LEARNING MADE EASY

4th Edition

Bipolar Disorder

for dummies®

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Reclaim your life from mania and depression

Discover effective medications and therapies

Support a loved one with bipolar disorder

Candida Fink MD

Board Certified Child and Adult Psychiatrist

Joe Kraynak

Wordsmith

Bipolar Disorder

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by Candida Fink and Joe Kraynak

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Bipolar Disorder For Dummies®, 4th Edition

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Contents at a Glance

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Introduction

Imagine yourself cruising down the highway at a comfortable speed of 65 miles per hour when your cruise control goes berserk. The speedometer climbs to 75 and then 85 . . . you hit the button to cancel . . . tap the brakes . . . 90 . . . nothing slows you down . . . 95 . . . your car is shaking and weaving . . . 100 . . . people are honking . . . 105 . . . police cars are chasing you . . . 110 . . . your spouse is yelling at you to SLOW DOWN . . . 115 . . . 120 . . . .

Or imagine the opposite: You're driving through town in a 30-mile-per-hour speed limit zone. Nobody's in front of you — you're practically pushing the accelerator through the floor — but your car can only creep along at 3 miles per hour. Your neighbors are honking, passing you on the right — on bicycles — and giving you dirty looks and other gestures of discontent.

When you have bipolar disorder, your brain's accelerator is stuck. At full speed, it launches you into a manic episode. In low gear, it grinds you down into a deep depression. If this were a situation with your heart, somebody would call an ambulance; doctors and nurses would flock to your bedside; loved ones would fly in from other states; and you'd get flowers and fruit baskets. But when your brain is stuck in park or overdrive, people tend to think you're lazy, you've snapped, or you're too weak to deal with life. Instead of flowers and fruit baskets, you get a pink slip and divorce papers.

The good news is that the mind mechanics — psychiatrists, psychologists, and therapists — have toolboxes packed with medications and therapies that can regulate your brain's accelerator. In this book, we reveal those tools along with self-help measures you can take to achieve and maintain mood stability and to help yourself feel a whole lot better.

About This Book

Although psychiatrists, psychologists, and therapists are better equipped than ever to treat bipolar disorder, studies increasingly show that the more involved patients and their loved ones are in the treatment plan, the better the outcome. Our goal in writing this book is to make you a well-informed patient or support person and to empower you to become a key player on the treatment team.

Organized in an easy-to-access format and presented in plain English, the newest edition of *Bipolar Disorder For Dummies* brings you up to speed on bipolar disorder, explaining what it is, what causes it, and how it's diagnosed and treated. We present the most effective treatments, explain why preventive treatment plays such a critical role in keeping symptoms at bay, and point out the positive prognosis that you can expect with the right combination of medication, therapy, lifestyle adjustments, and support.

In addition to comprehensive coverage of bipolar disorder, this book contains numerous first-person accounts from people living with bipolar disorder and their loved ones. These stories give you a glimpse inside the minds of people living with bipolar disorder along with additional insight into how people deal with the challenges in their own lives.

Foolish Assumptions

When you are (or a loved one is) diagnosed with bipolar, you automatically become a rank beginner. You never needed information about this illness before and probably had little interest in the topic. Now you have to get up to speed in a hurry. With that in mind, we assume that you know very little about bipolar disorder. If you've been to a doctor or therapist and received a diagnosis, however, you know at least a little. And if you've already researched the topic, you may know more than most people. But we assume that however much you do know about the topic, you want to know more, and you're committed to getting information from a reliable source.

We also assume that you or someone you know has bipolar or that you're at least somewhat curious about the condition. The more the disorder affects you, your family, or someone else you know, the more this book can help.

Finally, we assume that you have a sense of humor. Yes, bipolar disorder can be brutal, but laughter is one tool that enables you to rise above the absurdity and frustration of dealing with it.

Icons Used in This Book

Throughout this book, the following icons appear in the margins to cue you in to different types of information that you may or may not care to see:

REMEMBER

If you happen to forget the rest of the stuff in this book, at least remember what we mark with these icons.

TIP

Tips provide insider insight from behind the scenes. When you're looking for a better, faster way to do something, check out information flagged with this icon.

WARNING

"Danger, Will Robinson, danger!" This icon appears when you need to be extra vigilant or seek professional help.

BIPOLAR BIO

Throughout the book, we feature cameos of people living with bipolar disorder. We use this icon to flag the stories they shared.

Beyond the Book

This book's Cheat Sheet offers assistance in identifying bipolar disorder, a list of bipolar medications, a guide for maintaining mood stability, and some advice on helping a loved one with bipolar disorder. You can get it simply by going to `www.dummies.com` and searching for *Bipolar Disorder For Dummies Cheat Sheet*.

We also offer some bonus goodies at `finkshrink.com/bonus`. There you can find a mood tracking chart, a bipolar disorder glossary, and additional articles related to bipolar disorder, including "Ten Questions to Ask a Psychiatrist or Therapist," and "Helping a Loved One with Bipolar Disorder: Key Principles."

Where to Go from Here

Think of this book as an all-you-can-eat buffet. You can grab a plate, start at the beginning, and feast on one chapter after another, or you can dip into any chapter and pile your plate high with the information it contains.

If you want a quick overview of bipolar disorder, check out the chapters in Part 1. Before you visit a psychiatrist for a diagnosis, see Chapters 4 and 5 to find out what to expect during the diagnostic process and be sure that you're leaving the office with a comprehensive treatment plan. For information and insight into the medications used to treat bipolar disorder, head to Chapter 7. Turn to the chapters in Part 4 for self-help strategies. If you have a friend or family member with bipolar, skip to Part 6. Use the index to look up any bipolar term you're unfamiliar with and find out where we cover it in the book. Wherever you choose to go, you'll find plenty of useful information.

1 Getting Started on Your Bipolar Journey

IN THIS PART . . .

Understand what bipolar disorder is and what it isn't according to the diagnostic categories spelled out in the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition*-Text Revision *(DSM-5-TR)* — the book psychiatrists look to when developing their diagnosis.

Explore genetic and nongenetic factors, such as physical and emotional stress, that likely team up to trigger the manic and depressive episodes characteristic of bipolar disorder.

Take a look inside the different parts of the brain to understand the biology of bipolar disorder.

Get a bird's-eye view of the diagnosis and treatment of bipolar disorder, so you know what's involved and the sort of outcome you can expect when treatment proceeds according to plan.

IN THIS CHAPTER

- Meeting the manual used to diagnose bipolar disorder
- Recognizing the two "poles" of bipolar: mania and depression
- Telling the difference between bipolar I, bipolar II, and other types
- Augmenting the diagnosis with specifiers and distinguishing it from other conditions
- Diagnosing bipolar in children . . . or not

Chapter 1
Grasping Bipolar Disorder: Symptoms and Diagnosis

When you initially encounter bipolar disorder, one of the first questions you're likely to ask is, "What is it?" The short answer is this: *Bipolar disorder* is a medical illness characterized by alternating periods of persistent abnormally elevated and depressed mood. The second question that most people ask is, "Can I get tested for it?" And the short answer is no. Doctors arrive at a diagnosis by conducting a physical and mental status examination; taking a close look at a person's symptoms, medical history, and family history; and ruling

out other possible causes. For guidance, doctors use a book called the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*), which presents the diagnostic criteria for determining whether a person is likely to have bipolar disorder.

This chapter digs deep into the *DSM* to reveal what bipolar disorder is and isn't. It describes what elevated and depressed moods look like and provides you with the details you need to tell the difference between the various bipolar diagnoses, including bipolar I, bipolar II, and a related cycling mood disorder called cyclothymia. We discuss diagnostic *specifiers* that enable doctors to more precisely describe a person's symptoms and inform their treatment decisions. We distinguish bipolar disorder from conditions that may have similar symptoms and discuss other conditions that commonly accompany bipolar disorder, such as alcohol and substance use disorder. We wrap up with a discussion of the challenges of diagnosing bipolar in children and young adults.

Cracking Open the Diagnostic Manual: DSM-5-TR

When a doctor in the United States diagnoses a mental illness, such as bipolar disorder, they turn to the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders (DSM)* for guidance. This manual defines numerous patterns of symptoms and illnesses that are supported by scientific research and a consensus among a wide variety of experts. During the writing of this book, the APA recommends using *DSM-5-TR,* the fifth edition text revision, which was published in March 2022. Don't be surprised if you see references to earlier editions, such as *DSM-IV,* the fourth edition.

Throughout this chapter, we describe the symptoms of bipolar disorder according to the diagnostic criteria presented in *DSM-5-TR.* Although the fundamental criteria haven't changed much over the past decade, some of the language has been modified and criteria have been added in the most recent edition to help doctors arrive at and describe a person's condition more precisely.

REMEMBER

Diagnosis isn't a simple matter of matching a list of symptoms to a label. Doctors are expected to use the *DSM* along with their training, clinical experience, and professional judgment to arrive at the correct diagnosis.

THE INTERNATIONAL CLASSIFICATION OF DISEASES (ICD)

Doctors in countries throughout the world rely on the World Health Organization's (WHO) *International Classification of Diseases*, a classification system for all health issues. Chapter V of the *ICD* specifically addresses mental and behavioral disorders. The first edition of DSM (DSM-I), in 1952, grew out of ICD-6, which was the first ICD to include a section on mental disorders. Since 1980, Medicare and Medicaid (and therefore all other insurers) have required an ICD-9 code to be submitted for payment to be made. The DSM-III was released at the same time, and it designated ICD-9 codes for all psychiatric diagnoses. When DSM-5 was released in 2013, the authors added ICD-10 codes in anticipation of the 2015 transition of all medical billing systems to ICD-10. Although the two systems have always had their differences, the current systems are closely aligned.

The APA and WHO work together closely to coordinate their efforts. So, in clinical practice, a doctor using one manual should arrive at a similar diagnosis as a doctor using the other.

Exploring the Poles of Bipolar Disorder: Mania and Depression

Bipolar diagnoses rely heavily on the type of mood episode(s) a person is experiencing or has experienced in the past, so to understand the different diagnoses, you need to know what constitutes a mood episode — specifically a manic, hypomanic, and major depressive episode. In the following sections, we present the *DSM-5*-TR diagnostic criteria for each type of mood episode.

Manic episode

A *manic episode* is a period of abnormally elevated energy and mood that interferes with a person's ability to function as typical for that individual. Merely having some manic symptoms isn't the same as experiencing a manic episode. The symptoms must meet the following four criteria.

Distinct period

The episode must last for at least one week *or* require hospitalization, and it must be characterized by atypically and persistently elevated, expansive, or irritable mood and atypically and persistently increased goal-directed activity or energy that's "present most of the day, nearly every day."

Three or more manic symptoms

Three of the following symptoms must also be present during the week of mania (four, if the mood is irritable rather than elevated or expansive). The symptoms must be present to a significant degree and represent a change from the person's usual behavior.

- Markedly inflated self-esteem or grandiosity
- Decreased need for sleep (for example, feeling well rested after three hours or less of sleep)
- Excessive talking or the need to talk continuously (pressured speech)
- *Flight of ideas* — when thoughts flow rapidly and topics shift rapidly and indiscriminately — and/or the feeling that one's thoughts are racing
- Distractibility — attention too easily drawn to unimportant or irrelevant external stimuli as reported or observed
- Significant increase in goal-directed activity (socially, at work or school, or sexually) or *psychomotor agitation* — purposeless, non-goal-directed activity)
- Excessive involvement in activities that have a high potential for painful consequences, including sexual indiscretions, unrestrained shopping sprees, and/or overly optimistic investments

Functional impairment

The mood episode must be severe enough to

- Impair the person's ability to socialize or work, or
- Require hospitalization to prevent the person from harming themselves or others, or
- Cause psychotic features (paranoia, hallucinations, or delusions) indicating that the person is out of touch with reality (see the section, "Presence or absence of psychosis," later in this chapter)

Not caused by something else

For a manic episode to count toward bipolar diagnosis, the mania must satisfy the following conditions:

- **The mania can't be exclusively drug-induced or attributed to medical treatments.** For example, if you're taking an antidepressant, steroid, or

cocaine at the time you experience manic symptoms, then the episode doesn't count toward a diagnosis of bipolar disorder, unless symptoms persist after the effects of the substance have worn off.

- **The mania isn't attributable to another medical condition.** Mania caused by a medical condition is identified as a separate form of bipolar disorder, as described in the later section, "Distinguishing Types of Bipolar Disorder."

Hypomanic episode

A *hypomanic episode* requires the same number and types of symptoms as a manic episode that we discuss in the preceding section. For instance, the symptoms must represent a distinct change from a person's usual behavior patterns, and the changes must be observable by others. However, a hypomanic episode differs from a manic episode in the following ways:

- May be shorter in duration (just four consecutive days is enough to qualify as a hypomanic episode)
- Doesn't cause severe functional impairment
- Doesn't require hospitalization
- Doesn't include psychosis


REMEMBER

Hypomania doesn't typically result in serious relationship problems or extremely risky behavior, but it may make others feel uncomfortable. On the other hand, hypomania can make you more engaging, so you may become the center of attention, which may feel good to some people or awful to others. For some people, hypomania creates periods of high creativity and/or productivity that are positive experiences.

Major depressive episode

During a *major depressive episode*, you may feel like you're swimming in a sea of molasses. Everything is slow, dark, and heavy. To qualify as a major depressive episode, five or more of the following symptoms must be present for at least two weeks straight. These symptoms must be changes from usual behavior, and the episode must include at least one symptom of depressed mood or loss of interest or pleasure.

- Depressed mood most of the day nearly every day
- Markedly diminished interest nearly every day in activities previously considered pleasurable, which may include sex

- Notable increase or decrease in appetite nearly every day or a marked change in weight (five percent or more), up or down in a span of one month or less that isn't due to planned dietary changes
- Sleeping too much or too little nearly every day
- Psychomotor agitation or slowing (moving and thinking uncharacteristically slowly or experiencing mental and physical agitation) nearly every day, which is observable by others and not just internal sensations
- Daily fatigue
- Feelings of worthlessness, excessive guilt, or inappropriate guilt nearly every day
- Uncharacteristic indecisiveness or diminished ability to think clearly or concentrate on a given task nearly every day, experienced internally and/or observed by others
- Recurrent thoughts of death or suicide (*suicide ideation*), a suicide attempt, or a plan to commit suicide

These symptoms must cause significant problems in your day-to-day life and function to qualify as indicators of a major depressive episode. If they occur solely in response to use of a medication or substance, or another medical condition, then the episode has its own category, such as s*ubstance/medication-induced depressive disorder* or *depressive disorder due to another medical condition*, and, therefore, doesn't count toward a diagnosis of either unipolar or bipolar depression.

REMEMBER

Of course, people who experience a significant loss or crisis in their lives may have many of these same symptoms. Doctors must rely on their clinical experience, observations, and what their patient tells them to determine whether the person is experiencing a major depressive episode or intense sadness that's a normal part of the grieving process. In addition, cultural factors may play a role in how deeply a person feels and expresses emotion in response to a loss.

Not your average moodiness

Most people experience mood fluctuations to some acceptable degree, but bipolar mood episodes are amplified and extend far beyond the usual levels of discomfort — to the point of impairing a person's ability to function and enjoy life. Episodes associated with bipolar disorder make a person think, feel, speak, and behave in ways that are extremely uncharacteristic of the individual. And they may drag on for weeks or even months. They strain relationships, disrupt lives, and often land people in the hospital or in legal trouble. And they're not something a person can just snap out of. Figure 1-1 illustrates the difference between normal mood fluctuations and those related to bipolar disorder.

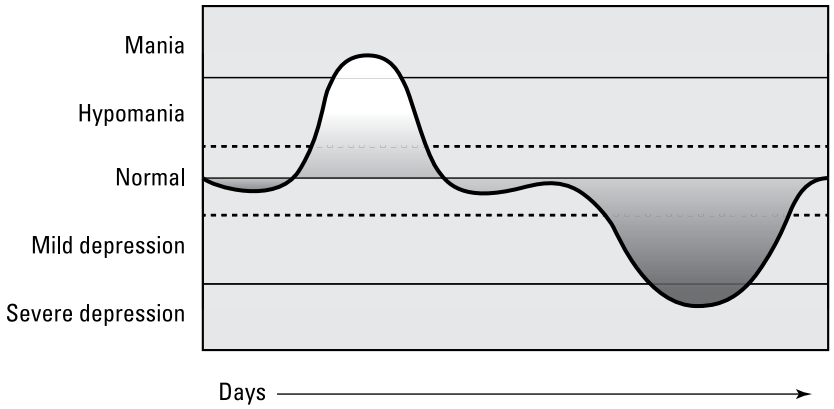

FIGURE 1-1: Normal mood variation versus bipolar mood episodes.

Not attributable to other psychotic disorders

To make a diagnosis of bipolar I, bipolar II, or cyclothymia, the doctor must determine that at least one manic episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum or other psychotic disorder.

Schizoaffective disorder is a separate diagnosis from bipolar disorder. With schizoaffective disorder, psychotic symptoms persist after the mood episode resolves. The point is to clarify that a bipolar diagnosis can't be made if symptoms include disordered thinking and reality testing that aren't part of a mood episode.

For more about psychosis, see "Presence or absence of psychosis," later in this chapter. The other psychotic disorders listed in that section do not include mood symptoms in their diagnostic criteria. If someone with one of these conditions experiences a manic episode on top of their pre-existing diagnosis, it would not be coded as bipolar disorder.

Distinguishing Types of Bipolar Disorder

Bipolar disorder wears many masks. It can be happy, sad, fearful, confident, sexy, or furious. It can seduce strangers, intimidate bank tellers, throw extravagant parties, and steal your joy. However, based on research, psychiatrists have managed to bring order to the disorder by grouping the many manifestations of bipolar into categories that include bipolar I, bipolar II, and cyclothymic disorder. In the following sections, we offer guidance for distinguishing among the many different types of bipolar disorder.

YOU'RE IN GOOD COMPANY

Bipolar disorder is often considered the Cadillac of brain disorders because so many famous and creative individuals — Vincent van Gogh, Abraham Lincoln, Winston Churchill, and Virginia Woolf — are thought to have struggled with it and perhaps even benefited from it. This may be small comfort when your symptoms are severe and painful, but it can give you a sense of kinship with people who made a positive impact despite this disorder. Maybe it can motivate you to find and focus on the talents that make you stand out in this world.

More good news: With advances in treatment, people with bipolar no longer have to swap creativity for good health. In fact, most people with bipolar find that they're more consistently creative and productive with the right combination of medication, self-help, and therapy.

Bipolar I

To earn the *bipolar I* label, you must experience at least one manic episode sometime during your life (see "Manic episode," earlier in this chapter). A major depressive episode isn't required for the bipolar I diagnosis, although most people with bipolar I have experienced one or more major depressive episodes at some point in their lives. In fact, depression is actually the phase of bipolar that causes the most problems for people with bipolar.

REMEMBER

Bipolar I requires a manic episode. If you've never had a manic episode, you don't have bipolar I. If you've only ever had a hypomanic episode, you don't have bipolar I.

Bipolar II

Bipolar II is characterized by one or more major depressive episodes with at least one hypomanic episode sometime during the person's life. The major depressive episode must last at least two weeks, and the hypomania must last at least four days. (For more about what qualifies as hypomania, check out the earlier section "Hypomanic episode.")

Although hypomanic episodes on their own don't cause severe functional impairment, the diagnosis of bipolar II does entail impaired function. The criteria state that the depressive episodes or the unpredictability caused by frequent alternation between depression and hypomania causes significant distress or impairment in important areas of function.


REMEMBER

Bipolar II requires at least one major depressive episode and one hypomanic episode that together or apart cause significant distress or impairment in important areas of function. If you've ever had a manic episode that can't be attributed to some other cause, then you have bipolar I, not bipolar II.

Cyclothymic disorder

Cyclothymic disorder involves multiple episodes of hypomania and depressive symptoms that don't meet the criteria for a manic episode or a major depressive episode in intensity or duration. Your symptoms must last for at least two years (or one year in children or adolescents) without more than two months of a stable, or *euthymic,* mood during that time to qualify for a cyclothymic disorder diagnosis.

Additionally, the symptoms must not be caused by substances or a medical condition and cannot be attributed to schizoaffective disorder. And the pattern of shifting mood states must cause significant distress or impairment in important areas of function.


REMEMBER

Some people with cyclothymic disorder eventually experience a full-blown manic or major depressive episode, changing the diagnosis to either bipolar 1 disorder or unipolar major depressive disorder. Medical supervision is important so treatment planning can change if symptoms change.

Substance/medication-induced bipolar disorder

The *substance/medication-induced bipolar disorder* diagnosis applies when someone presents with all the symptoms of bipolar disorder (elevated, expansive, or irritable mood with or without depression), but only in the context of acute substance intoxication or withdrawal or medication effects.

Bipolar and related disorder due to another medical condition

When a person's mania or hypomania can be traced to another medical condition, such as *hyperthyroidism* (overactive thyroid), based on medical history, physical examination, or lab results, the person may receive a diagnosis of bipolar and related disorder due to another medical condition, and the doctor will identify that other medical condition.

Other specified bipolar and related disorder

Introduced in *DSM-5*, this category enables doctors to diagnose bipolar disorder when symptoms characteristic of bipolar disorder significantly impair normal function or cause considerable distress, but don't quite meet the full diagnostic criteria for the other bipolar diagnostic classes. Here are some examples:

- Someone with major depression experiences hypomanic episodes that aren't long enough or don't include enough symptoms to meet criteria for the full bipolar II diagnosis.
- Cyclothymic symptoms that haven't gone on for the full two years needed to make the diagnosis.
- Hypomanic episodes that cause functional problems but aren't associated with major depression.
- Manic symptoms superimposed on schizophrenia or other psychotic disorder, but don't meet criteria for schizoaffective disorder.

REMEMBER

All bipolar diagnoses require that the symptoms cause significant clinical distress or functional impairment. Although doctors certainly want to diagnose and treat people with bipolar disorder and other conditions covered in the *DSM*, they don't want to overdiagnose and overmedicate. Treatment is provided only when it begins to disrupt a person's ability to function normally and enjoy life's pleasures.

Unspecified bipolar disorder

The *unspecified bipolar disorder* designation is used to diagnose individuals who present with symptoms characteristic of bipolar disorder that cause clinically significant distress or functional impairment but don't fully meet the diagnostic criteria for the other bipolar disorder diagnostic categories. This diagnosis is used instead of *other specified bipolar and related disorder* when a doctor, for whatever reason, doesn't want to go into detail about why the criteria for a specific bipolar diagnosis hasn't been met; for example, in emergency room settings by doctors who need to diagnose and treat the symptoms immediately and may not have the time or sufficient details to make a more specific diagnosis.

CLARIFYING THE PURPOSE OF THE BIPOLAR DIAGNOSIS

Your doctor doesn't use *bipolar disorder* to label you or minimize your worth as a human being. The diagnosis provides a convenient way to refer to your condition among insurance and healthcare providers. It helps all the people involved in your treatment to quickly recognize the illness that affects you and to provide the appropriate medications and therapy. You aren't bipolar disorder. Bipolar disorder is an illness you have, and you can manage it with the right treatments.

Digging Deeper with Bipolar Specifiers

The *DSM* provides *specifiers* to help doctors more fully describe a person's condition. Think of specifiers as adjectives used to describe nouns, the noun being the primary diagnosis.

Specifiers indicate the nature of the person's current or most recent episode, the severity of symptoms, the presence or absence of psychosis, the course of the illness, and other features of the illness, such as anxiety or a seasonal pattern. Specifiers serve two useful purposes:

- They allow for the subgrouping of individuals with bipolar disorder who share certain features, such as people who have bipolar disorder with anxious distress.
- They convey information that's helpful and relevant to the treatment and management of a person's condition. For example, someone who has bipolar with anxious distress likely needs treatment for both bipolar and anxiety.

In the following sections, we describe the bipolar specifiers in greater detail.

Current or most recent episode

This specifier identifies the most active or recent phase of illness, with a primary goal of identifying the most appropriate treatment. These specifiers are coded in the patient's medical record, where they're also important for insurance reimbursement purposes:

- **Manic:** The current or most recent episode is primarily mania.
- **Hypomanic:** The most recent or current episode is primarily hypomania.

- **Depressed:** The most recent or current episode is primarily depression.
- **Unspecified:** The most recent or current episode is unspecified, in which case severity and other specifiers presented in the following sections are not used.

Severity of illness

Severity specifiers have been part of the diagnostic system for a long time, and they continue to be part of the *DSM-5*-TR. They assist in treatment planning and in following the course of illness; for example, a patient moving from severe to mild symptoms suggests that the acute episode is resolving. Historically doctors making the diagnosis would use their clinical judgment and experience to estimate severity. *DSM-5*-TR encourages the use of more objective data, particularly by using scales that patients or doctors fill out, to provide more consistent ratings across patients and across treatment providers.

In DSM-5, severity ratings were the same for manic and depressive episodes. But because mild depression has only minor effects on functioning, and any manic episode has a major effect on functioning, DSM-5-TR introduces separate severity ratings for depression in mania.

For major depressive episodes, the severity ratings are as follows:

- **Mild:** Few, if any, symptoms in excess of those required to meet the diagnostic criteria are present, the intensity of the symptoms is distressing but manageable, and the symptoms result in minor impairment in social or occupational functioning.
- **Moderate:** The number of symptoms, intensity of symptoms, and/or functional impairment are between those specified for "mild" and "severe."
- **Severe:** The number of symptoms is substantially in excess of those required to make the diagnosis, the intensity of the symptoms is seriously distressing and unmanageable, and the symptoms markedly interfere with social and occupational functioning.

For manic episodes, the severity ratings are now as follows:

- **Mild:** The manic episode meets the minimum symptom criteria.
- **Moderate:** The manic episode causes a very significant increase in impairment.
- **Severe:** The person experiencing the manic episode needs nearly continual supervision to prevent harm from being done to themselves and/or others.

Presence or absence of psychosis

Perhaps the most frightening accompaniment to depression or mania is *psychosis*, which may include delusional thinking, paranoia, and hallucinations (typically auditory as opposed to visual). Although psychosis isn't a necessary part of the bipolar diagnosis, it can accompany a mood episode. The extremes of depression and mania are sometimes associated with profound changes in the reality-testing system of the brain, which lead to severe distortions in perception and thinking. When making a diagnosis of bipolar disorder, the doctor will specify whether any psychotic symptoms accompany the mood symptoms. If you experience psychosis during a mood episode you may experience any of the following symptoms:

- Feel as though you have special powers
- Hear voices that other people can't hear and that make you believe they're talking about you or instructing you to perform certain acts
- Believe that people can read your mind or put thoughts into your head
- Think that the television, newspaper, or Internet is sending you special messages
- Think that people are following or trying to harm you when they're not
- Believe that you can accomplish goals that are well beyond your abilities and means
- Believe that you have or can hurt others because you're a terrible person
- Believe that you're guilty of things that are outside your control


REMEMBER

Psychotic symptoms usually reflect the pole of the mood disorder. So, if you're in a major depressive episode, the psychotic thoughts are typically dark and negative; in a manic state, the symptoms tend to be more about super strengths, abilities, and insights. However, this doesn't always hold true; psychotic content can be all over the map.

Course of illness

This specifier overlaps with the presence or absence of psychosis when a diagnosis is coded. If the illness is active, the specifier notes whether psychosis is present.

If the illness is moving out of active phase, then one of the following specifiers is used:

- **In partial remission:** Symptoms have started to decline in severity and/or frequency, function has improved to some degree, and these improvements have been sustained over at least several weeks.
- **In full remission:** Function has returned to levels that existed before the illness, symptoms are much less active, and this state has sustained for several weeks to months.

Additional features that doctors use as specifiers in making the diagnosis

Bipolar is often accompanied by other conditions, such as anxiety, and may have some features that vary among those who have the diagnosis. The following specifiers are used to label these extras:

- **With anxious distress:** Anxiety commonly co-occurs with bipolar disorder even in the absence of a full-blown anxiety disorder, and the presence of significant anxiety symptoms may influence treatment decisions.
- **With mixed features:** Mood episodes in bipolar disorder often aren't completely clear-cut. People with mostly manic symptoms may still express symptoms of depression, such as guilt and hopelessness or suicidal thoughts. Or someone who is primarily depressed may have a lot of physical agitation and racing thoughts characteristic of mania. This specifier accounts for these types of presentations, which may affect treatment planning.
- **With rapid cycling:** *Rapid cycling* is a specifier that identifies bipolar disorder characterized by four or more mood episodes in a 12-month period. This subtype is thought to be more severe and often doesn't respond as well to medications.
- **With melancholic features:** This subtype of depression is quite severe. It includes features such as very low mood, with characteristics of despair and despondency, that shows little or no response to improved external circumstance, very low energy, almost no interest in or response to pleasurable stimuli, agitation or slowing of movements and thoughts, *diurnal variation* (mood and energy worse in the morning), sleep interruptions including early morning awakening, impaired thinking and concentration, and severe loss of appetite or weight loss. It's really the most extreme presentation of most or all the symptoms of a major depressive episode.

- **With atypical features:** This specifier describes a pattern of depression symptoms that used to be considered less typical of depression but are now recognized as a frequent feature of depression. The name has stuck though. Symptoms include responsiveness to changes in external stimuli — feeling better if things improve or worse if something bad is going on, increased appetite or weight gain, excessive sleep and severe fatigue, feelings of *leaden paralysis* (heaviness in the limbs), and longstanding patterns of interpersonal rejection sensitivity.
- **With catatonia:** *Catatonia* is a state of minimal responsiveness to the environment and abnormal thinking and movement. It can present as extremely slowed thinking, moving, and speaking or agitated, repetitive nonsensical movements and speech. Catatonia is an emergency medical condition that can occur with many psychiatric conditions, including depressive or manic poles of bipolar disorder. It can also be associated with medical conditions and autism.
- **With peripartum onset:** This specifier is used when the onset of the bipolar mood episode is any time during pregnancy or in the four weeks after delivery, which is important because pregnancy and childbirth influence treatment decisions. (See Chapter 10 for details.)
- **With seasonal pattern:** This label indicates a well-established pattern of mood episodes that start and end at specific times of the year.

Distinguishing Bipolar from Conditions with Similar Symptoms

Before arriving at any medical diagnosis, doctors review a *differential diagnosis* to consider all the possible causes of the presenting symptoms. In bipolar disorder, the differential diagnosis often includes the following conditions that may involve symptoms similar to those of bipolar disorder:

- **Unipolar depression:** A major depressive episode without a history of mania or hypomania doesn't qualify as bipolar disorder. However, if you experience depression and you have a history of bipolar disorder in any first-degree relatives (parent, sibling, or child), your doctor may want to monitor you closely if you're prescribed an antidepressant, because of the increased risk that you may have bipolar disorder that hasn't shown its manic pole yet. Additionally, the differentiation between unipolar and bipolar depression can be quite difficult. If a symptom such as agitation is present, it can be part of a mixed-mood episode of bipolar disorder, but it can also just be part of

unipolar depression. Another difficult diagnostic situation is when during recovery from depression a person has periods of feeling particularly well. Are these periods symptomatic of hypomania or simply a strong recovery from a depressive episode?

- **Anxiety:** Anxiety may make you feel wired or tired with racing thoughts, poor sleep, and irritability, all of which overlap with symptoms characteristic of depression and mania. Many people with bipolar disorder also have an anxiety disorder, so these conditions can happen together, but determining whether anxiety is the primary disorder rather than bipolar is important.
- **Attention deficit hyperactivity disorder (ADHD):** ADHD and mania are both characterized by impaired concentration and attention, impulsivity, high energy levels, and problems with organization and planning. However, for those with bipolar disorder, these symptoms are present only during a manic episode, not all the time. In addition, diagnostic criteria for hypomania or mania include an increase in goal-directed behavior, a decreased need for sleep, and grandiose thinking; ADHD doesn't include any of these. The pattern of symptoms, especially the episodic nature of mood episodes, is a key way to distinguish bipolar disorder from ADHD.
- **Schizophrenia and schizoaffective disorders:** Schizophrenia and schizoaffective disorders are thought disorders characterized by psychosis — delusional thinking, paranoia, and hallucinations (usually auditory, rarely visual). Although psychosis may accompany mania and depression, in bipolar, psychosis is present only during an acute mood episode and goes away during times of normal mood. In schizoaffective disorders, psychosis occurs for at least some period of time separate from the mood episodes. Schizophrenia and related disorders are characterized by persistent and severe disruptions of thinking and reality testing unrelated to mood episodes.
- **Borderline personality disorder (BPD):** BPD shares a few characteristics with bipolar. For instance, someone with BPD may be impulsive, irritable, and argumentative much like someone who's experiencing a manic episode. However, BPD mood shifts are typically abrupt, short-lived, and in response to an external trigger, such as a conflict with another person; bipolar mood shifts are slower to develop, last longer, and may not appear to be in response to anything external. The rages that often characterize BPD aren't equivalent to mania. BPD symptoms are chronic, representing the person's baseline behaviors, whereas bipolar symptoms are episodic and different from the person's usual behavior patterns.
- **Other medical conditions:** Many medical conditions — including brain tumors, meningitis, encephalitis, seizure disorders, stroke, brain injury, various hormonal conditions, and autoimmune disorders, can produce symptoms similar to those of bipolar mania or depression. Infections, including COVID 19, can also affect bipolar symptoms.

- **Mood instability caused by medications, alcohol, or drugs:** A variety of prescription medications, alcohol, marijuana, and street drugs can affect moods. You and your doctor must rule out these possible causes before arriving at a diagnosis of bipolar disorder.


REMEMBER

Be sure to tell your doctor if anyone in your immediate or close extended family has been diagnosed with bipolar disorder, schizophrenia, or substance use disorder, especially if you're seeking treatment only for depression. A close family history of these conditions increases the risk that you may eventually experience a manic or hypomanic episode resulting in a bipolar diagnosis. Medication treatment of unipolar and bipolar depressions is different — treatment with antidepressant alone in someone with bipolar disorder can trigger a shift to mania. Knowing about a family history of bipolar, you and your doctor can make a plan for close monitoring of your response to treatment for depression.

Considering Comorbidity: When Bipolar Coexists with Other Conditions

Bipolar disorder carries the distinction of having some of the highest rates of *comorbidity* with other psychiatric illnesses, which means that someone diagnosed with bipolar disorder is likely to have at least one other psychiatric diagnosis. Some researchers suspect that because bipolar disorder may be closely related to some of these illnesses, in terms of underlying brain changes, they may not be separate disorders at all. Given how psychiatric illness is diagnosed at this point in time, we describe the disorders as separate entities and call them *comorbidities*.

Anxiety disorders

Anxiety disorders occur very frequently with bipolar disorder. According to one study, half of people diagnosed with bipolar disorder will have a co-occurring anxiety disorder at some point in their life. Rates for specific anxiety disorders vary:

- **Panic disorder** occurs in about 21 percent of people with a bipolar diagnosis, compared to about 3 percent in the general population
- **Generalized anxiety disorder** seems to occur in about 20 percent of individuals with bipolar, compared to about 3 percent in the general population.

- **Social and other specific phobias** seem to occur in about one third of people with bipolar — a rate much higher than the general population.
- **Post-traumatic stress disorder (PTSD)** occurs in about 16 percent of people with bipolar disorder, which is about twice as high as the rate found in the general population.

Treatment of anxiety disorders may complicate or complement the treatments of bipolar disorder but reducing anxiety symptoms is an important part of managing bipolar disorder effectively.

Obsessive-Compulsive Disorder (OCD)

OCD used to be considered an anxiety disorder, but in DSM-5 and now DSM-5-TR it's a separate diagnosis. A painful and difficult disorder to live with, it's much more common in people with bipolar disorder than in the general population. The rates vary among studies, but somewhere between 10 and 20 percent of people with all types of bipolar disorder also suffer from obsessive-compulsive disorder, compared to the rate of about 2 percent in the general population.

Similar to the challenges in treating anxiety disorders, treating comorbid OCD can cause conflicting medication needs, but treating OCD along with bipolar disorder is key to improving quality of life for someone living with bipolar disorder.

Substance use disorder

Although the studies vary in exact numbers, studies overall suggest that about 60 percent of people with a bipolar diagnosis have had a substance use problem at least sometime in their lives, with more than 40 percent having current or past problems with alcohol use and similar but slightly lower numbers having had problems with other substance use disorders. Psychiatric hospitalization rates are generally higher for people with both bipolar and substance use disorder. The course of the illnesses seems to be more severe when both are present. Males with bipolar disorder have a higher incidence of substance use disorder than females, but the rates are high in both groups. The rates decline as people get older but are still higher than rates of substance use disorder in older people without bipolar disorder.

Treatment of both substance use and bipolar disorder is challenging, and having both adds many layers of challenges to the treatment. Resolution of bipolar symptoms may be quite difficult to achieve in the context of active substance use, and substance use is particularly difficult to address during active mood episodes. Successfully managing both disorders is necessary for long-term recovery.

Attention deficit hyperactivity disorder

Research in this area has suggested that between 10 and 20 percent of adults with all types of bipolar disorder have ADHD. This compares to about 3–4 percent of adults with ADHD in the general population. In children with bipolar disorder, the distinction between bipolar and ADHD and the levels of overlap in symptoms can complicate the diagnostic story. The diagnostic challenges make it difficult to pin down the rate of ADHD in children and teens with bipolar disorder. The research is ongoing.


REMEMBER

The general consensus is that those with ADHD and bipolar disorder have worse outcomes for their bipolar disorder. Treatment is complicated because use of stimulants such as Ritalin to treat ADHD can significantly exacerbate bipolar symptoms. And with the high rates of substance use disorder among those with bipolar, potential misuse of these medications must also be considered.

Personality disorders

Personality disorders are conditions in which the development of emotional, social, and behavioral systems is disrupted, causing significant, lifelong problems with function. Personality disorders are divided into *clusters* and then further into specific types; for example, Cluster B personality disorders include borderline, antisocial, histrionic, and narcissistic personality disorders. Studies suggest that about 30 percent of people with bipolar disorder also meet criteria for a personality disorder.

Personality disorders are difficult to treat and often don't respond to medications. Psychotherapies are becoming more and more effective; people with personality disorders often have difficulty gaining insight into how their patterns of thought, behavior, and emotion affect their lives, because they've never known different ways of functioning. Without insight, trying to address the problems is quite difficult. Layering bipolar disorder onto a personality disorder diagnosis adds tremendously to the difficulties of achieving sustained recovery.

Childhood trauma may be closely related to the development of some personality disorders, including borderline personality disorder. Early trauma can have damaging effects on the development of emotional and interpersonal skills. Identifying and addressing trauma is an important part of managing these conditions.

Memory and thinking problems

Problems with cognitive skills such as memory and attention and the ability to think clearly are common in bipolar disorder, both during and between mood episodes. Compounding the cognitive issues inherent in bipolar is that fact that some medications used to treat bipolar can cloud thinking as a side effect. Addressing

problems with thinking and memory is important in recovery from bipolar disorder to help people get back on their feet in terms of work, life management, and interpersonal and leisure time skills.


REMEMBER

Certain medications used to treat bipolar disorder may have *neuroprotective properties;* that is, they may prevent damage and perhaps help the recovery or regeneration of brain cells. Some recent studies have suggested that lithium, while sometimes causing short-term mental cloudiness, may actually protect brain cells over time and may prevent or reduce cognitive decline.

Confronting the Challenges of Diagnosing Children and Teens

The diagnosis of bipolar disorder in children (up to the age of 12) and adolescents (teenagers) had been the subject of significant controversies in the field of child psychiatry for decades. In recent years, though, the field has reached consensus. Child psychiatrists are now clear that manic episodes — necessary for a diagnosis of bipolar disorder — do occur in children under 12 years old, but not frequently. The vast majority of first manic episodes present in adolescence or early adulthood. For children to be diagnosed with bipolar disorder they need to exhibit the same patterns of energy and mood changes that adults do — at least one period of mania or hypomania, often associated with episodes of depression. When doctors use these criteria, it significantly reduces the risk of overdiagnosing bipolar disorder in children.


REMEMBER

Central to the controversy about childhood bipolar disorder has been the symptom of chronic irritability. For some time, some researchers speculated that high levels of irritability in children were a symptom of or a predictor of bipolar disorder.

With the benefit of time, research has now followed highly irritable preschoolers into adolescence. The studies suggest that these children have higher rates of many emotional and behavioral symptoms, problems in school and social function, and poorer physical health. The research doesn't support any specific connection to bipolar disorder.

For irritable mood to count toward a diagnosis of bipolar disorder in a child, it must occur or notably worsen in cycles — sustained periods of time in which it's much more severe than the child's usual temperament. *DSM-5* added a new diagnosis called *disruptive mood dysregulation disorder (DMDD),* which is unchanged in DSM-5-TR. The purpose of introducing this diagnosis is to have a way to describe and research chronically irritable and explosive children without inappropriately labeling them as having bipolar disorder. The criteria for DMDD include the following:

- Severe recurrent temper outbursts that are grossly out of proportion in intensity or duration to the situation or provocation.
- The temper outbursts are inconsistent with developmental level.
- The outbursts occur on average three or more times per week.
- The mood between outbursts is persistently irritable or angry most of the day, nearly every day, and is observable by others.
- The symptoms have been present for 12 or more months without a period of three or more months free of patterns of irritability and outbursts.
- The symptoms are present in at least two of three settings — school, at home, with peers.
- Age of onset is before 10 years. Diagnosis isn't made before 6 years or after 18 years.
- The symptoms aren't part of a manic episode or better explained by major depression or other psychiatric or neurodevelopmental disorders, including anxiety disorders and autism.
- This diagnosis cannot coexist with bipolar disorder, oppositional defiant disorder, or intermittent explosive disorder.
- The symptoms can't be attributed to substances, medications, or medical or neurologic condition.

Also key to the evolving consensus about bipolar disorder in children is that the high energy and impulsivity that are part of an ADHD diagnosis don't count toward a manic episode diagnosis unless they form a cyclic pattern — episodes — in which those symptoms get notably worse and then stay worse for a sustained period of time (days to weeks, not hours).

This research is ongoing and understanding mood, behavior, and energy symptoms in children is a priority in the field of child psychiatry. But, whatever the studies reveal, doctors know that they must be cautious and diligent when evaluating young patients with mood symptoms. The medications used to treat mania are powerful and have many side effects, and a diagnosis of bipolar may prevent the use of medications to treat ADHD or anxiety and depression. Therefore, a misdiagnosis in a child can have significant long-term consequences.

Obtaining an early, accurate diagnosis of a child's difficulties and identifying whether the cause is bipolar disorder or something else is the most critical step in helping the child or adolescent manage a mood problem. Often, diagnoses in children may evolve over time as they get older, so doctors also need to remain vigilant for and open to changing their diagnoses over time. See Chapter 21 for more about diagnosis and treatment options for children and teenagers who may be dealing with a mood disorder.

BIPOLAR BIO

BATTLING THE STIGMA OF A BIPOLAR DIAGNOSIS

During my battle with bipolar disorder, I was unaware of the consequences of my risky behavior — abusing substances, having promiscuous sex, staying up all night, and counterfeiting art — but I was high-functioning.

My diagnosis put me in a category of the population called *bipolar*. In my mind, I was a lunatic, freak, psycho, crack-up, and mental case. I had officially stigmatized myself, long before anyone else had the chance.

I invited my parents to dinner to tell them the news, and they had a ton of questions. "Are you sure your doctor is right? Where did it come from? What's going to happen to you? Is it genetic?" They struggled with the stigma of having a son with bipolar, and, even worse, they worried that it might run in the family — we might have more like me!

Family and friends didn't come rushing to my side to support me in my battle. In 1993, the mere mention of bipolar disorder frightened people; someone with bipolar was "crazy." And because my insidious illness wasn't tangible, like diabetes or MS, it was easier for people to blame it on me. At a time when I was most in need of support from my friends and family, stigma pushed them away.

Most people thought I had the skills and strength to "kick" my bipolar disorder and get better on my own because the symptoms didn't show up on my body as a wound. Many people thought it was a figment of my imagination, that I was lazy or just seeking attention, and I started believing these ideas. But when symptoms surfaced, I was reminded that I really was suffering from bipolar disorder.

When medication didn't quell the mania, I opted for the last resort — electroshock therapy. That decision in itself pretty much confirmed that I was officially mentally ill. It was too much for some of my friends to handle, and they simply disappeared. Nobody seemed to want a friend who was now a psychiatric patient and, after electroshock, a "certifiable zombie."

Stigma prevents many us from seeking help and isolates us when we're most in need of supportive friends and family. Even in my recovery today, when I speak openly about my diagnosis, I'm keenly aware that many people are uncomfortable and afraid. Stigma is a form of discrimination, and debunking the myths about bipolar disorder and disseminating the truths are critical to educating the public and creating a social environment that's more conducive to mental health and recovery.

— Andy Behrman, author of *Electroboy: A Memoir of Mania*

IN THIS CHAPTER

- Examining genetic vulnerabilities
- Investigating other possible contributing factors
- Understanding the brain and the way it functions and dysfunctions
- Looking at how medications can help

Chapter 2

Exploring Possible Causes: The Brain and Body Science of Bipolar Disorder

As with all mental illnesses, doctors currently diagnose bipolar disorder by observation only — identifying patterns of change in how a person is feeling and behaving. Medical science has no brain scans or blood tests that can conclusively make the diagnosis, and research now shows that the chances of eventually developing one simple screening test are next to nothing. Bipolar disorder arises from multiple gene variations that interact with the environment in complicated ways, which means no single test or *biomarker* (biological indicator of an illness) will be able to predict or detect bipolar disorder.

The search for genetic causes of bipolar disorder have evolved over the last few decades and have reached new levels of complexity in the last 12 years. Technological advances have pushed this research to next-level genetic understanding of bipolar disorder, but full understanding remains a work in progress. And although

genetics account for most of the risk for bipolar disorder, genetic variations aren't the sole cause. How these variations interact with the environment poses even more complex questions that are profoundly challenging to study.

Although our understanding of the *neuropathology* (brain changes) underlying bipolar disorder remains incomplete, it reveals a fundamental fact about bipolar disorder. It dispels the persistent and stigmatizing myth that bipolar disorder is some type of weakness or defect in moral character. Make no mistake — bipolar disorder is a real *physical* illness affecting the brain.

In this chapter, we explore the biological basis of bipolar disorder, looking at factors inside and outside the human body that may contribute to its onset and progression with the goal of understanding what is currently known about what causes bipolar disorder and what is yet to be uncovered by science.

Digging Up Bipolar's Genetic Roots

Scientists established that bipolar disorder was hereditary decades ago through twin studies, family studies, and adoption studies. These findings laid the groundwork for research looking for the gene or genes that cause bipolar disorder. The search has been far more complicated than anyone could have imagined, but it is crucial work. Finding gene variations that increase the risk of bipolar disorder builds our understanding of the biological mechanisms behind bipolar disorder.

Genes are blueprints for cells to produce proteins and other substances that are the building blocks for all bodily structure and function. Altered genes mean different blueprints. Identifying the genes that are altered in people with bipolar disorder can shed light on which brain mechanisms may be different. This knowledge can help in developing more targeted treatments and possibly predicting the risk of bipolar disorder and developing more specific and accurate diagnoses.

Exploring the genetic connection through twin, adoption, and family studies

Much of what's known about bipolar's genetic roots comes from three study types — twin, adoption, and family studies:

- **Twin studies** are done to determine the percentage of an illness caused by genetics in a given population. The researchers figure this out by comparing rates of bipolar disorder between identical and fraternal twins. Because

identical twins share 100 percent their genes and fraternal twins share only about 50 percent, comparing rates between these two groups results in a figure that reflects "heritability." Bipolar disorder has a 60 to 80 percent heritability rate, which means the majority of risk for bipolar disorder comes from someone's genetic makeup.

- **Adoption studies** compare the rates of bipolar disorder in biological versus adoptive relatives. The data suggests that the biological parents of a person with bipolar disorder have higher rates of mood disorders (not just bipolar disorder). Thirty one percent of biological parents had a mood disorder but only 12 percent of adoptive parents did.
- **Family studies** compare the rates of bipolar disorder among family members of people with and without bipolar disorder. Overall, family studies have shown that first degree relatives of a person with bipolar disorder have about nine percent chance of developing bipolar disorder, compared to about a one percent risk for family members of people without bipolar disorder (the control group).

  The family studies also show that first degree relatives of people with bipolar disorder have about 14 percent chance of developing unipolar depression, compared to about five percent in the controls.

  Family studies also suggest that some types of bipolar disorder may be more heritable than others. Family members may be at an increased risk of developing bipolar disorders with certain characteristics. These include bipolar disorder with psychosis, early onset bipolar disorder, and bipolar disorder that responds well to lithium.

Shaking the family tree

A history of bipolar disorder in an immediate family member is important to know because it influences your risk of getting the disorder. However, family members of people with bipolar disorder have higher rates of many other psychiatric conditions, as well. When considering your risk for bipolar disorder, a look at all major psychiatric disorders in close family members can help identify some genetic susceptibility to bipolar disorder.

Unfortunately, if you ask relatives whether anyone in your family has had bipolar disorder, they may not know the answer, even if they think they do. Older relatives may have been misdiagnosed as having schizophrenia or may never have been diagnosed but had a history of self-treating with alcohol or drugs. Or a relative may have been considered eccentric, but for whatever reason was never diagnosed.

To obtain better answers, try rephrasing the question:

- **Has anyone in the family had alcohol or substance use problems?** Many people with bipolar disorder develop substance use disorders. Some research also suggests that bipolar disorder and substance use may share some genetic risk factors.
- **Have any family members been diagnosed with schizophrenia?** In the not-so-distant past, doctors commonly misdiagnosed bipolar disorder as schizophrenia. A relative with bipolar disorder may have been misdiagnosed as having schizophrenia. In addition, schizophrenia is thought to share genetic risk factors with bipolar disorder, so a family history of schizophrenia may increase a person's risk of developing bipolar disorder.
- **Has any family member been treated for depression?** Due to the challenges to diagnosing bipolar disorder, if a family member has received treatment for depression, that person may have bipolar disorder that hasn't presented itself or has yet to be diagnosed.
- **Has anyone in the family had to go away for a while to an institution, sanatorium, or rehab center?** Families sometimes filter out memories of relatives who had to be hospitalized for mental illnesses by saying that they "had to go away for a while."
- **Have any family members been known to be particularly energetic or eccentric?** In the past, people politely described relatives with various degrees of mental illness as eccentric.
- **Has anyone in the family suffered from physical symptoms such as chronic exhaustion, migraines, pain, or digestive problems?** These symptoms may be associated with mood and anxiety disorders that have or haven't been formally diagnosed.
- **Has anyone in the family died of suicide?** Bipolar disorder is a risk factor for dying by suicide. If a family member died in this way, there could have been an undiagnosed/untreated bipolar disorder. This topic is off-limits for many families for many reasons including stigma, shame, and grief. Asking about this is important — but it may take time for family members to give you an answer.

REMEMBER

Families can be secretive, especially when protecting the reputation of the dead. People can become even more defensive if you confront them while you're in the throes of mania. Choose a time when you're level-headed to explain how important an accurate and detailed family history is for your diagnosis.

Grasping the genetic complexities

Even though indisputable evidence proves that bipolar disorder has strong genetic components, it is also now indisputable that no single bipolar gene exists. The search for genetic causes of mental illnesses — including bipolar disorder — has discovered that all these disorders have multiple genetic components. Figuring out how genes play a role in bipolar disorder remains an active research goal — one that's still in process. But in recent years key findings, have substantially expanded our understanding of these genetic risks. Here's a summary of genetic studies related to bipolar disorder from their early years to now:

- Early genetic research found some possible genes related to bipolar disorder, but further studies couldn't replicate those findings. A scientific discovery must be repeated in other studies to ensure that it is a valid finding. Unfortunately, the genetic and computational technologies at the time were not particularly effective in looking at disorders caused by multiple genes.
- Since about 2010, genetics researchers have used a newer technology called Genome Wide Association Studies (GWAS). These studies have been able to look at millions of genetic variants in ways the older techniques could not. Specifically, they can identify common genetic variants called single nucleotide polymorphisms (SNPs) — changes at the level of a single DNA building block. SNPs occur commonly and usually don't affect risk of illness. But when these studies are done on big groups of people with bipolar disorder compared to people without the condition, patterns start to emerge suggesting common variations that may contribute to genetic risk for bipolar disorder.

  GWAS studies of SNPs are much more powerful when the studies include huge numbers of people. These types of studies have been done on illnesses such as diabetes, heart disease, and some types of cancer. The bipolar studies haven't been as large but are growing in size and results. These studies are now identifying and sorting through genetic variations that are associated with bipolar disorder. The process has reached important milestones, but tremendous work remains to be done.
- Another type of genetic variation is called *copy number variation (CNV)*. These variations are associated with much bigger chunks of genetic material, and they're rare, in contrast to the common SNPs above. Researchers have connected several of these variants to individuals and families with bipolar disorder. Although these variations are uncommon (so not likely to be the cause of bipolar disorder in most people who are diagnosed), knowledge about the variations in these regions give powerful information about the underlying mechanisms of the disorder.
- Genetic studies also continue to examine the overlap of genetic vulnerabilities to bipolar disorder with other disorders such as schizophrenia, major

depression, autism spectrum disorder, ADHD, OCD, Tourette's syndrome, and anorexia nervosa. Numerous studies show strong connections between genetic risks for bipolar disorder, schizophrenia, and major depression. The other disorders listed seem to share some broad underlying risk factors with bipolar disorder but don't share as many specific genetic risk variations as the other three.

The future of genetic research into bipolar disorder is bright given the computational resources available now and the expansion of *biobanks* — facilities that collect physical specimens (including DNA) and health information from people with illnesses and healthy people without illness. Researchers can access these large repositories of information to study and analyze patterns among large groups of people. Researchers using biobanks don't have access to the donor's personal information — it is deidentified.


REMEMBER

Major limitations to all genetic studies revolve around a lack of diversity in populations that are studied. The vast majority have typically been of European ancestry, which limits generalizability to the wider population. Efforts are underway to diversify this field of research, which is essential for this work to help everyone.

Flipping the bipolar switch: Epigenetics

Epigenetics is the study of changes that affect how genes are expressed without affecting the genes themselves. These changes occur through a variety of chemical interactions with the DNA. Sometimes these changes in expression occur as part of typical development and function, but some changes can disrupt normal processes and healthy cell function.

The science of epigenetics helps to explain the interplay between nature and nurture — how an organism's *genotype* (genetic makeup) interacts with the environment to produce the organism's *phenotype* (observable characteristics). Epigenetic changes occur as part of normal cell development and growth as well as in response to environmental events. Smoking, for example, causes epigenetic changes to DNA, but it seems that quitting can sometimes reverse those changes. Likewise, infections can trigger changes to how genes are expressed.

When a mother is pregnant, epigenetic changes can be passed on to the baby. A well-known example of this occurred during the Dutch famine of 1944–45. Children conceived during the famine were compared to siblings born before the famine. Those who were exposed to the famine had higher rates of schizophrenia, type 2 diabetes, and coronary artery disease. Six decades later researchers looked at the DNA of both exposed and non-exposed people and they identified persistent epigenetic changes that may partly explain some of these higher disease risks.

So far, epigenetic research has not yielded specific information about the relationship between epigenetic changes and the risk of bipolar disorder, but scientists expect to learn much more about this possible connection going forward.

Investigating Nongenetic Factors

Genetic studies indicate that about 60 to 80 percent of bipolar disorder is related to inherited factors, but that leaves a significant percentage of the risk for developing bipolar disorder squarely in the realm of environmental exposures. Research in this area is still preliminary, largely because many new gene findings have yet to be examined in terms of their relationship to environmental events. But scientists already know a great deal about environmental stressors that impact risk for bipolar disorder. Many of these stressors are present in the very early phase of brain development — before birth and in the first months and years of life. However, scientists also believe that ongoing nongenetic factors contribute to the development of bipolar disorder and its course over time. Some of these factors include the following:

- **Stressful life events:** Studies of people with bipolar disorder have found a number of abnormalities in the biological systems that regulate the body's response to various types of stress. Interactions between these vulnerable systems and environmental stress more than likely play an important role in both the development and progression of bipolar disorder. Acute life events have been found to occur more frequently before mood episodes in people with bipolar disorder.
- **Early life stress:** That same interaction between impaired stress response systems and stress may occur many years before the development of bipolar disorder. Studies suggest that early childhood trauma is associated with a higher risk of bipolar disorder in adulthood.
- **Substances:** Alcohol and/or other substance use disorders often accompany bipolar disorder. The full story of the overlapping risks remains unclear, but some studies suggest that substance use and bipolar disorder may have overlapping genetic risk factors, so that rather than being a behavioral response to the illness, these conditions may develop alongside one another. Some evidence even suggests that the use of alcohol and drugs may increase the risk of developing bipolar disorder, which raises the question of whether early intervention to stem drug and alcohol use can help reduce the likelihood of ever having that first mood episode. Tobacco use is also being looked at as possibly interacting negatively with genetic vulnerabilities to bipolar disorder.
- **Nutrition:** Malnutrition during fetal development increases the risks of mood disorders, including bipolar disorder. Less clear is whether specific nutritional

deficits later in development play any role in the development of bipolar disorder. That people with bipolar disorder have higher rates of illnesses such as cardiovascular disease and type 2 diabetes is well established, but the exact relationships remain under investigation. All these conditions stress cellular function and cause physical damage. Supporting access to and engagement with a range of nutrients and micronutrients are important steps in reducing the harmful outcomes of these conditions.

- **Infection:** Studies suggest that maternal viral infections, particularly with the flu virus, during pregnancy are associated with higher rates of neurodevelopmental disorders such as autism and neuropsychiatric disorders such as bipolar disorder and schizophrenia. How much of this connection is related to the infection itself or to the mother's immune response to the infection remains unclear. The overlap of the maternal infection with genetic risk factors is thought to be important in the development of bipolar disorder in some people. In addition to prenatal infections, research also shows a higher rate of infection with *toxoplasmosis* (a parasite found in cat feces) in adults with bipolar disorder, but the mechanism of that interaction remains unclear.
- **Sleep/circadian rhythms:** Researchers have identified a strong relationship between bipolar disorder and sleep problems. Several different genetic variations may contribute to these difficulties. Sleep deprivation is a well-established trigger for mania, and because people with bipolar disorder experience significant sleep problems during depressive episodes and between mood episodes, they're at much higher risk of sleep deprivation. Sleeplessness creates a vicious negative spiral — with bipolar causing sleeplessness and sleeplessness contributing to bipolar. Sleep management is important in trying to slow the progression of bipolar disorder.
- **Reproductive hormones:** Reproductive hormones are mood modulators and may contribute to the development and presentation of bipolar disorder. Research suggests that they interact with the genetically vulnerable brain and body systems in people with bipolar disorder to influence the onset and progression of their illness. Women are particularly vulnerable to this effect because of their frequent hormone shifts throughout their lives, but testosterone levels in both men and women may impact bipolar disorder symptoms. Hormonal transition times such as the onset of puberty, pregnancy, and menopause may be vulnerable or protective periods for mood episodes (refer to Chapter 10 for more discussion).

REMEMBER

Some of the genetic differences in people with bipolar disorder interfere with their body's ability to regulate or turn off their stress responses — even between mood episodes. These factors stress the body, layering with other genetic risk factors. Finding ways to reduce stress triggers, reduce harm from substance use, and manage sleep and nutrition are some strategies that may help reduce the severity of the illness. Throughout this book, we describe various techniques for reducing the risks of experiencing mood episodes and managing them when they do occur.

BIPOLAR BIO

ALL OF THE ABOVE

Was it the drugs, the genetic predisposition, or the trauma? Likely, all of the above.

My parents, Marcia and Martino, were impoverished, had two kids, and were using illicit drugs. I was born premature and addicted. Each had manic depression, now called bipolar disorder.

They coped with their mental battles by using drugs and alcohol. They would leave my brother Jordache and me unattended, lying in our own filth, screaming, barely clothed, to score. They left us just one too many times. On that day, at a seedy motel, the clerk heard our cries and called the police, and we were then taken into child protective services. It was a gift, our first.

Clearly Jordache and I were predisposed to bipolar disorder. The question remains, did we have a chance? How much did neglect, malnutrition, and abandonment have to do with my condition? How much did the drugs in my system, in utero, contribute to the eventual onset of bipolar disorder?

After Jordache and I were placed into foster care, he developed bronchitis and died. Feeling even more abandoned, I developed a detachment disorder, which would follow me into adulthood. Even today, I battle with anxiety, detachment disorder, and abandonment issues on top of bipolar disorder.

I bounced around from foster home to foster home. Day after day was spent vomiting and having ongoing diarrhea. I was every foster parent's nightmare. Finally, at nine months of age, I was placed into the loving arms of Patrick and Debi Hines. They were my second gift, my greatest blessing next to getting taken in by child protective services.

Soon after I was placed in their care, Patrick and Debi decided to try and adopt me. They fought a two-year court battle to keep me.

Patrick hired the best lawyers he could find to retain custody and won. He and Debi proceeded to adopt me. They cared for me throughout this time and were there throughout the progression of my bipolar disorder I with psychotic features. Even though our lives were rough when I struggled most, we got through it and have come out on the other side.

I will never know to what extent my traumatic infancy, the drugs that entered my system before birth, my predisposition to a mental health condition, or any other factors

(continued)

(continued)

may have contributed to my getting bipolar disorder. There is no way to measure those things that changed my brain forever. There is no way to tell which played a bigger role or when they overlapped.

For now, I remain confident that no matter my suffering, I will prevail.

— Kevin Hines (`www.kevinhinesstory.com`), mental health advocate, speaker, and author of *Cracked, Not Broken: Surviving and Thriving after a Suicide Attempt*

Examining the Circuitry of Bipolar

Many people refer to bipolar disorder as a chemical imbalance, but this is false. The biological anomalies being discovered in people with bipolar disorder are complex and affect numerous biological structures and systems — throughout the body and brain — and they all interact with one another. Keep in mind that the current knowledge about bipolar disorder is in its infancy and likely to change quickly and substantially as more research is done. In the following sections, we explore the facets of bipolar at work in the body that science has discovered so far.

REMEMBER

The discussion of brain structure and function that follows is heavy and dense, so you need to know some basic terminology to help it make sense. We start by discussing the *anatomy* (structure) and *physiology* (function) of the brain and the cells that comprise it to bring you up to speed on the basics. Then, we get to the good stuff — where we explain how structural and functional anomalies in the brain may be linked to bipolar.

Brushing up on brain structure and function

Pinpointing the location of bipolar disorder in your brain is almost as difficult as finding affordable health insurance. Brain imaging studies have found few consistent changes when looking at large brain structures. They've had much more success looking at changes at the cellular level and, in particular, at functional changes in cells and groups of cells in specific brain areas. Here is some basic brain anatomy and physiology that helps explain the research.

Dissecting the brain

Looking at a whole human brain from the outside, as shown in Figure 2-1, you see the *cerebral hemispheres* (the large sections, not labeled in the figure, that

comprise most of the brain), the *cerebellum* (the small ball toward the back of the hemispheres), and the brain stem (a long, thin structure leaving the brain and connecting it to the spinal cord). The cerebral hemispheres are divided into four sections that serve broadly different functions — the frontal lobe, the parietal lobe, the temporal lobe, and the occipital lobe.

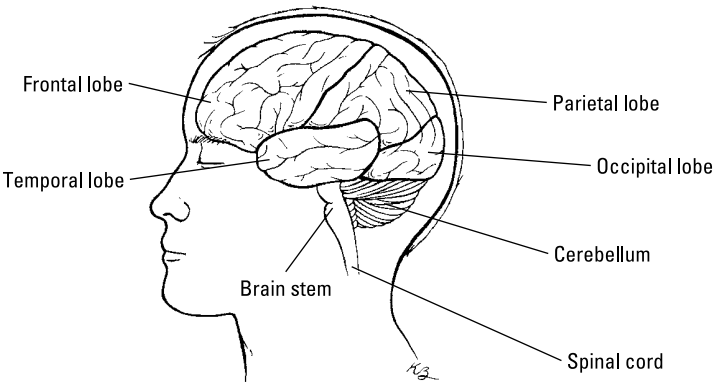

FIGURE 2-1: The human brain from the outside looking in.

The brain consists of two equal parts — the left and right hemispheres. The thin outer layer of each hemisphere is called the cortex, often described as the "gray matter." This layer primarily consists of nerve cell bodies and dendrites — the main part of the neuron and its connecting branches. The cortex of the brain integrates and manages key functions including thought and language, reasoning, emotions, memory, and consciousness.

The cortex is broken down into subsections (lobes) that manage different areas of function:

- The *frontal lobe* is the executive of the brain, serving to coordinate, integrate, and manage many functions within the body and brain such as voluntary movement, thinking, emotional and behavioral control, executive function, and expressive language.
- The *parietal lobe* is involved in processing, integrating, and managing sensory information such as touch, temperature, pain, and spatial orientation.
- The *temporal lobe* is important in memory formation, processing auditory stimuli and language and processing visual stimuli around object and facial recognition. It is also an important part of the *limbic system* discussed later in this section.
- The *occipital lobe* is the center for processing visual stimuli.

All these areas perform many other functions, as well, and functions may overlap between areas.

The lobes of the frontal cortex are further subdivided into smaller areas that drive frontal lobe functions. These areas interact extensively with each other and with other parts of the brain, outside of the cortex and frontal lobes. Several of these areas appear frequently in studies of bipolar, including the *prefrontal cortex* and the *anterior cingulate cortex.*

Below the large outer layer of the cortex is the "white matter" consisting of long extensions of neurons that are critical for transporting all the information that travels within the brain and that travels into and out of the brain. Each of these neurons is covered in a fatty layer of insulation called "myelin" (the white of white matter) that ensures the integrity of the signals being transmitted.

Below the cortex are some gray matter structures and specialized collections of cells called nuclei that play important roles in many functions including thinking/learning, emotions, and social behaviors. These functions involve a number of structures, some of which are quite important in bipolar disorder research, including the following (see Figure 2-2):

- The *hippocampus* is especially important in learning and memory.
- The *thalamus* serves as a relay station for sensorimotor input, conveying it to areas of the cortex. It also regulates sleep, consciousness, and levels of alertness.
- The *hypothalamus* is also subcortical and regulates many survival mechanisms such as hunger/thirst and sleep/wake and energy cycles, and all components of *circadian rhythms* — physical, mental, and behavioral patterns that occur in approximately 24-hour cycles.
- The *amygdala* is a major player in the brain's reaction to emotions.
- The *basal ganglia* is a collection of smaller groups of cells called nuclei that generate and regulate movement as well emotion, executive functions, and decision making.
- The *cerebellum* is a separate lobe of the brain, sitting below the cerebral hemispheres, that is essential in managing motor movement regulation and balance. It controls *"gait"* — how you walk, your posture, and your muscle tone, among other motor control functions.
- The *brain stem*, which sits below the cerebral hemispheres, connects the brain and the spinal cord. It manages basic survival mechanisms, such as breathing and the heartbeat, and is involved in the management of consciousness, alertness, and sleep/wake cycles.

- The *limbic system*, sometimes referred to as the *limbic network*, is a system of interconnected parts of the cortex and subcortical regions that work together in processing memories and regulating the fight or flight (fear/anxiety) response, as well as aggression and sexual responses. It's located next to the thalamus and within the cerebral hemispheres.

  The components of the limbic system continue to be described and understood, so different sources may list different areas as making up the limbic system. But well-established subcortical areas include the parts of the thalamus, the amygdala, the hippocampus, and the hypothalamus. Cortical parts of the system include the *anterior cingulate gyrus* (part of the frontal lobe), which has been shown to be important in mood regulation, and some parts of the temporal lobe cortex.

- The *ventricular system* is a collection of cavities, including spaces called the *ventricles*, that make, circulate, and then re-absorb *cerebrospinal fluid*. This fluid serves as a mechanical shock absorber to the brain but also brings nutrients from and filters waste back into the bloodstream.

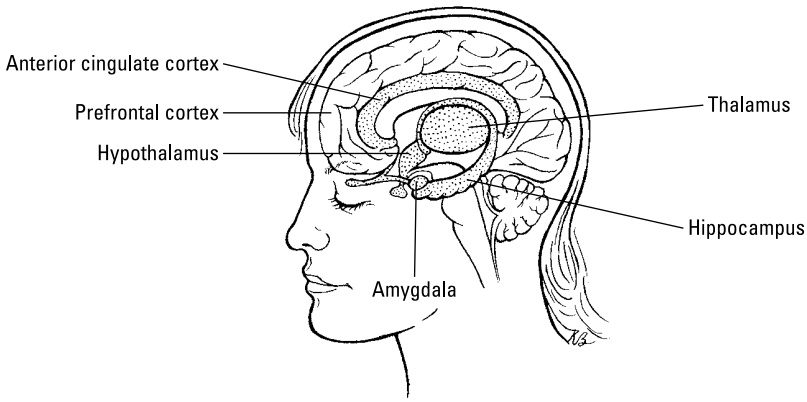

FIGURE 2-2: Inside the human brain.

Recognizing two brain cell types

Understanding brain anatomy also requires an understanding of the two types of cells that make up all the structures of the brain:

- *Neurons* form the telecommunications system in the brain and body, dictating body functions by generating, sending, and reacting to electrochemical signals.
- *Glial cells,* once thought to be just a support network for neurons, play a major role in brain function and in the brain's communications and reaction systems. Specifically, glial cells play key roles in the connection between the body's immune system and the brain.

Understanding how brain cells communicate

Neurons communicate with one another in many different ways, but a primary communication path is across the *synapse* — the space between neurons or between neurons and other cells such as a gland or muscle cell. The most common type of communication occurs when one end of the neuron (often the axon but not always) releases a *neurotransmitter* (a chemical messenger) into the synapse (as in Figure 2-3). Another cell (often the dendrite of another neuron) receives the neurotransmitter.

Receptors on the outside of the second cell latch onto the neurotransmitter. Cells have many different types of receptors for each type of neurotransmitter; the type of receptor influences how the neurotransmitter is received and processed and how the instructions are sent to the second cell. After a neurotransmitter occupies the receptor, it can generate many different responses in the receiving cell, depending on the neurotransmitter and the receptor type. After the neurotransmitter has done its job, it's released from the receptor and then taken back into the first cell, a process called *reuptake*.

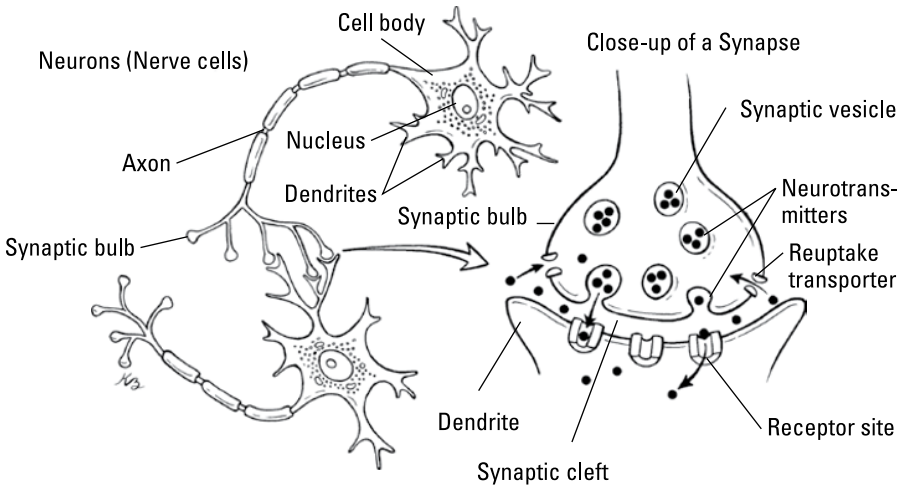

FIGURE 2-3: Cell-to-cell communication via neurotransmitters.

Nervous system cells communicate in ways beyond the synapse; for example, chemicals called *neuropeptides* communicate between cells but not across synapses. Of great importance in the current research on bipolar disorder is the communication between glial cells and neurons.

Disruptions in these communication systems may be at least as important as problems in neuron-to-neuron transmissions. *Intracellular* (within-cell) communication may also play a role, as we explain in the later section, "Intracellular signaling."

Connecting the brain to bipolar disorder

Given the complexity of the brain's structures and functions, the many interactions throughout the body, and the many different presentations of bipolar disorder, research has been difficult, and findings are often inconsistent from study to study. The research into understanding the disruptions to brain processes that contribute to bipolar disorder bridges many specialized fields including genetic studies, examination of blood and cerebrospinal fluid samples, imaging studies that can look at structure or function of brain areas, microscopic examination of brain tissue *postmortem* (after someone with bipolar has died), *neuropsychological tests* (having a patient answer questions and perform specific mental tasks — sometimes while getting their brain imaged), and a variety of other ways of examining the brain and body. Animal model studies continue to be an important part of research into bipolar disorder as well.

Scientists are still working toward developing a clear picture of bipolar disorder at work in the brain. Some findings are beginning to shed light on what goes on in the brain of someone with bipolar, whereas others are just beginning to be explored. This section gives you a glimpse of the emerging picture.

REMEMBER

The findings presented in this section only touch the surface of the tremendous work being done to better understand bipolar disorder. All factors highlighted in these findings, along with many others not discussed here, interact with one another in numerous complex ways. Uncovering the many factors that cause or contribute to bipolar disorder and their relationships brings us closer to completing the puzzle that is bipolar disorder, but much work remains to be done.

Examining bipolar's impact on brain structure

Researchers have been looking at the structure of the brain in bipolar disorder for many decades and the research techniques have increased in technological sophistication and complexity of computer processing of the images. Numerous findings have started to come together to yield patterns in brain changes that occur in bipolar disorder.

One of the earliest findings that remains clearly identified is the overall loss of gray matter in the brain over time after multiple mood episodes. As the gray matter is reduced, the ventricles increase in size. This means that the neuron cell bodies are decreasing in size and/or number, which can be associated with changes in thinking, memory, motor skills, and other important processes. These findings help us understand the importance of trying to reduce the number of mood episodes someone with bipolar experiences. More episodes are associated with more harm to the brain.

In more recent decades, imaging research has detected important findings in the white matter of the brain — the connection and communication systems between different parts of the brain. These changes occur across several networks including parts of the limbic system. These changes in white matter disrupt the movement of information across neural networks, which can cause changes in how the brain functions.

Other structural changes that have been seen repeatedly in bipolar disorder include increased volume of the amygdala and decreased volume of the hippocampus. These are both critical parts of the limbic system affecting emotion and memory processing.

Connecting bipolar disorder to disruptions in cellular communication

Brain function relies heavily on communication within and between brain cells and across networks and circuits. Many studies focus on these areas to identify dysfunctions that may be related to bipolar disorder.

NETWORKS AND CIRCUITS

Communications between different functional areas in the brain occur in circuits or networks of brain cells. These circuits pass information back and forth that generates and regulates brain and body activity, with certain areas focusing on specific functions. Some studies have focused on *dysconnectivity* — disrupted communication patterns, particularly within the limbic network, where important connections exist between *cortical cells* (the neurons in the outer layer of the hemispheres) and subcortical structures, which include white matter and the *subcortical nuclei* (specialized neurons/gray matter deep in the brain, below its outer layers).

Numerous studies point to hyperactivity of the connections between the hypothalamus (part of the brain), the pituitary gland (in the brain), and the adrenal glands (one atop each kidney). This HPA axis is part of the fight/flight system, which revs the body's engine when it senses a threat. This brain/body circuit is essential to normal function, but in bipolar disorder, the body's ability to turn off or tone down the fight-or-flight response appears to be impaired. These stress responses are risk factors for worsening bipolar disorder. In addition, an overly sensitive HPA axis can release too much cortisol. Excess cortisol is harmful to the body in many ways and is associated with problems in blood sugar and insulin management as well as heart disease and other significant medical problems that are more prevalent in people with bipolar disorder.

SYNAPTIC TRANSMISSION

In addition to disrupted communications in circuits between functional areas of the brain, signaling systems between individual brain cells also show changes in bipolar disorder. Disruptions in the pathways and functions of neurotransmitters appear to play key roles in developing manic, depressive, and psychotic symptoms. Some of the important neurotransmitters in bipolar disorder include the following:

- **Glutamate** is an *activating* neurotransmitter, often having to do with turning things on rather than off. Many bipolar studies consistently have found problems in the networks that use glutamate.
- **Dopamine** is a neurotransmitter related to reward- and pleasure-seeking behaviors, attention and focus, and muscle movement. Some research has identified dopamine as possibly being poorly regulated during manic episodes — affecting thought, emotions, and motor activity.
- **Serotonin** is a chemical messenger highly involved in networks related to mood, anxiety, and general survival mechanisms such as eating, sleeping, and reproduction, with well-established relationships to depression. Extensive research shows a clear and consistent connection between serotonin and depression.
- **Gamma-aminobutyric acid** (GABA) is a transmitter that plays a role in *inhibitory systems* (systems that turn things off) and may be abnormally regulated in bipolar disorder.
- **Norepinephrine** is important in the brain stem and may also exhibit some abnormalities in bipolar.

INTRACELLULAR SIGNALING AND FUNCTION

Intracellular signaling and function refers to processes that go on inside a nerve cell after the receptor on the outside of the cell latches on to a neurotransmitter. Many studies point toward a number of these signaling systems being disturbed in bipolar disorder including how brain cells use energy, how active or inactive they are, how much signal they generate to send to other cells, and how well the cells respond to and recover from damage due to different types of stress on the cell. Some of the medications that effectively treat bipolar disorder are known to target intracellular processes.

Immune responses and inflammation

Some of the most fundamental understanding of the underlying *pathophysiology* (changes in function that cause disease or illness) of bipolar disorder has been in the realms of immune responses and inflammation. Immune responses are the body's way of responding to stressors. In this context, stressors are anything that

causes harm or damage to the body, down to the cellular level. The causes of harm include but aren't limited to infections, toxic substances, and emotional stress.

In response to a perceived harm, the body mounts an immune response, which includes generating specialized immune cells as well as creating a variety of proteins. This response causes inflammation in the body — including the brain. Inflammation is part of the process by which the body tries to heal damage or eliminate an infectious agent. Inflammation as part of the immune response to an infection such as influenza helps to recover from the infection, but in the meantime makes you feel miserable — fatigued, aches, and fever, for example. Persistent and/or misdirected inflammation can harm the body.

Many studies of many kinds show clear evidence of elevated levels of inflammatory cells and disrupted immune cell responses in bipolar disorder. The immune/inflammatory responses are likely fundamental to the pathophysiology of bipolar disorder. How this response gets triggered is unclear, but the evidence currently points to a combination of multiple gene vulnerabilities layered with something from the environment. The immune/inflammatory response may be at the root of some combination of white matter damage, neurotransmitter/signaling disruptions, and intracellular changes that are known to occur in bipolar disorder.

Circadian rhythms

Sleep disruption is a primary symptom of bipolar disorder — sleeping too much when depressed or too little when manic. At the same time, studies have consistently shown that many people with bipolar disorder also have underlying irregularities in their *circadian rhythms* (the flow of wakefulness and sleepiness over a 24-hour period). Everyone has their own natural circadian rhythms — think of "larks" who are morning people and "owls" who feel most energized in the evening — but most people are wired to a 24-hour cycle, with sleep at night and wakefulness during the day.

Studies on people with bipolar disorder have observed that many of them are much more likely to be wakeful in the evening or struggle to sleep at night and be awake in the day — even when they're not experiencing a mood episode. Some research suggests unusual patterns of *melatonin* (a hormone that the body releases when it gets dark to signal that it's time to sleep) secretions in people with bipolar disorder — across mood states. And genetic research has shown overlap in some genetic variations found in people with sleep and circadian rhythm problems and people with bipolar disorder.

Understanding the relationship between circadian rhythm patterns may shed light on the underlying brain changes in bipolar disorder, and it may help in developing sleep/wake cycle monitoring and intervention strategies to predict and mitigate mood episodes.

Exploring the microbiota-gut-brain axis

Microorganisms — ranging from bacteria to viruses to fungi and more — live in and on human bodies as part of maintaining *homeostasis* (the tendency toward balance in function). A community of microorganisms is called a *microbiota*, and the collection of genetic material from these organisms is called a *microbiome*. The largest of these collections in the human body lives in the gastrointestinal tract and is referred to as the human *gut microbiome*. The gut microbiome is known to regulate health within the gut and throughout the body and has recently been found to play a significant role in brain health.

The interactions between the gut microbiota and the brain are collectively referred to as the *microbiota-gut-brain axis.* This axis is a bidirectional information system between the brain and the gut. These communications are thought to occur through a variety of mechanisms including immune modulation, endocrine/hormone production, building neurotransmitters and their precursors, and sending and receiving signals through the autonomic nervous system, including the *vagus nerve* (a key nerve in the parasympathetic or rest-and-digest system). The details of how this axis is related to brain health and illness remain unclear but it is an area of intense research with hopes for uncovering markers of illness and targets for treatment.

