefore commonly the “go-to” drug for people who need an antipsychotic chronically but have weight gain issues. That said, the experience of many bipolar specialists is that it is less effective than the other atypical antipsychotics for mood stabilization. Abilify has the FDA approval for the depressed phase of bipolar disorder and my experience is that it is the best in its class for this. I rarely use Abilify for acute mania because it typically isn’t sedating enough to induce sleep in such individuals, and as noted above can activate at low doses, and with the high incidence of akathisia it can be difficult to distinguish between activation, akathisia or mania in patients whose ability to describe what they are feeling is compromised by the acute mania.

**Saphris** is a relatively new antipsychotic with the FDA approval for bipolar mania and mixed states. It is a unique molecule, truly a new antipsychotic, unlike the other new antipsychotics which are minor variations on an older drug. It is sufficiently new that its ultimate role in the treatment of bipolar disorder remains to be seen. The early studies, which only compare to placebo, claim a similar low incidence of weight gain and a much lower incidence of akathisia than Abilify. It is also a bit sedating so it may promote good sleep if given at bedtime. Presently I am using it only in cases that have failed with Abilify due to side effects, pending the drug being out longer and seeing how it compares to existing agents. Saphris is administered under the tongue and is therefore very rapidly absorbed. However, the taste is rather nasty and this can make compliance an issue. If the drug proves to be as good as the initial marketing claims indicate, it will become a major player in the treatment of bipolar disorder.

**Invega** is a recently approved antipsychotic and has FDA approval for schizophrenia and schizoaffective disorder. It is sufficiently new that its ultimate role in schizoaffective disorder or bipolar disorder is not yet clear. It is quite similar structurally in terms of all of its other properties to Risperdal, and was released by the same company that makes Risperdal just as Risperdal was due to become generic. One advantage over Risperdal is that it is an extended release formula so in people who require round-the-clock antipsychotic coverage, fewer doses are needed. I am not presently using the drug for acute mania, as I have yet to see its advantage over older agents, and am highly skeptical that it will demonstrate true advantages over the much less expensive Risperdal parent drug.

**Fanapt** is the second most recently approved antipsychotic for the treatment of schizophrenia. It remains to be seen whether or not it will have a role in bipolar disorder or schizoaffective disorder. Like Geodon, it can slow the rate at which the pacemaking electrical impulse travels through the heart. At the time of this publication, I would say that Fanapt would only have a place for the treatment of bipolar disorder under a research protocol or when further data arises to demonstrate its role in treating this disorder.

**Lurasidone** is the newest atypical antipsychotic on the market and is awaiting a decision regarding FDA approval for bipolar disorder. It is so new that I have no
way of comparing it to the other antipsychotics and am treating it like most new drugs: I will use it when other established interventions fail.

**Clozaril** was the first of the atypical antipsychotics or D2 blockers. It is strongly sedating with a low tendency to cause EPS or akathisia. It can cause weight gain. Its effects on the depressed phase of bipolar disorder are not entirely clear. This is more or less the antipsychotic medication of last resort because it has so many side effects, and a particularly severe side effect. The severe side effect is suppression of the bone marrow’s ability to make infection-fighting white blood cells called neutrophils. This is a common enough side effect that at the outset of treatment, weekly blood work is required and even when one has tolerated the drug for a long time, monthly blood work is required. This drug is only available by participating in a program that checks neutrophil counts prior to each prescription. Fatalities are not unusual on the drug. For the purpose of this chapter, I would say that if all else fails this can be discussed with your doctor, but it is extremely rare that all else fails and we have to go to this drug. Additionally, it may be considered when TD develops on other antipsychotics, but an antipsychotic is required in the particular patient.

**Mood Stabilizers:**

The traditional mood stabilizers include both lithium and a group of drugs developed to treat epilepsy called anticonvulsants. It is not at all unusual to have to use multiple mood stabilizers simultaneously in the same patient, but such mood stabilizers should be introduced one at a time and carefully adjusted rather than starting multiple drugs at once. The table below summarizes these medications,

<table>
<thead>
<tr>
<th>BRAND NAME</th>
<th>GENERIC NAME</th>
<th>SEDATION</th>
<th>ANTIDEPRESSANT PROPERTIES</th>
<th>KIDNEY ISSUES</th>
<th>THYROID ISSUES</th>
<th>LIVER ISSUES</th>
<th>BONE MARROW ISSUES</th>
</tr>
</thead>
<tbody>
<tr>
<td>ESKALITH CR</td>
<td>LITHIUM SLOW RELEASE</td>
<td>+</td>
<td>++</td>
<td>++</td>
<td>++</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>DEPAKOTE</td>
<td>VALPROIC ACID</td>
<td>+</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>++</td>
<td>++</td>
</tr>
<tr>
<td>LAMICTAL</td>
<td>LAMOTRIGENE</td>
<td>0</td>
<td>+++</td>
<td>0</td>
<td>0</td>
<td>0 to +</td>
<td>0</td>
</tr>
<tr>
<td>NEURONTIN</td>
<td>GABAPENTIN</td>
<td>++</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>TEGRETOL</td>
<td>CARBAMAZEPINE</td>
<td>++</td>
<td>0++</td>
<td>0</td>
<td>0</td>
<td>+++</td>
<td>+++</td>
</tr>
<tr>
<td>TRILEPTAL</td>
<td>OXCARBAMAZEPINE</td>
<td>+</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>ZONEGRAN</td>
<td>ZONISAMIDE</td>
<td>+</td>
<td>++</td>
<td>0</td>
<td>0</td>
<td>+</td>
<td>0</td>
</tr>
<tr>
<td>KEPPRA</td>
<td>LEVITERACETAM</td>
<td>+</td>
<td>+++</td>
<td>0</td>
<td>0</td>
<td>+</td>
<td>0</td>
</tr>
</tbody>
</table>

and then each is discussed in turn. The charts shown below demonstrate the degree to which each medication causes the listed effects and are indicated by plus signs.

Lithium was the first effective drug for the treatment of bipolar disorder. It remains
a very useful drug, working in some individuals when nothing else works. There has been great debate in the decades since its discovery about how it works, but current thinking is that it works at the level of the “biologic clock” on a compound called “BDNF” or brain derived neurotrophic factor and glycogene synthase kinase beta and phosphotidyl inositol turnover (for the neurochemists amongst us). Regardless of how it works, it is particularly effective in non-rapid cyclers, but thought to be not as effective in rapid cyclers. Unfortunately, lithium has some problematic long term risks, and problematic immediate side effects that cause us to typically reserve it for use after other agents have failed.

The principle long-term risks of lithium are damage to the thyroid and to the kidney. Lithium can cause permanent damage to the thyroid gland, which is involved in the regulation of energy, mood, metabolism, and other essential life functions. Typically it does so gradually, so when people are on lithium, blood work is done to monitor the thyroid gland, and the medicine is stopped when the blood tests indicate developing problems. Of the three commonly ordered blood tests (TSH, T3 and T4), it is the TSH that functions as the early warning system. Generally speaking, prior to the actual thyroid hormones themselves (T3 and T4) going down to subnormal levels, the TSH rises in an effort to make the damaged thyroid produce more hormones. In general, a TSH is drawn one month into a lithium trial, then quarterly thereafter for as long as one takes the drug. Physicians vary in how often they order T3 and T4, but annually is a general rule of thumb if the TSH remains normal. Should the thyroid gland be damaged to a sufficient degree (milder damage is often reversible), and if lithium is the only drug that works for a person, then we sometimes have to accept that side effect. If this is the case, one will need to take thyroid replacement medication for life.

Kidney damage was a common side effect in the early years of lithium use. This is because reliable blood levels and reliable preparations of lithium were not available, so people were often experiencing blood levels that were toxic to the kidneys. With modern preparations and quarterly blood work to monitor kidney function, kidney damage is an infrequent side effect which tends to occur over decades of use. The exception to this is in people who overdose on lithium. Such overdoses can do considerable damage to the kidneys. The blood test that is primarily used to monitor the kidneys is called the creatinine level, and it is an indicator of how well the kidneys are filtering.

It is important that lithium levels be measured and adjusted to ensure both a sufficient amount of lithium in the blood to work and to avoid levels that are toxic. Most commonly, lithium levels are kept in the 0.8 to 1.2 ng/dl range though some people respond well at lower levels.
The more common problems with lithium are the immediate and annoying side effects which many patients complain of. In those who are prone to acne, it can significantly worsen the acne. While all of us have a tremor of the hands to some degree, lithium can increase this tremor (usually to a mild degree, but sometimes quite severely). This tremor side effect can be treated with a drug called Propanolol, which blocks the adrenalin receptors responsible for the tremor. People on lithium can become quite thirsty, and need to be well hydrated. This can require frequent trips to the bathroom. Rarely, this can lead to problems with the electrolytes (salt balance) in the blood, and the doctor will need to check the electrolytes with the other kidney functions on a quarterly basis. Children placed on lithium may return to wetting the bed at night. In the elderly, or in those with compromised kidney function, the dose may have to be adjusted downward.

In addition to being eliminated through the kidneys, lithium is also excreted in sweat. This can become an issue in endurance athletes, like marathon runners, who sweat a great deal in their training. One can have a perfectly normal lithium level, then upon commencing endurance training the level can drop due to sweat excretion. Conversely, one might adjust the lithium dosage in a person who is an endurance athlete, then if that person stops training the level may climb as they are no longer excreting very much of it in sweat.

Lithium generally does not cause weight gain, unless one quenches their thirst with excessive calorie containing beverages. Water should be the beverage of choice, and caloric liquid intake should not be increased in response to the increased thirst. Lithium can also interact with drugs used to control hypertension, called thiazides, hydrochlorothiazide or Diazide. If an internist changes dosage of thiazide, ones lithium level can change, causing sickness.

Some people show a good antidepressant response to lithium, and indeed it is occasionally used in non-bipolar depression for this reason. A distinguishing feature of lithium is that it has the strongest data of any mood stabilizer for the reduction of suicide. There is also some data that argues that patients respond best to lithium when it is started soon after onset of their illness. A subset of patients are outstanding lithium responders, who have almost complete symptom relief with lithium. These patients have clinically distinct features such as predominance of euphoric mania rather than irritable mania, good recovery between episodes and lack of other psychiatric illnesses such as alcoholism or anxiety disorders. Use of lithium has declined in recent years due largely to its perceived greater risks and marketing by drug companies. But every patient with bipolar disorder should probably be tried on lithium at some point to see if they are an outstanding responder.

Depakote is an anticonvulsant that also works as a mood stabilizer. It is not clear why any of the anticonvulsant mood stabilizers work, though the current thinking is that they may work not at the level of receptors, but at a more basic level within the nerve cells on compounds called “second messengers” or it may slow the rate at which neurons fire. Additionally, there is evidence in many of the anticonvulsant
mood stabilizers that they protect neurons in some areas of the brain from premature death, and this "neuroprotective effect", particularly in an area of the brain called the amygdala, may be an important part of their action. Neuroprotective properties appear to exist with all of the anticonvulsants.

Depakote has been a mainstay in the treatment of bipolar disorder for at least two decades. It seems to be an effective drug in both rapid cyclers and nonrapid cyclers. It is most commonly given in a slow release version called Depakote ER, and is available in a generic form. Most commonly, all of the Depakote ER is given at bedtime to minimize daytime side effects like sedation. Depakote does not have issues with kidney damage. However, it is metabolized in the liver, and liver damage can occasionally occur. Similarly, it can occasionally result in bone marrow damage which presents as a drop in the number of infection-fighting white blood cells called neutrophils. As with lithium, Depakote blood levels are important. Laboratories typically define therapeutic Depakote levels as between 50 and 100 ng/dl, and will flag a level above 100 as potentially toxic. That said, those of us who treat a lot of bipolar patients sometimes find that we need blood levels in the 100 to 120 ng/dl range. In most people this is well-tolerated. If a physician has to achieve these higher levels, one may run into the situation where a primary care provider is unfamiliar with this practice and panics when he sees it. Such concerns should be referred to the psychiatrist.

Depakote side effects include the potential for sedation and weight gain. Weight gain can be a reason that we have to stop Depakote, just as with the atypical antipsychotics previously discussed. Also, Depakote can lead to polycystic ovarian disease in women. It seems that Depakote is only infrequently effective in treating the depressed phase of bipolar disorder.

Tegretol has been used even longer than Depakote for bipolar disorder. It has an unfortunate property called “autoinduction.” This means that when we begin Tegretol, it causes the liver to make more of the enzymes that break it down. This can lead to the need to make considerable upward dosage adjustments every week or two for the first couple of months of treatment. During this period, the levels of other medications can also fluctuate. Like Depakote, Tegretol can lead to liver and bone marrow damage.

A minor chemical modification of Tegretol leads to Trileptal, a drug which does not have the autoinduction property. Further, the probability of liver and bone marrow damage is reduced by this modification. Since these properties make the drug a lot easier and safer to use, we typically use Trileptal over Tegretol. While there are some patients who only respond to Tegretol, experience suggest that they are a small subgroup.

Trileptal appears to work well in both rapid cyclers and nonrapid cyclers. Damage to the liver or bone marrow is quite rare and most physicians do not routinely follow blood counts and liver functions. While no therapeutic blood level for Trileptal has been established specifically for bipolar disorder, we do know that a therapeutic blood level for epilepsy is generally between 10 and 30 ng/dl. The studies that
established that Trileptal works for bipolar disorder were done in Europe in the early 1980’s. One center used 900 mg a day of Trileptal; the other used 1200 mg a day. No blood levels were done, and the two centers got similar results. Having said this, neurologists often use substantially higher doses of Trileptal than this to get blood levels in the 20s. While no studies exist, clinical experience is that some people with bipolar disorder require more than 1200 mg a day to respond to this medication. Therefore, in non responders, it is my habit to check blood levels and push the dose upward to achieve levels in the 20s before I conclude that there is no response.

There are two important drug-drug interactions to mention in this chapter. The first is that both Trileptal and lithium can affect the blood salt balance (specifically reducing the amount of sodium). This can lead to a host of symptoms, including confusion. When the two drugs are used together, the likelihood of low sodium is increased. Therefore, electrolyte levels should be measured more frequently on the combination than on lithium alone. Secondly, Depakote can lower Trileptal blood levels. Therefore if Depakote is added into a Trileptal regime, one should not be surprised if higher doses of Trileptal are needed.

It seems that Trileptal is only infrequently helpful for the depressed phase of bipolar disorder. Trileptal is generally weight neutral, so one may select it over Depakote in individuals who are prone to being overweight.

Lamictal is a remarkable anticonvulsant mood stabilizer. What makes it so remarkable is that it is very frequently effective in the depressed phase of bipolar disorder. This medication has resulted in many bipolar individuals who suffered with chronic depression on older traditional mood stabilizers, to no longer experience depression. Additionally, Lamictal is an effective drug at preventing cycles into mania. With the exception of one serious side effect, discussed below, it seems well-tolerated with the majority of people not complaining of side effects. Further, in one study, bipolar individuals in whom Lamictal was added to existing medication regimens, reported that they felt they were more clear-thinking on it.

The primary risk of Lamictal is a very serious skin reaction called Steven’s Johnson Syndrome. This can progress to a life-threatening rash called Toxic Epidermal Necrolysis. When the drug was first approved, the rate at which doses were increased was rather aggressive, and this resulted in approximately a 1% incidence
of this side effect in adults. More recently, slower dosage adjustments have become the norm, and we think the rate of this side effect is much lower, though data is hard to come by. Manufacturer Glaxo Smith Kline now reports a reaction rate of

| Table 1: Escalation Regimen For Lamictal In Patients Greater Than 12 Years of Age With Epilepsy |
|-------------------------------------------------|---------------------------------|---------------------------------|
| For Patients TAKING Valproatea                   | For Patients NOT TAKING Carbamazepine, Phenytin, Phenobarbital, Primidone b, or Valproatea | For Patients TAKING Carbamazepine, Phenytin, Phenobarbital, or Primidone b and NOT TAKING Valproatea |
| Weeks 1 and 2                                   | 25mg every other day            | 25 mg every day                 | 50 mg/day                                       |
| Weeks 3 and 4                                   | 25 mg every day                 | 50 mg/day                       | 100 mg/day (in 2 divided doses)                 |
| Weeks 5 onwards to maintenance                 | Increase by 25 to 50 mg/day every 1 to 2 weeks | Increase by 50 mg/day every 1 to 2 weeks | Increase by 100 mg/day every 1 to 2 weeks |
| Usual maintenance dose                          | 100 to 200 mg/day with valproate alone | 225 to 375 mg/day (in 2 divided doses) | 300 to 500 mg/day (in 2 divided doses) |

0.1%

The currently recommended titration schedule for Lamictal is set out in the following table:

It is important to note that children are more likely to develop Steven’s Johnson Syndrome and particular caution is needed in this population, but the drug has great utility in this age group and should not be rejected out of hand because of this risk.

Unfortunately, there are many psychiatrists who are frightened that they might be sued should Steven’s Johnson Syndrome develop, and as a result, never offer the Lamictal option to their patients. This is a travesty of effective treatment, as most of the disability from bipolar disorder relates to the depressions, not the manias, and Lamictal is very effective on the depressions.

Additionally, there are no studies to define what a therapeutic Lamictal blood level is for bipolar disorder. As a result, most psychiatrists don’t measure blood levels and do not even approach the kinds of doses that neurologists use comfortably
(300 to 500 mg a day is typical in adults). Therapeutic blood levels of Lamictal are generally thought to be between 3 and 15 ng/dl. Having said that, it is my experience and that of many colleagues who, like me, primarily treat bipolar patients in general, and treatment resistant cases in particular, that while the antidepressant properties of Lamictal often declare themselves at blood levels of under 5 ng/dl, the antimanic properties often don’t seem optimal at these lower levels. When I am trying to prevent manias with Lamictal, I aim for blood levels in the 8 to 12 ng/dl range, which can require 300 to 500 mg a day in adults. While this is squarely in the range routinely used in neurology, many psychiatrists are not familiar with this level of dosing and are frightened when they see it. If you or your loved one has a particularly difficult version of this illness, and the blood levels were not pushed up to the range described above, you may consider seeing someone who primarily treats bipolar disorder and as a result has a higher comfort level with the drug.

Neurontin is another anticonvulsant that is sometimes used for bipolar disorder. There was a lot of excitement about it as a mood stabilizer more than 10 years ago when it was rumored (a rumor not backed up by any real facts) to be a good mood stabilizer. Psychiatrists rushed to prescribe it, and the results were mixed. Looking backward from our current experience with the drug, it is often effective for anxiety, from which half of bipolar patients suffer, but does not seem very good for mood cycling to mania or depression. Those who concluded it was a good mood stabilizer may have been confusing the antianxiety properties with actual mood stabilization. As a result, its use will be discussed later under antianxiety medications.

Topomax is another medication that was rumored to be useful for bipolar disorder. There does appear to be a subset of really good Topomax responders, however, they are a fairly small subset. An issue to watch for if Topomax is used is cognitive (thinking) side effects, in particular difficulty finding one’s words when speaking. I have seen a number of children who developed reading and math difficulties on it as well. In general, Topomax is probably best reserved for use as an anticonvulsant or as a drug to address binge eating, but rarely as a medication for bipolar disorder. Zonegran is a newer anticonvulsant rumored to work as a mood stabilizer. There isn’t enough data to say whether it works or not. As it is the most “Lamictal like” of the anticonvulsants, I occasionally have tried it in people who responded to Lamictal, then developed a rash. I have done this so infrequently that I cannot hazard a guess as to how frequently it is effective.

Keppra is another anticonvulsant that sometimes works in bipolar disorder. Because there isn’t much data on this medication, it should be reserved for cases that have not responded to more established therapies. That said, a response to this drug when all others have failed, can be life changing.

Having described the antipsychotic mood stabilizers which are often used in the above defined phase I of treatment, and the traditional mood stabilizers that are often used in phase 2 of treatment, medications that address any residual depression (phase 3 of treatment) are now considered.
As previously discussed, most physicians treating bipolar disorder agree that antidepressants tend to worsen the course of the illness over time and also have a strong tendency to induce manias or mixed states. Of course, there are exceptions to this general rule. To the extent that they induce severe mixed states, they can precipitate a suicide attempt. For this reason, we try to avoid antidepressants in people who have bipolar disorder, and when we have to use them, we try to make it a very short-term intervention. Additionally, in the largest long-term study every undertaken on bipolar disorder, called the STEP-BD study, antidepressants just did not work.

So how do we treat bipolar depression without using antidepressants? There are several “tricks of the trade” that can be helpful. The three most standard interventions utilize medications already discussed: Lamictal, Seroquel, or Abilify. Each of the options for treating bipolar depression is typically added into the existing mood stabilizer regimen, then adjusted to treat the depressive symptoms. In the case of Lamictal, one may then push the dose up to levels described above, and try to then reduce or get off of some of the other mood stabilizers.

As previously noted, Lamictal can be a remarkably effective drug both for treating the depressed phase of this illness as well as preventing cycles into mania. If one suffers frequently from the depressed phase and has not had an adequate Lamictal trial, this should really be considered.

Seroquel and Abilify were discussed above under “antipsychotic mood stabilizers.” As it turns out, Abilify is a pretty good antidepressant in people with bipolar depression, and even in people with regular depression without any history of manias. The same caveat that one must monitor for akathisia applies when it is added for depression.

**Natural Approaches:**

Two “natural” approaches have also been demonstrated in studies as useful for bipolar depression. The first is high dose omega-3 fatty acids in the form of fish oil. The original studies done in the 1990s looked at doses in the 3 to 6 grams a day range (3,000 to 6,000 mg a day). Typically, one takes the fish oil capsules or liquids with each meal. Following these initial studies, many companies have made fish oil preparations available and market particular types that have more or less of specific omega-3 fatty acids in them. Good data that the “load” of fatty acids leads to better response does not exist, but there is no data to the contrary, either. The doses in the original studies were not for any of these “designer” fish oils, rather, they were for basic fish oil. There are two important things to note when buying fish oil. The better ones are “enteric coated,” meaning they don’t release the oil until it has already passed through the
stomach. This can minimize unpleasant tastes if one burps after taking it. Some preparations, which tend to be expensive, are bottled in an oxygen-free environment so that the fish oil does not “oxidize.” This type of fish oil does not smell or taste like fish and can often be comfortably ingested as a liquid. We now believe that the fish oils work by becoming part of the membrane of nerve cells and increasing a property called fluidity, which helps them to more efficiently transport things in and out of neurons and thereby send their signals more efficiently.

The second natural approach, that never caught on very well in the United States is a compound called inositol. There were two studies done in Israel in which inositol was added to the regimen taken by bipolar patients who were no longer manic, but were depressed. Inositol is sometimes referred to as “vitamin B8” and is sort of an unofficial B vitamin. It is also structurally similar to glucose. Inositol is present in large quantities in the membranes of nerve cells and is also involved in the functioning of serotonin neurons. Serotonin neurons are well known to play a role in depression. The principal side effect of inositol in high doses seems to be loose stools in some individuals, though I once had a patient who seemed to get hypomanic on it.

**Other Approaches:**

A medication approach for which only one study exists in bipolar depression is Mirapex (Pramipexole is the generic name). Mirapex is FDA approved for Parkinson’s disease and for restless leg syndrome, but is also sometimes used for a type of headache called a cluster migraine headache. It works by stimulating dopamine receptors.

I began trying Mirapex around 8 years ago for my patients with profound depression for whom nothing else worked. Since it stimulates dopamine receptors, I was quite concerned that it might induce psychosis (as it not infrequently does in Parkinson’s patients) or manias. That said, I now have extensive experience with the drug in patients with bipolar disorder and have yet to observe anyone become psychotic or manic on it. The response rate seems very good, similar to Lamictal, and I typically use it in patients who failed with Lamictal. I typically begin with 0.25 mg once a day and may increase to 1 mg or more twice a day over time. This is not at all a standard approach to treating bipolar depression, but I have included it, as it has been effective for so many of my patients for whom all else had failed.

Another option which is being tried in some centers is ketamine for very treatment of refractory depression. The administration currently is usually done in a highly monitored level of care similar to an intensive care unit. As a result it is quite expensive, with treatments here in San Diego averaging $1800 per treatment. It is said to be miraculous for some patients, but this is really one of those last ditch options at present.

**Nonmedication Approaches:**

There are nonmedication but still biologic approaches to treating bipolar
depression. The oldest is ECT, which stands for “Electroconvulsive Therapy.” This involves using an electrical pulse, while the patient is anesthetized, to induce a seizure. Typically a series of 6 to 12 sessions is used. Often this puts the depressed person into a mania, then additional mood stabilizers are used to treat the mania. I find that this is rarely needed, and I try to avoid it as the norm in bipolar depression is that it comes back, and patients who require long-term treatment with ECT on a “maintenance” basis often complain of progressive memory impairment.

An ECT-like treatment which does not seem to cause memory impairment is TCMS or rTMS. A series of magnetic pulses are applied to precise brain areas in rTMS or TCMS. The treatment has been approved by the FDA for depression, though not specifically for bipolar depression. It is very expensive, as insurance companies presently don’t pay for the treatments, which are performed multiple times a week. Further, it seems that the “bugs” aren’t quite worked out, and although the treatment is promising and seems quite side effect free, the response rates in real patients in the real world don’t seem to approach what was reported in the studies that led to FDA approval.

Another biologic treatment of the depressed phase of bipolar disorder is deep brain stimulation. Developed by a group in Canada, it is currently only available under a study protocol at Emory University in Atlanta. Microelectrodes are inserted into a very specific nest of cells in the brain. Once the appropriate frequency and amplitude of the electrical impulses are found, this seems to treat the depression. Surgical technique is critical for success, and it may be some time before the technique gets FDA approval.

Sleep deprivation, under medical supervision, can also help one get out of a depressed state. The reason this should only be done with a doctor prescribing it is that one can quickly go from depressed to a mixed or manic state following sleep deprivation.

Although the focus of this chapter is on medications, a discussion would not be complete without mentioning that a type of therapy called Cognitive Behavioral Therapy (CBT) can also be helpful in bipolar depression. There is evidence that regular exercise can also improve the mood. In many individuals with bipolar disorder who grow more depressed in the winter, outside walks in the sunshine or the use of a full spectrum artificial light called a phototherapy light can be helpful. It is important to use the phototherapy light carefully and under the supervision of a psychiatrist, as overexposure to light can trigger a mania or a mixed state.

After addressing phases 1 through 3 as described above, one may then need to attend to additional or “comorbidity” illnesses traveling with bipolar disorder. The most common of these is anxiety, with 50% of people with bipolar disorder suffering from a diagnosable anxiety disorder. Without going into excessive detail regarding anxiety disorders, they include Generalized Anxiety Disorder (which is excessive worry or concern about multiple areas of life); Panic Disorder (which involves distinct attacks of extreme anxiety often associated with the sensation of shortness of breath, rapid heart rate, impending doom, sweating, or shaking); Phobias; and
Obsessive Compulsive Disorder (OCD). Obsessions are intrusive, unwanted, resisted thoughts that are disturbing to the patient. They are different from the negative thoughts or “ruminations” of a depression in that they are not primarily focused on some negative or depressed content. Compulsions are behaviors that one feels one must do over and over, despite that they become time consuming, interrupt daily functioning, and serve little or no useful purpose.

By far Generalized Anxiety is the most common of the Anxiety Disorders traveling with bipolar disorder. The treatment of Generalized Anxiety Disorder relies on cognitive behavioral psychotherapy, and sometimes medications. Commonly, agents in a class of drugs called benzodiazepines (Klonopin, Ativan, Serax, Valium, Xanax) are used. Such medications can be habit forming and can lead to withdrawal symptoms upon cessation. All of them have a tendency to be sedating, so when starting them one must be cautious about driving. Some literature suggests that Klonopin also helps stabilize the mood, and for this reason it is probably the most commonly used benzodiazepine in anxious patients with bipolar disorder.

In patients with Anxiety Disorders who are not bipolar, the serotonin reuptake inhibitor antidepressants are the first line drugs. These include Prozac, Paxil, Luvox, Zoloft, Lexapro, and Cipralex. A related group of antidepressants called Serotonin norepinephrine reuptake inhibitors are also sometimes used and include Cymbalta and Effexor. As previously described, the problem with antidepressants in people with bipolar disorder is that they tend to worsen mood cycling and induce mixed states. Therefore, we try not to use them in patients with bipolar disorder. The first of the serotonin active antidepressants to get FDA approval was an often forgotten drug called Anafranil or Clomipramine. While I can produce no study or data to prove it, it has been my experience that the drug is often helpful for Generalized Anxiety Disorder or Obsessive Compulsive Disorder in relatively low doses (25 to 50 mg at bedtime in contrast to the more typical dose of 150 mg at bedtime in nonbipolar patients). For reasons I cannot explain, it seems to usually not induce mania or mixed states, so this is one of the tricks of the trade that sometimes comes in handy in anxious but especially OCD bipolar patients. However, one should first try to target OCD or anxiety symptoms with some of the mood stabilizers like Neurontin, as even Anafranil can induce manias or mixed states.