The specific relationship between the microbiotia-gut-brain axis and bipolar disorder is just barely being uncovered, and most of the research is still restricted to animals. Several areas of interest have developed so far, including the following:

- **Dysbiosis:** An imbalance in the populations of microorganisms that inhabit the digestive tract. Studies have found that people with bipolar disorder have increased or decreased populations of certain microorganisms and lower levels of microorganism diversity.
- **Immune response/inflammation:** Gut microorganisms affect immune cells in the gut, and if the microorganisms are not working typically, this could trigger an immune/inflammatory response that could be related to the development of bipolar disorder.
- **Disruptions of the blood-brain barrier:** The gut wall is a key part of the *blood brain barrier* — a collection of body systems that protect the central nervous system from unwanted proteins and other substances. The gut microbiome plays a role in maintaining the integrity of that barrier. Disruptions to this function could play a role in the development of bipolar disorder.
- **Changes to brain development:** The gut microbiota plays a role in *synaptic pruning* (the process in brain development of clearing out connections that are no longer needed). Disruptions to the microorganism systems could disrupt neurodevelopment in ways that increase the likelihood of eventually developing bipolar disorder.

REMEMBER

In some circles, the gut is referred to as the body's "second brain" due to the vast network of neurons — the enteric nervous system — that populate the gut's lining.

Investigating Medication Mechanisms: What We Know and Don't Know

Medications that work for bipolar disorder continue to puzzle researchers, who don't yet fully understand how they do their thing — their *mechanism of action*. For example, although antidepressants and antianxiety medications are known to target certain neurotransmitters, this may not be their major effect in treating bipolar. Lithium and valproate (Depakote) — the primary antimanic medications — seem to operate on processes within the cell itself rather than on the transmitters between synapses.

The mechanism of action of mood medications may include any of the following activities or others still being discovered, depending on the type of medication:

- Increase the levels of a particular neurotransmitter within the synapse by preventing its breakdown by enzymes or by preventing it from being sucked back into the first neuron
- Change how a neuron receives a neurotransmitter — by blocking, opening, or otherwise changing the receiving cell's receptor proteins
- Strengthen neuroprotective factors that help cells recover from injury and maintain healthy cell development, growth, and function
- Inhibit or increase the activities of enzymes that are important to the signaling systems in neurons
- Change patterns of electrochemical pulses in the neurons
- Alter pathways that trigger changes in gene expression and possibly even alleviate negative environmental effects on the chemical packaging of DNA (epigenetics)

See Chapter 7 for more about medications used to treat bipolar disorder.

IN THIS CHAPTER

- Gaining hope through a positive prognosis
- Relieving current symptoms and reducing the likelihood of future episodes
- Taking a sneak peek at what treatment looks like

Chapter 3

Reining in Bipolar Disorder: Prognosis and Treatments

You can't fight an affliction you can't identify, so an accurate diagnosis is the first step on the path to wellness. If you know your enemy, you can draw up a proactive battle plan to defeat it . . . or at least keep it from ruining your life.

In this chapter, we reveal the positive *prognosis* (outlook for recovery) that accompanies the bipolar diagnosis. We show you not only how to conquer bouts of depression and mania when they afflict you, but also how to quiet them before they begin to roar. And we provide a list of treatment options, therapies, and self-help skills so you can start thinking about the many tools you have at your disposal.

Knowing What to Expect: Adopting a Long-Term Perspective

The difference between a negative and positive outlook for bipolar disorder largely depends on the choices that you, your doctor, and your loved ones make. If you accept the bipolar diagnosis, if you and your treatment team can discover an effective combination of medicines, therapies, and self-help strategies, and if your family and friends pitch in to support you, the prognosis is very positive indeed. But if you try to ignore the problem, avoid working on an effective treatment plan, or don't follow your plan, the illness and consequences of it will likely worsen, resulting in one or more of the following problems:

- Increased frequency and severity of mood episodes
- Increased stress from the fallout of mood episodes
- Damaged relationships
- Loss of job or career status
- Increased financial problems
- Problems with thinking and memory

That's the bad news.

The good news is that effective medicines, self-help strategies, and therapies are available, and researchers are constantly developing newer and better treatments to add to the toolbox. Through medication, therapy, support, and your own efforts, you can look forward to achieving the following goals:

- Reduce or eliminate symptoms of mania and depression.
- Reduce the chances of experiencing major mood episodes in the future.
- Reduce or eliminate stressors that trigger mania or depression.
- Find and retain fulfilling and rewarding work.
- Repair damaged relationships and build new, healthy relationships.
- Restore your social and financial security.
- Keep your thinking and memory sharp.

REMEMBER

Recovery isn't necessarily a return to the way things used to be, although it very well can be. For some people, finding out they have bipolar disorder is the first step toward a different life that's better and more fulfilling.

Responding Reactively and Proactively to Bipolar Disorder

Major mood episodes can sneak up on you with the silence of a brooding sadness or the furtive stirrings of enthusiasm. Maybe you feel a little less tired one day, a little more energetic. That's normal. You figure it's nothing to worry about. After all, you have every right to enjoy your life, and you're looking forward to the weekend — TGIF! After work, you head to Wilma's Watering Hole for an evening of rowdiness with your old college pals.

You get home a little late — actually, early Saturday morning — and you're not even tired. You lie in bed for two hours, replaying the excitement of the evening on the insides of your eyelids. You finally manage to doze off, expecting to sleep until noon, but you wake up bright and early, raring to go. Why sleep when life's smorgasbord summons you to its feast?

Requiring less sleep and more stimulation, you race through each day of the week. By week's end, pedal to the metal, you're highballing down the hypomanic highway, and you don't even know how you got there. Now what?

Reacting: Extinguishing the flames

Enveloped by full-blown mania or depression, you face limited choices. If you pose no threat to yourself or others, you can choose to wait out the storm and hope the raging currents subside. But if your behavior becomes unbearable or dangerous — if you have suicidal or delusional — thoughts or become increasingly belligerent, for example — you or someone on your behalf may want to seek medical intervention in one or more of the following forms:

- **Hospitalization:** The safety and retreat that hospitalization provides is a good choice when you pose a threat to yourself or others, even though you may not think so at the time.
- **Intensive outpatient therapy:** A structured outpatient program allows you to focus on getting well by day and return home in the evening.
- **Medication:** You may require medicine to lift the depression or quell the mania.


REMEMBER

During a major mood episode, you may need to make some immediate changes, such as taking time off work and delegating responsibilities at home, especially if you're hospitalized. But even if you decide to use outpatient resources, allow yourself time away from immediate responsibilities at least until the medication

takes effect and you regain solid footing. Keep in mind that non-medication treatment options such as self-help and psychotherapy can be tough to get going and don't work as quickly as medication during active episodes. Those types of intervention are often better suited to long-term recovery, as we explain later in this chapter.

Preventing future flare-ups

How you respond to your diagnosis and how ambitiously you pursue treatment have a huge effect on your outcome. If you deny that you have a problem, lose hope, or try to self-medicate with alcohol and other substances, the disorder wins. If you discover the right medication, acquire some coping skills, confront your hidden demons through therapy, and remain vigilant, you prevail.


TIP

One of the best ways to derail a major mood episode is to remain attentive for signs of impending depression or mania and consult your doctor or therapist if you observe any warning signs. A medication adjustment or some help dealing effectively with a situation that's currently stressing you out may be all you need to avoid a major meltdown. To find out more about monitoring your moods, turn to Chapter 11.

HOW MUCH STRESS CAN TRIGGER AN EPISODE?

In the 1990s some researchers exploring the connections between life stress and mood episodes suggested that early mood episodes require a larger stress load whereas later episodes can be triggered with less severe stress. This is the *kindling hypothesis*, which is rooted in studies of seizures and epilepsy — the more seizures a person has, the lower threshold that person's brain seems to have for seizures.

Seizures and mood episodes are both associated with abnormal electrochemical signaling in the brain, and some antiseizure medicines help to reduce bipolar disorder symptoms. With these similarities in mind, some researchers suggested a similar kindling model in bipolar mood episodes, but the evidence so far has been inconsistent. In this original version of the kindling model, mood episodes were thought to prime the brain to be more reactive to stressors, so that smaller stressors would trigger later episodes.

Since then, substantial research has shown an association between early life stressors and a more severe course of bipolar disorder. This connection has led to alternative models of the kindling hypothesis in which negative childhood experiences may cause

a person to need only minor stressors to trigger their first bipolar mood episode — the childhood stress "kindled" the brain to be more reactive. This model suggests that further episodes may then happen regardless of stressors.

A number of studies have shown associations between the development of bipolar disorder and stressful early life events. Ongoing research continues to uncover the underlying neurobiological reasons for these connections. Given the complexity of these theories, their related models require much more research to understand more fully.

Evidence does seem clear that the more episodes people have, the more damage their brains suffer. But evidence isn't clear that these brain changes make it easier for someone to have a mood episode without a stress trigger.

Studies also show that stressful life events, including good stress (very happy events or goal attainment) and bad stress (loss, in particular), are associated with the onset of some mood episodes in many people with bipolar disorder. How the events actually trigger the biological responses of mood episodes is still being worked out.

Taking a Quick Look at Treatment Options

Bipolar disorder is a physical illness related to the neurobiology of the brain and the body (see Chapter 2), so standard protocol for treating it involves medication — typically a mood stabilizer and/or antipsychotic with or without an antidepressant added.

In rare circumstances, medication works so well that it's the only treatment needed. In most situations, however, medication isn't sufficient to offset the stressors and triggers in a person's life and to manage the new challenges that arise due to the illness. Additional interventions in the form of self-help, certain types of psychotherapies, and relationship and family education and counseling are usually needed. The following sections describe the treatment options and interventions that many people with bipolar have found most useful.


REMEMBER

What works for one person may not work for another. In addition, some people prefer certain treatments to others. Our approach is to present various treatment options as a menu from which to choose, typically in consultation with your treatment team. Although medication is usually the main course, many people find that adding self-help and therapy improves the fullness, speed, and durability of recovery.

Exploring medication and other biological remedies

The first order of business in treating bipolar disorder is to treat the dysregulated brain function. Such treatment usually requires medication and may also include other biological methods that specifically target brain function, such as nutritional supplements and light therapy. In the following sections, we touch on some common biological treatment options for bipolar. Chapters 7 through 9 describe these options in greater detail.

Getting the right meds for your condition

The first, fastest, and generally most effective treatment for mania or depression is medication, which treats *acute* (severe, short-term) symptoms and is used as a *prophylaxis* (preventive) to avoid further cycles. Chapter 7 introduces you to the medications most often used to treat bipolar depression and mania. The medication choices are based on where someone is in the cycle of the disorder:

- **Acute mania:** Lithium and valproate (Depakote) have historically been the mainstays of treatment for an acute manic episode. However, antipsychotics, such as olanzapine (Zyprexa), risperidone (Risperdal), or asenapine (Saphris) may also be used as first choices when someone is suffering with acute mania. Doctors usually try to use just one medication, but sometimes a combination of lithium or valproate with an antipsychotic is needed.
- **Acute bipolar depression:** Depression causes some of the most chronic and devastating effects in bipolar disorder, but it's still one of the hardest parts to treat. Treatment with antidepressant *monotherapy* (using a medication by itself without any other medications), such as fluoxetine (Prozac) or paroxetine (Paxil), appears to be less effective in bipolar depression and also carries a risk of switching someone from depression to mania. The research suggests that antidepressants, if used in bipolar disorder, should be prescribed with one of the antimanic agents, such as lithium or valproate, or an antipsychotic.
- **Maintenance treatment:** After an acute episode is resolved, medication is often part of the plan to help reduce the likelihood of having another mood episode of either the depressive or manic type. Lithium is the gold standard for maintenance care in bipolar disorder, but other medications such as valproate, lamotrigine (Lamictal), and certain antipsychotics are often used for this purpose.

These general treatment guidelines apply primarily to bipolar I. The treatment guidelines for bipolar II are much less clear. Although antidepressants may play a larger role in bipolar II than in bipolar I, the risk of switching to a manic or hypomanic episode while taking antidepressants still seems to be present.

Other categories of medications may be used to treat associated problems of bipolar disorder, including sedatives, such as lorazepam (Ativan) for agitation or anxiety, and sleep medications, such as zolpidem (Ambien) for severe insomnia.

The goal of medication treatment is to get maximum benefit while taking the fewest medications. Unfortunately, because bipolar disorder presents with completely opposite symptoms (manic and depressive) in the same person at different times, most people require more than one medication.

REMEMBER

Prescription medication isn't designed to cure bipolar or to solve all your problems. It's prescribed to treat the brain circuitry disruptions so the rest of your being can function without the interference of mania or depression. When your brain is functioning more adaptively you may be able to make adjustments that accelerate your recovery and offer added protection against new episodes.

Few people *like* taking medicine, especially to treat a chronic or long-term condition such as diabetes or bipolar disorder. Taking medication regularly is a hassle, some medications have undesirable side effects, and people don't want to think of themselves as needing a pill to function normally. Even people without bipolar have a tough time sticking with their treatment plans; just think of how many times people stop taking their antibiotics as soon as they start feeling better, even though the doctor and pharmacist made a point of telling them to take it until the bottle's empty. Coming to terms with medication is a big first step toward recovery. We address this issue in Chapter 8.

Exploring other biological treatment options

Although medication is usually the most effective approach for treating bipolar disorder, other treatments may have a role in treating bipolar disorder, depending on how well medication works or is tolerated. These can include interventions such as vitamins or supplements and brain stimulation therapies. These treatments generally fall into two categories:

- **Vitamins and supplements:** Omega-3 fatty acids (fish oil), folic acid, and N-acetyl cysteine (NAC), among others, are sometimes used to augment response to medications.
- **Brain stimulation:** Light therapy, electroconvulsive therapy (ECT), repetitive transcranial magnetic stimulation (rTMS), and deep brain stimulation (DBS) may replace or supplement medication treatment options.

See Chapter 9 for more details on these options and other alternative and complementary treatments.

Sampling self-care strategies: The big five

Overall health and stress levels impact the brain. Recent research even suggests that these factors can flip certain genes on or off to protect against or trigger illness. To give your body, including your brain, what it needs to function well, focus on five major areas: sleep, nutrition, exercise, stress management, and relationships.

Sleep

A decreased need for sleep is not only an early warning sign of an impending mood episode, but it's also a possible trigger for mania or depression. Sleep deprivation traumatizes the brain and the body and increases your risk of illness and injury, both of which make managing bipolar disorder more difficult.


REMEMBER

Your doctor may prescribe medication to help you sleep, but you can take additional steps to improve sleep quantity and quality. Many people find that establishing a regular routine of going to bed at the same time every night and waking at the same time every morning does wonders. Avoiding caffeine and other stimulants close to bedtime also helps. For more suggestions, check out Chapter 12.

Nutrition

Although no particular diet can stop the symptoms of bipolar disorder, making healthy and satisfying nutritional choices can help to reduce the risk of other major health problems, such as cardiovascular disease and diabetes, and improve your overall sense of wellbeing. Choosing foods that serve your health goals is more important than an overemphasis on losing weight; weight can be fickle and difficult to change, whereas your food choices are more manageable. Chapter 12 spells out how to incorporate nutrition into your daily life.

Physical activity

Physical activity is particularly helpful for relieving depression, but overdoing it can be a sign of a looming manic episode. Look for opportunities to get your body in motion on a daily basis; walking is a good start. Consider a super short period of vigorous movement; strongly increasing your heart rate even for just one minute a day may be enough to improve your overall health. Find an exercise or activity you enjoy, so you'll be more likely to do it and stick with it. Check out Chapter 12 for additional guidance.

Stress management

Stress is anything that stimulates or places a demand on the mind, body, or emotions. It can come from inside or outside and can be negative or positive. A ringing phone is a source of stress, but the actual content and intensity of the stress varies

widely depending on several factors, including who's calling and about what. In response to a stressor or a demand, the body kicks off a variety of internal changes to help respond appropriately to the situation.

Bipolar disorder affects the stress response system, making it harder for the body to turn off the internal chemical responses when they're no longer needed. High doses of stress such as big life events, both good and bad, can destabilize mood and trigger episodes, so look for ways to dial down the pressure in your life. You can't eliminate all stress, but identifying sources of high intensity stress or distress that's chronic and never lets up is a good first step. (See Chapter 14 for additional suggestions.)

Relationships

When you have bipolar disorder, you quickly find out who your true friends are. They're the ones who don't judge you, who try to learn about the disorder, and who offer to lend an ear and a hand without treating you like a child. Having at least one good friend in your corner is essential. Surrounding yourself with a network of supportive friends, family members, and others is even better. However, you may need to make some tough relationship choices along the way and work on the relationships you decide to invest in. (See Chapters 13 and 14 for communication and problem-solving tips that can help.)

Reviewing foundational skills for success

Assuming that you're *not* in the throes of a major mood episode, you can do a great deal on your own to maintain mood stability and avoid future manic and depressive episodes, especially if the people closest to you are on board. Here are some of the most effective ways to help (see Part IV for details):

- **Take your meds.** The best way to improve the course of the illness is to prevent mood episodes, and the most effective means for doing so is medication. The urge to stop taking bipolar meds is common and understandable, as we explain in Chapter 8, but it significantly increases the chances of a future mood episode, and every mood episode you have is likely to worsen the course of the illness.
- **Monitor your moods.** Keeping track of your ups and downs can help you identify what works to help you stay within a comfortable range and what doesn't. It can also reduce the chances that you'll experience a major mood episode. If you know you're starting to cycle into mania or depression, your doctor may be able to adjust your medications to help you avoid hospitalization.
- **Identify your triggers.** Certain situations, seasons, people, or activities may trigger mood instability. Try to identify patterns in your life that match up with

your shifting moods. These patterns may help you pin down triggers and open your eyes to creative solutions for dealing with them. For example, some people who tend to have mood episodes around the holidays scale back their traditional holiday activities.

- **Establish healthy routines.** Many people with bipolar disorder discover that a well-regulated life helps to regulate their mood. Routines may cover sleep/wake times, meal times, a regular work schedule, and even social engagements.

REMEMBER

By reading this book, you're already engaged in one of the most important self-help activities — *psychoeducation.* Finding out more about bipolar disorder and how to successfully live with it empowers you to make well-informed decisions about the various treatment options available. Psychoeducation also helps your friends and family develop the empathy they need to accept your illness and support you.

Comparing psychotherapies and other professional counseling

Certain therapies and types of professional counseling, if available and affordable, are often valuable additions to a bipolar treatment plan. Here are some therapies and other professional offerings to consider:

- **Cognitive behavioral therapy (CBT):** The premise of CBT is that thoughts, feelings, and behaviors are closely interconnected. As we explain in Chapter 11, CBT is especially effective in treating depression and anxiety. Its effectiveness in reducing manic symptoms is less studied.
- **Dialectical behavioral therapy (DBT):** A type of cognitive behavioral therapy, DBT is focused on helping individuals build a toolbox of skills for self-regulation and interpersonal relationships. (See Chapter 11 for more details.)
- **Interpersonal and social rhythm therapy (IPSRT):** This treatment focuses on helping people regulate their mood symptoms by learning about and managing their daily activity and social rhythms. Working toward more structured and predictable rhythms and establishing healthy routines can improve mood stability. Changes in these rhythms seem to disrupt the body's systems of mood regulation. IPSRT strives to build and maintain healthy rhythms in your life and improve interpersonal function. It targets resolution of acute episodes as well as reduction of recurrent episodes. (See Chapter 11 for more details.)
- **Mindfulness:** According to Jon Kabat-Zin, the creator of Mindfulness Based Stress Reduction (a meditation-based program for alleviating stress),

mindfulness is "awareness that arises through paying attention, on purpose, in the present moment, non-judgmentally." It's a type of meditation that, when practiced regularly, has been shown to improve mood, attention, and general sense of wellbeing. Other mindfulness practices (including yoga and tai chi) may have similar positive effects on calming the mind and increasing awareness in the moment. (See Chapter 11 for more about mindfulness.)

- **Vocational therapy or career counseling:** Jobs, bosses, and coworkers can be major stressors, especially if you're dealing with bipolar as well. A vocational therapist may be able to help you work with your employer to establish reasonable work accommodations that enable you to continue performing your current duties. Or a career counselor may be able to help you find work that's more conducive to your situation.
- **Financial-resource guidance:** People with bipolar often have serious financial problems that don't reflect their financial prowess; bipolar depletes resources, especially for those who can't afford or qualify for health insurance. A financial advisor may be able to help you better manage the resources you have, but guidance on where and how to access free and affordable assistance may be vital. See Chapter 18 for tips on overcoming financial setbacks related to this illness.


TIP

Hiring a professional therapist or advisor may be the ideal option, but this help may not be accessible because of where you live or what you can afford. You can still benefit from some of these therapies by reading about them, watching videos, and/or participating in support groups.

Rounding up the troops: Relationship and family support

Studies show that bipolar recovery is faster and more durable when it occurs in a community that understands and supports the person who has the disorder. Ideally, when someone experiences a major mood episode, the person's entire family becomes involved and the treatment team keeps them informed about what's going on and how to help. However, what often happens is that the person who has bipolar is treated and released to return to a family or community that doesn't understand the condition and lacks the knowledge and skills needed to cope with it. If you're a family member or friend of someone with bipolar disorder, we encourage you to explore the following:

- **Psychoeducation:** Understanding and accepting the fact that bipolar disorder is a physical illness are two big steps toward being able to empathize with a family member or friend who has the disorder.

- **Communication skills:** Even if you have no problem communicating with people in general, bipolar disorder can make it feel that typical communication is useless. You can develop and practice certain techniques to help you express yourself more effectively with your loved one. You can also develop strategies to allow for everyone to listen more fully and to reduce knee-jerk emotional responses on all sides. Flip to Chapter 13 to find out more.
- **Problem-solving skills:** Bipolar may seem to be one big problem, but it's actually a number of smaller problems, and if you approach it that way, you're more likely to improve your success. Sometimes, what you may think is a relationship issue is just a problem that needs to be solved, not a battle that needs to be won. In Chapter 14, we explore some problem-solving strategies.
- **Boundaries:** You can't control what someone else says or does or the demands they place on you, but you can decide how you respond. By establishing reasonable boundaries, you can make sure to take care of your own needs and protect yourself from factors outside of your control.
- **Self-help:** Taking care of yourself physically, emotionally, spiritually, and socially is essential to maintaining the health and strength required to support a loved one with bipolar.

WARNING

Families often require intensive, rescue-type support and intervention during an acute mood episode, but it's often best to wait until the depression or mania has lifted before attempting intensive relationship or family therapy. Trying to resolve issues with someone who's in the throes of depression or mania is likely to be counterproductive and lead to more conflict, not less.

Ensuring continuity of care

Continuity of care is an extremely important factor in the success of long-term management of bipolar disorder. If you shuffle from one doctor or therapist to the next and the changes result in medication and therapy adjustments, your moods are likely to fluctuate. Unfortunately, changes in health insurance and other factors outside of your control often lead to changes in doctors and treatments. A therapist, caseworker, family member, or friend can often help you advocate for services and maintain an effective and consistent treatment plan.

TIP

If you have an insurance provider, call and ask whether it has case managers. Many insurance companies have case managers to help control costs, but these folks can also serve as treatment advocates if you're having trouble obtaining certain medications or getting in to see your doctor or therapist. After all, hospitalizations are expensive, and insurance companies have a strong financial incentive to keep you out of the hospital. They can also help you maintain the continuity of care you need to stay healthy.

2 Obtaining a Diagnosis, Developing a Treatment Plan, and Building a Team

IN THIS PART . . .

Choose an expert who's fully qualified to perform your diagnosis — ideally, a board-certified psychiatrist or another doctor or nurse practitioner with extensive training and experience in diagnosing and treating psychiatric illnesses.

Get up to speed on the steps involved in making an accurate diagnosis and ruling out other possibilities so you can tell whether the person performing your diagnosis is being thorough.

Discover ways you can help your doctor make an accurate and precise diagnosis more efficiently.

Understand what a comprehensive treatment plan should contain, and be sure that yours addresses three main areas — medication and other biological treatments, therapy, and self-help strategies.

Get suggestions on how you and your loved ones can most effectively team up with your doctors and therapists and with one another for optimal results.

Build an effective and efficient mood management team with a psychiatrist or nurse practitioner to prescribe medication, one or more counselors to provide therapy, and one or more carefully selected family members or friends to help with everything else.

IN THIS CHAPTER

- Finding a qualified professional to perform your diagnosis
- Understanding what a proper diagnostic process entails
- Ruling out other possibilities with a differential diagnosis
- Exploring other medical tests and procedures that may provide additional insights
- Arriving at and understanding the diagnosis

Chapter 4
Getting an Accurate Diagnosis

The first step on the road to recovery is an accurate diagnosis. It's the key to unlocking the toolbox containing the medical and therapeutic interventions that can stabilize your mood and energy and empower you to reclaim your life. We can't stress enough the importance of your diagnosis, and in this chapter, our goal is to help you improve your chances of getting the most accurate diagnosis possible.

Here we introduce you to the professionals who are most qualified to perform a psychiatric evaluation, and we shed light on what the process entails so you'll be able to tell whether you're getting a cursory check-up or an in-depth examination. We also introduce you to the concept of a differential diagnosis, which is important in ruling out other conditions that could be causing or contributing to your symptoms. Finally, we explain how your diagnostician is likely to put all the pieces of the puzzle together to formulate your diagnosis.

WARNING

Avoid the temptation to self-diagnose or to diagnose a loved one, a colleague, or an acquaintance. It often results in misdiagnosis and can be counterproductive to recovery.

Finding a Specialist to Perform Your Psychiatric Evaluation

When you're in the market for someone to perform a psychiatric evaluation of you or a loved one, you want to select from the pool of the most qualified candidates. In this section, we explain how to do just that.

Narrowing your list to qualified candidates

Any medical doctor can technically make a diagnosis of bipolar disorder, but most are not trained to fully evaluate and treat it. Clinical psychologists may do testing and evaluations that support a bipolar diagnosis, but they need to refer to a medical provider who can perform a full medical assessment and prescribe needed medication. Other therapists and social workers often have a keen eye and can suggest that a patient should be evaluated for bipolar disorder by a specialist.

Even if you have a preliminary diagnosis from your primary care physician or therapist, we recommend that you follow that up with a more thorough examination with one of the following professionals:

- **Psychiatrist:** A medical doctor with additional training in psychiatry. Psychiatrists have four years of college followed by four years of medical school, receiving either an M.D. or D.O. degree. After medical school they go through residency training in psychiatry, which is at least four years long and often longer if they further specialize by doing a *fellowship.* After training, they take an exam to be board-certified in their specialty. Child and adolescent psychiatrists train for an additional two years and take a specialty exam to be certified in working with kids as well as adults.
- **Psychiatric nurse practitioner (NP):** A registered nurse who gets a master of science degree in nursing (M.S.N.) or a doctorate of nursing practice (D.P.N.) degree to become an advanced practice registered nurse specializing in psychiatry. They must take a certifying exam to practice. They can evaluate and diagnose patients and can prescribe medications. Some states permit NPs to prescribe independently, whereas others require NPs to be supervised by a physician.

If a psychiatrist or psychiatric NP isn't accessible, other medical specialties may serve as your primary treatment provider for bipolar disorder, including the following:

- **Family practice specialist or pediatrician:** These primary care specialties include substantial mental health training in their residencies. Although they're not typically the main prescriber for bipolar disorder, they may do primary psychiatric prescribing in some situations. Internal medicine doctors also have some additional mental health training.

  In locations without enough psychiatric practitioners, primary care may have access to a consulting psychiatrist who can offer guidance while not being the main prescriber.

  Physician's assistant (PA): Some primary care practices may bring in a *physician's assistant* with specialty training and experience in psychiatry to increase mental health care options A PA has graduated college with required science classes, then taken a 26-month graduate school program to earn a master's degree. PAs can prescribe medication, but in most states, they must be supervised by a physician.

- **Neurologist:** A neurologist is an M.D. or D.O. who spent at least four years after medical school in a neurology residency program. Although psychiatry and neurology come under the same specialty board (American Board of Psychiatry and Neurology), their focus is on different diseases of the brain and central nervous system. However, neurologists do have more psychiatry training than other specialties, and neurologists and psychiatrists may work together, especially if someone has psychiatric symptoms and overlapping neurologic changes, such as problems with motor or speech functions.

Seeking referrals

Most people are happy to tell you all about their favorite doctors; they eagerly share the names of their orthopedic surgeon, cardiologist, or gynecologist. But if you ask someone for the name of a good psychiatrist, you can feel the temperature of the room drop. You can Google "psychiatrists near me" and get thousands of results, which can be hard to sort through, and the listings and websites you find can't give you more than superficial information about a doctor or practice.

Is finding a qualified psychiatrist a hit-or-miss proposition? Not exactly. You need to do a little homework, remain persistent, and test-drive a few options until you find the one that's right for you. In this section, we offer suggestions on where to start your search.

- **Ask your primary care provider:** Your primary care provider probably knows at least one psychiatrist to recommend. So when you report mood-related symptoms that your doc can't trace to a medical cause and are told to see a psychiatrist, ask for names.
- **Call your insurance company:** Insurance companies have contracts with certain doctors, including psychiatrists, whom they refer to as *preferred providers.* These doctors agree to the insurance company's rates, which may make you responsible for only your co-pay (depending on your plan).
- **Pick your therapist's brain:** Treatment need not begin with your family doctor or psychiatrist. If you're currently seeing a therapist (a psychologist or social worker) you like, request a referral to a psychiatrist. Your therapist is probably familiar with psychiatrists in your area, possibly within the same office.
- **Go online (but be careful!):** The Internet is an excellent tool for tracking down professional help of all kinds. When searching online for names of psychiatrists, use established, professional websites provided by a local medical society or a specialty society, such as the following:
  - **WebMD:** WebMD has a physician directory at `doctor.webmd.com`.
  - **American Psychiatric Association (APA):** Go to `finder.psychiatry.org` to access the organization's Find a Psychiatrist page.
  - **American Academy of Child & Adolescent Psychiatry (AACAP):** Head to AACAP's home page at `www.aacap.org`, open the Families/Youth menu, and select CAP Finder to access the Child and Adolescent Psychiatrist Finder.

Knowing what to look for in a psychiatric care provider

When you're shopping for a psychiatrist, you may begin to wonder who's doing the shopping. Everyone is grilling *you* with questions. When do you get to ask questions and obtain the information you need to make an educated choice? The answer to that question is "the sooner, the better."

REMEMBER

We provide a list of ten questions to ask a psychiatrist or therapist online at finkshrink.com/bonus.

Before your first visit, review your questions and prepare yourself. If you're not the assertive type, ask a friend or relative who's a little pushier to join you. Bringing along a trusted ally, especially for the first visit, can make all the difference in

getting the information you need and walking away with a good sense of how a psychiatrist may (or may not) work for you. Your support person can also provide valuable information to the doctor — details you may forget to share or consider too insignificant to mention. Don't be afraid to bring a list of questions with you and to jot down notes during your meeting. This list and the notes you take help you remember the important questions you want to ask and highlight what the doctor has told you that you may not remember clearly after you leave.

When scouting for a psychiatrist, consider the following criteria:

- **Experience:** Experience in treating mood disorders usually ensures a more accurate diagnosis and use of more effective and current treatments. Be sure to ask candidates how much experience they have in treating bipolar disorder.
- **Sensitivity:** Your psychiatrist should validate your emotions and concerns, without judgment or condescension. You should not feel that they are scolding you or treating you like a child. They should respect your autonomy in this process — you are making decisions together, with their expertise guiding you, but you have final say.
- **Willingness to communicate:** Your psychiatrist should not only prescribe medications but also explain the thinking behind the diagnosis and treatment recommendations. All your doctors should carefully discuss with you the potential risks, benefits, and alternatives to any medications before prescribing. It is important that they are open to your questions and give you time to express yourself.
- **Availability:** During active medication trials, you will need to see your provider frequently — often monthly. Is this provider available for these appointments or are they booking two months out? Also, you may have questions or concerns between scheduled meetings. How does your provider handle between-visit communications? Do they use email or other messaging platforms? If you call with a question, will they call you back?
- **Virtual vs. in-person:** Is this doctor or NP available for in-person visits or only virtually? Or do they do a combination? Most psychiatric providers moved to virtual care during the COVID-19 pandemic. Many now offer some combination of in-person and online care. At the same time, fully virtual *Telemedicine* practices have sprung up — and they only do virtual care. Many factors go into deciding which type of encounter works best for you. See Chapter 11 for a more detailed discussion of decision making around in-person or virtual care.
- **Affordability:** Is the doctor you've chosen included in your insurance plan? Do fees for office visits fit in your budget? Does the doctor offer a payment plan?

REMEMBER

Your doctor should be *board-certified* in psychiatry, meaning the doctor has passed a rigorous set of exams that indicate mastery in the field of psychiatry. In the United States, you can find out whether a psychiatrist is board-certified by going to the website for the American Board of Psychiatry and Neurology, `www.abpn.com`, clicking the ABPN verifyCERT link, and searching for the doctor by name. Both medical doctors (MDs) and doctors of osteopathy (DOs) can become certified by the ABPN. DOs may alternatively or additionally be certified by the American Osteopathic Board of Neurology and Psychiatry (`certification.osteopathic.org/neurology-psychiatry`). You can search for a DO by location and specialty at `findado.osteopathic.org`.

Knowing What Happens During a Psychiatric Evaluation

The initial psychiatric evaluation can take place in a doctor's office, or it could be in an emergency room or in a psychiatric inpatient setting. The location depends on the severity of symptoms and how rapidly they developed. If the symptoms develop gradually and don't present a risk of harm to self or others, an outpatient doctor's office is more likely. If symptoms come on quickly and escalate rapidly, especially if psychosis or risk of harm to self or others are present, a loved one (or someone else) may contact 911. In an emergency setting, the emergency room doctor, usually in consultation with a psychiatrist, conducts a brief assessment, but if hospitalization becomes necessary, a more complete evaluation will be conducted in the hospital.

Regardless of the setting, the doctor should gather detailed information about your symptoms and your medical and psychiatric history and then order necessary tests and procedures to rule out other medical causes. Although the symptoms may look "classically" like mania or depression and the doctor may start medications for bipolar right away, other possible causes for your symptoms must be ruled out before fully committing to a diagnosis of bipolar disorder.

This section reveals what that diagnostic process looks like, so you know what to expect and can start formulating questions you may want to ask your doctor during the process.

Exploring what's happening now

During your first meeting, your psychiatrist (or other treatment provider) tries to write your story in medical terms that accurately describe your symptoms. Because

there's no test for bipolar disorder, your doctor will ask you lots of questions, many of which may strike you as highly personal, to gather the information and insights required to formulate an accurate diagnosis. The information gathered through this Q&A session can be broken down into two categories:

- **Subjective information:** The insight and details you choose to provide about how you feel, what you're thinking, how you've been behaving recently, and what other people have been noticing about you
- **Objective information:** Your psychiatrist's observations of your appearance, behaviors, speech, mood state, and thoughts as well as your reactions to the interview

TIP

Your best shot at receiving an accurate diagnosis is to be honest and open with your psychiatrist and to clearly describe your thoughts, behaviors, and feelings.

To prepare for your evaluation, gather the information we describe in this section in your head, in a note on your phone, or on paper, and get ready to share the intimate details.

Your chief complaint

The first thing your psychiatrist wants to know is your *chief complaint* — what's going on that prompted you to seek a psychiatric evaluation. This is a story that starts at the end and then goes back to fill in the details. Perhaps you've been bedridden for days, raging for weeks, spending money extravagantly, feeling completely overwhelmed by everything on your to-do list, or getting into more arguments than usual. If someone recommended that you see a psychiatrist or therapist, explain why that person thinks you need help — or even bring that person along for part of your initial meeting with the psychiatrist if you feel comfortable doing so.

Current medications and allergies

Before digging deeper into your current symptoms, your provider reviews your current medications — all of them, not just the psych meds you may be on. This critical step provides the doctor important information about your recent health, including mental health concerns. The doctor also looks for any psychiatric side effects of your medications or interactions between medications that could be contributing to your present problems. Any allergies or sensitivities to medications are also considered.

CAN'T YOU JUST TEST ME?

Unfortunately, at the time of this writing, the technology to test for bipolar disorder doesn't exist for several reasons. Among them are that bipolar disorder is probably a collection of different conditions; the related brain changes are at microscopic levels that are difficult for scans to detect; and blood chemistry tests don't accurately depict brain chemistry and function.

But don't throw in the towel just yet. The future holds out hope in the form of some new and improved detection tools. Some innovations include the following:

- A functional magnetic resonance imaging (MRI) scan measures tiny metabolic changes that determine activity patterns in different parts of your brain during mental tasks and mood states. This and other *functional imaging* technologies may someday be able to detect consistent differences between brains with bipolar disorder and those without.
- Genetic research is looking for genetic and epigenetic patterns associated with bipolar disorder in humans with the illness and in animal models of mania and depression. By identifying genetic patterns that are consistently associated with bipolar disorder, researchers can find out which proteins and patterns of proteins and enzymes play a role in the development of symptoms. This knowledge may allow for the development of blood tests for these *biomarkers* (substances whose presence indicate a condition).
- Neuropsychological tests (paper-and-pencil testing) may help map patterns of attention, memory, and information processing (executive function) that appear to be associated with bipolar disorder. These tests may eventually aid in the early identification of bipolar disorder in children with attention and behavioral problems.

The history of present illness

Next up is your *history of present illness* — the description of the development of your current medical condition. To find out more about your symptoms and what may be causing them, your doctor asks questions about your mood, thought patterns, behaviors, and so on that are causing problems now and may have caused problems in the past. Here are some sample questions you can expect.

Mood-related questions:

- How has your mood been? How long has this been going on?
- Are you experiencing sadness for longer than usual?

- Are you feeling happier than usual? Are you feeling happier than you have felt in your life?
- How about irritability and anger? Are you getting into more arguments than usual or experiencing extreme anger episodes?
- How different are these mood symptoms from your usual mood? Can people around you notice the changes?

Thought-related questions:

- Does your thinking feel slowed down to you? Are you endlessly criticizing yourself and experiencing guilty thoughts all the time?
- Do you feel mentally foggy? Are you having trouble with focus and/or memory? Do you think that things are hopeless?
- Do you think frequently about death and dying? Do you think about killing yourself or hurting anyone else? Do you think about just running away or just not being around anymore? Do you feel trapped?
- Are your thoughts going faster than usual? Are you stuck on certain topics or are you flying from subject to subject without clear connections? Has it become hard for anyone else to get a word in edgewise when you are talking? Do you feel like your focus is better than usual — maybe even the best it's ever been?
- Are you worried that people are trying to harm you? Do you notice more coincidences and suddenly see connections that affect you? Do you think you have special inside knowledge or information that you must share with others?
- Do you think that people are monitoring your devices? Have you suddenly become more religious than usual? Have you heard voices that other people can't hear, or do you see messages or codes directed specifically at you through TV, newspaper, or radio? Do you feel that people are getting into your mind and changing how you think or that you can get into other people's minds?

Behavior and energy–related questions:

- Do you feel as though your energy level is much lower than usual? Are you having a harder time doing things? Can you enjoy things you usually get pleasure from? Do you feel like your body is slowed down?
- Are you more energized than usual and doing more activities and making more plans? Are you more impulsive than usual? Are you taking risks that you wouldn't usually take?

- Are you drinking more alcohol or using more cannabis than usual? Are you partying and going out more often? Are you trying new or more extreme substances and or connecting more with social groups focused on substance use?

Body maintenance and rhythm questions:

- How is your sleep? Are you having trouble falling asleep or staying asleep? Are you tired all the time? Or are you sleeping less than usual and not feeling tired?
- Has your eating or appetite changed? Are you more or less hungry than usual? Have you gained or lost weight? Have you changed your diet dramatically — for example, fasting or limiting yourself to one food group?

Questions about anxieties and compulsive behaviors:

- How much do you worry about things?
- Are you over-thinking everything?
- Is making decisions more difficult than usual?
- Have you ever had a panic attack?
- Do you have unwanted thoughts that don't go away or illogical behaviors you can't stop doing?
- Do you freeze in social situations or avoid them altogether?

The review of systems

You can also expect your doctor to ask about your other current medical symptoms. Your answers to these questions may provide clues that point to other possible conditions that could cause your presenting symptoms. This inquiry is called a *review of systems.* Here are a few possible questions you may hear:

- Have you experienced headaches, muscle aches, or weakness? Changes in your ability to speak or use language? Memory loss? Known seizures? Have you had recent head injuries or concussions?
- Have you experienced nausea, vomiting, abdominal pain, or changes in bowel habits?
- Do you have joint pain or swelling?
- Have you noticed rashes or skin changes? Any changes to your hair texture or any hair loss?

- Are there any changes in your breathing or your exercise tolerance?
- Are you thirsty all the time? Do you have to urinate frequently? Have you noticed any changes in your ability to tolerate heat or cold?
- Has your sex drive or ability to function sexually changed at all?


REMEMBER

Although these questions may seem unrelated to your chief complaint, your answers guide your doctor toward lab tests and/or imaging and possibly referral to other medical specialists.

Current stressors — Possible triggers

Life events or stressors are related to developing bipolar disorder, so your doctor is likely to ask whether any recent events may be contributing to your symptoms. Do your homework and try to pinpoint events or times of change in your life that correspond with the onset of your symptoms, such as a medication change, a recent illness, an accident or fall, the loss of a loved one, a job loss or incident at work, final exams, a relationship breakup, a change in family structure (such as an adult child leaving home), or a pregnancy, menopause, or a change in your menstrual cycle.

Bipolar disorder has its roots in early brain development, so earlier life experiences will be important to discuss as well — see the later section "Digging into your past" for details.

What makes your symptoms better or worse

Your doctor is likely to ask additional questions to find out whether anything makes you feel better or worse or what interventions you have already tried. Your answers to these questions can help guide both the diagnosis and your doctor's treatment recommendations. Here are a few sample questions:

- Do you feel better or worse at any specific time of day? In the morning? After lunch? After work? Before bed?
- Do the seasons affect your symptoms?
- Do your symptoms worsen near certain holidays or anniversaries, particularly anniversaries of losses or other traumatic events?
- Do any medications you currently take make you feel better or worse?
- Do any activities make you feel better or worse?
- Do any substances, such as caffeine, nicotine, cannabis, or alcohol, alleviate symptoms or make them worse? (No, we're not recommending that you try these substances to see if they make you feel better.)

Symptom scales

Symptom scales are questionnaires that the doctor may ask you to fill out to help understand more about the patterns and severity of your current illness. These scales don't stand alone in terms of making a diagnosis — they're a small part of the evaluation. But they can help quantify some of the core symptoms present at the first visit. Monitoring how your scores change in response to treatment can also be very helpful.

REMEMBER

For some people, answering questions on paper or on the computer may be easier than talking about them. In those situations, rating scales may pick up important symptoms that could get missed in the interview.

Some of the most-commonly-used symptom scales include the following:

- **For depression:** The Patient Health Questionaire-9 (PHQ-9) and Beck Depression Inventory
- **For anxiety:** The GAD-7 and Beck Anxiety Inventory
- **For mania:** The Young Mania Rating Scale and the Mood Disorders Questionnaire (MDQ)

Outside of mood symptoms, providers may ask you to fill out other types of questionnaires about other symptoms such as trauma, substance use, attention deficit hyperactivity disorder, and memory and attention problems. A doctor who's concerned about memory or other neurologic problems may administer a brief cognitive test, such as the Montreal Cognitive Assessment (MoCA).

When evaluating a child or adolescent, doctors may use scales specifically created for the patient's age group. These scales usually include a mix of self-report (the child answers the questions), parent report, and teacher reports. Gathering "collateral information" is essential in child and adolescent psychiatry.

Digging into your past

After you fully describe what's going on now, your psychiatrist can start collecting details about your past history (psychiatric and medical), family history, history of substance use, social history, and more. Through this systematic, information gathering, your psychiatrist attempts to assemble important data that will tell a more complete story of your current difficulties.

Past psychiatric history

Your past psychiatric history includes any prior psychiatric treatment, including outpatient and inpatient (hospital). The more details you can share, the better

picture the doctor will have of what's happened up until now, which informs the current episode. Questions specifically address any suicide attempts or self-harm, along with medications you've been prescribed, whether they helped, and whether you experienced any adverse side effects.

Past medical history

Have you had any serious medical problems in the past? If so, how was the problem managed and what was the outcome? Did you have to be admitted to the hospital? Do you have any chronic medical conditions? What surgeries have you had?

Past neurological history

For example, any history of strokes, head injuries, or seizures. Your doctor will ask about pain syndromes, especially headaches such as migraine.

History of substance use

At some point in the initial evaluation, the doctor will ask about your current and previous use of substances — alcohol, tobacco, cannabis, and other recreational substances. Being totally honest is important regardless of how uncomfortable these disclosures may be. Your substance use is part of your overall health, is critical in the doctor's understanding of a possible bipolar disorder diagnosis, and informs decisions about medications to prescribe. If someone is with you in the appointment, and you don't want them to hear the whole story, you can ask for this to be a private conversation.

WARNING

Hiding drug or alcohol use from your psychiatrist can be fatal. Don't do it. Muster up all your courage, ditch your shame, and spill your guts. This will aid your recovery, and it may save your life.

Developmental and trauma history

In pediatrics and child psychiatry, the doctor always asks about the child's development until the present. Knowing about early challenges such as delays in speech or motor skills, provides valuable information in putting together a diagnosis for children.

Although doctors who work primarily with adults don't always ask about early development, knowing this information can help build the story of a possible bipolar diagnosis. Most research points to mental illness, including bipolar, being *neurodevelopmental* in origin. This means that the circuitry and brain changes that eventually become bipolar symptoms occur early in brain development — from in-utero through childhood. And although the actual bipolar symptoms may not

show until later, many people with bipolar have a history of some developmental and/or early emotional or behavioral difficulties.

The doctor will also want to know about your early life experiences, particularly *adverse childhood events (ACES)*. The science is clear that the number of ACES a child experiences has a large impact on health in adulthood, including mental health. Although the doctor won't be able to say for sure how your childhood experiences relate to your bipolar disorder, knowing about the connection between ACES and health can provide you with tools for monitoring and caring for your physical and mental health throughout your life.

It is also important for your doctor to know any history of trauma in your life, which can range from physical or sexual abuse or assault to losing your home in a fire, a motor vehicle accident, or anything that caused you extreme fear and distress, once or multiple times. Trauma affects brain development and is likely related to how some genetic vulnerabilities ultimately present as bipolar disorder.

Family history

When you start shaking the family tree of a person who exhibits classic bipolar symptoms, skeletons often rain down from the branches. Those skeletons, so to speak, can help your psychiatrist do the following:

- **Simplify the diagnosis.** If a first-degree relative (immediate family member) has a mood disorder, a schizophrenia diagnosis, or a history of suicidal thoughts or behaviors, your risk of having a mood disorder is significantly higher (see Chapter 2). Second-degree relatives (uncles, aunts, and cousins) count, too, but to a lesser degree.
- **Explore the risk of bipolar disorder if your only symptoms are depressive.** If you're experiencing depression and haven't experienced any manic or hypomanic symptoms but do have a family history of mania or schizophrenia, then you have a higher risk of eventually experiencing a manic or hypomanic episode.

  Prescribing an antidepressant alone to a person who has bipolar may be less effective for the depression and, in some cases, may increase the risk of a manic shift. So, if bipolar is part of your immediate family history — even if you have no manic symptoms — your psychiatrist will likely be cautious in prescribing antidepressants, may monitor you closely (especially in the first weeks you're taking the antidepressant), and may be quicker to add an antimanic drug to prevent a shift into mania.
- **Determine the most effective medications.** If a particular medication or therapy has effectively treated one of your first-degree relatives or caused a

terrible side effect in someone in your family, your psychiatrist may use that information when choosing your initial medications. But just because a certain medication worked or didn't for a close relative doesn't mean it'll have the same effect on you.

REMEMBER

Following are a few points to keep in mind regarding your family history:

- You may not have a formal diagnosis for people in your family — especially in previous generations. But if one or more people in the family showed serious behavioral quirks — never left the house, used alcohol or other substances excessively, or kept tinfoil on the windows to keep out the aliens — they're worth mentioning.
- Don't limit your family history to diagnoses of bipolar disorder. Report all psychiatric problems: schizophrenia, depression, anxiety disorders, panic attacks, anger/aggression, substance use, and so on. Different disorders often share common genetic factors, and substance use in a relative can hint at underlying mood or anxiety disorders.
- Tell your psychiatrist about any suicides in your family. The risk of suicide seems to run genetically, apart from bipolar and depression.

Social history

Your social history gives your provider a chance to learn more about your life beyond your symptoms. What do you do for a living and how is it going? How are the relationships in your life with your partner, family, friends? What do you do for fun? Do you have children? Your provider also wants to know how you take care of yourself physically and emotionally. Do you get a chance to exercise? Do you meditate or engage in some other mindfulness practice? What brings you joy?

REMEMBER

Some of the questions are much easier to answer with the help of a significant other or a close family member who can offer some details that you may not remember or see in yourself. If your significant other or another family member is willing and you're comfortable with that person being in the office with you, the two of you can provide more valuable information more quickly and completely than if you go it alone. (If you want to exclude them from any part of the conversation, you can ask them to step out.)

REMEMBER

At some point during your initial meeting, your doctor is almost certain to ask about your safety; for example, whether you feel safe in your current relationship and living situation, or if someone is hurting you emotionally or physically. These questions should always be asked in private — without your partner. If you're afraid of your partner or someone else in your home, and your doctor doesn't ask, request a private conversation so you can disclose this sensitive information.

Being aware of other steps a psych evaluation may involve

Your psych evaluation is likely to extend to information beyond what you provide during your meeting with your doctor — namely your medical records and anything your other healthcare providers may be able to offer that may shed light on your diagnosis.

Reviewing old records and reports

If you have had previous treatment, the evaluating doctor may ask for copies of previous records from doctors, therapists, or hospitals. If you have had any labs done or other testing such as brain scans, your doctor may ask to see those as well. These records and reports are most likely to include psychiatric care, but sometimes other medical records can be important, including neurology, rheumatology, and cardiology records.

You will need to sign a release for the prior doctors, clinics, or hospitals to send the information to your new doctor. You can refuse to have the information released, but discuss with your new doctor the reasons why you don't want to share that information.

Communicating with other providers

If you've been working with a therapist for a while, your doctor may want to speak with that person. The team of the psychiatrist and the therapist can be most effective when sharing information and coordinating care. If other providers are involved, such as a case manager, the doctor may also want to speak with them.

With children and teens, the doctor may want to speak with the treating therapist and with anybody providing counseling or support at school as well.

Starting with a Differential Diagnosis

After obtaining all the information described in the previous section, your doctor or NP begins the process of sorting out what diagnoses could cause your collection of symptoms. This process is called a *differential diagnosis.* The symptoms and problems that are associated with bipolar disorder can be associated with other medical and psychiatric conditions as well. When performing a differential diagnosis, your doctor assembles all the pieces of the puzzle to determine whether a bipolar diagnosis is the most likely explanation. Ultimately, arriving at the correct diagnosis is essential to choosing effective treatments.

Considering other psychiatric causes

The symptoms of bipolar disorder overlap with many other psychiatric diagnoses. It's only when they come together specifically in patterns of mood cycles, that include manic and depressive episodes, that the diagnosis is made. Before diagnosing bipolar disorder, your doctor must consider other possible diagnoses, including the following:

- **Unipolar depression:** Recurrent episodes of depression, without hypomanic or manic episodes is characteristic of unipolar depression. Identifying the presence of the higher mood/energy cycles is key to making the bipolar diagnosis; however a higher energy period after depression could be related to the relief and elation of finally feeling better and being more active. Time is often important in sorting this out. A type of depression that's accompanied by agitation can be another source of uncertainty.
- **Schizophrenia or schizoaffective disorder:** Schizophrenia and schizoaffective disorders is a mental illness in which *psychosis* (thinking disconnected from reality) is the primary symptom and occurs outside any mood episodes. In contrast, with bipolar disorder, psychosis occurs only during mood episodes — depression or mania.
- **Anxiety and panic disorders:** Anxiety disorders can sometimes look like a mood episode, and differentiating between the two is extremely important. Anxiety can cause racing thoughts, which are also present in manic episodes. People with anxiety and panic can also be charged up and energized like people with mania. Sorting out patterns is important here. Anxiety is present all the time, not episodic like bipolar moods. And panic attacks last minutes to maybe hours, not days to weeks as in bipolar disorder. Anxiety disorders do commonly occur with bipolar disorder, so teasing this out can be challenging.
- **Obsessive compulsive disorder (OCD):** Like anxiety disorders, OCD often co-occurs with bipolar disorder. But when making the initial diagnosis of bipolar disorder, differentiating between the two disorders can be difficult. OCD symptoms include unusual thoughts and behaviors that can present with high energy levels and can appear repetitive and pressured, somewhat like the thinking in manic or hypomanic episodes. The two disorders are distinct enough that the full history should help to tease this out, but it can be challenging, especially at first, because while OCD isn't episodic like bipolar disorder, it does come in waves for some people, which can look like mood episodes. Making this distinction can be especially complex when evaluating children and younger adolescents.
- **Attention deficit hyperactivity disorder (ADHD):** Some types of ADHD include many overlapping symptoms with hypomania including high energy and activity, impulsivity, racing thoughts/busy brain, and poorly regulated focus

and concentration. ADHD appears to co-occur with bipolar disorder in many people, but the research is uneven. The most important difference between ADHD and bipolar disorder is that those symptoms of ADHD occur all the time — they are the person's baseline — unlike in bipolar disorder when those symptoms occur in episodes and are noticeably different from the person's baseline. Before someone with ADHD can also receive a bipolar disorder diagnosis, those symptoms must be significantly worse during mood episodes.

- **Borderline personality disorder:** Borderline personality disorder is a collection of symptoms and patterns that cause people to struggle with regulating their emotions and behaviors and maintaining stable relationships, among other symptoms. People with borderline personality disorder often struggle with impulse control at baseline and they also suffer from episodes of mood dysregulation that can be associated with acutely worsened judgment and control of impulses. While this pattern is a form of mood instability, these episodes don't meet criteria for hypomania or mania, especially in duration — they don't last days to weeks. And they aren't a change from baseline — the dysregulation of borderline personality disorder is with them chronically.
- **Post-traumatic stress disorder (PTSD):** PTSD is a collection of symptoms resulting from acute or chronic traumatic events that a person experiences. The symptoms can include substantial mood dysregulation and sleep disruptions along with intrusive flashbacks of the trauma, which can present with a feeling of pressure and agitation. Although the patterns are different from those in bipolar disorder, sorting them out at first isn't always easy, especially because PTSD and bipolar disorder co-occur frequently. Also, in some situations, people are afraid or ashamed about sharing their traumatic experiences, so that information may be missing from the evaluation. Research suggests that trauma in childhood may be part of how people develop bipolar disorder (if the trauma interacts with genetic vulnerability), further deepening the connections between PTSD and bipolar disorder.

Investigating non-psychiatric causes

From the time of Aristotle to now, Western thought has endeavored to divide and conquer, to label and dissect. Western medicine is no different, holding firm to the distinction between "physical ailments" and "brain disorders," as if people push their brains around in grocery carts.

REMEMBER

The fact is that your brain is an integral part of your body, not only acting as the puppet master but also being subjected to imbalances and illnesses in other organs and physiological systems. Your brain affects and is affected by your body and various substances your body ingests. Any process that affects brain function, indirectly or directly, can cause psychiatric symptoms, depending on its location in and impact on brain cells.

In the following sections, we describe some of the conditions that may present with symptoms similar to those of bipolar disorder, which the doctor must rule out during a differential diagnosis before arriving at a diagnosis of bipolar disorder.

Hormonal disorders

Hormones are chemical messengers secreted by glands that are part of the body's endocrine system. These chemical messengers regulate many functions of the body and can have a significant impact on mood. Several hormonal disorders can cause bipolar–like symptoms, including the following:

- **Thyroid malfunction:** Your thyroid gland produces hormones that affect metabolism and function in almost every cell of your body. Low thyroid hormone (hypothyroidism) slows metabolism and body functions which can mimic depression with symptoms such as low energy, weight gain, brain fog with impaired concentration, and low mood. But cases of severe hypothyroidism can present with manic-like symptoms.

  High thyroid hormone (hyperthyroidism) can present with symptoms such as nervousness, irritability, hyperactivity, and mood reactivity similar to symptoms of mania.

  Because of these potentially overlapping symptoms, doctors must typically rule out thyroid disease when considering a diagnosis of bipolar disorder.

- **Disruptions in reproductive hormones:** The reproductive-related hormones, including estrogen, progesterone, and testosterone, affect many cells in the body, including brain cells. They impact mood, energy, concentration, and behavior directly and indirectly and can be important triggers and modulators of mood episodes.

  Onset of puberty in girls is associated with increased risks for depression. The postpartum period is high risk for depression and manic episodes in patients with bipolar disorder. Some women will present with their first manic episode around menopause. Some women with severe premenstrual dysphoric disorder (a severe form of PMS) can present with behavioral and emotional changes that can overlap with the irritability and cognitive changes of hypomania.

  Testosterone and other androgen levels may be connected with depression in men and women (although the connection has been questioned in some more recent studies). Identifying sex hormone imbalances that may be causing or triggering mood symptoms is necessary to provide full and effective care.

- **Cushing's syndrome or hypercortisolism:** Cortisol is a hormone that affects many organs in the body and is central to the body's response to stress. It also

reduces inflammation and immune responses. Conditions that elevate the cortisol level in the body can present with symptoms that can look like mania. People with Cushing's syndrome commonly exhibit elevated amounts of belly fat, increased fat around the neck, a rounded face, and thinning arms and legs.

Brain inflammation (encephalitis)

Inflammation of the brain tissue, called encephalitis, can affect emotions, thinking, and behavior producing symptoms that can mimic psychiatric illness. Brain inflammation has many different causes. The two primary causes to consider when evaluating mood symptoms are infections and autoimmune reactions:

- **Infectious encephalitis**: Viruses are the most common causes of this kind of brain infection, but bacterial and fungal encephalitis also occur. Because people are often acutely ill with these kinds of illnesses, the emotional and behavioral symptoms are usually identified as secondary to the infection fairly quickly. But changes in behavior and thinking can be predominant at first, and focusing care on treating the infection becomes the priority in care.
- **Autoimmune encephalitis (AE)**: This condition occurs when your immune system develops antibodies to brain cells or proteins that brain cells make. The symptoms of AE depend on which areas of the brain are being attacked. Presenting symptoms for some forms of AE include disruptions to thinking, mood, and behavior. The causes of AE are not well understood but include prior infections with viruses or bacteria and certain types of cancers or tumors.

ANTI-NMDAR RECEPTOR AE

Anti-NMDAR receptor autoimmune encephalitis is a recently discovered type of AE that often presents with psychiatric symptoms including delusions, hallucinations, agitation, and aggression. It eventually progresses to include problems with speech and movement as well as seizures and other neurologic symptoms, but these can come later, so if someone is presenting with sudden onset of these severe symptoms, the doctor will want to rule out the possibility of an autoimmune encephalitis.

A broad range of different types of autoimmune encephalitis affect different parts of the brain and different parts of the neurons, especially receptors. Not all of them present with psychiatric symptoms, but because many new types are being discovered, if you experience an acute onset of emotional/behavioral symptoms, especially with other neurologic changes, your doctor will want to work with a neurologist to rule out AE, because AE requires treatment that's different from that for bipolar disorder.

Traumatic brain injury

Injuries to the brain can cause mood, thinking, and energy changes, depending on location and type of injury. For example, manic episodes may be more likely to occur with injuries to areas associated with the limbic network. Doctors need to take a careful history of head injuries when evaluating someone with mood symptoms.

Chronic traumatic encephalopathy (CTE) is a pattern of brain changes related to recurrent traumatic head injuries; it's found in a variety of athletes, especially boxers and American football players. Depression and other mood or personality changes are common symptoms of CTE.

Stroke

A *stroke* is a brain injury that occurs when the blood supply to the brain is disrupted. It can occur when the blood supply is restricted for some reason (such as arterial blockage) or a blood vessel ruptures and bleeds into the brain. In either case, psychiatric symptoms can occur along with significant impairment to physical movement and speech. Depression, anxiety, fatigue, and apathy are fairly common in people who've had strokes. Manic episodes are less common but have been known to occur secondary to a stroke.

Stroke is a medical emergency, so it's more likely to be a consideration when a patient comes to the emergency room. However, people can have smaller strokes that aren't detected at the time they happen. If someone presents with manic symptoms and reports a history consistent with possible previous stroke or if evidence of prior stroke is found on brain imaging, consulting a neurologist to explore ways to reduce risks for future strokes is important.

Brain tumors

Because tumors can form anywhere in the brain, they can trigger different psychiatric symptoms depending on their location. Although it's not common, psychiatric symptoms can be the first presentation of a brain tumor. When evaluating someone with manic symptoms, the doctor needs to be looking out for anything suggestive of a tumor, such as "localized" findings — for example, weakness on one side of the body or changes to vision or speech. It's rare, but doctors still need to screen for it to ensure that in these rare cases, the patient is referred to the right specialist for treatment.

Lupus (systemic lupus erythematosus/SLE)

Lupus is a chronic autoimmune disorder that can range from mild joint problems to life-threatening damage to organs including the kidneys, heart, and brain.

Because it can affect many different body systems, it can mimic many other disorders, including psychiatric disorders. Fatigue is almost universal, and depression is common in people with lupus. Occasionally the brain effects can be the first identified symptoms of lupus, called "neuropsychiatric lupus," which is why it is included in the differential diagnosis of bipolar disorder. These symptoms can include agitation and delusions and mood changes that can look like mania. If lupus is suspected, your doctor is likely to refer you to a rheumatologist for further evaluation. The diagnosis of lupus is tricky so it's best left to the experts.

Autoimmune disorders like lupus are often treated at some point with medications called *corticosteroids* — powerful anti-inflammatory treatments. However, these medications carry potential psychiatric side effects that can include symptoms similar to those of mania. The doctor doing an evaluation for bipolar disorder must consider any current or recent treatment with corticosteroids as the possible source of manic symptoms.

Other brain conditions

Several other medical conditions affecting the brain can produce psychiatric symptoms that overlap those of mania or depression, including the following conditions:

- **Syphilis:** *Syphilis* is a sexually acquired infection that can be treated with antibiotics. If it goes untreated, it can progress to *neurosyphilis,* which typically presents with psychiatric symptoms that may include hallucinations, delusions, depression, and mania. Most people admitted to a psychiatric hospital with manic and/or psychotic symptoms are tested for syphilis as part of their initial evaluation.
- **Human immunodeficiency virus (HIV):** This virus, which attacks the immune system, can have devastating effects on the brain, including symptoms consistent with mania. These symptoms are more likely to occur in disease that has advanced to AIDS, which is less common now due to successful treatment with antiretroviral therapies. Doctors evaluating someone for bipolar disorder may consider testing for HIV if other parts of the history or other symptoms suggest that it may be present.
- **Alzheimer's, Parkinson's, and other degenerative brain diseases:** Early dementia may present with significant mood and behavior changes, so doctors must examine cognitive brain function, especially in older adults with symptoms related to bipolar (see Chapter 10). Parkinson's and other motor conditions are accompanied by high rates of depression, which may present as a primary symptom.

Other general medical conditions

Before deciding on a diagnosis of bipolar disorder, doctors need to screen for other general medical conditions that can present with psychiatric symptoms, such as the following two conditions:

- **Vitamin and iron deficiencies:** Vitamin B-12 deficiency can present with mood symptoms, such as depression. This vitamin deficiency, which is easy to overlook, can cause significant neurologic problems if not treated correctly. Doctors may check for B-12 levels in an initial screening of a patient presenting with severe depression.

  Studies about whether folic acid or vitamin D deficiencies are related to depression conflict, but many doctors routinely screen for these levels as well. Anemia from low iron levels can present with fatigue, which sometimes produces symptoms that overlap with depression; most people are screened for anemia during routine checkups.

- **Hepatitis:** Hepatitis is an inflammation of the liver, typically caused by a virus or a buildup of toxins. In addition to the characteristic yellowing of the eyes, hepatitis can make you feel weak and nauseous and may produce symptoms similar to those of depression. If certain waste products accumulate to toxic levels, hepatitis can cause hallucinations.

WARNING

Identifying a medical condition that can cause mood instability doesn't rule out a mood disorder. You may have a medical condition *and* bipolar that both require treatment. The only way to find out is to consult your doctor.

Medication, alcohol, and other substances

Because bipolar disorder has so much to do with brain wiring and chemical messengers (see Chapter 2), everything you consume, from candy bars to cocaine, can influence your moods. As soon as you start chewing, swallowing, inhaling, snorting, or injecting a substance into your system, your body begins breaking it down into chemical compounds and distributing the compounds to your heart, brain, lungs, muscles, organs, and so on.

WARNING

The list of medications and other substances that can affect your moods and thinking is too long to include in this book, but here are a few of the big names that can cause serious problems:

- Accutane (used to treat severe acne)
- Alcohol
- Amphetamines

- Caffeine
- Cocaine
- Corticosteroids
- Cough suppressants containing dextromethorphan
- Decongestants containing pseudoephedrine, ephedra, or ephedrine
- Ecstasy (NMDA), ketamine (Special K), and other "club drugs"
- LSD, mushrooms, and other hallucinogens
- Marijuana
- Sleeping aids, including those containing antihistamines, valerian, and melatonin
- Stimulants, including Vivarin and NoDoz

If you're taking any of these medications or substances, let your doctor know. Stopping cold turkey isn't always the best option. Your doctor can suggest safe ways to wean you off the substances.


REMEMBER

Keep in mind that just because something is "herbal" or "natural" doesn't mean it's mood and behavior neutral. Products sold as "dietary supplements" may include stimulating or sedating natural chemicals that can wreak havoc on your body and brain just as much as synthetic medications or drugs.

Possible complications with COVID

COVID-19, the illness associated with the SARS CoV-2 virus, has become a major public health threat since it first appeared in early 2020. It is well established that the stress related to the pandemic and all the changes it brought has been hard on people's mental health. But the virus itself attacks multiple organ systems, including the brain, and psychiatric symptoms have been associated with COVID infections. Studies have shown that new diagnoses of cognitive changes, psychosis, mood disorders, and anxiety are increased shortly after COVID-19 compared to infection with other respiratory viruses. Some of these risks decrease over time but risks for some, including psychosis and cognitive changes, have shown to remain higher two years after the initial COVID-19 infection.

COVID-19 has been known to cause encephalitis (see the earlier section "Brain inflammation (encephalitis)"), and the risks in children seem to remain higher for at least two years after diagnosis.

Although specific data connecting manic/bipolar symptoms to COVID-19 infection aren't yet available, given the known effects on the brain, doctors evaluating

someone for manic symptoms need to ask about COVID infections and symptoms and include that in their understanding of your mood disorder symptoms.


REMEMBER

Long COVID is a term for people who experience significant extensions of COVID symptoms after initial infection. The most prominent of these symptoms are fatigue, shortness of breath, and brain fog (impaired thinking, memory, and concentration) and can include depression and anxiety. Although these are not specific to bipolar disorder, the presence of Long COVID could create additional risks for mood episodes in someone vulnerable to bipolar disorder.

Digging Deeper with Additional Tests and Procedures

Depending on what your history and physical exam reveal, your doctor may order additional tests or procedures to pin down or rule out certain medical conditions. The following sections describe some of the common lab tests that your doctor may order and point out what the results of these tests may reveal.

Medical tests that your doctor may order

No routine medical tests are standard in the work-up of bipolar disorder. However, given the many possible conditions that can produce manic or depressive symptoms, the doctor is likely to order some tests to diagnose or rule out those other conditions.

- **Blood tests:** These tests check your thyroid function, blood counts (red blood cell count for anemia or white blood cell count for infections); iron levels and *ferritin* (a measure of iron stores in your body); glucose and lipid/cholesterol levels; blood chemistries to screen liver, kidney, and other organ function; and sometimes levels of vitamin B-12, folic acid, or other vitamins. Additional blood tests may be necessary if the initial ones indicate a problem — such as tests for cortisol levels or markers of inflammation in the body. Testing for syphilis or HIV may be recommended.
- **MRI or CAT scan:** If you're experiencing specific neurologic symptoms (changes in muscle strength, movement, balance, or sensation, for example), your doctor may order an MRI or CAT scan to check for structural abnormalities in the brain.
- **EEG:** If you're showing signs of a seizure disorder, your doctor may order an EEG.

- **Lumbar puncture/spinal tap:** If you have an accompanying fever or any signs indicating a possible infection affecting the brain, such as spinal meningitis or encephalitis, your doctor may order a spinal tap.


REMEMBER

Notice that we don't include any kind of blood test or scan for bipolar disorder in this list. A common misconception is that your doctor can test you for bipolar. The term "chemical imbalance" has been around for years, but it's not accurate. The brain changes in bipolar disorder occur in the communication systems between and within brain cells, different parts of the brain, and between brain and body. The complexity of these changes don't lend themselves to a simple blood test or brain image. Eventually, scientists will likely establish "biomarkers" for some of these brain changes that will help in diagnosing bipolar disorder, but that is still well into the future.

Thyroid tests

Early in the diagnostic process, your physician or psychiatrist should order thyroid tests to check your level of thyroid hormones to determine whether your thyroid gland is functioning properly. During the course of your treatment, your doctor may want to run the tests again, especially if you take medication that can affect thyroid function (such as lithium).

If your thyroid hormones are out of whack, your doctor may also order a thyroid scan, which is basically an X-ray of your thyroid gland that indicates how well it's functioning. Based on the results of your thyroid hormone tests and scan, your doctor may refer you to an endocrinologist (a doctor who specializes in the diagnosis and treatment of conditions related to the glands that secrete hormones) for a more in-depth evaluation.

Additional medical specialists who may help

Your doctor may refer you to other medical specialists depending on what comes up during your evaluation. Common referrals include the following:

- **Neurologist** for further work-up of any brain-related concerns that are outside of psychiatry, such as encephalitis, stroke, or brain injury.
- **Rheumatologist** to evaluate any concerns about autoimmune disorders.
- **Endocrinologist** to evaluate any concerns about a hormonal disorder, such as thyroid disorders or cortisol regulation dysfunction.

- **Primary care physician** for a complete physical exam if your psychiatrist sees evidence of other possible medical concerns that should be evaluated.
- **Obstetrician/gynecologist** if any of your doctors has concerns about female reproductive hormone regulation being part of the presentation.
- **Neuropsychologist** for a detailed battery of testing if another of your doctors has concerns about your cognitive function and/or memory.

Putting It All Together for an Official Diagnosis

After completing your examination and testing, your doctor evaluates all the data and determines which diagnosis or diagnoses are most likely responsible for the symptoms you're experiencing — for example, whether they're most likely caused by bipolar disorder or something else or a combination of conditions. Your doctor then presents a recommended treatment plan.

Although the diagnosis is sometimes clear-cut, complexity and lack of clarity can be a part of the process for a while, especially if overlapping medical, psychiatric, or substance/medicine concerns are layered into the story. For example, although your symptoms alone indicate depression, based on your family history, your doctor may also diagnose the possibility of bipolar disorder. Or your manic symptoms may occur during treatment with steroids for asthma but aren't getting better when the steroids are stopped. These kinds of situations require some time to tease out.

Because bipolar disorder is so damaging to people's lives, doctors often begin treatment based on a working diagnosis while waiting for additional information to come in. The process can continue to take time even after the initial evaluation. Working closely with your doctor through this period can help you understand your condition and the evolving treatments.

After arriving at a diagnosis, your doctor should sit with you to discuss the thought process behind the bipolar diagnosis. You should have plenty of opportunities to ask questions and get clarification. Consider taking notes during this conversation or having a loved one with you to help keep track of what the doctor says. This is not an easy conversation, and you need time and space to process it. This process of understanding the diagnosis and gathering more information will continue over your ongoing meetings with your doctor.

Responding to your diagnosis

Receiving your diagnosis can unleash a wave of emotions that can be all over the map. You may feel relief at finally understanding what has been happening to you. You may be angry and question whether it is accurate. You may feel sadness and grief over the problems your symptoms have already caused in your life and about what this diagnosis means for your future. You may experience all these emotions at once or none at all — you may feel numb.

Whatever feelings you have are valid; you're experiencing a huge life event with no right way to feel about it. Acknowledging your feelings is critical to eventually coming to terms with living with and managing your bipolar disorder. Your feelings aren't good or bad. What becomes more challenging is what you do with those emotions.

Accepting the diagnosis and entering into treatment planning are fundamental steps for recovery and reducing the negative impact of bipolar disorder on your life. This is no easy feat, and your emotional responses will influence how you go about handling your bipolar diagnosis. Ultimately, your emotions will inform your thoughts and actions in response to your diagnosis.

The process of hearing and coming to terms with this diagnosis will be influenced by where you are in your illness when the diagnosis is made. If you're in the hospital and in the throes of a manic episode, this process may not occur until after your most acute symptoms have resolved, when you can begin to process the information with your fully online thinking brain rather than a manic-hijacked brain. For most people, the process of understanding, accepting, and working with this diagnosis takes time. Patience with yourself and your loved ones (and your loved ones having patience with you) can be high value tools in navigating this road.

Understanding your prognosis

Your *prognosis* (the expected outcome of this condition) may be difficult to pin down at the start of the diagnostic process. Some components, such as the underlying biology and severity of your particular bipolar brain changes, are unknowable at this point. But you may have some control over other factors that can improve your prognosis, such as effectively managing stress or taking medication to reduce the risk of future mood episodes (because recurring episodes can negatively impact your prognosis).

The primary focus is treating your current symptoms. The next steps are all about reducing the risk of recurrent mood episodes and managing possible future symptoms. Prognosis shifts over time but taking care of yourself from the moment of diagnosis and going forward is the key to your future health.

IN THIS CHAPTER

- Understanding what goes into a treatment plan
- Getting input from the doctor who prescribes your psychiatric medications
- Adding one or more therapies to your treatment plan
- Enhancing your treatment plan with self-care options

Chapter 5

Building Your Treatment Plan

As soon as you receive a diagnosis of bipolar disorder, the first question that's likely to pop into your head is, "Now what?" To answer that question, your diagnosis should be followed closely by a proposed treatment plan detailing what's needed to put you on the road to recovery. Treatment almost always includes medication and therapy along with self-help — steps you can take to improve your outcome, such as taking some time off work or school and establishing healthy routines. Your treatment plan may also call for hospitalization (in the event of a severe manic or depressive episode), outpatient therapy, and other interventions.

What's important is that you receive a clear and comprehensive treatment plan that's tailored to your symptom profile and your situation and is acceptable and doable. In this chapter, we offer guidance on how to work with your doctor and therapist to craft an effective treatment plan and adjust it, as necessary, when conditions change.

Understanding Bipolar Treatment Plan Fundamentals

A *treatment plan* is a roadmap that you and your clinician create to help you advance from your starting point (symptoms and diagnosis) to your destination (improved mood stability and ability to function). The available routes are built on well-researched and time-tested interventions (such as first-line medications and proven psychotherapies) that have the highest likelihood of helping most people feel better. However, the roadmap differs from one person to another, and it usually changes over time in response to a patient's condition and situation.

If you've been meeting with a doctor as part of an outpatient evaluation, your doctor will discuss your treatment plan with you during an office visit — after discussing your diagnosis. If you received your diagnosis in a hospital during a crisis, your treatment plan will focus on quieting your most acute symptoms (mania with psychosis, for example), and then your long-term treatment plan will evolve as your brain and body start to recover. In either case, a treatment plan typically includes a combination of medication and therapy.

Generally, treatment plans that have proven most effective for bipolar disorder meet the following criteria:

- *Personalized* to the patient's personal, medical, and family history, along with the individual's treatment preferences when possible.
- *Collaborative,* ensuring that all members of the treatment team, including the patient, work together toward the desired treatment outcome.
- *Comprehensive,* considering every tool available, not just medication but also psychotherapy, self-help, support groups, and so on.
- *Flexible* — the treatment plan must evolve as a patient's condition and situation change.

In the following sections, we expand on these criteria.

REMEMBER

Understanding your treatment plan from the start and through any changes over time is essential to your recovery. The treatment plan requires you and your doctor to identify the most impairing symptoms and define treatment goals based on reducing or eliminating these symptoms. Being engaged actively with this process can help you focus on your recovery and track your progress along the way.

Appreciating the importance of having a personalized treatment plan

The work that goes into your diagnosis (see Chapter 4) isn't focused solely on labeling your condition. More importantly, your diagnosis captures your bipolar story, which includes important factors such as trauma history, other psychiatric diagnoses, substance use disorders, medical problems, and your current life situation and demands.

Your treatment plan grows out of your bipolar story, starting with a combination of medication and psychotherapy and evolving over time to include other elements, such as starting or stopping other medications, adopting self-care measures, and managing specific triggers and stressors.

Laying the groundwork for close collaboration

The clinician who makes the diagnosis is primarily responsible for your treatment plan fundamentals. This person has the expertise and experience to recommend medical interventions expected to be most helpful to you. But building a treatment plan isn't a one-way street between you and your clinician. Your input is crucial to all treatment decisions, and a successful outcome often requires the collaboration of multiple individuals beyond you and your clinician, including one or more therapists, your partner, and other family members.

Think of your treatment as a team effort. Your team may include only you and the person who's prescribing your medication, or it may extend to one or more therapists, specific loved ones, and others (such as fellow members of a support group). As you develop a comprehensive treatment plan, give some thought to what each person on your treatment team is responsible for and ways they can collaborate. For example:

- Your prescriber will most likely serve as team leader, primarily responsible for diagnosing your condition, managing your medications, and answering any questions you have.
- You're responsible for documenting and communicating how you're doing, tracking your moods and sleep, taking your medications as prescribed, following your therapist's recommendations, and asking questions when you need more information or clarity about your condition or the treatments being recommended.

- Your therapist is responsible for providing therapy and communicating and coordinating treatment with your prescriber. In some cases, your therapist may serve more as team leader with your prescriber in a more supportive role.
- Your loved ones may be responsible for providing observations about how you're doing and, with your approval, help with certain tasks, such as reminding you to take your medications and driving you to doctor and therapy appointments.

Close collaboration with your prescriber is essential. Be sure to provide your prescriber with the following information:

- The names of medications you've taken previously and any good or bad responses you may have experienced, especially if you're allergic to any medication or experienced a reaction to a medication in the past.
- All your current medications including all your prescriptions for psychiatric and any other medical conditions. Include over-the-counter medications including those for pain, allergies, cough, and colds.
- Any active medical conditions or recent surgeries or other medical procedures. Even if you don't take medications for them now, these can be important for the doctor to know about.

Your clinician/prescriber also needs to collaborate with you in the following ways:

- Take the time to explain the thought process behind your diagnosis and any treatment recommendations.
- Answer any questions you have about your diagnosis and treatment plan.
- Inform you of potential benefits and side effects of all prescribed medications and present any possible alternative medications.

Your treatment plan will be more effective if you understand it fully and are on board with it. Your questions can help your doctor fine-tune treatment decisions so they're more aligned with your preferences.

REMEMBER

This is a team effort. While your doctor has the medical expertise, you're the expert on how you're feeling, your preferences regarding treatment, and the medication side effects you can tolerate. If you don't feel that your doctor welcomes your questions and input, don't hesitate to continue to express yourself clearly and expect your doctor to listen. If you still don't feel that your doctor is working with you and respecting your input, seek a second opinion if you have that option.

Going beyond medications: A comprehensive approach

Your initial treatment plan is likely to include medication. This is standard medical care for a medical condition. But medication is only one part of a comprehensive treatment plan. Bipolar is a chronic medical condition, and like most other chronic conditions — such as asthma or diabetes — other interventions add crucial power to managing the condition in your daily life and reducing the likelihood of relapse into severe symptoms.

The clinician developing your treatment plan with you should spend some time discussing a comprehensive approach to your bipolar disorder, rather than just writing a prescription and sending you on your way. Your clinician may not have all the details about everything available to you but should at least touch on bipolar disorder as a chronic condition that responds best to multiple types of care and support. A comprehensive approach is essential to successfully managing bipolar disorder, and you can reasonably expect that perspective from your prescriber.

Non-medication components of a treatment plan for bipolar disorder often include one or more forms of psychotherapy, education and support for family and caregivers, self-care and monitoring skills, relevant support groups (such as Alcoholics Anonymous [AA]), and mobilizing basic services such as housing and food, if needed. See Parts 3 and 4 for more about medication and non-medication treatments.

Evolving and changing your treatment plan over time

The treatment plan that you and your clinician develop after your initial diagnosis is a starting point. After you start on medications and other interventions, your clinician monitors your responses and works with you to fine-tune your plan and make adjustments as conditions change. Your clinician wants to know whether the medication is alleviating your symptoms and, if it is, how well it is doing so; also, whether you're experiencing any adverse side effects and, if you are, what they are and how severe they are.

Your clinician needs your input to make well-informed treatment recommendations, so be honest and open about how you're feeling. Whenever you're starting a new medication, you can expect to touch base with your prescribing clinician frequently to provide feedback on how you're feeling. For certain medications, you may need to get blood tests to monitor their levels in your bloodstream or other tests to determine possible side effects that can't be seen externally.