Bipolar patients with Panic Disorder are also treated with a type of cognitive behavioral therapy and sometimes benzodiazepines, as well as the beta blocker Propanolol. In my practice, I usually don’t have to medicate people for Panic Disorder. Instead, I use a technique that I learned from Aaron Beck, the inventor of cognitive therapy. In this technique, the patient is taught in the office to intentionally induce panic attacks through hyperventilation, and then to terminate those panic attacks with breathing techniques that raise the serum carbon dioxide levels. These techniques include breathing into a paper bag with a hole in it; breathing through a tunnel created by making a loose fist with one’s hand; and skip breathing, a less obvious but harder to learn technique in which one “skips” every 4th breath, just exhaling a second time instead.

Obsessive Compulsive Disorder plus bipolar disorder is, in my view, the
psychopharmacologist’s Mount Everest. When we have to use medications for OCD, the only ones that work very well are serotonin antidepressants (SSRIs or Anafranil). Sometimes the atypical antipsychotics also can play a role. In order to avoid inducing manias, mixed states, and rapid cycling, we try to make as much progress as possible with a cognitive behavioral therapy called graded exposure and response prevention. In this therapy, one intentionally exposes oneself to stimuli that would ordinarily induce the desire to engage in a compulsion. Then one uses relaxation techniques to resist the urge to do the compulsion. Most patients find that if they do this, with lots of practice, they can ride out the urge to enact the compulsion and it passes. Similarly, a technique called thought stopping can be used to deal with obsessions.

However, there are lots of patients with bipolar disorder and OCD who also require medications. My personal approach is to be sure I have a rock stable mood by using mood stabilizers optimally, and then introducing Anafranil. One can also use other SSRIs, but my experience with them is that they are typically highly destabilizing for bipolar patients.

A second comorbid condition often seen with bipolar disorder is ADHD. ADHD comes in three subcategories: inattentive type, hyperactive impulsive type, and combined type. As counterintuitive as it is to have “Attention Deficit Hyperactivity Disorder inattentive type,” it means that patients are inattentive/distractible but not hyperactive, that is in fact the official label since the older ADD label was abolished. ADHD hyperactive impulsive type is reserved for those who have the hyperactive impulsive symptoms without inattention or distractibility. ADHD combined type, by far the most common in childhood, is used for people who are inattentive, hyperactive, and impulsive. The official DSM IV diagnostic criteria for ADHD or any other psychiatric disorder can be viewed at www.mentalhealth.com. Reprinting the full criteria is beyond the scope of this chapter.

Only one double blind placebo controlled study was published for treating ADHD symptoms in bipolar adults. It was done in patients who were adequately mood stabilized on Depakote, then Adderall was added. Adderall is a combination of four amphetamine salts that is commonly used, usually in its extended release or XR form for ADHD. In the study, a good response rate and no mood destabilization were noted, but the study did not have very many patients in it.

My clinical experience is that most bipolar patients who happen to also have ADHD do not destabilize with the addition of stimulant medications for ADHD if the 4 phase treatment approach I described above is followed. However, if one goes out of order and targets ADHD symptoms prior to obtaining mood stability, then mixed
states, manias, or rapid cycling can occur. While a full discussion of the medication treatment of ADHD is beyond the scope of this chapter, a general description is given below.

In general, stimulants are the drug of choice for ADHD. There are nonstimulant options, most notably Straterra or Wellbutrin, but the effect size of the response (i.e. how much they help, not just whether or not they are better than placebo) seems considerably lower than for stimulants.

Within the stimulant family, there are two basic types. The amphetamine based drugs that work by blocking the recycling or "reuptake" and increasing the release of norepinephrine and dopamine in the brain, while the Ritalin or methylphenidate based drugs work by just blocking the reuptake of dopamine and norepinephrine. While some people do better with one family versus the other, most respond to either one. If an amphetamine based drug doesn’t work well, we usually try a methylphenidate based drug, or vice versa.

Within each of these families are different tactics for making the drugs work longer. These tactics range from slow-to-digest pills to skin patches to a drug that must be broken down before it can work to a two phase timed release system. Your doctor can discuss and compare these if stimulants are considered for your ADHD.

This chapter would not be complete without mentioning the importance of lifestyle decisions in managing bipolar disorder. One can, quite literally, make the bipolar illness worse by engaging in some behaviors, and in the extreme this can lead to a loss of medication response. First, it is very important not to repeatedly go on and off your medications, as sometimes the drugs don’t work the second time around after being discontinued. This is particularly important in a difficult to treat form of the illness and if multiple medications were tried before you became stable. You can lose your response and have few alternatives available, all because the medication was stopped.

Second, bipolar disorder is in part a disorder of the biologic clock. Maintaining a sleep pattern of going to bed at the same time every night and getting up at the same time every morning is important. Pulling all nighters can cause destabilization. Similarly, travel from a place with very little sunlight (the northeast in December) to a place with a great deal of sunlight (Australia in December) can trigger a mania. If you travel across hemispheres, or even across multiple time zones, you need to discuss with your psychiatrist how to recognize and manage any resulting mood shift.

Third, in general, drugs of abuse are very destabilizing. This is true for all drugs of abuse, including Cannabis. Of the two general categories of Cannabis, Cannabis Sativa (the stimulating variety) is far worse than Indica (the sedating variety) though Indica is well known to induce depression with chronic use. Stimulant abuse including cocaine is very destabilizing as is the club drug Ecstasy. Even alcohol can trigger depression. In general, if you have bipolar disorder, it would be best to not use any substances, or at least to limit it to alcohol and not exceed one glass of wine or beer or shot of liquor per hour with a maximum of 2 alcohol containing
drinks on any one day.

Fourth, adequate nutrition and regular aerobic exercise, preferably in the morning and outside to get the sunlight in the winter, seem to help keep the biologic clock regulated and the mood stable.

To summarize, bipolar disorder is an illness that can be treated effectively. With optimal treatment and proper lifestyle choices, most bipolar individuals can lead happy, healthy, productive lives. The key is to seek optimal treatment, comply with recommendations, don’t stop your medications, and make healthy lifestyle choices.
Suicide and Bipolar Disorder

By Dr. Tom Jensen, M.D.

The purpose of this chapter is to describe what we know about suicide in bipolar individuals, as well as to describe how one can go about minimizing the risk of this terrible outcome. There are helpful tools to help prevent suicide in all three of the interventions that we use to treat people with bipolar disorder, including environmental, medication, and therapy interventions.

Twenty years ago, the generally published and truly horrifying statistic was that 20 to 25% of bipolar individuals ultimately died by suicide. However, there has been a substantial reduction in the suicide death rate in individuals with bipolar disorder with improved treatment. The 5% to 10% suicide rates that are now quoted seem to reflect that treatment is having a substantial impact on reducing suicide in those with bipolar disorder.

That said, one suicide is too many, and even a 5% rate is approximately 30 times higher than in the general population. We need to get better at treating this illness, and we need to apply what we know to reduce the risk further. There are tools that we know help, and therefore the challenges now are to be sure these tools are included in the treatment of each person with bipolar disorder. Of course while using what we know, we must continue to fund research into this illness and find better ways to treat or prevent it.

Unfortunately, there is no perfect formula that will predict who will make a suicide attempt. However, there are some common characteristics in those who die by suicide. The first and one of the most important of such risk factors is a mother, father, sister, or brother who has committed suicide. This is the single greatest multiplier of suicide risk. Those who commit or attempt to commit suicide are typically in a state of distorted thinking in which the suicide victim convinces themselves that they are in so much pain that it isn’t worth staying alive and that those around them will be better off without them.

The second multiplier is substance abuse. A majority of suicide victims have drugs or alcohol in their system at the time.

Another important multiplier is firearm possession. Suicide by firearm is extremely
common, especially in young people. Most self-inflicted gunshot suicide attempts are not survived, or if they are, it is with severe brain damage. In fact, we know that if we were given a large grant to reduce the number of suicide deaths in a community, the most effective thing we could do would be to provide trigger locks and gun safes.

Another multiplier is social isolation. This illness often manifests itself in adolescence, the very time when one is developing social skills and patterns of friendships. People who have been quite ill with early onset bipolar illness, often become so dejected about themselves and/or do not develop social skills needed for lasting adult friendships, so that they find themselves isolated. Even family members sometimes burn out after facing repeated crises with their not yet stabilized daughter, son, or spouse with bipolar disorder. Therefore, building a community in which those affected by the illness can find support, understanding, and associates whom they can engage in meaningful activities is an important goal and treating people with this illness. One of the things we learned about this illness over the past two decades is that half of the people with bipolar disorder also have an anxiety disorder (generalized anxiety, panic disorder, phobias, Obsessive Compulsive Disorder). This anxiety also appears to be a risk factor for suicide.

Please review the Medication Treatment chapter regarding how to reduce anxiety through cognitive therapy and medications, and take note that some medications commonly used for anxiety can cause mixed states.

Finally, inadequate mood stabilization and the presence of mixed states is a multiplier. This is why, as described in the medication chapter, we need to stay away from medicines that are known to induce mixed states (antidepressants and steroids, to name the two most common), and have a plan for medication(s) that allows detection of mixed states and aggressive treatment if they develop.

Perhaps one of the best suicide preventers is to help the person discover what it is that they have to give to other people and the world, and to help them develop that talent. Without believing one has something of value to contribute, it is extremely difficult to address social isolation and poor self-esteem.

All of us would like to know of any warning signs that a suicide attempt is imminent. The answer is sometimes there are, but sometimes the suicide occurs in a severe mixed state that occurs suddenly, and friends may have no way of seeing it coming. The warning signs that can tip one off are several, include talk of suicide or death, or just references to death. The individual may “put their affairs in order” by giving things away, updating a will, going through the garage full of stuff, and doing the things that would make it easier on those they leave behind. Acquiring information
online about how to commit suicide or researching materials to help one commit suicide are of course major red flags. Rehearsal, in the form of visiting the place one plans to commit suicide, tying a rope, or dry firing a gun are all serious red flags as well.

What can one do to minimize the likelihood that they or a loved one with bipolar disorder will commit suicide? In addition to securing firearms, treating or preventing substance abuse, helping the person to build a support group, and being especially vigilant with those who have lost a close relative to suicide, there are additional interventions available.

It is so important that those with bipolar disorder seek treatment with psychiatrists who are skilled at treating this illness. Sadly, it is not safe to assume that all psychiatrists treat this illness well. In order to find a physician where you reside, it may be helpful to go to the consumer support groups or call them and ask “who is the best?”

In this illness, where the mood can pivot on a dime, the psychiatrist needs to be responsive when you need to speak with him or her.

There are also specific psychotherapy interventions that can be performed by a therapist or psychiatrist. The therapy of bipolar illness should typically include the following elements: patients, and if possible family members, should learn how to recognize depression, mania or hypomania, and mixed states. It is best if a mood chart is used to spot seasonal and other patterns.

Also, charting the mood helps a person recognize that it is the illness making them feel badly, not just the events in their daily life. (See mood chart in the reference section) Once a person knows how to identify specific mood states, they can then receive cognitive behavioral therapy to learn skills to deal with the feelings and distorted thoughts in each mood state.

The therapist can also work with the patient and their family to make the home safer. In addition, the family can implement strategies to lessen social isolation and help their bipolar loved one to find one’s gift, and applying it so as to gain a sense of usefulness and worth.

The family can implement strategies to lessen social isolation and help their bipolar loved one to find one’s gift, and applying it so as to gain a sense of usefulness and worth.

Having a written plan of what to do if you or one’s loved one is contemplating suicide can be helpful.

Another intervention is to have trusted friends or relatives know about the illness and become educated about it, so that they can observe and help the affected person when they experience altered mood states. Spouses should be invited to
appointments with a psychiatrist or therapist.

Additionally, having a written plan of what to do if you or one’s loved one is contemplating suicide can be helpful. The midst of the crisis is not the best time to figure out who to call. Such a plan should probably include several elements:

1. Name and numbers of psychiatrist and therapist to call.

2. Phone numbers for suicide or mental health hotlines in your area.

3. A reminder that calling 911 is a safe thing to do if one is feeling suicidal and is having trouble accessing the psychiatrist or therapist.

4. Name and directions of the chosen hospital or emergency room.

5. Insurance Information to take it with you if you need to go to the ER or the hospital.

6. Written list of all medications.

7. A list of “reasons to live” and “why suicide thoughts are distorted” to reference when one is thinking of suicide.

Suicide is NOT the way to deal with this illness. Bipolar disorder is treatable, and new advances are made every year. In order to guard against a suicide attempt, there are practical things that you and your support group can do. Be your own advocate and make sure that the suicide prevention ideas you have read about become a part of yours or the ill person’s treatment. Also, though the person believes that he/she will never get better, remember that we are developing new ways to treat this illness everyday and most importantly, don’t give up.
If you have bipolar disorder but you abstain from alcohol and other substances, you may not need to read this chapter! Use of substances (including cannabis, alcohol, cocaine, heroin, etc.) generally complicates the experience of bipolar disorder. This chapter will explain why abstaining is the simplest and safest course of action. However, we will also provide information about when you may consider moderation as a potential option.

Two Case Examples:

**FRANK**
Frank is a twenty-six year old creative and intelligent young man who has struggled with bipolar illness and substance abuse throughout his young adulthood. His illness necessitated multiple withdrawals from college, but he persevered, eventually gaining his bachelor’s degree in history. In the midst of a bad economy, the only job that he found was as a waiter in a restaurant in his university town. The young people who worked in the town’s restaurant business partied hard, and it was not long before Frank had joined them. He would have been the first to tell you the risks. Yet, like most of us, Frank wanted to socialize and his co-workers were the peers available to him. Even after a long period of stability, which he attributed to his abstinence from recreational drugs as well as regularly taking a prescribed mood stabilizer and medicine to assist with sleep, he was soon partying hard with co-workers after closing time. Little sleep and too much alcohol and pot ignited the inevitable. He became convinced that he possessed all of Thomas Jefferson’s wisdom and felt compelled to wander the university at all hours channeling Jefferson to anyone who would listen, including the statues. He thought he was fine, perhaps better than ever. Those who didn’t understand him were the crazy ones.

**GABRIELLE**
Gabrielle’s mood instability initially emerged around age 12. Her moods were often dark and stormy characterized by strong irritability and frequent acting out. By high school, pot was a daily part of life. It softened the painfulness of her depressed mood and also took the edge off of some of her irritability. She did reasonably well with her high school grades, but chose to pass on going to college. Instead she found she was able to support herself through retail clothing sales. At age 20 one of her co-workers gave her some Oxycontin. She was curious, tried it and liked it a
lot. The guy who supplied the Oxycontin to Gabrielle’s coworker soon had Gabrielle converted to heroin. It worked, or at least so she thought. She no longer worried about where she was going with her life. She only had to worry about how she would come up with money for more heroine. After losing her job and winding up on the street, her family intervened and Gabrielle was hospitalized for heroine detox and substance dependency treatment. The intervention was partly effective as she finally stopped opiates, but she continued with her intermittent use of pot.

Over the next four years Gabrielle continued to work in retail. Her mood had shifted to a moderately depressed state with intermittent episodes of strong irritability. At age 25 she chose to start school at a small liberal arts college near her hometown. She began fall semester with strong hopes of getting her life back on track, but she quickly found she had little in common with most of the 18 and 19 year-olds in her general education classes. She also became increasingly anxious about her academic performance. After all, she was out of practice.

To ease her distress, she began smoking pot on a nightly basis. Increasingly, she found when she was high, her worries were replaced by a sense of energetic euphoria. Sleep also became less important as she was regularly awake until 4:00 or 5:00 AM surfing the web, chatting online and drawn into whatever caught her fancy. She found she no longer cared about her grades or even attending class. This trajectory took her towards a final first semester grade point of 1.3 and academic probation.

When this reality set in Gabrielle crashed hard. Her euphoric energy was replaced by despair and emptiness. She spent most of her time in bed and lacked the motivation to deal with even the smallest details of her life. She was eventually hospitalized due to her worsening condition only this time her diagnosis was bipolar disorder.

The Cost-Benefit Analysis

How might Frank or Gabrielle have had less painful outcomes? Let’s look at the role substance use played for each, by conducting a cost-benefit analysis, beginning with the benefits. For Frank the benefit of using alcohol and marijuana was simple. He wanted to have a social life. Alcohol and marijuana allowed him to socialize with the most easily available group of peers. For Gabrielle the benefit of marijuana was that it reduced her anxieties about grades and social acceptance.

Although we cannot say for sure, the cost of substance use in each case example appears to be instigating a manic episode. The cost analysis takes us to the specific question, was the substance use worth it? We assume you’ll agree that in both cases the benefits were not worth the costs.

We need to acknowledge that the goals each had (to fit in, to relax) are reasonable goals, and worth pursuing. Our work with bipolar individuals suggests that substance use is often related to one or more of the following factors: desires to 1)
calm elevated energy or agitation, 2) lessen depression, 3) deal with the boredom of mid-range mood, and 4) instigate, increase or prolong the intensity of the "up" feeling of hypomaniac mood. There is nothing surprising or abnormal about wanting to feel calm, up (or more up), not down and not bored.

The problem with using substances to pursue these goals is that if the substances are effective (as they are for most) it is difficult to moderate their use, particularly when the user has bipolar disorder. Furthermore, when used in excess substances typically: 1) can work so well that some of our other capacities (e.g., to socialize, to relax) become atrophied, 2) do not work as well over time and can even diminish or take away what they first provided (e.g., using cocaine for “energy” ultimately results in becoming exhausted, 3) increase the risk of various problems (e.g., accidents, infections, arrest, etc.) and 4) can precipitate bipolar illness (an initial hypomanic/manic episode or subsequent relapses.)

Perhaps you are thinking: “I see the risks here. I won’t let that happen to me. I’ll be careful.” To reiterate, the simplest way to “be careful” is to abstain from substance use. However, it is up to you to decide how much “margin for error” you want to have. Although there are some aspects of bipolar disorder that may be beyond your control, abstinence is entirely within your control. Consider how you’d feel if continued substance use were to result in a full manic episode requiring psychiatric hospitalization while retrospectively knowing that abstinence may have prevented the whole ordeal.

The remainder of this chapter will provide information that can help you to consider the moderation vs. abstinence issue in more detail. We will also review the statistics about substance use and bipolar disorder, what we know (and hypothesize) about how substance use interacts with bipolar disorder and how moderation can be accomplished.

The Relationship Between Substance Use and Bipolar Disorder

Many individuals misuse various substances. If the misuse is frequent enough, substantial enough, and problematic enough, the individual is considered by mental health professionals to have a substance use disorder. The less severe version is called substance abuse. The more severe version is called substance dependence. In this chapter when we use the term substance misuse, it includes substance use disorders (abuse and dependence). By substance misuse we mean any level of substance use that leads to problems in your life, even if the level of use is not high enough to merit a diagnosis.

Over the course of a lifetime, an individual with bipolar disorder has a 60% chance of having a substance use disorder (abuse or dependence), and a 50% chance of having an alcohol use disorder (Tolivar, B.K., 2010). Stated another way, six out of ten
bipolar individuals experience substance misuse that is severe enough to merit a diagnosis. Most of this group has an alcohol use disorder, with the others having other substance use disorders involving marijuana, opiates, stimulants, etc.

Although a substance use disorder is associated with substantial problems in anyone, the problems are even worse if you have bipolar disorder. If you have bipolar disorder and a substance use disorder, you are more likely to have:

- poor adherence with treatment
- more frequent and severe depressed, manic, or hypomanic episodes
- longer episodes
- more mixed state episodes and rapid cycling (which are hardest to treat)
- more sleep impairment
- more aggression and impulsivity
- more frequent suicide attempts
- more suicidal thoughts and feelings
- more anxiety (generalized anxiety, panic or PTSD)
- greater likelihood of infections (e.g., Hepatitis C)
- greater complications from medical conditions (especially Hepatitis C)
- more hospitalizations

Although sorting out cause and effect in bipolar disorder can be difficult, from a clinical perspective it appears clear that if substance misuse diminishes or stops, the risks of these problems also diminish. To illustrate some of the life problems associated with combining substance misuse and bipolar disorder in more detail, let us consider the issues of Hepatitis C and jail time. But before you become overly concerned, we also don’t want you to assume that Hepatitis and jail are the fate of most with bipolar disorder. We really see these kinds of consequences with the more severe combinations of bipolar illness and substance abuse. However, the issues themselves are nonetheless illustrative as we stay with a cost/benefit model.

**Hepatitis C**

While many of the complications of having a substance use disorder along with bipolar disorder may not be surprising, some recent findings about the relationship between bipolar disorder, substance use and Hepatitis C may not yet be well known. Bipolar individuals with substance use disorders can be seven times more likely to have Hepatitis C than patients with no mental illness (Himelhoch, S., McCarthy, J.F., Ganoczy, D., Medoff, D., Kilbourne, A., Goldberg, R., Dixon L., Blow F.C., 2009). In one study nearly one third of individuals diagnosed with bipolar disorder and a substance use disorder tested positive for Hepatitis C. This infection rate was five times higher than the rate for either diagnosis alone (Matthew, A.M., Huckans, M.S., Blackwell A.D., Hauser P., 2008). These high infection rates may be the result of injection drug use and risky sexual behavior while intoxicated and/or manic.

Having Hepatitis C makes treating bipolar disorder more difficult. The most common substance misuse problem with bipolar patients is alcohol, and patients
with Hepatitis C who are heavy alcohol users are more likely to have liver disease. They can have hepatic fibrosis, accelerated liver disease progression, and higher rates of sclerosis and hepatocellular carcinoma than Hepatitis C patients who avoid alcohol which is to say their liver is weakened (Bhattacharya, R. and Shuhart, M., 2003). But the medications used to treat bipolar disorder or alcohol dependence may have adverse affects on the liver. For example, valproic acid (Depakote) can improve drinking outcomes in alcohol dependent patients with bipolar disorder, but it is connected with higher (and therefore unhealthy) levels of liver enzymes in patients with Hepatitis C infection compared to those without it. Thus, the health of the liver needs to be continually monitored and liver problems may require adjusting bipolar medication dosages to sub-optimum levels.

Substance abuse and bipolar disorder also complicate Hepatitis C treatment. Interferon Alpha, the most effective treatment for Hepatitis C, is associated with psychiatric symptoms that are observed in bipolar patients. These include depression, mania, psychosis, and suicidal thinking (Onyike, C.U., Bonner, J.O., Lyketsos, C. G., Treisman, G.J., 2004). The emergence of psychiatric illness often requires discontinuation of interferon treatment. Presence of alcohol abuse and other substance abuse is a strong negative predictor of the likely success of the interferon treatment of the Hepatitis C.

**Jail Time**

You can guess that individuals who misuse substances also end up in jail more often. Jail time is even more common when substance misuse is combined with bipolar disorder. In one sample of inmates with bipolar disorder three out of four were diagnosed with substance abuse disorders compared with only one of five in a group of hospitalized bipolar patients (Quanbeck, C.D., Stone, D.C., Scott, C.L., McDermott, L.L., Frye, M.A., 2004).

Women overall have lower rates of substance abuse disorders than men, and women have much lower rates of incarceration than men. But the association of substance use disorders with arrest is particularly high in women with bipolar disorder. In the sample already cited, women with bipolar disorder who are incarcerated were 38 times more likely to have a substance abuse disorder than a group of non-incarcerated bipolar women being treated in the community (McDermott, B.E., Quanbeck, C., Frye, M.A., 2007).

Bipolar disorder is overrepresented among individuals with repeat arrests and incarcerations. In a study of over 79,000 inmates incarcerated in Texas in 2006 and 2007, bipolar individuals were 3.3 times more likely to have had more than four previous incarcerations (Baillargeon, J., Binswanger, I.A., Penn, J.V., Williams, B.A, Murray, O.J., 2009).

So if substance use causes so many problems for those with bipolar disorder, why do they do it? The explanation is self-medication: because mood regulation is so difficult at times, substances are used to accomplish this task. There is evidence to suggest that substance use does occur in an effort to cope with some bipolar
symptoms, and that some relief may come of this effort, at least initially. Of course, if the “medication” seems to be working, it is easy to assume that it will continue working with continued use. Here’s where there’s risk to encounter substantial problems.

Consistent with this hypothesis is the finding that individuals with mixed mood and/or rapid cycling states are twice as likely as others with non-mixed, non rapid cycling mood to misuse drugs and alcohol (Sublette, E.M., Carballo, J., Moreno, C., Galfalvy, H.C., Brent, D.A., Birmaher, B., John Mann, J., Oquendo, M.A., 2009; and Tolivar, B.K., 2010). The agitation and turmoil of mixed moods and rapid shifts can be difficult and substances can be used to ease the roller coaster-like intensity of these moods.

Contrary to the self-medicating hypothesis, much substance use in bipolar disorder appears to go in the opposite direction. When feeling down (and needing a boost) individuals with bipolar disorder often turn to alcohol or other depressant drugs. Unfortunately the choice to use alcohol for its immediate anti-depressant effects, does not take into consideration the depressant effects that follow. Similarly, when bipolar individuals are experiencing elevated mood (and needing to calm and slow down), we find that they often turn to stimulants (cocaine, methamphetamine, caffeine, etc.). Rather than self-medicating the high, they appear to be attempting to increase or prolong it.

Perhaps both substance use and bipolar disorder arise from a common underlying factor or set of factors. We do know that sometimes the substance use disorder comes first, appearing to promote the arrival of the bipolar disorder. It is as if the consequences of substance use “stress the neurochemical system” and lead to the onset of bipolar illness that might not have occurred in the absence of substance use. The appearance of a manic psychosis after using hallucinogenic substances is a prominent example of this possibility. However, in other cases substance use disorders seem to develop secondary to bipolar disorder. They occur as a result of the disorder. Substance use in manic states can easily become substance abuse or dependence, because the individual is behaving impulsively and without using good judgment or foresight. Quite literally, substance use impairs these capacities.

Perhaps substance use in anyone requires little explanation: we use substances because we want to! Many individuals vividly describe their substance experiences as fun, pleasurable, calming, exciting, exhilarating, “a chemical glimpse of paradise” and so forth. Weighed against these pleasures are the potential costs. Unfortunately, for individuals with bipolar disorder, these are higher than they are for someone without bipolar disorder.

If You’re Bipolar, What Should You Do About All of This?

Your relationship with substances falls somewhere on this continuum:
Abstinence ⇓ Moderate Use ⇓ Abuse ⇓ Dependence
For reasons which we will explain, we strongly recommend abstinence as the simplest and safest course of action for most with bipolar disorder.

However, substance use is very appealing and many don’t want to give up this pleasure and the pleasures that can be associated with it. Therefore, many individuals will want to attempt to balance the risks of misuse with the pleasures of use. Unfortunately, we find this is problematic for most during late adolescence and early adulthood, which also happens to be the window of time where we most often see the onset of bipolar disorder.

**Here’s Why:**

First consider all the factors that are shaping development somewhere between the mid-teens and the mid-twenties: progression to post-high school options (for many this is college), exploration of independence apart from the family unit, initial decisions about life direction (selecting a collegiate major), clarification of one’s own values apart from those of one’s family’s, dealing with realities of competition within the academic and early career contexts, exploration of sexual and love relationships, developing early stages of economic self-sufficiency, etc. Obviously this list only offers a taste and is not fully inclusive.

One of the stronger influences during this stage of development entails the need to fit in and establish strong interpersonal connection. This is pivotal because to be successful in gradually lessening ties to one’s family unit, new connections are needed to move towards. This need to belong and be accepted by peers is particularly important when we consider the prevalence of alcohol use within the university population. From the 2010 American College Health Assessment (American College Health Association, 2010) which draws from a nationally randomized sample of slightly more than 30,000 college students, we see 60% of students reported alcohol use at least once in the last month. Even more relevant is that students perceived 94% used alcohol within the past month. In other words, they overestimate the extent of alcohol use by their peers. Of this group of drinkers, close to 30% or almost one out of every three, said that when they socialized or “partied” they consumed five or more alcoholic drinks. We see that college students perceive most of their peers use alcohol, and amongst those who do drink, almost one third consume enough alcohol to become intoxicated when drinking. Such is life in the late teens and early twenties.

You might perceive this data differently and say “Wait, what about the 40% who report not using alcohol?” We agree, that’s a substantial figure. But much more powerful, is the fact that students “perceive” that nine out of ten students do drink. In other words, abstinence is not a perceived norm in the university population. When we reflect upon the importance of fitting in, it makes sense that many students will want to behave in a manner that’s consistent with what they perceive
their peers to be doing. Making alternative choices is far more difficult. For instance, going to a fraternity party and adhering to a one or two drink limit is a hard choice when most in attendance are having many more. And when a student’s peers are among those who are not doing well with moderation, then group affiliation can become a slippery slope towards a student’s own excessive drinking. By choosing to form close connections with a group of peers who drink, the student greatly increases his or her own substance use risks. Combine that with a genetic predisposition towards bipolar disorder and you’ve got a recipe for the kinds of dual diagnoses problems that we listed earlier in this chapter.

We generally find through our work with many bipolar teens and twentysomethings that alcohol moderation is usually not a successful strategy. More accurately, it is one with very low success rates. If failure at moderation meant that one would simply need to stop drinking and refrain from future alcohol use, then the substance use outcome would be unfortunate yet correctible. But given that we’re looking at the precipitation of bipolar onset or potential exacerbation of already existing symptoms, then we really are referring to non-reversible outcomes. This in and of itself should be sobering!

Let’s shift a bit and consider the realities of a 42 year old named Keith who has lived with his bipolar disorder for the last 20 years. Keith is married with two children in their early teens. He is employed as a mid-level administrator in the health insurance industry. From ages 20 through 24, he experienced a fair amount of mood instability, largely fueled by frequent and excessive alcohol use as well as intermittent pot smoking. After one hospitalization and two subsequent medical withdrawals from college Keith “got it” that substance use was his nemesis. In fact, he found that once he was able to stay away from alcohol and pot, his instability became less severe and more infrequent. As he progressed with his sobriety he would still occasionally dip into a moderate depressive funk which created some impairment. He would also go through periods of elevated mood where everything was moving too fast for comfort. The difference at his stage of life was that Keith was connected to a strong, healthy and enduring support system. His wife understood the realities of his disorder as did his employer. He also had seen the same psychiatrist over the last 10 years time and all involved through key roles in his life were able to make necessary adjustments as needed. The impact of Keith’s bipolar disorder wasn’t inconsequential, but at the same time it didn’t turn into a major disability. It was an ongoing factor that he had learned to manage.
Keith generally refrained from drinking but sometimes he and his wife had a glass of wine with dinner. He liked the wine for its flavor and the way it enhanced his meal. He rarely felt the desire for more than a glass or two. And on those isolated occasions where he went beyond that limit, he usually paid for it by having difficulty awakening in time to arrive at his office when his work day started. If Keith were being honest, he would acknowledge that his occasional slips into too much alcohol were never worth it. At these times he would feel fatigued, cranky and on edge for much the following day. He hated it. And he also rarely found that there was anything extraordinary about his alcohol-related experience from the night before.

You see, Keith was more connected to the life satisfaction that he found through structure, stability and abstinence as opposed to the excitement he had found through his previous college substance use. He was at point in his life where the entire equation for satisfaction and stability was different. Keith realized that the cost benefit analysis, which he finally understood, pointed toward minimal or no alcohol use. It just wasn’t worth it anymore.

Keith’s story is not unusual as it pertains to the differences between young adulthood and the mid-life years (or later). His story also bears directly on our advice pertaining to alcohol use. That is, alcohol use during adolescence and early adulthood for most bipolar disordered individuals is too risky. The importance of maximizing mood stability during the early course of the disorder is critical.

Later in life, the risk of bipolar destabilization from moderate alcohol use is much less due to the many other factors that augment stability and have us less vulnerable to the seduction of social conformity and excitement seeking. There is one very important caveat here: there are some who find they have no success with moderation. It seems that every time they drink they get drunk. Even just a little alcohol consumption stimulates cravings for more. And once that train has left the station it becomes very difficult to get things back on track without the destructive consequences of relapsing into excessive use. Where you fit on this continuum is something you will each need to discover. And again, if you’re at an earlier point in the lifecycle, then the very process of discovery is also fraught with danger. Instead, you’ll find that abstinence is your best friend.

Thus far, most of our discussion has organized around alcohol use. This is purposeful. When we broaden the focus to include the wider range of popular drugs (stimulants, opiates and hallucinogens) then we are back to the
slippery slope and our advice is that of strong caution. But we also don’t want to excessively generalize with excessive rigidity. Let’s parse the issues with more specificity.

**Stimulants**

Stimulants represent is a broad category of drugs spanning the range from an innocuous cup of coffee to smoking crack or injecting meth into one’s veins. The effects are not unlike the continuum of symptoms from very mild hypomania to full manic psychosis. But even at the mild end of the continuum, caution is in order. There are some with bipolar disorder who don’t do well with even mild chemical stimulation. They have a very low threshold for hypomanic activation. Caffeine or energy drinks, even in low quantities can be a powerful catalyst for these individuals. For others, a morning cup of coffee or two, or a mid-day energy drink is no big deal. Apart from the very mild feeling of activation, a small degree of chemical stimulation is just that. The task of the bipolar individual is to figure out where he or she is on this continuum. Do one or two cups of coffee represent a light lift or are they more like lighting a fuse? If the conclusion is that very moderate use of light stimulants is benign, it’s important to remain mindful of their danger, especially in today’s youth culture where caffeine and/or energy drinks are the chemical supports which facilitate academic all-nighters or even the experience of “raging” until the early morning hours. Eight or ten cups of coffee in a day or five red bull drinks at night are not innocuous and the outcome can be much more than bargained for.

Precisely because caffeine or herbal stimulants are perceived as benign, their risk of overuse is strong. Anything with mind, mood and energy altering qualities is potentially dangerous. When you apply this to the stronger substances like cocaine, crack or methamphetamine then the conclusion is clear. They are addictive, they are powerful substances and they are dangerous. Moderate, safe use with these potent drugs is highly unlikely for most, let alone the person with bipolar disorder.

And what about the use of psychostimulants used for treatment of Attention Deficit/Hyperactivity Disorder? Their use is complicated for the bipolar individual and must be closely monitored by a prescribed psychiatrist. The psychostimulants can have the same potential to evoke elevated mood symptoms as do the other stimulant substances. If they can be avoided, then there’s generally a better chance for achieving bipolar mood stability. On the other hand, strong untreated ADHD symptoms can wreak havoc on the task of bipolar treatment and sometimes taking a prescribed psychostimulant (such as Adderall, Ritalin, etc.) may become necessary. Suffice to say that the choices of when to use psychostimulants in order to manage ADHD symptoms and co-occurring bipolar disorder is the purview of psychiatrists who are knowledgeable about the interface of these two conditions. The bipolar
individual who uses these drugs as a study aid or to sustain energy when the drugs are not specifically prescribed is again engaging in risky behavior.

**Opiates**

A similar risk-related rationale applies to pain medications. They act upon the central nervous system to numb pain, including psychic pain. They are addictive, both physiologically and psychologically while also having a depressant effect upon mood. A few days use of opiates (Percocet, Vicodin, etc.) following a surgical procedure is fully appropriate. But for the bipolar individual, using opiates to numb the pain of depression, replace it with brief euphoria or to calm an agitated state only opens the door towards deeper depression and increasing dependency on the medication. As pointed out earlier it also erodes the capacity to manage psychic pain. Given that developing tolerance for recurring depression is crucial learning for those with bipolar disorder, it only makes sense that recurrent opiate use is counterproductive towards this end.

**Hallucinogens**

The hallucinogens are a broad class of drugs such as LSD, ecstasy, mescaline psilocybin, etc. They are nearly all produced and sold on the black market (illegally) except for substances which are used in strictly controlled research conditions. Because these drugs are not pharmaceutical quality, you never truly know what you’re getting. And even if there was reliable information about the drug’s chemical composition, each individual’s reactions to hallucinogenic drugs is unique. Five people can take the same substance and have five widely different experiences. When one has a bad experience with a hallucinogen, the “badness” can be acute enough as to cause psychosis. As you’ve learned through other chapters there is a risk for psychotic episodes with bipolar illness. We know that the more severe the bipolar illness, especially the severity of manic episodes, the more likely there will be episodes of psychosis with hallucinations and delusions (Goodwin and Jamison, 2007). It is obvious that the bipolar individual should refrain from drugs known to induce hallucinatory highs and even psychoses. Essentially, the unpredictability of hallucinogenic reactions and their positive correlation with manic psychosis is strong enough to exclude these drugs from the realm of moderate use. The risks for the bipolar individual far outweigh the rewards.

**Cannabis (marijuana)**

There are those that might argue that cannabis doesn’t belong within the group of hallucinogens as it is not a powerful enough substance. But “not powerful enough” really reflects how much is smoked. Besides, with today’s high-tech growing processes the concentration of THC (tetrahydracannabinol), which is the primary psychoactive substance in cannabis, is many times stronger than when the drug first began to receive widespread social use in the late 1960’s.

The problem with cannabis is similar to what we see with alcohol or with the milder stimulants. That is, it is perceived as fairly benign. In fact, there are some states
where its use is legal when medically prescribed and other states where possession of small quantities represents a level of misdemeanor not much different than a traffic ticket. It is this very perception of its benign characteristics that conveys the most risk.

Let’s imagine that someone with bipolar disorder gets high on cannabis a couple of times a month and essentially doesn’t experience any negative consequence (or so they think). And precisely because they seem to do well with infrequent use, they find that their use gradually becomes doubled. Even then, the thought of getting high about once weekly may still seem infrequent enough so as to carry relatively low risk. But what we’ve seen in clinical practice as well as through research data is that more frequent cannabis use is positively correlated with higher frequency of both bipolar onset and relapse (Baethge, C., Hennen, J, Khalsa, H.K., Salvatore, P, Mauricio, T. and Baldessarini, R.J., 2008). There are also those with bipolar disorder where even occasional use of cannabis brings about rapid mood destabilization, particularly within the elevated mood phases. This low threshold for instability can also be quite variable from one person to the next, depending upon one’s overall emotional/psychological stability. In fact getting high at one point in a year’s time may have very different impact upon one’s psyche than getting high at a different point in the same year. In other words, there are multiple variables at play in relation to the outcome of cannabis use, none of which make it a very predictable substance.

For the average, mentally healthy person who is not bipolar, the occasional use of cannabis may be no big deal. But for the individual with bipolar disorder, the picture is different. There are the risks that occasional use will become more frequent as well as the risk that even occasional use may still have negative impact upon mood stability. We’ve simply seen the same outcome again and again within the bipolar population. When people with bipolar disorder get high on cannabis they experience stronger mood variability than if they abstain. And once they get a handle on abstinence, they generally experience more sustained psychological well-being. It may seem that the information you’re receiving within this chapter begins to sound like a broken record. All substance use carries risk. With some drugs the risks are more obvious, and for those living with bipolar disorder, the risk with almost all substance use is amplified. Perhaps our experience is similar to ER physicians who speak out against motorcycle use. What they see is the death, injury and dismemberment caused by motorcycle accidents. Many of those riders thought “it will never happen to me.” We can only hope that all individuals with bipolar disorder will understand the risks we are pointing to in order to reduce their own risks of truly negative outcomes.

We’ll conclude with a real life story which demonstrates the many of the risk and reward issues discussed throughout much of this chapter.
Beth’s Bipolar Disorder and Summer Camp: A Corrective Combination

Beth, who was a 22-year-old, third-year college student, loved to party. So did most of her peers. At one point in her treatment she was consistently reporting that her prior weekend had included too much alcohol and too little sleep. Her medication adherence had become lax and she was continuing to have frequent episodes of hypomania and depression. She truly wondered if she would ever see stability again. She also had growing concerns about her capacity to effectively create a productive and satisfying future.

One summer, Beth was hired as a camp counselor for a summer-long residential camp in a remote mountainous area. She initially was concerned about the radical change to her lifestyle; but to her surprise, she saw the longest period of stability since the onset of her bipolar disorder five years earlier. Beth’s recipe for stability was initially imposed by the requirements of her job. Lights out was at 10 P.M. and the camp day began each morning at 6:30 A.M. There were also few options for after-hours partying with her counseling peers as most were in their cabins with campers. Without much effort, she had developed a stable sleep cycle and consistent medication adherence while also refraining from any drug or alcohol use. She found that by the end of the summer she felt better than she had in a long time. She essentially arrived at the same outcome as did Keith though she saved herself many years of struggle.

Now Beth says “the best treatment for bipolar disorder is camp life.” She has endeavored to maintain the same camp-like structure since her summer in the mountains, holding it as an internal ideal, rather than an externally imposed limitation. Although her risk of future relapse may never be zero, she loves her stable and enjoyable life. She discovered that abstinence and camp life were synonymous with her continued health and stability.

References


Frederick K. Goodwin and Kay Redfield Jamison. (2007): Manic Depressive Illness:


Shortly after the birth of her first baby boy, a healthy boy, Janine began feeling down. Her entire body felt heavy, and she wanted to crawl away and hide, but when she did get the chance to lie down and pull the covers over her head, she couldn’t get to sleep. Even when her baby was sleeping, or when her husband or mother was playing with him in another part of the house, she found sleeping almost impossible. She also worried constantly about her baby—that something would happen to him—he’d stop breathing, or tip over his bassinet. She would cry for no apparent reason several times a day, and eventually began to wonder if her baby and family would be better off without her.

Though she tried to hide her feelings, both her husband and her mother sensed that something was wrong. She told them she was fine, but they insisted she tell her doctor that she was crying, worrying, unable to sleep and unhappy most of the time. She worried that the doctor would say she was a bad mother, but she didn’t—he praised her for getting help. He diagnosed her with postpartum depression, and all together, Janine and her doctor worked to develop the right treatment plan for her. Eventually, she began to feel like herself again, and realized how important it was that she be there—and healthy—for her son.

Janine is not alone. One of every ten new mothers experiences symptoms of postpartum depression.

**What is Postpartum Depression?**

Postpartum depression is a treatable medical illness characterized by feelings of sadness, indifference, exhaustion and anxiety following the birth of a baby. Symptoms can appear immediately, or when your baby is a few months old. Postpartum depression can affect any women, regardless of age, race or economic background. It is not a character flaw or sign of personal weakness, and it does not mean there is anything wrong with your ability to be a mother. The exact cause of postpartum depression is not known, but certain chemical changes that take place in your body during and after pregnancy may contribute to it.

It is more important to remember that postpartum depression is not your fault, it
does not mean you are a weak or inadequate person, and it could not have been avoided by “snapping out of it” or “pulling your self up by your bootstraps.”

It can be hard to talk about feeling depressed after having a baby, because of our society’s belief that this should be the “happiest time in your life.” If you are suffering from postpartum depression, the time after you give birth feels anything but joyful. You may feel as if you aren’t a good mother, or that the baby would be better off without you. These feelings may make you feel ashamed or frightened, and you may feel that you should hide them from your family and friends. However, it is important that you can tell someone, whether it is your health care provider, a family member, friend or clergy member, and that you seek help. You can feel better, and getting treatment early is the best thing you can do for yourself, your baby, and your family.

Postpartum depression is not just “the baby blues,” a mild feeling of sadness after a baby is born that goes away on its own. If the “baby blues” don’t go away after 2 weeks, you could be suffering from postpartum depression, and should seek help. You need not feel ashamed of having an illness-or of any treatment you may need to feel better-any more than you would feel ashamed about having diabetes or asthma and taking medication to stay healthy.

**What are the Symptoms of Postpartum Depression?**

- Feelings of sadness or “down-ness” that don’t go away
- Inability to sleep, even when the baby is sleeping
- Changes in appetite-eating much more or much less; significant weight changes not related to pregnancy or birth
- Irritability, anger, worry, agitation, anxiety
- Inability to concentrate to make decisions
- Inability to enjoy things you used to; lack of interest in the baby; lack of interest in friends or family
- Exhaustion; feeling “heavy”
- Uncontrollable crying
- Feeling of guilt or worthless
- Feeling of hopelessness or despair.
- Fear of being a bad mother, or that others will think you are
- Fear that harm will come to the baby
- Thoughts of harming the baby or harming yourself
- Thoughts of death or suicide

**GET HELP RIGHT AWAY IF YOU HAVE ANY THOUGHTS OF HARMING YOUR BABY OR YOURSELF.**

Tell a medical professional, clergy member, loved one or friend immediately.

**What Might Increase my Risk for Postpartum Depression?**
Although postpartum depression can affect any woman who has recently given birth, there are some factors that may increase your chance of having postpartum depression, such as:

- A history of depression during or after previous pregnancies
- A history of depression or bipolar disorder at any time
- A history of depression, bipolar disorder or postpartum depression in relatives
- Lack of support from family or friends
- Difficult life events happening around the time of your pregnancy or birth.
- Lack of stability in your marriage or relationship.
- Feeling unsure about your pregnancy.

If you are reading this before the birth of your baby and you’re concerned about the possibility of developing postpartum depression, talk to your health care provider before your baby is due. Symptoms of postpartum depression may also begin to appear during pregnancy, discuss them with your doctor.

**How do I Talk to my Doctor/Health Care Provider about Postpartum Depression?**

It’s important to have a trusting relationship with your doctor or health care provider and feel confident in his or her skill, knowledge and interest in helping you. You should never feel intimidated by your doctor or feel as if you’re wasting his or her time. It’s also important to share all the information your health care provider needs to help you. Tell him or her about your medical history, all of your symptoms, and any medications or “natural” remedies you are using.

A skilled and interested doctor should address all of your concerns, but you may have additional questions. Don’t leave the doctor’s office until all of your questions are answered. Take notes if things seem complicated. If you have a lot of questions, write them down before your appointment and bring them with you. Discuss your most complicated or difficult issues first. You may want to ask for extra time with the doctor when you schedule your appointment.

If you are having trouble communicating with your health care provider or if you feel your needs are not being met, it is all right to look for another doctor who will be better able to help you.

**What are my Treatment Options?**

**MEDICATION**

Some mothers decide with their doctors that medication is the best choice of treating their postpartum depression. Some medications may pass into breast milk, but others are less likely to do so, and your doctor should have the information to help you decide which medication is best for both you and your baby. If you have to stop breastfeeding, it doesn’t mean you aren’t a good mother; it means you are taking care of yourself in order to be the best possible mother.
Some medications may have side effects, such as dry mouth, light-headedness, sexual dysfunction or weight gain. Sometimes side effects go away on their own; other times it helps to change medication. Don’t become discouraged if you experience side effects—discuss them with your doctor and find out what other options you have. There are many different medications available to treat depression. All of them work, they just don’t work the same on everyone. If one medication causes side effects or does not relieve your depression, another may work well and have fewer side effects. Don’t give up. Never stop taking your medications or change your dosage without first discussing it with your doctor. Check with your doctor before using herbal, natural or over-the-counter remedies, because sometimes they can interfere with prescribed medication.

PSYCHOTHERAPY
Psychotherapy or “talk therapy” can also be an important part of treatment. Sometimes it can work alone; other times, symptoms of depression must be reduced through another method of treatment such as medication before psychotherapy can be effective. A good therapist can help you cope with the feelings you are having and modify patterns in your life that may contribute to your depression. Choose a therapist with whom you feel safe and whose judgment you trust. You might choose to visit a psychologist, social worker, or counselor.

How Might this Illness Affect my Family?
Husband or partners and families can be affected by postpartum depression, too. It is equally important for men to seek treatment if they have symptoms that interfere with their day-to-day lives. Sometimes therapy involving both partners or the whole family can be helpful.

Other children may be affected too. It may be a good idea for one parent to spend more time with other children and talk to them about what is happening in a way that they can understand. You can explain depression as “not feeling good” or “feeling sad because of chemical changes in your brain,” and explain that you are getting treatment to help you feel better. It may be necessary to reassure children that your illness is not their fault. You might want to ask your doctor or therapist to sit down with the whole family and talk about your depression, its treatment, how it affects them and what they can do. If any of your children have symptoms of depression that interfere with their daily activities, school or friendships, talk to your pediatrician about it.

What can Families do to Help?
Don’t be afraid to ask for what you need during this time. If family or friends ask how they can help, consider giving them small things to do such as:

- Household chores
- Helping take care of the new baby or other children
- Spending quiet time with you
- Educating themselves about your illness
• Talk to your children about your illness
• Watching for symptoms of depression

What is Postpartum Psychosis?
Postpartum psychosis is far less common than postpartum depression, and it is characterized by delusions (thoughts that are not true or logical, such as believing you are receiving messages through the television) or hallucinations (seeing or hearing things that aren’t actually there). It is extremely important to get help immediately in cases of postpartum psychosis. Remember, it is a physical illness. Postpartum psychosis is not something you can control by yourself, but it is something you can treat with proper medical help. Avoiding treatment because you are ashamed or afraid may have tragic consequences.

What if I was Already Diagnosed and Treated for Depression or Bipolar Disorder Before I Became Pregnant?
A woman with depression or bipolar disorder can be an excellent mother-as good a mother as a woman without one of these illnesses. But a woman with a prior history of depression or bipolar disorder is at an increased risk to develop postpartum depression (1 in 4 develop postpartum depression) compared to a woman with no prior history (1 in 10 develop postpartum depression). Be the best mother you can by staying aware of your own moods, working with your doctor to monitor your illness, planning appropriate treatment during pregnancy, sticking with the treatment plan you are given and making sure you have a support network in place before the baby is born. Your support network may include a support group you attend, your family and friend, health care providers or other new moms.

Prepare written plans with the help of your family about what should be done if you should develop postpartum depression (or psychosis). These plans should include the names and phone numbers of your health care providers, names of medications which have worked for you in the past, medication allergies, insurance information, and a list of people who are willing to take care of your baby and other children if you are unable too.

How do Support Groups Help?
Support groups can help you stick with treatment plans, provide a forum for mutual acceptance and self-discovery, help rediscover strengths, humor and sense of community, and give you the opportunity to benefit from the experiences of others who have “been there.”

What are Some Things I Can Do to Stay Healthy?
Keep appointments with all your health care providers and stick with your prescribed treatment plan.

Learn all you can about postpartum depression and its treatment.

Keep track of your moods, things that cause you stress, and your response to treatment in a journal. This may help you spot future episode earlier.

Share your thoughts and feelings with others.

Set realistic expectations for yourself. Work on accepting yourself as you are.

Don’t skip meals, even if your appetite and energy are low. Eat a variety of foods to get the nutrients you need. Talk to your doctor about taking vitamin supplements.

Look for opportunities to be physically active. Even walking or climbing stairs can help improve your mood and health.

Develop stress reduction techniques, or ask your doctor about or therapist to recommend some.

With the right treatment and support, you can feel like yourself again and be free to enjoy life and your new baby.

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Webster’s Dictionary defines stigma as “any mark of infamy or disgrace; sign of moral blemish; stain or reproach caused by dishonorable conduct; reproachful characterization.”

The first known use of the word stigma occurred in 1593, with its origin from Latin stigmat-, stigma mark, brand, or from the Greek, from stizein to tattoo.

I know that my sister loves me. I know that my friends love me. But they still judge me and the stigma of being mentally ill still affects the way they perceive me, hence.. the way they treat me. As a single 36 year-old man, I notice that many people meet women through their friends and family. My sister and brother n’ law know plenty of women that I would get along wonderfully with. I know they love me, but there are never any introductions because of the stigma that sticks, even to those closest to me. And that makes me sad. Bret W.

Stigmatizing others has been around for centuries. Criminals, slaves, or traitors had a tattoo mark that was cut or burned into their skin in order to visibly identify them as blemished or morally polluted persons. These individuals were to be avoided or shunned, particularly in public places (1). Separating and judging groups by color, religion, sexual orientation, medical conditions (i.e. leprosy), and mental ability functions to establish a “us’ versus “them”. Discrimination, rejection, intolerance, inequity and exclusion all result from being stigmatized.

Erving Goffman defined stigma is an attribute, behavior, or reputation which is socially discrediting in a particular way: it causes an individual to be mentally classified by others in an undesirable, rejected stereotype rather than in an accepted, normal one.

Those with mental illnesses are unfortunately a target for stigma. Mental illnesses range from a rate of 26.4% in the U.S. to 8.2% in Italy. Combine other groups who are stigmatized against, and we practically have a world of people hating one group or another.

This chapter focuses on the stigma placed on those with mental illnesses, the myths involved, how to combat the phenomenon, and where to get help if you do encounter it.

Four of the 10 leading causes of disability worldwide are mental disorders.
According to the 2005 National Comorbidity Survey Replication study, approximately 1 in 3 Americans experience a mental health disorder in any given year. This translates to over 75 million individuals. Nearly half of Americans will experience a mental health disorder at some point in their lifetime. It is likely that you or someone that you know has or will experience a psychological problem.

The direct cost of mental health services, which includes spending for treatment and rehabilitation, is approximately $69 billion in the United States. Indirect costs, which refer to lost productivity at the workplace, school, and home, are estimated at $78.6 billion. (2)

The stigma associated with mental illness adds to the public health burden of mental illness itself. In general terms, stigma is the status loss and discrimination triggered by negative stereotypes about people labeled as having mental illness (3).

Mental disorder can strike anyone! It knows no age limits, economic status, race, creed or color.

Medical science has made incredible progress over the last century in helping us understand, curing and eliminating the causes of many diseases including mental disorders. However, while doctors continue to solve some of the mysteries of the brain, many of its functions remain a puzzle. Even at the leading research centers, no one fully understands how the brain works or why it malfunctions. However, researchers have determined that many mental disorders are probably the result of chemical imbalances in the brain. These imbalances may be inherited, or may develop because of excessive stress or substance abuse.

It is sometimes easy to forget that our brain, like all of our other organs, is vulnerable to disease. People with mental disorders often exhibit many types of behaviors such as extreme sadness and irritability, and in more severe cases, they may also suffer from hallucinations and total withdrawal. Instead of receiving compassion and acceptance, people with mental disorders may experience hostility, discrimination, and stigma. (4)

When I was twelve I invited my friend to come over for a play date. His father said no, they were going to his Grandmother’s. A few minutes later another boy invited him to play. The father said yes, and off they went. Court R.
The effects of stigma are especially painful and damaging to one’s self-esteem. It leaves people with mental illnesses feeling like outcasts from society. Whether the perceived stigma is real or not, it is the subjective interpretation that affects the person’s feelings of belonging.

I am a young girl in Tehran, because I am sick my family thinks I’ll be lucky if an old man agrees to marry me. (15)

Why do we, as a society, stigmatize our friends, family, and other members of our community? Perhaps it is due to a lack of education, mis-education, false information, ignorance, or a need to feel superior. The media must also claim responsibility for perpetuating the misconceptions about mental illness. Television and news print tend to focus on those who commit violent crimes rather than those with mental illnesses who contribute to our society. These infrequently committed crimes are sensationalized on talk shows, on the cover of popular magazines, and in headline news.

Mental illness plays no part in the majority of violent crimes committed in our society. The assumption that any and every mental illness carries with it an almost certain potential for violence has been proven wrong in many studies.

Current research shows that people with major mental illness are 2.5 times more likely to be the victims of violence than other members of society. This most often occurs when such factors as poverty, transient lifestyle and substance use are present. Any of these factors make a person with mental illness more vulnerable to assault and the possibility of becoming violent in response. (5)

Like most groups who are stigmatized against, there are many myths surrounding mental illness. According to the National Alliance for Research on Schizophrenia and Depression (NARSAD) here are the top 10.

**Myths:**

**Myth #1:** Psychiatric disorders are not true medical illnesses like heart disease and diabetes. People who have a mental illness are just "crazy."

**Fact:** Brain disorders, like heart disease and diabetes, are legitimate medical illnesses. Research shows there are genetic and biological causes for psychiatric disorders, and they can be treated effectively.

Yes, they discriminate against us; They don’t count on us; Our society in Iran has no capacity for us; I mean there is no cultural understanding in our society; They ridicule, insult and harm us; I wish they could understand that psychiatric patients are like other patients, like patients with cancer or cardiac disease and that they can live their lives. (15)
Myth #2: People with a severe mental illness, such as schizophrenia, are usually dangerous and violent.
Fact: Statistics show that the incidence of violence in people who have a brain disorder is not much higher than it is in the general population. Those suffering from a psychosis such as schizophrenia are more often frightened, confused and despairing than violent.

Myth #3: Mental illness is the result of bad parenting.
Fact: Most experts agree that a genetic susceptibility, combined with other risk factors, leads to a psychiatric disorder. In other words, mental illnesses have a physical cause.

Myth #4: Depression results from a personality weakness or character flaw, and people who are depressed could just snap out of it if they tried hard enough.
Fact: Depression has nothing to do with being lazy or weak. It results from changes in brain chemistry or brain function, and medication and/or psychotherapy often help people to recover.

Myth #5: Schizophrenia means split personality, and there is no way to control it.
Fact: Schizophrenia is often confused with multiple personality disorder. Actually, schizophrenia is a brain disorder that robs people of their ability to think clearly and logically. The estimated 2.5 million Americans with schizophrenia have symptoms ranging from social withdrawal to hallucinations and delusions. Medication has helped many of these individuals to lead fulfilling, productive lives.

Myth #6: Depression is a normal part of the aging process.
Fact: It is not normal for older adults to be depressed. Signs of depression in older people include a loss of interest in activities, sleep disturbances and lethargy. Depression in the elderly is often undiagnosed, and it is important for seniors and their family members to recognize the problem and seek professional help.

Myth #7: Depression and other illnesses, such as anxiety disorders, do not affect children or adolescents. Any problems they have are just a part of growing up.
Fact: Children and adolescents can develop severe mental illnesses. In the United States, one in ten children and adolescents has a mental disorder severe enough to cause impairment. However, only about 20 percent of these children receive needed treatment. Left untreated, these problems can get worse. Anyone talking about suicide should be taken very seriously.

Myth #8: If you have a mental illness, you can will it away. Being treated for a
psychiatric disorder means an individual has in some way “failed” or is weak.

**Fact:** A serious mental illness cannot be willed away. Ignoring the problem does not make it go away, either. It takes courage to seek professional help.

**Myth #9:** Addiction is a lifestyle choice and shows a lack of willpower. People with a substance abuse problem are morally weak or “bad”.

**Fact:** Addiction is a disease that generally results from changes in brain chemistry. It has nothing to do with being a "bad" person.

**Myth #10:** Electroconvulsive therapy (ECT), formerly known as "shock treatment," is painful and barbaric.

**Fact:** ECT has given a new lease on life to many people who suffer from severe and debilitating depression. It is used when other treatments such as psychotherapy or medication fail or cannot be used. Patients who receive ECT are asleep and under anesthesia, so they do not feel anything.

"These misconceptions can do irreparable harm to people with legitimate illnesses who should and can be treated," said Herbert Pardes, M.D., President of NARSAD’s Scientific Council.