To optimize the balance of benefits and side effects, your clinician may want to adjust your treatment plan. Adjustments may include dosage changes — up or down — or possibly adding or changing medications. As with your initial treatment plan, you have the right to ask questions and to understand the thought process behind the recommendations, the potential benefits and side effects, and any available alternatives.

Although your medical treatment is the focus of your meetings with your prescribing clinician, especially early in care, you and your clinician may also need to discuss other components of your plan. Maybe finding a therapist who accepts your insurance is a challenge or family members are struggling to support your need for care. Addressing these and other challenges is important because they can affect how well your medication interventions work. For example, if you're losing sleep because your family doesn't respect your need for regular sleep, your medications may not be as effective as they could be.

Addressing Medication Management

Although your treatment plan is likely to contain multiple components, addressing the biology of bipolar disorder is the most essential. Restoring the biology and physiology for maintaining mood stability enables the layering on of other interventions and makes those interventions more effective.

In this section, we address key considerations involved in medication management and explain a few of the key basic principles that govern medication management decisions. See Chapter 7 for a deep dive into specific medications.

Treating an acute mood episode

If you are experiencing an acute mood episode, your prescribing clinician chooses medications with the goal of reducing your symptoms as quickly and safely as possible. Choices generally are influenced by the following three factors:

- **The pole of your symptoms:** Depression, mania, or mixed (depression and mania together).
- **The severity of symptoms:** Mild to severe.
- **The setting:** Inpatient (hospital) or outpatient.

When symptoms are severe enough to require hospitalization, the doctor may use multiple medications to get you out of your episode quickly. If your symptoms aren't severe enough to require inpatient care, the doctor may want to add one medication at a time to get a clearer picture of what each medication does or doesn't do alone.

Here are the core principles of a first treatment plan, which include the names of some medications.(see Chapter 7 for more about medications):

- **For manic episodes,** most patients start on an anti-manic medication such as lithium or valproate, often combined with an antipsychotic such as olanzapine, aripiprazole, or quetiapine. A patient often needs several medication trials to find a medication, or combination of medications that's effective and well tolerated.

  The choice of specific medications depends on many factors including other health issues; for example, lithium is often avoided if someone has kidney disease; valproate is avoided in women of childbearing age or people with liver disease.

- **For bipolar depressive episodes,** the challenge is treating the depression without triggering manic symptoms. Antidepressants can activate the brain of someone with bipolar disorder, leading to manic symptoms or a manic episode — a phenomenon called "switching." Antidepressants alone are not typically used for someone with bipolar disorder in a depressive episode.

  The most common medications used to treat bipolar depression include several of the antipsychotics that have antidepressant benefits, including quetiapine, lurasidone, cariprazine, and lumateperone. Another option is a combination of an antipsychotic with an SSRI such as olanzapine plus fluoxetine (Symbyax). Because treating bipolar depression can be exceptionally challenging, many other medications and medication combinations may be tried including lithium, valproate, and lamotrigine, among others.

- **For episodes with mixed features,** the treatment plan focuses first on the primary symptoms; for example, if your primary symptoms are mania with some depressive features, treatment focuses first on the mania and then is expanded later as needed to address the other symptoms.

Preventing future episodes

After the acute episode is resolved, the treatment plan shifts to *maintenance treatment* with the goal of preventing recurrent mood episodes. In most cases, the first choice is to continue the single medication or combination of medications that

effectively treated the acute period. If continuing the medication isn't possible for some reason (for example, if you develop kidney problems on lithium), the doctor may choose a maintenance dose of a medication from the following list:

- Lithium
- Anticonvulsants such as lamotrigine or valproate
- Antipsychotics such as quetiapine, olanzapine, ziprasidone, and risperidone

Having someone on a single maintenance medication is the goal but isn't always possible. In some cases, a patient may need to stay on a combination of medications for a while until medications can be safely withdrawn under the prescribing clinician's supervision. For example, you may be on a combination of a mood stabilizer and an antipsychotic for several months until the antipsychotic can be safely and gradually discontinued.

Providing informed consent

Informed consent is the bedrock of making treatment decisions with your doctor:

- *Informed* means that you have been given the relevant details about a proposed treatment, so that you understand the potential benefits and risks to the intervention, as well as the risks and benefits of alternative treatment plans.
- *Consent* means that after you are informed, you agree to the plan.

Informed consent means that you make the ultimate decision about trying medications or other treatments. You should feel confident that you have received the information you need to give your informed consent and that your autonomy in that decision has been respected.

In emergency situations, informed consent may be delayed until the emergency is resolved. Being in the hospital in a manic episode with delusions is a medical emergency no different than a heart attack or stroke. Emergency personnel will do their best to obtain your informed consent but if you're in crisis, they'll provide treatment to stabilize you medically and psychiatrically and will address informed consent as soon as you're able to have those discussions.

One of the biggest challenges in receiving treatment for bipolar disorder is that the illness can change your thinking and impact your decision-making. Your autonomy in making these decisions continues even when you're in a manic or depressed episode, but you may make different decisions than you would

otherwise. Impaired decision-making can result in less consistent treatment with medications that can be harmful in respect to the long-term course of bipolar disorder.

No easy solution is available for achieving informed consent in emergency situations. The most effective approach typically includes trying to maintain a good working relationship with your treatment team, your family, your friends, and other support people to anticipate these periods (see Chapter 15 for details).


REMEMBER

In certain circumstances, your autonomy around informed consent may be withheld — for example, if you're deemed to be a risk to yourself or others or if you're thought to be unable to take care of even basic needs. In such situations you may receive treatment, such as inpatient care, without your consent. But this should happen only within strict legal and ethical guidelines. Removing your ability to consent, even for a short time, is an extreme step reserved for extreme conditions. See Chapter 16 for more about voluntary and involuntary hospitalization.

Getting your treatment plan in writing

Don't leave your doctor's office without a clear set of written instructions, especially if your doctor is adjusting your medication dosages between visits. You can write down the instructions yourself and go over them with your doctor before you leave to make sure they're correct or have your doctor provide you with your treatment plan in writing. Your treatment plan should include the following details:

Information about your medications:

- The name and dose of every medication, the number of pills or capsules to take, number of times per day, and times of day to take the doses
- Potential interactions with substances including alcohol and cannabis and over-the-counter medications and supplements
- Whether the medicine should be taken on an empty stomach or with food
- What to do if you miss a dose

Information about non-medical treatment plans:

- The names of any referrals such as those to therapists or other doctors
- Any order slips for labs — and where and when to get your blood drawn, if necessary

Scheduling your next appointment

Before leaving your doctor's office, schedule your next appointment. Don't plan to call later — do it before you leave. Also, get clarification about the following details:

- Location, frequency, and duration of visits
- Whether visits will be virtual or in-office — if virtual, obtain instructions about the app to use; if in-office, find out which office specifically
- Appointment cost
- Instructions on how to communicate between visits — phone, text, email, online messaging platform or patient portal
- How long the doctor typically takes to respond to a patient
- Emergency contact information — what number to call if you have an after-hours emergency, whether another doctor may be on call, what to do if you can't get hold of your doctor
- Whether you get scheduled quickly for an urgent visit, if necessary, and what to do if your doctor is unable to accommodate urgent visits

Incorporating Therapy in Your Treatment Plan

Psychotherapy is considered a fundamental component of any treatment plan for bipolar disorder. In addition to prescribing one or more medications, your doctor is likely to refer you to a therapist or recommend a type of psychotherapy. Here are some of the most common psychotherapies that have proven helpful to varying degrees for bipolar disorder (see Chapter 11 for details about specific therapies):

- Supportive psychotherapy to help you emotionally navigate your bipolar disorder diagnosis and treatment
- Cognitive behavioral therapy (CBT), which can be especially helpful if you have anxiety or obsessive-compulsive disorder (OCD) symptoms
- Dialectical behavioral therapy (DBT), which is particularly valuable for helping manage emotional outbursts or self-harm along with interpersonal relationships

- Psychoeducation — often in a group where you and your loved ones can get more information about bipolar disorder and its treatment as well as additional resources
- Interpersonal and social rhythm therapy (IPSRT) — a therapy specific to bipolar disorder that helps in reducing triggers for mood symptoms by adding structure to your daily activities, social interactions, and sleep/wake cycle
- Substance use support programs, including 12-step programs such as AA or more specific treatment programs for your needs
- Support groups in which people with shared lived experience come together to share experiences and support each other; support groups can be great venues for creative problem-solving because others in the group have likely come across similar situations

Finding a therapist

When you're in the market for a therapist, the best place to start is with your doctor during your treatment planning discussions. Choosing a therapist that your doctor has an existing relationship with (and maybe even works alongside in the same building) can improve communication and collaboration among members of your treatment team. Ask your doctor for a referral to a therapist.

Other resources to explore for therapist recommendations include your family doctor, friends and family members, your insurance company, or a local medical school/outpatient clinic.

Documenting how you, your doctor, and your therapist will work together

Your treatment team is likely to include at least two people (in addition to you) — typically a psychiatrist, who delivers the diagnosis and prescribes medication, and a therapist, who provides the psychotherapy. Ideally, they work closely together to provide coordinated, comprehensive, and consistent care.

Before leaving your doctor's office, be sure you have the name of a therapist along, a clear understanding of how they'll communicate with one another and work together, and the paperwork (information releases) that enables them to share information and insights about your treatment.

Adding Self-Care Strategies to Your Treatment Plan

You're a key player on your treatment team. In addition to following the guidance of your doctor and therapist and providing them with feedback about how you're feeling, you can play a more active role in your recovery and maintenance care by including one or more of the following self-care strategies in your treatment plan (see Part 4 for details about these self-care strategies):

- Monitoring your symptoms
- Improving your sleep hygiene
- Getting your body in motion for joy and health
- Addressing the nutritional needs of your body and brain
- Practicing mindfulness
- Managing work, school, and time off
- Strengthening family and social communication and connections

REMEMBER

Although these strategies are classified as self-care, include them as part of your treatment plan and discuss them with your doctor and therapist. They can help provide guidance on how to incorporate self-care strategies into your life gradually, without overloading you when you aren't feeling well.

IN THIS CHAPTER

- Understanding where your psychiatric care provider fits in
- Teaming up with a competent and versatile therapist
- Recruiting supportive friends and family members
- Collaborating effectively with others
- Advocating for the care you need and want

Chapter 6

Building a Winning Mood-Management Team

You can successfully treat many common ailments on your own. You can pop an antacid tablet to relieve indigestion, sip lemon tea at the first sign of a cold, or down a couple of aspirin to ease headache pain. But with bipolar disorder, you can be so blinded by the darkness of depression or so bewildered by the maelstrom of mania that you can't recognize your altered state of mind — let alone settle on an effective treatment.

If it takes a village to raise a child, it takes at least a small team to help you prevent your moods from swinging out of control. Your team ideally includes a psychiatrist and perhaps a therapist and one or more supportive family members or friends. Your psychiatrist typically makes the diagnosis and prescribes the medications that enable your brain to function properly; your therapist helps you solve

problems, develop coping skills, and let go of issues beyond your control; family members and friends provide feedback, support, and encouragement; and, as you're able, you advocate for the treatments, accommodations, and other assistance you need to achieve and maintain optimum health and function.

In this chapter, you find out how to begin to build your mood-management team. You discover the key role that each person on your team plays and the criteria required for each position. We also provide some suggestions for tracking down and selecting qualified professionals and supportive friends and family members to add to your team roster.

A Psychiatric Provider for Diagnosis and Medication Management

When your moods are out of sync with reality, your brain's physiology is disrupted. You need a medical professional with specialized training in psychiatry to help restore proper function — typically a psychiatrist, although this role may be filled by another medical professional, such as a primary care physician or psychiatric nurse practitioner. Your psychiatric provider prescribes medications to help adjust the neurobiological systems in your brain to enable it to respond appropriately. Medication doesn't cure your bipolar disorder, but it helps regulate your moods so you can function and begin to deal with real-life issues that may trigger mania or depression.

Your psychiatric provider's primary functions are to accurately diagnose your illness, develop a comprehensive treatment plan that includes education and support as well as appropriate medical interventions, and then help you manage your medications, as we explain in the following sections. (See Chapter 4 for guidance on choosing a psychiatric provider and Chapter 5 for more about developing a comprehensive treatment plan.)

Diagnostician

Before you can begin any sensible treatment, you need a diagnosis, and your psychiatric provider is usually the one who gives it to you. To find out how a psychiatric provider performs a diagnosis and what you can do to improve the accuracy of that diagnosis, see Chapter 4. Turn to Chapter 1 for a description of the diagnostic criteria used to arrive at a bipolar diagnosis.

Master planner

Typically, your psychiatric provider (often in consultation with your therapist) draws up the initial game plan with you — a comprehensive treatment plan that usually includes a combination of medication, education, therapy, and self-help tailored specifically to your profile. However, many people with bipolar disorder expand and personalize their plan as they become more aware of their own needs and the available treatments and supports. See Chapter 5 for more about creating and fine-tuning your treatment plan over time.

Prescriber/medicine manager

In the old days, psychiatrists handled all aspects of treatment. They diagnosed the illness, prescribed any necessary medications, and offered therapy and counseling. Although some psychiatrists still handle all aspects of treatment, what's more common now is a treatment team consisting of a psychiatric provider (doctor or nurse) who manages the medical care along with a therapist or clinical social worker (CSW) who provides the psychotherapy.


TIP

If the time you spend with your psychiatric provider is insufficient for successfully communicating your needs, voice your concern. You and your doctor may be able to arrange for longer visits that can be appropriately reimbursed.

A Therapist: For Non-Medication Treatments and Monitoring

As your psychiatric provider tweaks brain function with the right brew of medications, your problems may begin to resolve. For some people, medication alone is enough. For many people with bipolar disorder, medications provide only partial relief; some symptoms persist and additional interventions are needed for a more complete recovery. Even if you experience full symptom relief, your system may react in ways that override the medication's mood-moderating effects; for example, if you live under constant stress, don't get enough sleep, or struggle to find and use effective strategies to resolve problems and deal with conflict in your life.

This is where a good therapist comes into play. Your therapist's primary roles are to help you develop strategies to relieve symptoms, make lifestyle changes that reduce stress, and establish adaptive thinking and behavioral patterns so you can cope more effectively with life's ups and downs. For example, a therapist may teach you how to identify triggers and develop responses that serve you and your recovery instead of getting caught up in old thought patterns that get in your way.

A therapist can play many additional roles on your mood-management team, acting as coach, career consultant, mood monitor, and wellness manager. We describe these roles in the following sections.

REMEMBER

Your psychiatric provider and therapist often function as co-leaders of your treatment team, and their roles may overlap to some degree. Psychiatric providers tend to play some role in therapy, education, and support functions, whereas therapists, with their patients' permission, may contact psychiatrists to voice concerns when they think medication adjustments are necessary.

Skills trainer and coach

An effective therapist addresses not only the symptoms of your illness but also can help you build a repertoire of skills to navigate and regulate emotional responses, thought patterns, and behaviors. Getting more skilled in these areas reduces stress and conflict while helping you get your needs met — all of which serve to reduce the risk of future mood episodes and enable you to manage life more effectively between and during episodes. This work can include but is certainly not limited to the following:

- **Increasing emotional awareness and learning to label emotions without judging them.** Emotions, on their own, aren't good or bad — they bubble up from many sources that you can't control. Some feel good and some feel bad, but they don't make you good or bad for having them. Emotions are information — the brain telling you something about your situation. Recognizing and accepting baseline emotional patterns can help you see more clearly when your moods may suggest a brewing manic or depressive episode.
- **Recognizing thought patterns that serve you and those that don't.** You develop habitual cognitive (thought) responses to your emotions and environment over years of living and surviving. Some of those patterns may amplify painful emotions in ways you don't recognize until you sort it out with a therapist. Teasing out your default or automatic thought responses and replacing or rebuilding different ways of thinking are common goals in therapy.
- **Identifying behavioral patterns and responses and sorting out those that support you and those that get in your way.** Like thought patterns, behavioral responses build up over years, and reconfiguring them can be challenging. But identifying patterns, setting goals for change, and building new skills to make that change are often central pieces of work in therapy. Goals may include getting more regular sleep, increasing your activity in response to low energy, and pacing/tamping down your activity when you're charged up. They may include trying to inhibit impulsive behaviors or increase controlled risk taking to counter avoidant patterns.

- **Improving interpersonal communication and managing conflict.** Your emotional well-being depends on feeling safe, heard, and respected in the relationships in your life, and on you offering the same to those around you. Conflict is a prime source of stress, which can increase the likelihood of a recurrent mood episode. Building effective interpersonal skills can greatly reduce this outcome.
- **Identifying family patterns that generate and maintain conflict and stress in tasks such as raising children or managing finances.** Perpetually re-negotiating the same problems over and over, without any resolution, can derail your best efforts to maintain a stable mood.
- **Examining work and career challenges — from problems on the job and conflicts with coworkers to time off needed to manage your symptoms — that may help or hinder your recovery.** A therapist can provide valuable assistance; for example, suggesting reasonable workplace accommodations.


TIP

Look for a therapist who specializes in the form of therapy you need most. Chapter 11 describes therapies that are proven to improve mood stability and help people deal with the fallout from bipolar disorder.

Resident soundboard

Some forms of therapy don't involve the therapist offering any particular advice. The therapist sits and listens attentively as you, the client, describe a particular issue. Often, just the act of telling your story allows you to reflect on it differently than when it's just rattling around in your head. And after you've shared the story, your therapist can often work to gently guide you toward your own solutions, pieces of which may have been there all along. Other therapy models are much more proactive and focused on problem solving, but active listening remains the starting point in all therapy models for developing solutions and strategies that will work for you.


REMEMBER

If you can find a therapist who listens well and inspires you to solve your own problems, you've struck gold. But keep in mind that even if this is your therapist's primary way of working, it's likely to be less effective during more active periods of your illness. When a mood episode is brewing or active or even tapering off, a good therapist usually needs to play a role that's much more active than just listening.

Self-care guide and cheerleader

Your therapist is often the person who helps you build self-care and daily life changes into your recovery. Therapy may include suggestions to help you

implement plans to move your body more regularly or to practice mindfulness meditation. You and your therapist may explore ideas for sleep management or monitoring your social media usage. Because your therapist sees you more regularly than does your psychiatrist, your therapist can get into the weeds of daily life with you — helping you deal with real-life challenges such as getting off the couch or contacting a friend.

Make sure your therapist listens to you and makes recommendations based on your needs. Someone who throws out a generic list of "wellness" or "lifestyle change" tips may not be the best person for you.

Continuity of care person

One of the most important factors in the success of long-term management of bipolar disorder is the *continuity of care* — carefully planned and executed treatment that's consistent over time. A therapist (or a caseworker, family member, or close friend) can improve your continuity of care by helping you keep detailed records of medications and therapies that have (and have not) worked for you in the past. Your wellness manager can also help smooth the transition if you change doctors or therapists, so the new care provider doesn't engage in a process of trial and error that's already been done.

Referral service

Therapists are people who know people. If they can't solve a particular problem, they probably have the contact information for someone who can. They'll dig through their desk and hand you a business card or flip through their smartphone and jot down the name and number of a specialist you need. "Buried in debt? Here's a financial consultant that other clients rave about!" "Need a job? Here's a career coach I know." "Need a break from the drudgery of daily life? Here's the travel agent I use." "Can't pay me? Check out this information on government-subsidized health insurance."

Knowing where to turn when you're having trouble finding a therapist

Not everyone has access to a therapist or the money to afford one. When a therapist isn't an option, you may need to rely more on self-help strategies and your personal support network and formal support groups. Books, and in some cases videos, can bring you up to speed on the basics of various do-it-yourself therapies, including cognitive behavioral therapy (CBT) and mindfulness training.

Family members, friends, and fellow support group members can fill the role as soundboards and problem solvers, helping you track down solutions and resources to meet your needs.


WARNING

Be skeptical of self-help titles in bookstores; many self-help books espouse ideas that haven't been researched at all. Seek out reputable resources for information. National organizations, including the Depression and Bipolar Support Alliance (DBSA), the National Alliance on Mental Illness (NAMI), and the National Institute of Mental Health (NIMH), offer reliable information and resources. These organizations and your psychiatric provider or primary care physician can guide you toward reliable books and other resources for learning about well-researched treatments to try on your own.

Assembling Your Personal Support Staff: Family and Friends

A strong support network of family and friends can function as a valuable ally in the battle for mood stability. However, if your allies are lugging around their own agendas and emotional baggage, they can compound your problems and increase the likelihood of a mood episode. When you begin recruiting your support staff, you need to do three things:

- Decide whom you can trust.
- Talk about each candidate's fears and anxieties and establish a focus on open communication.
- Encourage your support staff to become educated about your illness and what they can do to help. (See Chapter 23 for a list of ten ways a loved one can help.)

Building a network based on trust

When scouting for family members or friends to add to your support network, look for stable and trustworthy people. Ask yourself the following questions:

- Can I confide in this person? Some people like to buddy up to others who have problems just so they can obtain some juicy gossip to pass along. Be sure the people on your support staff know how to keep information confidential.

- Is this person stable enough to support me? People with bipolar are commonly drawn to others who experience roller coaster moods and emotions. Only someone who's steady can help you steady yourself. Someone with bipolar who is stable in treatment may be a suitable candidate, but someone who's not managing the illness could be a liability.
- Do I interact with this person frequently enough? An ideal support person sees or talks to you at least once a week, so observations about possibly significant shifts in mood can occur in a timely manner. The more people you have in your support network, the more objective observers you have to monitor your moods. However, you need to choose these monitors carefully and train them accordingly, so they know when to step in and when to step back.
- Does this person judge me for having a mental illness? If a person thinks your illness is due to a character flaw, that person can't provide the support you need. You don't need people around who make you feel guilty for having bipolar disorder.
- Is this person reliable? If you foresee a possible support person bailing out at the first sign of trouble, that person may not be there when you're in greatest need of help. Be sure that you trust the people on your team to stick with you and do what's best for *you*.
- Does this person respect me? You don't want an intrusive caretaker who constantly nags you about your moods and meds and treats you like a child. Choose individuals who demonstrate genuine respect for you and who respect mutually agreed-upon boundaries. You don't want to surround yourself with mood police who try to control your life.

Understanding their fears, anxieties, anger, and other emotions

Family and friends who genuinely care about you and appreciate your unique gifts can often get under your skin, especially when they want to help or when you're in the middle of a mood episode. These people in your life have their own set of fears, anxieties, anger, and other emotions. For example, as you battle a lengthy bout of depression, they may be anxious, not knowing how long it will last, or angry that you don't seem to be doing enough to help yourself. When you're in the throes of mania, your loved ones may be unable to understand you or they may tell you to calm down. Something you say or do may trigger strong negative emotions in them.

REMEMBER

Although some people have thicker skin than others, nobody's skin is impervious. Remember that members of your support team are imperfect people and try to cut them some slack. Doing so isn't easy, especially when you're wrestling with your own demons, but if everyone on your team gives other team members the benefit of the doubt, you're all much more likely to work collectively toward the goal of maintaining a stable emotional environment.

Educating your supporters

Whenever you throw a party, you probably have guests who strategically avoid the after-party cleanup. If you're lucky, one or two close friends who know their way around your kitchen will start tidying up. You may see a couple others who linger around, waiting for instructions.

You can observe many of these same behaviors in your support team. When you're depressed or manic, most people — those who don't understand what's going on or what you expect of them — flee the scene. If they don't bolt, they stick around, become frustrated by not knowing what to do, and lose their tempers or pepper you with sarcasm. What you want is a close friend or relative who knows about mood disorders to intervene and provide a compassionate and gentle but firm guiding hand to help you stabilize.

You want as many knowledgeable people on your mood-management team as possible, and the only way to achieve that goal is to educate people in your life who want to learn about bipolar and are committed to helping you succeed. Knowledge gives people the confidence they need to jump in when you need them most. Whenever friends or family members ask what they can do to help, encourage them to discover more about the disorder, drawing from any of the following resources:

- **You:** You're the most qualified expert on *your* moods and what helps or hurts your mood stability. If you feel ready to discuss your situation with others, you can be a valuable source of information.
- **Depression and Bipolar Support Alliance (DBSA):** An organization that focuses on bipolar disorder and depression (run by and for people with the illness), DBSA offers free and confidential support groups for individuals with depression or bipolar as well as their families and friends. DBSA also offers free and easy-to-understand educational materials. Check out the DBSA website at `www.dbsalliance.org`.
- **NAMI Family to Family:** The National Alliance on Mental Illness (NAMI) offers an eight-session educational program called *Family-to-Family* for friends and family members of people with mental illness about major conditions and treatments. The course also functions as a support group. Visit the NAMI website at `www.nami.org` for more info and to find a local NAMI affiliate.

- **Books:** This book and many others on bipolar disorder can help friends and family members understand this illness and empathize with those who have it. Books can offer great tips on how to help someone with bipolar. We offer this information in Part 4 and in Chapter 23.
- **TV shows:** In recent years more and more television shows have included characters with bipolar disorder, and although they may not always portray the condition accurately, they do start conversations. *Lady Dynamite* is a fictional show based on the actress Maria Bamford's true struggle with bipolar disorder that takes the genre in a new direction.
- **Music/songs:** The music industry has a long history of songs that speak to mental illness, and more and more artists are sharing their own struggles in their lyrics and videos. If any of these songs or TV shows are meaningful to you, sharing them with loved ones can be a powerful way to help them start to understand your experience.
- **Movies and theater:** Although Hollywood takes a little poetic license with "true" stories, some movies, including *Silver Linings Playbook, Infinitely Polar Bear,* and *Canvas,* can start conversations about mental illness, which helps combat stigma. Plays and musicals, including the Broadway show *Next to Normal,* are also excellent for fostering understanding, empathy, and discussion.
- **Websites and blogs:** Numerous websites and blogs offer valuable information about bipolar disorder and provide insight specifically for friends and family members of people who suffer from this illness. Check out my blog at `www.psychologytoday.com/us/contributors/candida-fink-md`.

WARNING

When researching bipolar on the web or social media, remain skeptical. The internet has plenty of good information but it also attracts its share of quacks and armchair quarterbacks. Consult your doctor and therapist before making any change to your treatment plan, including stopping medication or starting a home remedy.

Establishing your team's level of involvement

Everyone on your support team needs to have the sensitivity to know when to remain silent and when to voice concerns, along with the strength to step in and help when you need it most, especially when you can't or don't want to ask for or accept assistance. Such people are rare, and even the best of them can't always get it right. But you can help your loved ones become better supporters by educating them about bipolar, communicating your needs, and defining the parameters for assisting you.

WARNING

You're probably aware that some people will gladly volunteer to live your life for you if you let them. They'd be happy to cook your meals, clean your house, raise your kids, and maybe even pay your bills (with your money, of course) — all in the name of charity or seeing themselves as the savior you need. Such assistance may seem nice in the short term, when you really need help, but when charity becomes chronic and invasive, the lifesaver quickly becomes an anchor, keeping you from moving forward. Beware of the following personality types:

- **The Nagger:** "Did you take your meds today?" Every day, sometimes two or three times a day, you can expect this nagging question or others like it — treating you like a disobedient child. If you want or need to be reminded to take your medications, the Nagger can be useful if that person is willing to remind you within guidelines that you prearrange; otherwise, the nagging is just another stressor.
- **Clueless/Avoidant:** A Clueless/Avoidant helper watches you, but never does or says anything that may offend you. You can be teetering on the edge of the cliff, and Clueless will patiently watch the events unfold. Giving this person permission to speak up may be necessary.
- **The Party Animal:** If you're prone to hypomanic or manic episodes that entail spending sprees, bar hopping, wild sex, and other frenetic activities, you can find plenty of Party Animals to join you for the fun, but they usually don't stick around when the hangover kicks in. Avoid people who encourage your most unhealthy behaviors.
- **The Heavy:** Unlike the Party Animal, who encourages you to have too much fun, the Heavy doesn't let you have any fun at all. And that's not . . . well, any fun. You should be able to enjoy a full life within the limits you set for yourself. Being happy and having fun aren't the same as being hypomanic, and you need and deserve to experience joy.

Encouraging open communication

Announcing that you're bipolar is a foolproof way to silence an audience. Most people don't know what to say, so they instantly go silent. In some cases, that's the desired effect; but when you approach your support team, you want to encourage open communication to achieve two goals:

- Help your supporters understand you and your illness more intimately.
- Become more aware of how your moods and behaviors affect others.

Establishing a relationship is like learning to dance together. You and your partner must move in sync, and communication is pivotal. At first, you step on each other's toes quite frequently, but as you become more accustomed to each other's movements, you begin to instinctively move to the rhythms that surround you. Here are some techniques that can open the channels of communication so you can start working on your rhythm:

- Write down what you want to discuss in advance.
- Sit in a quiet, private place whenever you discuss confidential topics.
- Agree on a physical sign or secret word that you can use to end a discussion, no questions asked, if it becomes too heated or painful.
- Encourage your friend or loved one to ask questions about bipolar disorder and the way it makes you feel.
- Ask your friend or loved one to share observations and emotions concerning your moods and behaviors. How is bipolar disorder affecting your loved one's life? Is it resulting in a situation in which your loved one's needs aren't being met?
- Encourage loved ones to do their own work to learn more about bipolar disorder rather than relying on you exclusively to teach them or provide them resources. Serving as the bipolar resource person may involve a great deal of emotional labor on your part, which can be exhausting, especially when you're not feeling well. You don't have to be their only teacher.

REMEMBER

You can help a person become more knowledgeable about bipolar disorder and your specific needs, but you can't force anyone to accept you or the illness. Some people, due to their own limitations, may not be ready to accept the illness and adapt to a new reality. For your own mental wellness, you may need some distance from these people for a while.

BIPOLAR BIO

REAPING THE BENEFITS OF HONESTY

I realized the importance of telling the truth to my family and providers when I was first hospitalized at the age of 19. It didn't take long to figure out that communicating honestly with the doctors and nurses caring for me allowed them to help me and respond to my needs. I also learned that signing a release form meant there was little I could hide from my family even if I wanted to.

After this initial hospitalization, I continued to communicate with my family about what I was going through, allowing them to be honest as well. We developed a deeper

understanding of one another as we shared our fears, worries, and triumphs. I continued to be honest with my medical providers as well. I made it a goal to always tell the truth to my doctors; in turn, they helped me get the treatment I need, found the medications that work best for me, and created a strong bond with me, allowing the trust to grow.

Sharing my truth with people is hard, but I'm rewarded for it over and over again. Whether it's closer bonds with my family, a truthful discussion about side effects with my psychiatrist, or an open talk with my therapist, I've seen positive results of honesty. What has inspired me the most, however, is that my honesty has allowed others to be honest as well. Honesty has made all the difference in my recovery, my stability, and my wellness.

— Linea Johnson, coauthor of *Perfect Chaos: A Daughter's Journey to Survive Bipolar, a Mother's Struggle to Save Her*

Working as a Team

All the key players on your mood-management team, including you, should be able to communicate openly with one another to ensure that you receive comprehensive, integrated treatment. If your therapist notices that your moods are fluctuating or that you seem more anxious and irritable than usual, your therapist should be able to contact your psychiatrist to talk about how to help you. You may need a medication adjustment, additional therapy sessions, other supports, or all of the above.


TIP

An effective strategy is to put one member of your support staff in charge of communications. Your communications manager should introduce the members of your mood-management team and ensure that critical information gets passed along. Such communication is especially important in situations that involve complications or transitions, such as the following:

- **Hospitalization:** Some hospitals have their own doctors in charge of treatment, so when you're hospitalized, the psychiatric provider who usually sees you may no longer be in charge of your care. Communication between your psychiatric provider and the new doctor at the hospital is essential.
- **Hospital release:** Before the hospital releases you, your regular psychiatric provider, therapist, and the person acting as your primary caregiver need to be informed in advance so they can provide a smooth transition to the outside world and make any necessary arrangements.
- **Changing doctors:** When you change doctors or therapists, key records need to be transferred to the new care provider.

REMEMBER

PROTECTING YOUR PRIVACY

The *Health Insurance Portability and Accountability Act* or *HIPAA* provides important guidelines to protect patients' private health information (PHI). Your doctor or therapist can't release information to family members without your express written consent (except in emergencies). Physicians and other care providers don't technically require consent to speak to each other when communicating with the intent of providing appropriate medical care. With therapists, it's a special case, because while they don't need to obtain your consent to speak to your psychiatrist to coordinate care, they can't reveal the content of their *psychotherapy notes* (detailed notes about therapy sessions) without your consent. In general, mental health providers ask you to sign a *release of information* form consenting to communications between team members See Chapter 15 for a sample release of information authorization letter.

Keep in mind that HIPAA is a one-way street related to information flow with family members. Your provider can't share information about you without your consent, but family members or other loved ones can provide information to your provider — for example letting your therapist or doctor know if they have concerns about recent changes in your mood or behavior. In most cases, your providers are expected to let you know when they've received this information about you.

Tapping the Power of Self-Advocacy

Self-advocacy is a term that refers to speaking up for yourself and your interests. It's a central tenet of the Disability Rights Movement. Historically, psychiatric patients had little say in their own treatment until the civil rights movement of the 1960s and 70s. And while advocacy groups worked to improve conditions for those with mental illness, those organizations did not typically include people with mental illness or disability. Self-advocacy is the term for people with mental illness demanding to be seen as competent to define themselves and their needs, and to be at the head of the table when decisions are made that affect them.

In your individual bipolar story, your self-advocacy means speaking up to let your treaters and your family members know what you need and expecting that your autonomy will be respected in decisions about your care. Self-advocacy requires a certain degree of assertiveness, which doesn't come naturally for many people, especially those who are most generous — those who are accustomed to giving more than they receive. It can be especially hard for those who are typically givers to set boundaries with others when their demands or expectations interfere with your mental health.

REMEMBER

Being assertive means knowing what you need and not settling for anything less than that. It doesn't mean that you need to be aggressive or try to prevent others from having their needs met; in fact, a combative or hurtful approach to being assertive will reduce your chances of success in getting your needs met. Assertiveness entails clearly and directly stating your needs and continuing to do so until they're met.

Here are a few ways to become more assertive:

- Write a list of your needs so they're clear in your own mind. Be specific in your expectations. Just telling someone to "be nicer to me" won't get much traction. Try something like "I expect you to respond to me without yelling" or "I need you to stop making jokes about me being 'crazy' when we're with friends." Or (for your doctor), "It's important that you look at me for this conversation rather than at the computer" or "Although you want me to continue this medication trial, I can't because I feel terrible on it."
- Rehearse what you're going to say prior to an encounter. You can rehearse alone or with a friend or family member. Be sure to rehearse what to say if you get a negative response.
- Prepare some responses in advance. For example, if you have trouble saying no, and that results in your taking on too much work, you may have a list of alternative ways to say no, such as "Let me get back to you on that" or "I'll need to check my calendar when I get home."
- Take time to respond if your request is misunderstood or denied. Don't feel that you must respond immediately. You can always disengage and return to the discussion later.
- Assume that *no* means *know*. In other words, if the person reflexively says no, assume that person doesn't *know* enough to say yes. Assume a "knowledge gap" and proceed to provide the information needed to fill that gap. If certain people aren't receptive or don't treat you with respect, you may need to set other boundaries so their inflexibility doesn't hurt you.

3 Managing the Biology of Bipolar Disorder

IN THIS PART . . .

Develop a deeper understanding of the medications used to treat bipolar mania and depression and other conditions that often accompany bipolar disorder, including anxiety and insomnia so you can have a well-informed discussion of medication options with your prescriber.

Weigh potential medication benefits against their possible adverse side effects to perform your own cost-benefit analysis while exploring the expanding range of medications and treatments beyond the basics.

Recognize the reasons why many people stop taking their medications and find ways to address many of the most common issues and deal with emotional factors that often play a role.

Discover other ways to treat the biology of bipolar disorder — including supplements, light therapy, and various methods of physically stimulating the brain — when medications are insufficient or produce unacceptable side effects.

Recognize unique needs that arise in treating bipolar in various populations, such as women across their reproductive lifespan, older people, and members of the LGBTQ+ community, and find out how to obtain care that respects and addresses those needs.

IN THIS CHAPTER

- Recognizing the different classes of mood-regulating medications
- Choosing the right medications for you and sticking to your prescribed regimen

Chapter 7
Leveling Moods with Medication

Most people with bipolar disorder need to take medication to help manage their moods, but doctors have no magic pill. Because bipolar disorder cycles through periods of vastly different symptoms, medications have a lot of ground to cover. The treatments work differently for everyone; a miracle to some may be a disaster for others. Medications that stabilize mood for some people may cause intolerable side effects for others. Medications that work today may stop working later.

USING MEDICATIONS OFF LABEL

Throughout this chapter (and the book), we discuss many medications and how licensed physicians can prescribe them for bipolar disorder and related conditions. They've been researched in scientific studies that help to understand what effects and side effects the medicines have and how they work in the body. The Food and Drug Administration (FDA) also labels medications in the United States as *approved* for use in certain conditions. If a pharmaceutical company wants to be able to market one of its medications for a particular illness, it must show the FDA a certain number of

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well-designed studies that support its use in that illness. The FDA then decides whether or not to approve the medication for that condition. If the FDA gives approval, then when a doctor prescribes the medication for that condition, it's being used *on label*.

Frequently, though, doctors also use medications *off label* — in ways that don't have specific FDA approval. In such situations, they're relying on other evidence, such as scientific research and clinical *standards of practice (*patterns of prescribing that are common in a particular specialty).

Discussions about medication in this book include both on-label and off-label uses. Your doctor should let you know when prescribing a medication off label, but because doing so is such a common practice, many prescribers may not spell this out in detail, so feel free to ask.

We can't tell you which medications are best for you, but in this chapter we introduce you to those that have proven useful in treating the most common bipolar symptoms and offer guidance on working with your prescriber in choosing and managing your meds.

Unlocking the Bipolar Medicine Cabinet

This section introduces you to many of the most routinely prescribed medications that treat bipolar and commonly associated conditions. The information you find here is based on the knowledge and prescribing practices in place at the time of this writing. We highlight the primary benefits and most common potential side effects of each medication and encourage you to use this information when talking with your doctor about the safest and most effective medication choices for you.

WARNING

If you're pregnant or planning to become pregnant, see Chapter 10 for additional considerations regarding medications to use based on possible effects on the developing fetus.

Lithium

Lithium for psychiatric symptoms has been around since the mid-1800s. In the 1950s, researchers began to look more formally at its use in bipolar disorder. Since the 1960s lithium has been the gold standard, treating the range of bipolar symptoms more fully than any other medication in use today. It treats mania. It has

antidepressant effects. It's also used in *maintenance therapy* as long-term medication to prevent or reduce recurrent depressive or manic episodes. And perhaps most importantly, it's the only medication that's proven to reduce the risk of suicide associated with bipolar.

Lithium truly is in a league of its own. Interestingly, this wonder med wasn't cooked up in a multimillion-dollar lab. Lithium is a naturally occurring salt that just happens to reduce a number of mood symptoms when safely managed under a doctor's care. Lithium is a first-choice medication to treat an acute manic episode, often in combination with an *antipsychotic* (see "Antipsychotics" later in this chapter).

No one yet fully understands how lithium works in the brain to treat bipolar disorder, but research has consistently shown it to have *neuroprotective* effects in the brain, meaning it limits damage to brain cells and supports their recovery when damage occurs. Lithium also acts on *signaling* systems (electrochemical messaging circuits within and between brain cells) and modulates *neurotransmitters* (chemicals that enable communication between cells). (See Chapter 2 for more about brain structure and function.)

Potential side effects of lithium can include nausea or diarrhea, frequent urination, tremor, brain fog, and acne. Long-term use can cause kidney and thyroid problems, which is why doctors who prescribe lithium monitor kidney and thyroid function with regular blood tests. Other side effects are possible; be sure to ask your doctor if something doesn't feel right.

Because of its potential harm to the kidney, lithium may not be the first-choice medication for someone with kidney disease.

REMEMBER

One downside to taking lithium is that it requires blood tests to monitor the concentration in your blood and to monitor for potential side effects. You must keep lithium blood levels in a very narrow range so that it can be effective without being dangerous, so always take the prescribed dose. Your doctor will test your blood levels every few weeks when you first start taking it and then every several months after the dose is stable. If lithium dips below its therapeutic level, it may not be effective. If it rises too high, the substance can become toxic, and lithium toxicity can lead to death.

WARNING

Lithium levels can rise as you lose fluid, so be wary of hot weather and vigorous exercise and limit your consumption of diuretics, including coffee, and alcohol, which can also amplify the sedative effects of lithium. Non-steroidal anti-inflammatory medications (like ibuprofen) can increase lithium levels, too, so check with your doctor before taking any of those meds along with lithium. Also, don't make dramatic changes to your salt intake, such as starting a low-salt diet, without consulting your doctor when taking lithium. If you experience

diarrhea, vomiting, dizziness, lack of coordination, shakiness, blurred vision, or other signs of lithium toxicity, contact your doctor immediately. If you can't reach your doctor, head to the nearest emergency room.

All that said, long-term use of lithium provides excellent management of bipolar for some people. Lithium prevents the onset of symptoms, so keep taking it even if you're feeling better. After all, taking lithium is likely what's making you feel better. Continue to see your doctor regularly to discuss your options in terms of how long you should stay on lithium. Some studies suggest that if you stop taking lithium, it may not be as effective for you if you resume taking it later, although this theory hasn't been clearly proven.

WARNING

On the web or at your local health food store, you may hear about *lithium orotate*, which is purported to be safer. But no reliable studies currently support the claim that lithium orotate is safer than or as effective as lithium carbonate. With any form of lithium, you and your doctor need to carefully monitor your blood levels throughout treatment.

Valproate (Depakote) and other anticonvulsants

Valproate is another *first-line* (recommended as a first choice) mood stabilizer. Originally used as an *anticonvulsant* (a medication used to treat seizures), it has become an important medication in treating bipolar disorder. Valproate is a one of the first-line medication choices for acute mania and maintenance treatment in bipolar disorder. It's considered a second- or third-line choice in treating acute bipolar depression.

REMEMBER

Lithium or valproate plus an *antipsychotic* is the first-line treatment for an acute manic episode.

Valproate is thought to reduce and prevent mood symptoms in multiple ways, including modulating levels of the neurotransmitter GABA, reducing excessive firing of neurons through various mechanisms, and affecting the expression of certain genes. (See Chapter 2 for more about how medications work — their *mechanisms of actio*n.)

Potential side effects of valproate can include nausea, vomiting, diarrhea, sedation, and hair loss. More serious adverse reactions can include inflammation of the pancreas or liver, changes to reproductive hormones and metabolism (specifically in girls and women of childbearing age), and damage to blood cells. This is not a comprehensive list, so be sure to review potential side effects with your prescriber and to let them know right away if you don't feel well.

WARNING

Because of its side effect profile, valproate is not a first choice for people with liver disease or for women of childbearing age.

As with lithium, when you take valproate, your doctor will order blood levels to make sure you have enough of the medication in your bloodstream to be effective. Your doctor will also order liver function tests and blood cell counts to monitor for any potential side effects in these areas.

WARNING

Withdrawing an anticonvulsant too quickly can cause seizures. Always consult your doctor before you stop or decrease a medication.

Carbamazepine (Tegretol)

Carbamazepine is another anticonvulsant that's used much less commonly than valproate in the treatment of bipolar disorder. It's generally considered a second- or third-line treatment in the US for bipolar mania, bipolar depression, and maintenance. Research shows that it's effective in treating acute mania. It's thought to work by reducing neuron hyperactivity and protecting brain cells from damage — similar to lithium and valproate.

Carbamazepine carries some significant potential side effects, including a severe skin reaction called *Stevens Johnson Syndrome.* Some people are genetically at such high risk that they shouldn't take this medication. This genetic vulnerability is particularly common in people of Chinese descent, so they'll always be tested before being started on carbamazepine. Other potential side effects include blood cell damage and liver problems. Carbamazepine also has many interactions with other medications that can make it difficult to use.

Lamotrigine (Lamictal)

Lamotrigine is another anticonvulsant that has a role in treating bipolar disorder, specifically for bipolar depression and maintenance treatment (to reduce the risk of future mood episodes). It's not effective in treating acute mania.

Lamotrigine is a well-tolerated medication for most people, although infrequently it can cause significant sleep problems. One potential side effect is the skin reaction called Stevens Johnson Syndrome, which can be deadly. The risk is substantially reduced by increasing the dose very slowly. Unfortunately, this means that it may take up to three months to get to the goal dose.

Lamotrigine can have negative interactions with many medications, including oral contraceptives. It can reduce the effectiveness of progesterone-only birth-control pills. Estrogen containing pills can decrease blood levels of lamotrigine. These potential issues are important to discuss with your doctor.

Antipsychotics

Antipsychotics are medications used to treat psychotic symptoms, including hallucinations and delusions. These symptoms can be caused by many factors, including illnesses (such as schizophrenia), brain inflammation or injury, and medications or other substances, to name a few.

The mood episodes of bipolar disorder, especially mania, commonly include psychotic symptoms. But even for manic episodes without psychosis, many medications in this class are first-line treatment choices, typically in combination with lithium or valproate. And some antipsychotics have a role in treating bipolar depression and in maintenance therapy to reduce the likelihood of recurrent mania or depression.

The first generation of antipsychotics evolved in the 1950s and include medications such as chlorpromazine (Thorazine) and haloperidol (Haldol). These medications block dopamine receptors. Although it's still used in some settings, this class of antipsychotics has become less popular with the development of the second generation of antipsychotics that first appeared in 1990. The antipsychotics in this group block multiple types of dopamine receptors and serotonin receptors. Each medicine in this class has unique and complex interactions with these receptors, which means that they have different effects on symptoms and different side effects. Some of these medications work well in acute mania, whereas others are less powerful for mania but more useful for depressive episodes, while some treat both mania and depression.

Some of the most commonly used antipsychotics for acute mania include haloperidol (Haldol), aripiprazole (Abilify), olanzapine (Zyprexa), quetiapine (Seroquel), and risperidone (Risperdal). Others include asenapine (Saphris), ziprasidone (Geodon), paliperidone (Invega), and cariprazine (Vraylar).

For bipolar depression, antipsychotics commonly used include quetiapine (Seroquel), lurasidone (Latuda), olanzapine, and lumateperone (Caplyta).

Side effects of the first-generation antipsychotics include sedation, tremor, stiff or slowed movements (like Parkinson's disease), acute *dystonia (*severe muscle spasms), and *tardive dyskinesia* — a syndrome of involuntary movements that can be permanent.

The movement side effects are much less common (although not impossible) with the second-generation antipsychotics, which is one of the reasons they're now used more often. The following list includes some potential side effects of this newer group of antipsychotics:

- Sugar metabolism and insulin resistance problems with increased risk of developing type 2 diabetes
- Weight gain and increases in cholesterol and other fats
- *Akathisia* — a feeling of extreme restlessness, commonly described as the overwhelming desire to jump out of your skin
- Changes in cardiac rhythms
- Some can increase levels of the hormone prolactin, which sometimes causes breast enlargement in men and lactation or menstrual problems in women
- Impaired sexual function
- Other general side effects, including sedation, dizziness, constipation, and headaches

WARNING

All antipsychotics carry the risk of a potentially deadly condition called *neuroleptic malignant syndrome*. Symptoms include confusion and agitation, muscle rigidity (that can cause severe damage to the muscles), fever, elevated heart rate, and rapid breathing. This is a medical/neurological emergency that requires treatment in the emergency room right away. Be sure to ask your doctor about this possibility and don't hesitate to call or head to the hospital if these symptoms arise when you're on an antipsychotic.

One atypical antipsychotic we haven't mentioned yet is clozapine (Clozaril). Psychiatrists often consider it to be a medication of last resort due to its severe negative side effects. Clozapine is most commonly used for treatment-resistant schizophrenia, but it's used off-label for severe bipolar mania or psychosis that isn't responding to other treatments. Clozapine also has an *indication* (that is, licensed approval for a particular use in the United States by the FDA or in Europe by the EMA) as a treatment for "recurrent suicidal behavior," in schizophrenia and schizoaffective disorder (although it may be used off-label for this indication in bipolar disorder as well).

Clozapine has a high risk of causing a severe reduction in white blood cells — a condition called *agranulocytosis.* People taking this medication must get their blood drawn every week for the first six months of treatment and every other week for the next six months, and then it becomes a monthly blood draw. Clozapine also tends to cause significant weight gain.

Mood-boosting antidepressants

Although mania grabs all the bipolar headlines, recurrent and severe depressive episodes interfere with people's lives at least as severely as mania, and often

cause more of the day-to-day devastation for people living with bipolar disorder. Depression is often the first type of mood episode to show up before any manic symptoms, and therefore antidepressants are often the first medications prescribed. But bipolar depression is different from unipolar depression. Particularly in bipolar I, antidepressants are often less effective and can cause serious negative effects, including triggering mania. Using antidepressants in bipolar depression is tricky business.

WARNING

If you (or your doctor) have any suspicions that your depression is related to an underlying bipolar disorder, your depression treatment will be a complex process and will require close monitoring. See the later section "Lifting bipolar depression" for a more detailed discussion.

The following sections describe the various types of antidepressants and the specific medications that fall within these groups.

SSRIs

Serotonin is a neurotransmitter that helps regulate mood, anxiety, sleep/wake cycles, sexual behaviors, and many other brain and body functions by communicating information between brain cells. The communication happens in the space between cells called the *synapse* (see Chapter 2). The first cell releases serotonin into the synapse, and the serotonin attaches to a *receptor* on the second cell. After the receptor is activated, it sends instructions into the cell. When communication is complete, the serotonin releases from the receptor and gets vacuumed back up into the first cell to be used again.

Selective serotonin reuptake inhibitors (SSRIs) block the vacuuming back into the first cell, leaving more serotonin in the synapse and on the receptors, changing the instructions being communicated between cells. However, the mechanisms of action of SSRIs go beyond that process and can produce other effects, such as reducing inflammation or protecting cells from damage.

Some of the most common SSRIs include fluoxetine (Prozac), paroxetine (Paxil), sertraline (Zoloft), citalopram (Celexa), and escitalopram (Lexapro). Symbyax — a combination of fluoxetine (an antidepressant) and olanzapine (an antipsychotic) — is often used to treat bipolar depression.

SSRIs are generally well-tolerated physically, but they can cause some sleep changes, eating or appetite changes, headaches, or gastric discomfort. Night sweats can be an uncomfortable side effect. Sexual side effects are not uncommon and relate primarily to reduced sensitivity in the sexual response, but some people also note decreased interest in sex.

SSRIs are also primary medications for anxiety disorders and OCD, which are common comorbidities in bipolar disorder.

Children and young adults are at an increased risk of SSRIs causing *activation* — meaning elevated emotions, activity, and distress. In people with bipolar disorder, SSRIs can trigger manic symptoms. In rare instances, SSRIs have been associated with new onset of suicidal thoughts, but not with increased risk of suicidal behaviors or deaths.

REMEMBER

SSRIs may take several weeks to become fully effective, so keep taking the medication even if you don't experience immediate relief.

SNRIs

Like SSRIs, selective serotonin and norepinephrine reuptake inhibitors (SNRIs) block the *reuptake* of serotonin but also the reuptake of another neurotransmitter — norepinephrine. As with SSRIs, the additional mechanisms of action of SNRIs are still being worked out. But researchers know that, like serotonin, norepinephrine plays an important role in regulating mood and anxiety. It also contributes to regulating alertness and concentration. Commonly used SNRIs include venlafaxine (Effexor), desvenlafaxine (Pristiq), and duloxetine (Cymbalta).

Like SSRIs, SNRIs are also commonly used to treat anxiety disorders, and sometimes OCD.

Potential side effects for SNRIs are the same as those for SSRIs, as explained in the previous section.

REMEMBER

SNRIs may take several weeks to become fully effective, so keep taking the medication even if you don't experience immediate relief.

Other serotonin-related antidepressants

Two newer antidepressants — vilazodone (Viibryd) and vortioxetine (Trintellix) — work as SSRIs but also have direct effects on the serotonin receptor sites. They're used primarily to treat depression, not anxiety, but may reduce anxiety symptoms as well.

Other antidepressants considered "atypical" include trazodone (Desyrel), which is so sedating that it's used mostly as a sleep aid now, and serzone (Nefazodone), which has limited use now due to reports of liver problems. Both of these medications are considered serotonin antagonist and reuptake inhibitors (SARIs). They affect several neurotransmitters, including serotonin, and they work at several sites in the communications between brain cells.

Bupropion (Wellbutrin)

Marketed as the antidepressant Wellbutrin, the smoking cessation product Zyban, and the combination weight-loss medication Contrave, bupropion is a norepinephrine and dopamine reuptake inhibitor, meaning it blocks the reuptake of those two neurotransmitters back into the first cell of a synapse, leaving more of the molecules to land on receptors on the second cell. Bupropion doesn't cause weight gain and doesn't have sexual side effects, making it a common first choice for many adults with depression. It's sometimes added on to SSRI/SNRI treatment to reduce the sexual side effects of those medicines.

Although some people experience some relief of anxiety symptoms with bupropion, it's not considered an anti-anxiety medication.

Bupropion does carry risks of triggering manic symptoms and rarely of causing new onset thoughts of suicide. Other side effects can include insomnia and reduced appetite, as well as jitteriness. It can also, infrequently, cause seizures, so anyone with a history of seizures must avoid it. It's also not used in people with eating disorders. Medication interactions that increase the blood level of bupropion can increase the risk of seizures, so be sure that your doctor knows all your other medicines and any new ones that get added for other medical conditions.

Mirtazipine

Mirtazipine is another antidepressant that's in its own class. It affects norepinephrine and serotonin transmission through completely different mechanisms than the reuptake of neurotransmitters.

Mirtazipine can be very sedating, which can make it harder to use as an antidepressant, but it has a niche as a sleep aid. Interestingly, the sleepiness effect occurs only at lower doses; it goes away when you get into more therapeutic doses for antidepressant effect.

It also stimulates appetite, which can be a downside for many people but a boon for people whose appetites are diminished by their depression. It also has significant anti-anxiety properties.

Tricyclics and MAOIs

Tricyclics and *monoamine oxidase inhibitors* (MAO inhibitors or MAOIs) are older classes of medications that work differently from the antidepressants discussed previously and even differently from one another. These meds are used much less often than many of the other treatments for bipolar that we describe in this chapter because the side effects of tricyclics and MAOIs can be difficult to manage:

- **Tricyclics:** Tricyclics affect norepinephrine and serotonin levels primarily, but they also touch a number of other brain chemicals, including histamine. These "extra" chemical events cause many side effects, which may include sedation, dry mouth, constipation, and dizziness, as well as cardiac rhythm changes.
- **Monoamine oxidase inhibitors:** MAOIs prevent the action of an enzyme that breaks down norepinephrine, serotonin, dopamine, and a number of related brain chemicals, which increases the levels of these chemicals in the brain. People taking MAOIs are restricted from eating certain foods, including but not limited to aged meats and cheeses and certain types of beans, to prevent a dangerous spike in blood pressure. MAOIs can also have severe interactions with many other meds and are very dangerous with SSRIs and SNRIs in particular. If you're changing to or from MAOIs to an SSRI or SNRI, you must have a complete two-week washout of one medication before starting the other. When changing from fluoxetine to an MAOI, the washout period between medicines is five weeks.

All antidepressants can have some *withdrawal symptoms* — effects that can occur when the medication is stopped. Some are more or less likely to have such symptoms. For example, SNRIs as a group seem to have more clear discomfort than SSRIs when a dose is missed. Withdrawal is much more likely if the medication is stopped abruptly rather than *tapered* (the dose decreased gradually over time).

Most withdrawal symptoms abate within a couple of days to weeks after stopping the medication. However, some patients have reported their withdrawal symptoms lasting much longer. Sorting out withdrawal symptoms (related only to the medication discontinuation itself) from recurrent symptoms can be challenging at times. Depression and anxiety can have long or chronic courses, so sometimes stopping the antidepressant can lead to recurrent symptoms because the disorder is still present. That's not the same as withdrawal.

Calming anxiolytics and sleep agents

Anxiety and sleeplessness often accompany bipolar disorder. If you don't address them effectively in treatment, they can worsen mood episodes and other bipolar symptoms. To help you calm down and get some sleep, your psychiatrist may prescribe one or more anti-anxiety medications or sleep aids, which we describe in this section.


REMEMBER

SSRIs or SNRIs are powerful anti-anxiety medications and are the first line of treatment for anxiety for many people. But given the risks of agitation or mania that accompany these meds, they can be hazardous for people with comorbid bipolar disorder. Still, this class of medications is important and offers primary

treatment for anxiety either alone or in combination with other meds, depending on your particular situation and symptoms. See the earlier sections "SSRIs" and "SNRIs" for details.

Benzodiazepines

The most commonly used purely anti-anxiety meds are *benzodiazepines* (also known as *anxiolytics* or *tranquilizers*). These medications slow down the whole nervous system, thus reducing agitation and anxiety levels, both of which can be problems in bipolar disorder. Benzodiazepines affect the neurotransmitter *GABA (gamma-aminobutyric acid)*, which has a calming effect on neurons. For many people, just knowing they can take a medication to stop a panic episode helps reduce the secondary fear of having an episode. Sometimes, these medications can also be used as sleep aids when taken at night.

Benzodiazepines are often useful at the beginning of mood or anxiety treatment because they take effect much faster than other medications — within 20 to 30 minutes. They provide immediate relief during the two to six weeks or more you're waiting for another medication such as an SSRI to take effect for the depression and/or anxiety symptoms. But when the SSRI takes effect, your doctor may want you to decrease and eventually stop the benzodiazepine. For some disorders, such as panic disorder, doctors may prescribe benzodiazepines for infrequent (as needed) but long-term use.

Some commonly used benzodiazepines include alprazolam (Xanax), lorazepam (Ativan), clonazepam (Klonopin), and diazepam (Valium).

In choosing a specific benzodiazepine, your doctor considers a wide range of issues related to your condition as well as factors such as how long the medication effect will last. Check out the section "Selecting the best medications for you," later in this chapter, for details. Another important factor in choosing a benzodiazepine for you is how it interacts with other medications you're taking, including antidepressants and antipsychotics.

WARNING

Approach benzodiazepines cautiously. If the dose is too high, benzodiazepines can shut down various brain functions, causing severe sedation and stupor and eventually slowing a person's breathing, which can be fatal. Also, benzodiazepines work on the same receptors that alcohol affects, so combining benzodiazepines and alcohol vastly increases the risk of a serious central nervous system shutdown. Another big problem with these meds is the potential for addiction and dependence: The body eventually becomes dependent on them and then requires ever-increasing doses. Careful monitoring of dose and use of these medications is important.

Other anti-anxiety medications

Other prescribed anti-anxiety medications include buspirone, pregabalin, and gabapentin, which aren't considered tranquilizers:

- **Buspirone (Buspar):** This medication is specific to the treatment of anxiety. It is not an antidepressant. It affects serotonin, like an SSRI, but works directly on particular serotonin receptors rather than affecting reuptake. Also like an SSRI, buspirone takes time to build up in the bloodstream to have its intended effect. Like benzodiazepines, this medication is used specifically for anxiety and has no known antidepressant effect, but unlike benzodiazepines, it doesn't have any potential for addiction.

  Many prescribers find minimal benefit with buspirone alone, so they often prescribe it as an add-on to other medicines. Buspirone can be a good option for people with a history of alcoholism or abuse of benzodiazepines, but its effectiveness is inconsistent.

- **Pregabalin (Lyrica):** This medication is approved for the treatment of several types of pain syndromes and as an add-on agent for treating seizures. Although it's not currently formally approved for treating anxiety, it's often used off-label for treating anxiety and several studies have shown it to be helpful in treating some anxiety disorders. It may be used when the doctor is trying to avoid using SSRIs, SNRIs, or benzodiazepines. Side effects may include dizziness, sedation, tremors, and weight gain.

- **Gabapentin (Neurontin):** This antiseizure medication is also used to treat some pain syndromes and has some use as a sleep aid. Like pregabalin, its use for anxiety is off-label; doctors may use it when they're trying to avoid using an SSRI or SNRI or limit or reduce use of benzodiazepines for medical or substance use concerns.

Sleep aids

Doctors commonly prescribe sleep aids for the short-term treatment of insomnia, which is often associated with depression and mania. The benzodiazepines listed in the previous section are sometimes used to help with sleep, but a number of sedative hypnotic medications similar to those are used exclusively for insomnia and aren't used to treat anxiety. These medications aren't usually combined with benzodiazepines because the combined sedative effects can be dangerous. Like benzodiazepines, these sedative hypnotic agents carry risks of addiction and dependence.

In addition to the benzodiazepines and sedative hypnotics, doctors use a variety of other medications to reduce insomnia, especially if they're concerned about issues of dependence and addiction. The antidepressants trazodone, amitriptyline, and

mirtazapine are often used in low doses for sleep because they're sedating (see the prior section on antidepressants for more details). One antidepressant, doxepin, has been repackaged, in low doses, as a sleep aid called Silenor, and the FDA formally approved it to treat insomnia. Antihistamines, such as diphenhydramine (Benadryl), commonly used to treat allergies, are also used to treat insomnia because of their extremely sedating side effects, but they can lead to significant *hangover* (daytime sedation) and a number of other medical risks. Don't start using any sleep aid without talking to your psychiatrist.

A relatively new group of medications to treat insomnia are the *dual orexin receptor antagonists (DORAs). Orexin* is a group of proteins in the brain that promotes wakefulness. Blocking its effect at the receptor sites in the synapse helps to discourage being awake, therefore allowing sleep to occur. All other medications used to treat insomnia work by increasing sedation, rather than decreasing wakefulness. DORAs don't seem to cause dependence or respiratory depression, so may be safer in that regard. They're not first-choice medications yet, in part because they're so new, so experience with them is still building.


TIP

Another sleep aid you may want to discuss with your doctor is ramelteon (Rozerem), which is often used in people who have a medical or substance use concern that increases the risks of using benzodiazepines or sedative hypnotics. It works through the melatonin system. *Melatonin* is a chemical that the brain releases in response to changing light at the end of the day; it induces sleep by targeting the *chronobiology* of the brain (the timing system related to day and night, sleep and wakefulness). It doesn't carry risks of dependence and addiction and therefore isn't a controlled substance like most other prescription sleep medications. It won't make you feel groggy the next day. It's not recommended for individuals who have a history of liver or respiratory problems, sleep apnea, or depression; for women who are pregnant or breast-feeding; or for those who take certain medications (your doctor must consider possible drug interactions). Ramelteon may interact with alcohol, and high-fat meals may slow the absorption of the medication.

Exploring Bipolar Psychopharmacology

Psychopharmacology is the use of *psychotropic medications* (any prescription meds that affect mood, emotion, behavior, or perception) to treat mental illness. In the case of bipolar, psychopharmacology has five primary goals:

- Alleviate acute manic symptoms
- Ease depressive symptoms

- Eliminate or lessen any psychosis
- Maintain mood stability and reduce the likelihood or frequency of future mood episodes
- Minimize any adverse side effects

The treatment goals are clear, but bipolar disorder has many features that make meeting these goals especially challenging, including the following:

- **Symptoms vary dramatically.** Depending on the *pole* of the episode — whether it's primarily depressive or primarily manic — the symptoms being treated aren't just different, but they're almost mirror images. When treating bipolar disorder, doctors must target individual poles *and* the broader illness (the fact that cycles re-occur).
- **Symptoms change over time.** Someone experiencing a manic episode may quickly begin to experience depression or vice versa. Target symptoms can seem hard to pin down.
- **Some episodes can have mixed features.** Although someone may be experiencing primarily manic symptoms, they may also experience hopelessness or other depressive symptoms; people in a bipolar depression may be quite agitated and irritable. These mixed features further complicate treatment planning.
- **Symptom stories differ from person to person.** One person's mania may be primarily irritable whereas another person may seem quite euphoric. Sometimes depression presents with a lot of irritability.
- **Other conditions may impact diagnosis and treatment.** An individual may have bipolar disorder coupled with anxiety or substance use disorder, for example. Having a coexisting condition may affect how the bipolar disorder presents and progresses. Treatment for each of these conditions can interact, causing negative physical responses or making treatment ineffective.
- **Effectiveness and side effects differ for each individual.** A medication that works for one person may have no effect or the opposite effect on another. One individual may feel fine taking a particular medication, whereas another may feel groggy or gain weight.
- **Medications can worsen symptoms.** For example, some antidepressants can induce mania or increase anxiety or agitation in certain individuals.
- **Medications can interact with each other.** Treatment often requires the use of two or more medications at the same time, which can affect the efficacy or side effects of either or both medications. See the later section "Juggling meds for comorbid conditions" for more on this complex topic.

In this section, we explain how to work with your prescriber to select the best medications for you and effectively manage your meds.

Selecting the best medications for you

When doctors are deciding which medication(s) to prescribe, they consider numerous factors, including the following:

- **Current symptoms:** If you're experiencing acute mania, for example, your doctor may withdraw any antidepressant and prescribe one or more first-line antimanic medications, such as lithium, valproate, or an antipsychotic. When treating acute depression, your doctor may start by prescribing an antimanic that has antidepressant properties, such as lurasidone or quetiapine and maybe layer an antidepressant on top if those don't relieve your symptoms adequately.
- **Medications you're already taking:** If you're already taking medications to treat symptoms for bipolar or a different condition, your doctor may check the dosage or (for some meds) the level of the medication in your bloodstream, adjust the dosage, and add another medication to supplement the one you're currently taking or prescribe a different medication entirely.
- **Response to previous medications and treatments:** If you've tried certain medications in the past and found that they were ineffective or produced intolerable side effects, then your doctor is likely to avoid those options this time around.
- **Risk of relapse or shift to the opposite pole:** When adding or withdrawing a medication or adjusting dosage, your doctor considers whether the change may trigger the onset of depression or mania or other emotional/behavioral side effects.
- **Side effects and other health risks:** All medications have side effects, and some meds are known to contribute to other health problems. Your doctor can help you evaluate side effect profiles for different medications and avoid certain options if your risk of developing other serious health issues is too high.
- **Sex and age:** Sex is a major factor in choosing the right meds, especially in females of childbearing age or those who are pregnant or breast-feeding. Doctors also give special consideration to older patients who may be at a higher risk for cognitive side effects or are more likely to have other health issues. (See Chapter 10 for details on treatment considerations for females and other specific populations.)
- **Patient preference:** As you discuss medications and their possible side effects with your doctor, do your own cost-benefit analysis and provide your doctor with input.

- **Cost:** Depending on your health insurance coverage, different meds may have very different costs to you. Your doctor may not know this, and you may need to do some research on your own to find out. Don't be embarrassed to talk to your doctor about medication costs. You can sometimes save a significant amount of money with a simple change (like choosing a generic over a brand name).

We encourage you to work closely with your doctor whenever you consider your medication options. If you think a particular medication may be effective, ask your doctor about it. If you're not comfortable with the potential side effects of a medication being prescribed, say so.


TIP

If a family member has bipolar disorder and is responding well to a particular medication or combination, the same medication(s) may work well for you. This is particularly true for lithium, because research suggests that a specific subgroup of people with strong family histories of bipolar have a higher likelihood of excellent response to lithium.

Pharmacogenetic testing

Pharmacogenetic testing involves examining a small number of genes to determine how they affect how medications affect the body and how the body affects the medications. Some of the information (the *pharmacokinetic* data) identifies variations at particular gene sites that determine how quickly or slowly you *metabolize* (break down) certain medications.

Note that the word *metabolism* here has nothing to do with your more general metabolism, such as how much you can eat without gaining weight. Metabolism in this context relates only to how your body breaks down and eliminates medications.

Results from pharmacogenetic tests can be useful in managing side effects in some situations. For example, if you metabolize a certain medication more slowly than most people, you may have higher blood levels of the medication at the standard doses, which may translate into more (or more severe) side effects. Having that information can help the doctor make dose adjustments that could reduce side effects while maintaining the medication's effectiveness.

These tests are not helpful for all people or in all situations; their benefits remain limited in general psychiatric use . . . for now, but the science is getting better all the time, and these tests are likely to be used much more regularly in the coming years.

Knowing what to expect

When your doctor prescribes a certain medication, the assumption is that it'll work — it'll treat the symptoms that brought you to the doctor in the first place. If your doctor offers little more information than that, ask some questions, including the following:

- What is the medication likely to do?
- When can I expect to notice an improvement?
- What are the possible side effects? (For tips on managing side effects, see Chapter 8.)
- What side effects need immediate medical attention?
- What should I do if I miss a dose?
- Should I avoid mixing any other medications or substances with this?


REMEMBER

The more you understand about your medications, the better equipped you are to truly partner with your doctor to find effective medications with side effects that you can tolerate.

Testing for med levels and health issues

Many medications require regular medical tests to ensure that they meet but don't exceed their recommended therapeutic levels (the levels at which they work) and that they're not causing any other medical problems. Common tests include the following:

- **Blood levels:** To test the concentration of the medicine in your blood
- **EKGs (electrocardiograms):** To monitor heart rhythms and evaluate for evidence of heart disease
- **Thyroid function:** To ensure your thyroid gland is working properly
- **Liver function:** To ensure that your liver is functioning properly
- **Blood sugar and insulin levels:** To make sure your blood sugar levels are where they should be, especially if you're taking a second-generation antipsychotic medication (see Chapter 8 for details)

Note: Throughout this chapter, we don't mention the tests required for specific meds unless a medication has a unique side effect that generates significant concern. Ask your doctor if tests are required for any of the medications you're currently taking or considering.

FINDING THE RIGHT MEDICATION: AN ONGOING JOURNEY

I was diagnosed with bipolar disorder in 1997 when I was 12 years old. I spent time in the children's psychiatric hospital while doctors tried to find medications that would stabilize me. Being diagnosed with bipolar disorder at such a young age was rare at the time, making it much more difficult to find the right medication. All I wanted was to go to school and play sports on the weekends just like my two siblings! I wanted to be like other kids my age.

I was too young to understand what bipolar disorder was, but I did understand that I needed to find medication that would make recovery possible. It took a long time — three years — to find a combination that worked for me. And the process was like searching for a needle in a haystack. But it was, indeed, a journey to find stability in my life. At the age of 15, I became well enough to go back to school; a year later, I was in college.

Now, at the age of 30, I still need to change my medication from time to time. My moods often cycle with the seasons. So my journey to find the right medication is a road I keep walking. When the road becomes a bit bumpy, my psychiatrist and I make little changes. When you're first diagnosed with bipolar disorder, it can feel as if you'll never find the right medication, but it just takes time.

— Natalie Jeanne Champagne, an advocate for mental health and author of *The Third Sunrise: A Memoir of Madness*

Mixing your pharmaceutical cocktail

The key to finding the right medication or combination of meds is to remain persistent and in regular communication with your doctor. By providing detailed feedback about how you're feeling and whether you've noticed any changes in your routine or behaviors, you can help your doctor more expertly mix a pharmaceutical "cocktail" that's both safe and effective for you. (Chapter 11 features a mood chart designed specifically for this purpose.)

Practicing safety first

Always make sure that any medication you add to your regimen is safe to use with any medications you're already taking, including over-the-counter remedies and "natural" or herbal supplements. Most prescription medicines include a list of *contraindications* (advisories against using a particular medication if you have a

certain medical condition) and drug interactions, which your doctor uses to determine one of the following degrees of safety:

- **Dangerous:** Some combos can be toxic. For example, never combine an MAOI with an SSRI.
- **Very risky:** Some combinations may be dangerous to some people, but the potential benefits outweigh the risks. For example, taking lithium with some diuretics or older antipsychotics is risky but may improve symptoms for some individuals.
- **Risky:** A combo with minimal risk may be reasonable when the potential benefits outweigh the risks. For example, mixing valproate and lamotrigine is risky, but this can be an effective mix if it's well managed.
- **Safe but with possible changes in medication effectiveness:** Some medications may change the effectiveness of other medications.
- **Safe:** Frequently, two medications have a very low risk of negatively interacting with one another, making them safe to combine.

REMEMBER

Consult your doctor if you have any questions about the effectiveness or safety of a medication or combination. Inform your doctor of any meds, supplements, herbs, or natural remedies you're currently taking. If you're seeing several different doctors for different conditions, make sure they all know which medications you take. Communication among your prescribers may be important at certain times, and you can ask one doctor to contact another if you think it'll help with your medication management.

Taking a gradual, systematic approach

Few psychotropic medications act as quickly as aspirin. And your doctor may gradually ramp up your dosage over time to reduce the occurrence of some side effects, even though the medicine itself may take several weeks to achieve full effectiveness. Furthermore, whenever you add a medication to the mix, you and your doctor need some time to observe the effects, side effects, and interactions. Under psychological distress, your patience may be strained, but following a steady course is critical.

TIP

Because so much can change with each medication adjustment, medications are typically adjusted one at a time, but that's not always possible — particularly in emergencies or in the hospital. When feasible, a systematic, scientific approach can reduce the number of variables at play and make it easier to track down the cause of any specific side effect or benefit. If you introduce two or more new meds at the same time and experience a negative side effect or a great benefit, you may not be able to tell which medication (or combination of medications) is causing it.

Staying abreast of the changes

Over the course of your life, your brain physiology and chemistry change, your symptoms change, and your environment and relationships change. To remain in sync with these changes, check in with your doctor regularly, even when you're feeling fine, to determine whether you can make any of the following adjustments:

- Change a medication dosage to reduce any undesirable side effects
- Change dosage or switch a med to address a new or nagging symptom
- Eliminate or reduce a medication to minimize long-term risks


TIP

A common trap is to start taking a combination of meds during a period of crisis and then continue on the same regimen after you resolve the crisis. During a period of stability, ask your doctor when it's reasonable to consider scaling back or eliminating some of your meds. Most people with bipolar require some medication throughout their lives, but you and your doctor should seize any opportunity to strip away unnecessary layers of medication.

Juggling meds for comorbid conditions

As you weave your way through the brambles of bipolar, you're likely to pick up a few burrs — diagnoses of comorbid conditions. *Comorbid* is a fancy word for any psychiatric or medical condition that accompanies another diagnosis. Of course, the bipolar category already assumes two coexisting conditions — depression and mania or hypomania; comorbidity doesn't apply to that. It applies to other distinct illnesses, such as the following:

- **Attention deficit hyperactivity disorder (ADHD):** This disorder can coexist with bipolar, sharing symptoms such as hyperactivity and impulsivity. Amphetamines often treat ADHD effectively but can jump-start mania or psychosis in people with bipolar. Certain antidepressants may be effective in treating ADHD, but you need to use both stimulants and antidepressants with care when bipolar is also in the picture.
- **Anxiety disorders (panic, generalized anxiety, or social anxiety):** These disorders show up in about 25 percent (or more) of people with bipolar. Some medications used for bipolar (such as the second-generation antipsychotics) can reduce anxiety, but they may not be adequate, and the anxiety may shut you down and prevent a return to daily life. SSRI antidepressants reduce anxiety in many cases, but they may not be safe to use without an antimanic agent. Benzodiazepines, such as clonazepam, may be quite useful for anxiety, but they carry risks of sedating you and requiring higher doses over time to get the same effect. Benzodiazepines can also lead to dependency and addiction.

- **Obsessive-compulsive disorder (OCD):** OCD is a common co-morbidity with bipolar disorder, and when present is associated with more difficulties in managing the bipolar disorder. OCD is often treated with SSRIs or SNRIs — and these carry risks of causing manic symptoms in someone with bipolar disorder. Balancing the medical treatment needs can be quite challenging if you experience the combination of bipolar disorder and OCD.
- **Substance use disorder:** Substance use disorder, particularly involving alcohol, occurs in one-third to one-half of people with bipolar disorder. Many bipolar meds, including lithium, can be dangerous with alcohol. Benzodiazepines, such as diazepam, are chemically similar to alcohol, and people with alcohol use disorder are more likely to become addicted to them. In combination, alcohol and benzodiazepines can cause death. For someone with substance use disorder and bipolar disorder, treating the substance use disorder — medically and with other interventions — is a priority.
- **Memory and thinking problems:** Cognitive problems commonly accompany bipolar disorder. Adding insult to injury, some of the meds used for bipolar can cloud your thinking. Of course, depression and mania can cloud thinking, too, so treating them effectively often helps these issues. Lithium, in particular, may cause some brain fog in the short run but may protect brain cells over time and may prevent or reduce cognitive decline. Work with your doctors to find a medication combination and dosage level that can stabilize your mood without clouding your thinking.
- **Personality disorders:** Disorders such as borderline personality disorder or narcissistic personality disorder may coexist with bipolar. This layering of conditions increases the likelihood of impaired function between mood episodes, and it complicates recovery. Personality disorders can be difficult to treat medically. Psychotherapy is crucial to managing these issues (see Chapter 11 for details on therapy).

Treating Mood Episodes and Preventing Future Episodes

Treatment for bipolar disorder involves managing manic and depressive episodes and trying to prevent future episodes. The following sections give you an idea about how a doctor approaches each challenge. In this section, we focus on bipolar I, the classic form of bipolar, which involves alternating periods of mania and depression. (For more about the different types of bipolar disorder, turn to Chapter 1.)

Muffling mania

Full-blown mania is a medical emergency. Often, especially during the first episode, hospitalization is necessary. The medical interventions often include the following:

- Starting lithium or valproate along with an atypical antipsychotic
- If the initial medication or combination doesn't deliver enough benefit, or a medicine isn't tolerated, replacing the lithium with valproate or vice-versa
- Changing the antipsychotic if it's not effective or if the side effects aren't tolerated
- Trying other medication combinations, such as layering lithium and valproate or trying carbamazepine with an antipsychotic

Whatever medication combination is used often takes some time to work — a week to ten days at least, sometimes longer. Figuring out the best medication or combination of medications for a specific individual may add to the recovery time. Numerous medication combinations are possible. Finding the combination that produces the best results requires close collaboration between patient and doctor.

Lifting bipolar depression

Bipolar depression looks like unipolar depression; the same diagnostic criteria are used to identify both types of depression. But the two conditions are different and respond differently to treatment. (Refer to Chapter 1 for a comparison of unipolar and bipolar depression.) The routine treatment of unipolar depression includes antidepressants such as the SSRIs, but they often work less effectively and/or cause serious negative effects in bipolar depression, particularly in bipolar I.

The typical first-line treatments for bipolar depression, as of this writing, are as follows:

- Quetiapine (Seroquel) alone
- Lurasidone (Latuda) alone

If neither medication is effective, next steps could include one of the following:

- Trying Symbyax (a combination of olanzapine and fluoxetine)
- Adding lithium or valproate to quetiapine or lurasidone

- Trying one of the newer agents — cariprazine (Vraylar) or lumateperone (Captyla)
- Combining an antidepressant with lithium, valproate, or an antipsychotic

Many other combinations or variations can be tried, depending on how you respond to each medication trial. Treating bipolar depression is challenging and often takes time to get right.

REMEMBER

Given how many combinations can be tried, work closely with your prescriber is critical in arriving at what's best for you.

Keeping mania and depression at bay: Maintenance treatment

The most common plan for *maintenance* — prevention of future mood episodes — is to continue what worked for you during the acute episode. However, one goal is usually to peel away some medications and, if possible, find a single medicine (a *monotherapy*) that can effectively do this for you. Some common monotherapies for bipolar disorder maintenance include lithium, valproate, quetiapine, lurasidone, olanzapine, aripiprazole, and lamotrigine.

Although the ultimate goal is monotherapy, many people continue to need a combination of medications for maintenance, because one medication alone is insufficient, fails to treat all symptoms, or produces side effects that must be addressed with another medication. Avoiding long-term use of antidepressants for maintenance in bipolar I disorder is a goal, but it can be challenging. Maintenance treatment for bipolar II may be slightly different; the research is evolving.

Treatment-resistant bipolar disorder

The term *treatment resistant* is used to describe situations in which two to three of the standard medications or combinations have been tried for long enough and at high enough doses, but the symptoms aren't *remitting* (going away). When this happens, doctor and patient usually discuss some of the most common reasons that treatments aren't working as well as expected, which include the following:

- **Not taking the medication regularly or correctly:** The most common reason a prescribed medication doesn't work as effectively as expected is that the person stops taking it, takes less of it, or takes it less often than prescribed. Communication with your doctor is essential; if you're not comfortable with your medications, talk to your prescriber to address your concerns. (See Chapter 8 to find out more about dealing with medication issues.)

- **Incomplete diagnosis:** Maybe something else is going on medically and/or psychiatrically that is causing the symptoms. Going back to the drawing board diagnostically, getting a second opinion, and involving a neurologist or other specialist are some common approaches.
- **Substance use disorder:** Using alcohol, marijuana, or other drugs actively while trying to find medications to treat bipolar disorder can interfere with the success of the treatment. Even something seemingly harmless like excessive caffeine use can be a problem.
- **Genetic differences:** People differ in how their bodies respond to medication and how their bodies break down and eliminate the medicine. For example, some people may be *rapid metabolizers* of certain medicines because of the genetics of particular liver enzymes that break down the medicine, so they may have trouble keeping a high enough concentration of the prescribed medication in their blood. Or a very slow metabolizer may have a high risk of side effects even at low doses. (This type of metabolism has nothing to do with your metabolism of food.) Some easy genetic tests can look at some of these possibilities and may help in making decisions about medications in treatment-resistant situations. These tests are being used more often specifically for this kind of decision making.
- **Differences in the presentation of bipolar disorder:** Chapter 2 discusses the brain science of bipolar disorder, pointing out that it's not just one illness but a range of underlying brain disorders. Likely, some forms of the illness don't respond as well to the medications that are currently available. Working carefully with your doctor and/or getting a second opinion to determine other options, including possibly adding or trying newer or less well-studied medicines or supplements, may be valuable. If you live near a medical school, you may be able to participate in a research study that provides access to medications that aren't yet widely available.