Despite the alarming number of people affected with a mental illness, statistics show that only one-third of these individuals seek treatment. According to Dr. Thomas Insel of the NIMH, psychiatry is the only part of medicine — where there is actually greater stigma for receiving treatment for these illnesses than for having them.

While there are many reasons for the discrepancies in help-seeking behavior, stigma can prevent people from receiving the help that they need. Individuals with a mental health disorder may feel similarly ostracized and feel embarrassed about having a psychological or emotional problem. (6)

This barrier to seeking help can have a ripple effect. Some individuals may attempt to handle their “issue” through drugs or alcohol, both of which only exacerbate the illness by increasing the feelings of sadness and despondency. Left untreated, the illness only gets worse causing more isolation, emotional pain, and distress. In some cases, suicide may seem to be the only option.

The stigma impedes recovery by eroding individuals’ social status, social network, and self-esteem, all of which contribute to poor outcomes, including unemployment, isolation, delayed treatment-seeking, treatment-refractory symptoms, prolonged course, and avoidable hospitalizations. (7)

The downward spiraling behavior impacts everyone. The family member, friend or boss who is not privy to the person’s illness, may misinterpret behaviors, once again
wrongly judging them.

In 1994, I was studying neuropharmacology at the Wake Forest University School of Medicine in Winston-Salem, NC. One day a laboratory technician took me aside to complain about his mother who was “manic-depressive”. I said, “Well, I’m manic-depressive maybe I can help”. So we talked. A few days later, my advisor, “Dr. C” called me into his office. He told me that he would not let me complete my PhD in his lab and that he would give me a what does this mean, a terminal Masters?? terminal Masters degree because “People with bipolar disorder do not succeed in science”. Not only was this the beginning of the end of my scientific career, but it precipitated a cascade of miserable events. Sheryl S.

**Challenging stigma**

Stigma, although powerful, does not have to be inevitable. Countries around the world are joining forces to combat stigma and its harmful effects. Anti-stigma campaigns, legislation, public education, mobilizing communities in anti-stigma efforts, and personal commitments to end stigma are all underway. Changing the belief systems of those who inflict stigma is only one aspect to producing change, the second of which is to challenge the internalized negative beliefs of the stigmatized.

Most anti-stigma campaigns focus on educating the public, increasing community awareness about the myths of mental illness, and promoting treatment and services. Campaigns obviously vary according to funds available, access to technology, and demographic-specific needs. In many cases, celebrity spokespeople are used to help deliver the message. Here are some examples:

- The You KNOW Me Alaska anti-stigma campaign uses of a popular Alaskan Iditarod musher as a spokesperson for television ads, trading cards, newspapers, posters, and radio. [www.mhtrust.org](http://www.mhtrust.org)

- "On June 11, 2009 Wayne Cho completed a 8207 km cross-Canada run to raise awareness for anxiety and depression. These debilitating illnesses affect a great number of people and can cause great physical/mental/emotional harm to not only the affected individuals, but also to those closest to them. Wayne Cho has battled an anxiety disorder for many years and knows all-too-well the stigma to which people suffering from mental illness are subjected. His journey to achieve his dreams, the people that he has met along the way, and the millions more people that are affected by mental illness worldwide have inspired Wayne to challenge the stigma surrounding these disorders."

- Actress Glenn Close has a campaign called BringChange2Mind with a PSA directed by Ron Howard: [http://www.bringchange2mind.org/](http://www.bringchange2mind.org/)

- Fidgety Fairy Tales—The Mental Health Musical is an original 40-minute
musical produced by the Minnesota Association for Children’s Mental Health (MACMH) www.macmh.org

- In Our Own Voice (IOOV) is a unique informational outreach program, developed by the National Alliance on Mental Illness (NAMI), that offers insight into the recovery that is possible for people with severe mental illnesses. The program aims to meet the need for consumer-run education initiatives, to set a standard for quality education about mental illness from those who have been there, to offer genuine work opportunities for consumers, to encourage self-confidence and self-esteem in presenters, and to focus on recovery and the message of hope. www.nami.org

- The Iris the Dragon book series was developed in 2000 by Gayle Grass in Ontario, Canada. It was created to help reduce the negative attitudes that are associated with mental illness and to generate understanding and awareness of mental health problems in children. www.iristhedragon.com

- Developed in Andalusia, Spain, in September 2007, 1 de cada 4 (1 in 4 in English) is a campaign to increase public awareness of mental illnesses in order to reduce the stigma and discrimination experienced by people with mental illness. www.1decada4.com

- SANE StigmaWatch, an initiative of the national mental health charity, SANE Australia, monitors the Australian media to ensure accurate and respectful representation of mental illnesses. It does this through monitoring, correcting, and logging media misrepresentation of mental illnesses. www.sane.org

- Mind (National Association for Mental Health) provides information on a national level for England and Wales. Their activities promote the values of autonomy, equality, knowledge, and participation in the community for all people, especially those with mental illnesses. The group actively campaigns to improve the policy and attitudes of governing bodies in the United

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MASS MEDIA "Mass media is, far and away, the public's primary source of information about mental illnesses."---Survey of public attitudes, Robert Wood Johnson Foundation
Kingdom, and has developed highly successful local-level initiatives for consumers of mental health. http://www.mind.org.uk

Why should we be concerned?

Mass media are those sources that reach vast audiences on a daily basis and include television, film, radio, newspapers, advertising, and the Internet:
- the average American watches 4 hours of TV each day
- 1.36 billion movie tickets were sold in 2008
- 1.71 million DVDs were rented and over one billion sold in 2007
- the average Internet user spends 61 hours/month on the Internet (February 2009) (8)

Mass Media Tend to Inaccurately Show People with Mental Illness as Violent & Dangerous

- "Dangerousness is the most common theme of newspaper stories related to mental illnesses." (9)
- One study of prime time television programming found that people depicted with mental illnesses were 10 times more likely to be shown as a violent criminal than non-mentally disordered television characters. (10)

Not only does the media depict criminals as being mentally ill, they further expound on the stigma by showing the mentally ill as unlikely to recover. Use of cartoons, advertisements, and films ridicule the mentally ill and make light of their issues.

Journalists in all forms of media play an increasingly important role in shaping public understanding and debate about health care issues. The Rosalynn Carter Fellowships for Mental Health Journalism program, created in 1996, is part of a national effort to reduce negative attitudes and discrimination associated with mental illnesses. The fellowship program aims to increase accurate reporting on mental health issues; help journalists produce high-quality work that reflects an understanding of mental health issues through exposure to well-established resources in the field; and develop a cadre of better-informed print and electronic
Unfortunately, a joint study by Indiana University and Columbia University researchers found no change in prejudice and discrimination toward people with serious mental illness or substance abuse problems despite a greater embrace by the public of neurobiological explanations for these illnesses.

Recent research has found that:
- 48.6 percent of the public are unwilling to work closely on a job with someone with depression

> When a new colleague was hired at my office, I felt certain that he must struggle with depression. It was months before he confided in me that he was diagnosed with bipolar disorder. I kept this information strictly confidential. Later, due to complications with his health and medication, my colleague exhibited behavior at work that made others uncomfortable. He sought medical support and gave me permission to share his diagnosis with our colleagues, hoping that they would be understanding. Their responses horrified me: "He's just using this diagnosis as a way to keep his job!", and "I just don't think he should work here. That's what disability payments are for..."

> While I don't struggle with bipolar disorder myself, I do have a history of depression and anxiety. I told our Board of Directors that I was deeply offended by these remarks and that the staff needed training in sensitivity around mental health issues. I received no response.

> Although this experience tarnished our feelings for the company and its employees, the silver lining is that we are happily planning to spend the rest of our lives together. So there was a reason why he came into my life and ended up going through such a dark time at our place of employment --- he had to meet me. Thankfully, his health is much better now. Caroline W.

- The percentage of people associating mental illness with violence has doubled since 1956.

> "Prejudice and discrimination in the U.S. aren't moving," said IU sociologist Bernice Pescosolido, a leading researcher in this area. "In fact, in some cases, it may be increasing. It's time to stand back and rethink our approach."

> "Often mental health advocates end up singing to the choir," Pescosolido said. "We need to involve groups in each community to talk about these issues which affect nearly every family in America in some way. This is in everyone's interest."
The research article suggests that stigma reduction efforts focus on the person rather than on the disease, and emphasize the abilities and competencies of people with mental health problems. Pescosolido says well-established civic groups -- groups normally not involved with mental health issues -- could be very effective in making people aware of the need for inclusion and the importance of increasing the dignity and rights of citizenship for persons with mental illnesses. (14)

**Combatting Stigma:**

So, what can we do to combat stigma? SAMHSA has a “4-P’s” approach: Praise, Protest, Personal Contact & Partnership. Here are some specific do’s and don’t’s:

1. In a recent survey by the American Psychiatric Association, 79% percent of those surveyed believed that seeking and receiving support from family and friends reduced feelings of stigma.

2. Share your experience with mental disorder. Your story can convey to others that having a mental disorder is nothing to be embarrassed about.

3. Help people with mental disorder reenter society. Support their efforts to obtain housing and jobs.

4. Watch the language you use:
   - don’t use generic labels: “retarded”, “our mentally ill”
   - don’t use psychiatric diagnoses as metaphors: “schizophrenic situation”
   - don’t use offensive words: “psycho”, “loon”, “crazy”, “wacko”, “slow”, “crackpot”
   - don’t refer to a person as a diagnosis: “he’s bipolar”, instead say, “he has bipolar disorder”

5. Document stigma in the media whenever possible

6. The media also offers our best hope for eradicating stigma because of its power to educate and influence public opinion, so remember to thank journalists when they get it right.

7. Send letters, make phone calls, or e-mail the offending parties

8. Ask your local, regional, and national leaders to take a stand

9. Support efforts to actively expose stigma in the media

10. Educate yourself - the elimination of stigma begins with you

11. Volunteer, join a campaign
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HERE’S TO YOUR HEALTH!
We human beings are naturally social creatures. Interacting and connecting with others is a vital part of our wellbeing, and neglecting our relationships can in turn be detrimental to our mental health. Those who are already inclined to emotional reactivity and behavioral complications have a heightened sensitivity to relational distress and are more vulnerable to negative situations. It is important to be attuned to the health of our relationships with family, spouses, and friends, in order to improve our mental health and maintain stability.

The Importance of Supportive Relationships

Building and maintaining supportive relationships is a critical part to our overall wellbeing. Connecting and relating to others brings a sense of purpose, meaning, and belonging. Isolation is often a symptom of mental health disorders, particularly depression. With bipolar disorder, it is not unusual for one to isolate and withdraw when depressed. As such, it is vital to work to maintain our relationships throughout our ups and downs to prevent complete detachment in our most critical times of need.

When we have strong and healthy relationships with friends, family members, and significant others, we are given an opportunity to learn and grow in a supportive companionship. These relations allow us an outlet to share our fears and aspirations, to enjoy positive and uplifting activities, and to be comforted and consoled when we are struggling. A healthy relationship allows us the opportunity to call on someone for support and assistance when we need it most. The love and support fostered through healthy relationships can in itself be a tool for recovery from mental health symptoms. It is natural and healthy to turn to others as a means to cope.

Moreover, social interaction can help improve our overall mood and outlook. Engaging in recreational activities or social conversation with others can contribute positive emotions and fend off negative ones. Positive relationships bring us enjoyment in life, and life satisfaction can help ease symptoms of mental health disorders, including bipolar disorder.

Improving the Bonds Within Your Family

When we are struggling with our mental health, our relationships often suffer. The ones we are closest to, such as spouses, children, parents, and siblings, are pushed away. We become detached, and this often drives us further into an unhealthy state.
When stress and anxiety increase, we lash out, isolate, or shut down. This only fuels the stress and instigates anger and resentment in our loved ones. Instead, reaching out and connecting with those nearest to us will help fight the stress and strengthen our bonds. Supporting our loved ones when they are struggling and allowing them to be there for us will improve the bonds within the entire family.

The best time to practice these skills is not while in the midst of a manic or depressive episode. Rather, it is important that you take steps to strengthen your bond before a stressor hits. Regularly engage in mutually enjoyable activities. Go on outings together, initiate uplifting conversation, and exhibit support for one another’s goals and accomplishments. Maintaining a connection during stable times will help you be strong and prepared for the harder times to come.

If you have already injured the bond between you and a family member, you must make the conscious decision whether or not to repair it. Is this relationship worth saving? Was it a healthy relationship to begin with? Will it bring something positive to your life if you restore it? If so, consider reconciling and moving forward. This will require you to acknowledge your own weaknesses, as well as others’. It will require you to make a choice as to which behaviors you will no longer engage in to prevent another injury upon the relationship. Expect this to be difficult. If the relationship is important to you, it will be worth the effort. It might be helpful to engage in therapy to assist you in preparing for this reconciliation process.

If you are serious about maintaining and strengthening the bonds with your family members, and even developing new relationships, you should pay particular attention to two things: educating your loved ones about bipolar disorder, and remaining cognizant of your personal impact on your loved ones. Without this mutual understanding, the future of your relationships will be jeopardized.

**Education About Bipolar Disorder**

Perhaps the most important aspect to strengthening a relationship after mental health symptoms have caused harm, is education about bipolar disorder. Of course, you must seek out information about bipolar disorder for yourself, but you must also ensure that your loved ones are educated on your condition as well. The more they know about your struggles, the better equipped they will be to assist you when you are in need. In addition, the less inclined they will be to react poorly to stressors about your own behaviors and reactions.

Strongly consider educating your spouse about your mental health diagnosis. Although it is natural for a couple to have periods of decreased communication and intimacy, it is more likely that these periods will be exacerbated by the symptoms of bipolar disorder. Engaging your significant other in a discussion about your diagnosis may assist in alleviating the negative effects it may have on the relationship.
relationship. Providing literature on bipolar disorder will be beneficial, although explaining your experience in your own words might be most powerful. If possible, and if your spouse is willing, consider inviting him/her into a therapy session so he/she may gather information from a mental health professional. Ongoing couples counseling can also assist in resolving concerns and increasing the bonds between spouses.

Consider requesting that your family members accompany you in a session with a mental health professional to learn about bipolar disorder. Of course, you will first want to recruit your therapist’s approval and support for this collaborative meeting. Let your therapist assist you in preparing for this process and debriefing reactions afterwards, as it might be a difficult situation. This psycho educational process will provide your family members with greater understanding of your struggle. A foundational understanding of your diagnosis will help family members accept the past behaviors which might have harmed the family dynamic. It will also provide them with tools to comprehend and respond to your mental health symptoms as they arise.

For the younger children in your family, engaging in this process might not be beneficial and may even be detrimental. Again, discuss with your therapist which members of the family should be present for the discussion around your diagnosis. However, all members of the family must be made aware of the matter so that they will be better prepared to handle potential stressors and to provide support to you as needed. There are many books available for young and old alike to help with the education.

Be mindful that it is natural for children to have great difficulty understanding the reason behind your behavior when you are experiencing symptoms. When you are of sound mind, engage in a calm and compassionate discussion with your children. Explain that your past behaviors are not an indication of a lack of love. Show them that you are there for them as a parent now. Your actions today will help counter those of the past. Remember to tailor your conversation to your children’s developmental age. If they are able to comprehend more abstract concepts, consider engaging them, along with your spouse and other adult members of your family, in education about bipolar disorder. It might be particularly beneficial to also engage them in family therapy, to help process emotions and reactions and improve the overall household dynamic.

**Your Impact on Others**

When we are in the midst of our mental health disorders, we are often ignorant of our impact on others. Our perception of ourselves is skewed, and our beliefs and behaviors are often irrational. We say and do things we would not normally do. We do not understand why others do not see or think as we do. It baffles us that others do not agree with us unconditionally. Then, when we are well, we are often overcome with feelings of regret, guilt, and resentment. And we cannot understand why they cannot forgive us. Why can’t they just be there for us, support us, love us?
We may have acted in a way, which was harmful to them. Just as we were troubled by our minds, so were they, by our actions. As we became fearful, angry, and confused, so did they. We cannot combat our mental health symptoms overnight. Nor can they forgive and forget so easily. We ask them to understand, to be patient, to give it time. We must do them the same return favor. Relationships are reciprocal.

Be mindful of the fact that our actions do impact others. We push and pull especially those nearest to us, our spouses, children, and best friends, and it is only human for them to react. As you work to improve your wellbeing and fend off symptoms, remain conscientious of how your actions are perceived by others. Consider seeking assistance from a mental health professional to assist in increasing mindfulness of your actions and reactions.

Developing Healthy Friendship

It is important that we surround ourselves with positive, supportive, and encouraging people in our day-to-day lives. Why would we choose to engage with someone who is negative, condescending, or hostile? Instead, aim to engage with those you personally feel have something to offer you.

One effective way to meet new friends is to involve yourself in social groups and activities you enjoy. Joining a recreational club, taking a class, or even meeting a coworker for coffee can be a means to developing a new friendship. Centering relationships around common interests, such as hobbies or common vocations, can be a great way to foster sturdy relationships. Avoid activities and areas which are likely to induce stress or anxiety, and instead, seek out those which bring pleasure. If you feel your new friend is instigating stress or anxiety, remove yourself from the relationship. Remember to establish a new friendship on the foundations of open communication and mutual respect to foster a supportive friendship with healthy boundaries. (See section on Social Interaction)

Selecting a Romantic Partner

When entering into a romantic relationship, the most important thing to remember is that both parties are equally responsible for making it work. First and foremost, a successful romantic relationship is founded upon mutual respect, meaning that both individuals should show positive regard and consideration for one another. When with your partner, are your personal needs neglected? Do you feel your privacy is being invaded? Do you feel shut down or closed off by your partner? Have your rights to independence and choice been revoked? Has your partner ever intentionally hurt you, physically or emotionally? Do you feel controlled? If you answered yes to any of these statements, it is likely that your partner is not providing you with the respect that every person deserves. Now take a look at yourself: are
you infringing on your partner’s personal rights or needs? Are you disregarding their feelings or requests? If you do not show respect for your partner, you cannot expect to receive any in return. You cannot expect this relationship to stand the test of time.

Another crucial part to establishing a healthy and supportive relationship is mutual interest and reciprocity. Both parties must be invested in the relationship in order for it to last. Typically, a successful relationship will develop steadily, moving from curious interest to true affection to honest commitment. When both parties move through these stages at or around the same pace, a reciprocal level of investment is being sustained. So when selecting a partner, if you notice the other is not as engaged in your well-being, interests, or feelings as much as you are in theirs, or vice versa, then this relationship may not work. If you feel that as the relationship develops the other maintains equal (or close to equal) investment in you, then the relationship is sustaining mutuality and a long-term relationship is likely.

Once mutual respect and equal investment have been established, you can begin to consider other factors which you personally value. Consider your hobbies and interests in addition to the virtues you prize and your plans for the future. Do you want a family? Do you value education? Are you outgoing and loud or quiet and reserved? Outdoorsy or a homebody? Now consider your partner; do your interests and values line up? If all these aspects of a successful relationship are present in yours, then you must now approach what might be the hardest part.

As an individual diagnosed with a mental health disorder, it is important that you receive support and advocacy from those closest to you, especially your romantic partner. Explain to your partner the nature of your bipolar disorder and what it entails for you personally. Educate your partner on the importance of following a medication regimen and seeing a mental health professional on a regular basis so that they can support you in following through with these tasks. You might want to discuss your personal struggles, such as what a manic or depressive episode looks like for you, so that they can know what to expect and how to help during these times. Based on your comfort level with disclosure, it might be helpful to break up this discussion into several smaller conversations. Utilize your therapist or counselor to assist you in the process by discussing your plans beforehand and debriefing.
the experience afterwards. Throughout this important discussion with your new romantic partner, gauge his/her response for signs of understanding, compassion, and support. If you do not feel like this person respects you or regards you less for having this diagnosis, then he/she might not be worth your time. If they call you names, degrade you for your struggles, or discourage your efforts toward self-care, it might be best for you to withdraw from the relationship. Again, refer to your outside support system for assistance if you need it. If, however, while having this discussion, you feel your partner is engaged and interested, that he/she is willing to learn about bipolar disorder and to support and comfort you in your struggles, then congratulations. You have found a romantic partner with the foundational makings for a long-term relationship.

**Maintaining the Relationship**

In any relationship, ups and downs are bound to ensue. There is a natural ebb and flow, which manifests in any sustained interaction, whether romantic or platonic. The key is to expecting and accepting the bad times as well as the good. However, if you’re not careful, you could get stuck in the downswing. It takes time and energy to keep the relationship going strong. So how do you overcome the struggles? By following the critical steps below.

**Staying Involved**

Initially in the relationship, you search for common ground through mutual interests and values, and you establish respect and reciprocity. As the relationship develops, you must maintain involvement with your partner so that the relationship continues to grow and interest is sustained. Take time to schedule shared activities that you both enjoy. Consider a variety of activities, to include daytime and evening outings. Think about your mutual hobbies. If you’re both active, consider joining a sports league together. If you’re entertainment buffs, set regular movie or concert nights. Also, make it a point to express interest in your partner’s daily routine. Ask about his/her day at work and share your experiences. Expressing genuine interest in the other person is an effective way to sustain involvement in the overall relationship.

**Expressing Emotions and Keeping Open Communication**

Everyone experiences a range of emotions on a continuous basis. Some days you’re feeling much more positive than others, and some days you will feel down and upset. In a healthy relationship, you should be permitted to discuss your concern as well as your excitement. If you have established mutual respect, you should be able to easily vent about frustrations without feeling shut down or ignored. It is particularly important to voice emotional reactions around the status of the relationship. Verbalize your doubts and annoyances in a respectful manner, with
the intention of reaching a resolution. Also, do not neglect to articulate your satisfaction with the positive experiences you share. Sharing positive and negative emotions equally will help you express your respect and appreciation for your partner, as well as allow you to discuss upsetting matters more effectively. For example, if you express excitement about the gift your partner gave you, it will be easier to voice your hurt around not being acknowledged for the gift you gave him/her.

Remember, bipolar disorder is a mood disorder. You are more likely to experience emotional shifts than the average person. As a person diagnosed with a mood disorder, you know the importance of attending to stressors and frustrations in order to prevent triggering a manic or depressive episode. An effective preventative step is to discuss your emotions regularly with those within your support system, which of course includes your romantic partner. Remember, your partner cares about you and has already established a willingness to support you. Do not be afraid to process your emotions and thoughts before they become overwhelming.

Communicating your concerns as they arise, particularly those related directly to the relationship, will prevent these concerns from growing into a full-blown conflict. You might think that stifling the issue will result in its disappearance, but this is a misconception. The problem will fester within you, and not only will the relationship be at risk, but so will your mental health. Again, ignoring stressors is an easy way to trigger your mental health symptoms. This will only add fuel to the fire, and your relationship will likely be jeopardized. Voicing your concerns along with your satisfaction is a way to express continued respect for your partner and the relationship itself. It is a sign of sustained investment in the relationship, and it shows continued involvement with the other. Remember, you can always recruit your outside support system for guidance and assistance. However, your romantic partner is most likely your strongest support, so do your best to use this support on a continuous basis.

**Resolving Conflicts**

When emotions are stifled and matters of concern are ignored, the issue is likely to swell inside you and eventually explode. When this happens, the best thing to do is confront the conflict directly. Open the lines of communication with genuine concern and understanding. Listen to your partner’s opinions and consider them as best you can. Respond as calmly as possible. Articulate your concern and present a possible solution. For example, if you feel your partner doesn’t spend enough time with you, first listen to his/her reasoning. Maybe he/she feels overwhelmed at work, so he/she doesn’t arrive home until late at night and then simply wants to go
home and sleep. Really listen to their perspective. Consider their experience wholeheartedly. Then respond with a proposed solution. Maybe you could plan an outing on a weekend night when he/she feels rested and can give you the attention you desire. Or maybe you can offer to just listen to your partner vent about their frustrations at work in an effort to soothe his/her anxieties. Request your partner’s input after providing a suggestion. This might be a back-and-forth process before a solution is achieved, but it will be well worth it if you wish to maintain the relationship. When experiencing a bumpy road with your mood, you may suggest discussions at a later date when you are better equipped to handle it.

Remember, every relationship is bound to have ups and downs, and conflicts are an inevitable part of this process. Expect and accept them for who they are. Consider how important this relationship is to you, then take action to resolve the conflict so that you may maintain this connection. Always express your continued respect for your partner. Verbalize your interest in his/her point of view, then share your own perspective with the knowledge that this person does care about you as well.

Preserving Individuality

An often-overlooked aspect to maintaining a healthy romantic relationship is the importance of preserving your individuality. Although you are one of two people in the relationship, you are first and foremost an individual with your own thoughts, values, needs, and interests. Although you respect your partner and are considerate of feelings and demands, you must not neglect your own wants and needs. Healthy relationships are reciprocal. As such, your individual requests should be met with the same respect and consideration you provide to your partner. If this is ever not the case, return to opening the lines of communication and expressing your emotions.

One very effective way of preserving individuality is by establishing boundaries early on. Although you and your partner have shared interests, which you engage in mutually, so as to strengthen and maintain the relationship, you should also have interests independent of your partner. It is very likely that you and your partner will naturally have some differing hobbies and pastimes. Embrace these. It is okay to spend time with your own friends without your partner always present. It is okay to attend a cooking class while your partner is at a computer class. It is okay to make time for just yourself and no one else. In fact, it is necessary that you do this. Maintaining interests and activities separate from your partner sustains a sense of self and autonomy, which in turn will benefit the overall relationship.

More importantly, as someone with bipolar disorder, it is important that you tend to your own self-care to prevent an increase in mental health symptoms, including manic and depressive episodes. Make time to
attend to your personal needs on a regular basis. This includes maintaining your physical health, which has a direct impact on your mental well being. Exercise several times a week. Take time to rest and unwind after work. Watch your favorite movie, go on a walk, or treat yourself to a massage. Of course, it is completely acceptable to do these activities independently of your partner, as this maintains your individual identity.

Always keep in mind that if you do not take care of yourself, which includes setting boundaries, keeping hobbies separate from your partner’s, engaging in self-care activities, and embracing your autonomy, you will be ill-equipped to maintain a healthy and supportive romantic relationship. Just as when a relationship is unhealthy and jeopardizes your mental wellbeing, if you are not a healthy individual, the relationship cannot be healthy either.
Supportive Nutrition
By Karen Freeman, MS, RD, CSSD

Making healthy food choices may seem to be a simple task, but when faced with bipolar disorder, making those proper nutritional choices can be more challenging. Numerous variables such as mood swings and medication treatment, place even greater importance on understanding and implementing supportive nutrition and lifestyle choices.

Often times when faced with challenging feelings and emotions, a natural response might be to eat in an attempt to quell those emotions. Unstable moods such as with bipolar disorder, can make diet and healthy eating behavior even more challenging. However, there are several nutrition recommendations and guidelines that when followed, can assist us in maintaining nutritional health. The most important guideline is to eat on a regular schedule to provide continuous fuel to our bodies.

Timing of Meals is to be on a Regular Schedule
Our bodies tend to get hungry approximately every 4 hours. Knowing the timing of when we need to eat helps us differentiate true hunger cues from other cues such as emotions, triggering us to eat when we do not need to.

Becoming overly hungry affects mood states. Some signs and symptoms of low blood sugar, include irritability, feelings of impatience and/or anxiety, headaches, lethargy or hyperactive, dizziness, compromised ability to focus or concentrate, subtle uneven walking gait and mind racing. If you have not taken in enough food and several hours have passed between the last meal, you are setting yourself up for over eating. Therefore, eating every four hours will diminish the chances of overeating and help to maintain a stable mood.

In general, carbohydrates, take an hour to digest. Carbohydrate foods include whole grains, fruits, vegetables, beans and lentils. Less processed carbs are higher in fiber, and are absorbed in the intestinal tract more slowly, so that hunger returns more slowly.

Carbohydrates are the primary and necessary fuels used for brain function and for rapid muscle firing. Glucose is the digested byproduct or breakdown of carbohydrate metabolism. Carbohydrates are more rapidly absorbed than the other macronutrients, protein and fats. So, if we eat a light meal of primarily carbohydrates, such as toast and a fruit or cereal and
milk, the digestive process will only take approximately 1 hour, making it likely that we will be hungry again within 1 – 2 hours. Therefore, it is important to eat well balanced meals consisting of carbohydrates, proteins and fats to ward off hunger for 3-4 hours.

The sample meal below of a typical breakfast indicates the food, nutrient source, and the general number of hours the food might take to digest. This meal, with the combination of carbohydrates, protein and fat nutrients, would take approximately 3 – 4 hours to digest.

<table>
<thead>
<tr>
<th>FOOD</th>
<th>NUTRIENT TYPE</th>
<th># OF HRS TO DIGEST</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 slices of toast</td>
<td>carbohydrate</td>
<td>1</td>
</tr>
<tr>
<td>1 egg with a sprinkle of cheese (feta) ~ 1oz.</td>
<td>protein &amp; fat</td>
<td>2</td>
</tr>
<tr>
<td>1 - 2 oranges</td>
<td>protein &amp; fat</td>
<td>2</td>
</tr>
<tr>
<td>1 cup of decaf coffee</td>
<td>carbohydrate</td>
<td>1</td>
</tr>
</tbody>
</table>

**The Role of Protein and Carbohydrates on Meal Planning & Timing:**

As noted above, protein foods, those coming from meats, poultry, fish, eggs, and dairy products, take approximately 2 hours to digest. Fat is a natural accompaniment in all protein foods, and therefore, eating protein with fat allows satiety to last approximately 3 hours. Additional fat may further enhance flavor, satiety and fullness.

Other variables contributing to the satiety and timing include the quantity and the fat content of the meal as well as the exercise and activity factors. While meals containing excess quantities of protein, carbohydrate and fat, especially fried foods, can keep hunger at bay for 5 hours or more, it is also an indicator that the nutrient and calorie density of the meal was in excess of our calorie need and can result in unwanted weight gain.

Of course emotional factors may affect feelings of hunger, such as feeling less hungry during manic phases and more hungry during depressed mood states. While it is imperative to honor and listen to our body’s needs and hunger cues, it is equally imperative to control those urges when it is not necessary to eat. Ideally, the balance of our hunger cues correspond with our true nutritional needs.
this balance is out of sync, the importance of eating every 4 hours is imperative and will help keep our blood sugars, moods, mind and energy levels stable.

**How Much Protein and Carbohydrates Do We Need?**

After I graduated college with a BS degree in Dietetics, I was sure I was an expert in giving the answer to this question. For years, I told patients of the importance of having protein at every meal, or we would risk not replenishing lean body mass (muscle mass) or worse yet, not be able to repair and replenish the cells turnover. I was wrong. I later learned that the amino acid (what proteins are made up of) pool in our bodies and we can hold amino acid combinations for up to 3 days. As long as we get the 8 essential amino acids from a variety of food sources, we’ll be fine. Even if we are vegetarians and never eat protein from an animal source, our remarkable bodies are able to repair and replenish daily muscle and cellular needs for protein.

Vegetables, grains, beans, legumes, and lentils, all grow from the ground and are therefore mostly carbohydrates. They all contain protein as well, from 2-8 grams per _ cup cooked serving. An example of the protein power of combined vegetables can be taken from ethnic meals where food combining is a mainstay of the daily intake. Mexican cuisine routinely consists of rice and bean dishes. If rice (white, brown or mixed) is mixed with beans (i.e.: red, black, kidney, pinto) each incomplete in its protein content, the combined result is a complete “8” of all the essential amino acids.

For the specific detail and calculations on how to assess our personal protein and carbohydrate needs, the Recommended Daily Intakes (RDI’s) is 0.8 grams of protein per kilogram of body weight.

The protein recommendation for an active person ranges from 1.2 – 2.0 grams per kilogram of body weight and the protein need per day for a non-active person is 4-6 oz. for woman, 7-10 oz. for men.

**An example of how to calculate the protein need for a 130 pound active person is as follows:**

1. To get weight in kilograms (kg.), divide weight in pounds by 2.2.
   \[130/2.2 = 60 \text{ kgs.}\]

2. To calculate the recommended grams of protein, multiply weight in kilograms by 1.5 which is the mid range of the higher protein recommendation:
   \[60 \text{ kg} \times 1.5 \text{ gms protein} = 90 \text{ gms. of protein.}\]

3. To estimate how many ounces or protein 90 grams is equivalent to, simply move the decimal point over one place to = 9.0oz. of protein.
8 oz. of protein per day is equivalent to 1 serving of broiled fish from your favorite restaurant, 3 oz of protein looks like a deck of cards, and 1 oz. serving example is 1 cheese stick size.

Carbohydrates, as indicated earlier, are used as the primary source of energy for our muscles and brain function. Carbohydrate depletion is second to fluid depletion and is the primary reason for fatigue. To calculate carbohydrate need, we need to look at our exercise and energy expenditure:

- **Sedentary lifestyle, minimum movement each day**
  - 1 - 2 g/kg of ideal body weight

- **Light activity, housework, leisure walking, activity for everyday living**
  - 2 - 3 g/kg of ideal body weight

- **30 – 60 minutes of regular exercise each day**
  - 3 - 4 g/kg of ideal body weight

- **1 hour of exercise/day**
  - 5 g/kg of ideal body weight

- **2 hours of exercise/day**
  - 8 g/kg of ideal body weight

- **3+ hours of exercise/day**
  - 10 g/kg of ideal body weight

Using the Food Selection Guidelines below, we can create a sample menu that will provide the carbohydrate and protein needs for a 130 pound active individual who is engaged in regular physical activity of 30 minutes each day.

**Food Selection Guidelines**

Choose most of what you eat from plant sources: fruits, vegetables, beans, whole grain, unprocessed and unbleached carbohydrates foods.

Your goal should be 10 x ___ cup servings of fruits and vegetables per day.

Choose small portions of lean, high protein foods; fish, lean poultry and low or non-fat milk and/or yogurt.

Choose healthy oils such as; fish oils, olive oil, flax, nuts, nut butters, and avocado instead of the unhealthy oils. And avoid fried foods, trans (hydrogenated oils) fatty acids, and highly heated oils.

Drink plenty of water and calorie free beverages, flavored with natural foods such as orange, cucumber, lemon, lime slices. Limit or avoid liquids containing calories.
For example, it is nutritionally preferable to eat 3-4 oranges instead of drinking the _ cup of orange juice that requires 3-4 squeezed oranges.

<table>
<thead>
<tr>
<th>g. CHO/PRO</th>
<th>1 SERVING OF:</th>
<th>WHAT’S A SERVING SIZE?</th>
</tr>
</thead>
<tbody>
<tr>
<td>15/3</td>
<td>starch</td>
<td>~ 80 - 100 calories 1 slice of bread; 1/2 cup cooked rice, pasta, cereal, beans, lentils, corn; 1/2 cup dry cereal</td>
</tr>
<tr>
<td>12/8</td>
<td>milk</td>
<td>~90 – 120 calories 1 cup, low or non-fat milk, yogurt</td>
</tr>
<tr>
<td>15/0</td>
<td>fruit</td>
<td>~ 60 – 80 calories 1/2 cup juice, canned fruit, grapes cherries; 1 fruit, 1 cup berries, melons; 3 dates, 2 figs, 2 T raisins.</td>
</tr>
<tr>
<td>5/2</td>
<td>vegetables</td>
<td>~ 25 – 50 calories 1 cup raw, _ cup cooked</td>
</tr>
<tr>
<td>0/7</td>
<td>protein</td>
<td>~ 35 – 100 1 oz. fish, chicken, meat, cheese,</td>
</tr>
<tr>
<td>0/0</td>
<td>fat</td>
<td>~ 50 calories 6 almonds, cashews; 10 peanuts; 2 pecans, walnuts; 1 T seeds; *1 t. butter, margarine, mayonnaise, oil; 1/8 avocado; *1 T cream cheese; *2 T half &amp; half, 8 olives; *1 T coconut milk.</td>
</tr>
</tbody>
</table>

* saturated fat
Sample Menu for:

130 lb. female, light exercise at 30 minutes/day

Carbohydrate needs are 3-4 gm/kg body weight = 180 – 240 gms and
protein need are 1.2 – 1.5 gm/kg = 7 – 9 oz protein (=72 – 90 gms)

9 AM
1/2 cup lite cranberry juice
8 oz. hot chocolate (nonfat milk, 2 tsp coco)
1 egg
1 oz. cheese
1 slice toast
1 nectarine

10 AM
1 slice squaw toast
1 T almond butter

12:30 PM
1 banana
1 cup cottage cheese

3 PM
2 T raisins
1/2 cup bran flakes
3/4 cup Shredded Wheat or Cheerios
2 T wheat germ
1 cup nonfat milk

5:30 PM
1 tortilla
1 cup pinto beans
1/2 cup rice
1 oz cheese
1 cup green beans
salsa

8:30 PM
8 oz. nonfat milk and 3 cookies

TOTAL:

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Protein</td>
<td>96g</td>
<td>21%</td>
</tr>
<tr>
<td>Carbohydrates</td>
<td>266g</td>
<td>59%</td>
</tr>
<tr>
<td>Fat</td>
<td>40g</td>
<td>20%</td>
</tr>
</tbody>
</table>

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How Much Fat & What Kind of Fat Do We Need?

The Journal of the American Dietetic Association
Volume 111, Issue 5, May 2011 reviewed “The Great Fat Debate: A Closer Look at the Controversy.” While the consensus is inconclusive as to the ideal fatty acid content of a healthy diet, the following are some agreed upon aspects of fat intake:

- Calorie balance is important to maintain a healthy, normal body weight, as well as eating more healthful fats from food groups recommended by the 2010 Dietary Guidelines for Americans (DGA).

- The ratio of total fat intake is not as important as type of fats.

- Omega-3 fatty acids are beneficial and should be included in the diet at least twice weekly.

- Trans fats are unhealthy and should be kept to a minimum in the diet because they decrease HDL cholesterol and increase total cholesterol (19).

More specifically, we might achieve these agreed upon recommendations by limiting our total fat intake by minimizing saturated fats which are fats found in and from meats and poultry, lard and avoid trans fats such as fried food and hydrogenated oils. Instead, we should intake “healthy” fats such as monounsaturated fats such as nuts, natural nut butters, seeds, avocado, tofu and olives as well as Omega-3 fatty acids which are found in fish, flax seeds, walnuts, and canola oil.
Some practical ways to incorporate "healthy" fats in our diet include the following:

- add 10 – 20 nuts to low-fat yogurt, or as a "dressing" addition to salads, while drizzling the actual oil and vinegar dressing (vs.) pouring.
- drizzle vs. pour all fats.
- add _ - _ of an avocado to enhance flavors of salads and/or sandwiches.
- include natural nut butter sandwiches as a meal option.

**Omega-3 Fatty Acid Supplements and Other Supplements**

Omega-3 fatty acids (n-3 fatty acids) contain eicosapentaenoic acid (EPA) and docosahexaenoic acid (DHA). EPA and DHA are essential fatty acids and are Omega-3 fat found in cold water fish. EPA and DHA play a very important role in the function of our bodies and are vital nutrients necessary to maintain healthy functions of our body, one of which is the brain. The old wife’s tale of drinking cod liver oil to enhance health, decrease inflammation, prevent disease and optimize brain function, is now shown to be based in good science, since it is in fact high in n-3 fatty acid.

The USDA 2010 Dietary Guidelines for Americans recommends 4 oz of fish, twice per week, which would provide 250 mg/day of n-3 fatty acids. Research on the mental health benefits of n-3 fatty acid supplementation have been done with intakes at 5 – 15, 000+ mgs/day. This large quantity is unlikely to be consistently consumed in a healthy whole food diet without additional supplementation. Therefore, adding a n-3 fatty acid supplement in the amount of 1 – 2 grams of EPA plus DHA, has been shown to help a significant percentage of patients suffering from bipolar disorder with persistent signs of irritability, by reducing the irritability component of the mood state. (Sagduyu, 2005). However, as with all supplements, it is always advisable to discuss the health benefits and safety concerns with your medical doctor.
The chart below, from the 2010 Dietary Guidelines for Americans, provides a good estimation of the n-3 fatty acid content of fish:

<table>
<thead>
<tr>
<th>Common seafood varieties</th>
<th>Epa + dha mg/4 oz</th>
<th>Mercury mcg/4 oz</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salmon: Atlantic Chinook, Coho*</td>
<td>1,200 - 2,400</td>
<td>2</td>
</tr>
<tr>
<td>Anchovies, Herring and Shad</td>
<td>2,300 - 2,400</td>
<td>5 - 10</td>
</tr>
<tr>
<td>Mackarel: Atlantic and Pacific (not King)</td>
<td>1,350 - 2,100</td>
<td>8 - 13</td>
</tr>
<tr>
<td>Tuna: Blue fin, and Albacore</td>
<td>1,700</td>
<td>54 - 58</td>
</tr>
<tr>
<td>Sardines: Atlantic and Pacific</td>
<td>1,100 - 1,600</td>
<td>2</td>
</tr>
<tr>
<td>Oysters: Pacific</td>
<td>1,550</td>
<td>2</td>
</tr>
<tr>
<td>Trout: Freshwater</td>
<td>1,000 - 1,100</td>
<td>11</td>
</tr>
<tr>
<td>Tuna: White (Albacore) canned</td>
<td>1,000</td>
<td>40</td>
</tr>
<tr>
<td>Mussels</td>
<td>900</td>
<td>NA</td>
</tr>
<tr>
<td>Salmon: Pink and Sockeye</td>
<td>700 - 900</td>
<td>2</td>
</tr>
<tr>
<td>Squid</td>
<td>750</td>
<td>11</td>
</tr>
<tr>
<td>Pollock: Atlantic and Walleye</td>
<td>600</td>
<td>6</td>
</tr>
<tr>
<td>Crab: Blue, King, Snow, Queen and Dungeoness</td>
<td>200 - 550</td>
<td>9</td>
</tr>
<tr>
<td>Tuna: Skipjack and Yellowfin</td>
<td>150 - 350</td>
<td>31 - 49</td>
</tr>
<tr>
<td>Flounder, Plaise, and Sole (Flatfish)</td>
<td>350</td>
<td>7</td>
</tr>
<tr>
<td>Clams</td>
<td>200 - 300</td>
<td>0</td>
</tr>
<tr>
<td>Tuna: Light canned</td>
<td>150 - 300</td>
<td>13</td>
</tr>
<tr>
<td>Catfish</td>
<td>100 - 250</td>
<td>7</td>
</tr>
<tr>
<td>Cod: Atlantic and Pacific</td>
<td>200</td>
<td>14</td>
</tr>
<tr>
<td>Scallops: Bay and Sea</td>
<td>200</td>
<td>8</td>
</tr>
<tr>
<td>Haddock and Hake</td>
<td>200</td>
<td>2 - 5</td>
</tr>
<tr>
<td>Lobsters: Northern, American</td>
<td>200</td>
<td>47</td>
</tr>
<tr>
<td>Crayfish</td>
<td>200</td>
<td>5</td>
</tr>
<tr>
<td>Tilapia</td>
<td>150</td>
<td>2</td>
</tr>
<tr>
<td>Shrimp</td>
<td>100</td>
<td>0</td>
</tr>
</tbody>
</table>

**Seafood varieties that should not be consumed by women who are pregnant of breastfeeding**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Shark</td>
<td>1,250</td>
<td>151</td>
</tr>
<tr>
<td>Tilefish: Gulf of Mexico</td>
<td>1,000</td>
<td>219</td>
</tr>
<tr>
<td>Swordfish</td>
<td>1,000</td>
<td>147</td>
</tr>
<tr>
<td>Mackarel: King</td>
<td>450</td>
<td>110</td>
</tr>
</tbody>
</table>
Exercise

Exercise is a very important component to maintaining a healthy lifestyle. In addition to the obvious health benefits of a regular exercise routine, exercise increases endorphins in the brain thereby boosting a person’s mood. Utilize the exercise chart in this book to begin a regular exercise routine and check with your treating doctor before beginning any exercise program.

Drink Water

Our bodies are made up of 61.8% water by weight. It is therefore important to drink at least eight 8 oz. glasses of water each day. Many times our body tricks us into thinking we are hungry when in fact we are simply thirsty. Drink up and in turn, you will eat less.

And Other Supplements?

Should we be taking a multivitamin and mineral supplement and if so, which one and how much? Since researchers can define and understand the role of only approximately 20% of the substances in our food supply, it is difficult to actually know what we are “supplementing.” Yes, we know that we need many essential vitamins and minerals, much of which we receive in a food based healthy diet, but there are phytochemicals, antioxidants and countless numbers of other substances in a wholesome foods diet, of which we cannot replicate in a supplement form. If we can embrace the idea that a supplement is in fact a supplement, not a substitute for a healthy diet, then taking a 100% of the RDA vitamin and mineral supplement might be good insurance.

For those who don’t like to swallow pills, gummy bear multivitamin and mineral supplements are soft, chewable and have a touch of sweetness and therefore more motivating to take. Similarly, calcium chews, (they taste like caramel candy) contain vitamin D & vitamin K to enhance the absorption of calcium.

Supplement takers tend to be more health conscious and eat more whole foods and as a result, need supplements less. In general, large brand name supplement companies are more likely to have the nutrients in the bottle that is stated on the label. There is no mandatory government testing or controlled way to ensure product efficacy. Some supplement companies do voluntarily have independent testing done on their products to receive a seal of authenticity from independent laboratories such as “USP,” United States Pharmacopeia, “a non–governmental, official public standards–setting authority for prescription and over–the–counter medicines and other healthcare products manufactured or sold in the United States.”

Vitamin D is essential for calcium absorption and has been shown to enhance our body’s natural immunity. Those of us with limited exposure to natural sunlight year
round, due to where we live and/or the kind of work we do, are at higher risk of obtaining adequate vitamin D. Supplements at doses up to 1,000 IU have been shown to be safe. In addition, taking a 20-minute walk during the lunch hour is a great way to increase activity while getting a natural dose of vitamin D. Being out and about in natural daylight has also been shown to enhance one’s mood.

There are some nutrient-drug interactions that may increase the need for added vitamin and mineral supplements. The additional nutrient need is easily met with a 100% RDA multivitamin and mineral supplement. Psychotropic medications may have side effects of dry mouth, constipation, or increased appetite. Some may need to be taken with food or milk and may alter glucose and fat metabolism. (Pronsky 2004). Some medications should not be taken with certain foods or drinks. Some examples are as follows:

- Geodon: avoid grapefruit juice with oral form; is to be taken with food.
- Quetiapine (Seroquel); use caution with grapefruit juice.
- Risperdal may increase vitamin D metabolism and may require greater vitamin D intake.
- Phenothiazines may increase need for riboflavin, may decrease absorption of vitamin B-12.

For a complete list, contact your treating physician to determine what foods you should or should not consume with your prescribed medication.

**Alcohol**

Alcohol is to be avoided! It is a depressant, causes instability to the brain chemistry and may trigger depressive and manic episodes. In addition, alcohol is contraindicated with the following medication:

- First-generation antipsychotics: Haldol, Navane, Moban, Loxatane
- Phenothiazines: Chlorpromazine, Thorazine, Prolixin, Trilafon
- Atypical and second-generation antipsychotics: Abilify, Seroquel, Olanzapine, Geodon, Risperdal

**Caffeine**

Caffeine mildly stimulates parts of the body and brain. It increases heart rate and blood pressure and is never recommended for individuals with bipolar disorder. It interferes with sleep by leading to disturbing sleeping patterns and causes irritability, anxiety, nervousness, upset stomach, headaches and difficulty concentrating. It takes 3-4 hours for caffeine to be eliminated from the body.
Therefore, to cut back and eliminate caffeine consumption, do so gradually and try using some of these tips:

1. Mix half regular with half decaffeinated coffee or tea.
2. Drink decaffeinated coffee or tea.
3. To decaffeinate tea, steep tea bag in boiling water for 30 seconds. Discard the tea water and reuse the decaffeinated tea bag.
4. A one-minute steep can contain just half the caffeine of a three-minute brew.
5. Drink more water. Keep your favorite water container with you.
6. Also check the label of your over-the-counter medication. Some contain as much caffeine as one or two cups of coffee in just one dose.

Summary

- Assess what you “like” to eat and work with a balance to honor your preferences. Sometimes choosing food you think you “should” eat can be less healthy.

- Human bodies get hungry approximately every 4 hours. If you feel hungry and it has been almost four hours since your last meal, you are probably hungry and it is time to eat.

- Eat to satisfy your appetite. Appetite normally and naturally varies so it is normal to feel hungrier on some days and less hungry on others.

- Deprivation is a setup for overeating. Include your favorite food and enjoy social obligations and appointments. Getting overly hungry hurts. Avoid it when possible and nurture yourself.

- Limit total fat intake and allow for small amounts of healthy fats such as Monounsaturated fats: nuts, natural nut butters, seeds, avocado, tofu and olives as well as Omega-3 fatty acids: fish, flax seeds, walnuts and canola oil.

- Minimize Saturated Fats which are fats in and from meats, poultry and lard. Avoid trans-fats such as fried food, hydrogenated oils and sweets.

- Maintain a healthy protein intake and eat what you need per day: 4-6 oz. for woman and 7-10 oz. for men.
• Carbohydrate intake must be adequate to maintain energy and exercise needs. Fruits & Vegetables (10+/day); Lentils, beans, potatoes, rice, whole grains (4+/day.)

• Increase fiber intake to 35+ grams per day.

• Include low fat dairy products, such as nonfat milk and yogurt, for bone health and to help maintain normal weight.

• Drink Water! Often we feel hungry when we are actually thirsty. Limit or avoid liquid calories and caffeine containing beverages. Water is the #1 nutrient.

• Move about more and/or start an exercise program.

• Think before you drink alcohol. Alcohol is a diuretic and can cause dehydration, is a depressant, slows respiratory rate and is caloric. It is contraindicated with bipolar disorders.

Lastly, The Dietary Guidelines for Americans, 2010, published by the U.S. Department of Agriculture, U.S. Department of Health and Human Services (www.dietaryguidelines.gov), as well as ChooseMyPlate.gov, are excellent resources to assist you in developing and maintaining proper health and nutrition.
Mental Illness and Families of Faith

By Reverend Susan Gregg-Schroeder

Introduction

Secular society is finally talking more openly about mental illness but our religious communities are mostly in the dark ages when it comes to understanding mental disorders as treatable illnesses.

Based on the findings of the Surgeon General’s report on the magnitude of mental illness in this country, we know that one in four families sitting in the pews have a member dealing with mental illness. Yet the secrets of mental illness are kept, people are not getting the help they need, and the families of persons living with these brain disorders are not receiving the support they need. Many faith leaders are also keeping silent about their own mental illnesses. I know this because I am one of those persons.

My depression began in 1991. I was in my third year of ministry at a large urban church. I was enjoying my career and the many opportunities it offered for serving others. I liked being part of a large staff, and I had no doubt that I had made the right decision to answer the call and leave my teaching career to become an ordained minister.

Despite my experience in pastoral counseling, I did not recognize or understand what was happening to me. In the fall of 1991, a series of events hit me like waves, until I felt totally overwhelmed with despair. I had all the symptoms of major depression. I felt disoriented and disconnected from my feelings and myself. I couldn’t eat or sleep. Nothing brought me pleasure. I was simply going through the motions. I couldn’t stand to be around others and isolated myself from everyone. I felt so hopeless that I wanted to end my life and actually developed an elaborate plan.

I was sent to a psychiatrist, who happened to be a member of my church. It was one of the most humbling experiences of my life, as I was enveloped with guilt and shame. He wanted to admit me to a psychiatric hospital that day. After several days of denial on my part, and because my husband could not continue to stay home from work to be with me, I was admitted to the hospital. Ironically, it was the same hospital where I had conducted worship services when I was doing my Clinical Pastoral Education.

Few people at church knew about my depression and hospitalization. For two years I suffered in silence, hiding my condition from the church community for fear of losing my job.

It was my senior pastor who stood by me, who believed in grace and who believed in me. With his support, I finally decided to openly acknowledge my depression. I
wrote an article for our church newsletter entitled, "The Burden of Silence." My senior pastor wrote an accompanying article about the ignorance associated with mental illness. Our parish nurse set up an informational meeting on depression, and we had a turn-away crowd of over 130 people. Seeing such a great need, a depression support group was started, led by a professional counselor.

At the urging (and arm twisting) of a colleague, I was asked to speak at our Bishop’s Convocation. The stories that my colleagues shared with me behind those closed doors made me realize that I was being called to speak out about mental illness in the church. I was especially concerned about my colleagues from various ethnic groups, where there is fear that such a disclosure may bring shame to the family, not to mention the effects such a disclosure could have on a person’s future in the ministry.

I am one of the “wounded healers” described by Henri Nouwen, the author of the book “The Wounded Healer: Ministry in Contemporary Society.” I have had subsequent hospitalizations and a variety of DSM IV diagnoses, including Bipolar II that has changed over the years. But you cannot put a label on the human spirit. I know that I need to continue to have my medication monitored, maintain a good support system and practice good self-care, as well as preventative care at those times when I feel most vulnerable. I’ve learned coping skills and have developed inner resources. I relate to the words of Louisa May Alcott who wrote, “I am not afraid of storms, for I am learning how to sail my ship.”

Background

According to Glen Milstein in an article published in the Psychiatric Times in 2002, surveys show that 60% of Americans seeking help with mental health issues go first to their faith leaders. This is twice as many as those who went first to a psychiatrist, psychologist or family physician. Unfortunately, the response of clergy and congregations falls significantly short of what parishioners expect of their faith leaders. Individuals struggling with mental illness are significantly less likely to receive the same level of pastoral care as persons in the hospital with physical illnesses, persons who are dying or those who have long-term illnesses. People often visit others with physical illness, bring them meals and provide other helpful services. Mental illness has been referred to as the modern day leprosy.

There are a number of reasons why these needs are not being met. Clergy do not receive adequate education about mental illnesses in seminaries. Some faith groups see mental illness as a moral or spiritual failure. Congregations are made up of individuals who mirror the stigma we find in society as a whole. Even if people are aware that someone is struggling with mental illness, they may not know what to do or say.
The needs of families coping with mental illness are documented in the book, *Families and Mental Illness: New Directions in Professional Practice* (Marsh, New York: Praeger. 1992.) The needs fall into eight categories:

- A comprehensive system of mental health care
- Support
- Information
- Coping skills
- Involvement in the treatment, rehabilitation, and recovery process
- Contact with other families impacted by mental illness
- Managing the process of family adaptation to illness
- Assistance in handling problems in society at large (e.g. ignorance, fear, stigma)

Nearly every person has been touched in some way by mental illness. And yet individuals and families continue to suffer in silence or stop coming to worship because they are not receiving the support they so desperately need. They become detached from their faith community and their spirituality, which can be an important source of healing, wholeness and hope in times of personal darkness.

**Our Spiritual Imperative to Care for Those Who Suffer**

Hospitality is a core value of major religions: Muslim, Jewish and Christian. The words hospital, hospice and host are derived from hospitality. In Christianity, hospitality is literally extending our hand to another, touching another and getting close enough to recognize our mutual vulnerability to things in this life. Major religions share the conviction that we are called to care for those who suffer in this world. Both the Hebrew Scriptures and the New Testament contain many stories of people being called to reach out to those in need. The great prophets share a similar message that God asks us to be faithful, to love one another, to reach out to those who are broken and to seek justice for all God’s people.

**Treatment Options**

For many persons who suffer from a mental illness, psychotherapy (also known as “talk therapy”) allows the individuals to converse with a trained therapist to address issues such as low self-esteem, difficult childhood experiences, environmental trauma, losses of all kinds, relationship issues and the lack of any positive meaning for one’s life. The most common forms of psychotherapy are cognitive therapy, psychodynamic therapy, interpersonal therapy, group therapy and marriage and family counseling. Pastoral counseling that addresses emotional issues while respecting a person’s faith tradition adds an important dimension to treating the whole person.

Studies are increasingly demonstrating the relationship between the physical, mental, emotional and spiritual dimensions of our lives. We know that support from family members, friends and a person’s community of faith are a very important
part of a person’s treatment and recovery. People are more likely to comply with their medication therapy or participate in psychotherapy if they can envision hope for the future.

Because of a renewed interest in treating the whole person, more people are seeking out mental health professionals who will incorporate their spirituality in the treatment process. Professionals like those with the American Association of Pastoral Counselors (www.aapc.org) receive training in both psychology and theology. These counselors can add a spiritual perspective to the professional counseling relationship by incorporating a person’s spirituality with sensitivity to cross-cultural traditions. Mental health professionals who are sensitive to and respectful of the spiritual dimension can “walk with” persons as they seek their own path to personal growth and healing.

The religious community has much work to do to address the shame, guilt and stigma associated with mental illness. Because of a lack of information or theological beliefs, some religious groups do not understand mental illness as an illness unlike any physical illness. Sometimes a person is encouraged to stop taking medication and rely on prayer. Some continue to put blame on the family at a time when the family members are most in need of support. This is especially true with suicide. If the suicide is seen as a sin or an unfaithful act, the family has to deal with their grief as well as the guilt, shame and isolation from their community of faith at a time when the family most needs the support of their community.

There are no good words to describe the utter despair and hopelessness associated with severe mental illness. As more research is done on the brain, new medications and new therapies are rapidly being developed to address the physical and emotional stress associated with brain disorders. But, unfortunately, there is a split in treating mental illness using the medical model that makes little allowance for addressing issues of spirituality. Yet a person’s spirituality or religious views can be of great benefit in the treatment and healing of many illnesses, including mental illness.

**A Brief History of Beliefs and Treatment of Mental Illness**

Mental illness goes back as far as recorded history and has been known by many names over time. As with all faith traditions, beliefs about mental illness cover a wide range of theologies from biblical literalists who view mental illness as a moral or spiritual failure, to persons who understand mental illnesses as brain disorders that did not have a name and were not understood by persons living 2000 years ago. Most ancient societies regarded mental illness as a religious problem involving the health of one’s soul. There were elements of magic and mysticism in the rituals performed to cure persons with a mental illness.
With monotheism, as articulated by ancient Judaism, there was a shift in how mental illness was understood. While still almost completely religious in nature, mental illness became a problem in the relationship between an individual and God—a condition associated with the soul. The Hebrew and Christian scriptures are full of stories and laments of persons suffering from so-called demon possession, visions or hallucinations, depression and other forms of mental illness.

In the year 370, the Eastern Orthodox Church established the first hospital. Over the next 1200 years, the church built hospitals throughout Europe to treat physical illnesses. Many physicians were monks and priests. Nuns served as nurses. The physical and spiritual care of patients went hand in hand.