If medications aren't tolerable or as effective as desired, you and your doctor may look into other options (see Chapter 9 for details).

Peering into the Promising Future of Bipolar Medications

The medications that are available now to treat bipolar disorder work well in many, less well in some, and not well in a few. Scientists are exploring the underlying brain and body changes that are part of bipolar disorder with a long-term goal of identifying new ways to treat it. In the following sections, we introduce

and describe several medications that have shown some promise in the treatment of various aspects of bipolar disorder.

Meds that target the glutamatergic pathways

One of the hottest areas of research is in the glutamate system that we discuss in more detail in Chapter 2. *Glutamate* is a neurotransmitter related to excitatory or energizing circuits in the brain. Research increasingly shows a strong correlation between glutamate systems and depression and bipolar disorder. Researchers and clinicians are looking closely at new options in these areas, including the following:

- **Ketamine:** This medication is an antagonist of a particular type of glutamate receptor — N-desmethyl aspartate (NDMA). Numerous studies have shown that intravenous infusion of ketamine in some people with treatment-resistant depression almost immediately reduces depressive symptoms and suicidal ideation, making it very different from all other antidepressants in use, which take time to work. A number of studies now show that a single ketamine infusion can help some people with treatment-resistant bipolar depression, but how beneficial multiple treatments would be is less clear. How long the antidepressant effects of ketamine last is also unclear for both unipolar and bipolar depression.

  In May 2019, the FDA approved an intranasal medication closely related to ketamine, called esketamine (Spravato) for treatment-resistant depression or major depression with suicidality. As of this writing, it hasn't yet been approved for use in bipolar depression, but studies are ongoing. It's available only under strict risk-management protocols and must be given in a medical office where the patient can be monitored for two hours after administration.

  Ketamine and esketamine have potentially serious downsides, though. For one, they're very sedating and can trigger *dissociation* (feeling disconnected from yourself), psychotic symptoms, and other changes in perception of reality. They also have potential for abuse; ketamine has been used as a street/club drug for many years.

- **Memantine (Namenda):** This medicine helps reduce some of the symptoms of early dementia. Like ketamine, it works at the NMDA type of glutamate receptor, reducing glutamate activity there. Research is ongoing, but some data suggest that it can be helpful in treating mania. Depression and bipolar depression have not been helped by memantine in research so far.

- **Auvelity (a combination of dextromethorphan and bupropion):** This medicine, approved by the FDA in August 2022 for the treatment of unipolar

depression, is the first oral medication for depression that acts on glutamatergic receptors. Dextromethorphan is an NMDA receptor antagonist that has been previously studied as an add-on for treatment-resistant depression. It's commonly found in low doses in over-the-counter cough medications and can be abused if taken in very high doses. Bupropion is a well-established antidepressant that works to inhibit the reuptake of dopamine and norepinephrine in the synapse. Auvelity has not been studied in or approved for use in bipolar depression to date.

- **Riluzole (Rilutek):** This medication is currently approved to treat amyotrophic lateral sclerosis (ALS, commonly known as Lou Gehrig's disease). It modulates glutamate transmissions and enhances *neuronal plasticity* — a variety of cellular events related to the strength and development of circuits between brain cells. In some early studies, riluzole was shown to reduce symptoms in bipolar depression, but this has not been repeated in other studies. Riluzole has severe side effects, so it hasn't been considered for use outside of research.

Protein kinase C inhibitors

Researchers have started looking closely at *protein kinase C (PKC)* as a possible target in treating bipolar, particularly for mania. PKC is actually a group of *enzymes* (proteins that trigger chemical reactions in the body) that has many functions in the body. In the brain, PKC plays a vital role in coordinating and translating chemical messages from neurotransmitters on the outside of cells into particular chemical reactions inside of cells. Many studies suggest that over-activation of PKC pathways may be related to manic symptoms, and inhibiting the pathways (with PKC inhibitors) reduces mania.

Even though lithium and valproate are very different medications, they're both known to inhibit PKC activity. Exactly how reducing PKC activity reduces manic symptoms is unknown, but some working theories suggest that the process may be related to changing the excitability of neurons and/or to improving the growth and health of neurons over time. Much of this research is still *preclinical*, meaning that it is still being done in animal models rather than human subjects.

However, the estrogen inhibitor tamoxifen, used in treating breast cancer, is also a potent PKC inhibitor. Increasing evidence indicates that tamoxifen can be used in combination with lithium to reduce manic symptoms if other, more traditional medications aren't working for an individual. Tamoxifen isn't included in the U.S. practice guidelines at this time, but it is included in the Canadian practice guidelines. In studies that tested tamoxifen for treating acute episodes of mania, the treatment was well tolerated, but the studies didn't account for long-term risks and potential side effects of blocking estrogen receptors. These risks and side

effects need to be better researched before tamoxifen can be considered a viable option for treating bipolar on a long-term basis.

Other meds worth mentioning

Here are some other medications that are still quite a way from any regular use, but they give you an idea of the wide range of research being done in this area:

- **Pramiprexole:** This medication is used to treat Parkinson's disease by increasing the effects of dopamine in the brain. Increasingly, it has been considered a viable option for treatment-resistant unipolar depression but research on its use in bipolar depression is very limited. In treating depression and Parkinson's, it often activates people (giving them more energy and interest in pleasurable activities), which suggests that it could carry a risk for triggering hypomanic or manic symptoms. So, if it's used to treat bipolar depression, it must be used with a mood stabilizer or antipsychotic.
- **Allopurinol:** This medicine is used primarily to treat *gout* — a disease in which the body produces too much *uric acid,* which is then deposited in the joints causing severe swelling and pain. Allopurinol treats gout by reducing uric acid levels. People in a manic episode have elevated uric acid levels, so some studies have looked at adding allopurinol to other mood stabilizers to improve symptom relief. Some studies have been positive whereas others have shown no benefit so more research is needed to clarify whether allopurinol may be a valuable addition to the bipolar medicine cabinet.
- **Scopolamine:** Scopolamine is a popular medication on cruise ships, used primarily to treat motion sickness. It works in the *cholinergic* system (choline is another neurotransmitter), targeting a specific type of choline receptor called the *muscarinic receptor.* Some research suggests that depression (both bipolar and unipolar) may have some roots in this system. Studies have looked at using scopolamine *intravenously,* injecting it directly into the blood rather than taking it orally, and some evidence shows that it rapidly reduces depressive symptoms. However, the research remains incomplete, and more work needs to be done.
- **Cycloserine (an NMDA receptor antagonist):** This medication combined with lurasidone (Latuda) is being studied to treat acute suicidal ideation and behavior associated with bipolar depression. A version of cycloserine has been studied as an adjunctive treatment in anxiety disorders (specifically used to augment cognitive behavioral therapy).

IN THIS CHAPTER

- Recognizing common reactions to taking long-term medications
- Playing an active role in choosing the medications you take
- Discovering strategies to reduce unwelcome side effects
- Changing and stopping medications under a doctor's supervision

Chapter 8

Coming to Terms with Medications and Their Side Effects

For most people with bipolar disorder, effective treatment includes medications. It's truly amazing to witness someone in acute depression or mania enter a hospital — unable to think clearly and function well and perhaps even delusional or hallucinating — and then see that same person able to think, speak, and interact effectively after just six or seven days on medication.

Unfortunately, the need for medication doesn't stop when the person leaves the hospital. A maintenance dose of one or more medications is almost always needed to ward off future episodes. But when people begin to feel better on medication, they often start to think that they don't need it any longer, and sometimes they get so fed up with certain medication side effects that they can't tolerate it any longer. Such feelings are normal and common, and they're important to recognize as part of the process of coming to terms with a chronic illness and the prospect of long-term medication.

In this chapter, we confront some prevailing reasons for not taking medications, help you assess the pros and cons of taking versus not taking your meds, offer guidance on how to alleviate the most common annoying side effects, and walk you through the process of making safer medication changes.

Examining Objections to Taking Meds

Nearly all healthcare professionals will tell you that a major challenge in treating any long-term illness is getting patients to follow their doctor's instructions and take medications as prescribed. With bipolar disorder, the challenge is compounded when patients lack *insight* (when bipolar disorder, especially mania, convinces them that absolutely nothing is wrong).

Acknowledging the common objections to long-term medication is an important first step toward treatment success for people with bipolar. Understanding the reasons behind resistance can also help to alleviate frustration among friends and family who often become exasperated by their loved one's lack of adherence (following doctor's orders).


REMEMBER

People often have valid and reasonable reasons for not wanting to take or continue their medication. Here we explore some of the most common reasons that people with bipolar stop taking their meds, as well as different perspectives to consider as you engage in your own internal debate over the pros and cons of medication.

I'm not sick

Denying that anything is wrong is actually a common symptom of bipolar disorder, making treatment especially difficult, particularly in the early stages of illness. When you're manic, in particular, your brain is distorting thinking, perception, and mood. You feel like everything is fine — in fact, more than fine — you feel the best you've ever felt. You feel like you know things, special things, that other people don't know. Given that this is how you're thinking, why would you listen to people who are telling you something is terribly wrong? A core paradox of bipolar disorder that being unaware of the illness, lacking *insight,* is a key symptom and gets in the way of starting and sticking with medications.

Although depressive episodes don't make you feel so good and all-knowing, they often have profound thoughts of hopelessness, guilt, and self-loathing that convince you not to take medicine because you'll never get well or because you don't deserve to get well, for example. And if psychosis accompanies the depression, your thinking becomes even more disorganized and disconnected from reality, and decision-making about medications gets caught up in the illness itself.

However, even as your mind comes back to itself, and you can think more clearly again, denial is a powerful initial response to serious illness of all kinds, and mental illness is no exception. And when you're in denial, the last thing you want to do is pop a pill, admitting that you have an illness — a highly stigmatized *mental* illness. Talk about a tough pill to swallow! For some people with bipolar disorder and their loved ones, denial may last several years, or it may go away only to return later.

We can't provide a good rebuttal for this particular objection; no one can talk you out of denial. Paradoxically, you can't get past denial until you take medication for the disordered mood and thinking that convinces you that you're not sick or not worthy of help. People with bipolar disorder often must experience several major mood episodes and perhaps even a few hospitalizations before they come to accept that this illness is real and requires medication. This can be a long process.

REMEMBER

Acceptance of the diagnosis is a critical first goal in the treatment process; without this, treatment is unlikely to succeed. Those people around you can do their best to offer unconditional acceptance, strong shoulders to cry on, and active, empathic listening, but this journey will take some time for almost all people receiving a diagnosis of bipolar disorder.

They don't work

Aspirin and acetaminophen (Tylenol) can alleviate pain in a matter of minutes. Decongestants take less than an hour. Lithium, however, which is a very effective antimanic, takes at least seven days to start working. SSRI (selective serotonin reuptake inhibitor) antidepressants commonly require three to six weeks to achieve their full therapeutic effects. And the side effects often appear long before the benefits do. No wonder people suffering from depression or mania get discouraged and stop taking their meds! Having to wait more than a week for relief feels more like torture than treatment.

TIP

These suggestions may help you endure the delay and even shorten it:

- **Ask your doctor up-front how long each medication should take before it begins to work.** Sometimes, knowing that a medication may take a week or three weeks rather than 15 minutes or an hour to start working can reduce your anxiety. Mark the days on your calendar to keep track.
- **Ask your doctor what to expect when the medication starts working.** Doctors sometimes prescribe medications without explaining how they're supposed to help. Don't be afraid to ask! Knowing the potential long-term benefits of a medication can often encourage you to keep taking it, even when you don't see immediate results.

- **Expect some ups and downs during the initial recovery.** You probably won't wake up one day feeling cured. Expect to have good days, not-so-good days, and bad days. The goal is to string together more good days than bad.
- **Ask your doctor if there's anything you can take to feel better faster.** Your doctor may be able to add a medication to the mix on a temporary basis and then pull it back when you begin to feel better. For example, antianxiety or sleep meds are often useful for short-term relief or to accelerate recovery.
- **If you don't feel better in the time period that your doctor specifies, let your doctor know.** You may need a medication change, extra time, or a higher dose.

I'm fine now

Taking medication when you feel fine may seem about as rational as wearing a raincoat on a sunny day; what's the point? The point is actually twofold:

- Sustaining recovery from your current, *acute* mood episode
- Maintaining your mood stability *chronically* to reduce the likelihood of a future episode

Sustaining your acute recovery means that the medicine has to stay in your system for you to continue to experience its benefits. When you treat a mood episode, the episode doesn't just melt away; the medicine suppresses it. The episode has its own lifespan, and if you stop the medication too soon, the symptoms will bubble back up to the surface. Basically, you feel better because of the medicine; stop the medicine, and you stop feeling better.

The other primary goals of bipolar medication are *maintenance* and *prevention.* Even after the current episode fades, having bipolar disorder means you are at risk for recurrent episodes, so your doctor will usually prescribe long-term medicine(s) to function as *prophylactics,* meaning they don't just make you feel better when you become ill; they also reduce the likelihood that symptoms will return. And preventing symptoms has some solid benefits:

- Avoid potential fallout from mood episodes, such as broken relationships or loss of employment.
- Reduce the frequency and intensity of mood episodes.
- Improve the course of your illness. Every episode subjects the brain to additional trauma.
- Avoid a stay in the hospital.

The side effects are unacceptable

Medication advertisements in magazines often consist of a few words in big print that tout the benefits. These few alluring words are followed by a full page of tiny print that lists possible side effects. The choices these ads present are often absurd. For example, celecoxib (Celebrex) relieves arthritis pain and inflammation but may increase the risk of heart attack and stroke. When deciding which medication to take for bipolar, you face similar lousy choices:

- Valproic acid (Depakote) controls mania but can result in weight gain, pancreatitis, liver problems, hair loss, and other potential problems. It can also cause changes in young women's reproductive systems, as we explain in Chapter 10.
- Lithium stabilizes moods but may also cause weight gain, kidney damage, and/or thyroid dysfunction, among other adverse effects.
- Fluoxetine (Prozac), paroxetine (Paxil), sertraline (Zoloft), and other SSRI antidepressants alleviate depression at the risk of causing agitation or other emotional side effects, negative sexual side effects, and loss of bone density, among other potential side effects.
- Lamotrigine (Lamictal) helps control depression but may cause a potentially lethal skin reaction, sleep problems, and other possible negative effects.
- Antipsychotics can cause weight gain, sedation, movement disorders, changes in sugar or fat metabolism, and other undesirable side effects.

REMEMBER

Potentially negative side effects accompany all medications, even aspirin. If the medications are powerful enough to work, then they're powerful enough to cause problems. Always discuss potential side effects with your doctor so you know what to look for and what to do if you experience one or more negative side effects.

I forget to take them

When you feel well, you have better, more important things to do than think about your medications; and work, relationships, kids, and golf are much more fun. But when you have bipolar disorder, managing your medications needs to be a priority or at least a well-ingrained habit, allowing you to enjoy all the good things in life.

TIP

To stay on top of your daily medications, try the following tips:

- **Record your medications on an index card.** Keep the card in your wallet or purse or stick it to the side of your refrigerator for quick reference. Or keep your list of meds on your favorite mobile device. Bring your list with you to

every doctor visit and update it whenever your doctor adjusts your medications.

- **Use a seven-day pillbox.** A seven-day pillbox has a compartment for each day of the week so you know exactly what you need to take each day. You can even add a sticker to the box that lists the times of day for taking each medication, or you may want a separate pill box for each time of day that you take medications.
- **Store your medications where you can see them.** Doing so gives you a visual reminder to take them.
- **Link your medication to daily meals or events.** Remembering to take your medications when you wake up, before you go to bed, or at mealtime may be easier than setting a specific time, such as 10 a.m. Put a note on your toothbrush or near your contact lenses, for example, to remind you to take your medicine each day.
- **Assign the task of remembering to a responsible family member.** If you simply can't remember to take your medications on time, ask a family member to remind you. In some communities, service organizations have volunteers who can fill this role.
- **Go hi-tech.** Alarms on your mobile device can serve as reminders. Just be sure to change the alarm sound regularly so it doesn't become background noise that you ignore. Also, you can download medication reminder apps that tell you it's time for medication. If you don't indicate to the app that you took your medicine, it will let someone else know (you identify a medication buddy when you set up the app). This person can then reach out to you directly to see what's up.

WARNING

Having a family member or friend remind you to take your medication works for some people, but it isn't always the best idea. If you're the type of person who tends to feel nagged by reminders from others, this system may become a source of conflict. Know yourself and establish a reminder system that works for you in a positive way.

Normal is boring

The alternative to the extreme highs and lows of bipolar disorder is normalcy. How dull is that? You get to be like everyone else — the people who find small talk intriguing, who've never experienced the utter loneliness of depression, and who remain unfazed by a world gone mad. Your highs and lows may have given you new insights and ideas, a vivacious personality, and a high energy level. With medication, you may feel like the color's been washed out of your life and your mind is dull and gray; you may be bored and feel as though time has slowed down;

and you may wonder how you'll be able to enjoy life without mood-induced drama and excitement.

TIP

If your medications have flat-lined your moods, here are some tactics to try:

- **Realize that your muted mood probably is a temporary condition.** You may need several weeks to recover from a major mood episode. And the medications may take several days or weeks to begin working. Some of the flattening may be related to your mood system rebooting back to more typical variations. The good news is that the negative side effects usually wear off as your moods begin to stabilize.
- **Consult your doctor.** As your depression or mania settles down, your doctor may be able to tweak your medications so you can experience more acceptable mood variation.
- **Work toward accepting that your recovery is a process.** Side effects and medication trials can cause some people to get worse before they get better. Most healthcare providers do everything in their power to prevent this situation, but it does happen. Don't assume that you'll never get better, even if your first few treatments make you feel dull, slow, or sluggish or worsen your mood symptoms. Stay in close contact with your doctors and keep them informed about all your symptoms. Continue asking for more treatment options until you find one or more that work.

I just want to be me

When you've lived with bipolar disorder for most of your life, separating it from your personality can be difficult. Some people are fine with the stabilized version of themselves. They've known all along that something wasn't right, and when the wild mood fluctuations are gone, they finally feel some balance. Other people miss "themselves." They feel as though some essential qualities of their personality have been removed. They've lost their mojo, and they want it back . . . without the sleepless nights, ruined relationships, unpaid bills, and other inconveniences, of course.

Be patient with yourself as you mourn the losses of the life you used to have and adjust to your current reality. Give yourself time to fully embrace your future prospects — a life without debilitating mood episodes. Treatment for bipolar disorder can trigger genuine grief that takes time to resolve. You're still you. Medication doesn't take away your creativity or zest for life. With a stable mood, you have the power and control to discover things you really enjoy and pursue them. Therapy can help you through the transition (see Chapter 11 for info on therapy options).

I can manage my moods without medication

Some people claim that they can successfully manage their bipolar symptoms through diet, exercise, therapy, and the cooperation of family and friends — just as some people can manage some types of diabetes by making dramatic lifestyle changes. Is this really possible? Think of it this way: You can survive a free fall from 100 feet, but you have a much better chance of doing so if you're strapped to a well-anchored, 50-foot bungee cord. Trying to manage bipolar symptoms without medication is extremely risky. In fact, the medical community advises against it, and we don't recommend that you try it either.

Be skeptical of anyone who tells you that they have some miracle cure that the medical establishment is hiding from you. This usually means they want to sell you something — their own supplements or diets or other alternative interventions — by convincing you that you don't need medications. View anything that's "too good to be true" with a critical eye. Alternative treatments as augmentation to medications may be quite helpful, but always check with your prescriber before adding anything to your regimen.

That said, bipolar disorder can present across a range of symptom severity, and everyone is different. Bipolar disorder with mood episodes that are less intense, shorter in duration, or less frequent *may* be manageable with *less* medical intervention, just as some diabetes variants are responsive to lifestyle changes, but other variants require insulin regardless of other interventions.

WARNING

Never attempt to reduce or eliminate your medications without discussing the situation with your doctor. (For more about tapering off or stopping a medication, see the section "Switching, Reducing, and Stopping Meds.")

I want to drink alcohol or consume cannabis sometimes

Many people enjoy drinking alcohol or using marijuana. Both of these substances affect mood and brain function and may interact negatively or even dangerously with psychotropic medications. For example, combining alcohol with antianxiety medications — such as alprazolam (Xanax) or diazepam (Valium) — is dangerous because the combined effects of these central nervous system (CNS) depressants can lead to unconsciousness and death.

The best approach for alcohol and cannabis is to reduce or stop using until you can consult your doctor. With certain medications, moderate consumption may be

okay. In other cases, combining alcohol and/or cannabis with your medication is ill-advised or prohibited.

It's critical to talk to your doctor about this, because sometimes you will be told you can't use alcohol or cannabis while on bipolar medications, but this isn't true across the board. Having accurate information can sometimes make a big difference in your decisions about taking your medications.

Keep in mind that alcohol and cannabis use can have significant negative impact on the bipolar disorder itself and that substance use disorders commonly occur with bipolar disorder. So, reducing substance use helps in managing your bipolar disorder. In the meantime, knowing what you can and can't do, while still taking your medication, will be very helpful.

Other substances of abuse such as cocaine, MDMA (Molly or Ecstasy), hallucinogens (LSD or mushrooms), and others can have significant interactions with your bipolar disorder and your medications. Stopping or reducing use is an important part of your treatment plan, and talking to your doctor honestly about your use of any substances helps you and your prescriber make safe medication decisions.

They cost too much

Many medications used to treat bipolar disorder are inexpensive, but some are quite costly. Depending on your insurance coverage, your out-of-pocket costs can be a real barrier to long-term medication treatment. If the cost of medication is an issue for you, don't be embarrassed to ask your doctor about options. Your doctor may be able to prescribe a less-expensive medication or even a different form of the same medication, and manufacturers may offer discounts to reduce the cost. (See Chapter 18 for possible ways to overcome this obstacle.)

COMING TO PEACE WITH MY MEDS

When I was first diagnosed with bipolar disorder at age 22 — young, wild, and free — the last thing I wanted to hear was "take these pills." I had a desperate need to feel normal, and the idea of taking medication every day did not sit well with this rebellious girl. Then they told me I couldn't drink, and I *really* hated the idea. At every turn, I analyzed and argued the necessity of following my doctor's instructions. And when I felt better, I'd stop taking my meds because I thought I was okay. It was a dangerous tug-of-war game I played until my late 20s.

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Eventually, my attitude changed, and acceptance emerged. Compliance shifted from being a chore I loathed to becoming part of my daily routine. Each day I opened my trusty pill tray and down the hatch it went! Finding the right doctor was a pivotal part of this change. I turned a corner when he finally found that magic combo of meds for me; I was 30.

I'm 40 now. Thankfully, my medications and eight hours of sleep each night have kept me out of the hospital for nearly ten years. And though I'm aware that a bed is always available (if I need it), I'm not anxious to check in. When the road gets bumpy, as it can, my doctor tweaks my meds to smooth it. I shudder to think about where I'd be now without my medication, and I'm grateful for it.

I no longer view bipolar as an impossible illness to treat. Rather, it's one that requires vigilance. My medications are my life jacket. I'm a V.I.P. at my local pharmacy, and that's a place where I'm *glad* everyone knows my name.

— Wendy K. Williamson, author of *I'm Not Crazy Just Bipolar* and *Two Bipolar Chicks Guide to Survival: Tips for Living with Bipolar Disorder*

Performing a Cost-Benefit Analysis

Every major decision involves a *cost–benefit analysis.* Whether you're deciding to change jobs or careers, get married, or buy a new car, you weigh the potential benefits of each choice against the drawbacks to decide which option will ultimately provide you with the most of what you want while requiring you to sacrifice the least. The same is true of your decision to take medication voluntarily to treat the symptoms of bipolar disorder — or not. The following steps lead you through the analysis process:

1. **List the potential benefits.**

   Potential benefits to medication may include achieving more stable moods, staying out of the hospital, avoiding financial and legal problems, improving relationships, getting and keeping a job, increasing control over your own mental health, and reaching a place where you can pursue nonmedication treatments (such as psychotherapy).

2. **List the possible costs.**

   What do you have to lose by taking medication? Some drawbacks may include cost of medication, undesirable side effects, and the hassle of remembering to take it. Plus, you may miss the highs. Jot down why you don't want to take medication.

3. **Recognize the emotions in your thinking.**

   Review the list of possible costs you came up with in Step 2 and flag any that are more emotional than rational. Are you afraid of specific side effects? Does taking medication mean admitting that you have a mental illness? Does a need to take medication seem unfair? Acknowledging emotional thinking is just as important as listing your rational concerns because both parts are going to factor into your ultimate decisions. Fully owning the emotional components also helps make the decision-making process more transparent. You retain more control over your outcome when you're aware of the emotions at play than when you allow them to operate silently in the background.

4. **Bounce the idea off someone you trust.**

   Review your list of pros and cons with your doctor, therapist, or a close friend or relative to get a trusted third-party perspective. This other person may point out something you haven't considered or help you realize that a certain factor is really more or less important than you initially thought.

5. **Decide.**

   Weigh the costs against the benefits and make the call.


REMEMBER

Not taking prescribed medicine carries risks that can be quite serious, so carefully weigh the costs of not taking your prescribed medications against the costs of taking them. If you don't take the medications your doctor prescribes, what's likely to happen?

The decision of whether to take medication to treat bipolar symptoms may initially seem like an either-or choice, but it doesn't have to be. As we emphasize in Chapter 7, numerous medications are available, and each one has its own cost-benefit profile. The same medication may have different effects for different individuals. Also, as we explain in the next section, solutions may be available to minimize unwelcome side effects.

Alleviating Undesirable Side Effects

Every medication, even over-the-counter medications generally considered safe, can cause negative side effects; for example, aspirin may cause indigestion and stomach bleeding. Likewise, psychotropic medications have both desirable and undesirable effects. Sometimes the undesirable side effects lessen or even disappear over time. In other cases, people may decide to live with the negative side effects because they figure that a medication's benefits outweigh its drawbacks.

However, you don't necessarily have to live with undesirable side effects. Your doctor may have suggestions on how to reduce or eliminate certain negative effects of a medication you're taking. In the following sections, we describe a few approaches to discuss with your doctor.

Tweaking your doses and times

You may be able to reduce or eliminate undesirable side effects without changing medications by doing any or all of the following:

- **Gradually ramp up dosages.** Many negative side effects occur when you first start taking a medication. Your doctor may be able to increase the dosage gradually to avoid or diminish the intensity of the effects.
- **Change medication times.** If you typically take a medication in the morning, for example, and it makes you too drowsy for work, your doctor may recommend that you take it in the afternoon or evening or take more of it in the evening and less of it during the day.
- **Switch to an extended-release version of a medication.** Many medications come in extended-release tablets that gradually deliver treatment to your bloodstream. Ask your doctor if this type of med is an option for you.
- **Reduce the dose.** With your doctor's approval, try reducing the dose to see if you can get the same benefits at a lower dose that may have fewer side effects.


REMEMBER

Generic products typically produce the same effects and side effects but not always. People may experience a better or worse response to the brand or generic version of a medication, so switching to the other form may be worth a try.

Trying different meds in the same class

A medication that's in the same class as the one you've been prescribed (and that's giving you trouble) may be just as or more effective and offer a better side effect profile for you. For example, if you start taking olanzapine (Zyprexa) and experience weight gain that you can't tolerate, switching to another atypical antipsychotic such as aripiprazole (Abilify), which sometimes has less weight gain associated with it, may be a good move. See Chapter 7 for medications by class as well as their side effect profiles.

Another option is to try a medication in a slightly different class. Antipsychotics, for instance, come in two classes:

- **First generation (older):** Are more likely to cause movement disorders, including *akathisia* (severe restlessness) and *tardive dyskinesia* (involuntary movement of the face and jaw)
- **Second generation (newer):** Are more likely to cause weight gain and changes in metabolism but have lower risk of movement disorders

Exploring other options

Your doctors may have other tricks up their sleeves for alleviating unwanted side effects, including the following adjustments:

- Add a medication to counteract the side effect; for example, if you experience weight gain on risperidone (Risperdal), your doctor may prescribe topiramate (Topamax) to reduce weight gain.
- Replace or augmenting the medication (so maybe you need a lower dose) with a different type of biological intervention, such as a nutritional supplement, light therapy, or electroconvulsive therapy (ECT).
- Discuss changes to your daily self-maintenance activities such as modest dietary changes or increased physical activity, to counteract the side effects. Your treatment providers may recommend meeting with a nutritionist or physical therapist to help with these goals.

Dealing with specific side effects

Certain side effects are more common and bothersome than others. In the following sections, we offer specific suggestions for alleviating or minimizing common side effects of bipolar medications.

Fatigue and drowsiness

If your medication is making you feel tired during the day, talk to your doctor about the following options:

- Taking the medication later in the day or at bedtime
- Scheduling a nap for the time of day when you typically feel most tired or drowsy
- Consuming less sugar and simple carbohydrates and more protein and complex carbohydrates
- Engaging in some form of physical activity regularly

Weight gain, insulin resistance, and Type 2 diabetes

Many antidepressants, almost all atypical antipsychotics, many anticonvulsants, and lithium have weight gain as a possible side effect; in fact, it's one of the main reasons people stop taking these medications. Many of the atypical antipsychotics also carry the risk of disrupting insulin function, which increases the risk of developing Type 2 diabetes. The best way to monitor and manage weight gain and other metabolic risks when you're on one of these meds is to take a proactive approach such as the one we outline here:

1. **Monitor weight and appetite from the start so you can take action before the weight gain becomes a big problem.**

   You needn't jump on the scales every day; just weigh in during your regular doctor visits. Keeping a food/appetite journal can be helpful for many people, but some find it makes them overly focused on food and eating and is an overall negative intervention.

   Alternatively, for many people, monitoring and discussing weight triggers distress and can lead to spirals of maladaptive responses such as restricting food intake, binging, over-exercising, or shutting down. If monitoring your weight is counterproductive, at doctors' visits, you can request not to be told your weight, and you can look away from the scale when your weight is being taken.

   Changing your diet or activity levels are challenging tasks even without being in a mood episode or living with bipolar disorder. Knowing about weight gain isn't likely to make these tasks any easier, but it can provide you and your prescriber valuable information for making medication adjustments or changes to target the weight-gain side effect.

2. **Be sure to follow up with the routine lab work that your doctor will order depending on what medications you're taking.**

   Your doctor will order baseline blood work before starting certain medications, including second generation antipsychotics, lithium, and valproic acid. These medications have recommended monitoring schedules to help the doctor track certain types of adverse side effects. For antipsychotics, which are some of the most common culprits with weight gain and metabolic changes, blood work includes fasting blood glucose and lipid levels and *hemoglobin A1C,* which gives them a picture of the average range of blood sugar levels over the previous three months. This level is important in monitoring trends of glucose metabolism. If doctors have specific concerns, they may also order insulin levels to see whether the insulin is no longer as sensitive as it used to be; lowered insulin sensitivity is related to developing type 2 diabetes. The range on the lab slip shows the cutoffs, but noting significant shifts from your

baseline levels is also useful. If results from these routine tests change dramatically or you're experiencing other symptoms or problems, your doctor may order more comprehensive lab work and/or refer you to a specialist.

3. **When starting a new medication or changing medications, ask your doctor about food and activity choices that encourage healthy energy production and metabolism.**

   Find physical activities that you enjoy and engage in them every day or every other day. Even one minute of vigorously elevating your heart rate several times per week can change your health profile. Eat more vegetables and low-glycemic fruit (such as berries and melon), and try to pay attention to hidden added sugars in food, especially bread, crackers, and bakery items. Opt for whole-grain products and consume them in moderation. Avoid hydrogenated oils in processed foods. Eat whole food more than processed food. Focus on health rather than weight. Ask for help if you need it, such as referrals to nutritionists or physical therapists.

4. **If you're taking an atypical antipsychotic, keep your primary-care doctor in the loop.**

   Your primary-care doctor can keep a close eye on health issues related to these meds and offer suggestions to limit your weight gain, but beware of overly punitive approaches to diet and exercise or any judgments about the weight gain. You're trying to perform a balancing act of getting your brain and body healthy from bipolar disorder while trying to limit health risks of the medications that are helping you. Don't interpret it as a matter of willpower or strength; it's a difficult process. Support and compassion from others and from yourself are most effective in helping you navigate these difficult waters.

If you're currently experiencing weight gain, discuss the following options with your doctor:

- Switching to a medication in the same class that's less likely to cause weight gain. Ziprasidone (Geodon) and lurasidone (Latuda) are less likely to cause weight increases.
- Making approachable and manageable lifestyle adjustments, including dietary changes and increased physical activity as previously described.
- Adding topiramate (Topamax), an anticonvulsant associated with some mild weight loss in many people. It can carry important side effects, including hair loss and cognitive dulling, and even psychosis. Discuss these pros and cons in detail with your doctor when exploring this option.
- Considering other medications to assist in weight loss and modulation of glucose/insulin interactions, such as Glucophage (Metformin) or the newer

injectables such as dulaglutide (Trulicity) or semaglutide (Ozempic). These medications are best managed in consultation with your primary care doctor.

In severe situations related to weight gain, especially if you have longstanding obesity concerns that are complicated by psychiatric medications, you can talk to your doctor about *bariatric* (weight-loss) surgery. These procedures do show benefits such as weight loss and elimination of type 2 diabetes in some patients, but they also carry a risk of significant potential side effects and complications, and not all patients get the same degree of benefit. Outcomes depend on many factors, including the type of surgery, the surgeon's skill, and the level of follow-up and support available after surgery. And data about bariatric surgery specifically in patients with bipolar disorder is limited to date.

REMEMBER

Bipolar disorder itself may cause problems with metabolism and weight, so medications aren't the only factor in this situation. Body weight and metabolism are highly complex processes, affected by many things including medications. A compassionate, nonjudgmental approach to body and weight changes related to bipolar disorder and medications is essential.

Sexual dysfunction

SSRIs and some antipsychotics are notorious for causing sexual dysfunction, including reduced desire, erectile dysfunction, and inability to orgasm. If you experience sexual dysfunction while taking a prescribed medication, consult your doctor about the following possible remedies:

- Reducing the dose of the medication to a point where it still helps maintain mood stability without contributing to sexual dysfunction.
- Switching to a medication in the same class that's less likely to cause problems; for example, switching from an SSRI antidepressant to something like bupropion (Wellbutrin), which is much less likely to cause sexual dysfunction.
- Adding a medication to treat the sexual dysfunction. Some medications for sexual function are taken just for sexual activity; others are taken every day, just like an SSRI. Adding bupropion to an SSRI can improve sexual function for some people.
- Taking a medication holiday — skipping the medication a day or so during the week. Doing so may help improve sexual function without risking a mood episode.

Memory and cognitive difficulties

While some medications have neuroprotective properties that seem to help memory and cognition over the long term, others may cause difficulties. If you feel that a medication is negatively affecting your memory or ability to think clearly and sharply, consult your doctor about the following options:

- Changing the dose or time of day you take the medication
- Switching to a medication in the same class that's less likely to cause memory and cognitive difficulties
- Engaging in social and mental activities to stimulate your brain
- Engaging in physical activity to maintain mental sharpness

Switching, Reducing, and Stopping Meds

With bipolar disorder, medication adjustments are common. You and your doctor may decide to switch medications, increase or decrease the dosage, or perhaps even withdraw all medication at various points in your treatment journey. Whatever the case may be, some ways of making these medication changes are safer than others.

WARNING

Don't stop a medication abruptly unless your doctor specifically instructs you to do so. If your doctor believes that a medication is causing a serious and acute medical problem, removing it may be the best course of action, although doing that may mean that you must be closely monitored for a while after the discontinuation. However, the safer approach to medication adjustments usually involves making small changes over measured periods of time. Going cold turkey with certain medications may cause seizures or other withdrawal symptoms or increase the risk of relapse.

Here are some general guidelines to discuss with your doctor before you make any medication adjustments:

- **Taper doses gradually.** When reducing or stopping a medication, reduce the dosage slowly — usually over at least several weeks or sometimes a number of days; your doctor will discuss the details with you. This type of tapering is especially important if you've been taking a large dose for a long time. When going from a small amount to nothing, you may need to split a pill in half, but be careful because some pills are designed only to be swallowed whole, not cut or crushed.

- **Change one medication at a time.** By changing the dosage of only one medication at a time, you have a better chance of identifying the cause of any problems or benefits that arise.
- **When switching medications, gradually ramp up the new medication while tapering off the old one.** Although this doesn't follow the "one change at a time" rule, it may be necessary when changing to a different medicine in the same category. Sometimes you can move a little faster in tapering off a medication when introducing another one in the same class to take its place. If you're changing to a medication in a different class, your doctor may want you to continue taking the old medication with the new one for some time before tapering off the old medication.

Sometimes, people with bipolar may suddenly decide to stop taking the medications they've been prescribed, which is a really bad idea. Under certain circumstances, however, carefully discontinuing some or all medications in consultation with your doctor may be worth the risk. For example, if your moods have been stable for a long time and you and your doctor have good reason to believe that you experienced a one-time manic episode that was probably drug or medication induced, then it may be time to try living medication-free. This may also be the case if you're doing well on very low doses of medication and have made lifestyle adjustments and significant progress in therapy; these other supports may be sufficient for maintaining your mood stability.

If you're considering the possibility of stopping your medications, complete the following checklist and talk to your doctor to determine whether you're in a good position to make the attempt:

- ❑ Your moods are currently stable and have been stable for a sustained period of time — typically for one year or longer.
- ❑ Your doctor approves and agrees to supervise your attempt — *slowly* decreasing doses of your current medications.
- ❑ You're not currently experiencing (or have plans for) any major life events or changes, such as getting married or divorced, changing jobs or careers, or returning to school.
- ❑ You have a solid routine in place that ensures sufficient sleep activity during the day.
- ❑ You're not in a high-stress, sleep-sapping job and/or caregiver situation.
- ❑ You're not using alcohol or other drugs regularly or excessively.
- ❑ Your support network is cooperative and well informed.

- ❑ You and your support network have a system in place to carefully monitor your moods (see Chapter 11).
- ❑ You have a solid backup plan in case things go wrong (see Chapter 15).

WARNING

Even under these conditions, withdrawing mood medications entirely is extremely risky. Consider working out compromises with your doctor and therapist. With additional therapy and lifestyle changes, you have a chance to manage your moods with *less* medication rather than *no* medication. Think in terms of making minor changes over several months or years rather than major changes in a short period of time. Proceed only with your doctor's approval and under your doctor's careful supervision.

IN THIS CHAPTER

- Supplementing treatment with all-natural ingredients
- Brightening your moods with light therapy
- Rebooting your brain with ECT, rTMS, and DBS

Chapter 9
Expanding Your Biological Treatment Options

Pharmaceutical medication along with therapy and self-help strategies are usually sufficient to keep most bipolar symptoms at bay, but sometimes medication is ineffective or provides only partial relief. It may produce side effects that you can't or won't put up with, or you can't tolerate a high enough dose to get full symptom relief. In specific cases, especially if you're pregnant, the potential risks of certain medications may outweigh the benefits or may warrant decreasing doses or the number of medications you take. In situations such as these, you and your doctor may want to consider expanding your treatment options. In this chapter, you have the opportunity to explore these other options and weigh the potential benefits against the possible risks.

Treating Your Moods to Supplements

This section explores the pros and cons of some of the more promising non-standardized, non-pharmaceutical treatments (or interventions) for depression and mania and lists some of their potential risks and side effects. Researchers

refer to these types of interventions as *complementary and alternative medicine (CAM)*. A growing body of medical research explores complementary and alternative strategies for treating a variety of illnesses, including bipolar disorder. Some interventions clearly seem to be helpful without causing unacceptable risks. Others, however, seem to have more anecdotal than clinical evidence to support their usefulness and may not be effective or safe.


TIP

Don't assume that your doctor is ignorant or averse to trying alternative treatments. Most doctors know something about them, are quite willing to discuss them with you, and can help guide you in making informed and safe decisions for managing your health.

Fishing for a cure: Omega-3 fatty acids

Omega-3 fatty acids are a type of fat that the body can't manufacture itself and must take in through diet. They are necessary for healthy brains and cardiovascular systems, and you find them in high concentrations in many types of seafood. These nutrients play key roles in cellular function and maintenance, including reducing inflammation and supporting communication between cells. (See Chapter 2 for a discussion of how these processes relate to bipolar disorder).

Over the past two decades, researchers have looked at the potential benefits of using omega-3 supplements in the treatment of mood disorders. The data, although inconsistent, suggests that omega-3 supplements (most often in the form of fish oils) added on to antidepressants may help reduce symptoms of unipolar depression. However, the research so far has not shown any benefits of omega-3 supplements in treating bipolar depression or mania.

Some research suggests that people with a certain subtype of depression associated with high levels of inflammation may have a more robust response to omega-3 supplementation. This condition is not yet a formal clinical subtype of depression or bipolar disorder, but the early research is promising. Stay tuned for further developments in this area.


WARNING

Omega-3s aren't a replacement for your antimanic or antidepressant medication, especially if you're treating extreme mood episodes, so don't ditch your meds.

Omega-3 fatty acids consist of three types: Alpha-linoleic acid (ALA), which comes from plants, and eicosapentaenoic acid (EPA) and docosahexaenoic acid (DHA), both of which come from animal sources, primarily seafood. The human body can't make ALA. You must get it through the foods you eat. Sources include flaxseeds, chia seeds, walnuts, oils made from those seeds and nuts, tofu, and soybean oil.

The body can make EPA and DHA from ALA, but it's a highly inefficient process, and you can't get enough ALA in your diet to make enough EPA and DHA. In other words, supplementing your diet with ALA alone won't provide all the omega-3 fatty acids your body needs.

EPA and DHA come from oily fish such as mackerel, salmon, herring, tuna, and others. The typical Western diet is low in omega-3 fatty acids, because of lower intakes of this type of seafood. Eating more of these kinds of fish can increase your levels of EPA and DHA, but supplements made from fish oil are the primary recommended sources for psychiatric uses of omega-3 fatty acids.

Research suggests that EPA is the more important compound for central nervous system benefits, with recommended doses ranging from 1 to 4 grams per day. But these recommendations remain preliminary and something to be discussed with your doctor, especially at doses over 1 gram per day. The potential adverse side effects of fish oil supplementation are minimal and involve mostly nausea or other gastrointestinal discomfort. The most common complaint is the fishy aftertaste, or "fish burps," which can be reduced by freezing the fish oil capsules.

Newer options for omega-3 fatty acid supplementation are derived from algae. It turns out that fish have high levels of EPA and DHA only because the algae they ingest contains these fatty acids in high concentrations. Omega-3 fatty acid supplements derived from algae are more sustainable and more suitable for vegetarians and vegans or people who can't take fish oil for any reason. Algal oil supplements are becoming more popular and available.

Unfortunately, the U.S. Food and Drug Administration (FDA) doesn't control what goes into omega-3 supplements, fish oil or algae, so review dosage recommendations with your psychiatrist or primary-care doctor, ask for product recommendations, and check the label to make sure the supplement is consistent with what your doctor recommends in terms of concentration and dosages of EPA and DHA. Look for a product that has a high purity rating — with the fewest possible contaminants. You may need to try a few different brands to find one with the least fishy aftertaste.

Pumping up your brain with vitamins and minerals

In Western countries, where food is plentiful and enriched, true vitamin and mineral deficiencies are rare, but low levels of these nutrients, even when they don't qualify as a deficiency, may be related to some depressive symptoms. Although we wouldn't suggest that any vitamin or combination of vitamins is effective for

treating depression or mania, several vitamins and minerals, including the following, can have a significant effect on brain development and function:

- **B-complex vitamins:** Your body uses the B-complex vitamins in a variety of ways to build and maintain a healthy nervous system. Taking them together in the appropriate relative concentrations is important because too much of one may lead to a deficiency of another. Studies of B vitamins as adjunctive treatments in bipolar disorder show inconsistent results, but some relationships have been established. Here's what you need to know about the B vitamins:
  - **B1:** B1 (or thiamine) deficiencies can cause severe neurologic problems. Diet-related thiamine deficiencies are rare in the U.S., but deficiencies due to alcohol use disorder aren't uncommon and people who undergo bariatric surgery can be at risk. Bipolar symptoms aren't specific to this deficiency but can overlap with the neurologic symptoms of thiamine deficiencies.
  - **B6:** Isolated B6 (pyridoxine) deficiency is rare, but old age, alcohol use, autoimmune disorders, renal failure, some asthma and other breathing medications, and medications used to treat tuberculosis can increase the risk of low B6 levels. B6 can be dangerous in high doses, so don't take B6 beyond a traditional supplement unless prescribed by a physician.
  - **B12:** B12 (cobalamin) is central to the development of red blood cells and to the development and function of cells in the nervous system. B12 deficiency can cause symptoms of depression or other psychiatric illnesses. Strict vegetarianism, old age, certain stomach and intestinal illnesses, weight-loss surgery, and certain medications, including those used to treat acid reflux and peptic ulcers and the diabetes medication metformin (Glucophage) increase the risk for B12 deficiency. A genetic disorder called *pernicious anemia* prevents the gut from absorbing vitamin B12. Doctors often check B12 levels in people with acute depression.
- **Folic acid:** Folic acid is one of the B vitamins (B9), but it isn't always included in B-complex supplements. It's critical in the development of the human nervous system, so pregnant women must take folic acid supplements. Alcohol use disorder, certain diseases such as Crohn's disease, a number of different medications (including some anti-seizure medications and methotrexate, which is used in some cancers and autoimmune disorders), increase the risk for folate deficiencies, which can present with a variety of cognitive, emotional, and behavioral symptoms, including depression. Although folic acid is ingested through diet, the body has to transform it to the active form called l-methylfolate (Deplin). Genetic variations can reduce a person's rate of this essential transformation. *A medical food* version of L-methylfolate (Deplin) — (a supplement available only by prescription) — is now approved as an augmenting agent for people who aren't responding to antidepressant

therapy alone. Doctors may check for folic acid levels as part of an initial work-up of depression.


WARNING

Make sure your doctor checks for both folic acid and B12 levels before supplementing with folic acid. Normalizing folic acid levels may mask a vitamin B12 deficiency. Both folic acid and B12 deficiencies cause anemia — low red blood counts. If you start taking a folic acid supplement when you also have a B12 deficiency, the anemia may get better, but the nervous system damage from the B12 deficit will still occur or perhaps even worsen.

- **Vitamin D:** Vitamin D is key to the body's ability to build healthy bones. It also reduces inflammation, protects nerve cells from damage, and supports brain cell activity. Studies confirm a link between low levels of vitamin D and depression. Some recent reviews of the research have shown benefits to vitamin D supplementation in reducing symptoms of depression, although no strong, specific data shows any benefits of vitamin D for bipolar depression or manic symptoms.
- **Magnesium:** Magnesium is essential for the regulation of muscle tension and relaxation, transmitting information between nerve cells, and reducing excessive *excitation* (over activity) in nerve cells that can cause damage to the cells. A magnesium deficiency is rare, but high-risk groups include older adults and people who use alcohol, have diabetes, experience chronic diarrhea, or take medications such as some *diuretics* (water pills) or *proton pump inhibitors* (medications used for acid reflux or other gastrointestinal disorders). Research has shown clear connections between magnesium levels and migraine headache, and studies of anxiety and mood disorders suggest relationships with magnesium levels as well.
- **Zinc:** Zinc is a trace element that plays a key role in managing the oxidative stress (cell damage) process, which has been associated with bipolar disorder. Some recent data confirm a strong association between lower zinc intake and depressive symptoms, and some data shows similarly low levels of zinc in people with active bipolar depression symptoms. People who use alcohol or have gastrointestinal disorders, especially if chronic diarrhea is present, and people who've had weight-loss or other intestinal surgery are at risk of zinc deficiency. People with sickle cell disease, pregnant and nursing women, and vegetarians are also at risk of lower zinc levels. Even though the zinc levels are found to be low in people with depression, research doesn't yet clearly show that supplementing with zinc is helpful in reducing depressive symptoms.

Investigating herbs and other supplements

Nature provides a host of effective cures and treatments for common ailments, but does it serve up anything for bipolar disorder? Medical research suggests that

some of the supplements we list here may provide benefits to people with bipolar disorder:

- **Coenzyme Q10:** This substance plays a key role in energy metabolism within cells, which may be disrupted in bipolar disorder. One well done study of CoQ10 as an add-on to standard medications in bipolar depression showed a notable improvement compared to placebo. Although that's encouraging, *replication* (a study having similar results) is needed to support this finding.
- **5-HTP:** This supplement provides your body with the building blocks it needs to assemble *serotonin* (a key mood-related neurotransmitter). Some small studies suggest that 5-HTP may be a helpful add-on in the treatment of depression and bipolar depression, but more studies need to be done to support its use. Potential risks include inducing *serotonin syndrome* — a potentially deadly effect of very high serotonin levels in the body — if combined with antidepressants such as SSRIs or MAOIs. This risk seems to be low, but talk to your prescriber before taking this in addition to an antidepressant.
- **GABA:** GABA (gamma-aminobutyric acid) has been touted as a treatment for mood disorders because it's a neurotransmitter related to depression, anxiety, and mania. However, GABA taken as an oral supplement only crosses the blood-brain barrier in small amounts, so it's unlikely to affect those symptoms. This particular "natural" cure is a fraud.
- **Glutathione:** Glutathione, one of the most common antioxidants in the human body, may reduce *oxidative stress* (literally, cell damage), which may be related to bipolar disorder. Glutathione also modulates the effects of *glutamate,* another important mood-regulating neurotransmitter. Studies have shown that blood levels of glutathione are reduced in the blood of people with bipolar disorder with psychosis, and those levels are lowest during active episodes. Taken orally, glutathione doesn't significantly raise the levels in the brain, but you can raise glutathione levels by taking N-acetyl cysteine, as explained later in this list.
- **Inositol:** Inositol is a chemical in the body and brain that is important in many cellular processes. Studies have shown elevated levels of inositol in the brains of people with bipolar disorder in manic phase and lower levels during depressive episodes. Lithium and valproic acid, when used to treat mania, result in significantly decreased inositol in the brain; this may be one important mechanism in the effectiveness of these medications in treating mania *(the inositol depletion theory)*. Some studies support the use of inositol as an add-on medicine in depression and bipolar depression that hasn't responded fully to typical medications, but because high levels of inositol are associated with mania, it can be high risk for triggering mania. Talk to your doctor before using inositol to address bipolar symptoms.

- **Kava:** This plant/herbal product purportedly reduces stress and anxiety, but some reports link it to liver damage. As a result, it's banned in many places. Don't use kava without a doctor's permission and supervision.
- **Melatonin:** Melatonin is a hormone that the brain produces in response to light and dark; it's part of the body's sleep/wake machinery. Supplements may reduce insomnia for sufferers of some types of sleep problems. Melatonin is safe for short-term use, even in children. But check with your doctor before you use melatonin, because it can interact with some psychiatric medications.
- **N-acetyl cysteine (NAC):** This chemical is part of the system that produces glutathione (mentioned earlier in this list), which is important as an *antioxidant* (helping cells recover from various kinds of stress and damage) and as a key factor in the glutamate receptor system, helping to regulate how glutamate communicates between cells. One well done study showed that NAC added to standard treatment reduced symptoms of bipolar depression, but only after taking it for five to six months. This chemical may be an important building block of next-generation treatments for bipolar disorder and other psychiatric illness.
- **SAMe:** Short for S-adenosylmethionine, SAMe is a natural substance found in your body that has been proved to function effectively as an antidepressant in some studies, but inadequate data are available to support its regular use as an antidepressant. Some research also supports using SAMe along with a traditional antidepressant when the antidepressant isn't effective enough SAMe carries the risk of side effects similar to those of antidepressants, including agitation and manic symptoms, so it's not recommended for bipolar depression without close medical supervision. Another drawback: It isn't cheap.
- **St. John's wort:** Reviews of medical literature suggest that St. John's wort (a medicinal herb called *hypericum*) is effective in treating mild to moderate unipolar depression, but inconsistencies in the data remain. Some doctors continue to recommend it, particularly in Germany, and some people with depression continue to sing its praises. Be careful, though; like most antidepressants, St. John's wort may carry the risk of inducing mania. It can also interact with a number of meds.
- **Taurine:** Taurine is one of the most abundant amino acids in the brain. It increases activity at GABA receptors. Studies in animals have shown little support for its use in anxiety and depression, but it's still being explored, and some animal studies suggest it could be neuroprotective, but this has not been well studied in humans. Taurine is found in all of the so-called energy drinks, usually in combination with caffeine. Use of high doses of caffeine and energy stimulating products can be high risk in bipolar disorder because they can disrupt sleep cycles.
- **Valerian:** Valerian is an herb commonly marketed for the treatment of insomnia. It has been shown to have some benefits, especially if you use it regularly.

Valerian must be taken for about two weeks for it to have its full benefits. Valerian appears to be relatively safe, but check with your doctor first, especially if you're pregnant, nursing, or taking other meds, or if you have liver disease. Because it's sedating, it's best not to mix it with alcohol or other sleep medications or sedatives. Also, if you've been using it regularly and decide to stop taking it, taper it down gradually rather than stopping it all at once.

WARNING

Before ingesting any of these natural substances, check with your doctor and do your own research. A reliable information source is the National Institutes of Health's Office of Dietary Supplements (`ods.od.nih.gov`).

Assessing the safety of alternative remedies

People often think that vitamins, herbs, and supplements are "worth a try." If you can get them at the store without a prescription, they must be safe, right? Well, not exactly. These nutraceuticals carry their own potential risks and drawbacks, including the following:

- **Unconventional treatments may cause you to forgo more effective treatments.** The most serious risk associated with trying alternative remedies is that they may keep you from obtaining the best treatments currently available.
- **Unconventional treatments may not be cost-effective.** Alternative remedies and supplements can cost hundreds to thousands of dollars. People pitching "all natural" alternatives are usually trying to convince you to buy their product. A prescription for lithium or a generic mood medication may be more affordable and much more effective.
- **Insurance won't cover unconventional, over the counter treatments.** If you load up your cart at the local health food store with megavitamins, nutritional supplements, and herbal remedies, your insurance company is not going to pay the bill.
- **Unconventional treatments can require a lot of extra work.** Some treatments require you to perform extensive colon-cleansing and liver-cleansing routines and then take high doses of dietary supplements and herbal mixtures. Even worse, drastic body-cleansing routines can raise the concentrations of some medications, particularly lithium, to dangerous and potentially lethal levels.
- **Unconventional treatments have negative side effects, too.** Advertisers use the word "natural" to make their product sound harmless, but this is extremely misleading. Like prescription medications, "natural" substances

work by changing your brain chemistry. In fact, lithium is a natural product — a salt found in nature. Just because something is natural doesn't mean it can't have side effects.

- **Unconventional treatments are less strictly regulated.** In the U.S., dietary supplements and herbs are classified as food products, so they don't have to meet the same stringent FDA standards of efficacy, safety, quality, and content regulation that prescription medications have to meet. As a result, in many cases, you may not know what you're really taking or what it may or may not do to you. Unregulated products also carry a higher risk of containing toxic contaminants.
- **Your doctor may not be well versed in unconventional treatments.** Most physicians and psychiatrists invest their time and research treating their patients with the most effective and safest medications supported by medical research. Most prescribers are open to discussing and researching alternative interventions if they have been researched or if you bring it up to them. If a doctor claims to use only alternative approaches, seek another opinion to be sure you know all the standard approaches as well.


REMEMBER

Well-done scientific research remains the best tool available to assess the risks and benefits of any treatment or medication, including complementary and alternative interventions. CAM may be valuable for many people, but clarity about the potential risks is just as important with these products as it is with traditional medications.

Treating Depression with Light Therapy

Many people notice that their moods respond to light levels and seasons, even if they don't experience full-blown depression or bipolar disorder. But for some people, mood disorder symptoms can be triggered seasonally. Those who are particularly sensitive may experience a condition called *seasonal affective disorder (SAD)*. Seasonal affective disorder (SAD) is not a separate mood disorder, but rather a subtype of major depression or bipolar 1 or bipolar 2 disorder characterized by recurrent episodes of major depression, mania, or hypomania with symptom onset and resolution related to seasonal changes. (Check out *Seasonal Affective Disorder For Dummies* by Laura L. Smith, PhD, and Charles H. Elliott, PhD, published by John Wiley & Sons, Inc.)

The most common pattern of SAD is major depression with fall-winter onset. Another common pattern is spring-summer onset depression. Bipolar disorder can have seasonal patterns, too, typically with lower mood in fall/winter and symptoms of hypomania/mania in the spring/summer, but it can vary.

Bright light therapy has been well studied in SAD, major depression with fall/winter onset, as an add-on to standard medical treatment. Sitting in front of a 10,000 lux light source for 30 minutes in the morning (shortly after awakening) has been shown to improve symptoms of this form of SAD. Side effects of bright light therapy are minor (eye strain or headache were most common), but there were rare instances of triggering hypomanic or manic symptoms. The therapy should start well before days start getting shorter and be tapered gradually as spring approaches and the days get longer.

For bipolar depression, the research is not as consistent, but some results suggest that adding light therapy to standard medical treatment may effectively reduce depressive symptoms more than the standard treatments alone. These studies weren't specifically looking at seasonal bipolar disorder, just standard issue bipolar depression. One interesting finding was that the strongest positive results came from using the light midday rather than in the morning and for a duration of two hours per day rather than thirty minutes.

For safe, effective bright light therapy follow these guidelines:

- Consult your doctor first.
- Proceed with light therapy only under the direction and supervision of a qualified professional. Time of day, frequency, and duration of treatment are critical factors.
- Use a device designed specifically for the purpose of providing phototherapy. Most phototherapy light boxes use special fluorescent or LED bulbs rated at 10,000 lux.

WARNING

During the studies, switching to manic or hypomanic symptoms was rare, but possibly more common in people who had switched on antidepressants in the past, so if you're starting light therapy for bipolar depression be sure to tell your doctor about any past switching responses. Your doctor may want you to gradually increase your "dose" of light therapy rather than starting at the full dose.

Stimulating Your Brain with Electricity and Magnetic Fields

Doctors have various ways to re-set brain circuits by stimulating them with electricity or magnetic fields. These types of interventions are used to treat mood disorders as well as other psychiatric and neurologic/medical conditions, and research in many of these areas is ongoing.

These treatments can be broken down into two types — non-invasive and invasive. Electroconvulsive therapy (ECT) and repetitive transcranial magnetic stimulation (rTMS) are considered non-invasive. Invasive methods include vagus nerve stimulation and deep brain stimulation. The non-invasive interventions are in common usage, primarily for people with symptoms that have not fully responded to medicine alone. The invasive interventions are still done in research settings and reserved for the most severe, treatment-resistant cases.

As with medication recommendations, approach these treatments with your doctor's guidance, examining potential risks and benefits of using the treatment versus not using it. In the spirit of keeping you informed, the following sections describe four non-medication-based treatment options: electroconvulsive therapy, repetitive transcranial magnetic stimulation, vagus nerve stimulation, and deep brain stimulation.

Moderating moods with repetitive transcranial magnetic stimulation (rTMS)

Repetitive transcranial magnetic stimulation (rTMS) is a medical procedure that involves passing an alternating current through a magnetic coil placed on the scalp. This creates a magnetic field that passes through the skull and generates electric currents that change the electrical activity of the neurons below the coil. No anesthetic is required; you remain awake during the procedure. During the treatment, you sit in a chair with the coil attached to your head, and you may experience some skin tingling or muscle tightening or shaking around the coil and down into your jaw. During the procedure you hear repeated clicks as the current passes through the magnetic coil.

Substantial research has shown that rTMS can have significant benefits for some people who have not had a full response to medical interventions for major depression or who can't tolerate the medications. Although research into the use of rTMS in bipolar disorder is less extensive, a number of well-done studies suggest that it could be an effective intervention for some people's treatment-resistant bipolar depression. No good evidence shows that rTMS is effective in treating mania, and some people have reported rTMS triggering a switch to manic symptoms. Although switching is thought to be a rare occurrence, treatment with a mood-stabilizing agent while a patient is going through rTMS is usually recommended.

The typical course of rTMS is five sessions per week, about thirty minutes per visit, for about six weeks, but these parameters can vary. Some research has been done into higher intensity treatments, more frequently, over days instead of weeks, but this is not a standard protocol yet.

Side effects of rTMS tend to be mild and can include headache or scalp pain, temporary sensations of reduced hearing (like after attending a loud concert), and skin discomfort or muscle tenderness in the scalp and jaw. rTMS carries an increased risk of seizures, but not much higher than with most antidepressants. However, due to this risk, people with seizures or at high risk for seizures may not be candidates for rTMS. People with implanted metal devices, or clips or cochlear implants may also not be able to receive rTMS safely. No evidence suggests that memory loss is a side effect of rTMS.


REMEMBER

Multiple rTMS devices have now been approved in the U.S. for treatment of depression that hasn't responded to antidepressant medication. Some of the devices are also cleared for treating OCD and anxiety as part of depression. This procedure is increasingly available as an option for many people, and insurance typically covers it. Doctors and patients often choose to try rTMS before going to ECT, because rTMS is less medically involved.

Zapping your moods with electroconvulsive therapy (ECT)

Electroconvulsive therapy (ECT) is based on an observation made many years ago that seizures seemed to reduce depressive and manic symptoms in some people. Contrary to what you may think, the therapeutic mechanism of ECT isn't the electrical "shock" but rather the series of controlled seizures it induces. ECT is a very effective technique that can be life-changing for some people . . . in a good way, that is.

Modern techniques have significantly reduced the trauma and the drama of ECT. Modern ECT procedures are done in a hospital, under the care of an anesthesiologist, who puts you to sleep and paralyzes your muscles so you don't shake or move during the seizures. Your breathing is supported and monitored during the few minutes that the procedure takes place.

The psychiatrist then places a small electrical pad on one or both temples (unilateral or bilateral ECT) and administers a small electrical current that triggers a brief seizure. When the seizure is over, the paralysis and sedatives are reversed, and then you're monitored closely until you wake up completely.

The repeated seizure activity, usually three times a week for about 12 weeks, relieves mood symptoms. About 80 percent of people who undergo ECT experience significant relief from symptoms of both depression and mania and report relatively mild side effects, such as temporary memory loss and blood pressure changes.

If you have bipolar, you may consider ECT under the following conditions:

- Nothing else works for you.
- Your depression or mania is severe and requires fast relief of acute symptoms, usually during an inpatient hospital stay; symptoms include severe suicidal ideation and/or psychosis.
- You can't or don't want to take medicine.
- You're pregnant, nursing, or plan to become pregnant, and you're concerned about the effects of various medicines on the fetus.

Doctors commonly use ECT in elderly and frail individuals who can't tolerate antidepressants and antimanic medications. In these people, ECT has proven very effective.

ECT: NOT AS SHOCKING AS IT SOUNDS

The term *ECT*, formerly known as electroshock treatment, may send a chill down your spine. When my doctor recommended it, the horrifying images of *One Flew Over the Cuckoo's Nest* flashed in front of me. I resisted the treatment for three years. After yet another severe manic-depressive episode, I attempted suicide and was hospitalized. The doctor recommended ECT again. This time I accepted, and it was one of the best decisions I ever made. With my first treatment, I felt 50 percent better. With every treatment after, the heavy weight of depression lifted a bit more.

Yes, ECT has some drawbacks. I experienced disorientation, a lack of sense of direction, and forgetfulness regarding names and conversations, but my short-term memory returned soon after treatment ended. Unfortunately, I also lost some long-term memories. Because I was in such a critical state, I opted for intensive treatment given over the course of nine months. Most of the long-term memories I lost were within the ten years prior to treatment. The procedure didn't erase all my memories. It was more like someone pulled files randomly from my memory bank. But that was a risk I was willing to take. I sacrificed both good and bad memories in exchange for my peace of mind. I've been episode-free for ten years. I believe that going through ECT, along with staying on a medication regimen, played a big role in restoring my mental health. It may not be the best treatment for everyone — and everyone who has ECT experiences different side effects to varying degrees — but the trade-offs were well worth it for me.

— Janine Crowley Haynes, freelance writer and author of award-winning memoir *My Kind of Crazy: Living in a Bipolar World* (janinecrowleyhaynes@gmail.com)


WARNING

ECT's main side effect is memory loss, which is usually temporary. Other potential risks include reactions to the anesthetic or muscle relaxant and possible changes to heart rhythm and blood pressure. Your doctor will evaluate your health before treatment and monitor it during treatment for any signs of distress.

Soothing depression with neurostimulation

Doctors can directly stimulate particular nerves or brain locations with mild electrical currents to reduce depressive symptoms in people with extreme *treatment-resistant depression (TRD)* — depression that has failed to respond adequately to four or more medications and/or ECT. The two neurostimulation treatments that have shown the most promise are vagus nerve and deep brain stimulation, which we describe here.

Modulating the nervous system with vagus nerve stimulation (VNS)

The vagus nerve (actually two nerves, one on each side of the body) starts in the brainstem and winds its way down into the chest and upper abdominal cavity. It's one of the primary nerves in the *parasympathetic nervous system*, which is involved in "rest and digest" activities, as opposed to the *sympathetic nervous system,* which drives "fight-or-flight" responses. The vagus nerve facilitates communication between various internal organ systems and the brain. In this role, it helps to regulate heart rate, peristalsis (the intestinal muscle actions that move food and waste through your intestines), and the gag reflex.

Electrical stimulation of the vagus nerve has been performed by neurologists since the 1990s for treatment-resistant seizures. In the course of researching those procedures, mood improvements were noted in some of the patients and that led to research into using VNS for treatment-resistant depression. While the research on depression has shown inconsistent results, it seems possible that longer term use of VNS may help reduce depressive symptoms that haven't responded to multiple medication trials or ECT. Scientific research on the use of VNS in bipolar depression is less extensive, but it is still being pursued.

VNS is invasive. It is a surgical intervention that places an electrode around one vagus nerve (usually the left side) that is attached to a pulse generator implanted into the chest wall. Once in place and the body has healed, the device typically generates a pulse for about thirty seconds every five minutes, but then the timing is adjusted based on patient response. Because it involves surgery and anesthesia, it remains highly limited in availability and practicality.

The treatment carries a variety of risks, including voice changes, throat or neck pain, difficulty swallowing, worsening of depression, and risks associated with surgery. Currently, most insurance companies don't cover the procedure.

Targeting parts of the brain with DBS

Deep brain stimulation (DBS) involves implanting electrodes into parts of the brain that are thought to affect mood. Researchers are still exploring which areas of the brain to target. After positioning the electrodes, the doctor stimulates them a few times to get the pulse-dosing correct and make sure the patient tolerates it. A battery-powered pulse generator, implanted below the skin usually near the collar bone, is then activated and continually sends a small current through the electrodes to the targeted parts of the brain. Implantations are reversible; doctors can remove the pulse generator and electrodes at any time.

DBS has shown some promise in alleviating depression in people who haven't responded to numerous other treatments, but it's still considered an experimental procedure. Research on using DBS in bipolar disorder is minimal. DBS has a long history of use in treating movement disorders, including Parkinson's disease and is an experimental treatment for severe, treatment-resistant obsessive-compulsive disorder.

Surgical procedures such as DBS carry risks. With a DBS implant, you need to consider the possibility of stroke or bleeding in the brain; infection; speech, heart, or breathing problems; seizure or slight paralysis; undesirable mood changes; pain, swelling, or scarring at the incision points; a shocking sensation from the electrical current; and even the possibility of your body rejecting the implant.

Exploring the Effects of Marijuana on the Brain

Cannabis is now legal recreationally and medically in many states, and is often touted as a "natural" cure for many ailments, including mood disorders. And because of that "natural" label proponents often suggest that it doesn't have side effects. This is misinformation that can be dangerous.

As of this writing, no scientific evidence suggests any medical benefits to using cannabis in the treatment of bipolar disorder. In fact, the data shows the opposite. Many well-done studies have shown that cannabis use in bipolar disorder is associated with worsened outcomes, with more severe depressive, manic, and psychotic symptoms, as well as increased suicidal thinking. People with bipolar disorder who use cannabis need more support for day-to-day functions than those who don't use it.

WARNING

A commonly repeated myth is that you can't become addicted to cannabis/marijuana. Although the physical withdrawal symptoms may not be the same as those people experience when stopping something like opiates, people do become dependent on cannabis and struggle severely to stop using it. It can become the whole focus of life. And if you have bipolar disorder, having a dependency on cannabis can make it much harder to manage your bipolar disorder.

Reviewing the Research on Psychedelics

Psychedelics, including psilocybin, lysergic acid diethylamide (LSD), MDMA, mescaline, and ayahuasca, are having a resurgence of scientific interest as possible treatments for psychiatric conditions, including depression. These are still investigational substances — the research remains limited, and the results are inconsistent. The research has excluded people with bipolar disorder due to negative effects of psychedelics such as triggering mania and psychosis.

The fact that ketamine, a psychedelic, is now an increasingly mainstream treatment for depression (see Chapter 7) may eventually drive a more rigorous scientific understanding and usage of other psychedelics for mood disorders, but for now, the risks, especially in bipolar disorder, seem to be quite high while the benefits are not clearly established.

If you have strong interest in using psychedelics, for whatever purpose, discuss the possibility with your doctor before you "microdose" or undergo a "guided" psychedelic experience of any kind. Having bipolar disorder puts you at high risk of serious side effects from these substances, and even small doses could be problematic.

IN THIS CHAPTER

- Recognizing how bipolar disorder may look different between men and women
- Addressing medication issues before, during, and after pregnancy
- Exploring unique risks and needs in the LGBTQIA+ communities
- Identifying and reducing risks specific to various minority populations
- Identifying special treatment needs for older people with bipolar

Chapter 10
Addressing Bipolar Disorder Across Diverse Communities

In the adult population, the criteria for diagnosing all types of bipolar disorder don't differ based on age or gender identity. Patterns of diagnosis and recommended treatment options, however, may vary considerably among different populations and circumstances, especially with respect to biological women during childbearing years and people in the geriatric (older age) population.

For marginalized communities, including people of color and the LGBTQIA+ community, getting an accurate diagnosis and effective treatment can be affected by implicit biases across systems of care.

In this chapter, we explore key differences in diagnosis and treatment considerations in women and older adults. We also explore ways to ensure equity in care for vulnerable populations.

Bipolar Disorder in Women

Women experience hormonal and physiological changes across their lifespan as their body develops the ability to conceive and bear offspring. These processes influence both symptoms and treatment decisions.

In the following sections, we highlight how bipolar differs in women and describe how hormonal fluctuations throughout the life cycle impact the illness. We also point out vital issues to consider when choosing bipolar medications and other treatment options for people considering or experiencing pregnancy and subsequent childbirth.

Considering the nature of the illness

Historically, research has shown equal rates of bipolar I in men and women, but there are well-established differences in symptom patterns of bipolar between these two populations, including the following:

- **Depression:** Women are more likely to experience depression as their first episode of bipolar disorder whereas men more often present first with mania; women tend to have more depressive episodes compared to men; and women are more likely than men to experience psychosis during their depressive episodes.
- **Hypomania and bipolar II:** Hypomania, and therefore, bipolar disorder type II, is more common in women than in men.
- **Rapid cycling and mixed presentation:** *Rapid cycling* (four or more mood episodes per year) and mania with depressive symptoms (mixed presentation) seem to be more common in women than men.
- **Suicide:** Women seem to have more suicide attempts, whereas men more often die by suicide.
- **Age of onset:** According to the Centers for Disease Control and Prevention (CDC), the median age of onset for bipolar disorder is 25 years, and women may tend toward later onset than men. A form of "late onset bipolar disorder" can occur in people in their 40s to 50s, and women seem more likely than men to experience this.

- **Comorbid psychiatric conditions:** Women with bipolar disorder seem to have more co-occurring anxiety disorders, PTSD, and eating disorders. Men have higher rates of comorbid substance use disorders but some research suggests higher rates of alcohol use disorder in women with bipolar II.
- **Comorbid medical conditions:** Other medical conditions, especially thyroid disease, migraines, and autoimmune disorders may be more common among women than men. These comorbid conditions often adversely affect recovery from bipolar disorder in women.
- **Misdiagnosis:** Because women tend to experience more depressive episodes, they may be more likely to be misdiagnosed as having unipolar depression as opposed to bipolar disorder (because the manic pole may not have fully presented yet). Be sure to tell your doctor about any periods of time when your mood, thinking, sleep, behavior, or energy changed from your baseline, even if you actually felt much better than usual or were just much more irritable and angry. This information can nudge the needle from a diagnosis of depression to bipolar disorder and help to ensure that you obtain the most effective treatment and reduce the risk of a future shift into mania.

Tracing reproductive development

Hormonal changes drive body and brain development for all humans. Reproductive hormones interact with other body systems, including the brain. The primary sex hormones in the human body include the following:

- **Estrogen:** This reproductive hormone is responsible for primary development of biologically female sex characteristics and function. Estrogen is at its lowest level at the beginning of the menstrual cycle and peaks near the time of ovulation (approximately day 14 of the cycle). If pregnancy occurs, estrogen levels remain high. If the egg isn't fertilized, estrogen levels drop. Biological males also have circulating estrogen, but in much lower levels.
- **Progesterone:** This hormone prepares the lining of the uterus for a fertilized egg. If the egg is fertilized, progesterone levels continue to rise, and they remain high throughout the pregnancy. If the egg isn't fertilized, progesterone levels drop. Males also have circulating progesterone, at low levels.
- **Testosterone:** This hormone is responsible for primary development of biologically male sex characteristics and function. It is also present in female development, at lower levels, and is important for many brain and body functions. Testosterone levels vary during the menstrual cycle.

Biologically females experience significant hormonal changes through their lifespan that support the body's ability to reproduce. Key steps in that development include the following:

- **Menarche:** This is the time period when a menstruation begins and is often considered the start of puberty, although many hormonal changes happen before this. Before puberty, boys and girls have about the same rates of depression, but after puberty, the rate of depression becomes higher in people with female developing reproductive systems. How or why this occurs is unclear, but it certainly suggests a close connection between reproductive hormones and mood.
- **Menses (menstruation):** Menstrual cycles occur in response to rhythmic changes in sex hormones that occur in anticipation of pregnancy. If a pregnancy doesn't occur, the hormones reset and the cycle begins again. Throughout a monthly cycle, many people experience some level of mood and behavioral symptoms:
  - **Premenstrual syndrome (PMS):** PMS is characterized by physical symptoms and mood changes (often sadness and/or irritability) in the days between ovulation and menstruation. Some symptoms occur in most people who menstruate, with somewhere between 20–50 percent experiencing symptoms significant enough to affect daily activity. The symptoms resolve within a few days of the menstrual period.
  - **Premenstrual dysphoric disorder (PMDD):** PMDD is a severe form of PMS that presents with mood symptoms, such as labile (fluctuating) mood, depression, anger, or anxiety, that significantly affect function. The symptoms resolve shortly after the period starts. The diagnostic criteria are listed in the DSM 5, where PMDD is classified as a mood disorder. An estimated 3 to 8 percent of ovulating people suffer from PMDD.
  - **Premenstrual exacerbation (PME):** PME is a worsening of manic or depressive symptoms that occurs in the two weeks before menstrual period and may be associated with a more chronic, severe course of bipolar disorder. Whether this is a separate entity or a co-occurrence of bipolar disorder and PMDD remains the subject of research.
- **Pregnancy:** Consistent information about how pregnancy affects bipolar symptoms is scarce. Sleep deprivation and energy changes are certainly important considerations, as are the underlying hormonal shifts that occur throughout pregnancy.
- **Postpartum:** People with bipolar disorder are at higher risk for experiencing a mood episode immediately or shortly after giving birth; this is well established. The body experiences swift and dramatic hormonal shifts after giving

birth, and these shifts are thought to contribute to the increased risk of developing depressive and/or manic symptoms in the postpartum period. The first 12 months after having a baby are usually considered the postpartum period.

- **Perimenopause/menopause:** During this time, estrogen levels gradually decline, and menopause is clearly associated with a higher risk of depression. Some more recent research on women with bipolar disorder has shown increased rates of mood elevation in this time period as well, suggesting it could a vulnerable period for elevated and depressed mood episodes.

TIP

If you experience severe premenstrual mood symptoms, your doctor may consider prescribing a selective serotonin reuptake inhibitor (SSRI) antidepressant for you to take only during the week immediately preceding your period. Taken this way, low-dose SSRIs have an almost immediate effect on PMDD symptoms. This effect is surprising, because SSRIs typically take weeks to work when used for depression. However, if you have bipolar disorder, SSRIs can sometimes cause serious negative effects, including triggering manic symptoms. Make sure the doctor treating your premenstrual mood symptoms is aware of any psychiatric diagnosis and any symptoms that could influence medication decisions.

Bipolar disorder and pregnancy

All people who can bear children and are being treated for bipolar disorder should discuss contraception and pregnancy with their doctors and have contingency plans in place for an unplanned pregnancy. These discussions must cover the different aspects of reproductive healthcare — both in terms of how bipolar affects pregnancies and how pregnancies affect bipolar. After all, half of all pregnancies are unplanned, and the percentage may be higher for those with bipolar disorder because they're at an increased risk of experiencing irregular menstrual cycles and periods of impulsive sexual behavior.

In the following sections, we point out important decisions to be made around bipolar disorder and pregnancy. We also provide important information for making medication choices before, during, and after pregnancy. This section also includes guidance on planning and preparing for pregnancy and managing bipolar during pregnancy.

Deciding whether to get pregnant

Bipolar disorder doesn't exclude you from parenthood. Many parents with bipolar disorder have raised healthy, well-adjusted children. When you're thinking about having children, ask yourself the following questions and discuss them with

anyone in your support network who's likely to be involved in or affected by your decision:

- **What are the odds that my child will develop bipolar disorder?** If only one parent has bipolar, the child has a 5 to 10 percent chance of developing the illness. If both parents have it, the risk may be as high as 25 percent. (See Chapter 2 for more about the genetic factors of bipolar.) The individual risk for any one child — for bipolar or other psychiatric disorders — is impossible to predict.
- **How will the medications affect fetal development?** Many of the medications used to treat bipolar disorder can be dangerous to a developing fetus. (Check out the next section for details.)
- **How will the pregnancy affect my moods?** Pregnancy may increase the risk of mood episodes, but the data is lacking. The postpartum period is a high-risk time for manic and depressive episodes. Careful monitoring during pregnancy and at least 30 days after delivery can help you and your doctors identify early warning signs and respond accordingly.
- **How will my bipolar disorder affect my pregnancy?** People with bipolar disorder have higher risks of adverse outcomes including placental problems, low birth weight babies, high blood pressure in pregnancy, and increased rates of induced labor and caesarian section deliveries. Although studies are insufficient to determine whether these outcomes are related to bipolar disorder itself or medications, it is well known that mood symptoms can be stressful on a pregnancy.
- **Can I manage the stress?** Being pregnant, delivering a baby, and raising an infant and child will undoubtedly disrupt schedules, change relationship dynamics, and increase stress. You may be able to mitigate the stress by looping your support team in to know who can help and how, expanding your networks of supports and resources, and becoming an expert in the fine art of asking for help.

Choosing medications before, during, and after pregnancy

If you're pregnant or may become pregnant, you and your doctor should carefully consider the benefits and risks of using medications during pregnancy. The following sections highlight important considerations to discuss with your doctor at various stages of reproduction.

BEFORE PREGNANCY

Anyone with bipolar disorder who can get pregnant needs to discuss the following factors with their doctors when choosing medications for treating bipolar symptoms — even if they're not planning to become pregnant any time soon:

- Some medications, including carbamazepine (Tegretol), oxcarbazepine (Trileptal), lamotrigine (Lamictal), and topiramate (Topamax), may decrease the effectiveness of some types of birth control pills.
- Birth control pills may affect concentrations of other medications in the bloodstream, particularly lamotrigine, lowering the levels during the three weeks of exposure to estrogen and allowing levels to increase up to 50 percent during the pill-free last week.
- Certain antipsychotics may raise prolactin levels and reduce the chances of conception. If you're planning a pregnancy, your doctor may test your prolactin levels and discuss alternative medications.
- Valproate (Depakote) increases the risk of *polycystic ovary syndrome* (PCOS), a disorder in which the ovaries produce excessive *androgens* (testosterone and other masculinizing hormones). PCOS disrupts ovulation cycles and periods and can cause acne, weight gain, skin changes, and *hirsutism* (excessive body hair growth). It increases the risks of type 2 diabetes and may cause infertility. Check out *PCOS For Dummies* by Gaynor Bussell and Sharon Perkins (John Wiley & Sons, Inc.) for more information.