Islam began to spread across Asia, Africa and southern Europe about a thousand years later. Like Judaism, the Qur’an frequently talks about the spirit or the soul. But there was not the conception that mental illness was a punishment from God. Those suffering from mental illness were thought to be possessed by supernatural spirits, but these jinn (genies) were not seen as good or bad.

Since mental illness was not seen as wrongdoing, Islamic scholars and physicians in the 10th century were the first to move toward a more scientific look at the causes and symptoms of mental illness. During this time a hospital was established in Baghdad with a psychiatric ward.

Such treatment did not exist in Europe during the late Middle Ages and the Renaissance, because mental illness was seen as witchcraft or demonic possession. Those found acting irrationally or suffering hallucinations were thought to be possessed and were often tortured and killed. Others were sent away on “ships of fools” and excluded from the community. Persons with a mental illness endured horrific treatment like bloodletting and the drilling of holes in the head to allow the “evil spirits” to escape.

With the age of Enlightenment in about 1750 and the introduction of the science of psychology, attention was directed to the mind. Psychoanalysis looked at such things as unhappy childhood experiences or other conflicts arising from the unconscious mind. Followers of Freud viewed spirituality as superstition and the church’s influence all but disappeared. The split with the church was complete. Mental illness was no longer a spiritual issue associated with the health of a person’s soul. It was a problem with the mind or one’s thinking.
Insane asylums were opened and an era of so-called moral treatment began. From 1750 to about 1950, persons with a serious mental illness were put in an asylum or other locked facility. Treatment in the early asylums was very poor, often secondary to prisons. Some early forms of treatment included lobotomies and a primitive form of electro convulsive therapy or ECT.

Some persons from pacifist faith traditions, like the Mennonites, did their alternative service during World War II in hospitals that included mental hospitals. Appalled at the deplorable conditions in the psychiatric hospitals, these faith groups were among the first to bring compassionate care to these persons. Some of these religious groups established psychiatric hospitals.

With the advent of anti-psychotic medications around 1950, the focus was on symptom reduction. Another shift occurred that de-emphasized both the spirit and the mind and put the focus on biological changes in brain chemistry. We have moved from mental illness being understood as an illness of the soul or the spirit to it being a condition of the mind to the medical model which we have today.

Differences Between Spirituality and Religion

Spirituality has become a popular and often misused word in our time. Spirituality is different from organized religion. Spirituality springs from a belief system. It is what gives meaning to our lives, and it grows out of life experiences rather than doctrine. Paul Tillich talked about the divine as the “ground of our being.” Spirituality is a universal truth, but a highly individual journey.

Religion, on the other hand, refers to the beliefs and practices associated with organized groups such as churches, synagogues, mosques, etc. It provides a hierarchy for some faith groups and guidelines for finding meaning. Today a new phenomenon is taking place. It is called “interfaith spirituality.” It is an integrative approach because it focuses on the common threads of all faiths such as love and mercy.

The search for meaning is a timeless pursuit. The question of why there is suffering in this world and what God has to do with suffering is one of the focuses of the spiritual journey. There are many biblical accounts of God’s people struggling with intense emotional pain. Some of the most profound descriptions of emotional and faith struggles are found in Job and in the psalms.

Psalm 88 portrays the experiences of a depressed person from an emotional spiritual perspective. The words of the psalmist describe many of the symptoms of depression; sadness, isolation, anger, abandonment, mistrust, spiritual emptiness and hopelessness.
Mental illness affects all aspects of our life including our spiritual well-being. It strikes at the very soul of our being, making us feel cut off or separated from God’s love and acceptance. It is like a thief in the night. It steals a person’s sense of self worth, their hopes and dreams for the future and it feels like it will always be this way. Mental illness challenges our core beliefs and values, and we often feel unworthy of God’s love and acceptance. We feel alienated from God. We feel alone, helpless and hopeless in the dark despair of our illness.

Today many are espousing a more holistic approach that is being supported by scientific studies. This perspective gives credence to modern biological discoveries and complements them with an understanding of a person’s emotional and spiritual makeup. It is the mind/body/spirit approach.

**Integrating Spirituality into the Treatment Process**

We still face the long-standing conflict between faith and science. The scientific medical model looks for a cure. The emphasis is on finding answers and the relief of symptoms. As we know, many times there is not a cure.

Healing is the peace that comes from knowing that God is working in our lives to bring about the best possible outcome, which is healing mind, body and spirit. This sense of peace and wholeness are gifts from a loving and compassionate God, even as we learn to live with mental illness. The challenge we face today is not the choice between faith and science. We need both.

For decades, professional training programs have discouraged discussion of religion or spirituality with clients, as it was thought to foster delusions. Publicly-funded programs must be careful not to promote specific religious traditions. Incidents of discrimination or violence based on religious beliefs can create more fear. There is a mistrust of those concepts and processes that are more difficult to measure. But things are gradually changing as studies find that spirituality can be an important part of the treatment and recovery process and spiritual assessment tools are being developed for mental health professionals. We need to continue to find ways to encourage collaboration and partnership that includes a myriad of support systems.

*The President’s New Freedom Report on Mental Healthcare in America* (2003) states that our current delivery system for mental health services is in shambles and only a total “transformation” of the system will benefit consumers. From a
theological perspective, transformation refers to a spiritual process of growth and change. The commission for this report, which was made up of some of the most respected mental health professionals in America, asks for more coordination of services and providing treatment through community-based groups rather than institutions. It also calls for assisting persons to reintegrate into being successful and productive members of society through such means as job training and community support. Our faith communities can be an integral part of this process.

The goal is recovery! Recovery is a process rather than a completed goal. Instead of using our resources to focus on the results of mental illnesses, the New Freedom Report encourages using resources for lifelong assessment and treatment.

**Spiritual Care**

If there is one word to describe the emotional pain of mental illness it would be “disconnection.” People with a serious mental illness often lack insight into their illness or experience confusion regarding their symptoms and treatment. Clergy with pastoral skills can address the spiritual and religious dimensions of persons dealing with different forms of life experiences.

Persons with a mental illness often struggle with issues like the inability to experience God’s love and acceptance, the inability to accept oneself, the need to confess one’s sins and know God’s forgiveness, the need to be reconciled with others and the lack of hope that things will get better. Pastors, rabbis, imams, priests and other faith leaders can offer wisdom and hope from their faith tradition. In listening carefully to a person’s struggle, faith leaders can explore the cause of one’s separation from God, share the biblical stories of persons struggling with similar issues and share stories of God’s forgiveness and acceptance.

The rituals and sacraments of one’s faith tradition can be of great comfort during times of distress. Clergy can hear a person’s confession and offer the assurance of forgiveness. Sacraments like communion and anointing in the Christian tradition can help the person reunite with his or her faith community. Praying with the person and the family also helps offer assurance that they are not alone in their struggle and builds a relationship of trust and confidence.

Because faith leaders are respected by their congregations, they can model an acceptance that will help diminish the stigma associated with mental illness. This is easier if mental illness is treated like any other physical illness in sermon illustrations and in small group educational settings. By including persons with mental illness in pastoral prayers and liturgies, clergy are helping to educate the congregation that mental illness is not caused by lack of faith or spiritual commitment.
Pastoral care needs to include visitation to persons and families struggling with mental illness as with any other physical illness. Devotional material from a faith tradition can be given to individuals in a counseling setting. Scripture and other resources from a faith tradition can bring comfort to persons in a psychiatric hospital, group home or other setting.

**The Ministry of Presence**

Being in relationship with caring persons is an important part of the recovery process. Henry Nouwen describes hospitality as “creating safe space” where each person is treated with respect and dignity. It is walking beside the person to help them discover their potential, worth and the promise of hope.

Suffering is terrifying and meaningless if isolated from the whole of people’s lives and when suffering is excluded from the community. Those who are suffering do not need to be judged. They need to be assured that someone cares and that God loves them unconditionally. Integration rather than isolation is what restores wholeness of mind, body and spirit.

**The Journey Continues**

Hope in the future was a gift that grew out of my relationship with my therapist, who is also a pastoral counselor. The relationship began in the traditional way of therapist and client. But over time it evolved into a relationship of trust, respect and a mutual sharing of life experiences. We became companions in our respective spiritual journeys. In sharing our stories, I was empowered to make responsible life choices based on my inner wisdom.

In my deepest depression, several people stepped in to “rescue” me. I am fortunate to have a loving husband who wanted to help. I am fortunate to have access to good medical care. I am fortunate to have a competent and compassionate psychiatrist who has stayed with me as my doctor since my first hospital admission.

But the unconditional presence of the holy was revealed to me through my pastoral counselor. While everyone else was trying to “fix” me in some way, my counselor accepted me as I was. While others were looking for a cure, my friend offered care. He was vulnerable enough to enter into my dark place without judgment. He modeled for me an image of a God who surrounds us and holds us in a caring presence. He modeled an unconditional acceptance that I had never felt. In my feelings of worthlessness, he held on to a faith that I was loved as a child of God, just as I was. He became a lifeline to hope.
I now preach the importance of being in relationship with other people and with our faith community as one of the gifts that allowed me to gradually emerge from my deepest darkness and discover the most important gift of the shadow, the gift of hope. Medications may stabilize symptoms. But it is relationship and love that heal the soul.

I look back and I realize that I was not alone in my deepest darkness. I also realize that I persevered, and with the help of others, I was able to choose life. I have found hope in listening to and reading stories of healing and wholeness restored in the lives of other people who have struggled with this illness.

After the drowning death of his brother, the great poet William Wordsworth wrote these few words that hold so much truth. Wordsworth wrote, "A deep distress hath humanized my soul.” The journey toward wholeness never ends. Knowing we can trust that the fertile darkness will hold us until we are ready and able to glimpse the first light of hope, leads us back again into the fullness of life.

Because of my experience with the church, I will continue to help congregations find ways to be caring communities for persons living with a mental illness and their families. For me the most painful part of my illness was the feeling of disconnection. A supportive faith community would have helped me feel that I was connected to something bigger than my own feelings of worthless and hopelessness. A supportive faith community would have embraced my family. We would not have had to suffer in silence. I pray that the time will come when families living with a loved one with mental illness will be silent no more!

Spirit God, you know our needs
our wounds
our hurts
our fears
Even before we can form them
into words of prayers.

You are patient with us.
You are protective of us
You are present with us
until such time that we are able
to ask for what we need.

Thank you, Spirit God,
for your healing taking place within
before we are even aware
of how broken we have become.
Do you or do you not tell your employer about your disease? That is a question that many people with bipolar disorder ask themselves. Whether to disclose your illness directly to your supervisor is a very personal question. Some people have had very positive experiences while others have not.

If your illness is affecting your performance, it is realistic to assume that your employer is noticing it. Having a frank discussion with your supervisor may ease the concern they have about performance issues that may arise when you are experiencing a manic or depressive episode.

If you ultimately chose to disclose your illness to them, you may want to explain what bipolar disorder is, how it affects you and how it may affect your work. You can always reassure your supervisor that you do not expect that your illness will affect your performance and that you will be able to fulfill all your work requirements.

The following are two people’s experiences with bipolar disorder in the workplace that may assist you in making the decision to disclose or not. Remember, you have control over your life and your illness. How you chose to handle that in the workplace is your choice.

A Day at the Office By Christi Huff

&

Bipolar in the Workplace By Wendy McNeill
A DAY AT THE OFFICE
By Christi Huff

I'm racing out the door with my work bag slung over my shoulder, a glass of water in one hand, and my handful of morning medications in the other. Anti-depressant? Check. Mood stabilizer? Check. Adderall? Check. Anti-anxiety? Check. I gulp them down with the water and race to the bus stop. It's 7:45 am and I'm running late for work. On the walk/half jog to the bus, I pull out my phone and check all my emails, Facebook messages, Twitter alerts, and text messages.

Once on the bus, I try to catch up on a few minutes of "me time" and I pull out my Kindle to check all the updates from Psych Central, Bipolar Beat, Mental Floss, and anything else that has updated, just like the other twenty to thirty other commuters on the bus are doing. I transfer to the subway and pull out a stack of medical records that need to be reviewed for work. I begin reading and highlighting while smashed like a sardine with the other fifty or so passengers who are all trying to get to work as well. I get some of the work done, unload from the train with a handful of people, and take the escalator up to the closest Starbucks. Minutes later, and armed with my Starbucks, I have arrived at my building, swiped my ID badge in the lobby, taken the two different elevators up to my floor and am now walking up to the ID swipe pad to let me into the floor of my office.

I take a deep breath, swipe my ID, and with the click of the door, it signals it's time to check Mr. Bipolar Disorder at the door (or at least try to) before I walk in. I walk through the door and pass the cubicles to my office. I turn on the computer and take out the medical records I was reviewing on the train. I've been reviewing these records for so long now, but I just can't focus on them long enough while in my office to get a decent amount done. I have to read things over a million times because I get easily distracted and sometimes I experience a huge fall in my mood and start crying for no reason. I try distracting myself with another task and sometimes that helps, yet sometimes it “helps” to the point that I finish that project and then start something else related to that project, the one without a deadline. And I keep on going and going in a completely different direction, forgetting I have other projects that do have a deadline, or have other uncompleted projects I should work on instead of. It’s hypomania at its finest for me. So what is the end result? It results in my taking home medical records to review there (or while in transit) because they didn’t get done during the day as hoped, thus turning my work day into a ten to twelve-hour day. This is how the typical workday goes for me.

Some days I am more focused than others, and get a million things done. Other days it takes me almost an entire day to just read through a small stack of documents. You see, as a paralegal, I have to log a certain number of billable hours within my work day. All those ups and downs and distractions makes it difficult to get those hours at times, so in order to not just get the required work done, but to make up those required hours, I have to get the work done at home. You can imagine then how that affects my life outside of work. My fiancée frequently has to
do things alone or not at all because I have to work. I miss out on events with my friends and other social interactions because I am always working. Not having any time to socialize makes me feel secluded and feeds into my depression, making some of the symptoms of bipolar disorder worsen. Being at home so much gives me even more opportunity to start getting lost in my own thoughts while ruminating, which can either send me into further depression or can start causing hypomania because I begin to obsess over a project or new idea that launches a whole list of new ideas that must be started immediately. Those ruminations distract me from getting my work done at home, leading to a lot of frustration and the desire to just give up.

This whole cycle begins again tomorrow and then leads to spending the weekends trying to make up for the work that didn't get done during the week. Again, this leads to more disappointment from my fiancée, and at times anger. There is frustration on my part, anger at myself for not being able to focus, hopelessness because I begin to fall behind, fear I am going to lose my job, and then the weekend goes by with very little done again and ends with so much anxiety about going to work the next morning, I make myself physically ill. As you can see, the work day is not easy, however, projects DO get done, I don't miss any calendared deadlines, I don’t miss any meetings or appointments, and I haven’t caused any sort of negative impact on any case I have been assigned (that I have been made aware of!). The attorneys I have worked with have given me great reviews and are happy with my work. So, if that’s the case, should I tell my employer and see if accommodations could be made when I start feeling the effects of what I like to call "the Bipolar Coaster?" Well, that is one question I get asked a lot. I don’t have an easy answer for it either.

While working for the employer (a law firm) I was with when I was hospitalized several years ago (and was finally diagnosed with bipolar disorder), I went back to work for a few days and regretted ever returning. Everyone stared at me and whispered when I walked past them in the halls. At first I thought I was imagining those things, but then my secretary came into my office and informed me my confidentiality had been breached and the information on some of the forms I needed to complete for my leave of absence had been told to others within the office. That information, in addition to other things being said as a result of that breach, caused attorneys to not want to work with me and it wasn’t long before I realized I could no longer continue working for them. I felt forced out because the environment was so uncomfortable, and there was no way I could work there again. Luckily, I had a backup plan and after my departure: I went to law school for a year. Another law firm I worked for called me into their Human Resources office because I was a few weeks behind on my time entry. I had been trying to catch up, but it was overwhelming due to not just my own issues, but because I had been switched to different departments, was covering for other paralegals on vacation, my office had been moved and I was trying to process so much new information all at once. I felt like I was in quicksand. Then, I was also told there was an issue with me keeping my office door closed all the time. Having such a hard time focusing, I keep the door closed to prevent distractions from those walking by and the other conversations occurring outside my office, and because I have my ups and downs,
I don’t necessarily want the whole office to see me going from up and doing ok to suddenly crying my eyes out. There was no policy about keeping my door open, so I had no idea I was doing anything wrong. At that point, I felt I needed to explain the necessary reasons for why I kept my door closed.

After explaining that I have bipolar disorder and needed it closed because of distractions and my ups and downs, I was told I was a HUGE liability to the company and all these issues needed to be dealt with by my doctor. The person I spoke to informed me there was nothing they could do, asked why I was telling them, and how could they be sure I wouldn’t miss a deadline or something else that would put their company at risk? I simply replied that none of those things have ever been an issue because I take extra measures to ensure those things won’t happen, and also pointed out that none of the attorneys I have worked for have ever had an issue with anything like that or had ever given me a review that was poor. The end of the discussion resulted in keeping the door to my office open and then meeting with my doctor to get myself together. It wasn’t really helpful, but I at least still had my job and my confidentiality.

Those are just two situations in which I have told my employer about my bipolar disorder. There were plenty of instances where I didn’t disclose my illness to employers, and no one even knew I had one. Even with the two employers I mentioned above, many of the co-workers I worked hand in hand with for many years had no idea I had bipolar disorder and had told me they would have never guessed it in a million years. Would I tell other employers about having bipolar disorder? So far, not telling them has worked for me because I have not had to take any sort of extended period of time off due to my symptoms (aside from the hospitalization). The response I received when I did divulge that information was not helpful and just reinforced my previous and future decisions to not be as open.

Don’t I have rights under the American’s with Disabilities Act? Absolutely, but unfortunately, I don’t think many employers are as informed about mental illness and how the ADA applies to them. The Family Medical Leave Act also allows for leave of absence or extended periods of time taken off (up to a certain number of weeks per year) not only for events such pregnancy, but also for mental illness if it impairs your ability to substantially perform your duties. Again, I don’t think there has been enough education for employers about mental illness and how the FMLA applies to those with mental illness either. Outside of the office, employers are regular people too. They aren’t superhuman, powerful, or king and queenlike figures that know all and only see the positives of everything. Stigmas and other information learned outside the office can be taken into the office. That’s just how the world works. I believe as advocates, we not only need to educate the public, but make sure employers are educated with correct information as well.

What is supposed to be an eight hour workday, five days a week ends up being a ten to twelve-hour day, seven days a week for me, triggering a lot of my symptoms, which makes it harder to work, perpetuating the cycle to occur again and again. It not only affects me, but those around me as well. Should I speak up? I could. Will I? Probably not. Past attempts have not shown positive results and right now, I
don't think I want to take that chance again.

Does this mean that nobody should tell their employer about their bipolar disorder? Of course not. Every employer is different, just like every job is different. I believe the decision to tell one’s employer should definitely be a decision based on their own relationship with their employer and their own comfort level. In the meantime, targeting employers in our advocacy should become a priority so that this type of a decision does not have to be made by individuals with bipolar disorder, or any other mental illness, and we don’t have to continue working around the clock battling the “Bipolar Coaster” just to keep up.
**Bipolar in the Workplace**
By Wendy McNeill

The word *workplace* conjures all kinds of images depending on who you are and what you do. In fact, when thinking about the word *workplace*, “who we are” and “what we do” become strangely intertwined. We say, “I am a teacher.” “I am an engineer.” “I am a barista.” Alternatively, if we are not explicitly our jobs, we are in a field, “I’m in retail,” or “I’m in sales.” In all cases, our workplace tells us and the world where we fit in the scheme of things, determining our status, our wealth, and to a certain extent, our identities.

Me? I’m as guilty of this labeling as anyone else. I’m a tutor, a tutor at San Diego Mesa College. I’ve been a tutor for over ten years, working at Mesa for a couple of years in my twenties and almost all of my thirties. I’m an anomaly. The tutoring position is essentially a transient position, one occupied oftentimes by students. Tutors come; tutors go. It is unheard of, unless you’ve heard of me, for someone to stay in that position for such a long time. But I myself have bipolar disorder, and since I can only make a low income since I am on disability, my tutoring job is perfect. It affords me intellectual stimulation, social interaction, structure, and of course, an extra bit of cash on top of what I receive from the government.

Without my job, I would flounder miserably in the quagmire of unemployment. In fact, the times that I am on winter or summer break, I cringe in horror as the wasteland of unproductive hours stretches before me. So, that is the downside of my job.

The other downside is the job itself. I don’t want to spend the rest of my life as a tutor. I want a real job. A real job with real hours and real benefits. A job that stretches me, that uses more of my talents, not just a scant handful. Isn’t that the dream of all under-employed people on disability? Unfortunately, some are too smart to be satisfied with the situation, but too sick to change it.

*Am I too sick to change it?* Getting a real job means getting out of the disability ghetto. It means leaving the security of the State and surviving on my own. Why is this so hard to do? Why haven’t I done it before? No, I did not lose my bootstraps somewhere. Getting that better job is hard because I have a disability, a severe mental illness, with symptoms and impairments and obstacles and barriers and stigma. These are perfectly valid reasons why I stay in a sub-standard job. At least I can do my sub-standard job.

However, I believe in recovery, and I believe that remission from bipolar disorder is possible. I believe that I have reached a stable enough plateau where I can start taking some risks and pursuing some more education, in this case, a Masters in Social Work degree from SDSU, so eventually I can serve in the community as a social worker.

But it has been quite a journey up until this point. If I am to judge myself through
“society’s” eyes, one might call it a journey filled with mediocrity and defeat, as I have come not even close to having a “real career.” In the context of my life, however, in the context of my struggles, what I see is a journey of determination, grit, doggedness, and the pursuit of happiness in spite of a mental illness.

Against popular wisdom that says people with bipolar disorder are discriminated against, what I primarily experienced in the workplace was compassion. My bosses and coworkers over the years have shown me innumerable kindnesses, and I could not be more grateful for the support that I’ve received.

No one plans to be bipolar. When I was in high school, I wanted to work for a magazine. Then, in college, I majored in Literature/ Writing at UCSD, a stepping stone to my dream of publishing articles and seeing my name in print. As a freshman, I applied for a job as the Editor-in-Chief of the Warren College newspaper and was turned down, but Revelle College, the most prestigious and toughest college at UCSD, needed an Editor-in-Chief for their newspaper, so they hired me. My job was to start the next academic year.

This is the time when my life went south. The last day of my freshman year in college, when I had just finished my Edgar Allen Poe final, I came home to an apartment stripped of all my belongings. My mother and aunt were there along with some church friends. My mother and aunt took me by my arms and took me down the elevator. On the way down, they told me that my father had died the day before. He had taken his own life.

From that moment, my life was never the same again. It was the pivotal moment, the “trigger.”

When my sophomore year commenced, I started my new job at Revelle College, working under the new Assistant Dean, Laura Mendez. My behavior was strange from the get go. I was intensely hard working and fast but quick-tempered, and disrespectful. I stopped eating and sleeping regularly and my weight plummeted. The paper took on monumental significance for me and had to be perfect, and the people working with me had to be perfect. Laura was disturbed by her new intern, and she told me later that she confided in the Dean, “I don’t know if I can work with Wendy. She’s so Type A!”

I may have seemed Type A; what I was was Bipolar I.

I had my first psychotic break right after finals. This experience landed me in the hospital for two weeks, and I returned to the campus shocked and shaken, my tail between my legs.

Laura took me under her wing. She had me meet her at the office, and then she took me for a long walk around the campus. She told me about her neighbor’s daughter, an eerily similar story. The young girl was going to college, but living at home. She started talking faster, making all kinds of plans. Then she started rearranging the furniture in the house (including the piano.) When she started
swimming in the pool in the middle of the night, her parents knew that she needed help. She was taken to the psychiatric ward and diagnosed bipolar. She was like me, nineteen years old. Laura told me this story, and then she told me her plan. I could keep my job if I agreed to see a counselor at psychological services. We also agreed to cut my workload in half, so I would publish two papers a month instead of one a week.

I continued working under Laura that year, although even with half the amount of work, I struggled mightily to meet my deadlines. Most importantly, I learned that employers can be sensitive and kind and do the right thing. It was an important lesson to learn early, as things would get more difficult later down the road.

It is important to remember that the notion of success is individual, and every person with bipolar disorder is going to experience it differently. Although I do not work full time, that is not to say that someone with bipolar cannot. It certainly happens, depending on the severity of the illness and how far along in recovery a person has come. But many do not. Many find themselves in part time employment, sometimes underemployed. Sometimes chronically unemployed.

I think it’s interesting, as well, that because of the economic downturn, non-traditional situations seem much more common. Even unemployment is losing the powerful stigma it once had. In a sense, the instability in today’s economy has challenged the notion of “you are what you do.” Even though this notion is being challenged, our culture still places a huge premium on employment as a way of socially ranking or valuing someone.

Jobs today are at a premium. Although I was very, very fortunate to work with employers who were understanding of my situation, going forward, I have become very circumspect about revealing to an employer that I have bipolar disorder, and I would only do it if absolutely necessary. That way, the illness stays out of the picture.

I have recently picked up another part time job - very part time - working for an organization that provides supportive housing for women with mental illness. I’m a Mental Health Specialist, which means that I am the staff member on duty at a house with 15 women. I’m there to provide a set of eyes, and for the ladies, a set of ears.

Now, my immediate supervisor, who I knew through the mental health community, knows that I have bipolar disorder, but the President and Founder do not, and I intend to keep it that way. I think I want to be in one organization where I am not viewed as someone with a mental illness. Even in an environment that supports people with mental illness, I think a supervisor’s attitude changes when she hears about a mental illness. She may think, “Wow, she’s so normal for someone who
has bipolar disorder!” I think even enlightened people, or people in the mental health field, feel this way. I think the bias in our culture is so strong that even the most well intentioned person can have this reaction. So in this one instance, I have protected my anonymity, although I am “out” in every other area of my life.

Bipolar disorder is a serious disability, and symptoms can get in the way of job performance. The best thing to do for a bipolar person is to try to maintain as even keel of a lifestyle as possible and to manage the illness with every strategy at one’s disposal. This means employing the regular cast of characters: eating right, sleeping right, exercising, abstaining from substances, staying around positive people, practicing cognitive therapy, being nice to oneself, among other things. I also think it is imperative for recovery to have interaction with peers. A support network of friends with the same disorder is, ironically, necessary to maintain sanity.

Ultimately, maintaining sanity is the goal for all people struggling to manage bipolar disorder. If it means sacrificing the traditional view of success, then so be it. Of course, productivity and meaningful use of time are paramount to recovery, but that might not look like a traditional career for someone who has bipolar disorder.

Like me: I still “am” a tutor. This is a bittersweet admission. On the one hand, I should be happy to have a dignified job that is relatively stress free that contributes something positive to people. On the other hand, god only knows where I would be if I didn’t have the illness. I could have been Something Else.

However, my job has served a specific purpose. I was right about working part time; I haven’t been in the hospital for eight years. That’s after annual hospitalizations for nearly ten years straight. I broke the cycle, and I credit my “cushy” job for creating that statistic, in part.

Has my job fulfilled me, though, even as I plug away at a minimal wage? I try to remember the words of my students, “Thank you, Wendy. You really helped me. You helped me a lot.”

If ten people have that experience per day, four times a week...for however many weeks a year...for ten years...and if I think of that in human terms, I’m humbled and proud.

And dare I say it, a success.
Going to College with Bipolar Disorder

By Russ Federman, Ph.D., ABPP

The Desire to Leave the Diagnosis Behind

The transition from high school to college is an exciting time. For many, it’s their first extended time away from home; as well, the first big step towards adult identity where one is less defined as the child of Mr. and Mrs. Parent. This is a time of intense striving towards autonomy and individuality. It’s also a time of modifying existing identifications based on new attachments and group affiliations.

These new beginnings also give rise to hope for new outcomes. It’s not uncommon that a graduating high school senior will want to leave his or her mid-adolescent difficulties behind while getting a fresh start in a new college environment. Some of that intention is warranted: a newly declared academic major, choices of new group memberships and even new love relationships may further serve to anchor emotional attachments within one’s contemporary world; however, the big disappointment here is that this same progression doesn’t apply to bipolar disorder.

While it is true that college students will gradually settle in to their new college student identity, it’s also true that students’ bipolar reality will accompany them into their college environment. It’s not something they get to leave behind. A fresh start with bipolar disorder really means revisiting one’s approach to treatment and deciding what’s most appropriate for the next stage of development.

Considering the Best Choices for a College or University

It’s important to note that smaller institutions of higher education, particularly those without large graduate programs, are often referred to as “colleges” whereas larger institutions with much broader ranges of academic programs and graduate schools are typically referred to as “universities.” Sometimes we see that these different terms are even used interchangeably. For simplicity sake, the remainder of this chapter will refer to the generic term “college.” It should also be noted that whether referring to a college or a university setting, the advice pertaining to higher education with bipolar disorder applies equally to both.

For the high school student who has already been diagnosed with bipolar disorder, selecting the right college is no simple matter. The choice does not only hinge upon the strength of the college’s reputation, its unique areas of study, or even whether the school provides much needed scholarship money. Equally important, if not more so, is finding an environment that will be optimal for maintaining emotional and psychological stability.

Close to Home or a More Distant School?