DURING PREGNANCY

Medication decisions during pregnancy require close collaboration between the person with bipolar and that person's psychiatrist and obstetrician. Research shows that stopping bipolar medications during early pregnancy greatly increases the risk of a recurrent mood episode, especially in those with a history of frequent or severe mood symptoms. Such a mood episode can pose a danger to birther and baby. At the same time, many of the medications used to treat bipolar disorder carry risks to a developing fetus.

REMEMBER

Comparing the risks of medication with the risks of developing mania or depression while pregnant is a nuanced conversation between all involved parties.

Until 2015, the FDA used a letter system to designate classes of pregnancy risk for medications. This is being phased out and replaced with text descriptions of available research relating to the medication and pregnancy and lactation (breastfeeding). Although covering the risks in all medications for bipolar

disorder is beyond the scope of this books, here are some highlights about important bipolar medications in pregnancy:

- **Lithium,** one of the primary medications used in treating bipolar disorder, carries risks of problems in the developing heart, especially if taken during first trimester of pregnancy, as well as other possible effects to the fetus. Although every effort is made to avoid using lithium in the first trimester, if it is essential for managing bipolar disorder, it may be used, carefully, at lowest possible doses. Blood level may change over pregnancy and so needs to be monitored very closely. Lithium does cross into breast milk, and it is generally recommended to avoid breastfeeding in a birthing parent who is taking lithium.
- **Valproate,** another primary mood treatment medication, can cause significant organ malformations, including in the spinal cord, face, heart, and limbs. It is only considered for use in pregnancy if other medications have failed and treatment is essential. If valproate is used during pregnancy, blood levels must be monitored closely. Taken in pregnancy it can cause clotting abnormalities. Similar to lithium, valproate is present in breast milk, and breastfeeding can cause problems for the infant.
- **Olanzapine, aripiprazole, and quetiapine (Zyprexa, Abilify, and Seroquel),** all second-generation antipsychotics, have not been shown to cause significantly increased risks of major birth defects or adverse maternal or fetal outcomes. Taken later in pregnancy, exposed infants may experience abnormal muscle movements and/or withdrawal that can include breathing problems, low or excessive muscle tone, and feeding problems. The risks of weight gain and insulin resistance in pregnancy are considered relevant but do not contraindicate use in pregnancy. Although these medications are found in breast milk, available data doesn't show significant adverse events in most infants exposed to it. However, monitor for appetite changes, sleep problems, sedation, or irritability.
- **SSRIs, including sertraline, citalopram, escitalopram, fluoxetine, and paroxetine (Zoloft, Celexa, Lexapro, Prozac, and Paxil).** Paroxetine has been found to have some connections to fetal malformations, and fluoxetine also has some associations, although fewer than paroxetine. The other SSRIs listed here have not been associated with fetal malformations. Although many people with bipolar disorder don't take SSRIs, if they're part of a stable treatment plan, the risks of triggering a mood episode by stopping the medication must be weighed carefully against risks of the medications. Babies exposed to SSRIs in utero will be monitored for breathing problems, irritability, abnormal muscle movements, and feeding problems, among other concerns. They will also be monitored for *persistent pulmonary hypertension of the newborn* (increased pressure in one of the major blood vessels coming out of the heart) but the risk of this is low. SSRIs are present in breast milk, but

breastfeeding may be safe in certain circumstances and can be considered in consultation with your doctor.

- **Benzodiazepines:** This class of medication carries minimal risk of fetal malformations. When used late in pregnancy, it can cause *floppy baby syndrome,* a condition associated with impaired temperature regulation, breathing and feeding difficulty, and lethargy. Benzodiazepine exposure in pregnancy can cause withdrawal symptoms in the infant after birth, which can be especially difficult with alprazolam (Xanax) exposure.
- **Lamotrigine (Lamictal):** Available data has not shown an increased risk of major fetal malformations, but some risk of cleft lip or palate may be heightened. Risks appear to be higher with higher dose of lamotrigine and when it's used with another anti-seizure medication. Lamotrigine blood levels may change during pregnancy, so dosage adjustments may be needed. Lamotrigine is present in breast milk, so decisions about breastfeeding must take that into consideration.

  Every medication information sheet now has sections listing pregnancy and lactation considerations. For more details about pregnancy considerations for medications you're taking or are considering, you can look up possible side effects and contraindications at `www.fda.gov`, `www.drugs.com`, or `www.webmd.com`.

WARNING

Don't change your treatment regimen or stop taking medications without consulting your doctor. Relapse rates during and after pregnancy are relatively high and increase the risk of impulsivity, poor self-care, and suicide. Work with your doctor to develop a treatment plan that balances your well-being (which is just as important for the baby as it is for you) with security regarding the baby's development. Often such plans include choosing medications that carry less risk in pregnancy, reducing the number of medications you are on (if possible), and keeping the doses as low as possible. (See the section "Planning and prepping for pregnancy" for details.)

POSTPARTUM

The postpartum period is known for its high risks for recurrent mood episodes. Many women and their doctors restart the pre-pregnancy medications right after delivery to reduce the likelihood of a mood episode occurring. Here are a few key issues to discuss with your doctor:

- Many medications are transmitted through breast milk, so you may choose to use formula only or discuss other options with your doctor such as "pumping and dumping" breast milk when medication levels are highest and breast feeding when medication levels are lower.

- Fatigue or other side effects of restarting medication may be especially challenging with a newborn at home. For example, nighttime caretaking is not recommended if you're sedated from medications, so be sure to arrange for someone to help with overnight care until you've adjusted to your medications or aren't taking a sedative.
- Getting medication levels on track can be challenging immediately after delivery, when body weight and fluid levels shift so much.

Planning and prepping for pregnancy

If you're trying to get pregnant, work with your doctor to develop and write a plan to facilitate the pregnancy, minimize risks to the fetus, and stabilize mood. Your planning and preparation should target the following goals:

- **Stabilize your mood for several months prior to conception.** Starting a pregnancy when moods are stable improves your chances for maintaining mood stability throughout the pregnancy.
- **Monitor your moods more closely.** Recruit a few trusted friends or relatives — ideally those you see a few times or more every week — to help monitor your moods. Make sure your recruits know your early warning signs and know what to do if they notice a problem.
- **Use the least number of medications at their lowest effective doses.** Work closely with your prescriber to achieve this goal going into your pregnancy.
- **Try to minimize riskier medications.** This involves careful discussions, thoughtful decision-making, and trying to make changes before getting pregnant, if possible.
- **Ramp up non-medication treatments and support.** Proper nutrition (which includes prenatal vitamins with folic acid), getting regular and adequate sleep, psychotherapy, and family support ease the added burden of the pregnancy and help make up for any reduction in medication.

Managing bipolar and pregnancy

If you think you may be pregnant, confirm the pregnancy as soon as possible and schedule a meeting with your psychiatrist and your OB/GYN to plan a course of action that's most appropriate for you and your pregnancy. As part of your plan, consider the following steps:

1. **Schedule more frequent doctor and therapist appointments.**
2. **Discuss and make medication adjustments with your doctor.**

3. **Monitor your moods and get as much sleep as you can.**
4. **Eat when you're hungry. Talk to you OB/GYN and or a nutritionist if you have concerns about eating and food during pregnancy.**
5. **Set boundaries with others on your time and energy. Trust yourself — if you feel too tired or you can't do something, be honest, let people know, and rest as you need to.**
6. **As always, if you observe the early warning signs of a change in mood, contact your psychiatrist immediately.**

If your mood starts to shift toward mania or depression, you and your doctor may want to adjust medications or consider the non-medication alternative of electroconvulsive therapy (ECT). ECT is considered a relatively safe option for pregnant women experiencing severe mania or depression that's not responding to medication or if medication is not tolerated or safe. ECT doesn't appear to be associated with significant fetal malformations; the issues that arise are mostly related to possible cardiac problems in the fetus related to the use of anesthetics. In rare cases, ECT can also trigger uterine contractions. ECT is still a second or third choice after medications, even in pregnancy, simply because it's a more invasive and complicated procedure. (For more about ECT, see Chapter 9.)

Managing bipolar during menopause

Perimenopause, the years leading up to menopause, as well as menopause and postmenopause are times of significant shifts in hormone levels, particularly a decline in estrogen. It's known that this developmental period is associated with increased risk for depressive episodes, even for those without a preexisting mood disorder. Research suggests that for people with bipolar disorder, the menopausal transition can be a period of increased risk for bipolar depression and hypomanic and manic episodes. Some data indicates that people who experienced postpartum depression are at higher risk of mood symptoms in menopause — possibly because both are associated with notable declines in estrogen levels.

People going through menopause may also be at higher risk of the late onset type of bipolar disorder — experiencing their first manic episode in or around the menopausal transition. Research into this phenomenon is limited, but keep in mind that people can be diagnosed with bipolar later in life, because it might get missed if it's not being looked for.

If mood irregularities arise or worsen as a result of menopause, your doctor may consider some form of hormone replacement therapy (HRT) instead of or in addition to prescribing an antidepressant or antimanic medication. This would usually

be in conjunction with a gynecologist or endocrinologist. HRT isn't for everyone, especially if cardiovascular problems are a concern, but some people with severe mood symptom around menopause respond well to HRT.

Bipolar in the LGBTQIA+ Community

Individuals who identify as lesbian, gay, bisexual, transgender, questioning, queer, intersex, asexual, pansexual, and so forth (LGBTQIA+) experience higher rates of mental illness compared to cisgendered, heterosexual individuals. Although the research is still limited, these higher rates of mental illness are due to external forces — rejection and discrimination of those in these communities. Queerness is not a mental illness.

Whether bipolar disorder is more common in this population than in the general population is unclear, but those living in the LGBTQIA+ space face a host of unique challenges when dealing with a diagnosis of bipolar that include the following:

- **Stigma:** With a diagnosis of bipolar disorder, the stigma of mental illness adds to an already heavy burden for LGBTQIA+ people and their loved ones. Queer and transgender people commonly experience hostile and sometime violent responses to their existence. These responses come from their own communities, online spaces, and all too often, families. Rejection, taunting, bullying, and physical and sexual harm cause trauma that further inflames mood symptoms. Layering stigma around gender and sexuality issues on to stigma related to mental health challenges demands extraordinary levels of support from loved ones and service providers.
- **Provider awareness:** Treatment providers vary widely in their knowledge, awareness, and levels of internalized stigma and bias when working with LGBTQIA+ individuals with bipolar disorder. Sexuality in general is poorly taught in medical school and training, and many doctors don't even bother to ask about sexual orientation or gender identification. If your provider is not supportive of who you are — your name and pronouns, for example — or if they don't respect your sexual life and decisions, do whatever you can to seek care elsewhere. Gender-affirming and sex-positive care is recommended by all major medical societies.
- **Complex reproductive health needs:** *Gender-affirming care* means supporting a person's sexual and reproductive health needs regardless of their gender identity. For example, transgender men may maintain the ability to get pregnant and have children, and if they also have bipolar disorder, the intersection of their psychiatric and reproductive health care will present

complex needs to be addressed without judgment and with great compassion.

- **Suicide:** People who identify as LGBTQIA+ have higher rates of suicide compared to cisgendered, heterosexual people. LGBTQIA+ youth are especially vulnerable. Fighting stigma, offering acceptance and support, and providing gender-affirming care are essential tools to counteract this risk pattern.

Bipolar Disorder in Historically Marginalized Communities

Bipolar disorder is a serious, chronic mental illness that can be treated and managed successfully with access to accurate diagnoses and high-quality medical care. This pathway is littered with challenges due to stigma, lack of awareness, and limited mental health resources, but these obstructions are magnified many-fold in minority communities (Black/African American, Hispanic/Latino Native/Indigenous, and so on), leading to lower rates of accurate diagnosis and effective care. Wide knowledge and skills gaps persist around these disparities, and solving these problems requires social change beyond the scope of this section.

If you're a member of one of these communities, your bipolar journey, or that of a loved one, may be deeply influenced by these problems. With the right information, you're better equipped to seek out and demand culturally competent, high-quality care. In this section, we cover what you need to know if you're a member of a traditionally marginalized community.

Recognizing additional risk factors for individuals in these communities

No community is a monolith; each includes people from many different locations, heritages, and personal experiences, so any discussions here are meant to address big-picture concerns that can inform getting care for bipolar disorder in marginalized people. A common theme among all these discussions is the lack of enough people of color — Black, Indigenous, Hispanic/Latino, and others — included in research studies of every kind. Most research on the diagnosis and treatment of bipolar disorder has included primarily White, non-Hispanic people. This creates a huge gap in our understanding of bipolar disorder outside of that perspective. What research is available paints a picture of dangerous disparities.

REMEMBER

The observations highlighted in the following sections barely scratch the surface of the disparities in mental health/bipolar care. Listening to and giving a greater focus to people in these communities provides deeper and more accurate information about how bipolar affects a more diverse population. More importantly, this deeper understanding leads to more accurate assessments of how members of these communities and their loved ones experience bipolar disorder, ensuring so that these disparities can be addressed and people can obtain the solutions and support they need.

Bipolar in Black/African American communities

Research on bipolar disorder in Black and African American people has shown the following:

- Higher rates of misdiagnosis of bipolar disorder, especially being diagnosed with schizophrenia as opposed to an accurate bipolar diagnosis. When examiners were blinded to race and used structured, standardized assessment tools, rates of bipolar disorder were no different between Black and White patient groups.
- Black patients with bipolar disorder with psychosis were more likely to be sent to jail rather than treatment settings.
- Black people were more likely to be placed on antipsychotics than other mood stabilizers.
- Black people were less likely to have quality outpatient treatment following hospitalization, which researchers suggest is related to the lack of culturally competent providers.
- Mislabeling symptoms as psychosis due to lack of cultural competence is well documented. This includes patterns such as labeling culturally reasonable mistrust of medical care systems as paranoia and labeling fears of persecution paranoia rather than anxiety proportionate to years of racial trauma and systemic racism affecting their lives.
- Increasing rates of suicidal thoughts and behaviors in young adult Blacks between the ages of 18 and 25 years and a new pattern showing that Black adolescents are at higher risk of attempting suicide than their White counterparts.

Bipolar in Hispanic/Latino communities

Research on bipolar disorder in Hispanic/Latino communities has shown the following:

- Research on bipolar disorder in Hispanic/Latino communities is extremely limited, with almost no research that looks at subgroups based on country of origin and language spoken.
- Existing data has shown low rates of effective pharmacologic treatment of bipolar disorder in Hispanic/Latino patients.
- Research on broader trends in mental health care shows that Hispanic/Latino individuals may be more likely to seek help from a primary care provider rather than a mental health provider.
- Communication barriers, especially language-based, cause problems in diagnosis and treatment. Spanish-speaking mental health care providers are in short supply at every level of care.
- Lack of cultural competence in understanding symptom reports can lead to misdiagnosis and ineffective treatments. Some common areas of misunderstanding may include more focus on physical symptoms rather than emotional or behavioral problems, as well as culturally consistent spiritual experiences that may be misunderstood as psychosis.
- Hispanic/Latino young adults are showing increasing rates of suicidal thoughts, plans, and attempts.

Bipolar in Native/Indigenous communities

Research on bipolar disorder in Native/Indigenous communities reveals the following:

- High-quality research on bipolar disorder in Native/Indigenous communities in the United States is nearly absent, with almost none of the research accounting for the extraordinary experiences of racialized trauma in this community.
- Broader mental health data shows that access to mental health care is a primary concern due to high poverty rates in this community and a lack of service providers both within and outside of Indian Health Services.
- Native/Indigenous people lack health insurance at three times the rate of White/non-Hispanic people.
- Cultural perceptions of symptoms may not fit neatly in White-majority-defined diagnostic assessments and criteria, which can impair diagnostic and treatment decisions.
- Inclusion of spiritual/traditional healers and concepts may be the first line of help that many in the Native/Indigenous community seek, and culturally competent care will include this in building engagement with care and treatment planning.

- The suicide death rate for Native/Indigenous people in the United States between the ages of 15 and 19 years is more than double the rate in non-Hispanic White people.
- Substance use tends to start at younger ages in Native/Indigenous youth and continues at higher rates than other ethnic groups, which severely affects mental health and specifically bipolar disorder.

Finding culturally competent providers

A constant theme in the research discussed above is the dearth of culturally competent providers across all marginalized communities. Diverse cultural representation in mental health care is scarce among psychiatrists, psychologists, and other care providers from these communities. Seeing a care provider who is a part of your community can improve engagement and outcomes in healthcare. Until this is rectified, training in cultural competence for providers needs to be ramped up and central to training, but this is slow going in many places.

If you're a member of a minoritized community, you're entitled to culturally competent care. Finding that care may be extremely challenging, but it's getting a little better in some places. If your provider is not fluent or competent in your cultural identity, you should expect that they show willingness to listen, believe, and learn and that they will not center their cultural identity in their work with you. Access to care in your own language, with interpreters who are not family members, is also critical to good medical care and something you have a right to request and expect.

Older Adults and Bipolar Disorder

Diagnosing and treating bipolar in older adults poses unique challenges. Here, we highlight some characteristics of this population that don't apply to others, and we offer information about treatment challenges including managing medications when bipolar disorder threatens to take the shine off your golden years.

What's so different about older adults?

Only about 10 percent of people with bipolar disorder receive their diagnosis when they're past the age of 50, but whether you've been diagnosed before or after your 50th birthday, aging brings new challenges in managing the illness. The common thread in both situations — new and preexisting diagnoses — is that the changing

body and brain in older adults create the following important differences in the presentation and treatment of bipolar disorder:

- Risks of medical and neurologic conditions are much higher in older adults. If someone presents with new symptoms of mania or depression in his later years, a doctor must perform a careful differential diagnosis to rule out other possible causes of the mood symptoms. (See Chapter 4 for information on what constitutes a differential diagnosis.)
- Doctors need to put together a careful medical work-up for people with preexisting bipolar disorder and worsening mood symptoms, especially if the symptoms are inconsistent with previous patterns.
- Older people tend to take more medications, and the risk of side effects increases due to age and the layering of medicines. Some medicines can trigger depression or mania. New manic symptoms or severe depression in older people can be a result of medication toxicity or interactions.
- People who've been on medications for bipolar disorder for many years can develop long-term side effects, including kidney damage and thyroid abnormalities, which can trigger behavioral changes. In addition, side effects of bipolar medications, including lithium toxicity, are much more common in older adults. When someone experiences worsening mood symptoms, the doctor needs to carefully consider medication-related problems as possible causes.

Addressing dementia and bipolar

Declining cognitive function — ranging from mild memory issues to severe dementia — can present with mood and behavioral symptoms, including irritability, impulsivity, low energy or motivation, sadness or apathy, and inappropriate emotional responses. A careful evaluation for dementia is critical in someone presenting with new mood symptoms or in someone with bipolar who appears to be getting worse with age. Bipolar disorder is associated with higher rates of dementia in later life compared to the general population. Some of this may be specific to bipolar, and some may be overlap with Alzheimer's and other dementias.

Evaluation for dementia often starts with a Mini Mental Status Examination (MMSE) and/or the Montreal Cognitive Assessment (MoCA). If these exams suggest evidence of cognitive decline, the doctor orders more detailed cognitive or neuropsychological testing. Medicine, combinations of medicines, and many different medical conditions can cause symptoms of dementia. So just as with mood and behavioral symptoms, after dementia is detected, a full medical work-up is required to rule out treatable causes of the cognitive changes.

Medication issues for older adults

Medication profiles for older adults with bipolar differ from those of younger populations, and doctors must consider these differences when choosing medications and determining the proper dose. In this section, we point out key issues for choosing treatments, especially medication, for older adults.

Treating mania

The same medications are used to treat mania in all adult groups, but the goal of limiting the number of medications is very important for older people. Note the other differences:

- **Lithium:** Kidneys are likely to function less efficiently with age, so lithium levels may build up more quickly, causing toxicity symptoms to occur at lower doses. In addition, a number of medications, including nonsteroidal anti-inflammatory drugs (NSAIDs), angiotensin-converting enzyme inhibitors, and thiazide diuretics can raise the lithium level.
- **Anticonvulsants:** Valproate (Depakote) remains in the bloodstream longer in older adults; plus, it interacts with many other medications. Carbamazepine (Tegretol) has been effective in treating mania in older adults, but it has many potentially dangerous interactions with other medications. Lamotrigine (Lamictal) has shown to be effective in maintenance treatment in adults over 55 years old.
- **Antipsychotics:** The recommended dose of atypical antipsychotics for older adults is generally one-half to one-third the dose prescribed for younger adults. However, both older (typical) and newer (atypical) antipsychotics carry significant risks in elderly people with dementia, because they're associated with increased risk of death most often due to heart problems or infections. These medications must be prescribed carefully for older adults. (See Chapter 7 for more information.)
- **Electroconvulsive therapy (ECT):** ECT has proven effective in treating acute mania and depression in older adults with bipolar disorder and may be considered for someone who's not responding to or can't tolerate medications. (For more about ECT, see Chapter 9.)

Treating depression

Treating bipolar depression is always a challenge — no matter how old you are. Options for treating older adults are similar to those for the general population, with some variations:

- **Antidepressants:** An antidepressant–antimanic combo is a common treatment choice for older adults, but possible side effects, impact on other medical conditions, and drug interactions must be considered.
- **Lithium:** This is a standard part of antidepressant care for many people with bipolar disorder, but as previously noted, it carries increased side effect risks in older people.
- **Atypical antipsychotics:** Quetiapine and lurasidone are medications in this family that are used to treat bipolar depression. They carry additional risks (as previously noted) that must be considered when choosing them for the elderly.
- **Lamotrigine (Lamictal):** Evidence suggests that lamotrigine is effective in preventing and treating bipolar depressive episodes in older adults.
- **Psychotherapy and self-care:** Psychotherapy and social interventions are often useful in treating depression in older adults, especially if medication isn't an option or isn't fully effective. Maintaining social connections, regular physical movement, and enjoying pleasurable activities are important for improving mood, but they can be harder to access for some older adults. Mobilizing these activities can make a big difference.
- **Optimize sensory input:** Vision and hearing decline in older age, and these changes increase risks of mood and cognitive problems. Make sure optical prescriptions are up to date and glasses are accessible and replaced when lost. Regular ophthalmologic checkups can monitor for cataracts, glaucoma, and macular generation, any of which can cause vision problems in older people. Regular hearing tests and keeping hearing aids or devices up to date, charged up, and readily accessible help with mood and thinking.
- **Electroconvulsive therapy (ECT):** ECT has proven effective in treating depression in older adults and may be considered if you're not responding to or can't tolerate available medications.

Treating anxiety and sleep disorders

Because older bodies eliminate medication more slowly, sedating medications (such as those used to treat anxiety and insomnia) can build up over time. This can cause problems with memory and concentration. And long-term use of benzodiazepines and sedative/hypnotics carry some risk of changes to cognition, even when maintained at relatively low levels in the blood. Because these problems build slowly, the link to medication may not be obvious. It's important to reevaluate the benefits and risks of taking these medications as you get older.

4 Developing Essential Survival Skills

IN THIS PART . . .

Discover what you can do beyond medication to manage your moods, such as mood monitoring, self-care strategies, and lifestyle adjustments that may help reduce or eliminate triggers that often contribute to mood instability.

Find out about psychosocial therapies that have proven effective in managing bipolar disorder and reducing the frequency and severity of symptoms.

Obtain guidance on how to improve your communication and problem-solving skills to alleviate or reduce the frequency and intensity of interpersonal conflict.

Find tips on how to plan ahead for a major mood episode so that you and the rest of the people on your treatment team are better equipped to reduce an episode's severity and duration and manage the fallout that commonly results from such an episode.

IN THIS CHAPTER

- Keeping track of your moods, sleep patterns, and energy levels
- Recognizing what really sets you off . . . and addressing it
- Exploring therapies, mindfulness, and other approaches

Chapter 11

Exploring Self Help and Professional Therapies

In the midst of a major mood episode, you may be powerless to help yourself, but after the episode subsides and you feel more like your old self, you can begin to engage in therapy and self-help efforts that have proven useful in maintaining mood stability and warding off future episodes. Simple, free activities include monitoring your moods, sleep patterns, and energy levels and getting involved in a local support group. Professional help is also available in the form of various psychotherapies, mindfulness training, relationship and family therapy, and group therapy.

In this chapter, we explain different ways you can monitor and manage your moods on your own and with outside assistance. We also encourage you to keep track of how different treatment tactics work for you so you can do more of what works and less of what doesn't.

Monitoring Your Moods

One of the most useful activities you can do to help in your recovery and avoid mood meltdowns is to monitor your moods. Mood monitoring offers the following benefits:

- Increases your awareness of your moods and fluctuations
- Serves as an early warning of impending mood episodes
- Helps gauge the effectiveness of medications and therapies

REMEMBER

Go to `finkshrink.com/bonus` for a mood chart to help you monitor your moods and track variations over time. You can use it to record your mood every day on a scale of +5 (manic) to −5 (depressed). Normal, baseline is 0. Simply place an X in the box that best represents your overall mood level for each day — even if your mood hasn't fluctuated, see if you can note the overall tone of the day. Keep in mind that some people experience symptoms of depression and mania at the same time. If that's true for you, be sure to record them both. This means that one day may show a +3 and a −4.

The Notes area at the bottom provides space for you to log any medication changes or significant events that affect your moods on any given day. If you already have a calendar, just write a number in every daily block from +5 to −5 to indicate your mood level.

For a more comprehensive mood and wellness tracking system, the Depression and Bipolar Support website offers downloadable sheets that you can fill in and keep notes on to monitor mood, energy, sleep, and other important markers of your mental health. Visit `www.dbsalliance.org/wp-content/uploads/2020/07/DBSA-WellnessTracker-07.20.20-FLT.pdf`.

Share your mood charts with your doctor and therapist. The daily information can help you identify your stressors and triggers, manage your medications, and track the success of your treatment. When your doctor or therapist asks you how you've been doing since your last appointment, the charts enable you to answer accurately with data.

Sharing this information with a trusted family member or partner may add value to this process. Sometimes their feedback will match your experience, and sometimes they will offer insights you didn't observe. This process works only if the other person can offer feedback nonjudgmentally and without escalating into their own dysregulation or anxiety about your moods.


TIP

If you have a smartphone, consider installing an app for monitoring bipolar moods. Search your device's app store for "mood tracker app" to find options for digital mood tracking systems. These types of apps provide an easy way to monitor mood along with sleep, energy, and other key markers of your mental health. You can usually customize them, and after you have entered some data, they can generate graphs and charts that can give you vivid visual representations of your symptoms.

More and more of these appear online every day, but research to back up their benefits and risks lags behind. Try a few before deciding which one works best for you. Many are free or low-cost, but check before registering for any products or services that charge high upfront costs or monthly fees. Also check their privacy practices. If you're not tech savvy, ask a more experienced friend to set up your phone or device to minimize tracking and data collection.

Charting Sleep and Energy Levels

A decreasing need for sleep is an almost universal early indication of an impending manic episode, while an inability to get out of bed is a pretty good indicator of depression. We encourage you to keep a sleep log or at least note on your mood chart or daily calendar how much sleep you're getting and what your daily energy level is.

Most digital and analog mood monitoring systems include an option for recording how long you sleep every day, but you don't need a complex system. Simply record the total number of hours you sleep each day on any calendar or in a notebook, including naps, and record your energy level for that day on a scale of 0 to 5. (You may find that your energy level is a pretty good reflection of your overall mood for the day.) The mood chart we provide online at `finkshrink.com/bonus` has an area for recording the number of hours you sleep and your energy level each day.


TIP

If you're tech oriented, consider using some type of activity tracker that can measure sleep patterns as well as activity levels during the day — a gadget that syncs to a smartphone app. The new smart watches may be ideal for tracking activity.

You can use your sleep log to identify early warning signs and patterns that you may need to address for optimum mood stability. Monitor your sleep log each day for the following patterns and warning signs:

- **Increasing need for sleep:** If you're sleeping more and your energy levels are sinking, your mood may be on a downswing.

- **Decreasing need for sleep:** If your energy levels are climbing and you're sleeping less, you may be working up to a manic episode.
- **Trouble falling asleep or staying asleep (insomnia):** Most people take about 20 minutes to fall asleep and have some awakenings at night but can fall back to sleep pretty quickly. If you're taking a long time to fall asleep, waking up frequently in the night and can't get back to sleep, or waking up very early in the morning and can't rest again, take note of these red flags, particularly for depression.
- **Variations in sleep patterns:** If you're sleeping in on weekends, taking long naps during the day, and/or unable to sleep when you normally go to bed, then you may need to work on regulating your sleep patterns.

If you're having trouble falling asleep or sleeping through the night, flip to Chapter 12 for suggestions.

Identifying Stressors and Triggers

People, places, jobs, events, seasons, and even holidays can play a significant role in your mood stability. By identifying your mood triggers and the primary sources of stress in your life, you can begin to remove them or at least diminish the toxic effects they have on your moods.


REMEMBER

The body reads all highly charged environmental stimuli as stress whether it's strongly negative or strongly positive. So triggers can range from situations that feel bad or uncomfortable to those that feel especially exciting or stimulating. Some studies suggest that manic episodes can follow a big positive life event.

Jot down the major sources of good and bad stress in your life, along with situations that seem to trigger depression or mania. Here are some common stressors and triggers that may help you identify your own:

- **Seasonal shifts:** Certain seasons can trigger mood problems for some people. Spring seems to usher in more mania, while the winter months tend to bring on depressive episodes. Daylight saving time may also contribute to mood and sleep irregularities.
- **Holidays:** Holidays often deliver a double dose of dysfunction: They disrupt a carefully structured routine and frequently place you in contact with family members who may be exciting or irritating. Planning for the holidays may include sticking to your daily routines, avoiding or limiting contact with certain

people and situations, and consulting your doctor for a short-term medication adjustment or the addition of an anti-anxiety med.

- **Work- or school-related stress or conflict:** Conflicts with coworkers, irregular hours, unreasonable goals, and unpredictable job responsibilities are just a few of the on-the-job stressors that may contribute to the onset of bipolar symptoms. Promotions, new responsibilities and expectations, and the completion of major projects can also trigger stress reactions, so watch out for those, too. For children, adolescents, and young adults, back-to-school demands and transitions to a next level of education (such as from middle to high school or from high school to college) are common triggers.
- **Relationship issues:** Relationship conflict is a common cause of stress. It may arise from numerous sources, and bipolar disorder can contribute to it by seeking out conflict to feed its insatiable appetite for stimulation or simply from the manic and depressive symptoms themselves. The cycle of conflict and symptoms can be difficult to break. Highly positive feelings and events in relationships can also be stressful. If avoiding or ending a negative relationship isn't possible or desirable, then you and the other person may need to work on addressing the challenges together, perhaps with the help of a qualified therapist.
- **Parenting issues:** Raising children is stressful, and it can be even more so when bipolar disorder is part of the family. The birth of a child is a huge life event, and parenting affects your sleep and other life patterns in ways that are often unpredictable. If you find yourself arguing frequently with your children or partner about parenting duties and approaches, then parenting is probably a stressor that you need to address, possibly with the help of a qualified therapist.
- **Financial strain:** Bipolar disorder often strains finances in two ways: It removes sources of income and increases the cost of living. If you're worried or arguing over money, consider finances as a source of stress. In Chapter 18, we provide suggestions on how to overcome the financial setbacks that often accompany bipolar.
- **Downtime:** In modern times, having too much to do is more common than not having enough to do; but having too little to do or coming down from a period of high activity can trigger stress as well. In quiet times, the mind may ruminate on worries or negative thoughts. Structuring some of your downtime and keeping your brain and body engaged in tasks or activities can help minimize this source of stress.

WARNING

Don't try to fix everything at once. Make a list of your stressors and triggers and deal with one issue at a time, in order of importance.

Exploring Therapies That May Help with Bipolar Management

Although medication is the first-line treatment for bipolar disorder, several therapies and other supports have proven effective in helping people with bipolar disorder maintain mood stability. In the following sections, we introduce you to these therapies and provide exercises and resources you can use right now to sample each approach.


TIP

You may need different types of help depending on the symptoms or problems you're experiencing. If you're struggling with depression, for instance, your focus may be on overcoming negative thoughts, increasing your involvement in positive activities, and finding more support in your important relationships. If your mood is stable, you may want to concentrate on maintaining a healthy routine and keeping an eye on early warning signs of a mood episode. If instead you're experiencing mild symptoms of mania, you may need to explore techniques for managing impulsivity and irritability.


TIP

Keep track of your treatment successes and failures in a journal or some other document. In one column, list what has worked for you in the past; in the other, describe what hasn't helped. This record can be very useful for you and the people on your treatment team as you try to find the best tools for maintaining mood stability.

Psychoeducation

Psychoeducation is a type of therapy that can improve your treatment outcome by educating you about bipolar disorder and making you more aware of symptoms and early warning signs so you can more effectively maintain mood stability. Through psychoeducation, you gain the following benefits:

- A clearer understanding of bipolar disorder causes and treatments
- Knowledge of why medication is necessary
- Insight to how therapy can help
- Improved ability to recognize symptoms that signal the onset of a mood episode
- Insight to the stressors and triggers that may contribute to your mood shifts
- Confidence that proper treatment can improve your condition
- Strengthened resolve to adhere to your treatment plan

This book is a type of psychoeducation. You can also learn more about how to effectively manage bipolar disorder from doctors and therapists, support groups, group therapy, and websites and blogs that provide accurate information (not all do).

REMEMBER

One of the main goals of psychoeducation for bipolar is to improve *insight* (your ability to recognize warning signs) in the early stages of mania or depression, so you can take steps to prevent a full-blown mood episode.

Cognitive behavioral therapy (CBT)

If you've ever beaten yourself up over something you said or did, you're well aware of your brain's power to turn against you and make you feel terrible. *Cognitive behavioral therapy* (*CBT*) is based on the concept that thoughts are major drivers of emotional and behavioral responses. CBT is designed to guide you toward recognizing and recalibrating thoughts and behaviors that interfere with your goals for healing and recovering. A subset of CBT is called *exposure response prevention (ERP)*, which works to modify your physical, cognitive, and emotional responses to internal and external stimuli through exposure techniques, gradually increasing exposure to these triggers to help reduce those responses. ERP is most often used to treat anxiety and OCD symptoms, but it has uses in mood treatment as well, especially depression.

When examined as a step-by-step process, CBT that includes ERP looks something like this:

1. **Identify distorted thoughts and beliefs that trigger *unhelpful* emotional and behavioral responses and/or reinforce other symptom patterns.**
2. **Quiet your brain to become aware of thoughts and beliefs that are central to recurrent disruptive emotional and behavioral patterns.**
3. **Practice using more observational (rather than judgmental) language to begin replacing, reframing, and/or "talking back to" the unhelpful thoughts and beliefs.**
4. **Develop and practice new, more helpful behaviors based on the evolving thoughts and beliefs.**

ERP begins by developing a list of easiest to hardest symptoms to approach. This list guides the development of assignments to gradually increase levels of exposure to anxiety or mood triggers, sometimes purposefully triggering controlled responses that enable the brain and body to change big reactions to smaller ones.

Within CBT are a variety of subtypes of approaches, which means you can work in ways that feel best to you. These approaches include the following:

- **Therapeutic journaling** uses writing about thoughts and feelings in connection with personal experiences as a tool for healing. It can help identify patterns of thought and behavior that may be causing distress. This approach has specific use in some PTSD treatments, as well as more general use for mood and anxiety symptoms.
- **Behavioral activation** works on increasing engagement in activities to create positive mood experiences. During depressive periods, people may struggle to engage in even the smallest of tasks or activities, which becomes part of a negative mood spiral because those activities could improve mood. Behavioral activation meets someone where they are (however reduced their activity is) and works to build up activity beginning with the smallest of steps (for example, getting out of bed and moving to a chair) and transitioning to bigger challenges (such as taking a walk or texting a friend).
- **Acceptance and commitment therapy (ACT)** grew out of CBT, but it takes a more intentional approach to accepting and experiencing all your thoughts, feelings, and sensations rather than trying to avoid them or change them. This approach focuses on identifying your values — how you want to live your life — and connecting with all experiences, including unwanted or negative ones. It works on building skills to change how you relate to those experiences to create behaviors in line with your values.
- **Mindfulness-based cognitive therapy (MBCT)** merges CBT with the practice of mindfulness-based stress reduction (see the later section, "Mindfulness and other centering activities"). MBCT uses all types of mindfulness including meditation, controlled breathing, and disciplines such as yoga to nonjudgmentally connect with feelings, sensations, and thoughts as part of working to reframe and replace unhelpful patterns with ones that serve to reduce mood and anxiety symptoms.


REMEMBER

A qualified therapist can teach you techniques to help you identify and modify unhelpful thoughts, beliefs, and behaviors. But much of the actual change happens when you practice these skills and strategies between sessions. You and your therapist will agree on assignments, often referred to as "homework," to work on between your meetings.

As in sports when you practice well before a big game, practicing your CBT work daily, when your mind is quiet and life is settled (not during a full-blown mood episode), is more effective because the brain has a tough time learning anything new when it's out of control. With new skills firmly in place, when the dust hits the fan, your brain will be poised to keep itself clearer and more focused than it otherwise could.

Psychotherapists have used CBT successfully for years to treat unipolar and bipolar depression. CBT is also a primary treatment for anxiety and obsessive-compulsive disorder. Because antidepressants often aggravate mania, CBT can be an important tool for helping to alleviate depression in ways that can reduce the need for medication and its undesirable side effects. Brain scans have shown that CBT actually changes activity levels in brain regions related to mood and anxiety — decreasing overactivity in some *circuits* (pathways between brain cells) and increasing the activity in underpowered circuits. Like medication, CBT is a powerful modulator of brain activity at its most basic cellular levels.

Theory has it that CBT may also help with early stages of a rising hypomanic or manic episode by toning down overly positive, optimistic beliefs to bring them more in line with reality. Research is less prevalent for this application of CBT than for its use with depression, but the potential benefits of CBT in mania are being explored.


REMEMBER

For more about CBT, check out *Cognitive Behavioural Therapy For Dummies* by Rob Willson and Rhena Branch (John Wiley & Sons, Inc.). To find out more about ACT, check out *Acceptance and Commitment Therapy For Dummies* by Freddy Jackson Brown, Duncan Gillard, et al. (John Wiley & Sons, Inc.).

Dialectical behavioral therapy (DBT)

Dialectical behavioral therapy (DBT) is a spin-off of CBT that focuses on building a set of skills for regulating emotions, managing interpersonal relationships and conflict, and tolerating distress. Dr. Marsha Linehan developed DBT as a treatment for individuals with borderline personality disorder (BPD), but it has become much more widely used in practice. Through DBT, people become more sensitive to the ramping up of their emotions, and this increased awareness helps them intercept their emotional arousal and respond to situations in an even-tempered, problem-solving way.

DBT traditionally involves work with an individual therapist every week as well as weekly group sessions to develop the fundamental skills and provide participants with opportunities to practice their skills by interacting with others, including friends and family members who agree to participate.

In several studies, DBT has been proven effective for borderline personality disorder. Evidence of its effectiveness in the treatment of bipolar disorder is evolving and some research supports its use. From a practical standpoint, though, DBT often makes sense as an adjunct treatment, because it helps those living with bipolar do the following:

- Identify patterns of emotional responses.

- Develop skills for tolerating and regulating those emotional responses without paralysis or impulsive actions.
- Discover how to effectively navigate interpersonal relationships.

Interpersonal and social rhythm therapy (IPSRT)

Interpersonal and social rhythm therapy (IPSRT) helps you develop a structured routine along with positive personal and social connections. Ellen Frank and her colleagues developed IPSRT at the Western Psychiatric Institute & Clinic at the University of Pittsburgh to reduce the frequency of mood episodes by balancing the stimulation and rest cycles of day-to-day life and resolving interpersonal discord. This therapy typically follows a four-stage process:

- **Initial:** In this phase, you and your therapist develop a detailed history of your disorder, identifying mood episodes and their severity and any life events, medications, or work history that coincided with each episode. The therapist helps you develop an interpersonal inventory, highlighting important people in your life and the roles they play, and assists you in identifying relationships and social activities that support or undermine stable biorhythms. The therapist also provides psychoeducation about bipolar disorder.
- **Intermediate:** In this phase, you gradually regulate your schedule and work toward establishing relationships and participating in social activities that are conducive to regulating your biorhythms and less likely to disrupt them. The goal of this phase is to establish a regular schedule of sleep, wake, and mealtimes.
- **Maintenance:** Maintaining routines in the midst of discord can be quite a challenge. This phase, which can last for several years, helps you identify events and anticipate and resolve conflicts that threaten your rhythm and routines.
- **Termination:** When you no longer need your therapist's help to maintain your rhythm and routines, the therapist leads you through a termination phase, essentially weaning you from therapy.

If you want to pursue this type of therapy, teaming up with a therapist who specializes in IPSRT is usually best; but if that's not an option, the following sections offer a basic do-it-yourself guide.

Identify your natural rhythm

The first step toward a more predictable schedule is to determine your current patterns and preferences. Figure 11-1 provides a daily grid that you can fill out to record your activities for a week. For each day, log your activities from the time you wake up until the time you go to bed, including meals, work, social functions, family time, exercise, naps, and anything else you do. This exercise can help you notice trends in your own natural rhythms — for example, whether you're more energetic and active in the mornings or in the evenings.

Structure your daily routine

After you complete your weekly activity log (refer to Figure 11-1), examine it for the most dramatic variations in your daily schedule and draft a schedule with less variation. Don't make drastic changes that you can't possibly tolerate. Take a gradual approach and keep your own natural rhythms in mind. You can make additional adjustments later. Part of IPSRT calls for formulating goals and expectations for change. When your expectations are realistic, you're more likely to stay on track.

IPSRT helps you identify your most out-of-sync patterns so you can moderate them. For example, if you go to bed at 10:30 p.m. every night except Friday when you stay out until 3 a.m., IPSRT may help you see the value in going out a little earlier on Friday and getting to bed at 1 a.m.

Regulate your interpersonal and social rhythms

As you work toward regulating your schedule, also strive toward building relationships and engaging in social situations that are conducive for maintaining a regular schedule and a stable emotional environment. Everyone's relationships and interests are different, so we can't provide exact details on how to achieve this, but consider these suggestions:

- Avoid or *dose* relationships that tend to disrupt your daily routines or are emotionally charged. (*Dosing* relationships is like adjusting doses of medication; you regulate the frequency or intensity of a relationship and make adjustments over time as conditions change.)
- Identify and address relationship issues that lead to conflict.
- Team up with the people closest to you to support your efforts toward establishing and maintaining a regular routine.
- Get involved in a group that meets regularly — a support group, yoga class, volunteer organization, or church group, for example.

My Daily Activities							
Time of Day	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
6 a.m.							
7 a.m.							
8 a.m.							
9 a.m.							
10 a.m.							
11 a.m.							
Noon							
1 p.m.							
2 p.m.							
3 p.m.							
4 p.m.							
5 p.m.							
6 p.m.							
7 p.m.							
8 p.m.							
9 p.m.							
10 p.m.							
11 p.m.							
Midnight							
1 a.m.							
2 a.m.							
3 a.m.							
4 a.m.							
5 a.m.							

FIGURE 11-1: Record your daily schedule on this grid to determine your personal rhythms and needs.

Maintain your rhythm in the midst of change

IPSRT recognizes that change is an inevitable part of life. People get married and divorced, have children, change jobs, and so on. Part of IPSRT involves anticipating change and developing strategies to replace certain routines while maintaining others. The following ideas can help you prepare for change:

- **Plan ahead for holidays.** Don't let your family dictate the routines you follow. Someone else's rhythms may not coincide with yours.
- **Plan your weekends.** Unplanned weekends can leave you with nothing to do, which can be depressing, or leave you open to unrestrained spontaneity, which can lead to manic impulsivity.
- **Seek immediate treatment for any physical ailments.** Coughs, colds, night sweats, incontinence, and other illnesses can really foul up your sleep-wake schedule and other routines. See your doctor for help.
- **Resolve conflicts as soon as possible.** Allowing conflicts and relationship issues to fester builds tension, which eventually finds a way to express itself. Seek counseling if necessary.

Mindfulness and other centering activities

CBT and other therapies we describe in this chapter usually include many strategies for reducing your emotional charge and quieting your brain, including breathing exercises, meditation, and progressive relaxation techniques. One common feature of all these techniques is *mindfulness* — the process of focusing your brain on the moment and being fully present. Mindfulness focuses your attention on something while letting unrelated thoughts come and go. It calms your nerves and allows you to discover new ways of responding emotionally, cognitively, and behaviorally. In fact, DBT and MBCT use mindfulness as a core technique for quieting the nervous system to provide cognitive and emotional space to evolve more helpful thought and behavior patterns.

Numerous scientific studies support the emotional and behavioral benefits of mindfulness strategies, and imaging studies have demonstrated positive changes in brain and body circuits as a result of mindfulness training. MBCT, a direct descendant of *mindfulness-based stress reduction* (*MBSR*), is a form of mindfulness practice directed at reducing distress, improving attention and *cognitive control* (regulating your mental activity), and enriching life. MBSR was developed by Jon Kabat-Zinn at the University of Massachusetts Medical Center and is now being used widely to treat depression and anxiety, as well as other challenges such as attention deficit hyperactivity disorder (ADHD).

Consider including some form of mindfulness training as part of your therapy to help integrate it into your daily life. Possibilities include the following:

- Breathing exercises
- Visualization techniques
- Progressive muscle relaxation procedures
- Yoga
- Tai chi
- Meditation


TIP

A quick and simple mindfulness exercise is to shift awareness to each of your five senses in turn. While you perform a chore, such as folding laundry or pulling weeds, bring your mind to what you're experiencing in the world at that moment. What do you see? Smell? Hear? Touch? Taste? You may be surprised at what you hadn't noticed around you; in the meantime, you're able to focus your brain and escape the whirlpool of worries, demands, and judgments in your head. Take a deep breath and move forward with fresh mental energy.

For more mindfulness techniques, check out *Mindfulness For Dummies* by Shamash Alidina (John Wiley & Sons, Inc.).

BEYOND MEDICATION: TAKING CARE OF MYSELF


BIPOLAR BIO

I'm a 48-year-old author and blogger from Slovenia. In 1996, I was diagnosed with schizoaffective disorder, bipolar type — a mixture of schizophrenia and bipolar disorder. Now I'm a rather calm and, for the most part, mentally healthy girl.

Taking my medication is only a part of what I do to stay healthy. I start my day with a Phyllis Krystal (`www.phylliskrystal.com`) method of meditation called The Maple. While meditating, I burn incense and listen to soft instrumental music. I also do yoga daily, and I love to take long nature walks. Throughout the day, I do various exercises according to the Phyllis Krystal method, such as the Fear Exercise when I'm scared or the Anger Exercise when I'm angry. Occasionally, I also engage in the Cutting the Ties Exercise, which is designed to free me from control of people, thoughts, and behaviors, including bad habits, addictions, and destructive roles I often get stuck playing. From 2006 until today, I have cut about 20 ties.

Since 2009, my work-at-home job as an author and blogger has relieved a great deal of stress and provides me with a flexible schedule to perform the exercises that help me maintain my health. I used to be an avid runner but now find short hikes to be more relaxing, and I find a great deal of solace in drawing and painting in my spare time.

— Helena Smole (www.helenasmole.com), author of *Balancing the Beast: A Bright View of Schizoaffective Disorder — Bipolar or Manic-Depressive Type*

Relationship and family therapies

Family therapy can be very effective in helping family members come to terms with bipolar disorder and work together as a team; it also tends to improve the prognosis for the person who has the diagnosis. Therapy that includes psychoeducation, communication skills (see Chapter 13), emotional regulation (see Chapter 12), and problem-solving strategies (see Chapter 14) can help family members acquire much needed knowledge and skills to support one another.

Group therapy

Group therapy leverages the power and connections of social interactions and connection to enhance other forms of mental health care. Various types of groups serve different purposes and can include the following:

- Psychoeducation and skills training brings people together with a professional to increase awareness and knowledge around specific health and mental health issues. For example, a bipolar disorder psychoeducation group may help newly diagnosed patients and families/caregivers learn about bipolar disorder and develop basic skills for managing the condition.
- DBT group is a fundamental component of DBT. The basic skills "modules" are taught in group settings with multiple adults or, if the patient is a child or adolescent, with multiple families. The patient has an individual therapist as well.
- CBT groups are variations on the individual CBT model in which the same basic principles are applied with groups of patients and/or family members. Creating group versions of CBT can improve access to care when individual therapists are in short supply. Groups can also be less expensive per session.
- Support groups led by professionals are considered group therapy, unlike support groups run and led by people with lived experience, such as those described in the later section "Getting Involved in a Support Group." Support groups led by professionals typically bring people together around a shared

concern such as grief, specific physical illnesses, specific mental illnesses, and caregiving. The leader guides and encourages the conversation, offering expertise when needed. These groups help participants feel less alone while providing opportunities for shared ideas and solutions from people with lived experience — not just from a professional.

Exploring Online Resources

Over the past couple decades, the world has become increasingly digital. In nearly every industry, including healthcare, resources have been moving online. And thanks to the COVID-19 pandemic, this movement has accelerated, especially in education, healthcare, and self-help.

As a consumer, you have more resources available than ever through the click of a button or a tap of a screen, but you need to be careful. Although more resources are available, some may not be the right fit for you, others may be misleading, and many are rip-offs or scams. In this section, we provide the guidance and insight you need to make well-informed choices as you explore online resources for help with managing bipolar disorder.

Weighing the pros and cons of online care

Prior to the COVID-19 pandemic, virtual care was available but not so prevalent. Some clinics offered services to patients in rural settings via remote setups, with some companies starting to offer online therapy. Now, however, nearly every mental healthcare clinic offers virtual sessions, and companies offering virtual appointments exclusively have become big business.

As a consumer, you need to decide whether virtual care is right for you. Meeting with your mental healthcare providers online may make the most sense if you're in any of the following situations:

- Living far from providers
- Working long or unusual hours and scheduling in-person sessions is difficult
- Living with a disability that makes travel or access to your provider's office difficult
- Raising children and needing to find and pay for childcare to come to sessions or having to work around the many different schedules in the household

- Struggling financially — some online therapy companies offer lower cost options, including therapy via text and email (video sessions may be less expensive than in-person visits, but not always)


WARNING

Insurance coverage for these newly evolving therapy options is not always clear, so be sure to check with your insurance company before choosing a provider. Also, the quality of the therapy is still inconsistent as this business has exploded rapidly and staffing with therapists has been a challenge.

Be sure to consider your preferences and those of your provider. For example, you may relish the privacy and convenience of an online therapist and/or psychiatrist. Texting your therapist intermittently, rather than having a weekly session, might be a better fit based on your attention span, lifestyle, or temperament. On the other hand, you or your therapist may prefer meeting in person. Staying focused and reading social cues may be more difficult over video. You may feel more comfortable and protected interacting in a separate space and time. Or the appointment may be a rare time you have outside of home or work that is part of the therapy process for you.

Ultimately, the decision of whether to meet remotely or in person is up to you and your provider. In some cases, what's best is a combination of in-person and online sessions. Discuss your options with your provider, being sure that your personal preferences and needs are considered.

Differentiating information from misinformation

The Internet is chock full of mental health information, but studies have shown that the vast majority of it is inaccurate at best and potentially harmful at worst. So how can you tell what's what? If you're looking to the Internet for professionals with information or people with shared experiences to commiserate with, keeping an eye out for misinformation is critical. To avoid misinformation, follow these guidelines:

- If anyone claims to have a "shocking new finding" that no one else knows about or claims that they are the only one who can help you, block them and move on.
- If something sounds too good to be true, it is.
- If you find information that you think relates directly to your treatment plan, don't do anything until you've spoken to your treatment team.

- Don't respond in any way to any contact that you didn't initiate. Don't reply to any text messages or click any links in text or email messages that aren't part of conversations you started.
- If a company is offering online therapy of any kind, do extensive research and due diligence before signing up and giving them payment or personal information. Read independent reviews (not on the company's website). Ask someone you trust what they think.

Getting Involved in a Support Group

Friends and family have much more invested in your well-being than any third party, including your psychiatrist or therapist, but other people who have bipolar (or a loved one with bipolar disorder) may be able to offer much more in terms of empathy, insight, and connections. Bipolar support groups can offer the following advantages:

- Camaraderie with people who share your experiences and emotions
- Understanding that a mood disorder doesn't define who you are
- Motivation to follow your treatment plan
- Opportunity to rediscover strengths and humor you thought you lost when you became ill
- Insider information on medications, treatments, and therapies
- First-hand perspectives of local doctors and therapists
- Information about your legal rights
- Tips about education and IEPs (individualized education plans) for children with bipolar disorder
- Access to credible books and videos about bipolar

You can tap into the resources a support group offers by joining one. Organizations such as the Depression and Bipolar Support Alliance (DBSA) and the National Alliance on Mental Illness (NAMI) sponsor support groups in most cities and many towns to help people with mental illnesses find peer support and encourage advocacy. To find out about support groups in your area, contact the following organizations:

- **Bipolar Scotland:** Visit www.bipolarscotland.org.uk.
- **Bipolar UK:** Visit www.bipolaruk.org.uk.
- **Church:** Many churches provide meeting places for support groups, including those affiliated with DBSA and NAMI.
- **Depression and Bipolar Support Alliance:** Visit www.dbsalliance.org.
- **Local mental health centers:** Most states and large counties have mental health services that can refer you to support groups in your area.
- **Mental Health America:** Call 800-969-6642 or go to www.mhanational.org.
- **National Alliance on Mental Illness:** Call 800-950-6264 or go to www.nami.org to find contact information for local NAMI affiliates.
- **Your psychiatrist or therapist:** Ask your psychiatrist or therapist for information about local support groups.

What can you expect when you walk into your first support group session? That depends on the composition of the group and its organization. Some groups are more structured than others. Some invite experts in the field to give presentations; others encourage members to talk about their emotions and engage in group problem solving. Generally, you can expect members to be very open, welcoming, and willing to lend an empathetic ear.

If you have trouble finding a local support group that suits your needs, consider expanding your search to online support groups. Many organizations offer virtual support groups, which can expand the number and types of support groups you can explore. Always remain cautious online (as explained in the previous section) as you check out online groups.


TIP

Every support group has its own chemistry and dynamic, so don't give up if you feel out of place at the first one you visit. Try a few groups until you find one that feels comfortable. And if you don't like support groups, that's okay, too; not everyone is comfortable in a support group setting.

IN THIS CHAPTER

- Creating a healthy home environment and getting in a healthier groove
- Connecting with supportive friends and relatives
- Alleviating stress through physical activity
- Eating food that nourishes and supports you
- Getting a support or service animal . . . or a pet

Chapter 12
Making Lifestyle Adjustments

When you survive a major mood episode, the whole experience can scrub the sleep out of your eyes and give you a clearer vision of life. You're reborn in a way, baptized by fire. After a period of mourning for the passing of old plans and expectations, you may find this time liberating. It offers an opportunity to start anew — to reinvent yourself, create a life that's more manageable and rewarding, and paint new dreamscapes.

That's what this chapter is all about. Here, we lead you through the process of restructuring your life in a way that helps you maintain your mental health and achieve a meaningful, rewarding existence.

Cultivating a Healthy Home Environment

If you have bipolar disorder, your home becomes your sanctuary, and everyone in your home needs to brush up on bipolar disorder and work together to create an environment that's conducive to your recovery and the mental wellbeing of the entire household. In this section, you discover various ways to tone down the emotional volume and set healthy boundaries.

Educating all household members

Everyone in your home, from Grandma to toddler, needs to know the basics of bipolar disorder (in developmentally appropriate ways, of course), including how it affects you and what they can do to help. If your housemates are on a different page, they may work at cross-purposes and undermine any potential progress. For example, if someone in your household "doesn't believe in medication," she may make offhand comments that discourage you from taking your meds.


TIP

Sensitivity is important, but be sure that the home environment encourages open communication. Successful management of bipolar disorder is much more likely if everyone is involved in the discussion and has an opportunity to ask questions and voice concerns. Consult your loved ones to determine the best time and the most effective way to open discussions and present information. Having other household members read this chapter is a good way to start the discussion.

Note to family members: A common mistake that family members make is to begin discussing issues without involving the person who has bipolar disorder. Don't create a secret society with the goal of protecting your loved one. Doing so can make her feel as though everyone wants to gang up on her — as if she's the family problem.

Setting a more structured schedule

Some households can function quite well with individual family members following different schedules, but if the person with bipolar disorder relies on the rhythms of other family members, the entire family may need to work together to establish an adaptive schedule and routine.

For example, if Junior likes to have his buddies over on Friday night to play video games until 2 a.m. but that particular activity at that time disturbs the rest of the household, he may need to move the party to a friend's house or reschedule it for earlier in the evening. Sorry, Junior. For more about the importance of structure, see the later section "Establishing Healthy Routines."

Cranking down the volume

You don't want to turn your home into the neighborhood "SHHHH!" zone, but all your housemates should be aware of how their voices, stereos, guests, and televisions affect the other people living in the house. Here are a few suggestions to muffle the noise:

- **Crank down the stereo, the TV set, the computer speakers, and other noise producers.** Headphones are a must-have. Keeping a few extra sets around the house can be a quick crisis prevention and management strategy.
- **Limit the shouting from room to room.** This is actually a good basic rule: Have conversations only when you're within speaking distance and preferably having already made some eye contact. Surprise commentary, questions, or demands, especially delivered loudly and facelessly, can push buttons for everyone, but especially for those individuals working hard to regulate moods and reactions.
- **Avoid slamming doors, banging pots and pans, and stomping from room to room.** If you're angry and need to move forcefully, try walking or running around the block, hammering away at a project in your garage, or energetically moving your body in other ways that can defuse your emotions without setting off anger/fear alarm bells in the home.

Reducing conflict and criticism

Some studies show that in families with high levels of conflict and criticism, people who've had a major mood episode are much more likely to suffer a relapse. Researchers use the term e*xpressed emotion* (*EE*) to refer to the levels of criticism, hostility, and emotional over-involvement or over-protection. Although *expressed emotion* sounds as though it refers to the expression of all emotions, it doesn't. The term comes from research that associates high levels of negative patterns of emotional communication with higher rates of relapse into episodes of mental illness, including depression and possibly mania, although the connection to mania is less clear.

Any emotional expression that can make a loved one feel nervous, anxious, angry, frustrated, or guilty (for having the disorder or for not meeting some expectation) falls in this category. A high level of conflict and criticism in the home — even if it's indirect — can destabilize someone with a mood disorder. Every family member must be a caregiver to some degree, so all family members must work

together to establish a healthier emotional tone. The following three approaches can contribute significantly to dialing down expressed emotion in your home:

- Learning more about bipolar disorder typically increases empathy for the diagnosed family member, thus reducing expressions of criticism, blame, and emotional over-involvement. Discovering how to focus anger and frustration on the illness and not the person with the illness is a critical starting point.
- Improving communication skills helps family members express themselves in healthier ways. (See Chapter 13 for more about communication.)
- Enhancing problem-solving skills enables you to resolve issues logically and rationally. (See Chapter 14 for problem-solving strategies.)

Considering the kids

If you have children living with you, they suffer from the fallout of bipolar disorder as well. As a guardian, you may need to physically protect your children from any harm during extreme mood episodes, but shielding them from learning about the disorder is usually a mistake. Perhaps even more than adults, children need to understand what's going on. Otherwise, their developing brains, which are still self-centered, shift into high gear, and they may think that they're the reason why Mommy and Daddy are fighting or why Mommy's crying.


TIP

When explaining bipolar disorder to young children, use age-specific language. *Depression* and *mania* may mean nothing to a 5-year-old, so use phrases like "Mommy gets really excited sometimes and can't calm down" or "Daddy can't help getting really sad, even when everything is okay" to help your children understand what's going on. Just be sure to leave some time for questions and answers. Encourage your children to express their perceptions and emotions. Actively and empathically listening to your children and tolerating any and all questions and responses without judgment goes a long way in helping them cope with a parent's bipolar disorder. Using play and other nonverbal expressions such as art, dance, and music can also be wonderful ways to help children express themselves and be part of the family story.

Establishing Healthy Routines

By establishing healthy routines and making efforts to build them up a little at a time, you can improve your hold on your general wellbeing and often prevent depression and mania from establishing a foothold. If you're committed to being in bed only eight hours a night and up and about the rest of the time, for example, no matter how you feel, you may prevent some mood episodes or reduce the

severity of them when they do occur. Your routines help keep the sleep and energy changes of depression and mania down to a dull roar.

In this section, you find out how to regulate your sleep and schedule social activities to gain more control over your moods, while giving yourself some wiggle room for a little variety.

Regulating your sleep

Show us a person with bipolar disorder, and we'll show you a person who sleeps too much, not enough, or not deeply enough. The disorder messes with your sleep patterns, and your disrupted sleep patterns often aggravate your moods. To remain healthy, get some sleep. The following suggestions can help you establish a regular sleep schedule:

- **Go to bed and get up at the same time *every* day.** Refer to Chapter 11 for suggestions on how to build a structured schedule.
- **Nap only if it's part of your sleep routine.** Napping is like snacking: It can ruin your appetite for sleep. If you're napping and having trouble sleeping at night, try decreasing or stopping the naps as a first step toward getting better nighttime sleep.
- **Don't fight insomnia.** Ordering yourself to sleep is usually counterproductive. Use some of the centering exercises in Chapter 11 to quiet your thoughts, or engage in a quiet activity, such as reading.
- **Avoid caffeine and other stimulants.** Sleep specialists say that any caffeine after noon impacts your sleep. If you have sleep problems, keep this in mind. Also avoid spicy foods, alcohol, nicotine, decongestants, and other enemies of sleep.
- **Turn off the TV.** If you have a TV or computer in the bedroom, consider moving it out. If you simply can't miss an episode of your favorite show, record it to watch later. If music helps you fall asleep, great; otherwise, turn off the tunes.
- **Transition to sleep mode.** Avoid all stimulating input, including phone calls, TV shows, work or schoolwork, and computer activities, for one full hour before bedtime. The very nature of phone calls and work wakes you up, and computer and TV screens shine light into your eyes, signaling the brain that it needs to be awake instead of sleeping. Stick to reading, listening to quiet music, and doing other soothing activities instead.
- **Turn on a fan.** Monotonous noise, commonly referred to as *white noise,* helps some people sleep. It may also block out more disturbing noises, such as dogs barking. Some people like other types of soothing background sounds such as ocean waves, rain, trains, or highway sounds. Track down something you like and download it to your phone for some comforting background noise.

EMBRACING IMPERFECTION

Nowadays, everyone needs to be perfect: the super mom, the beauty queen, the sensitive male hunk, the successful investor, the apprentice, the swan. And if you don't stack up to what society and culture expect from you, you'd better get to work. Head to your neighborhood bookstore, load up on all the self-help books and videos you can carry, and pile on a few magazines while you're at it. And don't forget to turn on the TV to get blasted with more messages that you're not good enough, smart enough, or talented enough to make it. And social media has magnified this constant comparison to others into monster proportions.

Today's society and media glorify perfection, and people doggedly pursue it, often to the point of self-destruction. Families can't just be made up of loving individuals who hang out together; they have to be "amazing" and achieve some incredible goal. A loving, available mom doesn't quite make the cut unless she has a certain body type and wears the right clothes and makeup to complete the package.

Learning to accept yourself, imperfections and all, is the only key to achieving genuine satisfaction and peace. People with bipolar disorder discover more quickly than others that you can't keep trying to do more and be more. You have to evaluate what you need to do and what you love to do and then carefully sort through everything else that gets piled onto your plate. The word *no* must be become your mantra because people will always ask you to do one more "little" thing. If you're a working mom, you probably can't make it to every school function. If you or your spouse has bipolar disorder, you may have to decline a few dinner invitations. Maybe you can't have your children in organized sports because you don't have the time to get them there. Perhaps you can't take on a promotion that will saddle you with ridiculous hours. Only you can make these decisions and live with them. But whatever you choose to do, don't let society define perfection and set unrealistic goals for you. "Doing it all and doing it well" isn't a realistic option for most people, let alone people living with bipolar disorder. "I am good enough" is a solid affirmation to reel in the pounding self-criticism for not being perfect.

- **Don't exercise right before bedtime.** Unless, of course, you consider sex exercise. Exercise often acts as a stimulant, so try moving your exercise time to earlier in the day.
- **Get family support.** If family members keep you awake at night or encourage you to stay up later than you know is healthy, explain how important it is for you to maintain your sleep routines. If that doesn't work, you may need to be firmer and clearer about what you'll be doing to manage your sleep and what the outcomes will be if family members can't or won't support your actions.

- **Work with your doctor.** Ask about changing the time you take your medications, adjusting dosages, or switching/adding medications to help with sleep. If your meds don't put you to sleep soon enough or leave you groggy in the morning, you may need to take them earlier in the evening.

Scheduling social activities

Remaining social as bipolar ravages your life can be quite a challenge. When depressed, you may shun company. After a manic episode, you may hesitate to mix it up with your usual circle of friends, especially if you said or did something embarrassing during your last episode. But maintaining social contact on a regular basis often delivers these and other valuable benefits:

- Regulates your schedule and adds activity to your day.
- Connects you with others who can often lift your mood.
- Offers you a chance to be present for others, which often feels good in moderate doses. Being a friend to someone, just being a good listener, can often bring you satisfaction and a sense of connection to others.
- Widens and reinforces your support network.
- Provides a social context that enhances your perspective.
- Reduces isolation, which may contribute to depression.


REMEMBER

Not everyone is a social butterfly, so don't feel as though you need to pack your schedule with social events. Some people value their time spent alone much more than others. But try to get out of the house regularly, even if it feels a little painful at first.

Leaving room for spontaneity

Some people think the perfect vacation is to ride around on a tour bus, visiting roadside attractions. Others prefer to ramble about on their own, searching for hidden gems. And some are content to sit in one place and watch the world go by. Knowing yourself and your own temperament is critical to creating successful outcomes for any activities or plans.

If you enjoy a more freewheeling lifestyle, a rigid routine may feel like too much starch in the collar. To loosen up, program some unplanned time into your schedule. Put regulations on your sleep, work, and meal times, but leave the remainder of your schedule open. Alternatively, people who thrive on structure and predictability may do better with minimal unplanned time.

TIP

To ensure successful long-term changes, consider making minor adjustments over an extended period of time. You're unlikely to follow through on dramatic changes that don't align with your temperament.

Enjoying Nourishing Foods

When you're feeling depressed or manic, your diet is likely to change. You may not notice when you're full and eat more than your body asks for. Or, you may hardly eat at all because you don't notice when you're hungry. You may crave comfort foods more than usual. You may have minimal energy to prepare meals, so you fill up on fast foods and snacks. In manic periods, you may try to fast and "cleanse" your body, causing you to avoid eating meals or drinking enough fluids.

REMEMBER

Avoid judging your changed eating patterns as failures or "being bad." That kind of self-criticism only feeds the negative mood spiral and creates unpleasant and conflict-driven relationships with food and eating.

The following basic principles of eating for well-being can be helpful guideposts as part of maintaining your overall health and managing risks for mood episodes:

- Eat regularly — three full meals a day or several small meals throughout the course of a day. Importantly, make sure to eat when you're hungry. Restricting intake or trying to white-knuckle through hunger is risky business for mood management.
- Don't skip meals, especially breakfast, if possible. Some people aren't remotely hungry when they first wake up, but try to make time to eat something as soon as your body is ready. Don't put off eating until lunchtime if you feel hungry at 10:00 a.m.
- Eat a well-balanced diet, including plenty of vegetables, fruits, nuts, and whole grains.
- Consume coffee and alcohol in moderation, if at all.

TIP

Even if you can't bear the idea of food first thing in the morning, try to get something in, even just a glass of milk or a handful of nuts. Get something into your system before starting your day. Breakfast (breaking the overnight fast) is essential to well-being because the brain doesn't function well on fuel that comes from the breakdown of stored fat or protein which is what happens when you've

been fasting all night. Your brain needs fresh fuel to function; regular food intake is the only way to keep the brain sharp. If you skip breakfast, your brain is operating on "fumes" — the fuel tank is literally running dry, and this impairs all kinds of brain function. A spread of eggs and bacon every day isn't necessary, but try to get a little protein and a little fat into your belly to hold you through the morning. Donuts and sugary cereals aren't the best choice, as we explain in the next section.

TAKING CARE OF MY BRAIN

For me, the goal of making lifestyle adjustments to manage bipolar disorder is to give my brain what it needs to function well, and that means *everything in moderation*, especially the basics — sleep, diet, and exercise:

- **Sleep:** A good night's sleep is essential. I need a solid eight hours each night. When my sleep patterns are off, it's usually my first sign that something's brewing. Too much sleep, and I'm tilting toward depression. Not enough, and I'm getting manic.
- **Diet:** A well-balanced diet nourishes my brain. When I'm manic, I tend not to eat much or drink enough water. When I'm depressed, I crave junk food and tend to overeat, which makes me even more lethargic.
- **Exercise:** Getting outside and walking is one of my favorite forms of exercise. I also find yoga, breathing techniques, and meditation to be great ways to de-stress and maintain a healthy lifestyle. But too much exercise can send me straight into a manic episode, and too little turns me into a couch potato.

When my brain chemistries are out of balance, even the relatively small challenge of maintaining moderation in all things is difficult. After 20 years of struggling with bipolar disorder, I finally realized that I also needed to adjust my attitude. I needed to come to terms with being bipolar. Once I accepted my diagnosis, I stopped brooding. When I stopped feeling sorry for myself, I took responsibility. And once I owned it, I gained control over my disorder instead of letting it control me. I learned to manage my illness with foresight. If I'm truly honest, I know when I'm slipping into an episode. Identifying the early signs and getting professional help before it gets out of control is a skill worth honing.

— Janine Crowley Haynes (janinecrowleyhaynes@gmail.com), freelance writer and author of award-winning memoir *My Kind of Crazy: Living in a Bipolar World*

Cutting back on simple carbohydrates

Sugar, sweets and foods such as white rice, potato chips, cookies, crackers, and white pasta are packed with simple carbohydrates that often take your body on a roller coaster ride of sugar highs and lows. You may feel an initial energy surge, but 30 to 60 minutes later, you'll probably crash as your blood sugar drops, leaving you drained and craving your next fix. Whole grains can help keep your blood sugar more stable, so including them as much as possible can be a boost to managing moods.

Watch out for hidden sugars in products such as bread, cereals, yogurt, crackers, protein bars, snack bars, fruit juices, coffee drinks, fast food, and many other processed or prepackaged foods. When you start reading labels, you'll be surprised at how much sugar is in some of those products. Even more deceptive, some food companies use a bunch of different types of sweeteners so they can put them farther down the ingredient list. The list always moves from the highest percentage ingredient to the lowest. So although all the sugars together in a cracker may add up to the highest or second highest percentage ingredient, if food companies divide the sugar content into many different sweeteners, the names of all of those sweeteners move down the ingredient list, making it much harder to sort out. Be sure to check out total sugars as well as the ingredient list.

REMEMBER

A sugary dessert can be a wonderful way to end a delicious a meal or take a mid-afternoon break. Just be sure that you identify your sugar snack as such, and look for way to reduce the unneeded and hidden sugars in the rest of your diet.

Getting your fill of vegetables and fruits

To improve your overall health and wellbeing, increase your daily consumption of fresh or frozen vegetables and fruit, which offer nutritional benefits that are unavailable in most processed foods:

- **Fiber:** Improves digestion and cardiovascular health among many other important body functions
- **Vitamins and minerals:** Provide the nutrients your body needs to develop and function properly
- **Complex carbohydrates:** Provide a steady flow of sustenance and energy throughout the day (instead of the highs and lows associated with refined sugars and starches)
- **Antioxidants:** Prevent and slow cell damage

CHOCOLATE, GLORIOUS CHOCOLATE

Considered by some to be the perfect mood food, chocolate has several ingredients that contribute to mood alteration: a dash of sugar to increase energy and serotonin levels, a pinch of phenylethylamine (a brain chemical that your body releases when you fall in love), smidgens of theobromine and magnesium to enhance brain function, a touch of caffeine to make you more alert, and a few grams of protein to boost the excitatory neurotransmitters. Of course, too much chocolate can give you a bellyache, a definite downer. But a couple squares of dark chocolate, 70 percent or higher in cacao, may be just the treat you need to get over that midafternoon speed bump.

Eating vegetables, fruits, and nuts is also helpful in maintaining healthy populations of beneficial bacteria in your gut. Healthy bacteria in the body, especially in the gut, referred to as the *microbiome,* play vital roles in overall health, including preventing illnesses such as heart disease, type 2 diabetes, gastrointestinal disorders, and autoimmune diseases. As research reveals more about the importance of the microbiome, healthy gut bacteria will likely become a bigger part of the nutrition conversation. High intake of vegetables and fiber is associated with healthier gut *flora* (bacterial collections) and may be one of the connections between a more plant-based food intake and healthier bodies.

Powering up with protein

When you hear the word *protein,* you probably think *muscle.* But protein contributes to many other areas of the body as well. The basic building blocks of proteins are amino acids — building blocks of many of the chemicals the body uses to function, including neurotransmitters, which are essential in mood regulation. When you consume protein, your body immediately breaks it down into amino acids so it can transport them to where your body needs them.


TIP

Obtaining sufficient protein is necessary for stable energy and moods. Meat provides the easiest way to obtain the nine essential amino acids that comprise complete proteins, but vegetarians can get protein by combining complementary food items, such as beans and rice, beans and corn, and whole wheat and peanuts. Vegetarians should also monitor their intake of essential vitamins and minerals (especially B-complex vitamins and selenium); refer to Chapter 9 for information about supplements.

Feeding your brain healthy fats

Fat has gotten a bad rap over the years, but research has shown clearly the vital role of healthy fats in the diet. This doesn't mean you should always slather butter

on your biscuits, but it does mean that you shouldn't go out of your way to avoid all fats — some are actually good for you! Here's the lowdown on good fats, not-so-good fats, and bad fats:

- **Health-promoting fats:** Unsaturated fats, typically labeled polyunsaturated and monounsaturated, are generally good for you. Plant based sources include olive oil and most vegetable and nut oils, including sesame oil. These oils are typically liquid at room temperature. Many nutritionists add coconut oil to this list, even though it's a saturated fat. Animal sources of these fats are primarily seafoods.
- **Health-risk fats (if eaten in high amounts):** Saturated fats are primarily in the form of animal products, including beef, pork, chicken, eggs, milk, cheese, and butter. Most nutritionists recommend consuming such foods in moderation. By the way, one of the top sources of saturated fat in the United States is pizza. Enjoying these foods is not a bad thing, but paying attention to how much of your diet they make up can be important in promoting health across the body, including the brain.
- **Health-harming fats:** Trans fats, typically labeled hydrogenated or partially hydrogenated oil, are the fats to avoid. They're typically found in a wide variety of bakery items and other processed foods, fried foods, and all types of butter substitutes. They increase the risk of heart disease and inflammation, which is at the root of many chronic illnesses. As of June 2018, manufacturers were no longer permitted to add trans fats to their products, but previously manufactured products could still be in circulation and some products may still contain trace amounts.

REMEMBER

Healthy fats are essential for maintaining cell health and function, generating energy, maintaining stamina, and growing healthy babies. They also make food taste good and keep you full. A low-fat diet is deeply unsatisfying and may have indirect effects, such as rebound binge eating to satisfy hunger, an increased craving for refined carbs and simple sugars, and feeling generally unhappy about food and eating. Make sure to include healthy fats in your diet and don't forget to enjoy what you eat.

Banning all comments about bodies, weight, and food

Although you have many nutritional facts to keep in mind when trying to eat foods that support your body and brain, an over-focus on being thin is a huge problem that translates into shaming and judging of people (including ourselves) for the size and shape of bodies. Fat-shaming and fat-phobia are still accepted because of society's glorification of thinness. But these attitudes are extremely harmful and increase risks of depression and anxiety for many people.

Body size is not about willpower. Numerous factors go into any individual's weight and body type, and into one's food intake. Genetics, financial resources, medical needs and medications, culturally important foods, and the food industry's machinations to get people to buy and eat their non-nutritious products are just some of these layers. A person's body size doesn't tell you anything about their health — that's a longstanding myth that needs to be busted.

Supporting yourself or a loved one with bipolar disorder includes paying attention to nutrition, but even more importantly, it must include acceptance and compassion about eating and body size. Comments and attempts to over-control will backfire, increasing risks for mood symptoms and making food and eating painful and unhappy parts of life, which wears and tears on well-being nearly constantly.

As a rule of thumb, the best approach is to ban all comments about bodies, weight, and food toward others and yourself. Shift focus to what bodies can do and who a person is, rather than their appearance. Help to build positive relationship with food and eating — exploring foods that help your body feel good and bring you joy. Eating and food are deeply connected to our relationships, so eating with others is best done without a sense of shame or worry, but rather of connection and community.

Building Healthy Relationships

Relationships can contribute significantly to stabilizing moods. A friend who's more gregarious than you may encourage you to become involved in activities that lift your moods. A companion who's calm and stable may help set a slower pace that keeps your mania in check. This section offers some tips for considering the state of certain relationships and strengthening important bonds that may be suffering through the course of bipolar disorder and other contributing factors.

Checking relationship vitals

Whether you want to work on improving a current relationship or building a new one, remain aware of the following aspects of relationships that can affect mood stability:

- **Healthy shared interests:** If your shared interests consist of drinking, smoking, or taking drugs, consider structuring the relationship around healthier activities or spending more time with other friends.

- **Acceptance and understanding:** Accepting and understanding bipolar may be difficult for you, but it can be even more so for friends and relatives who don't have first-hand experience with it. If these people criticize you for your illness with words or through body language and behavior, the criticism adds to your burden. By becoming more informed about bipolar disorder, the people in your life can learn acceptance and empathy.
- **Appreciation:** The people who love you and find you attractive do so despite your bipolar disorder and also frequently because of it, or at least partially because of it. When building new relationships, look for people who appreciate your attributes and talents. But be careful of people who appreciate your extreme highs and lows too much; they may encourage unhealthy lifestyle choices for their own benefit, even though they may be completely oblivious to the effect of their actions.
- **Support:** Stabilizing your moods requires extra work on your part. You need to manage your medications, make lifestyle adjustments, and possibly even face periods of unemployment and diminished cash flow. During times of crisis, you need supportive people around you to meet both your physical and emotional needs.

Every so often, evaluate your current relationships to determine whether any of them are undermining your mood stability. If you spot potentially harmful relationships, decide whether they're valuable enough to save. You may benefit from ending such relationships and investing your time and energy in new, potentially more productive connections.

REMEMBER

Criticism, demands, judgment, and abuse (physical, emotional, and verbal) have no place in a healthy relationship. Through therapy, you can often identify some of the harmful elements and root them out, assuming all parties involved are committed to improving the relationship. But if you're in an unhealthy relationship and the other party refuses to negotiate, you face the difficult choice of remaining in the relationship and risking your health or leaving the relationship. If you're in an abusive relationship, make sure to seek counsel from someone or an organization familiar with intimate partner violence. Traditional couples counseling may not help; it may worsen the situation. And ending the relationship may increase the likelihood of escalating aggression or violence, so if you're ready to end the relationship, do so very carefully, with outside support.

Having some fun

Cultivating healthy relationships means more than just avoiding conflict and "getting along." It requires that you and your loved ones have meaningful discussions and share experiences that increase intimacy and strengthen bonds. When

bipolar disorder enters a relationship, you can become so caught up in crisis intervention and damage control that you lose touch with each other emotionally. Encourage your loved ones to become involved in family activities, including meal preparation, physical exercise, games, religious or spiritual programs, family outings, and family meetings to discuss plans.


REMEMBER

Mood medication and therapy can do wonders in terms of controlling the symptoms of bipolar disorder, but even a successful combination of medication and therapy is rarely sufficient to return full *functionality* — an ability to carry out all the expected duties as a healthy family member, friend, or worker. Functionality typically improves as you gradually increase your level of involvement and activity in a supportive environment.

Taking breaks from one another

Two people may make for good company for a few hours or days, but after several weeks, even two begins to feel like a crowd, especially when you both have to deal with a long-term health condition. Your loved ones don't need to stand 24-hour watch over you; doing so isn't healthy for you or them. When your moods are cycling, a loved one may need to spend more time and energy as a caregiver, but when your moods stabilize, consider taking a break from each other so you can both recharge your batteries and connect with others. Having outside activities and friendships is healthy for people in a relationship. Maintaining and building these networks of people and interests is especially important in these times of relationship overload.

Getting Your Body in Motion for Joy and Health

You're probably aware that aerobic exercise is good for both body and mind, but you may not know how physical activity specifically helps people with bipolar:

- **Physical activity improves depressive symptoms without inducing mania.** It's a powerful tool for generating and sustaining more positive mood states, and it doesn't carry the risk of triggering mania (although excessive exercise can be a sign of hypomania).
- **Physical activity boosts metabolism:** Bipolar disorder and many of the medications used to treat it commonly lower energy and disrupt metabolic systems. Physical activity helps reduce the risks of these disruptions while improving energy. For more about regulating metabolic factors, see Chapter 8.