When deciding near or far, we look to the student’s recent history of stability as an indicator of the kind of support network that will be necessary at college. If
relatively stable for the last year or two without hospitalizations or frequent medication changes, then perhaps being close to home is not so important. With a good track record of sustained stability, attending schools that are several hours or even several states away from home should not arouse concern.

On the other hand, if management of bipolar symptoms has been difficult and the student is struggling with instability while applying for college, then perhaps a community college setting or a four-year school fairly close to home would be a better choice. The real issue here is the extent to which one may need to rely upon family support as part of his or her essential support network. If this is unclear, there’s no reason why one couldn’t begin attending a community college and then transition to school away from home once stability has been demonstrated. Besides, transfer to a four-year school becomes easier when one has shown a year or two of strong performance at the community college level. If bipolar symptoms are in the mild to moderate range and have been well managed during the preceding year or two, then there’s no reason why a college can’t be considered that is some distance away from home. If, however, the choice is to fly far from the nest then the next question becomes whether the college of choice has the resources to provide adequate support.

**Mental Health and Psychiatric Resources at Today’s Colleges**

These days, most universities provide counseling and psychiatric services for their enrolled students. More commonly, these services are provided within the same department, usually named something like Counseling and Psychological Services. At some universities counseling and mental health may actually be split into different service units. There may be a university Counseling Center and a separate unit such as Student Health, Mental Health Services where psychiatrically oriented treatment is provided.

As each university has its own unique configuration of student services, it will be important to investigate what is offered and where it will be found. For purposes of this continued discussion, the generic phrase, “university counseling center,” will be referred to as if it were a full-service treatment setting.

For any student the choice of where to go to college is crucial. For students with bipolar disorder, it’s imperative to investigate the scope of services available through a college’s counseling center before making any commitment to attend. If those resources are minimal or without a clear psychiatric component, then one should also make sure good psychiatric services are accessible in the nearby community.
This isn’t to say that mental health treatment resources should be the primary criterion for college selection; but for bipolar students, it really should be high up on the list of priorities. Clearly a bad choice would be to attend a college where access to psychiatric services was limited, both at the college and in the local professional community. Simply put, excellent treatment resources should always be readily accessible for those with bipolar disorder.

One caution: Often university counseling centers are faced with higher student demand for services than they are easily able to provide. Therefore, it is common that university counseling centers primarily provide short-term counseling with focus upon stabilization and community referral for long-term help, if needed. Since bipolar disorder is typically an ongoing condition, students should not be surprised if counseling center professionals want to refer them into the local community for longer-term treatment. These practices will vary from one school to the next, but if counseling center professionals talk about a referral, this must not be taken as a rejection. It’s simply the reality of limited resources that many counseling centers are facing today. There’s also an inherent benefit to a private referral. Given the brief treatment focus of many university counseling centers, a bipolar student may not be able to see the same provider over an extended period of time. If one is fortunate to obtain a good psychiatrist and psychotherapist in the local community, then this treatment team can be in place for the duration of college enrollment. Continuity of treatment is a good thing.

**Important Preparatory Steps Before Arriving at School**

Once a college has been selected there are a few more steps the bipolar student should take to assure a smooth transition. First, it is recommended that the student contact the university’s counseling center either before arriving on campus or shortly afterwards, and make an initial appointment to see a counselor, even if things are going fine. In fact, if the chosen college is not too far from home, then setting up a meeting during the summer months preceding fall enrollment is also a viable option. By doing so, the student is able to establish a personal connection with a mental health professional which will enable rapid access to help if needed for future bouts of instability. It’s also far easier to accomplish this at the beginning of the semester than two thirds of the way into the semester when counseling centers have become quite busy responding to the high volume of other students seeking help.

When transferring treatment the student should also sign a release allowing his or her previous treating psychiatrist to forward copies of medical records to the counseling center, new psychiatrist or community-based, mental-health professional. With this information in hand, any new psychiatrist or psychotherapist can easily review previous treatment history in order to best serve the student in the new location.

Students should be aware that their medical records belong to them and they have a right to receive copies at any time. During late adolescence and young
adulthood, when students are likely to be on the move, it’s actually recommended
that they maintain a notebook of their medical records so that they’re able to bring
copies of records with them when transitioning to college, graduate school, a first
job, employment relocation, or whatever may come next.

**Keeping Stress Manageable: Not Taking on Too Much Too Quickly**

Sometimes the array of offerings at the outset of college can be like a cornucopia
of new possibilities. Fascinating courses, social clubs and organizations, sports,
student government, new recreation options, music and drama … the list goes on.
Boredom will not likely be a part of the college experience.

While considering all these choices, strong feelings of anticipation and excitement
are perfectly normal. Why not just dive in and fully immerse yourself? Simple -
doing so activates a lot of intensity. And while intensity can feel
pleasurable, especially if accompanied by mild to moderate
hypomania, it is nonetheless stressful. For students with
bipolar disorder, the stress of intense engagement is not
necessarily their friend. In fact, stress is often the most
common trigger for mood destabilization.

First year bipolar students are strongly advised to
step back and select from the cornucopia with a
sense of moderation. So what does moderation look
like? Perhaps it’s signing up for 12 or 15 credits
instead of 16 or 18. Perhaps extracurricular activity
choices are delayed by one semester or at least not taken
on with multiple concurrent commitments. And when a
road trip is impulsively suggested by suitemates the second
weekend of the semester … hopefully the bipolar student will choose wisely to
remain on campus and stay focused upon building a stable foundation.

Keep in mind that starting college is an important juncture where many aspects of
change are occurring simultaneously. Saying no to some things at the outset of
school doesn’t mean they won’t remain available as future choices. Approaching
things gradually also does not equate with being left behind. For the bipolar
student, figuring out moderation is far preferable than taking on too much too
soon, becoming overwhelmed and having to bail out prematurely.

**The Potential Pitfalls of University Life**

If the symptoms of bipolar disorder did not emerge until sometime around age 35
or 40, the effective management of mild to moderate symptoms would be a much
easier undertaking. Consider the reality that by middle-age, important maturational
adjustments such as relying upon structured daily routines, employing good sleep
hygiene, significantly limiting drug and alcohol use and more generally refraining
from impulsive, risky behavior, are all choices that one has come to value in the
broader context of a stable lifestyle.
Once these life skills have been achieved, many of the factors precipitating bipolar destabilization are rendered far less potent. That is precisely why we often see an improvement in mood and overall functioning as individuals with bipolar disorder transition out of early adulthood and progress towards later lifecycle stages.

But the middle-age onset of bipolar symptoms is mostly fantasy. Reality is, for many with bipolar disorder, their full symptom presentation generally emerges somewhere between the mid-teens and the mid-twenties. And instead of much needed balance, the accrual of structure, healthy routine and sobriety tend to become delayed due to the behavioral norms of late adolescence.

For many who are starting a four-year college much of their previous life experience has been defined by parental norms and rules. And while parental roles tend to ease up as one becomes older, it is still the case that by the end of high school, students are usually chomping at the bit to have a taste of freedom. At college, they’re no longer being told what time to go to bed, what time they need to be home or even what they can or cannot do when they are out and about. Many of these life choices become their own and it absolutely makes sense that college students want to relish this freedom and throw away limitations that may feel “parental.” The natural consequences to this progression are that during the college years, we usually see that 1) good sleep hygiene is discarded, 2) experimentation with psychoactive substances is common and 3) strategies for managing high work volume are far from being stress free.

The good news is that for most of these late teens and twenty-somethings, their approaches to work and play will undergo significant modification over the next 10 to 15 years. But if you’re bipolar and headed off to college, or even if you encounter your disorder while already attending school, you don’t have that kind of time to make necessary adjustments.

Why not? For the individual with bipolar disorder, good stable sleep can be as effective (if not more so) than prescribed medicine. It’s often the case that inadequate sleep and/or inconsistent sleep patterns are some of the most common precipitates of bipolar mood destabilization. Similarly, research is showing that frequent and excessive use of psychoactive substances is a potent destabilizing influence for those with bipolar disorder (Baethge, C., Hennen, J, Khalsa, H.K., Salvatore, P., Mauricio, T. and Baldessarini, R.J., 2008). On the other hand, it’s also common that most college students with bipolar disorder report that substance use is something they have struggled with. The third part of the terrible triad is stress. Stress usually worsens
psychiatric disorders. Stress makes people feel worse even when they are free of any psychiatric diagnosis. For those with bipolar disorder the combination of high stress, substance use and poor sleep habits is quite simply like introducing a lit match to gasoline. The outcome isn’t good.

So it makes sense that the freedom and opportunities of college life present the bipolar student with enormous challenges. The solution is simple: get good sleep, stay away from substances and become masterful at handling the stresses of college life. Ah, if only it were that simple! You see, there’s something else, quite significant, that’s wedged between the pitfalls of college life and effective solutions.

Accepting the Diagnosis: The Most Difficult Challenge of the University Years

Most students with bipolar disorder don’t want it. That’s not to say they don’t value their experience of mild hypomania where they feel energized, optimistic and cognitively turned on. Think about it; there’s a lot of brilliant creation that has occurred throughout history as a function of bipolar mood elevation. But the full picture isn’t as desirable. Depression is depressing. Unpredictable mood creates a roller coaster-like reality. And full mania usually wreaks havoc. Again, most students don’t want it.

But isn’t that so for the many difficult and painful things in life? Imagine one has been diagnosed with Type I Diabetes where daily blood level monitoring and insulin shots are an integral part of maintaining healthy functioning. Diabetic university students usually don’t welcome this daily regimen; however, they generally comply because the alternative is far too detrimental for their well-being.

Similarly, when a student’s parent dies from cancer during the student’s first year of college, the event will usually take an enormous emotional toll. No one is really prepared to lose a parent at age 18 or 19. But the student’s life doesn’t end because of parental loss. The student usually endures a painful period of bereavement. It’s also probable that the student will successfully continue forward once figuring out how to live with the new reality of having a deceased parent.

Whether we’re considering the loss of optimal physical health or the loss of a loved one, we generally do find ways of adapting and moving forward, but not without loss and adjustment. In many respects, this is what maturation is all about.

Late adolescence is a time of striving towards goals and ideals. Going to a good
school, finding a fulfilling major, connecting with a wonderful love partner, developing options for gratifying and rewarding employment are dominant themes for the late adolescent and young adult. As we progress through the lifecycle we all have to accept some modifications of our hopes and dreams. An ideal life exists in fairytales and movies. It doesn’t exist in our lived realities. For most, these modifications of hopes and dreams typically occur somewhat later in life, when it gradually becomes clear that adolescent fantasies and adult realities aren’t a close match.

But the college student with bipolar disorder needs to adjust expectations at an earlier age. The predominant lifestyle norms of university life won’t work for the bipolar student. Indeed they’re a recipe for instability. In order to work with this, the bipolar student needs to try to embrace his or her diagnosis; not because it’s desirable, but because it’s real and to some degree, unchangeable. Denial won’t make it go away. Denial of the bipolar disorder will temporarily allow students to do what they want. But when such choices disregard aspects of bipolar stability then there’s the inevitable price to pay for brief forays into denial and temporary wish fulfillment.

The necessary psychological adjustment for the bipolar student entails letting go of their ideal self - that person the student was striving to become - and accepting the realities of living with the bipolar diagnosis. This adjustment is a painful one and it usually isn’t achieved quickly. Just as with the process of grief, it needs to be revisited again and again in order to gradually be replaced with a deep sense of acceptance. It actually is a process of grief: grieving the loss of that person that one wants to be.

So what does this look like in practice? Maybe it means working hard to find others whose lifestyle revolves around recreational activities other than drinking and partying. Maybe it means getting a physician’s letter documenting the need for a single dormitory room in order to have more control over “lights out” time. Maybe it even means getting some additional help or life coaching in order to develop really good study habits and effectively distribute one’s academic load over the duration of the semester. These are all important pragmatic approaches.

Beyond pragmatism, the real work underlying all of this entails the emotional process of coming to terms with the diagnosis. This is also where some good psychotherapy can be very helpful. Ultimately, once the reality of “being bipolar” is comfortably integrated into ones identity, then the pragmatic pieces will fall into place without a lot of difficulty.

Unfortunately, most students are not ready for this kind of acceptance during their late teens. In fact, for some the reality of bipolar disorder is so not what they want, that they intentionally try to reject the whole ball of wax. It’s not uncommon to
have some students say, “I’ll deal with this all once I’m out of college!” Well, yes, they may have to. There’s also potential long range negative consequence to this attitude.

Recent neuroscience research is pointing to a phenomenon where the long range prognosis for the course of one’s bipolar disorder is a reflection of the degree of instability that occurs early on with the disorder. In other words, early mood instability left untreated = long-term difficulty with continued instability, whereas early instability that is successfully contained = better chances for longer-term stability. This is referred to as the kindling effect (Post, 2007).

Think of a sprained ankle. Once an ankle is badly sprained it makes the ankle more susceptible to future sprains. Each successive sprain lowers the threshold for the kinds of physical stresses that will lead to subsequent sprains. The brain is not all that different. Vulnerabilities towards bipolar instability, especially when they are disregarded and simply allowed to occur, actually lower the threshold for future episodes of instability. This means that the strategies of those who want to wait until later years before they seriously deal with their disorder are significantly flawed. Once the neural circuitry of the brain is primed for longer-term instability, the individual doesn’t get to return to late adolescence for a redo.

So accepting one’s diagnosis and adjusting accordingly is a big deal! The intent here is not to paint a picture of doom and gloom or to frighten one towards a preventative position, but more to draw attention to what’s really at stake. When students are in the midst of their college life it’s not easy to maintain a healthy perspective on the bigger picture. For college students with bipolar disorder, this very perspective may be essential to living a life that’s well-grounded in stability, effective functioning and fulfillment.

The Appropriate Use of Academic Parachutes

An academic parachute refers to those supportive processes that can be put in place to assist a student during times of functional difficulty. When used appropriately, an effective parachute will also help a student land on his or her feet while avoiding the reality of a more devastating crash landing.

One of the frustrating aspects of living with bipolar disorder is its unpredictability. Even with the right combination of medications and lifestyle modification a student can find that the stresses of academics and college life can still turn things upside down. Given these potentials it’s prudent for bipolar students to know what kinds of parachutes are available to them.

Most universities have an office that serves students with physical, psychiatric and learning disabilities. Typically this office is referred to as Disability Support Services;
though on some campuses it may have a different title. The Americans with Disabilities Act requires that institutions of higher education provide assistance and necessary accommodations to students with diagnosed disabilities. Clearly no college student wants to consider themselves as having a “psychiatric disability,” but there are times when bipolar symptoms can be just as disabling as any other condition. If a student was in a wheelchair due to cerebral palsy, there wouldn’t be much question as to whether some special assistance would be needed for that student. His or her classrooms would all need to be wheelchair accessible. If a student’s arms were affected, it would also make sense that student receive copies of comprehensive class notes. In other words, some accommodations would need to be made to assist the student to participate equally in the educational process along with other nondisabled students. Why should bipolar disorder be viewed any differently?

Strong symptoms of depression and/or hypomania can absolutely impair work productivity. The different medications used to help stabilize a student may also have unwanted side effects such as drowsiness, impaired attention and concentration or even the intensification of agitation. The process of trying to return to stable mid-range mood after a period of depression or hypomania is not always a simple one. Here’s where a good connection with a college’s Disability Support Services, as well as one’s academic Dean, can make an important difference.

Through these services it is usually possible for students with bipolar disorder to receive accommodations such as: flexible class attendance requirements, extended work submission deadlines and receipt of class notes when a student is not able to attend class. Usually, the main hurdle to receiving this help is not the institutional system itself. More often than not it is students’ reluctance to swallow their pride and ask for help. Clearly this is an echo of the kinds of issues raised in the discussion of accepting one’s diagnosis.

A student’s academic dean can also be an effective advocate when communicating with professors around issues of disability-related performance difficulties. A good example involves medically excused late course drops. Most schools have an initial period of time each semester where students can add or drop courses without consequence. Occasionally a student may recognize that his or her performance in a particular course is more negatively impacted than performance in other courses; however, it’s not uncommon that for the bipolar student, course-specific performance deficiencies may not become apparent until after the last date to drop a course. In these instances, when accompanied by appropriate medical documentation, academic deans can sometimes play an important role in facilitating exceptions to standard course drop policies.
Beyond the helpful advocacy roles provided by others, one of the best strategies is for a student to meet with professors and share the realities of his or her bipolar condition. It’s even more helpful when this is done proactively, early in the semester, rather than waiting until the point where it feels like the semester is a lost cause. In most instances university professors are more than willing to be flexible and supportive of students as long as they perceive the student’s sincerity and all claims are backed up by appropriate documentation.

There’s also the occasional outcome where the semester does become a lost cause. A ten day hospitalization occurs and the student doesn’t return to effective stable functioning until a month later. A hypomanic high derails a student’s productivity for the entire first half of the semester. By the time things have smoothed out the possibility of catching up with missed work is unrealistic. A student enters college in late August and does quite well, but hits a wall of depression by mid-November. The student’s energy, motivation and ability to concentrate are all greatly diminished and the challenges of completing the semester are only compounding the depressive symptoms. In instances such as these a full medical withdrawal from enrollment can be a wise decision.

The official notation on one’s transcript is simply “Withdrawal,” or something quite similar. There is nothing on an academic transcript which reads “Withdrawal Due to Psychiatric Instability.” By taking this course of action a student is also able to protect against strong negative impact of Ds and Fs upon their overall grade point. Such can be especially important if long-range goals are to gain access to a competitive graduate school or some other post-baccalaureate professional program.

It’s not uncommon that when discussing these choices with students, their response is something like, “but that will put me behind the rest of my class.” Well, it may. But there’s always the potential of making up courses during summer school or doing the kinds of two week intensive courses that some universities offer just following winter break.

It’s also important to recognize that getting an education isn’t a race to the finish line. Some will get there ahead of others while some will take longer. That’s life both in and out of college. There is no official established formula for success in higher education. It’s also a given that by the time students reach midlife, they’re not going to be looking back on their college years and thinking that things would have been so much better if only they had graduated one semester sooner!

**Conclusion**

We’ve often heard the phrase uttered by adults, “My college years were the best years of my life!” Typically when such is expressed we’re seeing some degree of
retrospective distortion. No doubt, the college years do involve some wonderful experiences. But if the truth be told, they are also years of high stress and high complexity.

Even for those without any psychiatric diagnosis, the transition from late teens to early adulthood is no walk in the park. For those transiting this phase of development while also trying to manage their bipolar disorder, the experience is more like a trek through the Himalayan peaks. There are amazing highs and dangerous precipices. The journey requires good preparation, excellent conditioning, extra gear and well developed skills. It’s also a time to connect with the best guides you can obtain. There will be setbacks. There will even be times when adverse conditions seem overwhelming. However, if the bipolar student is able to successfully commit to the journey and accrue many new life skills in the process, the experience will provide a strong foothold in the realm of emotional stability. Once that position is well established, the student can continue forward with a sense of resilience that will last a lifetime.

References

Social Interaction
By Ellen Frudakis

Social interaction is a basic human need. Whether you have bipolar disorder or not, everyone needs to have opportunities to socialize. Social interaction can be fun, leading to friendships, and/or provide us with a deeper appreciation and sense of who we are. I have bipolar disorder and have experienced this first hand. Social interaction has brought me a feeling of belonging, friendship, laughter, and joy. At times, it gave me an escape from the challenging aspects of this illness and a belief in the possibility of recovery. I have also seen this occur for many of the young people who have joined Impact Young Adults (IYA), a nonprofit organization that I co-founded that provides social activities and leadership experiences for young adults with mental illness.

Social interaction can come in many different forms. Whether you are having coffee with a friend, attending a meeting, hanging out with family, or even just talking on the phone, in all of these cases, you are interacting with others. It doesn’t have to be a big event or anything planned; it could be as spontaneous as going for a walk with your neighbor.

In this chapter, I will focus on the needs and benefits of socialization for people with bipolar disorder, acknowledge some of the challenges that make social interaction difficult, and offer some tips that I have found helpful in my own journey towards creating ongoing social relationships that enrich the quality of my life, as well as the lives of many of the young adults in IYA.

If you are someone with bipolar disorder, my hope is that you will find this chapter affirming and the tips useful. If you are a friend or family member of, or treatment provider for, someone with bipolar disorder, I hope that reading this offers you the chance to see how healthy socialization can contribute to one’s overall wellness. There is a huge need for social interaction to be recognized as a primary part of living a balanced life with bipolar disorder, just like a proper diet, enough sleep, medication, and therapy. It is my belief that people need to have access to positive experiences and people in order to create a life they can be proud of.
Realizing the Needs and Benefits of Social Interaction

Some of the many benefits of ongoing social interaction are:

- A feeling of acceptance
- The possibility for friendship
- An increase in self-esteem
- A chance to have fun
- Access to social support when needed

**ACCEPTANCE** I have been told by many young people with mental illness that acceptance is a feeling that they long for. However, it is not just important to young people; I think everyone wants to feel that they are accepted. I know that when I am with other people who accept me for all that I am, including my bipolar disorder, I am reminded that there is nothing wrong with me. I feel more comfortable in my own skin. There are many people I know who feel like they have to censor themselves when it comes to talking about their mental illness, particularly when they aren’t yet ready to reveal the fact that they have one.

Joe is someone I know with bipolar disorder. He once told me that the hardest question for him to answer from strangers and acquaintances is “How are you doing?” Unless it is a friend or someone he feels is accepting of him, he has trouble answering this question because he feels that most people will not want to hear about it if he is having a bad day. Joe says that with people he knows, he is able to be honest without worrying what they may think of him. This kind of acceptance helps to relieve his anxiety and other symptoms related to his disorder. Acceptance from others makes it easier for him to accept himself and the illness he manages.

**FRIENDSHIP** At a basic level, a friend can offer a feeling of connection and belonging. Janet, one of the members of IYA, says that friendship also opens doors to new experiences, exposing her to interests that she wouldn’t have pursued on her own. Prior to one of her friendships, for example, she had not been interested in art. Then one of her friends introduced her to painting, which has now become a huge part of who she is. She considers this interaction to have altered her reality, bringing fresh energy and ideas into her daily life. Janet tells me that human interaction is so important to all of us, especially those of us with mental illness, because our number one way to cope when things are tough is to retreat. Her experience with friends has helped her change this, and she says that she no longer feels as alone as she had felt in the past.
FUN This is also an important part of social interactions. Recently, another one of the members of IYA, Scott, said that going on the IYA overnight trips make a big difference in his life. Specifically, he enjoys getting to spend time with friends, staying up late talking and making jokes. Scott expressed that one of the best things about it was not just the fun he had at the time but that it improved his mood for several days afterwards. He followed up this statement by saying that it made him feel like he is more than his illness and that he belongs somewhere.

SOCIAL SUPPORT Sometimes social interactions can be supportive, even if support wasn’t the primary goal. This was the case for Christine, one of my friends with bipolar disorder. In the last year she made friends with some people by joining a hiking group so that she would have something fun to do on the weekends. She was recently admitted to the hospital due to an increase in the severity of her symptoms and a concern about her safety. When Christine’s new friends found out about her being in the hospital, many of them came to visit. I asked Christine how that made her feel. She said it helped her tremendously to talk about what was going on for her and know that she was understood. Christine went on to say that she had experienced this once before on a previous hospital stay when a group of her friends got together and signed a get-well card. She said it made a big difference because it felt really supportive and ended up improving her mood. This in turn helped her in her recovery. It is empowering to have support outside of the structure of a support group. Having a friend that is supportive can help you in your recovery process and can boost your self-esteem.

In my personal experience, as well as my experience leading a social activity program for young adults with mental illness, the need is clear, and the benefits of socialization are endless. Sometimes getting started is the most difficult part. Read on to find ways to come to terms with the challenges that can keep you isolated.

**Challenges In Socialization For People With Bipolar Disorder**

Despite how simple it may seem to some, finding a way to create meaningful connections can be difficult for those with bipolar disorder. This is particularly true in the beginning stages of restoring a sense of balance in your life. Sometimes it may feel like the cards are stacked against you. You may be managing difficult symptoms or stress, your lifestyle may not bring you into contact with others you can relate to, and there is a stigma associated with this illness. Further, low self-esteem can take so much of your attention that trying to add anything else in your life seems impossible. I will outline these challenges in the following section not to discourage you, but in hopes of acknowledging what you may be going through.

- **SYMPTOMS** There are many symptoms associated with bipolar disorder,
but there are two primary symptoms that can make social interaction difficult: depression and mania.

**Depression** For me, like many other people, depression involves feelings of insecurity and uncertainty about the future. These feelings can be extremely overwhelming, and it is easy to get caught in the revolving door of negative thoughts. The longer I listen to the negative thoughts, the harder it is to get out of the trap they put me in. Added to this, one of depression’s “closest friends” is isolation, and unfortunately this, along with the negative thoughts, make it even more difficult to get out of the house and socialize. Other symptoms of depression include: lack of energy and motivation, dietary issues, and cognitive impairments like poor concentration or inability to think clearly. If any of this has stopped you in the past, a few of the ideas listed in the How-to section at the end of the chapter may be helpful. You can also try setting small goals for yourself so that you won’t feel intimidated or overwhelmed. For example, if you want to go to a support group, tell yourself that you don’t have to stay the entire time. If you can only stay five minutes, that is ok. The success is that you got out of the house. The important thing to remember is to make it as comfortable as you can for yourself as you work to try something new.

**Mania** The effects of mania on relationships can appear different depending on whom you talk to – the person with bipolar disorder or the person without it. For example, when I was manic I thought I was much more fun to be around. But to others, possibly, my presence was a whirlwind of confusing energy. Manic behaviors are easily misunderstood, often leaving people wondering if they can trust your behavior, and your relationships can become strained or even dissolve. Additional symptoms that can make socializing difficult are restlessness, irritability, paranoia, incoherent speech, and grandiose thoughts. My experience with these symptoms is that it is best to get them under control by working with your treatment provider before taking on anything more. During this period you might find support groups or clubhouses will help. Once things have settled down, you can try other ideas listed in the How-to section.

- **LIFESTYLE** When your ability to function gets handicapped by this disorder, it can affect your lifestyle, making the usual meeting places for meeting people less likely to occur in your life. Common ways of meeting new people include work, school, or through other friends. As an individual begins treatment or is managing symptoms, those outlets can become inaccessible.
I, like many others with this illness, have gone through periods when I was unable to work or attend school.

If you do find yourself able to meet people, the next barrier is being able to relate to them. They may have a job, a family, or attend a school, etc. If you don’t share a common factor in these areas, you may not know what to say or how to answer questions that may be directed at you. Before I found my social network and before I was able to go back to school and work, this was a big issue for me. I was very self-conscious about the fact that, in my opinion, I wasn’t doing anything of value worth sharing. Like Joe, who I mentioned earlier, I also had a fear of a common question which is, “What do you do for a living?” Each time I found myself with people I didn’t know I would get extremely nervous, expecting that one little question that put me on the spot.

I found that by having a prepared response, I could feel comfortable answering that question. For example, I could say “I’m taking some time off work right now due to some health problems.” If the person probes further, it is fine to tell them that you would rather not go into detail. Most people will respect that.

• **STIGMA** With the exception of a few movies, television shows, and an occasional personal interest story in the press, people with mental illness are generally portrayed negatively in the media. For people with bipolar disorder, or other mental illnesses, being portrayed in public as “dangerous,” “irresponsible,” “unreliable,” or “odd” can make us feel like we have two choices: either deny the existence of the illness or keep quiet. If we lack positive role models, many times we lack the ability to accept the illness. This, in turn, makes it much harder for those around you to accept it.

Unfortunately, unless they know someone or have personal experience, the media is the primary source of education about mental illness for the general public. So, if you have this illness, it makes sense that you would worry about how others will perceive you. It is hard to put yourself out there if you feel like you will be judged and misunderstood.

What I have found is that the more I accept my bipolar disorder, the more others tend to. Also, knowing how to talk about it helps. If I need to explain why I wasn’t able to be somewhere, I have referred to my illness as a “health problem;” at school I refer to it as a “learning disability.” Ultimately, I look forward to the day when bipolar disorder is viewed just like any other health condition, but until then I feel content to use these alternatives. (See section on Stigma)

• **LOW SELF-ESTEEM** It is very common for self-esteem to develop with the onset of bipolar disorder. For me, losing the ability to trust my mind made me feel like I was losing control of my life. Ultimately, I lost my sense of self.
Before the onset I could say to myself with confidence, “I am a good student, I am a thoughtful friend, I am a talented artist.” But bipolar disorder attacked and invalidated everything I thought I knew about myself and turned my life upside down. It was hard to put myself out there when I didn’t feel good about myself. The risk was too great. I could be misunderstood, rejected, or worse… ridiculed. No one I know is up for that, whether they have a diagnosis or not.

One thing that helps my friend Mary, when she is having trouble with self-esteem, is to think about something she is good at. For example, when Mary is healthy she can recognize that she has a lot of courage and persistence when it comes to her career. When her symptoms flare up she can still see this courage and persistence in how she works at her mental health. She can see these qualities in herself despite her circumstances. The goal is to try basing your self-esteem on who you are as opposed to what you do. Keep in mind that this is something everyone has trouble with, so you are not alone.

• **LIMITED BUDGET** Many of the people I know with mental illness have a lower level of income compared to others without the disorder. This may be because they have had to go on disability due to the severity of their symptoms, or if they are able to work, sometimes they cannot work full-time. This limits the amount of money available to spend on fun activities. For some, a trip to the movies is way over their budget. I have listed many social options in the How-to section at the end of this chapter that are low to no cost.

• **STRESS** Stress is like lighter fluid for the fire that is this illness. Stress puts pressure on a system that is prone to ups and downs. That is why people with bipolar disorder have to be careful during periods of high stress and make sure they are getting the support they need, or limiting situations that add to their stress. Sometimes this means that a social life has to take a back seat to treatment, and that’s ok… it will be there when you are ready. Hopefully, if you have already started to make friends, they will understand if you aren’t available for the time being.

Knowing yourself and what coping skills work at different times can be especially helpful when you are feeling stressed. There are many stress management techniques out there – discuss these with your treatment provider or go to the library or bookstore and look through any books available on the subject.

These challenges and others may have stopped you in the past from having the type of social life you desire. Hopefully, the next section will help you overcome that with ideas on how to meet people and have fun.

**How To**
So, how do you get started creating a new social life? Let’s say you are like I was a few years ago before the creation of IYA, with no one to hang out with except for the television... how do you step out of that? Below are some ideas that have worked for me and others I know. You may have taken part in or had experience with these at some point. I encourage you to get involved in the options that sound interesting to you. Many of the avenues listed are free or involve minimal costs.

**ONLINE RESOURCES**

For some people, one of the easiest and least intimidating ways to put themselves out there is to take advantage of what the Internet has to offer. If computers make you anxious, please feel free to skip to the next section that discusses in-person opportunities. If you don’t have your own computer, most libraries offer community computers that you can use free of charge.

- **Online Support Groups** – Some online support groups are message boards where people can “post” how they are feeling or ask a question that others can respond to. Others are more like chat rooms, where people all log in at the same time and are led by a facilitator. Some national organizations like DBSA (Depression Bipolar Support Alliance, http://www.dbsalliance.org) offer online support groups, like the chat room example.

- **Meetup.com** (http://www.meetup.com) – This is a website that lists groups of people that get together with specific interests. There are groups for everything! Just to name a few that I have seen: cooking, art, hiking, spirituality, and even politics. If you name it, you can probably find it. These groups are run by everyday people who started out looking for something to do, just like you. If you don’t see one you like, start a new one!

- **Facebook/LiveJournal** – These are just two examples of many websites that have online communities that you can join – some of which may announce in-person events that you can find out about. This is one way you can connect with the people who live in your area.

Make sure not to limit yourself to online friendships. Use the Internet as a starting point and then ease yourself into something outside of your house. What you experience online can never fully substitute for an in-person interaction.

**IN-PERSON OPPORTUNITIES**

If you are someone who feels uncomfortable making conversation with others, try something where you start out as a viewer or inactive participant. Some examples of this are listed below:

- **Religious Institutions** - If you believe in some form of higher power you can attend a religious service. There are many different types of religious institutions, from traditional Christian, Buddhist, Jewish, or Muslim congregations to Unitarian Universalists or other diverse groups that gather together. If this appeals to you, it can be a great way to get started.
• **Mental Health Related** - If you are insecure about being around others because you worry that they won’t understand your illness, or if you are still experiencing symptoms that make it difficult to connect with others, try reaching out to mental health communities first. This can be less intimidating.

  - **In-Person Support Groups** - Whether the group is led by a therapist or is a peer-support model, either can be good for you in multiple ways. First, they get you out of the house and around others. Second, they give you a chance to get support and understanding for what you are going through from people who know about it firsthand. Generally, you are not required to share, especially if it’s your first time. So, just sit back, listen, and learn what it is all about. The following organizations are generally peer-led and have locations and meetings all over the United States. Check them out online to find more information.

    - DBSA (Depression and Bipolar Support Alliance): http://www.dbsalliance.org
    - NAMI (The National Alliance on Mental Illness): http://www.nami.org
    - If you have a dependency issue, support groups like AA, NA, or SMART Recovery (http://www.smartrecovery.org/) may also be good options.

  - **National and International Mental Health Organization** - Some have been mentioned previously for their support groups but also offer other types of education programs and community events for anyone facing challenges related to mental illness. Call your local office to see if they know of activities in your area.

    - International Bipolar Foundation: http://www.internationalbipolarfoundation.org
    - NAMI (The National Alliance on Mental Illness): http://www.nami.org
    - RI (Recovery Innovations): http://www.recoveryinnovations.org

  - **Mental Health Clubhouses** - These are places where people with mental illness can go during the day to find support and structure. Some have support groups and social activities. Others offer job rehabilitation programs and job placement. Many times lunch is available for a minimal fee. The best thing about the one I attended was a support group for young people. I was able to meet others my age going through similar challenges.
• **Impact Young Adults** - This is a consumer-led social activity and leadership experience program for young adults with mental illness in San Diego, California. (http://www.impactyoungadults.org)

• **Compeer** Compeer provides one-to-one supportive friendships and mentoring relationships with volunteers for adults and youth in mental health recovery. It is not available in all areas, so check their website for more information. (http://www.compeer.org)

• **Parks and Recreation Clubs** - Some communities have Parks and Recreation departments that focus on providing fun activities in their area. Some even offer specific programs just for people with disabilities.

• **Volunteer** - Volunteering is a great way to get connected in your community and be involved with a cause you are interested in. For example, if you like the beach you might try volunteering for a beach clean-up event. If you love art, see if there are any local galleries that need volunteers to help out. Sometimes you can find people or agencies that keep track of all the organizations that need volunteers in your area. This can make it easier to find something that interests you without having to ask around or contact each organization individually.

• **Neighbors** - Not everyone knows their neighbors these days, but chances are you have passed them as you come and go from your home or apartment. Start off slowly by saying hi and asking how their day went. This may lead to longer conversations here and there, and slowly you might find that you are building a relationship with them. If you feel comfortable, ask them if they would like to go to a movie or on a walk with you.

• **Education/School**
  o Take a no cost / no credit course through your local Community College District. This can take the pressure off if you are unable to make a semester-long commitment but want to try something new.

  o Take an arts or crafts class at a local art studio.

  o Join a book club. If you are a book lover this is a great way to get involved with others with similar interests.

  o Join a writing group. I have a good friend who joined a writing group with a few people she has met over the years. She loves to write, and it gives her deadlines that help her accomplish what she might not get done on her own.

• **Politics** - If you are interested in politics and want to be around others like yourself, you can generally find a local group that organizes rallies or supports political candidates running for office. This is a great way to build
skills and also meet people who share similar interests with you.

- **Family** - Spending time with members of your family can be a safe and less intimidating way to socialize with people you already know. If this is not a healthy option for you, do not feel bad. There are plenty of other ideas listed here to choose from.

- **Interaction with animals** - If you are an animal lover, this can be a good way to get yourself out there. Many local animal shelters look for people to help out. This way, you can be around animals and other people who like them as much as you.

I hope that some of these ideas will work for you, or at least inspire you to think about what interests you. If you are not happy with your current social situation, there is no time like the present to start changing it. As you move forward, just remember that getting involved socially can take time. Making friends isn’t always an easy thing to do, so give yourself credit for trying (many people without bipolar disorder struggle with this as well). I wish I had been able to recognize the difficulty and give myself credit when I was first diagnosed, as it would have saved me a tremendous amount of grief. What I know now, after years of trying to create positive social experiences, is that it’s completely acceptable if this feels difficult, because it can be. But hang in there. It is worth it. I have seen people who lacked any social activity come into IYA and become transformed by being around others and having fun (in addition to being in treatment, of course). Their lives went from activities relating to mental illness to activities while having mental illness.

As I stated in the beginning of this chapter, social interaction has brought me a feeling of belonging, friendship, laughter, and joy. At times, it gave me an escape from the challenging aspects of this illness and a belief in the possibility of living a truly balanced life. More than anything else, it has brought me a new sense of myself; one where I have been able to integrate the lifestyle changes that have come with this illness into the rest of who I am. What I know now that I didn’t know at the beginning of this journey with bipolar disorder, is that I am more than my illness. I am a person with many interests and talents. Yes, I have bipolar disorder, but it is just one of the many parts of me. Yes, I have to make sure to do what is necessary to stay well, but I must also nurture and encourage other parts of myself to grow.

When you are ready, I invite you to come join in the fun of social interaction.
Putting baby locks on the kitchen cabinets to protect my toddler was one thing, but locking away the steak knives from my seven-year-old was not something I ever imagined would be necessary. I also never imagined that I would need to use my skills as a psychiatric nurse on my own child.

When my youngest son Courtland turned four, my husband and I began noticing behaviors that were foreign to us. Court had become unusually aggressive; having uncontrollable temper tantrums in the grocery store aisle, throwing toys across the room at his brothers, and kicking me at the slightest parental control. Once a gregarious, outgoing child, he had become fearful, frightened to go to school, afraid to be in his room alone, or afraid to go outside to play. Court now shunned the beach; the sand bothered his toes, and in summer he wore winter clothes, complaining he was cold. The inside labels on his shirt and seams on his socks sent him into fits of rage.

I worried that like my other two children, Courtland might also have Attention-deficit Hyperactivity Disorder (ADHD), but perhaps a really, really bad form of it. Over the next three and a half years, Court saw five psychiatrists, each offering a different diagnosis including Obsessive-Compulsive Disorder, ADHD, Oppositional-Defiant Disorder, and Post-traumatic Stress Disorder. Finally, after being incorrectly treated with an anti-depressant, Court experienced a full blown manic episode and was ultimately diagnosed with Early-onset bipolar disorder.

Even with medical training, my husband and I were ill prepared for the frustration we experienced trying to steer our way through the mental health system, the fear we encountered not knowing what the future held for our youngest son, and the lack of understanding and support we met on a daily basis. Our lives changed dramatically. We read every book printed, searched the internet for any clue offering help or hope, sought multiple opinions from varying disciplines (psychiatrists, psychologists, neurologists, etc.), and clicked on every available website.

I quit my job and dedicated my waking hours to learning more, helping my son, and emotionally supporting my family. We looked into alternative schools and ultimately sent him to 4 different schools. We used mood charts, star charts for good behavior, practiced Ross Greene’s “3 basket approach”, and hired a mentor as we learned that author Danielle Steele did for her son, Nick Traina. We went to family therapy, individual therapy, and social skills groups.
The first 10 years were particularly difficult. We walked around as if on egg shells. We chose our words carefully so as not to upset Court; learned to disguise his many pills in pudding; in order to monitor his sleep we allowed him to stay in our room; repaired multiple broken windows, and sheltered our two other boys from Court’s untempered profanity.

Bipolar disorder does not just affect the diagnosed person. Marriages are stressed to breaking points, siblings feel left out or slighted, friends may be ignored, and parents may harbor feelings of guilt or helplessness. All relationships are challenged in one way or another.

Within the first year following Courtland’s diagnosis of bipolar disorder, I found very little support, both for myself and my family. I began talking with other moms at the playground, explaining why my son was different and what his aberrant behaviors meant. I wanted my son to grow up not feeling ashamed that he had this disease. We talked openly and honestly about it and encouraged him to do so, as well.

In the early years, our openness came back to haunt us. Parents whispered about him at t-ball games, no one invited him to birthday parties, sleepovers or play dates. The children on the playground called him names like psycho, looney head and mental case. The boys taunted him and told him to go back to the mental hospital (even though he’d actually never been at one). Each day when I picked him up from school, he would shuffle over to the car with his head hanging down, telling me of yet another example of the bullying he had endured.

I wanted so badly for him to fit in, for the other kids to understand him and to accept him for who he was. After all, the children with diabetes or other physical illnesses were not excluded. Only those with mental illnesses were.

Like a mother lion, we all do whatever is necessary to protect our cubs, but I felt like I was losing this battle. I learned that the special education teacher curriculum in California does not include a “chapter” on bipolar disorder, although it does include autism, Asperger’s, ADD, & ADHD. Therefore, how could they understand my son’s behaviors and respond to him in an appropriate manner? They couldn’t and didn’t, so I gave in-services to the teachers to help educate them about bipolar disorder. I worked with the school Superintendent and Principal to incorporate anti-bullying tenets and even hired a theater group that specialized in anti-bullying vignettes. Nothing seemed to help, but as much it seemed an insurmountable obstacle, we did not give up.

When my son was 9, we allowed a television station in Los Angeles to interview us. After telling a co-worker what I had agreed to, she sent me a scholarly paper about children with AIDS, advising parents not to be public about it. I understood her
concern, but chose not to succumb to the unjust negative stigma associated with the biochemical brain disorder with which my son was born.

As I continued to talk openly about his disorder, people I had known for years, began secretly sharing with me that someone in their family was also diagnosed with bipolar disorder. Strangers called or emailed me, confiding that their son or daughter, mother or uncle also had bipolar disorder.

They all shared their stories of sadness, grief over a future now robbed of its potential, loneliness for their excluded child, fear for their child’s safety and unanswered questions about medications, hospitalizations, conservatorship, doctors - the lists were endless.

If you are reading this chapter, then you are probably all too familiar with my examples of living with someone who is not stable, or of the bullying and negative stigma and the futility of attempts to correct them.

As caregivers of someone with the disorder, we need to be aware that just as with so many other illnesses, the symptoms of bipolar disorder range broadly within a spectrum. Although one person may be psychotic (loss of touch with reality) or a danger to himself (one in five children with bipolar disorder will kill themselves before the age of 18), another may be relatively high functioning, attend regular school, and hold a meaningful job. Think Rachmaninoff, Hemingway, Vincent Van Gogh, and Carrie Fisher. All are highly successful, extremely creative people, all who have/had bipolar disorder. Caring for someone with bipolar disorder can be especially difficult given the nature of the disorder.

Not only is healthcare coverage more limited than for other illnesses, there is the issue of getting someone to treatment when he or she may not want to go. A person who is in a manic phase (up) may refuse to seek treatment and may even discontinue his medication. The medications are powerful and have unpleasant side effects. Someone in a depressed phase (down) may feel so helpless and worthless that getting help seems not to be an option. Furthermore, most of the medications used to treat bipolar disorder are powerful, have unpleasant side effects and may thwart their “high” feelings. Because there is not yet a cure for bipolar disorder, these medications must be taken for life, which is a scary prospect for most people.
For caregivers, coping with someone with bipolar disorder takes a heavy emotional toll and strains the relationship, often to the breaking point. An added burden is the stigma of mental illness, which leaves families feeling frightened and isolated, unaware that many other families share their experience.

For purposes of this chapter, a caregiver is anyone who has primary care responsibility for someone diagnosed with bipolar disorder. Caring for a child, however, is much different than caring for an adult, for whom you probably have no legal rights. Not only does the type of care change with age, the typical course of the disorder tends to differ in children and adults.

So what can we as caregivers do to help our loved one with bipolar disorder?

**CARING FOR A LOVED ONE WITH BIPOLAR DISORDER:**

- **Educate yourself** (congratulations - you’re already on the right path by reading this). Visit our website for downloadable educational brochures, videos, other web links, and suggested reading. [www.InternationalBipolarFoundation.org](http://www.InternationalBipolarFoundation.org)

- **Seek treatment** from a reputable, board certified psychiatrist. Ask for referrals from your pediatrician, friends and mental health organizations. As a family caregiver, you can help by scheduling appointments, keeping track of medications and making sure they are taken as prescribed, and report any mood changes to the clinicians.

- **Meet with your loved one’s clinician**. Although clinicians are bound by laws of confidentiality, you can ask to go with your family member to the appointment.

- **Establish an atmosphere** where symptoms, medications and concerns can be discussed freely. Understanding the early phases of the illness will help everyone seek appropriate help when it is needed. Sometimes, those with bipolar illness aren’t aware when they are depressed or manic, although it is quite obvious to the caregiver. Pointing out when it is time to see the doctor or re-evaluate the medication needs to be done in an open, accepting way. Watch for triggers, and watch the behavior for clues of an upcoming change of mood or frame of mind. You are in the best position to recognize this.

- **Consider a contract** that you and your loved one with bipolar disorder agree on when he or she is calm, stable, and lucid. If the person is 18 years of age or over, you will generally not be able to learn much about his treatment because of HIPAA (The Health Insurance Portability and Accountability Act). Write out a statement describing agreed-upon treatment plans that you can show to your loved one when he or she is no longer rational or is refusing treatment.
• **Learn what services** are available from your school, community, church, and government.

• **Prepare a resource list**, even if you don’t think you need the service, (example) Psychiatric Emergency Response Team (PERT) in your area.

• **Enlist support and build a network.** This is extremely important, not only to help you with the day –to- day stressors and limit your isolation, but also to learn what is “normal.”

• **Look into a Special Needs Trust.** Wikipedia defines this as, “A special needs trust is created to ensure that beneficiaries who are disabled or mentally ill can enjoy the use of property which is intended to be held for their benefit.” In addition to personal planning reasons for such a trust (the person may lack the mental capacity to handle their financial affairs) there may be fiscal advantages to the use of a trust. Such trusts may also avoid beneficiaries losing access to essential government benefits.

• **Let your family member know that you care.** According to Dr. Andrea Bledsoe of Everyday Health, here are some things TO SAY and NOT TO SAY to someone with bipolar disorder:

  **Please don’t say:**
  1. You’re crazy.
  2. This is your fault.
  3. You’re not trying.
  4. Everyone has bad times.
  5. You’ll be okay — there’s no need to worry.
  6. You’ll never be in a serious romantic relationship.
  7. What’s the matter with you?
  8. I can’t help you.
  9. You don’t have to take your moods out on me — I’m getting so tired of this.

  **Some of the best words of encouragement include:**
  1. This is a medical illness and it is not your fault.
  2. I am here. We’ll make it through this together.
  3. You and your life are important to me.
  4. You’re not alone.
  5. Tell me how I can help.
  6. I might not know how you feel, but I’m here to support you.
  7. Whenever you feel like giving up, tell yourself to hold on for another minute, hour, day — whatever you feel you can do.
  8. Your illness doesn’t define who you are. You are still you, with hopes and dreams you can attain.
• Embrace the diagnosis, it’s not going to change, and may not improve. Medications can control it, but there is not yet a cure.

Caring for a loved one with bipolar disorder can be exhausting and disruptive to your daily patterns. More often than not, you may even overlook your own personal physical and emotional needs. First and foremost, you must take care of yourself. If you are not strong both physically and emotionally, you are no good to yourself or others. As they say in the airplane, “put your oxygen mask on first before assisting another.”

When you take on the role of caregiver, you add more than just one new hat to your repertoire. Now you are “nurse,” “doctor,” advocate, case manager PLUS your previous roles as wife, mother, father, sibling. Where there’s caregiving, there’s stress — that feeling that comes from having too many demands on your time. Chronic tension suppresses your immune system, making you more susceptible to illness. Research shows that caregivers’ stress hormone levels were 23 percent higher than those of their non-caregiving counterparts. They also had lower levels of disease-fighting antibodies. This is why it is crucial to find ways to take stress-relieving breaks.

So, what can we do to help ourselves in our role as caregivers?

1. **Exercise daily**, even if for only 20-30 minutes a day.

2. **Get adequate rest and sleep.** Adhering to a healthy sleep schedule may be difficult with all you are now dealing with. Here are some helpful hints to get those much needed Z’s: **Avoid** paying bills, having difficult discussions, or other stressful events in the evening. Try scheduling them early in the day.

   **Clear your mind.** Try imagining a calming scene bringing into play the five senses. Walk on the beach, listen to the waves, smell the salt air, feel the warm sun...

   **Take a warm bath** an hour or so before going to bed.

   **Smooth on some lavender cream** or put essential oil on a cotton ball near your pillow. Research shows that the scent of lavender eases anxiety and insomnia.
Listen to soothing music and turn off the TV and video games an hour before going to bed.

Make love, not war. Research shows that sex actually helps induce a sleepy state by releasing endorphins.

Try some slow, deep breathing. This type of breathing relaxes your body, oxygenates your blood and reduces the stress you feel.

3. Eat nourishing foods. Try to avoid caffeine, sugar, and processed foods. Avoid alcohol. Many believe alcohol helps them relax and sleep, however, alcohol disrupts the sleep cycle causing a nonrestful sleep.

4. Enjoy some “me” time. Plan ahead for some “me” time, whether it’s a walk with your dog, lunch with a good friend, or curling up with a good book. “Me” time can be very restorative.

5. Acknowledge and understand your negative emotions. Guilt, anger, isolation and resentment are normal feelings often associated with the caregiving process. If you notice yourself feeling this way, take a step back and remind yourself that these are part of the normal process.

6. Laugh. Enjoying a good belly laugh helps the body relax, raises your blood oxygen levels, produces endorphins, stimulates your internal organs, and boosts your immune system. Know a good joke?

7. Give yourself a pat on the back. You aren’t doing this to win a caregiver award but at the same time, you may not have realized how taxing it would be. If your loved one with bipolar disorder does not show his or her appreciation, don’t take it personally. Appreciate your own efforts and how they’re helping.

8. Find support. Whether you seek support from your church, a professional therapist, or simply check in with a cheery friend, support is essential. Caring for your loved one is not a one-person job, although we tend to think it is. Connect with others who are in the similar situation. Support groups can work wonders for your morale. Your situations always seem so much worse until you are in the company of those going through the same thing.

9. Redefine your priorities. Taking care of someone with bipolar disorder may leave you with little time and energy for yourself. Adjust your expectations of yourself and explain to others why your time and focus on them may need to change.

11. **Consider Supplements.** Low serotonin levels have been linked to low spirits, says Marie-Annette Brown, PhD, RN, of the University of Washington. Getting 400 micrograms of the B vitamin folic acid; 50 milligrams each of B1, B2 and B6; and 400 international units of vitamin D every morning has been shown to boost serotonin and, as a result, people's mood and energy. In Dr. Brown's research, combining these supplements with daily exercise and exposure to natural light helped women overcome depression.

12. **Have hope.** Remember, bipolar disorder is treatable and in most cases can be stabilized. Be prepared for the condition to worsen and/or improve at times. We won’t give up hope.

My dreams for Courtland have not disappeared, they have just changed.
Medication Chart

<table>
<thead>
<tr>
<th>Start Date</th>
<th>Name of Medication/Vitamin</th>
<th>Who Prescribed</th>
<th>Dosage</th>
<th>Frequency (morning and night, with food?)</th>
<th>Side Effects</th>
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Please use this chart for all the medications you are taking. Include all vitamins, over-the-counter and any homeopathic medications you may be taking, no matter what the reason. Keep this chart with you and share it with all of those on your treatment team including your pharmacist.
Gráfico de Medicina

<table>
<thead>
<tr>
<th>Fecha de Inicio</th>
<th>Nombre de Medicamento/Vitamina</th>
<th>¿Quién lo prescribió?</th>
<th>Dosage</th>
<th>Frecuencia (mañana y noche, ¿con comida?)</th>
<th>Efectos Secundarios</th>
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</thead>
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</table>

Favor de usar esta diagrama con todos los medicamentos que usted está tomando. Incluya todas las vitaminas, con y sin prescripción, y cualquier medicina homeopática que usted está tomando, independiente de la razón. Guarde esta diagrama y compartala con todos los miembros de su equipo de tratamiento.
Color Mood Chart

- **Yellow**
  - Energy
  - Joy
  - Alert

- **Blue**
  - Calm
  - Relaxed
  - Confidence

- **Green**
  - Normal
  - Safety
  - Healing

- **Orange**
  - Enthusiasm
  - Excited
  - Creativity

- **Purple**
  - Happy
  - Energized
  - Peaceful

- **Red**
  - Sad
  - Tired
  - Confused

- **Black**
  - Stressed
  - Tense
  - Worry

- **Gray**
  - Nervous
  - Anxious
  - Irritated
Medication Side Effect Checklist

__Blurred vision
__Changes in weight
__Swelling of hands and feet
__Dizziness
__High or low blood pressure
__Headaches or migraines
__Changes in menstruation or breasts
__Change in sexual functions
__Dry mouth
__Excess saliva
__Constipation
__Diarrhea
__Nausea

__Changes in urination patterns
__Muscle stiffness
__Trembling of muscles
__Trembling of tongue
__Tics or abnormal movement
__Tremors
__Decrease in muscle strength
__Jittery
__General fatigue

__Memory loss
__Difficulty in concentrating
__Anxiety
__Agitation
__Thoughts of suicide

If you experience any of the above side effects from your medication, please contact your treating physician.
Use this form to log your daily exercise to keep you motivated. Make multiple copies to use in order to maintain a consistent exercise program.

<table>
<thead>
<tr>
<th>WEEK OF _________________________</th>
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<tr>
<td><strong>MONDAY</strong></td>
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<td><strong>TUESDAY</strong></td>
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<td><strong>WEDNESDAY</strong></td>
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<td><strong>THURSDAY</strong></td>
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<td><strong>FRIDAY</strong></td>
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<td><strong>SATURDAY</strong></td>
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<td><strong>SUNDAY</strong></td>
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</table>
Use this form to log your daily food intake to encourage eating healthy eating habits. You may want to make multiple copies to use in order to maintain a consistent health food plan.
Doctor Contact Sheet

Primary Care Doctor
Name: _____________________________
Address: ___________________________
Phone: _____________________________

Psychiatrist
Name: _____________________________
Address: ___________________________
Phone: _____________________________

Therapist
Name: _____________________________
Address: ___________________________
Phone: _____________________________

Other
Name: _____________________________
Address: ___________________________
Phone: _____________________________
Questions For Your Doctor

Use this form to prepare for your upcoming doctor’s appointments. Make a list of questions you have for the doctor so that you use your limited time with them wisely and don’t forget to ask the important questions.

1. ________________________________________

2. ________________________________________

3. ________________________________________

4. ________________________________________

5. ________________________________________

6. ________________________________________
Resources

Below is a list of mental health resources in the USA. For a more comprehensive list and for our international database, please go to:
http://www.internationalbipolarfoundation.org/resources-and-links

**Suicide Prevention**

If you are in a crisis please call

Suicide Hotlines:

National Hopeline Network: (800) 784-2433
National Suicide Prevention Lifeline: (800) 273-8255
Suicide hotline, 24/7 free and confidential.
National Youth Crisis Helpline: (800) 442-4673
International Suicide Information: www.befrienders.org

**YELLOW RIBBON SUICIDE PREVENTION PROGRAM**

http://www.yellowribbonsd.org/

**Resources in the U.S.A.**

**ACTIVE MINDS**
(202) 332-9595
Email: alison@activeminds.org
http://www.activeminds.org

**AMERICAN ACADEMY of CHILD and ADOLESCENT PSYCHIATRY (AACAP)**
Doctor Directory

Parents’ Medication Guide for Bipolar Disorder in Children & Adolescents

**AMERICAN PSYCHIATRIC ASSOCIATION**
Toll-Free: 1-888-35-PSYCH or 1-888-35-77924
From outside the U.S. and Canada call: 1-703-907-7300 Email: apa@psych.org
http://www.psych.org/

**AMERICAN PSYCHOLOGICAL ASSOCIATION**
www.apa.org

**BIPOLAR SIGNIFICANT OTHERS**
http://www.bpsso.org/

**BPCHILDREN**
www.bpchildren.org

**BRAIN and BEHAVIOR RESEARCH FOUNDATION (formerly NARSAD)**
http://bbrfoundation.org/
DEPRESSION AND BIPOLAR SUPPORT ALLIANCE
USA Toll-free: (800) 826-3632
Fax: (312) 642-7243 http://www.dbsalliance.org

INTERNATIONAL BIPOLAR FOUNDATION
http://www.internationalbipolarfoundation.org

INTERNATIONAL MENTAL HEALTH RESEARCH ORGANIZATION (IMHRO)
https://www.imhro.org/

JUVENILE BIPOLAR RESEARCH FOUNDATION
Phone: 866-333-JBRF (National Toll-Free) Fax: 973-275-0420
Email:info@jbrf.org http://www.jbrf.org

MCMAN’S DEPRESSION & BIPOLAR WEB
http://www.mcmanweb.com/

MENTAL HEALTH AMERICA
Phone (703) 684-7722 Toll free (800) 969-6642
Fax (703) 684-5968
http://www.nmha.org/

NATIONAL ALLIANCE ON MENTAL ILLNESS
Member Services: (888) 999-NAMI (6264) Information Helpline:
1 (800) 950-NAMI (6264) http://www.nami.org/
Patient Prescription Drug Assistance Programs:
http://www.nami.org.Template.cfm?section=about_medications&Template=/Cont
entManagement/contentDisplay.cfm&ContentID=19169

NATIONAL ASSOCIATION OF THERAPEUTIC SCHOOLS and PROGRAMS
http://natsap.org/

NATIONAL INSTITUTE OF MENTAL HEALTH
Phone Numbers
301-443-4513 (local) 1-866-615-6464 (toll-free) 301-443-8431 (TTY) 1-866-415-8051
(TTY toll-free) 301-443-4279 (Fax)
http://www.nimh.nih.gov

SCHOLARSHIPS
http://www.reintegration.com
http://peacecharlie.com/
http://www.mhatc.org/scholarships.php

SHARECARE
www.sharecare.com
STANLEY MEDICAL RESEARCH INSTITUTE
http://www.stanleyresearch.org/dnn/

WebMD DRUG DATABASE
http://www.webmd.com/drugs/

WORLD FEDERATION FOR MENTAL HEALTH
http://www.wfmh.com

International Mood Disorder Resources
Please go to: http://www.internationalbipolarfoundation.org/resources-and-links