You don't need to run a 5K and pump iron every day to get in shape. If your primary goal is to regulate your moods, a 15- to 20-minute daily walk is all you really need. With a daily walk, you can immediately begin to reap the mood-stabilizing benefits of aerobic activity:

- Increased ability to sleep (in many cases)
- Improved digestion
- Increased energy
- Sense of accomplishment
- Feelings of pleasure and happiness triggered by the movement itself

WARNING

If you're considering a strenuous workout routine, consult your doctor first, especially if you're taking lithium. When you perspire, you lose fluids, which can increase the concentration of the medication in your system. In the case of lithium, increased levels can create a potentially fatal condition. Your doctor can recommend ways to reduce the risks.

Avoiding the Stuff That Doesn't Serve You

Caffeine, nicotine, diet pills, alcohol, marijuana, and other uppers and downers form a veritable cornucopia of legal and illegal mood manipulators. If you wash down your antianxiety medication with an energy drink and head out for a night of bar hopping with your buddies, you may be doing more harm than you can possibly imagine. Although these substances may seem innocent enough, they can wreak havoc on your carefully crafted medication combination and attempts at improving your diet and physical activity.

Following is a list of the most common substances that can cause problems. This list isn't exhaustive, and we don't include plenty of dangerous street drugs:

- **Caffeine:** Monitor your caffeine intake and reduce or eliminate consumption. You may not want to break your habit completely. Just remain sensitive to how it's affecting your energy and mood.
- **Nicotine:** Stop smoking or vaping or cut back on the number of cigarettes or vape pens you go through during a given period (day, week, month). This applies to tobacco chewers and cigar aficionados, too.

- **Amphetamines and cocaine:** *Amphetamines* and cocaine are high-powered brain stimulants that can easily trigger full-blown manic episodes or psychosis. If you have a problem with amphetamine or cocaine use, speak to your doctor or seek community support, such as Narcotics Anonymous (`www.na.org`).
- **Alcohol:** Stick to one or two beers or glasses of wine, if you choose to drink at all, or avoid it entirely, if you can, especially if you're taking benzodiazepines or other sedating medications. Alcohol can contribute to depression, reduce impulse control, and interact in dangerous ways with some bipolar meds, especially lithium.
- **Marijuana:** Although marijuana can generate feelings of euphoria, it can also trigger paranoia and anxiety, decrease inhibitions, and affect cannabinoid receptors in the brain that are strongly tied to mood modulation. Because marijuana is still unregulated in many places, its active ingredient, THC, varies in concentration with each batch, so you may not know how much you're getting. But even if you have a prescription for marijuana, or are buying in a recreational dispensary, make sure that all your doctors know about it before you purchase and use cannabis in any form.
- **Weight-loss, energy, and body building supplements:** Many diet pills and energy tonics are laced with potentially dangerous stimulants — some that are just as dangerous as nicotine or caffeine. Consult your psychiatrist before taking anything to help you lose weight or build muscle. Your doctor may suggest other approaches that carry a lower risk of destabilizing your moods.
- **Over-the-counter medications:** Consult your doctor before taking any over-the-counter medications, regardless of how safe they may seem. Be especially cautious of the following:
  - **Pain relievers such as ibuprofen:** Avoid pain relievers such as ibuprofen and naproxen when you're on lithium. Your kidneys clear these meds, which can affect lithium levels, and they can potentially cause kidney damage.
  - **Decongestants such as pseudoephedrine:** Decongestants such as pseudoephedrine (Sudafed) are stimulants and can exacerbate mania or depression or worsen symptoms, even when calming agents are onboard.
  - **Cough suppressants containing dextromethorphan:** Avoid dextromethorphan, a cough suppressant, when you're taking selective serotonin reuptake inhibitors (SSRIs). In some cases, people abuse this medication and take very high doses to induce euphoria. Read the labels and choose a cough suppressant that doesn't use dextromethorphan.
  - **Over-the-counter sleep aids:** Avoid over-the-counter sleep aids unless your doctor gives you the thumbs-up.

- **Herbal and all-natural remedies:** Many herbal medications may sound no more harmful than parsley, but they can be quite powerful. Be especially cautious of ephedra, valerian, kava, and St. John's wort. See Chapter 9 for details about herbal and natural products, and always consult your doctor before adding a substance to your medication brew.

Seeking the Support of a Four-Legged Friend

Animal-assisted therapy has gained many supporters over the years and for good reason. A dog or a cat can provide a sense of calm and good feelings even in dark and difficult moments. Beyond trained service or therapy animals, having a pet of your own may be a valuable contributor to your mood management routines. You may already have a furry family member, but if you don't yet, you might consider it.

The potential benefits include their unconditional love (dogs probably beat cats out here, although cats can be quite affectionate and loving, too), and ever-present friendship. Also, the routines of feeding, walking, and caring for a pet can be valuable in helping you develop your own more predictable schedule to help reduce the risk of recurrent mood episodes.

Potential downsides include the increased responsibilities of caring for another living thing, cost, and making sure your pet is cared for if you get sick or have to go to hospital. Getting a pet is a commitment, and if you're just beginning to adapt to living with bipolar disorder, waiting a bit to make that commitment may be best. But if you have the support and resources to do so, a pet may be a great companion on your recovery journey.

IN THIS CHAPTER

- Setting a tone that's conducive to positive interactions
- Avoiding the top four communication killers
- Using "I" statements to dodge the blame game
- Reflecting feelings to validate them
- Disengaging from lose-lose battles

Chapter 13
Communicating Effectively

In any group of two or more people, effective communication is essential to keeping the peace, maintaining a healthy emotional environment, and facilitating collaboration. When communication breaks down, often due to fear, a lack of empathy, or misunderstanding, emotions heat up and can fuel ferocious interactions in which nobody wins and everyone loses. Add bipolar to the mix, along with the fear, suspicion, irritability, depression, resentment, and lack of impulse control that often accompany it, and even the best efforts of the most well-intentioned individuals fall short.

In this chapter, we offer guidance to help you establish an environment that's conducive to productive communication. We also get you up to speed on applying communication skills and strategies that promote understanding and help resolve conflict.

Setting the Stage

Successful conversations begin with careful preparation and a working knowledge of basic communication skills. In the following sections, we offer tips to help you prepare for productive interactions by explaining how to choose the right time and place, set ground rules, keep emotions and body language in check, and choose words carefully to avoid triggering heated responses.

Choosing the right time and place

Timing and location aren't everything when it comes to successful communication, but they certainly play a big part. Here are some suggestions on how to choose the right time and place:

- **Wait for a relative calm.** Don't try to resolve differences when emotions are heated or someone in the group is experiencing a mood episode.
- **Set aside time for discussion.** Schedule time for difficult conversations; otherwise, they may keep getting put off. Choose times that are convenient for everyone so nobody is in a rush to get somewhere else.

  With difficult topics, a an informal setting can be helpful — for example, while driving in the car or doing the dishes. Counselors often suggest car time for talking with teenagers because it avoids the "face off" that can generate a feeling of being cornered. (However, don't get into or continue a heated conversation while driving; doing so can be dangerous.)


TIP

- **Choose a quiet room free from distractions.** The dining room table is a great place to talk; a table serves as a subtle barrier that gives people a sense of safety and security. Another great place is the living room or den, assuming the TV and computer are turned off and all phones in the vicinity are off or silenced.

  Avoid meeting in a public place unless that's the only place you feel you can safely talk. People are less likely to open up when outsiders can listen in, and this hesitancy diminishes the effectiveness of a conversation.

Establishing ground rules

With all parties gathered, the first order of business is to work together to establish communication ground rules. Encourage everyone to contribute so each person has some buy-in to the rules that the group eventually settles on. Here are some sample ground rules:

- Focus on one issue at a time.
- Stick to observations rather than judgments.
- Take turns.
- Converse at a normal volume.
- Try to find ways to express frustration without profanity.
- Collaborate — no threats, intimidation, or violent behavior.
- Anyone can call for a timeout at any time.
- Really listen; try to be an active rather than passive listener.
- Try to see the issue from the other person's point of view.


TIP

If you can't seem to communicate without arguing, consider recruiting a therapist, friend, or family member to facilitate. Choose someone with a cool, analytical mind whom everyone respects and whose guidance everyone will follow. The facilitator can help enforce the ground rules and ensure that everyone has a chance to be heard.

Watching what you say

Effective communication calls for clarity, honesty, and accuracy, but try to be clear, honest, and accurate in a way that keeps people receptive to what you're saying. Here are some tips for choosing words and phrases that listeners are likely to absorb rather than refute:

- **Express yourself with "I" statements, especially when offering an opinion.** Use phrases such as "I think . . ." and "I feel . . ." to begin your sentences. To dive deeper into "I" statements, see the later section "Becoming Less Confrontational with 'I' Statements."
- **Stick to the present as much as possible.** You can discuss the past to learn from it and improve outcomes, but don't get mired in the past because you can't fix it. Don't use past events to blame or launch attacks against someone as a defensive posture.
- **Don't engage in criticism, judgment, demand, or blame.** In short, all discussion participants need to show respect for one another. See the later section "Avoiding the Four Big Tiff-Makers" for details on avoiding criticism, judgment, demand, and blame.
- **Don't exaggerate.** Do your best to accurately depict a situation and avoid absolutes, such as *always* and *never.* Rarely is something always or never the

case. If you find yourself saying something like, "You never . . . ," you're committing two no-no's: blaming the other person and speaking in absolutes.

- **Avoid comparisons, especially comparisons between two people.** Telling a wife that she's just like her mother or a son to act more like his father is almost guaranteed to elicit a strong negative reaction. Instead of generalizing a person's behavior through comparisons, focus on specific behaviors or issues to discuss.

Keeping a neutral tone

Sometimes *what* you say isn't as much of an issue as *how* you say it. A sarcastic tone of voice, for example, can transform the meaning of a phrase into its exact opposite. For instance, if you say something like, "I really appreciate your love and understanding," in a sarcastic tone, it means "I really *don't* appreciate your lack of love and understanding."

Be sensitive to your tone of voice and try to maintain a tone that's positive, upbeat, and encouraging. Avoid negative tones that convey anger, frustration, and bitterness. Striving toward a more positive tone of voice may even encourage you to think more positively. But if you just can't summon positive feelings, try your best to stay neutral.

Being sensitive to posture, position, and body language

Posture, position, and body language all convey meaning and emotion nonverbally. You can read entire books on the topic of nonverbal communication, but when you're communicating with someone you know pretty well, just be sure to do the following:

- Stand or sit at a comfortable distance from the person, remaining sensitive to personal space. Be at the same eye level; avoid one person towering over others.
- Remain relaxed and nonthreatening. If you feel any muscles, including facial muscles, tensing up, you're probably getting angry, upset, or defensive. Breathe deeply and remind yourself to relax.
- Be and appear attentive. Maintain appropriate eye contact (not staring or glaring) and use verbal and nonverbal cues, such as nodding and saying "yes" or "okay," to indicate that you're hearing what the person is saying.

REMEMBER

Sometimes indirect attention is more appropriate and can make an exchange feel less confrontational. While walking, washing dishes, driving, or engaging in some other activity, you can still remain and appear attentive nonverbally by nodding, saying "yes" or "okay," and using posture and body language to show that you're listening.

- If you're addressing more than one person, shift your attention every one or two sentences so nobody feels left out.

HOW TO APOLOGIZE . . . AND HOW NOT TO

People with bipolar disorder shouldn't have to apologize for what the disorder makes them do, but apologies have the power to heal relationships and liberate everyone involved from guilt and resentment — assuming, of course, that the apologies are sincere and delivered in an appropriate manner. Following are some do's and don'ts for delivering effective apologies:

- **Be sincere.** Apologize only if you truly feel that you played a role in upsetting the person and are committed to not making the same mistake again.
- **Describe what you're sorry for.** Specifying what you said or did that upset the other person acknowledges your role.
- **Validate the other person's feelings.** Describe how you think what you did hurt the other person. Doing so demonstrates that you're aware of the consequences of your words or actions.
- **Don't try to weasel out of it.** Don't try to justify what you said or did, and don't apologize only for how the other person feels. Saying something like, "I'm sorry you feel that way, but . . ." is a self-serving apology. The person you hurt will notice immediately that you're apologizing only to alleviate your guilt and not because of sincere regret for your words or actions.
- **Let it go.** Accept the fact that you have no control over whether the person accepts your apology. Remember that you apologized for that person, not for yourself, so don't get bitter if the person refuses to forgive you.

Keep in mind that an apology isn't always what a person really wants or needs. Sometimes when someone expects an apology, what that person really wants is empathy or validation. Your loved ones may just need to hear that you know they're hurting and understand that although you may not understand why they hurt, their emotions are valid. Sometimes they're not blaming you or expecting you to apologize for something you had no control over; they just need to be heard. See the section "Validating Other People's Feelings" for details.

Adding mood symptoms to the mix

In the midst of bipolar disorder, you're up against more than your average everyday communication breakdowns. Bipolar symptoms and the emotional fallout they leave in their wake undermine the efforts of the most reasonable individuals in several ways:

- **Depression commonly causes loss of confidence and feelings of low self-esteem or worthlessness.** Feeling that way can prevent you from asserting yourself when a situation is unfair or hurtful, and you may resent it later. Low energy can make speaking up for yourself difficult, especially if you aren't good at it to start with. If you're experiencing depression, try to notice how your mood prevents you from speaking up to express your needs. Practicing this skill when you're not depressed can make it more accessible when you're exhausted from depression. You can also ask for help in asserting your needs, possibly from a therapist or friend.
- **Irritability and anger outbursts are common symptoms of mania and depression.** When you don't feel well, you may be more likely to impulsively say or do things that you later regret. If you're feeling irritable, try to use mood regulation skills or other self-calming strategies that you have learned to cool down before responding to others or making statements that may fuel conflict.
- **The emotional fallout from having to live with bipolar disorder may lead to persistent relationship issues that surface whenever certain topics arise.** If previous mood episodes resulted in sexual indiscretion, for example, that could fuel future conflict. Resentment over having to take medication or a perceived loss of status in the family can lead to conflict, as well. Fear, suspicion, regret, and other powerful emotional responses can also play a role in destabilizing relationships.

Although medical treatments can help remove the bipolar symptoms from the equation, therapy is often necessary to help those with bipolar disorder and their loved ones deal with the big and small upheavals that contribute to conflict. The emotional damage that bipolar leaves behind is often as difficult to repair as the illness is to treat.

Avoiding the Four Big Tiff-Makers

Conflict often arises when someone feels attacked. When the person who feels threatened goes on the defensive, the exchange can turn ugly and counterproductive. One way to prevent someone from feeling threatened is to avoid the four

major factors that tend to put people on the defensive: criticism, judgment, demand, and blame. These approaches seek to control someone rather than understand them, and they shut down effective communication and problem solving.

Criticism

Criticism (especially if not balanced by positives and empathy) wears people down and triggers anger and/or fear, which immediately shuts down collaboration. So instead of dishing out criticism, try fostering a light attitude in which you accept people for who they are.

For example, parents of an out-of-work adult son who has bipolar disorder may feel compelled to urge him to get a job or move out, because most adult children have achieved these goals. Instead of criticizing his lack of action, the parents may try to ask how he feels about his situation, validate his feelings, and together develop a strategy that reflects his story and not just what they expect.

Judgment

Judgments are often a knee-jerk response when someone doesn't meet your expectations such as "He is so lazy. He sleeps all day." Like criticism, judgment is a tool of power and control that often masquerades as helping someone else to "be better." It triggers strong emotions in the person being judged and reduces the likelihood of effective problem solving.

To reduce the amount of judgment that makes its way into your life and relationships, follow these steps as best as you can:

1. **Recognize judgment in your daily communications.**

   Notice how you feel when you're being judged and how people respond when you're the judge. Notice how your feelings change when you internally judge yourself.

2. **Accept or at least tolerate your differences.**

   Acceptance/tolerance must be mutual for communication to gain traction.

3. **Understand or acknowledge the source of your differences.**

   Everyone has reasons, knowledge, and experience that inform their belief and value systems. Sometimes understanding the source of a person's beliefs and values leads to tolerance, if not agreement.

Demand

Demands go hand in hand with criticism and judgment as ways to try to control another person's behavior. Of course, asking someone to do something for you is perfectly normal and acceptable. In certain formalized relationships (such as between a boss and employee), demands are expected. With loved ones, however, issuing demands rather than approaching tasks and problems in a respectful, collaborative way is far less likely to get the desired results. Even if you get what you want, demands typically trigger backlash and emotional fallout as part of a cycle of pain and hurt that only reduces effective problem solving.

Blame

Blame is the natural outcome of criticism and judgment and is, by its nature, a way of issuing demands on others to change their behaviors. Blame is personal and about the past. The keys to overcoming it are to focus on the present and approach every issue as a problem to be solved. Everyone involved should participate in solving the problems that arise. If you feel a need to blame something, blame the illness. But don't blame yourself, and definitely don't blame a loved one who has bipolar disorder — it's not your loved one's fault.

THE FIVE-TO-ONE RULE

Drs. John and Julie Gottman, researchers, have found that the ratio of five positive feelings/interactions to one negative feeling/interaction during a conflict was an important part of stable and durable couples' relationships. This ratio helps in many settings, including parenting and other adult interactions. Building up positive interactions creates a closer emotional connection that can withstand disagreements more adaptively.

Keeping an eye on the ratio of positive interactions to negative ones can dramatically change the dynamic between adults and between adults and children. You don't have to put on fake compliments or grit your teeth and not express your concerns. But if you spend time building up a protective wealth of positive feelings, you can manage conflicts more adaptively.

Examples of positive interactions include validating the person's emotional response, being genuinely curious about the person's experience, really listening without interrupting, noticing their efforts and things they do well, offering encouragement, using humor (but not harmful teasing or sarcasm), making small gestures of appreciation (a note, a card, a text), reminding them how much they matter to you, and many others that you can think of and lean into.

Becoming Less Confrontational with "I" Statements

An "*I" statement* is a way to express what you're thinking or feeling without putting the other person on the defensive and giving that person something to argue about. Here's an example of the bad and better way to phrase a statement:

Bad: *You* stay up too late watching TV, and I can't sleep.

Better: *I* can't sleep with the TV on.

The "you" statement blames the person for staying up late and making it impossible for you to sleep. Blaming puts the person on the defensive, and saying that the person stays up too late gives him something to argue about: "I don't stay up too late!" or "The TV isn't that loud!" or "Maybe you go to bed too early!"

The "I" statement merely says you can't sleep when the TV is on. By omitting blame, you avoid criticism and judgment and don't place a specific demand; more importantly, you leave things open to problem solving. The conversation that begins with an "I" statement has a better chance of developing into a problem-solving session focused on meeting both people's needs — one person needs to sleep; the other needs to stay up and watch TV.

Here are a few more examples:

Bad: (You) Hurry up!

Better: I really don't want to be late.

Bad: You embarrassed me when you started talking about bipolar disorder at the dinner table.

Better: I was embarrassed when the topic of bipolar disorder came up at dinner. I don't like talking about it in public.

Bad: You need to back off and stop attacking me every time I disagree with you.

Better: I feel as though I can't express myself when we have a disagreement without causing a scene.

Bad: You criticize me for everything!

Better: Sometimes I feel as though I can't do anything without being criticized for it.

TIP

In the middle of a disagreement, remind your loved ones that you still love them and you still care. During disagreements, when feelings get hurt, remembering the positive connection can be difficult. Being reminded of your bond can help redirect your loved one's emotions to solving the issue at hand and away from the fear and anger that often take over when one person thinks the other has stopped caring or has checked out of the relationship. Reassuring people that you haven't stopped loving them keeps this fear and anger out of the mix, and the whole situation just feels better. (For more about problem solving, see Chapter 14.)

REMEMBER

The only thing worse than a "you" statement is a "you always" statement. Rarely does someone *always* behave or react in the same way. Don't exaggerate or make something sound worse than it really is. That tends to derail productive conversation into an exhausting exchange over what exactly was said and how.

Validating Other People's Feelings

Feelings (emotions) are brain and body responses that grow out of intricately connected systems responding to external and internal stimuli. You feel emotions all the time, and they give you information about how you're doing. Despite their central role in function, feelings themselves aren't logical. Your brain plugs feelings into complex equations to make decisions about your behavior, and most of the time emotions seem to match the situation. But because emotions aren't built from reason or logic, they can often bubble up in ways that don't fit the situation.

Feelings that don't make sense can range from temporary reactions, such as "Why am I so angry at my friend — I am so happy for their new job" to the more extreme mood states of bipolar disorder. And although you may have a hard time understanding your own feelings, people around you may be even more confused, feeling frustrated by emotional responses that don't make sense to them.

Validating emotions — acknowledging that feelings are not good or bad on their own, that they don't always make sense or seem reasonable — provides a foundation for effective communication, with ourselves and others. When you feel something that doesn't make sense to you, you can avoid a self-critical thought spiral if you don't judge the feeling, but rather experience it and use it as information to guide your actions.

When communicating with others, validating their emotions even when you don't understand them can open up the conversation instead of shutting it down. Negative feelings such as fear, anger, bitterness, jealousy, and so on are at the root of many interpersonal conflicts. Validating the other person's feelings can

relieve pressure in an emotionally charged interaction. You demonstrate that you want to understand what that person is feeling and acknowledge that the person's feelings are valuable to you even if you don't understand them.

Validating is one step beyond reflective listening. With *reflective listening*, you merely acknowledge that you've heard and understood what the person said. With *validation*, you're saying it's okay to have that feeling, even if you don't understand why they feel that way (they may not always understand why they feel a certain way either). Here's an example of a typical interaction with four different responses:

Opening statement: I'm so angry with all of you! Whenever we're in family therapy, everyone gangs up on me, as if I'm the only one responsible for the problems we're having.

Typical defensive response (bad): Nobody's ganging up on you! You have nothing to be angry about. Everyone knows this isn't all your fault.

Reflective response (better): Sounds like you're pretty upset about how our family therapy sessions are going.

Validating response (even better): I get that you're angry. I'd be pretty upset, too, if I felt as though everyone in the family were ganging up on me.

Unconditional/open-ended validation (best): Seems like you're angry and upset right now, which is okay — your feelings are important to me. Can you tell me more about what's going on for you?

REMEMBER

Unexpressed, unaccepted feelings tend to simmer below the surface and ultimately show up in destructive ways — for example, through sarcasm, anger, and sometimes violence.

Validating someone's feelings certainly sounds easy enough, but doing so can run counter to how you may have been socialized to respond. Keeping emotions buttoned up is highly valued in many cultures. If someone expresses a strong emotion, people may respond in one of the following counterproductive ways:

- **Counterattacking:** Big emotions often trigger bigger emotions — fear and anger in many situations. Avoiding the urge to jump into the fray when your own emotions are triggered is a huge challenge. But giving in to an emotional counterattack will quickly regress to blame and criticism, both of which are hurtful and counterproductive interactions.
- **Discounting:** The listener rejects the other person's emotion as invalid by saying something like, "Why are you so angry? No one is trying to hurt you." Don't try to argue against how someone feels. The fact is, the person feels that way.

- **Advising:** The listener assumes that the expressed emotion is a cry for help and begins to offer advice that the speaker never asked for. A good rule of thumb is to avoid offering advice unless the other person specifically asks for it. If you're not sure, ask the speaker something like, "Do you want me to make some suggestions?"
- **Ignoring:** Another way to reject the validity of someone's emotion is to remain silent about it or to try to change the subject, which is nearly equivalent to ignoring what the person said. If you don't know how to respond to something, at least try to indicate that you heard and understand the person by paraphrasing what the person just told you and/or requesting clarification.

Disengaging from Unproductive Conflicts

While no family member is to blame for having or causing bipolar disorder, all family members can work together to try to resolve conflict and keep the tone of unavoidable disagreements to a dull roar. Strong emotions tend to fuel conflicts, which isn't good for anyone involved. If a disagreement begins to heat up, you may need to disengage for a while to let emotions cool. Following are some techniques to help you disengage from heated, unproductive discussions:

- **Call a timeout.** Anger comes in waves. Waiting out the worst of it — away from the person or people you're arguing with — allows for the strongest emotions to settle so everyone can return to the discussion in a more even state of mind. Remember to acknowledge the feelings first, because ignoring them tends to escalate conflict. But everyone needs a chance to disengage. Saying something like, "Don't you walk away from me," is unproductive and an attempt to control someone else's behavior. Taking timeouts or walking away to cool off must always be an option.
- **Share some humor.** Humor can be a great defuser but be careful; it's only funny if everyone laughs. Dismissing someone else's concerns by laughing is likely to trigger more conflict. Yet shared humor as a reminder of affection can be great; humor can help everyone remember that these things blow over.

  Sometimes it helps to remember something that you fought over before but later laughed at because it was really silly or because you figured out what the miscommunication was. Or bring up a memory of a time when you struggled together over something and then laughed about it later.


TIP

- **Take a walk.** Walking helps alleviate conflict in a couple of ways. When you walk with someone, you're physically side-by-side, moving in the same direction, which is less confrontational than face to face. Also, the activity of walking tends to act as an emotional release in and of itself, and if you're walking in a public place, you may be more motivated to lower the tone.

These strategies aren't a magic cure for disagreements, but they often help to de-escalate conflict, and reduce its duration. All people in relationships have disagreements and argue at some point. But finding ways to maintain composure and compassion can keep conflicts from becoming toxic.

REMEMBER

Disengaging is a temporary fix. After emotions cool down, you still need to resolve the underlying cause of the conflict, which you can often accomplish by practicing the communication techniques we describe earlier in this chapter and engaging in productive problem solving, as we describe in Chapter 14. Disengagement is a temporary cease-fire to prevent casualties while regaining composure.

WARNING

Using verbal assaults, calling names, making intimidating or threatening movements or gestures, throwing things, damaging property, and being physically aggressive are never acceptable forms of communication. No matter how someone tries to rationalize these behaviors, they're forms of abuse — plain and simple. If you see these patterns in your adult relationship, talk about it with someone you trust — a friend or family member — and seek support from programs or counselors who work with abuse situations.

IN THIS CHAPTER

- Preparing for a successful problem-busting session
- Focusing on the actual problem at hand and recognizing each person's needs and interests
- Coming up with and implementing solutions
- Steering clear of actions that worsen problems and letting go of problems you can't solve

Chapter 14
Solving Problems and Resolving Conflict

Problems tend to come and go with an entourage of tension and conflict. The good news is that every problem has a solution, usually more than one, that can help alleviate tension and resolve conflict at the same time.

REMEMBER

Many experts and organizations have developed structured approaches to problem solving. In fact, some therapists offer a specific type of psychotherapy called problem-solving therapy (PST). Most structured approaches to problem solving are similar, recommending something like the following steps:

1. **Define the problem.**
2. **Set goals or identify needs.**
3. **Brainstorm solutions.**
4. **Rank solutions and choose the most promising one.**
5. **Implement the solution of choice.**
6. **Evaluate the outcome.**

If your first choice doesn't work, return to Step 5 to try one of the other solutions on the list or go back to Step 3 and brainstorm more solutions.

In this chapter, we recommend a similar approach to problem solving with other people to address not only the problem but also the interpersonal conflicts that accompany it. We also point out some unproductive problem-solving styles and describe situations when letting go of a problem may be the best course of action.

Setting the Stage for Effective Problem Solving

If you're problem solving a solo situation, then setting the stage for effective problem solving is easy: Go wherever you want and mull it over in your own way. Things get more complicated when you're problem solving with others. To set the right tone for a successful — or at least productive — problem-solving session, take the following steps ahead of time:

- **Invite all stakeholders.** Everyone affected by the problem should play a role in solving it. Anyone who's excluded is less likely to follow through on implementing the solution.
- **Set an agenda.** Let all the stakeholders know what you're planning to discuss during the problem-solving session so they can begin formulating ideas. You may have already defined the problem, as discussed in the next section, or you may just sense conflict and want to find out what's at the root of it.
- **Schedule a time block.** Choose a time that's convenient for everyone and after emotions have cooled. Make sure you have at least one hour of uninterrupted time. If you wrap it up in less time, good for you! If you can't solve the problem in an hour, schedule another session.
- **Choose a setting that's conducive to problem solving.** Choose a quiet setting that's free of interruptions, including phones, computers, and TVs. Sitting around a table often makes people feel safe; it also provides a surface for taking notes.
- **Set ground rules.** The first item on your agenda may be to discuss ground rules so everyone feels safe and comfortable. Some good rules to start with remind everyone of basic communication techniques (see Chapter 13):
  - No blaming.
  - No yelling.

- No dwelling in the past (in other words, staying in the present and working toward a better future).
- Stay positive, constructive, and practical.
- Respect one another's opinion, even when you disagree.
- Allow for brief timeouts if emotions escalate and anyone needs to step away for a few minutes.

WARNING

Don't try to engage in problem solving when you or your loved one is currently experiencing mania, hypomania, or depression. In the midst of the mood episode, the problem you need to focus on is the mood episode. Clear thinking is essential for productive problem solving, and trying to resolve problems during a mood episode is often counterproductive.

Identifying the Problem

The first step to solving any problem is identifying what the problem is. One way to identify a problem is to start with how you feel. Are you angry, frustrated, afraid, hurt? Then ask yourself what's making you feel that way. Try to form a statement that starts with the way you feel and ends with the cause. For example, "I get upset when my family treats me like a child" or "I'm afraid we're going to lose our home because we're spending more money than we're earning."

REMEMBER

Keep in mind that if you're problem solving as a couple or as a family or group, one person's problem is everyone's problem; however, each individual may have a different perspective on what the problem really is. Trying to work toward a definition of the problem that everyone can agree on can be challenging. Sometimes you can get through a deadlock by first breaking things down into smaller problems that may be easier to define and agree on.

TIP

Another way to identify a problem, particularly when the problem is causing conflict with another person, is to exchange stories. This method allows everyone to share their perspective on what's going on and perhaps their ideas about the underlying issue. If you can't talk about the problem without arguing, exchange stories with one another in writing. Exchanging stories is most productive when everyone turns off their judgment response and tries to listen actively and be aware of the other person's experience without criticizing or judging the other's perspective. (See Chapter 13 for guidance on communicating without judgment.)

WARNING

Because different sides of any story invariably diverge and these exchanges often trigger big emotions, sharing conflicting stories is usually best done in the presence of a skilled mediator or family therapist who can ask questions, help regulate emotional responses, and facilitate a productive narrative of what's going on. If you choose to exchange stories on your own, give each party an opportunity to present uninterrupted, and then take turns asking each other questions until everyone involved has a clear understanding of everyone else's position. Leave plenty of time and space for emotional reactions to flare and cool down as needed. Try to flesh out what's going on by asking open-ended who, what, when, where, why, and how questions, such as the following:

- Who's usually involved when the problem occurs?
- Whom does the problem affect and how?
- What's happening when the problem occurs?
- What makes the problem better or worse?
- When does the problem typically occur or become most serious? Is the problem more common or serious at a particular time during the day or year or during certain types of events or situations?
- Where does the problem usually occur? At home, work, school, in the car, at a restaurant?
- What are the identifiable triggers — events, words, actions, or emotions — commonly associated with the problem or conflict?
- How have you dealt with the problem up to this point and what have been the outcomes?
- How do other people deal with similar problems? Are their methods effective?

Questions elicit details, and details often deepen people's understanding of the problem and point the way to solutions.

WARNING

The process of identifying problems often gets clouded by past events, other problems, and emotions, especially when you're dealing with a group of people. Here are three tips that can help you avoid the most common pitfalls associated with this stage of the problem-solving process:

- **Stay in the present.** You can't change the past, so don't ruminate over it. This is tough advice to put into practice, so try to develop a way for the group to mediate when discussion is drifting into past hurts and redirect everyone's attention back into the present.

- **Focus on a single problem.** Problems tend to come in waves, but if you try to solve them in waves, you'll drown. Pick the single, most pressing issue. Solving problems one at a time can be difficult to do, so develop a plan for noticing when things are moving away from a single problem and a plan for getting back on track.
- **Remain objective.** Try to view the problem from the perspective of someone who's sitting in the balcony rather than interacting onstage. Doing so can help you develop a more objective perspective and become less reactive and more proactive.

REMEMBER

If you're teaming up with others to solve a problem, good communication is crucial. Chapter 13 offers guidance for communicating with loved ones.

Redefining the Problem/Conflict: From Right Versus Wrong to Unmet Needs

People often view problems, especially those that result in conflict, in terms of right versus wrong. In fact, if your problem were to find its way to a courtroom, the entire focus would be on who's right and who's wrong. The legal system for civil complaints revolves around rights, obligations, and *remedies* — relief that's usually in the form of money for the party who's been wronged.

Unfortunately, loved ones often approach problems as legal battles. They try to argue and prove their case to one another, usually in vain. With no judge or jury to decide the case, issues remain unresolved and often fester.

A more effective approach is to redefine the problem in terms of unmet needs or interests. This approach is one that professional mediators often use to resolve conflict. Here, all parties communicate their needs and expectations and then work together to find ways to address concerns and meet everyone's needs. In the language of problem-solving therapy, this step focuses on identifying goals that meet the needs of all involved.

REMEMBER

The goal of interest-based problem solving is to make all parties winners. Instead of defending conflicting positions, you communicate interests and then work collaboratively to find resources that address those interests.

To identify needs, ask yourself and any other people involved in the situation what they want — what must happen to make you feel that the problem or issue has been resolved? Answers vary depending on what the problem is and whether

you're working alone or collaboratively to solve it. Here are some examples of needs:

- We really need to stop fighting at dinner.
- I need medications that I can't afford.
- I need transportation to work because I lost my driver's license.
- We need to earn $1,000 more every month or spend $1,000 less.
- I need to know that you're safe.
- I need some assurance that you're taking your medications.
- I need for everyone to stop nagging me about taking my medications.

After you've identified everyone's needs and goals, the process moves to the next step of brainstorming solutions and working to find strategies and resources to meet those needs.

Brainstorming Possible Solutions

Now for the fun, creative part of problem solving — brainstorming possible solutions. The goal here is to come up with as many solutions as possible. If you're problem solving on your own, just start jotting down ideas. If you're collaborating with a group, go around the circle and ask each person to contribute at least one idea. Put one person in the group in charge of writing down all the ideas. (A whiteboard comes in handy for this process.)

TIP

Choose the process that works best for everyone involved. Some people do better thinking of solutions on their own and then bringing them to the group, whereas others are most creative in the context of a lively group discussion. The goal is to generate a lot of potential solutions, and there's no single "right way" to accomplish that goal.

REMEMBER

Be creative, not critical. You can eliminate less helpful ideas later, but criticism at this stage discourages the creative thinking that often leads to the best solutions. Have fun tossing around ideas and thinking outside the box.

When you've run out of ideas, switch to feedback mode. (You may want to cross out any solutions you tried in the past that didn't work, but keep in mind that a failed solution from the past may be successful with better planning and execution.) For each solution on your list, jot down a list of pros and cons or do a cost-benefit analysis. Ask questions such as the following:

- How costly is the solution to implement in terms of time, money, effort, emotional investment, and so on?
- Can all parties do what is asked of them? Disabilities, temperaments, and inconsistency of available internal resources must be acknowledged and considered when assigning roles in a solution.
- Which solution, if it works, is likely to deliver the greatest benefit?
- Looking at the pros and cons or costs versus benefits, which solution looks best to everyone?

Rank the solutions to identify the top two or three and choose one. Save the others as backups.

Planning and Implementing Agreed-Upon Solutions

To improve your chances of successfully resolving the problem, develop a plan for implementing the chosen solution. Be sure to include the following elements in your plan:

- **Resources:** Sometimes resolving problems and conflicts requires additional resources, such as alternative living arrangements, money, or transportation. If you've identified certain needs, make sure your plan includes a list of resources to explore.
- **Tasks:** If the solution is complex, break it down into smaller chunks of action to make implementation seem less overwhelming and more doable.
- **Assignments:** Figure out who's going to perform each task and make sure everyone feels up to their assigned role in the solution.
- **Deadlines:** Set a deadline for implementing your plan and perhaps interim deadlines for accomplishing the various tasks. Be sure to discuss flexibility such as "hard" deadlines that can't change versus "soft" ones that could possibly be extended. Having some flexibility in deadlines can reduce anxiety about task completion.
- **Signs of success:** Write a short description of what success will look like so you have a point of reference to determine how successful you've been in solving the problem.

BIPOLAR BIO

PROBLEM SOLVING THROUGH "SELF" EDUCATION

I'm a problem solver . . . no, not the mathematician sort and not some thug you hire to rough up a troublemaker. That's not me! I'm a problem solver who likes to use his mind to figure out solutions — whether the problem is mechanical, as with a friend's vehicle, or emotional. I listen closely, question what's really going on, and then try to come up with possible fixes. So when I was diagnosed with bipolar disorder, my very first thought was, "How can I solve this problem?" Not long after that, I started to realize that bipolar disorder wasn't the problem. The real problem was how I viewed it.

For me, education is key. I'm not just talking about education through books, blogs, and websites, although those sources are all valuable, too. I had to get educated about *myself*. That was the only way to solve the problem I was facing. I had to take myself out of the equation as "the victim" and look at bipolar disorder objectively as a disturbance in the biology and physiology of the brain. When I took the time to learn about myself and how bipolar disorder was affecting my life, I was able to map out a course to recovery.

It was important for me to realize that I'm not living with a character flaw. It's a mood disorder caused by chemicals in my brain. The simple solution is never the simplest treatment. So the first part of solving my bipolar problem was open and honest communication with loved ones; the second part was seeking professional help — through therapy, medications, or cognitive approaches. A final element was to find what works and stick to it.

Personally, I use humor as a stepping stone toward wellness as I courageously continue to work toward real recovery. Family members, community organizations, national and local mental health groups, and drop-in centers have also helped me stick to my road to recovery. It took all my faith, love, support, and hope to benefit from my bipolar self-education and take control so that I could solve the problem that is bipolar disorder.

— Chato Stewart, husband, father, mental health advocate, and cartoonist. He creates positive, provoking, and sometimes even funny cartoons drawn from his personal experience of living with bipolar disorder. You can find Chato online at `www.facebook.com/chato.b.stewart`.

TIP

Consider adding a way to celebrate your success. For example, if you successfully solve the problem or reach a particular milestone, celebrate together with a dinner out or a movie.

With your plan in place, you're ready to roll. Put that plan into action and monitor the situation. Schedule another meeting to discuss your progress. If you've fallen short of your goal, you may need to adjust your plan or ditch it and try another solution (see the preceding section for details on how to come up with other solutions).

Sometimes solving a problem or resolving a conflict is a simple matter of making trade-offs. For example, to get her dad to stop calling her cellphone to check up on her, Tara agrees to call home once a day to let her dad know she's safe. In other cases, you may need to explore available resources. Suppose a loved one with bipolar can't live at home because the situation is too stressful for recovery. The family may look into renting an apartment, having their loved one move in temporarily with another family member, or explore alternative living arrangements through their church or community organizations.

REMEMBER

Resources are usually available to meet everyone's needs, although finding and securing those resources may require some creative thinking and research. If the required resources cost money, check out Chapter 18 for some leads on where to start looking for assistance.

Avoiding Unproductive Approaches

Everyone approaches problems a little differently — rightfully so. But some approaches are typically more constructive than others. The problem-solving technique we present in this chapter — identify the problem and take action to resolve it — seems to work well. But others work, too. Just do your best to avoid the following unproductive approaches:

- **Avoiding:** If you have an aversion to conflict, you may tend to avoid talking about issues or doing anything to resolve problems because you're afraid that the process will trigger arguments. While that may be true, try to weigh the cost of the short-term pain against the relief you're likely to feel from a long-term fix. Problems often become worse and more entrenched over time, so avoidance typically results in temporary relief and a bigger problem to deal with later.

- **Giving up:** Persistent problems can derail even the best attempts at solving them. Fight back by being even more persistent. Every problem really does have a solution if you can get everyone to work together and stick to the goal of achieving a positive outcome. Don't give up!
- **Taking charge:** Declaring ownership of a problem isn't necessarily bad or unproductive, especially if you're working on it alone. In a collaborative effort, however, outcomes improve when everyone involved participates in solving the problem. If you're a take-charge person, you may need to step back a bit and let others play an active role.
- **Talking without action:** Talking about a problem is helpful, but action is usually required to solve a problem. If you notice yourself or a loved one constantly complaining about the same issue, it's time to start planning and acting to solve the issue.

WARNING

First do no harm. Sometimes simply sitting with a problem without taking action is best, at least until you have a promising solution in mind and a solid plan for implementing it. "Sitting with" a situation means to try to be more aware of the situation — taking in the problem and your feelings about it — without reacting or taking action. This process allows for more careful problem solving or gives you a chance to just tolerate the difficult feelings and recognize that some things are out of your control. Even the best plans can backfire and make matters worse, but knee-jerk reactions carry a greater risk of disaster. Do your best to avoid undercutting the trust required to deal effectively with current and future problems. Carefully consider the potential fallout of both action and inaction as you determine the best approach to solve the problem.

Letting Go of Problems You Can't Solve on Your Own

Just because every problem has a solution doesn't mean *you* can solve every problem. Some problems simply aren't yours to solve. And although you may be able to convince someone of the benefits of a certain course of action, ultimately you can't control another person's responses or willingness or ability to follow through. If you're working on a problem that requires someone else's cooperation that you're not getting, you basically have four options:

- Convince or cajole the person to cooperate through encouragement and support; help identify the positives of trying something different, especially outcomes that may help them achieve their goals.

- Enlist the assistance of an objective third party whom everyone trusts and respects to mediate and perhaps offer solutions that nobody involved in the situation has thought of. (The third party can be a friend, family member, therapist, or even a professional mediator.)
- Compel the person to cooperate, such as by contacting law enforcement or working through the courts. This option is usually reserved for cases in which you fear for the safety of yourself or your loved one.
- Let go of the problem and do whatever possible to shield yourself from it. In other words, set and enforce boundaries. (See Chapter 12 for more about setting boundaries and expectations.)

REMEMBER

Keep in mind that the problem-solving approach we outline in this chapter is just a starting point. Certain situations call for additional or more specific strategies. For example, financial problems call for an exploration of external resources, as we explain in Chapter 18. For problems that are rooted in ineffective communication, everyone involved may need to build communication skills; see Chapter 13 for details. If you're dealing with work- or school-related issues, turn to Chapters 17 and 21 for some solutions that can help deliver positive results.

IN THIS CHAPTER

- Keeping all your care providers in the loop
- Preventing a mood episode from spinning out of control
- Checking out the psychiatric facilities in your area
- Jotting down everything your loved ones need to know in an emergency
- Signing medical releases to facilitate communication among care providers

Chapter 15
Planning Ahead for a Mood Episode

Have you given your loved ones consent to talk with your doctor in an emergency? Should they call other family members? If so, whom? When they reach someone who can help, what do you want them to say? Should they freeze your bank or credit card accounts? Do they have power of attorney to do so? Don't wait until an episode is underway to address these questions. By then, you and your loved ones should already have the answers.

If the idea of sitting down with your loved ones to discuss the "what ifs" of bipolar disorder is a little overwhelming, don't panic. This chapter provides information that can help you develop a personalized emergency plan so you and your loved ones are prepared if a crisis hits.

Teaming Up with Your Care Providers

Doctors and therapists are helpful when you're not feeling well or you have a specific problem; but when you're doing fine, they rarely bring up the painful topic of "what if?" As in, what if symptoms return or get worse? At your next session with your doctor or therapist, ask the "what if?" question and get details on what to do if you or others start to notice a return or worsening of symptoms. Make sure you discuss the following:

- **What to watch for as early warning signs:** A nearly universal early warning sign is sleep irregularity — sleeping significantly less or more than usual. Here are some other early warning signs commonly associated with mania or depression:
  - **Symptoms of mania or hypomania:** Increased energy, restlessness, or irritability; being extra happy no matter what's happening, rapid, pressured speech (can't stop talking and people can't get a word in edgewise); impulsive speech or behaviors, such as being overly honest or open; overspending on shopping sprees, vacations, and so on; grandiose thinking; hypersexuality/promiscuity; flight of ideas (changing topics quickly in ways that don't make sense to the listener), impaired concentration; inflated self-esteem; increased interpersonal conflicts; starting to see patterns and coincidences everywhere; big ideas and schemes.
  - **Symptoms of depression:** Loss of interest in pleasurable activities; fatigue or decreased energy; social withdrawal; unexplained aches and pains; weight loss or gain or increase or decrease in appetite; unexplained sadness that won't go away; feelings of guilt, worthlessness, or indifference; lowered self-esteem or increase in self-criticism; a sense of hopelessness or despair; increased focus on death or mortality; suicidal ideation (thinking about suicide); suicidal plans (envisioning or planning suicide).
- **What to do when you or others notice your early warning signs:** The first step is to contact your doctor or therapist. She may offer several courses of action depending on the duration and severity of the early warning signs. Actions may include increasing the dose of a medication, changing medications, engaging in more frequent or additional outpatient therapy sessions, or checking you into a psychiatric facility. See the next section, "Thwarting a Mood Episode," for details.
- **Who to give permission to tell you about symptoms they noticed:** You may not want to hear what this person has to say, so choose someone you trust and who can be honest and gentle. Make sure this is someone who sees you or at least talks to you most days.

- **Who's in charge if you become unable to care for yourself:** Lack of *insight* — an inability to notice that something's wrong — is a common symptom of bipolar, so ask one or more trusted people in your life if they would be willing to take charge if you become delusional, disinhibited, or shut down and you can't see that you need help. This job can be difficult — you may react angrily and say mean things to this person when you're in a severe mood state — so be sure the individual(s) you choose know what to expect and what to do in response.
- **How to reach your doctor or therapist during off hours:** If you haven't received emergency phone numbers to reach your doctor and therapist on nights, weekends, and holidays, get them now. Also, ask your doctor or therapist what to expect when you call the number. Will you reach a doctor on call or get an answering service? If you leave a message, how long will it take for someone to call you back? What should you do while you're waiting for that call? What should you do if nobody calls back?
- **Whom to call or where to go if you can't reach your doctor or therapist:** If you end up in the emergency room of a hospital that doesn't have a psychiatric facility, the doctors there are going to want to know which psychiatric facility to take you to. Ask your doctor ahead of time so you know where to go. See the section "Scoping Out Psychiatric Facilities" for details.

Thwarting a Mood Episode

Ideally, effective mood management hinges on prevention. But even when you're doing everything right, you can experience *breakthrough episodes* — symptoms that occur even when you're taking therapeutic doses of medication and receiving other therapies that had been working. This is why mood management requires ongoing monitoring even when things seem to be okay.

When you or others notice the early warning signs of depression or mania (see the preceding section), consult your doctor for guidance. Your doctor may recommend one of the following courses of action, depending on the severity of your symptoms:

- **Discontinue a medication that may be contributing to symptoms.** For example, if you're currently taking an antidepressant and you begin to notice symptoms of hypomania, your doctor may have you temporarily decrease or discontinue the antidepressant.

- **Increase the dose of one or more medications you're already taking.** Your doctor may advise you to take more of a medication that you already take. Depending on the medication, your doctor may order a blood test before making this kind of change.
- **Add a medication.** If your moods have been stable while taking a certain medication, your doctor may prescribe an add-on medication to help treat the same symptoms — at least temporarily, until mood stability is reestablished.
- **Enroll in intensive outpatient program (IOP) or partial hospital program (PHP).** If your symptoms are serious but not a threat to your safety or the safety of others, IOP or PHP may be the best options, allowing your moods to be more closely monitored while any medication changes have time to take effect.
- **Head to the hospital or a psychiatric facility.** If symptoms are serious and pose a threat to you or others, calling 911 or having someone drive you to the nearest emergency room or psychiatric facility is essential.


REMEMBER

The earlier you get help, the more input you have in the treatment approach. If you wait so long that you lose control over your thinking or senses, decisions may be out of your hands.

Scoping Out Psychiatric Facilities

One way to reduce some of the anxiety about hospitalization is to choose a mental health care facility before you need one, assuming you have a choice. Insurance restrictions and the shortage of inpatient psychiatric beds (in many places) may leave you with little or no choice when hospitalization becomes necessary. Ask your doctor for a list of facilities in your area or call your local hospital or community mental health center and get a list of options. With this list, start to filter your choices by answering these questions:

- Which facility does your doctor or therapist recommend?

  Your doctor may "do rounds" at only one or two facilities on your list. In some locations, psychiatrists admit their own patients to a local hospital and function as their patient's primary doctor during the hospitalization. In other areas, a doctor on staff at the hospital takes over the patient's care during the hospitalization in consultation with the outpatient doctor.

- Which mental health care facilities does your insurance policy cover?
- If you belong to a support group, which facilities do your fellow members think are best and worst?

After you've trimmed your list to two or three possible candidates, schedule a visit to each facility. Consider inviting one or more close friends or family members (people in your support network) to go with you so they can provide additional input. Visiting a facility can be an emotional experience, so visit only when you feel ready and expect some emotions to well up.


TIP

Most psychiatric hospitals won't allow you to physically tour the actual patient spaces due to confidentiality, but you can still inspect the public areas of the facility and/or speak to someone by phone to ask specific questions such as the ones in the following list. Some may offer virtual tours of inpatient units. However you get your information, try your best to obtain answers to the following questions:

- Does the facility seem clean and well organized? (Check bedrooms, bathrooms, and common areas, such as the cafeteria and group therapy room.)
- Does the staff seem to treat the patients with respect and empathy?
- Does each patient have her own bedroom?
- Does the facility provide outdoor access? If so, for how much time each day?
- Will you be able to see your doctor, or does the facility have its own doctor who will manage your inpatient care?
- How often will you see your doctor or the doctor on staff?
- How long is an average stay?
- What is the phone call policy for patients?
- What can you take with you, and what is prohibited?
- Does the facility allow smoking — where and when?
- Which days and times are visitors allowed? (Be wary of visiting hours that are highly restrictive.)
- What types of therapy are offered?
- How much time each day can you expect to be in therapy sessions?
- What is the policy on "seclusion and restraint"? (See Chapter 16.)

Documenting Essential Information

Digging through someone's purse or wallet for doctor names and phone numbers or rummaging through the medicine cabinet to piece together prescription information during a crisis is frustrating and often produces a wealth of unreliable information. Fortunately, it's also unnecessary. You should keep a list of all pertinent information in a single document, store it on a computer or smartphone in a format that's confidential but accessible to loved ones, and print a copy for each member of your team. This document should include the following information:

- Current medications, doses, and instructions
- Prescriber's name and office and emergency phone numbers
- Therapist's name and office and emergency phone numbers
- Name, address, and phone number of preferred treatment center, hospital, or emergency room, along with backup choices
- Insurance information, including customer service number and the policyholder's group number and member ID
- Names of people to contact (and not to contact)
- Description of what has and hasn't worked in the past

With the help of your loved one, fill out the Crisis Information Sheet shown in Figure 15-1, distribute it to all the people on your support team, and keep it handy at all times.


REMEMBER

Keep several copies of the Crisis Information Sheet on hand: one at home, one at work, one in your purse or briefcase, and one on your computer or smartphone. Also make sure to keep the information up to date.

Contact Information		
To Call	**Name**	**Phone Number**
Psychiatrist		
Therapist/Social Worker		
Primary Care Physician		
Preferred Hospital/Psych Facility		
Backup Hospital/Psych Facility		
Local Mental Health Crisis Team		
Local Support Group Crisis Responder		
Local Police		
State Police		
Friend/Relative		
Friend/Relative		
Friend/Relative		

Medication		
Medication	**Dose**	**Times Per Day**

Insurance Information	
Insurance Company	
Member Services Phone Number	
Mental Health Services Phone Number	
Member ID	
Group ID	

Work/School Information	
Employer/School Name	
Employer/School Phone Number	
Contact Person Name	
Contact Person Phone Number	

FIGURE 15-1: A sample Crisis Information Sheet.

Signing Releases . . . Or Not

Sometimes laws intended to protect an individual's rights undermine the efforts of others to do what's in the person's best interests. For example, the Health Insurance Portability and Accountability Act (HIPAA) Security Rule may discourage a doctor from discussing a patient's condition with a family member — even if doing so would help the family member deal with a particular situation more effectively.

Your loved ones usually find out about rules like HIPAA when you're in crisis mode and they can't get the doctor to speak with them about what's going on. Don't wait until a crisis occurs. Consider getting legal documents signed in advance so your loved ones can obtain information and act on your behalf when necessary. The documents you may want to sign are a release of information authorization, power of attorney, and advanced directive, as we explain in the following sections.


REMEMBER

You don't have to sign any of the legal documents described in the following sections. Do so only if you fully trust the people named in the documents to use their authorization only when necessary and to serve your best interests.

Keep in mind that HIPAA specifically does not preclude the doctor speaking to family in a medical emergency when patients can't speak for themselves, such as in the emergency room. This practice is standard for medical emergencies and holds true for psychiatric emergencies as well.

Release of information authorization

A *release of information authorization* enables your doctor or therapist to share information about your condition with others. The type of information and the people authorized to receive it are entirely up to you. You can stipulate restrictions in the release itself. Figure 15-2 provides an example of a release of information authorization, though your doctor may have a release she wants you to use instead. (In the U.K., the release of information authorization is more likely to be a part of the advanced statement or directive. See the section "Advanced directive," later in this chapter.)

Provide signed copies of the authorization to your doctor, therapist, and the person (or people) you're authorizing to receive information. Advise each person to store the document in a secure location. Make sure to keep your own digital and paper copies with easily accessible reminders about where to find them when you need them.

REMEMBER

Laws, rules, and regulations may vary from one jurisdiction to another. In addition, people may interpret them differently. Don't assume that just because someone claims that the law prohibits her from sharing information or talking with you that what she's telling you is correct. Check with other reliable sources, such as an attorney who has experience and expertise in healthcare privacy laws in your area.

TIP

Even without a release of information authorization, a doctor or therapist can receive input from a loved one, so if you're concerned about a loved one with bipolar to the extent that you think her doctor or therapist needs to know about it, you can call, email, text, or send a letter to the doctor or therapist expressing your concerns. Just keep in mind that the doctor or therapist may be required or feel obligated to share what you say with your loved one.

Release of Information

Dr. or Therapist's Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____

Consent to Release Information

I hereby give _____ (doctor/therapist) permission to share information — verbal or written — with the following individual/organization:

Individual/Organization Name: _____

Address: _____

Telephone: _____

... regarding:

Myself or My Child (circle one)

Name: _____ DOB: _____

Patient Name: _____

Patient/Guardian Name/Relationship: _____

Patient/Guardian Signature: _____

Dated Signed: _____

This consent expires within one year of date of signing unless otherwise specified here:

_____

FIGURE 15-2: Sample release of information authorization.

Power of attorney

Power of attorney (POA) enables you to designate another person to act on your behalf in a range of matters including financial, legal, and medical — you specify which areas are covered. In the world of bipolar disorder, POA can come in very handy, especially when overspending and impulsive financial and business decisions accompany mood episodes. While the specifics of POA vary by state and jurisdiction, four basic forms are available in most places:

- **Durable power of attorney:** This type of POA stays in effect even if the person who signed the POA (the principal) becomes incapacitated.
- **Medical power of attorney:** Also known as *healthcare proxy,* this POA enables you to designate another person to make medical decisions on your behalf when you're unable to do so for yourself.
- **Springing power of attorney:** Available in some states, this POA becomes effective only when something happens, such as the principal becomes incapacitated. The criteria for what qualifies as incapacitation and who makes that determination are spelled out in the POA. Although the determination is usually left to the principal's physician, legal and privacy challenges may complicate the process.
- **Nondurable power of attorney:** This type of POA is effective immediately and terminates if the principle becomes incapacitated, which totally defeats the purpose of using a POA for help during a mood episode.

Consult an attorney for guidance in choosing a POA that's best for you.

WARNING

A power of attorney relationship is serious and can lead to bitterness and resentment even when it's used in the best interest of an ill friend or relative. Family conflicts can arise when one person has power of attorney and others do not. Be very specific in describing conditions under which power of attorney may be granted and terminated and specifically identify which matters the person with power of attorney is permitted and not permitted to manage.

Advanced directive

Alternatively or in combination with a general or medical power of attorney, you may draw up an *advanced directive* or *advanced statement*, in which you spell out your treatment preferences ahead of a crisis. Two types of advanced directives are commonly used:

- **Instruction directive:** Like a living will, the *instruction directive* enables you to specify which facility you want to be taken to, which medications you want and don't want to take, who's allowed and not allowed to visit you, and so on.
- **Proxy directive:** Like a medical power of attorney, the *proxy directive* enables you to authorize someone to make medical decisions on your behalf in the event that you become incapacitated.

Laws authorizing advanced directives have been enacted in all 50 states in the U.S. and in the District of Columbia, but specific legislation varies from state to state and only a few states have enacted laws that govern psychiatric advanced directives specifically. For additional information and guidance about advanced directives, consult a local attorney. You can find additional information on the web at `www.dbsalliance.org` and `www.nami.org` and a sample Advanced Directive for Mental Health Treatment at `www.dbsalliance.org/wp-content/uploads/2019/10/sampleadvancedirective2.pdf`. Visit `www.nhs.uk/conditions/end-of-life-care/advance-statement` for a good summary of advanced statements in the U.K.


REMEMBER

Advanced directives have several qualities that can be good or bad depending on the situation: They can be used to try to refuse all psychiatric treatment, revoked at any time, and challenged on the grounds that they were signed under duress or that now, when the advanced directive is about to be enforced, the person who signed it claims to be fine. In addition, the treating physician may override a directive if the patient is deemed to pose a threat to self or others. Yet, advanced directives can be helpful in getting the treatment you need and avoiding treatments that haven't worked or that caused problems in the past.

5 Dealing with the Fallout

IN THIS PART . . .

Find out how to deal more effectively with hospitalization and get the most benefit out of the time you spend there.

If your loved one is hospitalized, find out what you can do to help. (*Hint:* It's not much different from what you would do if your loved one were hospitalized with any other illness.)

Weigh the pros and cons of returning to work and, in the process, decide what recovery means to you. Does it mean returning to the life you had or exploring new prospects?

Deal more effectively with financial setbacks by tapping into government programs, filing for disability, accessing sources of free or cut-rate medical treatment and pharmaceuticals, and more.

IN THIS CHAPTER

- Considering the benefits of hospitalization and developing realistic expectations
- Brushing up on patient rights
- Staying comfortable while in the hospital and keeping your doctors in the loop
- Pacing yourself during your recovery

Chapter 16
From Hospitalization to Recovery

Despite your best efforts and those of your mood-management team, breakthrough mood episodes may land you in a hospital or psychiatric facility, perhaps against your will. Hospitalization may be traumatic, but it's also the first step toward regaining both your mental health and your freedom from the debilitating symptoms of bipolar disorder.

In this chapter, we provide information to help you make the most of a stay in a hospital or psychiatric facility. We describe standard operating procedures so you know what to expect; offer tips on how to make your stay more comfortable; encourage you to keep loved ones in the loop; and offer suggestions for healing to minimize chances of a relapse soon after your release.

Coming to Terms with Hospitalization

Few people enjoy spending time in a hospital, but there is an upside. In addition to being a possible lifesaver, hospitalization gives you an opportunity to achieve some important goals. In a hospital setting, you have the opportunity to

- Recover in a safe place.
- Find relief from daily responsibilities, stressors, and triggers.
- Focus your energy on getting healthier.
- Stabilize your medications or switch to more effective medications.
- Engage in therapy to develop better coping skills.
- Find out about community-based services and supports that can help you after you're released.
- Give your loved ones time and space to seek help for themselves.


REMEMBER

Think of hospitalization as a way to reboot your brain after a crash. Try not to worry about letting other people down or falling behind at home, work, or school. Care first for yourself so you can get to a place where you're able to help yourself and function better when you're released.

Knowing What to Expect

Knowing how a psychiatric facility operates *before* you're admitted to one can help alleviate the anxiety that accompanies hospitalization, especially if you're hospitalized against your will. In the following sections, we describe what to expect when you're hospitalized. Keep in mind that every facility is different and every experience is unique.

Seeing the doctor

Waiting to see the doctor, especially when you're first admitted and when you're about to be released, is probably the most frustrating part of a hospital stay. Doctors normally make their rounds once every 24 hours, but on weekends you may only visit briefly with an on-call doctor, who will likely keep you in a holding pattern rather than developing a comprehensive treatment plan. Friday afternoon admissions sometimes mean waiting until Monday morning to see your assigned doctor and making plans for major medication changes. That can seem like an eternity when you're locked up, manic or depressed, and not thinking clearly.

Adjusting your medications

The doctor's first order of business is to evaluate your condition and prescribe medication. Because your symptoms were serious enough to land you in the hospital, you may need increased doses of first-line medications. If you were taking medications that have a relatively poor track record for treating acute mania or depression or that may be worsening your symptoms, the doctor may discontinue them and try something else. (See Chapter 7 for more about medications.)

The doctor's goal is to extinguish your mania or depression as quickly as possible. Because the inpatient stay is usually quite brief — one to two weeks at most — you'll complete your recovery from your acute mood episode in some type of outpatient setting. After you recover from the episode and experience several weeks of stable moods, you and your regular doctor can discuss the possibility of scaling back or stopping certain medications.

Engaging in therapy

Most facilities provide individual and group therapy sessions that begin at about 9:00 a.m. and continue into the early evening. In short, expect a fairly full schedule. Therapy sessions may include patient education, coping skills, reflection, spirituality, pet therapy, occupational therapy, art therapy, group or community sessions, mindfulness training, and other individual adjunctive therapies. Most facilities offer some form of family support, too, to help your loved ones better understand what's going on and strengthen their communication and problem-solving skills.

Looking into seclusion and restraint policies

Federal regulations mandate that hospitals use seclusion and restraint only when "absolutely necessary" using the "least restrictive alternative." Some facilities and personnel are better than others in using de-escalation skills (such as listening closely to patients, responding to their concerns and needs, and staying calm while encouraging patients to use self-soothing strategies) to manage aggressive and violent behaviors without the use of restraint or seclusion, but when these efforts fail, facility staff may restrain patients by using one or more of the following means:

- **Physical restraint:** Immobilizing a patient, perhaps by holding the patient a certain way or securing the patient to a hospital bed
- **Seclusion:** Isolating a person in a quiet, safe room, for example

» **Chemical restraint:** Sedating psychotropic medication, given acutely, often as an injection, that's not part of the standard treatment for the person's condition

Hospitals should use seclusion and restraint rarely and only as a last resort, when all other interventions have failed, and only when necessary to protect everyone's safety. Hospital personnel should use seclusion or restraint only with compassion and cool tempers — not in anger and in no way to punish or shame the patient. When you're the one being restrained, you'll likely have a hard time remembering that restraint is being used to keep you and those around you safe — to prevent unintentional harm that can arise from extreme symptoms. But that's always the goal . . . or should be.

You should have an opportunity to discuss a seclusion or restraint incident with your treatment team when things calm down. Hospital staff often debrief after a situation involving restraint, and you should have a similar opportunity. The post-restraint interaction with staff should be about healing and recovering from the event as well as offering feedback to staff about how you felt during the process.


TIP

Having a family member or loved one review the seclusion and restraint policy with the treatment team or unit staff when you're first admitted gives your family important insight to the unit's policies and procedures. A preemptive review of this policy also gives the hospital staff the heads-up that you and your support team are paying close attention to seclusion and restraint procedures and that you expect potential conflicts to be handled in the safest, most humane, and clinically appropriate way.

Exploring variations in visiting hours

Visiting hours at psychiatric facilities vary considerably. At some facilities, you can have visitors only on specific days. Others have daily visiting times that include one or more hours in the evening. Some of the more liberal facilities have two visiting sessions — one in the afternoon and one in the evening. Visitation policies that allow visitors to drop in any time are rare.


TIP

If you want to have visitors, call and ask certain loved ones to visit, or call your main contact on the outside and ask that person to contact others you'd like to have visit you. In many cases, loved ones avoid visiting because they assume you don't want visitors or don't want anyone to know that you've been hospitalized for a mood disorder. They just need to know that you're okay with them stopping by.


TIP

If you're planning to visit a loved one in a psychiatric facility, call ahead to see if there's anything she needs or wants and then check with the facility to find out what you're allowed to bring. Other than that, approach your loved one's hospitalization as you would a hospitalization for any illness. If you'd normally bring flowers, bring flowers (in a plastic vase). If you'd send a get-well card, send a card. Try to approach your loved one and their hospital stay with as much kindness and compassion as you would for any other hospital stay.

Knowing about how long you'll stay

According to the American Psychiatric Association, the average stay for adults in psychiatric facilities in the U.S. is 12 days. For many adults, their stay lasts just a few days — just long enough to intervene in the crisis, give the medication time to take effect, and schedule outpatient treatment for the day following discharge. In short, the days of three- to six-month hospital stays are over in the United States. It may be different in other countries.


TIP

Some insurance carriers cover home healthcare or visiting nurse services for psychiatric care; ask your hospital team to look into this option, especially if you live alone.

Getting released

When your doctor at the facility thinks you're well enough to leave, the doctor meets with you for a final evaluation and to provide you with prescriptions for any medications you may need to take. Give your doctor your preferred pharmacy's phone number to call in or *electronically prescribe* your medications so you can pick them up on your way home. Some medications, such as benzodiazepines, are controlled substances with special prescribing requirements. Depending on where you live, the doctor may have to give you a written prescription for them, but many states allow them to be electronically prescribed. Check with your doctor for details in your area.

You should also receive instructions that include information about your medications, a list of your outpatient appointments, and details about how to reach the hospital or other crisis options if you experience serious symptoms after discharge. Make sure that the hospital has communicated with your outpatient doctor and therapist about your hospital stay and discharge.


REMEMBER

The doctor, not the hospital staff, decides when you're discharged. Pleading with nurses and other staff members won't shorten your stay.

Knowing Your Patient Rights

Most jurisdictions mandate rights specifically for patients in mental health facilities. In most places, you have the right to

- Refuse to submit to treatment, including medication, if you're a voluntary adult patient
- Petition the commitment court for consideration of the treatment program if you're an involuntary patient
- Be free from harm, including unnecessary or excessive seclusion or restraint, emotional or physical abuse, and neglect
- Receive information about your diagnosis and treatment and participate in treatment planning
- Keep and use your own personal articles, including clothing and toiletries, with some restrictions
- Access individual secure storage space for your private use
- Keep and spend a reasonable sum of your own money for small purchases, if necessary
- Make and receive confidential phone calls

Patient rights vary according to the jurisdiction you're in and whether you're voluntarily or involuntarily admitted to the facility. In the U.S., you can find a mental health patient rights manual for nearly every state online. Use your favorite search engine to search for "mental health patient rights" followed by the name of the country, state, or other jurisdiction in which you live. You may also have access to mental health patient rights advocates.

Making Your Stay More Comfortable

The following survival tips can make your stay in the hospital a little more pleasant and productive:


TIP

- Bring any medications you're currently taking, including nonpsychiatric medications and any over-the-counter medications, supplements, or complementary/alternative products, or a complete list of your medications and the doses.

- Tell the nurse and doctor if you've been using alcohol or taking any other nonprescribed drugs. A withdrawal reaction can be dangerous, especially if no one knows what's happening to you.
- Bring your doctor's and therapist's contact information.
- Leave valuables at home.
- Leave your belt, pocketknife, and any other potentially harmful accessories at home. The hospital won't let you have anything that you or another patient could use to harm yourself or others.
- Bring slippers or loafers or some other footwear without shoelaces.
- Bring comfortable but modest clothing.
- If you can, bring your own pillow and a comfortable blanket.
- Bring a journal without spirals or wires to record your thoughts and feelings and to jot down any useful information you pick up from the staff, therapy groups, or other patients.
- Cooperate with the staff as much as your mental state allows.
- Get to know your fellow patients. Psychiatric hospitals are populated with interesting and intelligent individuals who understand your experience better than most people on the outside.
- If you smoke, bring an ample supply of cigarettes. (If your hospital is non-smoking, you may receive a nicotine patch.)
- Bring books, magazines, and a deck of cards if you play. If you usually play or read on a device, you may have to go analog while in the hospital, since you will have limited access to your phone.
- Pack one or two photos of family, friends, or pets — without glass frames — to warm up your space.

REMEMBER

Find out your visiting and phone privileges as soon as you can process the information. You can then plan a schedule to communicate with your family and other support team members. Continued contact and support from the outside world can be very beneficial, but avoid potentially dangerous or toxic interactions as much as possible. Use phone and visiting time to build up or rebuild your outside support network of healthy relationships, setting up a firm foundation on which to build your recovery.

Keeping Your Team in the Loop

Communication is an important part of building and maintaining your support network and getting what you need to facilitate your recovery both during your hospitalization and beyond. Be sure to keep your doctor, therapist, and loved ones in the loop:

- **Notify your doctor and therapist.** If you didn't notify your doctor and therapist that you were heading to the hospital, let them know where you are as soon as you can. Confirm that your inpatient team has contacted your outpatient caregivers to get past history and information on current medication/therapeutic interventions and to collaborate on your inpatient treatment plan and your transition from inpatient to outpatient status.
- **Stay in touch with loved ones.** Your support network of loved ones can contribute to easing your transition back to the real world after your hospital stay, so if you're feeling up to it, keep friends and family members in the loop, especially if this is your first hospitalization.

TIP

Some facilities offer family education and therapy, which can help family members start to develop understanding, empathy, and realistic expectations for your recovery. If the facility offers it, encourage your family to do their best to take advantage of it.

Making Recovery Your Top Priority

Leaving the hospital doesn't necessarily mean you're ready to return to your daily routines. A severe mood episode can leave you exhausted, and you may not regain your bearings for several weeks to months. No matter how much you want to get back to your normal routines, we encourage you to take it slow and make full recovery your number-one priority.

In the following sections, we help you come to terms with the aftermath of a major mood episode and deal with the fallout. We also reveal the importance of focusing on your health and wellbeing and offer ideas for how to retreat to a place that's conducive to convalescence.

REMEMBER

You may be tempted to try solving everything at once, especially if you're coming down from a manic high. In most cases, however, your overall health is better served by taking small steps and focusing on your own wellbeing, a process we discuss in this section.

Anticipating the aftershock

How fast and fully you recover from depression or mania depends primarily on how severe your mood episode is and how well you respond to treatment. You may be one of the lucky few who respond within days of treatment, or you and your doctor may spend weeks or longer trying to find the right mix of medicines and therapy. As your body adjusts to the meds and your mood begins to stabilize, you may experience one or more of the following effects:

- **Memory difficulties:** You may not recall periods of time during the mood episode, especially during a manic episode.
- **Increased/decreased energy levels:** Don't be surprised if you need significantly more sleep after a manic or depressive episode; your body and brain need time to recuperate.
- **Anxiety:** You may become anxious after a mood episode due to certain medications or worries about family, work, relationships, bills, and other facets of your life that may be in upheaval.
- **Confusion:** A major mood episode and the medications used to treat it can muddle your thinking. You may wonder who you really are and how the medications will affect you. Until you know more about bipolar disorder, you may realize that something's not right, but you may not know exactly what's wrong.

Many of these symptoms, if they're related to medication changes, are most prevalent when you begin taking a medication, but they diminish over time. If the symptoms are intolerable, contact your doctor. General body and brain recovery takes quite some time, so be gentle and patient with yourself and ask others to be as well.

Mastering the art of self-care

If you're one of those overachievers who puts everyone else's needs in front of your own, a mood episode may signal the time for a change — for you to become more aware of your own needs and more assertive in meeting them. This change may prompt you to begin working on developing the fine art of self-care. Self-care isn't selfish. It's essential to getting well. During your recovery, you need to put *your* needs first.

Assessing your needs and asking for and accepting help

The first step in mastering self-care is to figure out what *you* need and how to ensure that *your* needs are met (either by you or someone else). Asking people to

help you or accepting help that's offered may feel foreign and uncomfortable, especially if you're usually the *caregiver* and not *care receiver.* But defining your needs, asking others directly to help you, and letting them help when they offer are all important parts of recovery.

To assess your needs and get them met, try the following exercise:

1. **Write down five to ten needs, starting with the biggest one.**

   For example, "I need help getting the kids ready for school."

2. **Brainstorm ways to have each need met, including the names of people who can help, such as friends or family members.**

   You may be able to meet some needs on your own, by taking an hour at the end of the work day to wind down, for example. But for many situations you'll need help, so think about whom to ask.

3. **Draw up a plan for executing the best idea for meeting each need.**

4. **If you need assistance, write a detailed description of the type of help you need and the amount of time required to provide it.**

5. **Contact the people who can help and request their assistance**.

   If people have asked, "What can I do to help?" encourage them to look over your plan with you to see what needs they can help with.

6. **Put your plan into action.**

Getting used to saying no

Mastering the art of selfishness requires you to become sensitive to your own needs and to avoid overcommitting your time and energy. In short, you have to learn how to say no. If you have trouble saying no, try the following lines:

- "I would love to help, but I really have too much on my plate right now."
- "I'm sorry, but I really want to spend more time with my family."
- "I'm sorry, but we've experienced some financial setbacks and can't donate anything at this time."


TIP

Use the caller ID on your home phone or cellphone to screen out the most annoying callers. Or let your voicemail pick up and then return calls later. If telemarketers are infringing on your peace and tranquility, consider having your number added to the National Do Not Call Registry. You can do this online at `www.donotcall.gov`.

Retreating to a safe, quiet place

The most obvious place to recuperate from a major mood episode — your home — isn't always the best. If you live alone, the solitude may aggravate your symptoms, and without the watchful eyes of a support person and some human interaction, you may slip back into depression or mania. On the other hand, if your home is tense or you live with unsupportive family members, the environment can be downright toxic. The best place for your recovery is a safe and quiet place, a structured environment with the right combination of the following elements:

- **Tranquility:** Peace and quiet are essential in relieving anxiety, especially after a manic episode.
- **Activity:** Rest is important, but too much rest can lead to depression.
- **Interactivity:** Remaining connected to friends, family members, and colleagues provides additional social support.
- **Support:** Having somebody available to help you follow your treatment plan and remain on call if you need assistance can be a lifesaver.
- **Routine:** A structured routine with regular wake times, bedtimes, meals, and activities can help recovery.

Living arrangements that meet these criteria may include staying with a friend or family member or, if necessary, going into another type of temporary residence. Having a friend stay with you can sometimes provide support and companionship if you live alone or supply an ally and advocate if you live with family members who don't get it. Just remember not to stray too far from your medical and personal support networks when looking for places to stay.

WARNING

If your family situation has deteriorated, avoid the impulse to move out on your own, unless the situation is unsafe. Solitude can often deepen depression and unleash your manic impulses. Living alone sets up many new demands that you may struggle to meet. Some degree of personal support almost always improves the treatment outcome.

If you decide to return home with family members, we strongly encourage your family members to learn more about bipolar disorder and make any necessary adjustments to ease your transition. Family therapy can play a critical role in your successful recovery, as we explain in Chapter 11. Turn to Chapter 12 for additional guidance on how family members can help create a healthy emotional environment.

REMEMBER

You don't necessarily have to move to cultivate a safe, quiet place. With the support of friends and family, you may be able to create such a place at home.

Following your doctor's orders

Your doctor will give you an earful about the importance of taking your medications as directed and sticking with your treatment plan, so we won't bore you with another lecture. What your doctor may omit, however, are instructions about what to do if your medications don't work or if they produce undesirable side effects. Here are four rules for sticking with your treatment plan and making adjustments if the plan doesn't produce the desired results:

- **Give it time.** Some medications take several days or even weeks to become fully effective. During this adjustment period, many negative side effects taper off.
- **Keep a record.** Using the mood chart in Chapter 11 or a mood-tracking app for your phone, you can follow the medication changes and your emotional, behavioral, and physical responses to those changes.

  You can find a sample mood chart and instructions about how to use it at `finkshrink.com/bonus`.


REMEMBER

- **Communicate your concerns.** Feeling awful is unacceptable. If you experience intolerable side effects, contact your doctor for suggestions on how to minimize them. If your doctor seems insensitive to your concerns, find a doctor you can work with.
- **Consult with your doctor before making any changes.** Don't play doctor or stop taking a medication without your doctor's approval.


REMEMBER

Treatment for bipolar is highly individualized; what works for one person doesn't necessarily work for another. Team up with your doctor to create an effective, personalized treatment plan. Communicating how you feel enables your doctor to make well-informed treatment decisions and adjustments.

Reclaiming Your Life

You found the perfect place to recover — a private little beach in Aruba, two blocks from your psychiatrist's grass hut. You're resting in your hammock and reading this book without a care in the world. We hope you have a good vacation, but eventually, you need to sail back to reality — return to your family and friends, deal with your problems, and figure out how to support yourself financially, which typically includes finding or reconnecting with gainful employment that won't interfere with your recovery.

In this section, we help you determine when you're ready to board the cruise ship home, and we provide tips to ease the transition. For guidance on returning to work, see Chapter 17.

Knowing when you're ready

Recovering from a major mood episode calls for a slow and steady approach in which you first stabilize your medications and moods and then slowly transition back to normal activities. To prevent relapse and ensure a smooth transition, make sure you meet or exceed all the criteria in the following checklist before you head back to your normal life:

- Your medications are stable.
- Your moods are stable.
- You're getting sufficient sleep.
- You're thinking clearly.
- Your support group is in place.
- Your doctor/therapist believes you're ready.

WARNING

Don't divorce your spouse, quit your job, or make any other major life decisions while your moods are unstable. Mania, depression, and anxiety can often push you to make rash decisions you later regret. We're not advising you to stay in a toxic relationship or in a job that stresses you out. Our advice is to make these major life decisions when your brain is functioning properly and you're in the right frame of mind.

BIPOLAR BIO

I SHOULD'VE STAYED LONGER THE FIRST TIME

In May 2008, our daughter, Ali, was about to graduate high school. While I was wrapping up my school year (as a teacher), Joe (my husband) and I planned Ali's graduation party, and Ali and I prepared for a two-week excursion to Spain as soon as school let out.

Unfortunately, mania kicked in. Family tension sparked, and I wasn't sleeping well on the nights I slept at all. We knew the warning signs, so I doubled up on my therapy visits and checked in with my psychiatrist. With each visit, he adjusted a medication or added something like pregabalin (Lyrica) to help me sleep. He failed to fully grasp the severity of my condition.

Soon I was experiencing severe paranoia along with audio and visual hallucinations. When I'm manic, one of the nice side effects is that I see a crystalized version of the world. Because I couldn't sleep, I walked around outside enjoying the beauty of nature.

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On one of these outings, I decided to feed Cheerios to the carp and catfish in the lake behind our house. As I fed them, I could've sworn one of the catfish jumped out of the lake and turned into a cat.

Finally, it seemed as if my only option was to be admitted to the hospital. Joe drove. Soon after we arrived, we were led to a waiting room. But I wasn't in a waiting state of mind, so I went out to the lobby and struck up a conversation with a nice family, mistakenly thinking that their daughter had been one of my students. (When I'm in a manic episode, I tend to "recognize" complete strangers as people I know. All their faces blend together into the tapestry of my memory. Maybe it brings me comfort to be surrounded by familiar faces.)

The nice family played along until security personnel arrived and ushered me into the psychiatric unit, where a social worker handed me a stack of legal forms to sign myself in. In my agitated, manic frame of mind, I couldn't focus, so without reading the forms, I angrily scrawled a big X across each page as my signature. Later in the evening, I wrestled with a couple of orderlies who had different ideas than I did about what I should be doing, and I awoke the next morning with a few nasty bruises.

After just three days, I convinced the doctor to release me because my daughter and I had travel plans. Unfortunately, my mania had other plans. Two days after leaving the hospital, I had a severe attack of paranoia and I flushed some of my medications down the toilet. I had become convinced that I was under surveillance for drug possession and suspected of dealing, so I called the police to turn myself in. Officers showed up at our house, talked to my husband, and drove me to the emergency room. Later I was transferred to a different mental health facility, where I spent about ten days recovering.

This time, I emerged from the hospital feeling pretty stable. My daughter and I had to cancel our trip to Spain, but I was able to make last-minute arrangements for her to travel to Costa Rica on a trip with her Spanish class. Having to cancel our trip is another failure resulting from my illness, but Spain hasn't fallen off the map; hopefully we'll get there someday.

— Cecie Kraynak, teacher and author

Returning to friends and family

A mood episode doesn't always physically remove you from your family and friends, but it can drive a wedge between you and loved ones in some way. The first step toward reconciling with loved ones is to forgive yourself for whatever

may have unfolded during the mood episode. The only thing you're guilty of is having an illness. The next step is to encourage everyone to work together; this is the tough part, because it takes understanding, empathy, and an ability to forgive. Here are some ways to achieve these goals:

1. **Find out how you may have hurt the people in your family and then apologize or at least acknowledge their pain.**

   It's natural to be unaware that you hurt someone and how you hurt that person, especially during a mood episode. It's also okay to feel that you don't need to apologize for something you did while in the grip of bipolar, but acknowledging that you're not the only victim can help heal the hurt.

2. **Encourage family and friends to learn more about bipolar disorder.**

   The more they know, the easier it is for them to understand that this illness isn't a product of your volition. They can start by reading this book, especially Chapter 19.

3. **Involve family members in your therapy to a degree that you and they feel comfortable.**

   Chapter 11 provides details on how family therapy can help.

4. **Give family members specific instructions on how they can help support you.**

   By becoming involved, family members often feel empowered rather than victimized.

You may meet some resistance from family members or friends who feel as though *you* have somehow victimized *them.* What they need to realize is that bipolar disorder has victimized your entire circle, *you* most of all. You're doing your part by seeking treatment, managing your medications, and attending therapy sessions. Now it's their turn to step up and contribute.

REMEMBER

Following your doctor's orders and performing your due diligence in maintaining your health doesn't guarantee that you'll remain symptom-free. Sometimes bipolar disorder has a natural course that defies prediction or preparation, and an episode occurs regardless of treatment and planning. Realizing that setbacks are normal helps you and your family keep them in perspective so you don't feel as though your treatment has failed or that you've done something wrong when breakthrough episodes occur. The key is to remain vigilant, identify problems as early as possible, and address those problems quickly and aggressively.

IN THIS CHAPTER

- Gauging your return-to-work readiness and easing back in
- Choosing whether to disclose your diagnosis
- Checking out workplace accommodations that may help
- Deciding to do something else or not to work

Chapter 17
Returning to Work . . . or Not

The desire to return to work after a major mood episode can range from high to nonexistent or somewhere in between. You may want to get back in the game even as you feel unsure of your ability to perform and afraid of how your supervisor and coworkers will respond upon your return.

You probably have plenty of questions running through your mind. "Am I ready to return to work?" "Should I tell my coworkers or supervisor what happened?" "Should I ask for workplace accommodations; and if so, what kinds of accommodations are even feasible?" "What should I do if I'm unable to return to work?" In this chapter, we provide information and guidance that can help you make informed decisions and answer important questions about your return to work.

Reality Check: Are You Ready to Return to Work?

Nobody can tell you if or when you should return to work. The answer hinges on several variables, including the severity of your illness, the effectiveness of the treatment you receive, the amount of support you have at work and home, the stress level involved (and your capacity for handling it), and your eagerness to return to work. Instead of trying to answer the complex, all-encompassing question "Am I ready to return to work?," ask yourself what your return might look like:

- **Full return:** Some people with bipolar take a few weeks or months off work, obtain the medications or other treatments they need, and then return to work as though nothing happened.
- **Partial return:** Instead of returning full time, you may be able to scale back and work only three or four days a week if your situation allows for it. Some people who take this approach find that they can, over time, build back up to working full time.
- **Return with accommodations:** The Americans with Disabilities Act (ADA) covers mental illness, so you qualify for reasonable workplace accommodations. Check out the later section "Requesting Workplace Accommodations" for details.
- **Job change:** Instead of returning to the same job, you may be able to secure a less demanding position with the same employer, seek employment elsewhere, or change careers altogether.

If you're considering not returning to work, ask yourself whether you can afford *not* to work on a long-term basis. This isn't just about money and benefits. Work offers a host of other perks, including the following:

- **Structure:** People with bipolar often respond well to a structured environment and consistent schedule; work can often meet this need.
- **Positive self-esteem:** Being productive and receiving a paycheck provides a sense of self-worth.
- **Camaraderie:** For many people, work includes socializing, which can help level out a person's moods and provide support for recovery goals and adaptive habits.

Don't underestimate the value of these benefits when making your decision. But if bipolar prevents you from returning to work, don't assume that you're necessarily missing out on all this great stuff. You can structure your day, establish a healthy social life, and build self-esteem without a job; it just may take a different kind of effort — possibly in the form of volunteerism, new roles within your family, adult education, or hobbies.


REMEMBER

When you start to think about returning to work (or not), discuss your options with your doctor and therapist and ask for their input. They can help you weigh the pros and cons of returning and not returning to work, let you know if and when they think you're ready, smooth the transition back to work (if that's what you decide to do), or explore resources you may want to look into if you're unable or choose not to return to work.

Getting Back into the Swing of Things

If you decide to return to work and you and your doctor and therapist agree that you're ready, consider returning gradually instead of taking on a full workload right away. A gradual return may include the following scenarios:

- Working half days or at least fewer hours per day or week
- Working a one-day-on/one-day-off schedule
- Having a coworker assist you with some of your responsibilities
- Performing some or all your work tasks remotely


TIP

Schedule weekly appointments with your doctor and/or therapist for the first four to six weeks of your return to work so they can help monitor your condition throughout the transition. They can help you decide if and when you're ready to work more hours and take on more responsibilities.

BIPOLAR BIO

BACK TO WORK WITH BIPOLAR DISORDER

I had my first manic meltdown a week before Christmas break in 1999. I had been working as a junior high school Spanish teacher for 16 years and had heard it repeated many times since starting my teaching career that working at the junior high level was the most difficult level and would make anyone crazy. Little could my husband and I guess just how true this was! As if it wasn't enough that I was dealing with the stressors of raising two young children, the Christmas holidays, and teaching at the junior high full time, what we didn't figure into the equation was the looming presence of an undiagnosed psychiatric illness. When all these elements collided, no one was sure what had happened. All we knew for sure is that it couldn't continue for even one more day.

I ended up in the hospital and received my official diagnosis — bipolar disorder.

The doctor prescribed valproic acid (Depakote). After three long months of outpatient therapy, I had improved enough to return to work, or so everyone thought. Unfortunately, my moods hadn't stabilized enough. The medication I was on made my thinking foggy and unfocused, and I was unable to deal with the stressors of the job. I was disoriented and operating in a fog, surrounded by confused friends and family who had been as blindsided by the situation as I had been.

I was able to work a few weeks and then found it necessary to take time off due to emotional instability. Each time I returned, something would happen to break through my tenuous grasp of reality or "sanity." One day, I had to stop another teacher in the hallway because I couldn't find my classroom. I felt increasingly guilty about missing work, and I knew that the inconsistency wasn't fair to anyone, least of all the students. After a few years of these short spurts of working and then absences due to instability, I made the difficult decision to take early retirement. A couple of years later, when I had a better handle on managing my illness, I found a low-stress job as an English as a Second Language (ESL) coordinator for another school system. It was just what the doctor ordered. I was good at the job. It structured my days, and I had positive interactions with my students and peers. Every day I felt lucky to be rewarded with a sense of self-worth and accomplishment.

My advice for anyone who's thinking of returning to work is this: Don't be too eager to get back to work. It's well worth the time to take it slow and wait until you're ready.

— Cecie Kraynak, teacher and author

Disclosing Your Diagnosis . . . or Not

The question of whether to disclose a diagnosis of bipolar disorder to an employer often causes considerable anxiety for the person with the illness. Of course, it shouldn't be that way. If you were ill with cancer, diabetes, or heart disease, you'd probably disclose it without reservation. You may even get some sympathy. People with bipolar disorder, however, often fear the real possibility of being stigmatized. In the following sections, we help you decide whether disclosing your condition is in your best interest and then provide guidance on how to proceed if you choose to do so.

Weighing the pros and cons of disclosure

Telling the people you work with and for that you have bipolar disorder carries the risk of being stigmatized in the following ways:

- Getting fired, let go, or subtly forced out
- Getting passed over for promotions
- Being excluded from social gatherings by coworkers
- Worrying about people's perception of you

WARNING

Discriminating against a person because of a health condition is illegal, but that doesn't mean it never happens.

In the best-case scenarios (with employers who value their employees and understand that good people often have health issues that need to be managed), disclosing your condition can benefit you in several ways:

- You no longer have to carry the burden of hiding your illness.
- You become eligible under the Americans with Disabilities Act for reasonable workplace accommodations. (Your employer must be aware of your disability to be held accountable for providing accommodations. See the later section "Requesting Workplace Accommodations.")
- Your supervisor and any coworkers you tell may be more willing and able to offer assistance if they understand what's going on.
- In educating others, you may learn more about bipolar and feel empowered.

We can't tell you whether disclosure is the right course of action for you. You may be able to gauge how receptive people will be by considering their past behaviors and comments about psychiatric illness. If they've demonstrated empathy for others who've had similar conditions, you can predict that they'll treat your situation with care and understanding as well.


TIP

For more about the pros and cons of self-disclosure, you can access a 50-page booklet on the topic titled *Self-Disclosure and Its Impact on Individuals Who Receive Mental Health Services* at `store.samhsa.gov/product/Self-Disclosure-and-Its-Impact-on-Individuals-Who-Receive-Mental-Health-Services/sma08-4337` (Hyman, I. Center for Mental Health Services, Substance Abuse and Mental Health Services Administration).

Talking to supervisors and coworkers

When you're the one who's ill, you shouldn't have to invest time and energy into educating others about your illness. As caring human beings, the people around you should already demonstrate some empathy and make it a point to understand your condition. The reality, however, is that if you don't educate and advocate for yourself, your situation at work (or home or school or wherever) isn't likely to improve. The more others know about bipolar, the less fearful and more accepting they tend to be.

So how do you go about educating your supervisor, colleagues, and others at your workplace? Here are some suggestions:

- Start by disclosing your condition to people whom you trust the most and who seem understanding and open minded. They can model acceptance to others.
- Play the role of teacher. Take a nonconfrontational approach to presenting the facts about bipolar. (Keep in mind that you control exactly how much you choose to disclose to each individual. You don't have to tell everyone everything.)
- If your employer has a human resources (HR) department, consider involving the HR staff in meetings with your supervisor. HR people should know employment law and be able to explain to your supervisors their responsibilities to you as an employee.
- Describe the way you feel when you're depressed or manic. Most people won't argue or become defensive when you simply describe how the disorder makes you feel, but be aware that some people may question or try to invalidate your feelings. Disengaging is the best response in that situation.

- Describe your common symptoms. That is, tell your supervisor and coworkers how your behavior is likely to change when you're becoming manic or depressed, or during medication changes. By describing specific symptoms, you accomplish two things. First, you let people know what to expect so they're better prepared to handle emotional or behavioral changes. Second, you enlist them in helping you spot early warning signs, which you may not notice when you're feeling manic or depressed.
- Be sure to mention that not everything you say and do can be attributed to bipolar. You don't want a bunch of bipolar police sounding the alarm every time you raise your voice. Let them know that when you're healthy, you can be sad, angry, energetic, tired, frustrated, and so on — just like anybody else. Most people with bipolar want to be treated "just like everyone else."
- Point out that with treatment your symptoms usually remain in control.
- Keep in mind that it may take some time for people to absorb and accept the information and even longer to change their attitudes and behaviors.


TIP

If your company has in-services or guest speakers, consider inviting a psychiatrist, therapist, or qualified individual from a mental health group to speak or lead a discussion about mental illness — specifically bipolar.

Requesting Workplace Accommodations

When you receive a bipolar diagnosis (and disclose it to your employer), you gain protection under the law via the Americans with Disabilities Act (ADA). As long as you notify your employer of your condition and express some desire to get help, your employer is required to engage in a dialogue with you to determine whether reasonable accommodations can enable you to perform the essential functions of your job.

To qualify for protection under the ADA, your situation must meet the following conditions:

- You have a physical or mental impairment that substantially limits one or more of your major life activities.
- You have a record of such an impairment (your diagnosis, for example) or are regarded as having such an impairment.
- You are otherwise qualified to perform your job duties; that is, you must meet the skill, experience, education, and other job-related requirements of the position and, with reasonable accommodations, be able to perform the essential functions of the job.

So what exactly are reasonable accommodations? According to the United States Department of Justice, the definition of *reasonable accommodation* is this:

A modification or adjustment to a job or to the work environment that will enable a qualified applicant or employee with a disability to participate in the application process or to perform essential job functions. Also includes adjustments to ensure that a qualified individual with a disability has rights and privileges in employment that are equal to those of nondisabled employees.

Reasonable workplace accommodations for employees with bipolar disorder may include the following:

- Flexible scheduling, along with leave-time allowances for doctor's visits and therapy sessions
- A work schedule that doesn't disrupt your sleep patterns
- Scheduling adjustments to reduce interruptions
- Longer or more frequent breaks
- Separate office or cubicle to reduce workplace distractions
- Clearly documented job requirements, responsibilities, and consequences for not meeting expectations
- Education for coworkers and supervisors about bipolar disorder
- Referrals to employee assistance programs and other supports
- Regular meetings with supervisors to assess needs and performance and to develop strategies for addressing any issues that arise


TIP

Establish a procedure to evaluate the effectiveness of each accommodation and make adjustments as needed to improve the overall work environment and respond to any changes that may arise.

For further assistance in adapting to your workplace or adapting your workplace to meet your needs, consult an occupational therapist who has training and experience in helping people with bipolar disorder. Occupational therapists aren't exclusively for people with physical disabilities.

BEING SELF-EMPLOYED WITH BIPOLAR DISORDER

If you're self-employed, you may face unique challenges when managing your work life with bipolar disorder. Typically, you don't get sick leave or paid time off or even unemployment benefits in a self-employed position, so your income is immediately affected when you take a break. Yet, your expenses continue, including payroll and overhead. But self-employment also comes with greater flexibility in your schedule and, in most cases, freedom from reporting your whereabouts at any given time of day. In other words, you can give yourself reasonable accommodations and transition time. Not to mention, self-employment means you can manage the flow of information about your condition to your employees and coworkers.

Some advance planning can help with the potential downsides in this situation:

- Look into disability insurance, although this may be hard to obtain after you have your diagnosis.
- Develop an emergency plan for managing your business in case you're out of commission. Select a trusted friend, family member, or colleague to step in and manage for you while you're unable to do so. Try to work this out in some detail before a crisis arises.
- Try to stash away as much cash savings as you can to tide you over during times when you can't run your business.
- Try to ensure that your daily procedures and activities are well outlined somewhere, in writing, so that those covering for you can reference them in your absence.

Finding More Suitable Work

Some jobs just aren't conducive to mental health. Returning to such a job, even with reasonable workplace accommodations, could doom you to relapse. But just because you may not be able to return to the job you were doing doesn't relegate you to a life of unemployment. After all, you may be able to transition to a different position or profession, start your own business, or find a few enjoyable part-time gigs that pay the bills.

In the following sections, we provide guidance on how to choose work that's right for you and conducive to your mental wellbeing and then offer suggestions for how to pursue your work-related goals.

REMEMBER

Recovery doesn't always mean returning to the life you had before your bipolar diagnosis. In fact, the disorder often provides an opportunity to move forward and make changes that lead to a more rewarding and fulfilling life.

Dreaming up your ideal work situation

Some people seem to know from the day they're born what they want to do when they grow up. Others keep asking themselves that question until the day they retire. When bipolar disorder prevents you from doing the work you've been doing, you have to ask the same question again in the context of your new reality. If you're unable or unwilling to return to the work you were doing before bipolar entered your life, ask yourself what you want to do for a living now. Try to formulate a vision of your ideal work situation:

- Do you prefer to work alone or with others?
- Do you prefer working remotely or in-person?
- How many hours per week can you work without jeopardizing your mental health? (Be sure to account for the time you need for doctor appointments, therapy sessions, and self-help activities.)
- Do you prefer fixed hours, or do you want to set your own schedule? (Even if you set your own schedule, regular hours may help stabilize your mood.)
- Are you self-directed or do you work better under close supervision with clearly defined goals, deadlines, and direction?
- Are you more of a leader/manager or a worker bee?
- Do you prefer working for someone or owning your own business?
- What do you do best? (See the next section for details.)
- What do you most enjoy doing? (See the next section for details.)

Taking a skills and interests inventory

When you're thinking of changing jobs, the goal is to find something that you're good at doing but that you'll also enjoy, so start your job search by taking inventory of your skills, which may include any of the following examples or completely different activities:

- Working with children or teenagers
- Caring for the elderly

- Computer programming
- Writing
- Financial management/accounting
- Designing websites
- Repairing machines
- Gardening
- Teaching/training
- Organizing/scheduling

Then jot down a list of interests — what you like to do or feel drawn to do, regardless of whether you think you're qualified. What would you love to do even if you weren't getting paid to do it? What activities do you find most enjoyable and rewarding? Interests can include anything from interpretative dance to biochemistry.


TIP

Your lists of skills and interests point the way toward a variety of careers and can help you identify areas where you may need additional education and training. Consider consulting with an occupational therapist, psychiatric rehab professional, or career counselor to explore career options that match your skills, interests, and mental health needs.

Pursuing your dream job

Pursuing your dream job may be as easy as scrolling through online employment sites, but landing that job probably takes a bit more work. You may need to acquire additional education, training, or experience; establish contacts in a new field or industry; purchase special tools or equipment; or write a business plan (if you want to start your own business). To prepare yourself, consider exploring the following resources:

- **Family, friends, and colleagues:** Share your vision with supportive members of your inner circle. They may have information, advice, or professional contacts that can help you pursue your dreams. If your boss is supportive, you may even ask for help in transitioning to a different position in the company or to a related business or industry.
- **Your doctor and therapist:** Keep your doctor and therapist in the loop about your plans for finding rewarding work. They may have information about local resources to help people with bipolar disorder return to work, and they may have professional contacts of their own who are willing and able to mentor you or perhaps even hire you.

- **State Vocational Rehabilitation (VR) Agencies:** Each state has a federally funded agency that provides employment support for people with disabilities. These agencies are usually plugged into county, state, and federal resources as well.
- **Colleges or trade schools:** If you need additional education or training to enter a certain profession, contact local or online colleges or trade schools to find out what's available. Speak to someone in the financial aid office to see if you qualify for scholarships, grants, and loans. You can also find plenty of free courses and other educational opportunities online.
- **Businesses of interest:** If you want to work in a specific industry, contact businesses in that industry that you may like to work for. Try to arrange a meeting with the head of the department you're interested in to find out what you need to do to qualify for a position. Ask if the business has internship opportunities.
- **Volunteer organizations:** If you can't get on-the-job training and experience, look into volunteer organizations, where you can pick up all sorts of skills while donating your time and efforts to your community. Volunteerism also looks good on a resume.
- **Small Business Administration (SBA):** If you're thinking of starting your own business, head to www.sba.gov for information, guidance, and contacts for local counseling, mentoring, funding, and training.
- **Mental health support groups:** Don't forget to share your vision with the people in your support groups. Many people who attend support groups are professionals or small-business owners who may have job leads, connections, and information that can help you find the work you're looking for or start your own business.

REMEMBER

The most successful job hunts start with personal conversations. Describe your dream job, and let people know what you're doing to prepare for it. Your network can offer help only if the people in it know what you need. For more job hunting advice, check out *Getting a Job after 50 For Dummies* by Kerry Hannon (John Wiley & Sons, Inc.). Even if you're not older than 50, this book is chock-full of valuable advice on finding a job or starting a business that's right for you.

Is Not Returning to Work Right for You?

An "occupational hazard" of bipolar disorder is that it can trigger snap decisions, especially in the midst of a manic or depressive episode. The illness can limit your foresight. For instance, if you're depressed and can't work or foresee a time in the

near future when you'll be able to return to work, you may decide to quit, resign, or take early retirement. These options are certainly acceptable if you're in a position to take advantage of them and are making the decision in a state of sound mind and judgment. If you're not, however, making a snap decision to resign can seriously jeopardize your rights as an employee and your future prospects.

Before you submit that letter of resignation, consider what you have to gain and lose. Here are some suggestions for how to evaluate your situation:

- Take as much time as you need to feel better before making a final decision. Your employer probably isn't going to fire you when you're on medical leave and under a doctor's care, and if that happens, you have fertile grounds for a lawsuit.
- List the pros and cons of resigning. Spend some time reviewing your list so you clearly see what's at stake. Show the list to people you trust and ask them for any additional considerations.
- Discuss your options with your doctor and therapist as well as family members, friends, and associates you trust. Be honest with yourself and your support team as you sort through your thinking process; keeping your biggest worries hidden in the back of your mind doesn't help you find solutions.
- If you have a union at work, meet with your union representative to discuss your options and possible consequences of resigning. A union rep is likely to have experience with the situation and should be able to clearly explain what you stand to gain and lose if you resign. Your union rep may also have knowledge of lateral job positions that more effectively support mental health needs. Likewise, you may be able to access such information from HR or EAP (employee assistant program) professionals at your workplace.
- Before making a final decision, consider consulting your own attorney, preferably one who's well versed in employment law, to protect your rights as an employee. Even if your union rep and HR person are qualified to provide the guidance you need, they may feel more loyalty toward your employer than to you and offer you less-than-ideal advice.

We're not telling you to keep plugging away at a job that's making you miserable, but we hate to see people quit (especially when they're not feeling well) and then regret the decision later when it's possibly too late to do anything about it. But if you can't work or can't find employment to earn at least enough money to cover the bills, the last resort is to file for Social Security Disability benefits. See Chapter 18 for details.

IN THIS CHAPTER

- Cracking the code to get public mental health services
- Navigating the process for disability coverage
- Finding affordable health insurance and low- or no-cost healthcare
- Leveraging other resources for financial survival

Chapter 18
Overcoming Financial Setbacks

Bipolar disorder often pushes families to the brink of financial collapse. Yet, people are often reluctant to ask for help because they take pride in working to earn enough money to pay their bills. Even when they clear that hurdle and decide to seek assistance, many people face the daunting double challenge of finding out where to get help and navigating a process that's more puzzling than a Rubik's Cube to receive it.

Unfortunately, no one-stop shop is available to access all available financial support for mental health situations, so you need to tap a variety of resources to stay afloat. We can't give you detailed step-by-step instructions on how to obtain financial assistance and affordable medical care, but in this chapter, we suggest starting points for finding the financial help you need and deserve.

The Public Mental Health System

In the United States, you may be able to find help by turning to the public mental health system — resources for people with severe mental illness and limited income — but these resources are highly variable in terms of availability, access,

and funding by state, county, and municipality. Your local system may seem like an obscure secret society that's nearly impossible to find and join. But cracking the code is well worth the effort because these public services are a crucial lifeline for people living with serious mental illness, including bipolar.


TIP

Some areas in the U.S. have a 211 or 311 phone number that connects callers to a sort of switchboard for obtaining local and national social services, including help with food, housing, employment, healthcare, counseling, and suicide prevention. Visit `www.211.org` to look up the number for your area.

Surveying available resources

Public mental health care isn't limited to community and low-cost clinics. In many states, the system includes a range of services — called *systems of care* in some places — that attempt to provide appropriate levels of proactive mental health care. Here are services that a public system may include:

- Outpatient therapy and medication services
- Day treatment
- Job training and coaching
- Housing and in-home services
- Assertive Community Treatment (ACT), or individualized, intensive 24/7 support for people with high levels of need
- Case management services to help coordinate needs and access services
- Outreach to homeless people with mental health care needs
- Coordination of general healthcare needs
- Substance abuse recovery programs
- Help to apply for Social Security Disability, Medicare, Medicaid, and other financial safety net programs
- Crisis intervention
- Inpatient hospital care

Unfortunately, many states offer only some of these services and on a very limited basis. Access is typically granted through a central agency that operates at the state or county level. Finding the front door can be tricky, and qualifying for services is even tougher.

Accessing local financial support

Public agencies can usually help you apply for disability benefits through the Social Security Administration, Medicaid, and other financial safety net programs. If you qualify for Medicaid or Medicare, your mental health care costs are offset by these programs as well (see the later section "Filing for Disability Benefits" for details).

Try these approaches for accessing your local public mental health services:

- Contact the mental health department for your state or county. Most of these departments have websites you can explore.
- Contact your local Mental Health Association (MHA) for assistance. Find the contact info for your state or county MHA by searching online contacting the National Mental Health Association (NMHA) at 1-800-969-6642 or online at `www.mhanational.org`. The NMHA has more than 340 affiliates.
- Visit the website for your local National Alliance on Mental Illness (NAMI) or Depression and Bipolar Support Alliance (DBSA).
- If you're in a hospital, the staff social worker likely has information about your local system and can help you mobilize these resources.

Public systems in Canada and the U.K.

The Canadian Mental Health Association (CMHA) has a central website at `cmha.ca` that guides you to the central mental health service agency in your province. The local agency helps you gather referrals, find treatment, and interface with other public health services. In general, the Canadian system seems to encourage people to first seek help through their primary-care doctor, who then makes a referral to mental health services.

Similarly, in the U.K., mental health services are part of the National Health Service (NHS), and people can access them through the primary-care system. Like the U.S., the U.K. is trying to develop more accessible and effective models of mental health care; but unlike the U.S., the U.K. system is centralized and available to all citizens. (For more about NHS and mental health services, visit `www.nhs.uk`.)

BRUISES HEAL, SCARS DON'T

After I was sacked due to my third breakdown and subsequent hospitalization, I soon realized I had two battles on my hands — a recovery and no income.

I'd just crossed a line where, at the age of 33, I'd committed to a number of large financial outlays when I became seriously ill, and was now in a precarious position where everything that I had worked for could be affected and taken away. It's a cruel side effect of my disorder that began even before the unknown side effects of my meds kicked in.

What I should've done was wait and adjust to my illness and my medication; instead, I fought the situation all the way, trying to get better faster. This only resulted in aggravating my depression. As time went on, I learned that going with my disorder was the best option, as it seemed to have its own agenda.

At the time, I was looking but not seeing and needed help with every piece of paperwork, an endless supply of forms to complete, from the repetitious benefits forms to notifying my mortgage lender of my current situation. Then I had to deal with my car payments and a costly pension plan. Fortunately, I was assigned to a social worker who removed most of the stress for me.

Time is what it takes to recover from a breakdown — lots of it. After all, I wasn't suffering from a simple flu virus. I'd spent years coping with high-stress problems, one after another, and I wasn't going to get well in a matter of days.

It's an arduous and grossly unfair disorder to deal with. I climbed the greasy pole every day for years only to slip back down again, but in time I learned to prioritize. I may have lost my job but soon realized my new one was recovery. It's a humbling experience, but I helped myself by rethinking my personal values. It was either that or face a bitter future and recurring ill health, because I would've kept revisiting the episodes I had no control over.

In the beginning I felt isolated, but it didn't take too long before I was surrounded with people who understood my disorder. One key point I did discover is, if you keep telling yourself you have emotional scars, they will never heal but, if you reinforce the thought that you have emotional bruising, the bruises will heal.

After everything I had survived and lost, I was grateful that I had clothes on my back, a meal on the table, and a roof over my head. And, no matter how clever I thought I was, I couldn't change the past, but the future on the other hand . . .

—Neil Walton, author, mentor, mental health journalist, and comedy writer. For more about Neil, visit `bipolar-expedition.co.uk`.

Filing for Disability Benefits

If you're living in the U.S., you've been diagnosed with bipolar, and the disorder has reduced your income to the point that you need assistance, the first thing to do is file for the following two Social Security benefits:

- **Social Security Disability (SSD):** These benefits are based on the Social Security earnings record of the insured worker. If you qualify for SSD, you automatically get Medicare coverage after receiving SSD benefits for two years.
- **Supplemental Security Income (SSI):** These benefits are funded through general tax revenues, so benefits aren't based on prior work history. You qualify by having limited income and resources that meet the living arrangement criteria. In most states, if you qualify for SSI, you're automatically eligible for Medicaid coverage.

WARNING

In some states, the only way to get public mental health services for children with severe mental illness that requires long-term or high-intensity care is to surrender your parental rights to the state. These states cover such care only if the child becomes a ward of the state's child protection agency. Advocacy groups are working with Congress to change this, but it's still the only option for parents in some parts of the country. Find out everything you can about the laws in your state from mental health advocacy organizations and get help from an attorney or legal-aid organization before signing any papers that take away your parental rights. (Chapter 21 offers information on children and teens with bipolar.)

Meeting the guidelines

When you file for disability because of a mood disorder, Social Security representatives evaluate whether or not you can perform "work-related tasks." Using a set of guidelines referred to as the Residual Function Capacity (RFC) evaluation, the SSA checks to make sure you meet the following conditions:

- **You meet clinical criteria for bipolar disorder.** Your doctor may be able to provide the necessary documentation to enable the SSA to make this determination. The SSA may also require that you see one of its recommended doctors for a second opinion.
- **Your disorder results in marked impairment in categories such as**
  - Understanding and memory
  - Significant social difficulty

- Concentration deficiencies that result in failure to complete tasks on time
- Impaired adaptability, which makes it difficult to respond to changes and demands without significant *decompensation* (deterioration of mental health and ability to function)


REMEMBER

Disability doesn't have to be forever. Leaving your job and filing for disability may be painful, but remind yourself that you're doing what you must to regain your health and to prepare yourself to reenter the workforce in a healthier state than when you left it.

Improving your chances of approval

If bipolar disorder prevents you from holding down a job right now, consider applying for disability immediately — no matter how unsure you are about your chances of approval. Here are suggestions that may improve your chances of success:

- **Consult your doctor and therapist.** The approval, support, and assistance of your doctor or therapist are critical to helping you establish that bipolar disorder prevents you from working. If you're not currently seeing a doctor for treatment, the SSA is unlikely to approve your claim.
- **File immediately.** Disability claims can take several weeks or months to process, and you often need to file multiple appeals, so the sooner you file, the better. Most disability lawyers won't even talk to you until you've filed a claim and been denied, so don't waste your time consulting a lawyer at this point.
- **Appeal.** If the SSA denies your initial claim, which happens 60 to 70 percent of the time, consult a lawyer or other legal representative to file an appeal. A judge can override the SSA's original decision, but you may need to appear at a hearing, where a qualified legal representative is helpful. You may need to appeal several times.
- **Keep your doctor's appointments and maintain up-to-date health records.** Seeing your doctor regularly provides you with documented proof of your bipolar disorder and keeps your doctor in the loop. You can't expect your doctor to support your claim if she hasn't seen you in three months. Documented evidence can help your case.
- **Have your doctor complete an evaluation form for you.** Your doctor's evaluation of your ability to perform work-related tasks is a key component of your application. Usually, the SSA sends a form to your doctor as part of the process of applying for disability, so you may not have to request it from your doctor.

- **Be nice.** Treat the people involved in the application and approval process with courtesy and respect. Giving them grief can only hurt your case; it won't help. If you're upset, cool off before calling.
- **Keep copies.** Copy everything before submitting it and file your records in a safe place, keeping all your information together.
- **Document all communications.** Note the date and time of phone calls, appointments, and the names of people you interact with. Also jot down any details about the interactions that you may need to reference later.
- **Follow up.** Wait a few days after you mail your claim and any pertinent paperwork. Then call to make sure that the SSA received the documents. If you can establish a good relationship with an individual at your local SSA office, you have a better chance of keeping things straight.

The steps involved in filing for social security benefits may be daunting when you're managing your bipolar symptoms, so ask for help from a trusted individual — a family member or friend. Having someone to help with paperwork, organizing, or even going to meetings helps you stay the course.

REMEMBER

Don't give up. The SSA may seem to do all it can to discourage you from filing for disability benefits, but persistence often pays off. To find out more about SSD and SSI and even apply online for benefits, visit www.ssa.gov or call 800-772-1213 between 8:00 a.m. and 7:00 p.m. Monday through Friday. For specifics about benefits in your state, contact your local Social Security office.

Exploring Health Insurance Options

Living with bipolar disorder can be very expensive, especially if a severe mood episode lands you in a psychiatric facility, where a five-day stay can cost anywhere from $250 to over $20,000, depending on your insurance coverage. If you're lucky enough to live in a country that has universal healthcare inpatient care is often covered. In the U.S. if you have health insurance through your employer, then you're likely to pay less, but even some of those plans have high deductibles that can reach into the tens of thousands of dollars for a hospital stay. If you're less fortunate, you face the prospect of paying out of pocket or finding an affordable health insurance plan that provides mental health coverage.

If you don't have health insurance, several options may be available, depending on your situation, income, and assets:

- **COBRA:** If you're about to lose your health insurance due to a job loss or change of jobs, under COBRA (Consolidated Omnibus Budget Reconciliation

Act), your employer must offer to continue your group healthcare coverage for 18 to 36 months. Unfortunately, you have to pay your entire monthly premium; your employer doesn't have to pay a portion of it. Keeping your old insurance through COBRA is usually less expensive than buying new insurance with comparable coverage on your own.

- **Medicare or Medicaid:** If you qualify for Social Security Disability or Supplemental Security Income, you may also qualify for Medicare or Medicaid:
  - **Medicare:** The federal health insurance program that focuses primarily on covering people over the age of 65 who paid into the program throughout their careers. It also covers younger people who qualify for Social Security Disability.
  - **Medicaid:** The federal-state health insurance program that provides coverage for low-income people of every age. Federal, state, and local taxes help fund the program. If you qualify for Supplemental Security Income, you may also qualify for Medicaid. Although federal guidelines apply, states manage Medicaid programs independently, so coverage and access vary from state to state.
- **Private insurance (federally subsidized):** Thanks to the Affordable Care Act, you can purchase private insurance through your state exchange (if your state has set it up) or the federal exchange. Depending on your income, you may qualify for a federal subsidy to reduce your premium. Visit `www.healthcare.gov` or call 800-318-2596 to register. After answering questions related to your financial situation, you're presented with options and rates for different policies.
- **Veterans Benefits Administration:** If you served in the military, you may be eligible for healthcare through the Veterans Benefits Administration. Visit `benefits.va.gov/benefits` or call 800-827-1000 to find out about healthcare benefits.
- **Children's Health Insurance Program (CHIP):** The federal government has mandated that all children be provided health insurance, and states have a variety of systems to provide this coverage. CHIP is meant to cover children who don't meet criteria for Medicaid but whose families can't afford private coverage. Eligibility criteria differ by state. For more information, visit `www.medicaid.gov/chip/index.html`.


TIP

Parity for mental health coverage is now federal law. In other words, insurance companies aren't permitted to provide less or different coverage for psychiatric disorders, including bipolar disorder, than they do for any other medical condition. Parity isn't always being followed, however, so if you think your coverage is reduced or denied because you have a psychiatric diagnosis, contact your insurance company. If you don't get satisfaction, contact your state's insurance regulatory agency to make a report.

TIP

Trying to obtain affordable healthcare for yourself or family members can be incredibly frustrating, even for someone with a clear mind. If you're ill, now is the time to enlist the aid of a friend or family member to help with what is often a very challenging process.

Low- or No-Cost Healthcare Resources

Having no health insurance doesn't mean that self-care or public mental health care are your only options. Services are still available, but you may need to cobble together your own treatment plan, using several resources. In the following sections, we highlight some of those resources.

Tracking down a university medical center program

Medical schools are often on the cutting edge of research and may be able to provide the latest treatment options — possibly for free or on a sliding scale. Most psychiatric clinics associated with medical schools are also training programs, so you may be seen primarily by *residents* or *fellows* (doctors training after medical school graduation). This arrangement can mean changing doctors every year, which may cause inconsistencies or disruptions in your care. By recognizing this risk at the get-go, you can take steps to ensure continuity of care:

- **Make sure you know who the *attending psychiatrist* — the fully trained doctor who is supervising the residents or fellows — is.** The attending psychiatrist may not be the person seeing you during office visits; you're more likely to see a resident. The resident shares your information with the attending psychiatrist, who signs off on it if everything looks okay. But if you have any concerns, you have a right to request a meeting with the attending psychiatrist. Make sure you know the name of the attending psychiatrist and the resident you see during each visit. Keep a record of their names on your phone, so you can remember who to contact if you call the clinic.
- **Request explanations for any changes to your medications or treatment.** Why is the resident requesting the change? What are the desired results? How long should it take before you see a positive change in your condition? What are the possible side effects? What should you do if your condition worsens? Make sure you know how to reach the on-call doctor if you have an emergency before your next visit.

» **Coordinate communication with all members of your treatment team.** If you have a therapist working with you outside the clinic, be sure the trainee care providers keep your therapist posted.

Another option available at medical schools and research centers is to enroll in a study. When you participate in a study, your care is free — assuming you consent to be part of the research. Participating in a study isn't typically a consideration for regular care, but it may be an option if your regular care isn't delivering the desired results or you're interested in being involved in something that may help you understand more about bipolar disorder.


TIP

Although becoming involved in a controlled study is an excellent way to obtain access to the newest medications and to help the cause, ask yourself and your care providers some questions before you sign up. Discover the possible risks of the new medication and find out how likely it is that you'll receive a *placebo* (a "sugar pill" with no medication in it). Make sure your moods are stable enough to handle a change in medications, if that's what the study calls for. If you're doing well on your current medication and adjunctive treatments, we recommend that you stick with what's working.

Finding peer support

Everyone in your life has something valuable and unique to teach you — whether it involves a golf swing or a new therapy technique — and no one knows bipolar disorder better than someone who's living with it. You may feel reluctant to sit in a room full of strangers and talk about your life, but don't write off peer support until you've tried it. You can often find relief among people from whom you don't have to hide the fact that your brain short-circuits sometimes with unpredictable results. For details on tracking down peer support groups in your area, turn to Chapter 6.

Contacting religious organizations

Churches and other religious organizations often have qualified counselors on staff who provide therapy and other assistance. Many of these services are offered for free or at reduced cost to church members, but even if you're not a member, you may find that the organization has an open door.


WARNING

Be at least as careful when shopping for free counseling as you are when exploring options for private therapy. The quality of training varies widely, and many religious organizations have their own agendas, which may not quite follow proven treatment protocols. Avoid any organization that's against the use of psychiatric medications or requires you to make drastic changes to your life that you aren't completely comfortable with.

Prescription assistance programs

Some pharmaceutical companies, healthcare groups, and local organizations offer assistance programs that provide medications at no cost or discount prices. You may need to provide the following information to qualify:

- Your doctor's written consent
- Proof that your insurance doesn't offer a prescription benefit or doesn't cover the medication you need
- Proof that you qualify financially to receive the assistance

Check out the following sources to find out about assistance programs:

- Find out whether you qualify for assistance by using the Medicine Assistance Tool at `medicineassistancetool.org` or calling 571-350-8643.
- Mental health advocacy organizations can help you track down programs for which you qualify. See the section "The Public Mental Health System," earlier in this chapter.
- If you qualify for Medicare, you may be able to take advantage of its prescription drug programs. Go to `www.medicare.gov` to find out about these programs and to see whether you qualify for them.
- Some pharmaceutical companies offer their own prescription assistance programs for people with low household incomes. Your doctor or pharmacist, or sometimes your prescription label, can tell you the manufacturer of your medication, and you can find contact information online. In some cases, your doctor must contact the company on your behalf to get information on prescription assistance.
- An Internet search for "prescription assistance program" can help you find links to several other companies that provide information on prescription drug cards and coupons, generic medications, and other cost-saving plans.
- Check out the CostPlus Drug Company (`costplusdrugs.com`), which partners with providers and pharmacies to provide lower prices for medications.

TIP

Your doctor may be able to provide informal prescription assistance simply by supplying you with free samples.

Negotiating payment with a psychiatrist or therapist

Some psychiatrists and therapists offer payment plans that allow their patients to pay off bills gradually. If you don't have insurance, your psychiatrist or therapist may offer you a discount. Many clinics and university settings and some private practitioners offer a *sliding scale*, where the fee is based on your ability to pay. You usually need to fill out some type of financial worksheet to determine whether you qualify for reduced fees. Most large insurance companies negotiate with providers in this way to save on costs, so doctors and therapists commonly offer similar discounts to uninsured patients. Always ask.

Other Ways to Survive the Hard Times

The old saying "Desperate times call for desperate measures" often applies to individuals and families dealing with bipolar disorder. When you can't pay the bills, you may find that the only options remaining are those you thought you would never have to consider. In the following sections, we describe a few other places to find financial support.

Asking family and friends for help

When you're strapped for cash, consider seeking help from your family and friends. If you're reluctant to ask people for money, consider this: If someone you care about needed money and you had the resources to help, wouldn't you want know about it? Would you be willing to help? You'd probably even feel hurt if you found out later that your loved one needed help and didn't come to you


REMEMBER

Self-reliance is one of the most overrated virtues in our society. People have an emotional and spiritual need to feel needed and to serve others. By asking for and accepting help from your loved ones, you're actually helping them fulfill a need.


TIP

Several online crowdfunding platforms enable you to set up a page for soliciting donations from friends, family members, and even complete strangers to help with paying medical bills and other expenses. Popular crowdfunding platforms include GoFundMe (`www.gofundme.com`) and Fundly (`fundly.com`).

Finding temporary financial relief

When you're dealing with temporary cash-flow problems, you may be able to find some relief by taking the following actions:

- **Contact your creditors**. Call the banks, companies, or individuals to whom you owe money and let them know what's going on. They may be willing to work with you to accept lower payments or provide you with a grace period for paying bills. Utility companies may have assistance programs for helping to cover your monthly bills. Some lenders (for mortgages and student loans, for example) may allow you to temporarily stop making payments if you're experiencing a financial setback, especially if the setback is related to a medical condition.
- **Take out a home equity line of credit**. If you own a home and have equity built up in it, you may qualify for a home equity line of credit that lets you borrow against that equity. Contact local banks to see what they offer. If you qualify, the bank provides you with checks you can write and maybe even a debit card you can use to pay bills. You borrow only the amount you need only when you need it. Be careful, though: By putting your home up as equity for a loan, you may lose it if you can't make the payments on that loan or pay off the balance when it comes due. Use this tactic only to help with temporary cash flow problems and draw from the account only when you have a plan and timeline in place to pay back the money.
- **Borrow against your retirement savings**. If you have retirement accounts, you may be able to cash out some of that money or borrow against it without incurring a tax penalty, especially if you use the money specifically to pay for healthcare expenses. Consult your investment representative or an experienced accountant to find out more about your options. Again, use this tactic only for emergencies. You shouldn't have to put your future financial security at risk to deal with a current healthcare problem.
- **Transfer credit card balances to another credit card**. If you have two or more credit cards, you may be able to buy yourself some time by transferring the balance from one card to another. Just be sure to transfer high-interest balances to a lower-interest card and do your best to work toward paying down the debt and negotiating any breaks the credit card companies are willing to agree to.

Government safety net programs

Most people try hard to avoid asking for help, especially from the government. You value self-reliance and being able to pull yourself out of a hole. But sometimes, when bipolar disorder is a part of your life, you may need more help than you ever imagined you would. Government resources are available specifically for situations like yours — when bills become unmanageable and your basic health and safety are at stake. Here's a quick look at some of those resources:

- **Food assistance:** This program is now called Supplemental Nutrition Assistance Program (SNAP), and it's available for people whose income is low but not necessarily low enough to require other supports such as general assistance (welfare benefits). Don't be ashamed to seek out this benefit if you're struggling to keep food on the table. Benefits are usually managed at the county level.
- **Cash assistance/Temporary Assistance for Needy Families (TANF):** These emergency cash-assistance benefits are federal monies, managed through the state for families who are in severe financial situations. These benefits have many eligibility requirements and are available on a temporary basis, but they can be a lifesaver during critical periods. Applications are often filed at the county level.
- **Housing supports:** A variety of housing support programs are available at the federal and local levels. You typically need to speak to someone in a social services agency to access these kinds of benefits, but don't wait to do this if you're concerned about losing your current housing. These applications can take quite a while to complete, and you may have to add your name to waiting lists after you apply.

6 Assisting a Friend or Relative with Bipolar Disorder

IN THIS PART . . .

Build empathy, lend a hand, and avoid becoming overbearing — all without letting the disorder drag you down.

Find out what you can do to support your loved one, when to step in, and when to consider stepping back.

Plan ahead for a crisis, so you know what to do when a mood episode spirals out of control, and develop a plan B for when bipolar throws you a curve.

Understand the challenges of diagnosing, treating, and supporting a child or adolescent with bipolar disorder and find out about other conditions that may look a lot like bipolar but aren't.

IN THIS CHAPTER

- Getting your head in the game
- Grasping what your loved one is going through
- Setting parameters for when to call for help
- Helping a person who refuses help and attending to your own needs and emotions

Chapter 19
Supporting Your Loved One

When bipolar disorder afflicts a friend or relative, it afflicts you, too. Symptoms can confuse and bewilder you, strain your relationship with your loved one, and leave you physically and mentally drained. You want to help, but how? What can you possibly do to remedy "wiring problems" in the brain? What can you say to your loved one who loses all hope? What can you do when your friend is spending money recklessly or engaging in high-risk behaviors? And how can you help when your loved one resists your attempt to intervene and answers your well-intentioned advice with arrogance and anger?

In this chapter, we confront the confusion and the sense of helplessness that friends and family members can face. We explain the cold, hard facts about bipolar disorder to prepare you for the struggles ahead; we provide exercises to steer you clear of any tendencies you may have to blame yourself or your loved one for what's happening; and we reveal what you can and can't do to help your loved one on the road to recovery. We also offer suggestions on how to care for yourself and find support so that you and your loved one can step out of the shadow of bipolar and into the light of a hopeful future.

Establishing the Right Mindset

Becoming an effective caregiver and support person has as much to do with what you think as it does with what you do. If you approach your role with false expectations and misunderstandings, you may be more apt to say and do unhelpful things, become easily frustrated, and blame yourself for situations and events outside your control. By establishing the right mindset, you can function more effectively as a support person while maintaining your own mental health. The following sections can help you begin.

Forming realistic expectations

Everyone needs hope, but false hope can lead to disappointment and frustration. It can also cause you to let down your guard. In the case of caring for a loved one with bipolar disorder, you may begin to think your problems are fixed, the illness is cured, and you've "put all this behind you." If you do, you're likely to drift back into old patterns. You forget about how important it is for your loved one to take the prescribed medications. You become less vigilant of the warning signs. You get careless. And bam! You're right back where you were, watching your loved one battle major depression or a manic episode.

To help your loved one win the battle against bipolar disorder, you must first establish the right mindset and confront the realities of the disorder:

- Your loved one is and will remain vulnerable to mood episodes.
- Your loved one can't overcome the illness by "trying harder."
- Preventive long-term medication is almost certainly required to prevent relapse and to control symptoms.
- Even with preventive medication, symptoms may recur.
- You and your loved one may need to adjust your future expectations and lifestyles to maintain wellness.
- Your loved one may not want your help at times, but always needs your love and understanding.

REMEMBER

You and your loved one have every reason to look forward to remission and a wonderful life. But your loved one must stick to the treatment plan, and you both need to remain vigilant when times are good so you can short-circuit any escalation in mood instability.

Disassociating the disorder from the one you love

Your loved one personifies bipolar disorder for you. The disorder expresses all its negative symptoms through your loved one's actions and words, which makes it tempting to associate the disorder with the person and blame your loved one for problems that result from the illness.

To successfully battle the illness, team up against it. Start by disassociating bipolar disorder from the person who has it. In the midst of a major mood episode, disassociation is easier said than done, but when you have time to think things through, try the following exercises:

- **Use language that reminds you and your loved one that the illness, not the person, caused the problems.** If a depressed episode has left a trail of broken promises and cancelled connections, try to get mad at the bipolar disorder, not at your loved one. Together you can express your grief, anger, and frustration at this condition, being careful to separate it from the person you love.
- **Think back to a time before the first major mood episode disrupted your lives**. Did the person you love seem different? In what ways? Remember that the core of your loved one isn't gone, even if it can be hard to find in the current situation.
- **Look at photographs and videos of pleasant times that you and your loved one experienced together**. What has changed? Name some ways that the disorder affects your loved one's behavior during a mood episode.
- **List all the words and behaviors that seem out of character with the person you love**. Would your loved one say and do the same things when thinking clearly? What would be different?

WARNING

Don't go too far when disassociating the disorder from your loved one. You may be tempted to attribute *every* negative behavior to the disorder, even behaviors that are consistent with your loved one's character. By attributing too much to the disorder, you diminish the importance and value of your loved one's personality and ability to think independently, which can be just as damaging as attributing too little to the disorder.

REMEMBER

In the world of disability rights, people differ in their preference of using *person-first* or *disorder-first* language — "I have bipolar disorder" versus "I am bipolar." Currently, the standard in the medical and mental health care community is to use person-first language as the default. But some people with disabilities prefer to

use language that puts the disorder front and center of who they are. Ultimately, the person with the disorder has the autonomy to decide how to talk about it, and respecting that choice is a key way to support your loved one.

Figuring out how not to take it personally

When you're on the receiving end of an angry tirade and when nothing you do seems to please your loved one, you may react by taking it personally and becoming defensive. This reaction is perfectly natural, especially when you're in a close relationship with someone you love. Your happiness and the happiness of your loved one may be intricately intertwined, and when one of you is unhappy, the other suffers as well. You begin to think that if you could just figure out the right way to act and the right words to say, the situation would improve. When it doesn't, frustration and bitterness often follow.


TIP

Try to *depersonalize* your loved one's hurtful words and deeds in order to overcome the common trap of taking them to heart. Depersonalizing consists of coming to terms with the fact that much of what your loved one says during and around mood episodes has very little to do with you and much more to do with their unsettled mental state. Your loved one's feelings, thoughts, reactions, words, and actions can arise from multiple sources, including depression, mania, agitation, medication, or paranoia. By knowing that the disorder and other factors can hijack your loved one's brain, you may have an easier time shrugging off some of the reactions.

Nurturing a Sense of Empathy and Curiosity

You may not *know* what your loved one with bipolar is experiencing or feeling, but you can *empathize* (imagine and share in what your loved one is going through) and nurture your curiosity about bipolar disorder and your loved one's experience. When your loved one tells you how they feel, try to avoid asking why and lean into saying, "Tell me more." Even if you don't understand how or why they could feel this way, hold that thought and stay focused on what they're experiencing. Often your loved one doesn't know how or why they're feeling a certain way, but they can often tell you what they're feeling. This section is here to help you get a sense of what your loved one is going through.

Your loved one with bipolar disorder is wrestling with a severe mental illness that threatens her *self* — her self-esteem, self-control, self-confidence, self-determination, self-image, and so on. When she feels threatened, she instinctively resorts to fight or flight mode. In fight mode, your loved one may be angry, arrogant, or critical; refuse help; stop taking the prescribed medication; or blame others. In flight mode, your loved one may turn to drugs or alcohol, break off a relationship, seem indifferent or self-absorbed, or deny that anything is wrong.

Everyone is guilty of maladaptive responses to perceived threats. People become defensive in the face of criticism, deny when blamed, lash out when others offer support, refuse help even when they need it . . . and the list goes on. With mental illness, the negative spiral of events that drives maladaptive behaviors is compounded by at least two additional factors:

- **Major life changes:** In the midst of serious mental illness, people may lose their job, friends, sense of financial security, and a host of other external supports that people tend to rely on to feel secure.
- **Diminished capacity to deal with situations:** A person who's unable to think clearly lacks a key tool for dealing with complex challenges in rational, constructive ways.

REMEMBER

Although your loved one's words and actions may be counterproductive and seem irrational to you, they're actually normal and reasonable in the context of human psychology. In other words, under the same circumstances, most people, including you, would probably respond the same way. Empathy is all about accepting that fact and trying your best to see the situation through the eyes of your loved one.

Unfortunately, maladaptive behaviors tend to breed maladaptive behaviors, but you can begin to break the cycle by responding to maladaptive behaviors in more constructive ways and doing the following:

- Focusing less on criticism and more on praise
- Frequently reminding your loved one of your love and support
- Helping to reduce demands placed on your loved one
- De-escalating confrontation and arguments
- Shifting from blaming to problem solving
- Focusing on the here and now instead of digging up the past

Recognizing Your Limitations

When a loved one has bipolar, you stand by and watch the drama unfold. On the main stage, the doctor diagnoses and prescribes, the therapist counsels and educates, and your loved one wrestles with mood episodes. You wander backstage like a lonely understudy, wondering whether you have a role to play and something to contribute.

Naturally, you want your loved one to get well, but the situation is totally new to you. Should you get out of the way so the doctor and therapist can do their jobs? Should you take control? What would be most helpful? And how can you avoid making matters worse? The first step toward becoming an effective support person is to determine what you can and can't do to help. Lucky for you, that's what this section is all about.

Doing what you can

Your presence, patience, understanding, and willingness to help are perhaps the most valuable contributions you can make. Beyond these, you can offer many types of help, but keep in mind that a loved one who's an adult has the option of accepting or rejecting your offers or limiting your level of involvement. Being too pushy or overbearing can cause feelings of resentment and additional resistance to treatment, and you definitely don't want that.

REMEMBER

Here are some of the best and most effective ways you can help:

- Discover as much as you can about bipolar disorder and its symptoms and treatments, which you're already doing by reading this book.
- Keep in touch, especially during the tough times.
- Provide unconditional love and encouraging words while setting boundaries to keep your emotional reserves intact (such as "Let's have three planned calls per day and save all our checking in for those times").
- Reassure your loved one that with the proper treatment, symptoms can be managed.
- Encourage your loved one to seek professional help when necessary (but don't nag).
- Help your loved one find a qualified doctor and therapist.
- Assist in following up on insurance coverage and claims.

- Help with tracking moods and medications and watching for signs of impending mood episodes.
- Ask for permission to attend appointments with your loved one's doctor and therapist.
- Talk to your loved one about when and how to call the doctor or therapist if you become concerned.
- If your loved one can't make it to work, ask whether you can call their employer and ask what to say. If your loved one is self-employed, ask if you can do anything to help keep things running smoothly.
- Keep other people posted as directed by your loved one.
- Perform basic household tasks, such as grocery shopping, watching the kids, and paying bills.

Recognizing what you can't do

You can't control how your loved one chooses to deal with bipolar disorder. You can't force an adult to take medication, attend therapy, or even get sufficient sleep. If you attempt to take control, you risk taking ownership of a problem you can't fix.

You can and should step in at times when the illness makes your loved one incapable of making the right decisions, but the rest of the time, your job is to let go and allow your loved one to manage the situation. Your loved one will make choices about sticking with the treatment plan, making and keeping appointments, taking the prescribed medications, maintaining a healthy lifestyle, and asking for help.


REMEMBER

You didn't cause your loved one to get bipolar disorder, nor can you cure it. Don't feel guilty for the onset of bipolar disorder and don't think you have the power or the resources to fix the problem on your own.

Remaining Vigilant for Warning Signs

One of the more sinister characteristics of bipolar disorder is that the person who has it may not be able to recognize the onset of symptoms until it's too late to interrupt the cycle. A valuable role you may be able to play as a support person is to keep in regular contact with your loved one and watch for early warning signs of a mood episode.

REMEMBER

Not everyone has the knowledge, temperament, and sensitivity to differentiate between normal mood variations and symptoms and to intervene diplomatically. The ideal candidate for this job has the following qualifications:

- Knows and can recognize the signs of an oncoming mood episode
- Has close, regular contact with the person who has bipolar disorder
- Can openly communicate observations without instigating conflict
- Has permission to contact the person's therapist or doctor

During a period of relative calm, consult your loved one to determine whether having one or two people help with mood monitoring is acceptable. Avoid getting too many people involved. Nobody likes to feel as though everyone is watching their every move.

Knowing when to step in

If your loved one agrees to let you watch for warning signs of an oncoming mood episode, ask for additional details to help you determine the severity of the symptoms and the actions you should take when you see them:

- Make a list of common warning signs. (See Chapter 15 for more about common early warning signs of mania and depression.)
- Find out at what point you should be concerned enough to act.
- Determine the actions you should take, including sharing your observations and concerns with your loved one, contacting the therapist or doctor, taking away credit cards or car keys, securing objects the person could use for self-harm, or contacting another support person for assistance.

Knowing when to step back

Everyone has good and bad days. Don't assume you need to contact your loved one's doctor or therapist whenever you observe irritability or sadness. At these times, you can be a little more vigilant and convey your concerns, but try not to overreact.

In the midst of a major mood episode, don't step back simply because your loved one requests (or insists) you do so. Remain vigilant until treatment is obtained and moods begin to stabilize. Encourage your loved one to contact the doctor or therapist immediately for evaluation and consultation. A short visit with a qualified therapist is often enough to get your loved one back on the right track.

When the crisis abates and your loved one's mood begins to stabilize, be prepared to step back. Let your loved one know that you're available to help in any way possible.

Making a deal: Drawing up a contract

The whole scenario surrounding mood instability and treatment is fraught with fear. Loved ones are afraid they'll be powerless in the midst of a major mood episode if the person with bipolar disorder refuses help. Nobody appreciates having hypervigilant friends and relatives micromanage their lives and force treatment when they believe they don't need it.

One solution is to draw up an agreement (a *treatment contract*) during a time of relative calm and stability that spells out who and under what circumstances that person can intervene and what that intervention may entail. An effective treatment contract contains the following information:

- List of people who are permitted to step in (and perhaps a list of people who aren't permitted to step in, if necessary)
- Descriptions of external signs and symptoms of depression and mania
- Descriptions of verifiable signs that your loved one can manage the disorder independently
- Descriptions of observable signs that your loved one needs help
- Instructions on the types of help your loved one agrees to accept
- Instructions on the types of help your loved one absolutely refuses
- A clear statement that you may do whatever you think is best when you suspect that your loved one faces an imminent risk of harming themselves or others

REMEMBER

You can find a sample of a treatment contract at `finkshrink.com/bonus`.

Helping Someone Who Refuses Help

One of the symptoms of bipolar disorder is a *lack of insight* — an inability (not unwillingness) to notice a significant shift in one's own mood or behavior. This symptom happens most often during an acute mood episode but can also be part of the bigger picture of living with the illness. Family members agonize over how to help someone who doesn't want help, and they sometimes watch helplessly as

the illness destroys their loved one's life. What to do to help someone who refuses help or treatment varies depending on the situation. The following sections offer some suggestions.


REMEMBER

Solutions are very situation-specific. In some cases, if your loved one is managing to a certain degree, just not in a way that meets your standards, backing off is the best approach. If the person is a danger to self or others, you need to take more drastic measures, such as call for emergency services.

Taking action in an emergency

If your loved one is at risk of harming self or someone else, get help immediately. If you believe that your loved one needs medical attention and is willing to get help, and you can provide safe transportation, take your loved one to the nearest emergency medical center. If you're not completely confident that you can safely transport your loved one, call 911 or the emergency number for the area in which the emergency is occurring.


REMEMBER

When you call an emergency number, tell the dispatcher that you believe the person you're concerned about is experiencing a "mental health crisis" and describe specifically the behaviors that are causing concern. Request an ambulance, not just police response. Request a mental health team, if that's an option. When the police arrive, tell them that you want your loved one taken to a hospital or mental health facility and not to jail. You may not have a say in the final decision, but be sure to clearly express what you expect.


TIP

Some areas have *crisis intervention team (CIT)* officers trained to deal gently but firmly with situations that involve mental illness. If your area has CIT officers, request that a CIT officer be sent.

Expressing your concerns

If you're trying to help someone who's refusing help, you've probably already tried to discuss your concerns and maybe even convince the person to get help. But trying to convince someone to get help doesn't always work. In a nonemergency situation, try listening more than talking and agreeing more than disagreeing or trying to convince the person to accept help.

Use the communication skills we describe in Chapter 13 to bring up your concerns and apply the problem-solving skills we describe in Chapter 14 to team up with your loved one to address your concerns.

REMEMBER

Confrontation, criticism, and arguments are likely to be counterproductive and make your loved one even less likely to cooperate.

Calling the doctor or therapist

In a nonemergency situation, consider calling your loved one's doctor or therapist and expressing your concerns. The doctor or therapist can then provide guidance on how to proceed and may work with the family to get the person the necessary medical care.

REMEMBER

Your loved one's healthcare provider may not be able to tell you anything but *can* listen and take action on the information and insight you provide. Just remember that the provider may feel obligated to tell your loved one what you said; your loved one may perceive this as a breach of trust.

Contacting a local support group

Contact a local chapter of the National Alliance on Mental Illness (NAMI) or the Depression and Bipolar Support Alliance (DBSA). Local support groups often maintain lists of local mental health clinics and other nearby resources that may be able to provide answers and assistance. Check out `www.nami.org` or `www.dbsalliance.org` for details.

Contacting a local mental health center

Your loved one may have access to a community or county mental health center or clinic. The Substance Abuse and Mental Health Services Administration (SAMHSA) has a directory of mental health treatment facilities at `www.samhsa.gov/data/report/national-directory-mental-health-treatment-facilities`. Or you can search online for *mental health facility* followed by your loved one's location. Even if the mental health center can't directly intervene, it should be able to point you in the direction of useful local resources.

Considering involuntary hospitalization

You can't detain or hospitalize a person against his will unless certain legal standards are met, and those standards vary among jurisdictions. In Indiana, for example, a person must have a psychiatric illness and either be a danger to themselves or others or be *gravely disabled* — basically unable to function independently and provide for their own food, clothing, and shelter. In some places, a doctor or police officer can order a brief involuntary hospitalization. In others,

only a court-appointed mental health professional has that authority. Some places require a court order from a judge. Your local crisis line is probably the best source of information about the rules in your area.


REMEMBER

The duration of a detention or forced hospitalization varies. In the U.S., initial involuntary hospitalization orders are usually for a short period of time — about 72 hours in many states — and require more extensive legal procedures to extend beyond that. A full court-ordered commitment may last for 90 days or be indefinite and subject to review after a predetermined time period.

If a court hearing is required, you may be asked to testify that your loved one needs longer hospitalization. Having to do so can be stressful, but it's sometimes necessary. If possible, don't file the petition yourself. Do your best to have a doctor or treatment facility file the petition on behalf of your loved one; a medical professional has more pull with the courts and helps shield you from any resentment your loved one may feel. The best way you can help is to provide detailed documentation of the current crisis and be available to present detailed information if requested by the court.

Taking Care of Yourself

As a caregiver, you may feel lonely. Friends and family may ask how your loved one is doing, showing little concern for how you're holding up. Even worse, your circle of friends may scatter, perhaps out of fear, ignorance, or the mistaken (or valid) belief that you don't want them "meddling" in your affairs. If you let this behavior continue, you and your loved one may become isolated.

Isolation isn't healthy for you or your loved one. If you mope around, consumed by thoughts of the life you lost and the added responsibilities you bear, your loved one will recognize the pain in your expressions and gestures and feel the pangs of guilt. Look for ways to blow off some steam, grieve for your losses, attend to your needs, shore up connections with others, and then return to the relationship refreshed and renewed.

Although your loved one — whether a friend or relative — takes the direct hit from bipolar disorder, you deal with a lot of collateral damage. Suffering in silence forces you to hold back feelings that eventually find expression through blame and criticism. Try to find a healthy outlet for your emotions:

GETTING BETTER AT SUPPORTING MY DAUGHTER

People who love a person with a chronic illness like bipolar are part of their loved one's journey — whether they want to be or not. And while the symptoms of depression, anxiety, and mania are hardest for the person who has bipolar, mood episodes also have a profound effect on relationships. It can be difficult to stay steady and not react negatively when someone you care about struggles with severe depressions, anxieties, or manias. But there are many things you can do to provide understanding and support.

Throughout my journey with my daughter who has bipolar disorder, I've learned that taking care of myself and making sure I know as much as possible about bipolar are vital to my ability to offer real support. I cannot "fix" her symptoms, but I can change the way I react to her illness. She needs me to be centered, solid, and knowledgeable. She also needs me to listen. I had to learn how to really listen to her — to hear what she's saying . . . and not saying — and to respond to her with openness and honesty. After all, I can't expect my daughter to be honest with me and trust me if I don't do the same. Learning these skills took more than a few sessions with my own therapist and support group.

Bipolar disorder is a lifelong illness; we will continue to talk, listen, and work toward a close and honest relationship with coping and communication skills we hone each day.

— Cinda Johnson, coauthor of *Perfect Chaos: A Daughter's Journey to Survive Bipolar, a Mother's Struggle to Save Her*

- **Attend a support group for friends and family members of people with mental illnesses.** A support group can provide a forum for sharing feelings and information. See Chapter 6 for a list of support groups.
- **Discuss problems with your family and friends.** Feeling angry over what you're dealing with is normal, and you have every right to talk openly about it, but do it in the right setting. Loading up your loved one who has bipolar disorder with your emotional responses, no matter how reasonable they are, only stirs up more negative feelings in someone who's poorly equipped to manage them.
- **See a therapist.** A therapist can help you through the grieving process and provide you with an outlet for your emotions.

Bipolar disorder may be a part of your life, but it shouldn't overshadow your life. While your time and energy may be severely curtailed, especially during crises, do everything you can to engage in some nourishing and refueling activities for yourself to avoid burnout. You want to maintain your own identity and your own life as much as possible. Start with some of the following possible activities:

- Connect with old friends.
- Pursue interests and hobbies that you enjoy outside of your relationship with your loved one.
- Get involved in community activities.
- Invite friends or family members to your home.
- Do something fun just for the heck of it once a week.

IN THIS CHAPTER

- Communicating with your loved one's doctor and therapist
- Planning ahead so you know what to do when crisis strikes
- Managing different crisis scenarios

Chapter 20
Dealing with Crisis Situations

A family that lives with bipolar disorder tends to encounter more crisis situations than the average family. In the midst of these unsettling periods, friends and family members often experience a frustrating mix of chaos and isolation. If your loved one has bipolar disorder, you may not know what to do or even where to turn for help when a crisis hits. If you contact your loved one's doctor or therapist, you may be told that confidentiality rules prevent them from speaking to you. If you call the police, your loved one may resist and end up in jail instead of a hospital and, in either case, resent you for calling the authorities. So what should you do?

In this chapter, we try to help you answer that question, preferably *before* you need to ask it, so that you have a general idea of how to respond when a crisis occurs. But first, we look at something you'll probably need to do regardless of whether you have a more elaborate plan in place: Contact your loved one's doctor or therapist.

Consulting Your Loved One's Doctor or Therapist

In any mental health crisis, one of the first things you should do is call your loved one's doctor or therapist to let that person know what's going on and to ask for advice. We say "one of the first things you should do," because if you have reason to believe that your loved one poses a threat to self or others, you should first call 911 and describe the situation. Then you can call the doctor or therapist.


TIP

When calling 911, say specifically that your loved one is experiencing a "mental health crisis" and needs an ambulance to be taken to the hospital. Use the phrase *mental health crisis* so the dispatcher can communicate this to law enforcement and all other responders. Some police departments have crisis intervention team (CIT) officers who are specially trained to deal with cases that involve mental illness. Some municipalities have mental health responders, separate from law enforcement, who can approach the crisis as a medical/mental health emergency rather than a crime. Use the word *hospital* to send the message that you expect your loved one to be taken to a hospital, *not* to jail.

Calling your loved one's doctor or therapist certainly sounds easy enough, but in some cases, they may be unreachable or may tell you that the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule prohibits them from speaking with you about your loved one's medical condition without your loved one's consent. In fact, family members often report that this is one of the most frustrating aspects of dealing with mental illness.

Here are some insights that may help you overcome obstacles in obtaining information and getting the treatment your loved one needs:

- Although the doctor or therapist may be prohibited from telling you anything about your loved one's medical condition, no law prohibits them from
  - Listening to you or reading a letter or email or text message from you
  - Providing you with general information about a particular mental illness to help you develop a better understanding of what's going on and what to do in a certain situation
  - Speaking to you about specific concerns during a medical/psychiatric emergency when your loved one is unable to communicate effectively
- If your loved one has signed and filed a release of information with the doctor or hospital authorizing you to receive information, the doctor or hospital can't withhold medical information from you. Chapter 15 contains a sample release of information form.

TIP

If your loved one is already hospitalized and hasn't filed a release of information form, insist that the hospital present your loved one with that option.

- Your loved one's healthcare provider can share information with you if your loved one is present and has an opportunity to object to disclosures.
- The doctor and therapist aren't prohibited from sharing information with you if, in their professional judgment, it's in the patient's "best interest" — for example, if you need to know that your loved one is feeling suicidal so you can be more vigilant. When requesting information, explain that you need information to act in your loved one's best interest. Of course, the doctor must agree with your assessment of the patient's best interest before agreeing to release information to you without the patient's consent. In addition, doctors can share only information that's necessary for the patient's care.
- A doctor or therapist is likely to have more power than you in getting your loved one the help necessary when your loved one is refusing help.
- If your loved one is not yet receiving psychiatric care or if the doctor or therapist isn't being helpful, try contacting your county or community mental health center (CMHC) for guidance.

Keep in mind that your loved one's doctor and therapist may feel obligated to disclose that you've been in contact and perhaps even share what you told them.

Discussing the Emergency Plan

The worst time to decide what to do when your loved one is in a crisis is during the crisis. With a little planning, you'll know what to do (and not to do) when a crisis hits, including when to take action, whom to contact and how, and where to take your loved one if hospitalization becomes necessary. During a time of relative calm, arrange a meeting with all family members who may be called into action to manage a crisis, including the person with bipolar. (If possible, keep your loved one's doctor and therapist in the loop, too.) In the following sections, we provide details on topics to cover during this meeting.

REMEMBER

To make your meeting most productive, follow the communications guidelines we present in Chapter 13, focusing especially on setting the stage for effective communication.

Figuring out how involved to be

The first topic of a crisis-intervention meeting needs to be what role each person should play in the event of a crisis. When determining what your specific role in

managing your loved one's crisis will be, consider the various levels of support. For instance, will you play cheerleader, stepping in only when a crisis looms? Will you act as a referral service, calling others when you sense trouble? Or will you land a starting position on the mood-management team — going to the doctor, managing medications, and assisting your loved one directly? And when you do step in, how much power should you have?

Consider, too, some important questions that affect your ability to follow through on your commitment:

- **How available are you?** Geography and time may limit your availability. Are you close enough to your loved one to show up within moments of a problem, or do you need to hop on a plane? Can you take time off work or away from household responsibilities to devote to crisis prevention and management? Do you have ready access to childcare? Is your boss understanding about the situation?
- **How do you typically respond when tensions rise?** If you're the type who faints when someone at the office gets a paper cut or if you wig out when the basement floods, perhaps you're not the best person for a leading role during a crisis. To help your loved one, you need to keep a cool head, identify the signs of an impending mood episode, and act rationally in the midst of chaos.
- **How involved were you before the crisis?** The more involved you've been in everyday management, the more helpful you'll be when responding to crises. Do you have a sense of the patterns that lead up to a crisis? Do you know what's been happening with your loved one's medications? Do you regularly talk with your loved one about the stresses in her life or are you more on the sidelines?
- **To what degree are you willing and able to intervene?** Do you want to have power of attorney so that you can freeze credit cards and bank accounts and make other financial decisions? Is your loved one with bipolar willing to share information and control of finances? Will you be in your loved one's home, taking away car keys and alcohol? Answer such questions prior to a crisis to eliminate hesitation and guesswork during a crisis.
- **How much intervention can your loved one endure from you?** If the person you're helping has patterns of becoming explosive or dangerous during a crisis, you can do only so much before involving other levels of intervention, such as a crisis team or hospital emergency room. Your role in crisis management may have an early stopping point if your attempts to intervene trigger outbursts or destructive reactions.

REMEMBER

The limits you set for your involvement depend a great deal on temperaments, trust, and willingness to work as a team. You must identify your loved one's personal preferences desired levels of intervention. Just as importantly, communicate your comfort level for dealing with deeply personal issues such as money and healthcare. Your level of involvement isn't a given; it's a matter of negotiation. However, your loved one should have someone on the support team who's willing and able to step in during a crisis.

Determining when to intervene

Identifying the proper intervention point can be quite a challenge. You don't want to hit the panic button whenever your loved one looks a little glum or gets excited, but you also don't want to wait until your loved one becomes completely unreceptive or threatens harm.

Ideally, you can communicate your observations and concerns to your loved one well before a crisis occurs, assuming that you can identify the warning signs early enough and that your loved one is open to feedback. In such cases, you may offer your feedback in the form of a question, something like, "I hear more talking from you than usual, have you noticed that?" or "I think you seem less energetic than you were a couple weeks ago, have you been feeling that way?" Stick to describing what you see and hear and avoid making diagnoses, such as "You seem to be getting manic" or "You seem depressed today." Let your loved one draw her own conclusions based on your observations. Your loved one can then decide whether a call to the doctor or therapist is in order. If you feel doubt about when to speak up, these guidelines may help:

- **Act early and often.** Work on establishing open communication with your loved one about the experience of living with bipolar disorder, as we explain in Chapter 19. Such discourse gives you greater knowledge of the warning signs and improves your ability to identify them early. It also makes your loved one more comfortable when talking about the illness with you and others and more receptive to your observations and concerns.

  

  REMEMBER

  The sooner you can identify a mood cycle and take action, the more likely you are to be successful. As a mood cycle gains momentum, your loved one's resistance to your intervention is likely to increase, and your efforts can backfire.

- **Keep an eye on the mood chart.** If you live with your loved one, you may not notice the subtle escalation of mood from one day to the next, but a quick glance at a one- or two-week period on a mood monitoring app or chart can alert you to a growing problem. To be proactive, you and your loved one may agree to look at the mood patterns together at regular times. Mood monitoring

apps typically generate graphs that can be great for spotting trends. If your loved one agrees, you may chart your observations as well. Sometimes comparing notes and charts can help you both see patterns in your observations. (Chapter 11 has a sample mood chart that you can use; a number of mood-monitoring smartphone apps are also available.)

- **Identify "red flag" behaviors.** Is your loved one sleeping dramatically less or more? Beginning to lose whole evenings to shopping or planning numerous big projects? Eating much more or less? Has your musician friend stopped listening to music or playing instruments? Behavioral changes that indicate trouble are often very unique to the individual.
- **Err on the side of caution.** Your loved one's safety and survival are most important. By intervening, you always run the risk of hurting your loved one's feelings or sparking frustration or anger, but the alternative could be worse.

WARNING

If your friend or relative is talking about suicide or behaving recklessly, you must act immediately. If your loved one can't or won't listen to you, call for help, as we instruct later in the section "Suicidal threats or attempts."

Knowing whom to call for help

While you work on a crisis-intervention plan with your loved one, be sure to address the issue of who may become involved and at what point. Make a list of the people your loved one wants you to contact and the people you consider helpful and then edit as necessary. Cross off people who may cause more problems than they solve; you both know who they are. Record your final list of names and numbers on the Crisis Information Sheet we provide in Chapter 15. Regularly update contact information and keep a digital copy.

Keep in mind that you may need to call more than one person on your list. If you're trying to act early and dangerous symptoms aren't present, you're more likely to deal with the doctor and therapist. If you're acting during a dangerous episode, you're likely to call the hospital or 911 first, but you need to call the psychiatrist and therapist as well.

TIP

Bring your list of contact information to the emergency room or hospital. Doing so saves a lot of time for the admitting team. Also keep an updated list of medications with your contact list so you can tell the healthcare professionals exactly which medications and doses your loved one is supposed to be taking. Keeping all this information on your phone, if possible, is a great strategy because you'll always have it with you.

Deciding where to go

You need to know where to take your loved one in the event that hospital care is needed. Have a list of at least three options, such as these:

- **First choice:** What's your loved one's preferred mental health facility? In Chapter 15, we offer guidance on choosing a psychiatric facility before a crisis hits.
- **Second choice:** In the event that the first choice is unavailable (the facility has no available beds, for instance), you need a backup.
- **Emergency room:** The hospital emergency room is the choice of last resort. From here, doctors can determine the next steps.

In addition to this list, keep phone numbers and addresses of the mental health facilities on your phone, in your wallet, and in your car, just in case. You can put the hospital address into "favorites" in your navigation app or system so you can just pull it up when needed, or keep printed directions with the contact information. You don't want to be looking up this information in the middle of a volatile situation. If you're taking your loved one to the emergency room, you can just show up. If you're heading to a psychiatric facility, you need to call ahead to see if a bed is available.

REMEMBER

The hospital or psychiatric facility will get approval from the insurance company before admitting your loved one. However, having information about which hospitals and facilities are covered by insurance before a crisis hits is of the utmost importance. Encourage your loved one to contact her insurance company to find out which emergency and inpatient facilities are covered. (The insurer is unlikely to speak with loved ones due to confidentiality concerns.)

In a medical crisis, most insurers cover care received in any emergency room, but if that hospital's psychiatric units aren't covered, the ER staff will work with the insurer to find a bed in a covered facility.

Responding in a Crisis

People think nothing of buckling up for safety or wearing a bicycle helmet, but they often hesitate to take car keys away from someone who's driving recklessly or to snatch credit cards from someone whose spending is out of control. When you and your loved one discuss crisis prevention and management, be sure to cover risky behaviors and agree on a plan for dealing with them. Your loved one's

prior approval to intervene can strengthen your resolve to act forcefully during a crisis and perhaps make your loved one more receptive to your efforts.

In this section, we list risky behaviors that are common to bipolar disorder and offer suggestions for dealing with them in a crisis. How you choose to handle the behaviors is up to you and your loved one, but the best way often requires creative thinking and serious planning.


REMEMBER

The clever plans you develop during your rational meeting of minds may seem completely unacceptable to your loved one during a crisis, particularly a manic episode. Having a solid plan and taking early action can increase your chances of success, but be prepared to encounter unexpected resistance.

Suicidal threats or attempts

A person with severe depression is at high risk for suicide. The risk may be elevated if the person has recently started treatment for depression because the person may still be depressed but now have enough energy to actually go through with it. If you suspect that your loved one may be considering suicide, take the following steps:

1. **Keep watch; don't leave your loved one alone.**

   If you can't stay around, call someone to come over and then stay until your replacement arrives.

2. **Listen, remain supportive by expressing how much your loved one means to you, and encourage open communication about your loved one's thoughts and feelings.**

   Remind your loved one that how they feel right now is temporary and will pass, and keep your own distress in check — staying calm is critical. At this point, don't try to argue about why life is worth living and don't dismiss your loved one's feelings.

3. **Remove any weapons or medications that your loved one could use in a suicide attempt.**

   Don't leave anything around that could make suicide an easy option.

4. **Call your loved one's doctor or therapist or call 911.**

   If you can't connect with the doctor or therapist, don't hesitate to drive your loved one to the emergency room (if you can do so safely) or dial 911.

5. **Get help from other friends or family members.**

   They can help support your loved one, as well as you, through the crisis.

REMEMBER

Don't be afraid to ask about suicidal thoughts. Your loved one won't become suicidal just because you ask questions; the risk comes when you don't ask. Also, trust your perceptions and instincts. When dealing with a loved one who's becoming increasingly violent or suicidal, you may try to talk yourself out of believing that something bad can actually happen. If the situation is escalating, get help before it's too late.

Mental Health First Aid is an organization that seeks to train everyone in how to support someone with mental illness or substance use disorders, and particularly how to respond in a crisis. Consider getting training or finding out more at their website: `www.mentalhealthfirstaid.org`.

Agitated behavior

If agitated behavior accompanies a mood episode, don't try to fight fire with fire. Try to defuse the situation and deescalate the conflict.

WARNING

Safety is first. Position yourself so that you have access to an exit. Don't let the agitated person get between you and the only way out. Avoid talking in the bathroom or kitchen, where the risks of getting hurt are greater. Don't be alone with someone who is becoming increasingly agitated; call friends or family members to help or call 911.

Deescalating potentially volatile situations is all about effective communication, which we cover in Chapter 13. Following are some additional do's and don'ts for tense situations:

- **Give your loved one plenty of space.** A person who's experiencing a severe mood episode may have an altered sense of personal space, so back off and don't try to touch the person.
- **Move slowly.** Your loved one may interpret sudden, fast movements as threatening.
- **Remain calm.** Doing so is essential.
- **Don't blame, criticize, judge, order, or threaten.** All these actions escalate conflict.
- **Speak softly.** Try using a soothing tone of voice.
- **Engage your loved one in conversation.** Aggression often occurs as a result of someone's inability to communicate needs. Ask questions and use active listening skills, as we explain in Chapter 13, to get your loved one talking. Distracting conversation about light topics is also a good strategy if the person is receptive.

- **Offer something to eat or drink.** Or if the person smokes, suggest a cigarette break. These distractions can also help defuse a situation.

WARNING

If someone if aggressive, call 911; don't try to handle the situation yourself. The preceding recommendations help defuse situations before aggression occurs or while you're waiting for emergency services.

Reckless driving

Mania and depression can impair your loved one's ability to drive safely. Mania lifts inhibitions, essentially disabling the speed regulator inside the brain and pressing your friend or relative to disregard speed limits and defensive-driving techniques. Depression, on the other hand, can impair concentration and reflexes, slowing response times and resulting in erratic driving. A driver who feels hopeless and despondent and who doesn't care about living or dying may be unable to make safe driving decisions.

The obvious intervention in this case is to take away the car keys — obvious, that is, until you consider some of the ramifications. Driving is central to many people's lives and represents adulthood and independence. By grabbing the car keys, you remove your loved one's sense of independence and freedom and ability to get to work, shop, get to appointments, and perform other tasks necessary to stay on track and avoid a major mood episode. So before you snatch the car keys, plan for these contingencies:

- Can someone take your loved one to work?
- How will your friend or relative get to the doctor and therapist?
- Who can pick up your loved one's kids, take them to soccer, and buy groceries?

Taking away the keys is the easy part. Keeping your loved one's life going afterward requires serious planning and attention to detail. Ideally you and your loved one mutually agree to a period without driving. However, if someone is ramping up into mania, the situation may escalate quickly, and you may have to take away the keys without the opportunity for discussion. Ideally in your crisis planning, you can address the possibility that during a rising manic episode your loved one may not be able to think clearly and will give you permission to take this action unilaterally when necessary.

Overspending

Unrestrained spending is almost a cliché in stories about manic episodes. The logical intervention is deceptively simple: Hide the cash and checkbook, snatch

the credit and debit cards, and transfer the cash from the savings account to an account that your loved one can't touch. Just be aware that your loved one can find ways to work around these minor inconveniences and get to the cash. For example, your loved one could

- Memorize the credit card numbers.
- Use stored account information on Internet shopping sites to place orders.
- Shop by phone.
- Apply for new credit cards over the phone or on the Internet.

TIP

To stay one step ahead of the mania, you need to think creatively and invent ways to counter the preceding tactics:

- **Contact the credit card companies to place a hold on the accounts or change account numbers.** Procedures may vary, depending on the companies and the state in which you reside, so research the policies and credit card company phone numbers ahead of time. Remember that you may also need to change the card number at any places that use the card for regular or automatic payments. You'll need your loved one's account numbers and phone or online passwords, so setting this up during a pre-episode planning meeting is especially important.
- **Report the credit cards stolen.** Technically speaking, the bipolar disorder has stolen them, so you're not really lying. (Do this only in a pinch.)
- **Inspect the mail for any new credit card applications.** Most mailboxes receive a steady stream of tempting offers; shred them or simply write "Return to Sender" on the envelopes and drop them in the mail.
- **Monitor your loved one's Internet use and email for any activity regarding credit card applications or transactions.** This particular step is possible only if you have login information for your loved one's accounts. It can also backfire if it causes a breach of trust. This is one of those interventions that's best done by planning ahead and getting permission from your loved one when mood is stable.
- **Try to avoid saving credit card numbers on favorite shopping sites or remove them if a crisis is brewing.** That way, your loved one can't just log in to a favorite site and make extravagant purchases in the middle of a manic or depressive episode.

Of course, potential drawbacks accompany these clever plans. For example, if your loved one shares accounts with a spouse or significant other, how can that person access money to buy groceries and pay bills? One solution is to keep at least one separate account that the person with bipolar disorder can't access — money

available during a crisis. You may also want to consider keeping most accounts only in the spouse's name to reduce the potential sources of money and credit during a crisis, but make sure everyone is on board with this plan.

Hypersexual behavior

Hypersexuality — a supercharged state of sexual confidence and desire — is a diagnostic feature of mania that often results in risky sexual behavior. It stirs up boatloads of trouble for people with bipolar disorder and their families. Trying to reduce this risky behavior presents unique challenges. Sexual behavior is private stuff. Without trailing the manic person 24/7, how can you prevent dangerous sexual behavior? For starters, try the following:

- **Take the car keys and credit cards.** No car, no money, no sex. Well, it may not be that easy, but taking driving and spending off the table blocks the main access routes to unsafe sexual connections. Of course, taking away the car keys and credit cards presents other drawbacks, which we describe in the previous two sections.
- **Restrict or monitor Internet access.** The Internet is everywhere — phone, computers, tablets, TVs — providing constant access to a menu of sexual opportunities, including pornography, which may be the least of your worries. Hookup apps, social media platforms, online dating sites, and other virtual pickup joints are packed with people looking for sexual connections. Pornography doesn't carry the risk of sexually transmitted diseases or pregnancy, but hookup apps and dating sites can lead to physical encounters, including predatory ones.

  Restricting Internet access has some potential drawbacks to discuss with your loved one during your planning meeting. Can you restrict Internet access without eliminating communications (phone/texting, email, and work communications)? Should you limit texting or phone access? Will your loved one allow you to monitor or restrict Internet activities and communications? Tailor your plan so that both of you feel comfortable with it and confident that it will produce the desired results. Talk, talk, and more talk is the only way to cover all your bases.

Substance abuse

Bipolar disorder doesn't mix well with drugs or alcohol. In a person whose inhibitions are already compromised, these substances melt away any vestiges of good judgment. With depression, alcohol can result in a much higher risk of completed suicide. Helping your loved one stay away from these dangerous substances can be lifesaving, but your options are limited:

- **Cut off access to money and transportation.** A loved one who can't afford drugs and alcohol and can't get to them can't use them. However, even if funds are restricted, your loved one can still steal drugs or alcohol or trade stuff for them.
- **Restrict phone and Internet access.** If a friend or acquaintance delivers drugs or alcohol to your loved one, you can cut off communications to the outside world, if possible, to help block the courier route.
- **Monitor your loved one's activity.** Keeping watch is incredibly intrusive and restrictive for both you and your loved one, but standing guard is the most effective option in controlling almost every risky behavior we cover in this section. Obtain assistance from others, if possible, to reduce burnout.

Runaways and disappearances

If your loved one disappears and cuts contact with friends and family for an extended period, you must notify the police. If the police department has a unit trained to deal with people with mental illness, ask to speak to someone in that department. In any case, be sure to tell the person taking the report that your loved one has a mental illness and is at risk of unpredictable behavior. Although you may not have reached the required time frame for reporting a person missing, by identifying the mental illness, you may help law enforcement officials respond more quickly than standard operating procedure calls for.

Making this report in person rather than over the phone may be more effective because doing so allows you to assess how the police officer is reacting to the information. If you feel that you're not being heard or not being taken seriously, with respect and courtesy, ask to speak to a supervisor.

If your loved one is missing, contact the doctor and therapist, who may have some idea of where to look. They may have more sway with law enforcement as well. Make sure to contact friends and relatives (as many as you can think of) to broaden the network of people looking for your loved one.

Arrests

If your loved one with bipolar disorder is arrested, your goal is to transition the person as quickly as possible from the legal system to the healthcare system. Here are several guidelines you can follow to help achieve that goal:

- **Be supportive.** Remain calm and remind your loved one that everyone has a right to legal representation. If charges are filed and you have the resources,

consider hiring an attorney — preferably an attorney experienced with cases that involve mental illness.


TIP

NAMI offers a lawyer referral service to its members and the general public. To contact the NAMI Legal Center and request a referral, email `legal@nami.org` or call 1-800-950-6264. Provide your full name, address with ZIP code, and telephone number.

- **Don't sign a police report unless you want your loved one arrested.** Giving a statement to police may or may not put your loved one at risk of arrest or other legal complications, but don't sign anything until you've discussed the options with the police and are comfortable with the decision of where your loved one will be taken. To make an arrest, the officers will probably need a sworn (signed) statement.
- **Be proactive.** Have consent and be proactive in your communications with your loved one's attorney, especially if the attorney is a public defender who's been assigned to the case. Ask questions whenever you encounter something you don't understand or if you don't know the potential consequences of something you or your loved one is asked to do or sign.
- **Report the arrest to your loved one's psychiatrist, treating physician, and therapist.** If your loved one has been in treatment, keep the doctor and therapist in the loop.
- **Document everything.** Keep a journal of everything that happens and everything you and your loved one do to seek help. Keep copies of any letters, emails, text messages, and faxes you send and receive. Document phone conversations and messages you leave, including the date, time, and name of the person you speak with.
- **Don't discuss any criminal charges with authorities.** You don't want to inadvertently say something that hurts your loved one's case.
- **When speaking with the jail supervisor or watch commander, ask the following questions:**
  - When can I expect my loved one to be released?
  - Where will my loved one be released?
  - Does my loved one need to post bail? If so, find out how much and in what form; for example, cash, credit card, or certified check. If you can't afford to post bail, request information about bail bonds services. (Make sure your loved one has legal representation at the bail hearing.)


WARNING

Avoid the temptation to merely bail out your loved one. Always consider the endgame — if you bail out your loved one, then what? You're often better off working through the justice system to try to transition your loved one to a mental health facility for treatment. The justice system may have more power than you do to help someone who resists treatment.

- If charges are filed, when and where will the hearing take place?
- When and where can I visit my loved one?
- Does the jail have a medical or mental health services department? If it does, get the name, phone, and fax number of the person in charge.

- **Consult your loved one's attorney and obtain permission before discussing your loved one's diagnosis with authorities.** The people you're dealing with may not fully understand or accept mental illness. Mention of the mental illness can positively or negatively affect your loved one's situation, and a local attorney usually has a better sense than you do of how sensitive and knowledgeable a particular individual is.
- **Remember that medication may be withheld until your loved one's competency for trial is assessed.** Withholding medication is cruel, but defense attorneys sometimes fight to have medication withheld so their clients are more likely to be found *not competent to stand trial,* in which case the clients are more likely to be committed to a mental health facility and the charges are likely to be dropped. It presents significant ethical questions, though, so be sure to seek out lots of information and support before supporting this plan.


REMEMBER

Not competent to stand trial isn't an insanity defense. It means the person can't, at this time, understand the nature of the proceedings or assist in their own defense.

- **Keep in mind that the insanity defense may be an option, especially if charges pertain to violent behaviors.** The insanity defense can be helpful in transitioning an individual with mental illness from the criminal justice system to a psychiatric facility.
- **Speak with your loved one's attorney about providing sentencing input if a conviction results.** Several sentencing scenarios may unfold that vary according to jurisdiction and the nature of the crime:
  - In some jurisdictions, sentences are mandated for specific types of crimes, and the judge has little or no leeway in sentencing, in which case your input really doesn't matter.
  - In the case of a felony, a parole officer usually writes a pre-sentence report that the judge refers to in determining the sentence. You may be able to provide the parole officer with details about your loved one's mental illness to sway the sentencing toward treatment rather than incarceration.
  - In the case of a misdemeanor, the judge may proceed to sentencing immediately after ruling on the case, so the defense attorney needs to inform the judge at the appropriate time of your desire to provide input regarding sentencing.

- **Advocate for a *jail diversion program or mental health court* if one is available.** Some jurisdictions have jail diversion programs or separate mental health courts to handle some cases involving people with mental illness. Jail diversion is likely to require the person charged with the crime to receive treatment and stay out of trouble for a certain period of time to have charges dropped. This can help your loved one avoid a criminal record. Mental health court, when available, is the best option because they're plugged into the resources and knowledgeable about the intersection of mental health and the legal system.
- **Write letters.** If the system is being irresponsive and you sense that your loved one is about to experience an unjust conviction, research the chain of command and work your way up until you find someone who listens and is sympathetic to what you're going through. You may end up having to write a letter to your state governor.
- **Contact the press.** If you're not getting satisfactory results through the system, contact the local press and tell them your story. Public exposure can often correct an injustice and help to fix a broken system.

If your loved one is ultimately convicted and jailed, then you can advocate for treatment for your loved one without having to consult with your loved one's attorney. If the jail has a medical or mental health services department, fax the following information to both the jail supervisor or watch commander and the medical or mental health services department:

- Your loved one's full legal name, date of birth, booking number, and current residential address
- Your loved one's diagnosis or the reasons why you believe the behavior in question is the result of a mental illness
- The name, phone number, and address of your loved one's psychiatrist or treating physician
- A list of all current medications, dosages, time(s) of day to be administered, and the name and number of the pharmacy
- Information about medications that have proven to be effective versus ineffective or that have caused serious negative side effects
- Any history of suicide attempts or threats
- Information about other medical conditions that may require attention
- A written release of information consent form if your loved one has given you one; if you don't have a signed consent form, ask that your love one sign a written release of information consent form while in jail

IN THIS CHAPTER

- Accepting the challenges of diagnosing children and adolescents
- Seeking out a professional evaluation
- Developing a treatment plan for your child and family
- Figuring out how to parent your child after bipolar enters the picture

Chapter 21

Supporting Your Bipolar Child or Teen

Consider the following thought experiment: You notice something's not quite right with your daughter. It may be that she's always been more sensitive and irritable than other kids, but now she isn't herself at all. She's exhausted; even the tiniest task overwhelms her. She doesn't seem to enjoy much of anything, and she's hardly talking to friends anymore. You're worried about depression.

But after a few weeks, she seems better. Then, gradually or suddenly, she's over the top, again not herself. She never seems to sleep, she talks a mile a minute, and it's hard to follow her thinking. She's started several ambitious projects but can't seem to focus on any of them. She's texting everyone in her class — even kids she really doesn't know — or reaching out to strangers on the Internet. Or maybe she's angrier than ever and convinced that kids are following her, physically or online, and that her phone has been hacked and people are messing with her photos and her Netflix algorithm. Up all day and all night, she damages the phone and confronts her peers, scaring everyone.

Need some advice? When it comes to raising children, everyone's an expert. But trying to tough out the situation with advice from the Internet and a handful of parenting groups on Facebook isn't going to help you or your child. You're likely

dealing with a complicated medical problem that needs the same care and attention you'd give to diabetes, severe asthma, or other chronic illness.

In this chapter, we describe how bipolar disorder typically affects children and teenagers and why the diagnosis can be tricky. We also point out what a professional evaluation should involve and how to obtain one for your child. Finally, we lay out treatment options for a child with bipolar disorder and offer a brief introduction to what you can do as a parent (at home and at school) for your child with this condition.

Recognizing the Diagnostic Difficulties

The idea of childhood bipolar disorder was dismissed as a rare event until about 30 years ago when some researchers began to explore the idea that pediatric bipolar disorder was more common than previously thought. The researchers noted that many adults with bipolar disorder reported that their symptoms started before age 18. Some case reports over the years also suggested that mania could occur in younger adolescents and pre-pubertal children.

Over the next few years, a theory evolved that childhood mania may look different than adult mania; specifically, childhood mania looks more irritable than euphoric and more chronic than episodic when compared to adults. Chronic emotional *dysregulation* — a range of difficulties with modulating emotional responses — was identified as a core component of pediatric bipolar disorder. This was quite different from the defining feature of bipolar disorder being discrete mood episodes, which had defined the bipolar I and II diagnoses in adults for many years.

This theory took hold and became accepted practice quickly, in part because chronic irritability and emotional dysregulation are primary symptoms in many of the most challenging children seen by child psychiatrists. Bipolar diagnoses in children skyrocketed, as did the use of powerful antipsychotics and mood stabilizers to treat the children with these diagnoses.

Research since then has come to some clarity on this topic, and as described later in this chapter, pediatric bipolar disorder is diagnosed only in children and teens who have experienced a manic or hypomanic episode that meets the same criteria as those in adulthood, with some adjustment for developmental stage.

The likelihood of manic and hypomanic episodes increases with age, and by late teens, the rates of diagnosis approximate those in adulthood. Mania and hypomania are less likely the younger a child is. And mania or hypomania before puberty is uncommon, although it does occur.

The most rigorous research indicates that although many adults with bipolar disorder recall having symptoms such as irritability and mood dysregulation in childhood, those symptoms are not *specific* for bipolar disorder, which means that although irritability and dysregulation are common symptoms in children, in most cases they don't predict bipolar disorder. People who experience those symptoms in childhood are more likely to be diagnosed with depression or anxiety of some kind later in life.

The goal in using rigorous but developmentally appropriate diagnostic criteria is to be able to diagnose bipolar disorder accurately in children and teens so as not to miss a diagnosis of bipolar disorder when one is warranted and not to apply the diagnosis when something else is the root cause.


REMEMBER

A brief interview isn't adequate for a diagnosis of bipolar disorder in a child or teen. Get a careful evaluation, preferably with a board-certified child and adolescent psychiatrist, before you accept a bipolar diagnosis for your child. (See the later section "Requesting a Professional Evaluation" in this chapter for details.)

Diagnosing Bipolar Disorder in Children

As is the case with adults, a diagnosis of bipolar I disorder in children and teens requires the presence of at least one manic episode. (See Chapter 2 for the criteria used to determine when a certain mood episode qualifies as a manic episode.) A key feature in the criteria used to diagnosis mania is that the episode represents a *change from baseline.* A child may be chronically hyperactive, inattentive, or irritable, but the behavior isn't considered a manic episode unless the symptoms are substantially worse than usual for a period of days to weeks, not hours. The diagnosis can be tricky because many other childhood disorders have the same symptoms as bipolar disorder in children and teens, including the following:

- *Irritability* and *agitation* can be due to many conditions including, but not limited to, autism spectrum disorder, language disorders, unipolar depression, anxiety, trauma, substance abuse, and attention deficit hyperactivity disorder (ADHD).
- *Hyperactivity/high energy*, *talkativeness*, and *restlessness* are core symptoms of ADHD and may also be associated with substance abuse, some medications, trauma, medical and neurologic conditions, and developmental disorders.
- Trouble with attention and focus can be present at baseline in ADHD, and can also be a symptom of depression, anxiety, substance use, trauma, medical and neurologic conditions, medication side effects, and development disorders.

- *Sleep disturbance*s are common in childhood for a variety of reasons. Daytime fatigue from staying up too late, for example, isn't the same as the decreased need for sleep seen in mania. Trouble falling asleep has many causes, including typical adolescence, depression, and anxiety.
- The subjective sensation of *racing thoughts* can be associated with anxiety as well as mania.
- *Impulsivity* (poor judgment and high levels of risk taking) is often found in ADHD; it can also be related to typical adolescence, substance abuse, depression in which someone has given up and shows no regard for self-safety, and other developmental disorders.

The growing consensus is that some form of episode — a change from baseline — needs to happen to identify bipolar disorder in children and distinguish it from other childhood psychiatric or developmental disorders. The following sections briefly describe some of the most common conditions that complicate the diagnosis of bipolar disorder in kids — conditions that should be considered before arriving at a diagnosis of bipolar disorder.

Attention deficit hyperactivity disorder (ADHD)

The diagnostic criteria for mania clearly overlap with those for ADHD. Distinguishing between the two conditions is critical because treatment for ADHD is different from treatment for bipolar. For instance, the stimulants used to treat ADHD, such as Adderall (a combination of dextroamphetamine and amphetamine) and Ritalin (methylphenidate), can wreak havoc in a manic child, and antimanics, which can help with mania, don't help kids with ADHD. Here we explore the similarities and differences between ADHD and bipolar disorder and the possibility of the two conditions existing together.

Identifying shared symptoms of mania and ADHD

Mania and ADHD share a number of core symptoms that center on energy, impulse control, and mood reactions. Some important overlapping symptoms include

- High energy levels
- Excessive talking
- Poor impulse control
- Inattention/distractibility

- High risk taking/stimulus seeking
- Impatience/trouble delaying gratification
- Moodiness/short fuse (although this isn't a diagnostic criterion for ADHD, it's a commonly occurring associated symptom)

Distinguishing bipolar from ADHD

What are the differences between symptoms of mania and those of ADHD? How do you sort them out? The following considerations are important to evaluate when making a diagnosis:

- **Cycling/change from baseline:** In bipolar disorder, the manic and hypomanic symptoms typically come in episodes. In ADHD, the symptoms are *chronic* (present all the time).
- **Grandiosity:** Mania causes people to be full of irrational confidence and certain that they can do anything and achieve everything they imagine. Markedly distorted feelings of power and ability aren't part of ADHD. In fact, kids with ADHD typically struggle with low self-confidence and a sense that they're doomed to failure. Grandiosity is a red flag for mania.
- **Sleep disturbance:** Kids with ADHD often have trouble quieting their minds to sleep; these kids are usually fatigued the next day and have a difficult time waking up. In mania, kids need little sleep; they stay up late, get up early, and keep on going. They eventually crash, exhausted, but they have sustained periods of high energy with less need for sleep.
- **Euphoria:** Mania can be diagnosed in someone who has only angry, irritable moods — a symptom that's also associated with ADHD. However, the presence of *euphoria* — an expansive, overly happy mood with a persistent sense that everything is beyond wonderful, that everything is easy, even when life throws its usual curve balls — is part of mania, but not part of ADHD.

Considering comorbidity: ADHD and bipolar

How common is it for kids with bipolar disorder to also have ADHD? Can a child have both conditions? Research shows that bipolar disorder causes problems with attention and concentration, even between mood episodes. Children diagnosed with bipolar disorder are likely to have problems listening, focusing, and following directions. Teasing out the two diagnoses is a challenge for treating doctors and researchers. A child diagnosed with both disorders will require especially careful treatment planning.

Oppositional defiant disorder (ODD)

All children don't follow directions at least some of the time; it's part of growing up and developing independence and personality. For most kids, learning to meet age-appropriate demands usually grows out of standard parenting strategies where good outcomes result when the child can stay on track and less good outcomes result when they get off-track.

The diagnosis of ODD has been used when children's difficulty with following directions doesn't improve with standard approaches. ODD has evolved over the years and is meant to identify kids who have persistent problems meeting demands. The diagnosis also requires that these problems interfere with typical development and function. The *DSM-5* criteria for ODD essentially boils down to the following:

> A pattern of angry/irritable mood, argumentative/defiant behavior, or vindictiveness lasting at least 6 months . . . and is not exclusively directed at siblings.

ODD is a problematic diagnosis in many regards, because its core symptoms are nonspecific. Irritable mood and defiant behavior can be associated with a wide range of developmental and psychiatric conditions. Your child needs a careful medical and psychiatric evaluation to help understand the mechanisms underlying these difficult symptoms. Bipolar disorder/mania is one possible explanation, but others exist, including unipolar depression, ADHD, language disorders, autism spectrum disorder, and trauma, among others.

Another problem with the ODD diagnosis is that many studies confirm that it's used much more frequently in Black and Hispanic/Latino children than in White children. And White children are diagnosed with ADHD more often than ODD. ADHD is considered a more treatable disorder and comes with fewer negative associations about the child and parents. These disparities are related to implicit and systemic biases in individual providers and healthcare systems. Many clinicians have stopped using this diagnosis for these reasons.

If your child is diagnosed with ODD but you feel that your child hasn't been adequately assessed, seek a second opinion. A child presenting with a hypomanic or manic episode, or a depressive episode, could appear as oppositional, but it would have to be a new symptom or a noticeable exacerbation of a more chronic problem. The ODD diagnosis, when used, describes chronic challenges with meeting demands. In contrast, the mood episodes in bipolar disorder occur in episodes that are different from baseline.

Unipolar depression

Even though a manic episode is needed to make the diagnosis of bipolar disorder, most people with bipolar also experience periods of depression. In fact, bipolar depressive episodes typically occur more frequently and last longer than mania.

Depressive episodes often present long before manic ones do. Before treating depression, the doctor tries to assess the risk that someone will eventually develop mania, which is important because antidepressants alone can sometimes trigger manic symptoms if someone's brain is wired for bipolar disorder. Additionally, the treatment for bipolar depression differs from that for unipolar depression, and research suggests that they're different in their underlying brain changes (refer to Chapter 2). Without clear-cut mania, however, differentiating bipolar depression from unipolar depression is difficult even for the most experienced psychiatrists. In the following sections, we highlight differences in depressive symptoms that may help to predict the likelihood of bipolar depression now or in the future.

Sorting out depression in children and teens

Depression in children and teens can be especially difficult to sort out. People who develop depression early in life have a higher risk of developing bipolar disorder than people who experience depression at a later age; still, most kids who suffer from depression don't develop bipolar disorder. To sort out the risks of a child having bipolar disorder, the doctor may explore some of the following warning signs:

- **Repeat depressive episodes:** A kid who experiences numerous episodes of depression is a more likely candidate for an eventual bipolar diagnosis. Recurrent, relatively short but severe episodes of depression are a risk pattern for eventual bipolar disorder.
- **Family history:** Having a first-degree relative, such as a parent or sibling, with bipolar disorder increases the risk of developing bipolar disorder by 5 to 10 percent. Check out Chapter 2 for details regarding family history and genetics.
- **Response to antidepressants:** How someone responds to antidepressants is suggestive of, but not part of, the diagnostic criteria for bipolar disorder. Any of the following responses to antidepressants may lead a doctor to suspect the possibility of bipolar disorder:
  - Mania or hypomania occurs. (Note that people can become manic or agitated on antidepressants without having bipolar disorder, but if the mania persists after the antidepressants are removed, then this is part of the diagnostic criteria for mania/bipolar disorder.)

- Antidepressants don't work.
- Antidepressants work initially but then stop working, even after dose increases and trials of different antidepressants.

» **A larger-than-life temperament:** People with baseline hyperthymic personalities have a higher-than-average risk of developing bipolar disorder. *Hyperthymic* is a medical term describing people who have high baseline levels of energy, enthusiasm, and animation. They are often extremely outgoing and active, highly confident, and stimulus seeking. It's a bit like a chronic state of "not-quite" hypomania.

Repeat depressions, a family history of bipolar disorder, certain responses to antidepressants, and a hyperthymic personality aren't diagnostic for bipolar disorder; rather, you should consider them risk data points. If your child's doctor spots several of these warning signs, your child's treatment plan may be different from that of a child who presents without those warning signs.

WARNING

Whether it's unipolar or bipolar, child and adolescent depression is a condition that tragically results in one of the leading causes of death in teenagers: suicide. Depression is a serious medical condition that requires appropriate evaluation and care.

Recognizing depression in your child

Depression can be tricky to spot, particularly in teens who already seem moody and impulsive. Depressed kids and teens can appear angry, bored, or withdrawn rather than sad and dejected. In children and adolescents, irritability, instead of sadness, can be the major mood state in depression. Because irritability is also often prominent in manic episodes, sorting out mood symptoms in kids can be slippery.

To determine whether your child is sinking into a serious depression, look for the following signs:

» **Persistent changes in function:** Everybody has good and bad days — sometimes even a few in a row, but when your child or adolescent begins to experience extended periods of uncharacteristic thoughts, feelings, or behaviors, you need to pay attention. Explore further any significant changes in grades, friends, activities, energy, and enthusiasm that go on for more than a couple of weeks.

- **Any self-harm or references to suicide:** These are critical red flags that you must respond to immediately. Even if you think your child just wants attention or is trying to manipulate you, mentioning or attempting suicide or self-injury as a tool to achieve that goal is a major concern that requires immediate evaluation.

  
  WARNING

  Always take threats of suicide seriously. Don't try on your own to determine whether your child really means it. Involve a professional immediately.

- **Withdrawal:** Kids like their personal space, and adolescents, in particular, spend plenty of time in their rooms. But kids who hardly leave their rooms, lose interest in spending time with friends, or drop out of activities are showing signs of depression. This behavior can happen gradually and be easily overlooked.
- **Sleep/energy shifts:** Kids change their sleep patterns throughout development. Teenagers typically develop a need to stay up late and sleep later into the day. However, a kid who changes patterns and starts sleeping a lot more or a lot less than usual may be depressed. If your child's energy levels seem to drop and not rebound after a couple of weeks, schedule a medical exam. If the doctor finds no other medical cause, depression may be a possibility.
- **Substance use:** Drinking and marijuana use seem to be ubiquitous in high schools nowadays. Keeping kids away from these experiences is a difficult challenge, but a kid who uses drugs and alcohol regularly or significantly increases use may be self-medicating. Don't convince yourself that all kids do it. If your child gets high or drunk most weekends, you need to look into it. Even if depression isn't present, substance abuse in a teenager is a big problem and needs to be addressed as early as possible.


REMEMBER

Kids with depression don't usually look sad all the time. Children can have fun with friends while still suffering from an underlying depression. If they tell you they're depressed, believe what they tell you. Kids (and adults) can put on a happy face and can genuinely get momentarily relief from despair when seeing friends. Those moments don't mean that they aren't depressed.

Disruptive mood dysregulation disorder

DSM-5 introduced a new diagnosis that grew out of research on children with chronic mood dysregulation — irritability and emotional/behavioral outbursts. As we previously discuss in this chapter, the concept of chronic mood dysregulation has overlapped with the diagnosis of bipolar disorder, but they're not the same. This diagnosis helps to capture children with baseline irritability and outbursts who don't exhibit the cycles or episodes needed to diagnose mania and therefore bipolar disorder.

Disruptive mood dysregulation disorder (DMDD) is listed under Depressive Disorders in the *DSM-5*, and its diagnostic criteria are as follows:

A. Severe recurrent temper outbursts manifested verbally (for example, verbal rages) and/or behaviorally (for example, physical aggression toward people or property) that are grossly out of proportion in intensity or duration to the situation or provocation.

B. The temper outbursts are inconsistent with developmental level (they look like more typical reactions in a younger child, for example).

C. The temper outbursts occur, on average, three or more times per week.

D. The mood between temper outbursts is persistently irritable or angry most of the day, nearly every day, and is observable by others (for example, parents, teachers, and peers).

E. Criteria A–D have been present for 12 or more months. Throughout that time, the individual has not had a period lasting three or more consecutive months without all the symptoms in Criteria A–D.

F. Criteria A and D are present in at least two of three settings (at home, at school, with peers) and are severe in at least one of these.

G. The diagnosis should not be made for the first time before age 6 years or after age 18 years.

H. By history or observation, the age at onset of Criteria A–E is before age 10 years.

I. There has never been a distinct period lasting more than one day during which the full symptom criteria, except duration, for a manic or hypomanic episode have been met.

J. The behaviors do not occur exclusively during an episode of major depression and are not better explained by another mental disorder (for example, autism spectrum disorder, post-traumatic stress disorder, separation anxiety disorder, persistent depressive disorder).

K. The symptoms are not attributable to the physiological effects of a substance or to another medical or neurological condition.

Importantly, this diagnosis can't coexist with bipolar disorder or oppositional defiant disorder. If mania or hypomania is present, bipolar is the diagnosis. If symptoms of ODD are also present, then the DMDD diagnosis is used instead. DMDD can coexist with depression, ADHD, substance use, and other disorders.

Currently no specific treatment recommendations are available for DMDD. Because it's considered a subset of depression, treatment for depression is often the first place to start. If coexisting conditions, such as ADHD or anxiety, are present,

those are targeted. Multiple resources are typically needed for effective treatment in these children, including psychotherapy, parenting support, educational accommodations, as well as possible medications. The diagnosis of DMDD can be helpful to families who are trying to understand these difficult behaviors in their children. Realize that these responses aren't just children being difficult or willful, but rather are due to problems in their nervous system circuits that help to regulate mood and behavior. Understanding this difference in cause changes the treatment and parenting approaches considerably.

REMEMBER

An important consideration with a bipolar diagnosis is that certain medications, such as antidepressants and stimulants, may need to be avoided. The DMDD diagnosis doesn't carry these restrictions beyond baseline caution in using these medications in children. This is extremely helpful, because the overuse of the bipolar disorder diagnosis can lead to restricting the use of medications that may be helpful for conditions such as depression, ADHD, and anxiety disorders.

Anxiety disorders

Anxiety disorders are common in children, and they trigger changes in mood and behavior that can look like manic or depressive symptoms. Anxiety disorders cause fear and distress that are out of proportion to any actual threat. The fear and distress then trigger behavioral responses to try to reduce the threat with three primary responses: fight, flight, and freeze. Fight looks angry and out of control — the brain trying to save itself from a perceived danger. Flight can include running away from something, but can also present as avoidance and refusals. Freeze responses look like refusals and shutting down. Anxiety can mimic symptoms of bipolar disorder in some of the following ways:

- **Irritability:** Fear triggers a need to control the environment, to reduce threats, and to keep things safe. When the world doesn't cooperate (if children must do things that trigger fear or must stop doing something that is helping them stay calm), they can become angry and sometimes explosive. This behavior may look like the mood dysregulation found in mania and depression.
- **Racing thoughts:** Anxious people's brains are always scanning the environment for threats and are very busy worrying about potential dangers. This often presents as a subjective sensation of racing thoughts, also a symptom of mania.
- **Demanding and controlling behaviors:** People with anxiety work hard to control their environments. Parents are tasked with getting children to do things they don't want to do, which can be particularly difficult with anxious children, leading to hours of struggle with escalating tempers and mood changes.

» **Not doing as they're told:** The flight and freeze responses to anxiety can present as refusals and shutting down when given demands that trigger anxiety or distress. When the adult escalates the demands and becomes firmer (or even angry), the child's anxiety escalates, creating further paralysis and even less likelihood of meeting the adult's demand. This can easily turn into angry or sobbing outbursts that look like a mood disorder.

Obsessive compulsive disorder (OCD) isn't technically an anxiety disorder but is related. Children with OCD have repeated and out-of-the-ordinary fears (for example, that the doors are unlocked and a stranger will come in and hurt them) that they control with a variety of mental or physical rituals and behaviors (for example, checking door locks over and over before being able to sleep). If people with OCD aren't allowed to perform their behaviors, their level of distress can escalate dramatically and quickly. It can present as irritability with explosive mood and behaviors that are puzzling to parents and teachers and that look like mania or depression. Kids often can't or won't communicate their fears, which can make OCD difficult to diagnose. Your child's doctor should consider OCD, if your child has explosive outbursts.

Trauma

Children and adolescents who have been exposed to trauma, including neglect, abuse, domestic violence, death or loss of parents, bullying, or other extremely distressing/fear-inducing events and situations, are at risk of a variety of psychiatric disorders. Trauma and severe life events are contributing factors to the development of bipolar disorder in someone with underlying genetic risks (as we discuss in Chapter 2). However, trauma can lead to a variety of emotional and behavioral symptoms, including sadness, withdrawal, anxiety, irritability, distractibility, impulsivity, and sleep disturbances that may look like depression or mania but are part of the child's response to trauma.

Trauma must be considered and *ruled out* (determined to not be present) whenever children present with marked changes in their function. The term *trauma-informed care* has evolved to help healthcare professionals keep trauma at the front of their thinking at all times, because if trauma is present, the single most important step is removing the traumatic triggers and addressing them.

Autism spectrum disorders

Autism spectrum disorders (ASD) are developmental disorders that present with impaired social communication and restrictive/repetitive patterns of thought, speech, language, and behavior. The disorder presents during early development. ASD is described according to how much support the person with ASD needs. This can range from children with intellectual disability and language delays that

requires very substantial supports for daily function to people without language delay or cognitive difference who need some support.

Irritability and temper outbursts aren't uncommon symptoms in children with ASD, related to many factors, including the following:

- Rigid/inflexible thinking and behaviors
- Difficulties with self-expression
- Impaired social interactions and relationships

Additionally, anxiety is a common co-occurrence in ASD, which can cause moodiness and temper outbursts sometimes seen in bipolar disorder. ADHD may also be present in kids with ASD, and depression can occur more frequently than in children without ASD.

More severe presentations of ASD are usually diagnosed early in life, but children with less intrusive symptoms can be harder to accurately diagnose. If mood symptoms are especially pronounced, especially in young children, these symptoms may become a target of evaluation and treatment, and the ASD diagnosis may be missed or less clear-cut. Identifying these conditions is important, because the care and support include many features that aren't necessarily needed in bipolar disorder, such as speech/language therapy and other interventions to address the core symptoms of ASD.

Toxic exposures

The term *toxic exposures* refers to substances that are known to damage the body. Regarding bipolar disorder in children and teens, toxic exposure specifically pertains to substances that harm the central nervous system. These types of effects may be part of the development of bipolar disorder in some people (research is still trying to uncover what may trigger the development of bipolar in people who are vulnerable), but the more standard outcomes of these exposures can also be confused with bipolar disorder. Some examples include the following:

- **Prenatal alcohol exposure:** Alcohol exposure in the developing fetus can cause a wide range of developmental problems. Many children with *fetal alcohol spectrum disorders* can exhibit growth and learning problems, and many also have severe problems with mood and behavioral regulation as well as social interactions.
- **Lead toxicity:** Lead exposure damages developing brains. Even though children are monitored for lead, and lead paints are no longer sold, many children, especially those living in poverty, have elevated lead levels.

Emotional and behavioral dysregulation can be a prominent symptom in these children.

- **Alcohol and drug use:** In teens, substance use and misuse becomes a crucial part of the diagnostic workup of bipolar disorder. Intoxication, withdrawal, and dependence/addiction can all create severe changes in mood, thought, and behavior. Marijuana use is particularly noted to increase the risk of developing psychosis in young people who are vulnerable.

Requesting a Professional Evaluation

If you've read the first half of this chapter, you may still have no clear idea of what's going on with your child. All you know is that your child has *some* characteristics that *may* be caused by any one or more of a dozen different factors, such as normal adolescent angst, ADHD, depression, anxiety, lack of sleep, or a host of other conditions and contributing factors. You can now get your child to a professional who can help sort out the possible issues and pinpoint one or two factors that can steer you toward proper treatment. The following sections help you locate the right doctor and determine what to do as a parent.

Finding the right doctor

A good starting point in identifying the right professional to conduct a psychiatric evaluation for your child is your family doctor or pediatrician. Pediatricians are becoming increasingly familiar with psychiatric diagnoses in kids; yours can likely guide your family to the appropriate psychiatric help. Involving the pediatrician early is also beneficial, because your child's doctor can conduct a full medical examination to rule out the presence of any illnesses that may be contributing to your child's symptoms. In addition, the doctor can address general health issues, such as sleep and growth, which may be important factors in a mood disorder.

If you still have serious concerns about a mood disorder after a physician has ruled out other conditions, the next step is to consult a board-certified child and adolescent psychiatrist. Some adult psychiatrists work with adolescents and may be comfortable diagnosing and treating kids older than 16. Younger teens and children, however, should see a psychiatrist who's trained and experienced in working with kids.

Beware of doctors who proceed with a *diagnosis by prescription.* In this approach, the doctor spends 15 minutes with you and your child, hands you a prescription for methylphenidate (Ritalin) or an antidepressant, and then when your kid ends up in the hospital, tries a different medication to see if it works. A thorough evaluation takes time, input from various sources, and detective work. Continue your search if the psychiatrist you see doesn't seem genuinely invested in discovering the most accurate diagnosis for your child.

Finding a child and adolescent psychiatrist may take some work, depending on where you live. This field has a shortage of qualified professionals, particularly in some areas of the country. And even if you can locate a number of these doctors in your area, finding one covered by your insurance plan can be a nightmare. Look to the following sources for leads:

- Your child's pediatrician or family physician (in the U.K., this is necessary before accessing a mental health evaluation)
- The school counselor or special education department
- Friends or relatives
- A counselor or therapist who works with your child
- The American Academy of Child and Adolescent Psychiatry (`www.aacap.org`)
- Your local medical society
- A local support group, such as the National Alliance on Mental Illness (NAMI) or Depression and Bipolar Support Alliance (DBSA), where members often exchange information, recommendations, and concerns about specific doctors and therapists
- A local children's hospital or a medical school or university hospital that may have a department of psychiatry

Flip to Chapter 5 for tips on finding and choosing a psychiatrist, and check out Chapter 6 for guidance on assembling a mood-management team and support network. This information can help you put together and work with a team that's focused on your child's care.

If your child expresses suicidal thoughts or behaviors, *run,* don't walk, to the nearest mental health professional or emergency room. Get immediate help and sort through your long-term options later.

Knowing what to do when seeking help

As a parent or guardian, your role at this early stage of investigating the possibility that your child has a mood disorder is to find a doctor who's qualified to evaluate and treat your child and then to provide that doctor with the most accurate and complete history possible. Your child may be unable or unwilling to describe symptoms or to relate the details of various incidents that can help the doctor accurately assess the situation, so you need to supply that information in a way that protects your child's self-esteem as much as possible.

TIP

The following suggestions come from others who've been in the trenches:

- **Be open and honest.** If you and your spouse are having marital problems or if one of you has a drinking or substance abuse problem, don't keep it a secret. Family problems are important to consider when formulating a diagnosis. Don't let your child be misdiagnosed because you want to protect a family secret. Family therapy may be a necessary first step in treating your child.
- **Mention any family history of mental illness.** Genetics plays a strong role in bipolar disorder. If your family has a history of bipolar disorder, schizophrenia, depression, or other mental illness, tell the psychiatrist.
- **Share the history.** When did you and others first become concerned about your child's moods? Record details of any incidents involving your child that have raised concern. Also be sure to record periods of relative calm, when you observed few problems. Along with your child, try keeping a mood chart and sleep log or using a mood monitoring app for one or two weeks before your appointment.

  

  REMEMBER

  You can find a sample mood chart and instructions about how to use it at `finkshrink.com/bonus`. Keep in mind, however, that symptoms may differ significantly in children.
- **Gather input from others.** Ask caregivers, teachers, youth ministers, coaches, and others who interact with your child for their observations and input. Some therapists and psychiatrists have standard forms for collecting this data as part of their evaluation process.
- **Meet with the doctor privately.** Everyone who's closely involved with your child's situation should get a chance to meet with the doctor privately. Parents need to honestly report their concerns without shaming the child, and the child needs to be free to speak openly about their symptoms. Exactly how this plays out depends on the child's age and temperament, but the doctor needs information from both sources. Confidentiality weighs heavily in this situation, especially with teenagers. The usual arrangement is that a doctor won't tell parents what the patient says unless a safety risk is involved. Clarify the boundaries of confidentiality with your child's doctor from the start.

- **Obtain a copy of the evaluation.** In this day and age, people change doctors more often than they change clothes. Having documentation of your child's diagnoses and past and current medication trials can be very helpful when transferring care or if hospitalization is ever needed.

REMEMBER

If you don't feel confident about the diagnosis or treatment plan that a doctor provides or if you're uncomfortable with the answers to your questions, obtain a second opinion. Given the complexity of a mental health situation, a second viewpoint can help you make the best decisions and treatment choices for your child.

Breaking Out the Treatment Toolbox

With a diagnosis in hand and the assistance of your child's doctor and support network, your family can prepare to embark on a course of treatment. Your journey will meander along a path strewn with starts and stops, successes and failures, excitement and fatigue, and financial drain, but it will eventually lead to the land of stabilization for your child and family. Fortunately, you have several support vehicles to help you reach your destination:

- **Medications:** Balancing and calming an overcooked (overstimulated) nervous system usually requires at least some period of medication. Although you and your doctor may have concerns about using medications in children and teenagers, the right medication combination can ultimately be a lifesaver.
- **Therapy:** Individual therapy, family and parenting supports, and group and social skills therapy are the building blocks of treating children with bipolar disorder.
- **School support and intervention:** Kids spend much of their daily lives in school, and mood disorders disrupt school life in many ways. Building the right educational setting and support system, which we address in the later section "Tending to school matters," is critical to a child's wellbeing.
- **Lifestyle and self-care strategies:** Throughout this book, we point out the beneficial effects that lifestyle adjustments and self-care can have on the treatment outcome for adults. These lifestyle interventions apply to children, too but need to be adapted to their developmental needs. And parents will drive things like more regular bedtime routines and taking time to move and time to relax. Kids won't do everything you tell them, but modeling and supporting these types of strategies are good places to start.
- **Hospitalization:** Hospitalization is a last resort, but it may be the only option if your child is likely to harm self or others. Managing bipolar without hospitalization is possible, but children with the disorder are commonly hospitalized at least once for the illness.

The idea of treating a child with psychiatric medications may send shivers down your spine. If so, you're not alone. People often find it difficult to accept that a child's brain can misfire and experience mood instability beyond that of a normal child. The fact that bipolar disorder is a physical illness is tough enough to grasp when adults are struggling with it; in kids, for some reason, people seem to be even more resistant to accept this scientifically clear reality.

Considering medication issues

When mood problems threaten to destroy a child's chances of safely transitioning to adulthood or symptoms disrupt the child's development, medications are often the only viable solution. That is, despite all the diagnostic challenges, when depression or mania hijacks a child's life, biological treatment is often necessary. Yet, the process of medicating a child is complicated.

The study of psychiatric medication in children is still much less developed than studies in adults. In treating bipolar disorder in children and young teens, much of the medication planning involves taking what is known in adults and extending it into pediatric use.

We detail many of the medications used to treat bipolar disorder in adults in Chapter 7. Doctors prescribe most of these medications for children as well, using the adult-based research along with the scant information available about kids with the disorder. However, for many reasons, doctors must be especially careful when treating children and teenagers. Here are just some of the difficulties:

- **Different brains, different reactions:** Child and adolescent brains differ from adult brains, so medications may work differently in children. The potential benefits and side effects of different meds aren't as predictable in children as they are in adults because current research comes from studying adult brains.
- **Changing brains, changing reactions:** Not only do young brains differ from those of adults, but they're also developing more rapidly. You may get things stabilized, but when puberty strikes or some physiological event occurs, brain circuits evolve and change, requiring adjustments to medication combinations.
- **Murky diagnostic process:** The diagnosis of bipolar disorder in children can be challenging. (See the section "Recognizing the Diagnostic Difficulties" earlier in this chapter for details.) When a child rages, for example, you need to figure out whether it's a symptom of an oncoming or worsening mood episode or a result of sleep deprivation or social problems. Teasing out the answers needed to choose the best response or treatment can be difficult.

- **Lack of understanding/nonadherence with treatment:** A child's understanding of the illness and ability to manage it vary with age and developmental stage. Including the child in conversations and decisions as much as possible in age-appropriate ways is important. But given that many symptoms of bipolar disorder include refusals and emotional outbursts, convincing some kids to cooperate with treatment may be quite difficult. Like adults, kids can feel flattened by the medicine or dislike side effects enough to stop taking it.
- **Parental conflict:** Parents often disagree on the diagnosis of bipolar disorder and the necessity of medication for the child. Media images of psychiatric medication and the stigma associated with mental illness can weigh heavily on parents' minds. A parent with bipolar may influence treatment decisions. And if parents don't see eye to eye, the child often gets caught in the middle.

So what do you do? How can you decide what the best course of action is for your child's wellbeing? To start, gather as much information as you can before making a decision.

Understanding the diagnosis and treatment plan

Before you make decisions about medication and treatment for your child, be sure you understand the situation as it stands. Ask your child's doctor some of the following questions to draw out diagnosis and treatment details and to gain a clear picture of what you're facing:

- **How did you make this diagnosis?** You want to know the doctor's thought process, not just a pronouncement. Given the complexity of a bipolar diagnosis in kids, don't accept it without a careful review of how the doctor arrived at that diagnosis.
- **How did you choose this particular medication?** Just like making a diagnosis, picking a medication is a layered process with many pieces. You want to know your doctor's thought process so you can understand and then evaluate the recommendations. If the doctor hands you a prescription with no explanation, find another doctor.
- **Have studies in children been done with this medication?** Find out if the medication has been studied in kids and how often it has been used for children. Ask if the medication has an *FDA indication* for treating bipolar in children, which means that the US Food and Drug Administration (FDA) approves the medication for this particular use. Many psychiatric medications don't have FDA indications in children; they're used *off-label.* The off-label practice is completely legal, common, and often the right choice, but you want to know what information is available.

- **What are the target symptoms?** The answer to this question tells you what the goals of a particular medication are and how you can determine whether it's working. Keeping mood charts, rage counts, and sleep journals are ways for you and the doctor to follow your child's progress (see Chapter 11). Without these records, sorting out the response to medication can be quite difficult.
- **What are the possible side effects?** Find out what side effects to look for, whether any of them are dangerous, and how to measure them. Be sure you know what to do if you become concerned about a side effect. Also find out how to get in touch with the doctor — get the doctor's office number, email if available, and any other communication or messaging options available in the practice. Ask how long you should expect to wait for a return call or message. Be sure to also get an emergency number and instructions on what to do if you can't reach the doctor in an emergency.
- **How often will you see my child?** You want to know how closely the doctor needs to monitor your child on this medication and how often and how long the doctor will talk to you, the caregiver. Check to see whether you need to follow up with laboratory tests or medical exams.
- **How long will my child be on this medication?** You want to know about how long your child needs to stay on the medication if it's effective. Also ask how long your child must continue taking a medicine that doesn't seem to be working before trying something else. You also want to know what the criteria are for stopping or changing a medicine and how the doctor makes that decision.

  Getting the right medication combination can take months. Avoid the temptation to throw in the towel and give it all up when nothing seems to work. Persistence pays off.

REMEMBER

- **Will you collaborate with other caregivers?** You want to know if the doctor will communicate with your child's therapist, pediatrician, neurologist, and/or teacher. Ask whether the doctor can give you a written report and whether this kind of documentation costs more.

TIP

Bring a written list of questions with you to your child's appointment and write down the answers. Keeping this information in your computer, smartphone, or in the cloud can help you keep it accessible and updated. During appointments, you and the doctor exchange a lot of information in a short period of time; you won't remember it all if you don't write it down. Don't be embarrassed to take notes during the appointment. Doctors are usually supportive and know that detailed notes can help you follow through on the treatment plan.

FINDING MY WAY

If you're a child with bipolar disorder, you know you're different, and it's scary. I know because I was a child with bipolar, but I had no idea what was wrong and why I was different from all my friends. I was angry and would rage whenever my parents left the house. I got into a lot of trouble at school, and I seemed to be getting worse over time, not better. When I wasn't angry and breaking things, I was depressed, hopeless. At one point, when I was 12, I even threatened to kill myself.

My parents and teachers asked me what was wrong, but how could I explain to the adults in my life what was wrong with me when I had no idea what was going on in my brain?

Fortunately, my parents didn't give up. They took me to a therapist who was able to figure out what was wrong and sent me to Dr. Fink to confirm my diagnosis. But of course that's not the end of the story. Finding the right medications seemed to take forever, and the side effects were terrible. Antidepressants and antianxiety medications helped, but they also made me goofy. Lithium worked, but it made me gain a bunch of weight. On some of the meds, I couldn't concentrate at school. In junior high, I was so fed up with the side effects that I stopped taking my meds and ended up in the hospital.

My mom took some time off work to focus on helping me get better and return to school. She never gave up on me. My doctor encouraged me to be more open about my concerns regarding the medication side effects, and we were able to make some trade-offs.

After a hard teenage life and several tries at school, I moved to California and attended College of the Redwoods for cars and manufacturing technology, where I earned my associate of science degree in manufacturing technology. I am now living happily with a family of my own — my girlfriend and a son. My life is really good now.

— Matthew Durand

Parenting a Child with Bipolar Disorder

Parenting is a formidable challenge even when kids have the standard amount of control over their thoughts and emotions, but parenting children with bipolar disorder is even more demanding. Sure, medication can help stabilize the neurons and circuits in your child's brain, but the chaos of everyday life outside the brain — bedtime, the morning rush, sibling rivalries, family discord, and other commotion — requires intensive care. Many of the therapeutic approaches we

describe in Chapter 11 work well for both adults and children, but child therapy usually requires a higher dose of family training and coaching. Here, we bring you up to speed on what you can do as a parent to help your child more effectively navigate childhood with bipolar disorder.

Fine-tuning your parenting skills

Some standard parenting approaches not only are ineffective, but they also aggravate a child's condition, negatively affect self-esteem, and make parents feel powerless, guilty, and resentful toward their child. To survive as a parent and avoid the "everybody loses" confrontations, try the following suggestions:

- **Don't take your child's behavior personally.** You're not a bad parent just because you can't control your child's mood and behavior.
- **Don't blame your child for negative behaviors that are symptoms of the illness.** Remember that bipolar disorder significantly impairs a person's self-control, especially during an active depressive or manic episode but often between these periods as well. Many negative behaviors grow out of your child's distress, not from a desire to break the rules or anger you. Staying calm and avoiding power struggles can buy you some peace of mind.
- **Avoid shaming your child or using highly punitive discipline.** These tactics only make matters worse. If your child can't meet your expectations as a result of anxiety or low energy, for example, consequences won't make those obstacles go away. You both just end up feeling more hopeless and angry.
- **Do what you can to help your child develop self-acceptance and integrate the disorder into daily activities.** Acceptance and integration are the primary goals of therapy, and as a parent, you can help tremendously. Like adults with this disorder, children must work toward understanding that they *aren't* bipolar; they *have* bipolar disorder. It's a big, frustrating part of their lives, but it doesn't define them.
- **Let your child and yourself grieve.** Your child grieves over the differences with peers. As a parent, you grieve the loss of the child you knew before the illness, and some of the dreams you may have had. A skilled therapist can guide you and your child through what's often a long and arduous grieving process to help everyone move forward.

Parenting a child with special emotional and behavioral needs requires specialized skills. A child therapist or psychiatrist can provide you with strategies and techniques for managing everything from the biggest crisis to mundane matters, such as getting your child out of bed in the morning.

REMEMBER

Judgment, criticism, and demands may seem to have a place in parenting, but other, more positive ways to communicate with your child are far more successful, particularly when your child is dealing with bipolar disorder.

Tending to school matters

Kids with bipolar disorder are often sensitive and reactive, especially during mood episodes but often in between as well. They have a lower tolerance than most kids and can be extremely reactive to teacher temperament, schedules, task demands, peer conflict, and unanticipated change. Refusing to do work or follow directions, meltdowns, and social drama dot the school landscape for a child with bipolar disorder. Teachers and administrators can develop negative attitudes and expectations for your child, which only make success more difficult.

In the following sections, we provide suggestions to help you minimize the damaging impact of bipolar disorder on your child's school experience and include school-based resources as part of the process of reducing the negative effects of the illness and recovering into wellness.

Taking advantage of available services

Kids with special needs are entitled to appropriate modifications in the educational setting, and this includes children with mental illnesses such as bipolar disorder. Your children deserve appropriate services that enable them to participate in the educational process. If your child is struggling in school, look into the following options:

- **Special education services:** The Individuals with Disabilities in Education Act (IDEA) is a federal law that ensures students with a "handicapping condition" are provided a free appropriate public education (FAPE) tailored to their individual needs. To take advantage of special education services, follow this process:
  - **To obtain services, you, the parent, must request, in writing, that your child be evaluated for special education services.** Usually, this request goes to the director of special education in your school district.
  - **The school district has a designated timeframe to respond to your request.** Schools typically have 30 days to respond — 30 school days, not 30 calendar days.
  - **The evaluation includes a minimum of three types of assessments: psychological, educational, and social.** School or district psychologists and social workers usually conduct these evaluations.

- **A meeting of the Special Education team is held to determine if your child meets the criteria.** After the evaluations are complete, an IEP team holds a meeting to determine whether your child meets the criteria for services. The team must include you, your child's teacher, a district special education representative, and a special education teacher. States often require that a *parent advocate* (often another parent from the district) be on the team as well. You may also bring your own advocate. Some older children may benefit from being at these meetings as well.
- **The team develops an IEP.** If your child is eligible to receive services, the team develops an IEP to outline where and how the school will educate your child, based on your child's unique needs.
- **You must agree with and sign off on the IEP for it to proceed.** This step ensures that you have the final say in the IEP.

» **Section 504 and ADA services:** Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act are laws in place that prevent discrimination against people with disabilities. Section 504 is specifically focused on preventing discrimination in the K–12 school setting. To qualify for services under these laws, a student must be found to have a mental or physical disability that affects one or more major life activities, such as sleeping, learning, concentrating, communicating, and reading.

If this disability is found to interfere with access to the educational program, a 504 plan must be drafted to identify accommodations that improve access and meet the student's needs in an equitable manner. (Unlike IDEA IEP services, 504 services don't require that a student be failing or struggling; it's all about access, not remediation.)

Here are a few key points about 504 services:

- **Section 504 services are defined locally.** Procedures for obtaining these services vary from district to district. The district doesn't have to provide services just because a disability is identified and documented. The district determines whether your child qualifies for a 504 plan.
- **The evaluation process varies.** In some cases, the school may need to evaluate your child; in other cases, you simply need to produce a letter or report from your child's doctor that indicates a need for services.
- **Accommodations are the most common intervention.** Accommodations to standard school procedures are developed to meet your child's unique needs. Accommodations can include providing extended time on testing, separate testing locations, oral rather than written tests, and computer use in class, to name a few.

- **Accommodations may reduce make-up work:** Children and teens with bipolar disorder may miss school more frequently than other kids for many reasons including spending time in a hospital, adjusting to new medications, or experiencing elevated symptoms. Giving children a chance to return to school without overloading them with make-up work can be critical in keeping kids going to school. The sense of being so overwhelmed and behind that they can never catch up can trigger major problems with going to school and doing work.

Educating the educators about bipolar disorder

The process of obtaining an appropriate education for your child is often daunting. Schools are inundated with demands for services, and budgets are stretched thin. Schools and districts vary widely in their knowledge and skills around mental health needs for students. Stigma and a lack of understanding about bipolar disorder are rampant everywhere, including in schools.

During the process of securing services and modifications for your child, you'll probably need to educate the educators. Advocacy is your mission. Consider the following suggestions as you get started:

- **Remember that communication is key.** Begin by talking with and staying in touch with your child's teachers to get their perspectives on your child's needs. Get to know the guidance counselor, social worker, psychologist, and nurse who are working with your child. Ongoing communication provides you with information and demonstrates your concern and involvement — important tools in your ongoing negotiations with the school and district.
- **Gather supporting data.** Get reports from your child's psychiatrist and therapist. Bring them to meetings. Encourage phone or email communication between the school and your child's medical team.
- **Know your rights.** Federal education law mandates that every state maintain parent resource and training centers that provide guidance and information for parents as they navigate the special education system. The centers are sometimes referred to as *advocacy centers.* Your state department of education or your district's special education department should be able to give you a list of these centers.
- **Network with other parents.** Special education PTAs or informal gatherings of parents in your child's school system can provide a wealth of information, as well as camaraderie and support.

Practicing lifestyle management

Lifestyle changes can enhance the management of bipolar disorder and often alleviate symptoms. Many of the suggestions we offer here and in Chapters 11 and 12 apply to children with bipolar disorder as well as adults:

- Encourage and model regular sleep habits and a positive relationship with eating and food (see Chapter 12).
- Encourage and model regular physical activity and spending some time outdoors.
- Adjust expectations and develop predictable but flexible schedules and routines (see Chapter 12).
- Pace your family life and your child's activities (see Chapter 12).
- Map and track moods (see Chapter 11).

These techniques can contribute to your child's treatment success but battling with your child over things like food and exercise may not always be advisable — if, by doing so, you create rages or meltdowns, for example. Over time, though, working in small increments when possible, to establish some healthy lifestyle habits eventually pays dividends.

REMEMBER

Self-check your expectations and demands for your child and try to let go of some unspoken expectations that may be driving your responses. Embrace the child you have, not the child you expected, in order to empower and liberate you both.

Recognizing red flags for suicide

Bipolar disorder is a potentially lethal disease. An agonizing fact is that some people with this disorder do die from suicide. Suicide is a leading cause of death in adolescents, and bipolar disorder increases this risk significantly. To prevent suicide, follow these guidelines:

- **Never ignore threats of suicide or self-harm.** Don't try to determine if your child really means it. Let an expert evaluate your child to assess the risk.
- **Pay attention to substance abuse.** Alcohol intoxication dramatically increases the risk of completed suicide.
- **Watch for covert signs.** Seek professional help if you notice your child organizing and giving away belongings (preparing for being gone), experiencing sudden and extreme changes in activity levels or socialization, or talking of despair and hopelessness or death, even if suicide isn't specifically mentioned.
- **Monitor social media.** For younger children, routinely monitor their social media presence. As kids get older, they need more privacy, but when mental

illness is in the mix, parents need to be more involved. Let your child know that you'll be checking in as a way of monitoring safety. Don't do it without telling them. Some kids are comfortable with their parents or another trusted relative (maybe a younger aunt or uncle or family friend) accessing their social media but others, not surprisingly, will balk at that. Finding solutions that work for you and your child is a worthy investment of time and energy.

- **If you have concerns about your child, don't be afraid to talk about them.** Bringing up suicide won't give your child the idea; you don't create suicidal thoughts by talking about them. Not talking about your worries is much more dangerous.

If your child appears suicidal or unable to regain control, your doctor may recommend hospitalization. Don't panic if that happens. Psychiatric hospitalization is only for brief periods of time (often fewer than ten days) and is only for safety and crisis management. In some situations, it can also serve as a bridge to more outpatient services.

REMEMBER

Here are some things to do when considering hospitalization for your child:

- Ask the clinic where your doctor admits people or whether the doctor sends people to a hospital wither another doctor does the inpatient treatment. (Such policies vary regionally.)
- Review hospital choices with your insurance company because it may contract with only certain hospitals.
- Expect a long day during admission and plan to spend as much time at the hospital as you can during your child's stay. Being available, even when your child "doesn't want to see you," is critical for getting good care and for improving your child's wellbeing.
- Ask the hospital staff about the policies regarding seclusion and restraint and *prn meds* — meds administered to a child who's unable to regain control. Find out what the protocol/staff training model is to deescalate crises and avoid seclusion, restraint, and involuntary medication. You may be able to get information on frequency of restraints on the unit, but that data is often kept out of public hands. Ensure that the staff understands that you expect to be informed if any of these measures is necessary. Create a big stink if you're not contacted. Make sure they know you're watching.

In some cases, children can't stabilize at home and may require long-term care at a residential facility. This process is beyond the scope of this chapter, but you can obtain additional information from your doctor, your child's school system, the American Academy of Child and Adolescent Psychiatry (`www.aacap.org`), or the DBSA Parents and Caregivers page at `www.dbsalliance.org/support/for-friends-family/for-parents`.

7 The Part of Tens

IN THIS PART . . .

Focus on practical steps you can take to help yourself or a loved one with bipolar disorder.

Discover ten ways to manage bipolar mania and depression and fend off future episodes, nine of which have nothing to do with taking medication.

Find ten ways to help your loved one with bipolar disorder. Consider them the do's and don'ts of helping your loved one.

IN THIS CHAPTER

- Seeing your doctor and therapist and sticking with the agreed-upon treatment plan
- Regulating your sleep and monitoring your moods
- Developing daily routines and practicing mindfulness
- Remaining alert for early warning signs and being prepared to act

Chapter 22
Ten Tips for Managing Bipolar

Every illness has a better prognosis when the people who have it are informed, invested, and involved in their treatment plans. This is especially true for serious mood disorders, including bipolar. In general, the more involved you are in your recovery and mood maintenance, the better the outcome. This entire book is packed with strategies and skills for managing bipolar, but this chapter boils them down to the top ten.

Team Up with Your Doctor and Therapist

Managing bipolar disorder effectively is a team sport. To win, all team members must respect each other and communicate openly so that everyone remains well informed and can work together to achieve common goals. To team up with your doctor and therapist, put these suggestions into practice:

- **Make and keep regular appointments.** *Regular* may mean every three to six months when everything is going fine or once a week when warning signs appear.

- **Be open and honest.** Doctors and therapists are only as effective as the accuracy of the information you provide them. Be honest about how you feel, whether or not you've been following their advice and taking your medications, how much and what quality of sleep you've been getting, what your drug and alcohol use has been, and so on. Don't assume your doctor or therapist can read your mind.
- **Consult your doctor before making any medication or treatment changes.** If you feel the urge to reduce or stop taking a medication, contact your doctor before doing so. Your doctor may be able to suggest solutions for any concerns you have about your medications.
- **Ask questions.** When you know why your doctor or therapist recommends a certain medication, treatment, or therapy, you're more likely to stick with the treatment plan. Additionally, being aware of what symptoms the medicine should help with and what potential side effects may occur helps you feel more confident in the process. Your doctor and therapist are usually the best sources of information, because they know your specific situation. If you obtain additional information on the Internet or through friends and acquaintances, ask your doctor or therapist for confirmation of its validity.

REMEMBER

Visit `finkshrink.com/bonus` for a list of ten questions you definitely want to ask your doctor or therapist.

- **Don't hesitate to speak up.** You're a consumer of the medical services and products you're using, so you have a right to tell your doctor and therapist what's working and what's not, what you like and dislike, what makes you feel better or worse, and which side effects you deem tolerable and intolerable. Be patient and remember that some medications may require some time before they take effect and certain side effects may diminish over time. But also realize that sometimes you need to speak up to get the results you expect and deserve.

Take Medications as Prescribed

The single most important step for stopping and preventing a major mood episode is to take your medications as prescribed. Keep in mind that some medications require several weeks to establish a therapeutic level in the bloodstream and alleviate symptoms. If you're concerned about a medication's effectiveness or undesirable side effects, consult the prescribing doctor. When you start or change a medication, be sure to ask when (hours, days, weeks) you may notice any positive effects or adverse side effects.

WARNING

Don't stop taking your medication when you start feeling better. The meds are likely what's making you feel better. Plus, abruptly stopping an antimanic medication or antidepressant can trigger mania, depression, or seizures.

Regulate Your Sleep

Too much, not enough, or poor-quality sleep is both a symptom and a contributing factor to bipolar mania and depression. You should be getting eight to ten hours of quality sleep per day/night. Whether you sleep eight hours solid or divide it into smaller chunks is up to you, but try to establish a regular routine so you're sleeping at the same time(s) every day.

REMEMBER

Sleep deprivation can really throw your moods out of whack. For tips on getting some restful sleep, visit `www.sleepfoundation.org`. If you're having trouble getting to sleep or staying asleep, consult your doctor. Don't try to tough it out, thinking you'll eventually get tired enough to fall asleep.

Develop Daily Routines

Daily routines relieve stress, level moods, and help regulate sleep. Start with the basics, such as a specific bedtime and wake time and then add in your most comfortable meal and/or snack times to make sure you're eating. Track your schedule over the course of a week to spot any severe variations and try to bring them more in sync with your scheduled times. Some variation, especially on weekends and over the holidays, is probably not a big deal, but work toward reducing any major deviations in your daily routine. See Chapter 12 for tips on establishing healthy daily routines.

Build Mindfulness and Other Self-Centering Skills

Mindfulness is a mental state of active attention to your present experience, which is conducive to deliberate thought and action. In mindfulness, you bring heightened, nonjudgmental focus on your present thoughts, feelings, and sensations, while acknowledging and letting go of anything that pulls your attention from the current moment, including past regrets and future worries. In addition, studies

show that mindfulness has positive effects on how the brain processes sensory information. Try these basic mindfulness exercises to help you center on the present:

- **Breathe.** Close your eyes and focus on your breathing. Don't try to change it; just notice the rising and falling of your breath.
- **Focus on sensations.** Pay attention to what you see, hear, smell, taste, and feel at this given moment in time.
- **Shift from *doing* mode to *being* mode.** Most of the time, people are in *doing* mode — setting goals and trying to achieve them. In *being* mode, you accept your current situation and the way you're feeling instead of fighting or analyzing it.
- **Observe thoughts without judging them.** As you have thoughts, avoid the temptation to view them as good or bad or to become emotionally involved in them. By observing your thoughts objectively, you reduce their ability to trigger emotional reactions.
- **Accept yourself.** Comparing yourself to someone else or measuring your situation based on someone else's often leads to feelings of inadequacy and resentment. Focusing on gratitude can be a useful mental exercise in building self-acceptance.
- **Spend time in nature.** Leave your cellphone and any other gadgets at home and enjoy a walk in the woods or at the local park. In the midst of nature, people tend to become more aware of what's around them at the given moment and less absorbed in inner thoughts about past and future events in their personal lives.


TIP

You can practice mindfulness regardless of what you're doing by taking a sensory inventory. What are you seeing, hearing, smelling, tasting, and touching right now? This sensory inventory allows you to focus on the here and now instead of getting lost in the usual mental chatter about past and future events and concerns.

Clearly Communicate Your Needs

Even if you have the most supportive network of family and friends on the planet, get into the habit of advocating for yourself. Tell people what you need from them, express your preferences, and if they don't seem to understand, say so. You can say something like, "I think maybe I wasn't clear. What I really need/want is . . . ."

REMEMBER

Asking for what you want and need isn't selfish. Thinking that others should know what you want and need is ineffective. It places unrealistic expectations on others — namely, the expectation that they can read your mind. When you tell others clearly what you need, you're doing them a tremendous service.

Avoid Alcohol, Stimulants, and Other Counterproductive Substances

When you and your doctor are working hard to stabilize your moods with medication and therapy, avoid consuming any substances that may throw off that delicate balance. These include the following:

- **Alcohol:** Moderate alcohol consumption when you're stable (one or two occasional drinks) is okay, but you're asking for trouble if you have more than that. Drinking alcohol can neutralize the beneficial effects of medications, trigger a wide range of damaging mood and behavior changes, and interact with some medications to cause liver damage, seizures, unpredictable shifts in mood, and other health problems. If you struggle to drink in moderation, seek medical care or other supports.
- **Stimulants:** Caffeine, nicotine, energy drinks, amphetamines, and other stimulants can tip your mood balance, especially if they cause you to lose sleep.
- **Drugs and other substances:** Marijuana, cocaine, meth, ecstasy, psychedelics, and other drugs and medications that your doctor hasn't prescribed for you may also contribute to severe mood instability.

REMEMBER

Talk with your doctor about any supplements or over-the-counter medications you use or are thinking of using. Some of these products can have powerful effects on sleep, mood, and energy.

Monitor Your Moods

Early intervention is essential in preventing major mood episodes, and mood monitoring is the best way to tell when intervention is necessary. Hang a calendar on your wall, keep one in your purse or on your computer, or download a

mood-monitoring app on your phone. Rank your mood and other symptoms such as sleep and energy on a daily basis. If your mood drifts from the middle ranges to higher or lower levels for more than a few days, contact your doctor.


REMEMBER

You may not always be in the best position to assess your own mood. Consider enlisting a trusted friend or family member whom you see regularly to help you keep track of your moods.

Identify Your Early Warning Signs

Bipolar disorder has telltale signs, but they differ depending on whether you're experiencing mania or depression, and they vary among individuals. By learning what your early warning signs are and becoming more sensitive to these signs, you're in a better position to seek help before the mania or depression spirals out of control.

Common signs of escalating mania include the following:

- Missing an entire night's sleep and not feeling tired
- Rapid speech or racing thoughts; people tell you to slow down
- Being less sexually inhibited than usual
- Spending significantly more money than usual
- Engaging in reckless behaviors, including driving too fast
- Sudden surges of over-confidence, with big schemes and plans
- New worries about being spied on or harmed by others

Common external signs of escalating depression include the following:

- Hearing more and more people ask you, "What's wrong?"
- Getting plenty of sleep and still feeling tired
- Eating a lot less or a lot more than normal
- Being more socially withdrawn
- Crying or being upset for no specific reason
- Not being able to enjoy what usually brings you pleasure

Get Help at the First Sign of Trouble

No matter how carefully you care for yourself, monitor your moods, and remain alert for early warning signs, you can't always prevent symptoms. Through early intervention, however, you may be able to reduce the severity and duration of a mood episode by following these suggestions:

- Ask your doctor and therapist what to do if you begin to notice signs of depression or mania. Your doctor may be able to prescribe something for short-term relief.
- Contact your doctor or therapist as soon as you notice your early warning signs or a shift in mood that causes concern.
- Be prepared to call 911 or head to the emergency room if you feel that your moods, thoughts, or behaviors are escalating out of control. (Don't drive yourself unless you can do so safely — and you may not be in the right frame of mind to make that determination.)

IN THIS CHAPTER

- Educating yourself about bipolar disorder and medication options
- Sharpening your communication and problem-solving skills
- Teaming up with and encouraging your loved one and disengaging when necessary
- Keeping impeccable records and remaining vigilant for shifts in mood
- Avoiding bipolar disorder from taking over your life

Chapter 23

Ten Ways to Help a Loved One with Bipolar Disorder

When a loved one experiences a major mood episode, you may be at a loss for what to do. In this chapter, we suggest ten practical ways to help your loved one.

WARNING

Ultimately, the task of managing bipolar disorder is the responsibility of the person who has it, except for periods during which the person is incapacitated by a severe mood episode. Your job is to assist most of the time and to take charge only when necessary.

Find Out More about Bipolar Disorder

By reading this book, you're already doing the single most important and valuable thing to help your loved one with bipolar disorder — you're taking time to increase your knowledge and understanding. Knowledge is power and provides the basis for developing the empathy necessary to grasp the challenges that your loved one faces.

Without making bipolar disorder the sole focus of your life, continue to pursue additional information and insight about bipolar disorder. Consider the following resources:

- Websites and blogs, including `www.nami.org`, `www.dbsalliance.org`, and `www.psychologytoday.com/us/blog/changing-minds` (my Changing Minds blog hosted by *Psychology Today*).
- Books, including bipolar memoirs, several of which have been written by those who contributed bipolar bios for this book. (We also host bipolar-story.com, where you can read stories that people have shared, comment on stories, and post your own story of living with bipolar disorder.)
- Movies, documentaries, and theater productions about bipolar disorder, including *Next to Normal*, *Silver Linings Playbook,* and *Lady Dynamite.*
- BP magazine (`www.bphope.com`).


TIP

Go to Google Alerts at `www.google.com/alerts`, click or tap in the Create an Alert About text box, type **bipolar disorder,** enter your email address where prompted, and click the Create Alert button. Google emails you a notification whenever news about bipolar disorder is published on the web.

Treat Your Loved One with Respect

Whenever your loved one becomes ill, you launch into caregiver mode, but when you're caring for an adult, treat the person as an adult. As caregivers, people often slide into parent-child mode, treating the ill relative as a dependent. The caregiver may talk down to the ill relative, establish rules and punishments for noncompliance, or talk about the person in her presence as though she's not even in the room. This will fan the flames of conflict and disrupt goals of collaboration.

Adults living with bipolar disorder maintain their autonomy — their right to manage themselves — outside of extreme symptoms. You may not agree with their choices, and if their choices hurt you, you have the right to step away, but

you can't force anyone into behaviors, even if you feel confident that doing so would be best for them.

WARNING

Be careful not to *infantilize* your loved one, treating the person as a child. Treat your loved one as an equal, who has autonomy and is deserving of your respect.

Hone Your Communication Skills

Effective communication not only enables you to express yourself clearly, but also makes others more receptive to what you have to say. Here are a few communication techniques, strategies, and tactics that may help:

- **Listen.** Really listen to what your loved one tells you. If you can demonstrate that you heard and understood, your loved one will be more inclined to listen to you. Ask questions if you're unclear about what your loved one has said.
- **Verify that you understand.** Repeat back in your own words what you heard to demonstrate that your understanding is correct.
- **Believe and validate feelings.** When your loved ones tell you how they feel, even if you don't understand, avoid asking why or how, or expressing doubt or disbelief. Validating feelings is one of the most powerful tools available to you in building a trusting, working relationship with loved ones.
- **Show curiosity and empathy.** After believing and validating your loved ones' feelings, being curious (rather than judgmental), and developing empathy (trying to put yourself in their shoes) are the next logical steps. Saying something like, "You are so sad right now, and I want to learn more about how you're feeling" gives you a solid foundation for expanding communication.
- **Speak softly.** Loud talking intensifies the emotion. Set the tone of the conversation by example.
- **Speak in "I" statements.** Use "I" statements to express how you feel and what you think, so your loved one will be less defensive and feel less compelled to argue against whatever you have to say. Your feelings are valid, too.
- **Be specific and focused.** Stick to one issue or problem to keep the conversation on track. Stay in the present; don't dredge up past issues.
- **Avoid blame, criticism, and demands.** Blame, criticism, and demands undermine the spirit of cooperation required to make progress.

Become a Problem Solver

Whenever disagreements arise, approach the issue as a problem to be solved instead of an argument to be won. Think less in terms of *issues* and more in terms of *interests* or *needs.* Both you and your loved one have needs that you're seeking to meet. The right solution ensures that everyone's needs are met and all concerns are addressed.


REMEMBER

Problem-solving rarely, if ever, needs to be a zero-sum endeavor in which one side has to lose something in order for the other side to gain something. Effective problem-solving involves teamwork and results in a win-win outcome, often *creating* value, so neither side must compromise.

Disengage When Tensions Rise

When attacked, most people tend to respond in kind, but keep in mind that an emotional reaction pours fuel on the fire of emotional dysregulation. Your emotional reactions go right to the threat center of the brain of your loved one, escalating their emotional reactions further into a flight-or-flight scenario. Disengage when tensions rise to prevent a situation from boiling over.


REMEMBER

Disengagement isn't a solution. Take a timeout with the understanding that you'll address the cause of the conflict when you've both had time to cool down and approach the situation when everyone has more of their rational brain online.

Keep Detailed Records

To manage bipolar disorder effectively, you need to be able to make well-informed decisions about medications and therapies. Although doctors and therapists keep detailed records, you may not have access to those records, and information can get lost whenever you change doctors or therapists. Hence, someone on the treatment team should keep a log of all medications and therapies that have been tried, adverse side effects, and so on, to avoid repeated trials of treatments that didn't work or weren't acceptable.


TIP

Establish a system for collecting and storing records. If you're tech savvy, you may keep a record on your smartphone and back it up regularly to a computer. If you're old school, you can keep a notebook, folder, or binder and log noteworthy information about each visit to a doctor or therapist, medication changes, therapy trials, and so forth.

Partner with Your Loved One

Partnering with your loved one means working together to manage bipolar. It requires effective communication and problem solving along with cooperation as your loved one works toward making lifestyle changes that promote mood stability. It means not blaming your loved one for the challenges brought on by the illness, but working together to target the actual culprit — bipolar disorder.


REMEMBER

Depending on your relationship with your loved one, an effective partnership may call on you to make some lifestyle changes, as well, such as establishing predictable routines, going to bed earlier, joining your loved one on walks, planning healthier meals together, and (when appropriate) accompanying your loved one to doctor visits and therapy sessions.

Brush Up on Medications

After the bipolar diagnosis is made, finding and managing effective medical treatment becomes a primary goal. You and your loved one will learn an entirely new vocabulary and digest all kinds of new information and instructions. It can feel overwhelming. Many sources outside of your loved one's treatment team will also provide information and opinions about medications (with or without being invited to do so). Some ways you can be helpful regarding medications include the following:

- **Seek out reliable and accurate information about medications.** Some of the websites presented in the earlier section "Find Out More about Bipolar Disorder" may help. You can also find information at sites such as `www.mayoclinic.org/drugs-supplements`. Avoid sites or pages that are dominated by advertisements for medications. Share what you discover with your loved one and encourage independent research.
- **Take opinions and information from family and friends with a grain of salt.** Family members or friends will offer their experiences with and feelings about medications. These stories can be helpful, terrifying, or somewhere in between. Every person responds differently to medications. Although an immediate family member's response to a certain medicine may be important information for your loved one's doctor, anyone else's experience with a particular medication doesn't predict anything about how your loved one will feel on it.
- **Play a role in doctor visits, if allowed.** If your loved one allows you to come to the doctor's appointment, listen carefully (take notes even) and ask questions if you need more information. If you're unable to come, help your loved one prepare for the appointment and encourage your loved one to report side effects and to ask the doctor questions.

- **Keep tabs on medication effectiveness and side effects.** Using empathy and other communication skills described earlier in this chapter, ask your loved one to share experiences on the medications and help keep track of the positive and negative effects of the medication. Encourage your loved one to contact the prescriber if the medication isn't delivering the desired results or is causing unpleasant side effects.
- **Team up with your loved one for medication reminders, if allowed.** If your loved one is agreeable, work together to set up ways to remember to take the prescribed medications. Don't offer judgments or criticism. If your loved asks for help, create a system that doesn't feel like nagging. You can find apps to set alarms for medicine times, and with your loved one's permission, serve as a medication buddy or friend.

Flex Your Expectations

Bipolar disorder often wreaks havoc on the lives of those it touches, but it's not a death sentence. You may find yourself grieving over the losses or being angry over the injustices suffered at the hands of the illness. If you expect your life to return to what it was before bipolar disorder entered the scene, you're likely to be disappointed. The truth is that your reality has changed, as it does with any chronic illness affecting a loved one.

Grieving the loss is normal, but the sooner you can begin to accept the new normal, the sooner you can begin to adjust your course and explore new paths and opportunities. Be open to new ways of thinking and living, so you can adjust your ideals, goals, and lifestyle to match your new reality.

Enjoy Your Life

People who have bipolar disorder tend to lug around a lot of guilt for becoming a burden to their loved ones. If you mope around feeling sorry for yourself, you reinforce your loved one's guilt and shame, which isn't helpful. Grieving is natural and acceptable. Throwing yourself a pity party every now and again is okay; but don't do it around your loved one. Enjoy your life, both for your own sake and for the sake of your loved one. Strive to build healthy, pleasant activities into your life and get enough sleep and eat regularly and healthfully. You can't help anyone else if you're burnt out. As they say at the start of a flight, you have to put on your own oxygen mask before taking care of anyone else.

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About the Author

Candida Fink, MD, is a board-certified adult, child, and adolescent psychiatrist in private practice in the New York area. Dr. Fink graduated from Boston University School of Medicine and did her residency and fellowship at Harvard Medical School training programs. She has worked extensively with children and adults with complicated psychiatric illnesses. Mood disorders, including diagnostic and treatment questions surrounding bipolar disorder in children, are an area of expertise. She also consults frequently with schools and other institutions regarding developmental and psychiatric challenges. Dr. Fink grew up with mood disorders in her family, and in 2018 one of her adult children, Jax, was diagnosed with bipolar disorder, so she has seen these conditions from every angle and knows the importance of mobilizing the family as a part of any successful treatment. She previously coauthored the first three editions of *Bipolar Disorder For Dummies* and, with Judith Lederman, *The Ups and Downs of Raising a Bipolar Child: A Survival Guide for Parents* (Fireside). She frequently writes and speaks on bipolar disorder in children. For more about Dr. Fink, visit `finkshrink.com`.

Joe Kraynak, MA, is a freelance writer who has written and coauthored dozens of books on topics ranging from slam poetry to personal computers. In this book, Joe shares his experience and insight of managing bipolar disorder from a family member's perspective. On December 10, 1999, Joe's wife, Cecie, a Spanish teacher, was diagnosed with bipolar disorder. Since that day, they have bounced around to a half dozen doctors and even more therapists, broken in a few young marriage counselors, survived several changes in health insurance coverage, attended dozens of support group meetings, helped launch a NAMI support group, and endured the career changes and financial hardships that often accompany bipolar disorder. For more about Joe, visit `joekraynak.com`.

The authors also host a site called *Bipolar Story* (`bipolar-story.com`), where you can post your story of living with bipolar disorder and read and comment on stories posted by others.

Dedication

To my children, Julia and Jax, who never cease to amaze me with their boundless love, generosity of spirit, and intellectual curiosity. They lift me to new places every day. — Candida

To my wife, Cecie, whose zest for life and genuine interest in the lives of others engage and inspire everyone she touches. — Joe

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Linea Johnson (`lineacinda.com`), coauthor of *Perfect Chaos: A Daughter's Journey to Survive Bipolar, a Mother's Struggle to Save Her*

Cecie Kraynak (`ceciekraynak.com`), Spanish teacher and author of *Spanish Grammar For Dummies*, among other *Spanish For Dummies* titles

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