

# Healthy Living *with* BIPOLAR DISORDER



**internationalbipolarfoundation**

*A world of hope, resources and support*



# Healthy Living with Bipolar Disorder

## I. ABOUT BIPOLAR DISORDER

a. What is Bipolar Disorder.....	17
b. Children and Adolescents with Bipolar Disorder .....	19
c. Treatment Modalities .....	31
d. Suicide and Bipolar Disorder .....	39
e. The Risks of Substance Use for those with Bipolar Disorder.....	43
f. Pregnancy & Bipolar Disorder.....	57
g. Stigma & Mental Illness .....	63
h. Aging.....	75

## II. HEALTHY LIVING

a. Healthy Family Life and Relationships.....	91
b. Supportive Nutrition .....	101
c. Natural Treatments .....	117
d. Mental Illness and Families of Faith .....	141
e. Bipolar Disorder in the Workplace .....	151
f. Going to College with Bipolar Disorder .....	161
g. Social Interaction.....	173
h. Travel Smart.....	183
i. The Caregiver .....	195

## III. RESOURCES

a. Medication Chart .....	203
b. Mood Chart .....	204
c. Medication Side Effect Check List.....	205
d. Exercise Journal .....	206
e. Food Log .....	207
f. Doctor Contact Sheet.....	208
g. Questions for Doctor .....	209





**internationalbipolarfoundation**

*A world of hope, resources and support*

## **Book Dedication**

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

*The information compiled in this book is meant to provide useful information on the topic of Bipolar Disorder. This book is not meant to be used, nor should it be used, to diagnose or treat any medical condition. For proper diagnosis or treatment of any medical problem you must consult your own physician. The publisher and authors are not responsible for any harmful physical or mental health consequences resulting from the misinterpretation or misapplication of the information or advice contained in this book. References provided are for informational purposes only and do not constitute an endorsement by any of the contributors to the book or by the International Bipolar Foundation of any websites or other sources.*

# Acknowledgments

The International Bipolar Foundation was founded in 2007 by four mothers with children affected with bipolar disorder. Their desire to ensure a better future for their children and others affected by this illness resulted in an organization dedicated to improving understanding and treatment of bipolar disorder through research.

In this manual, we are so fortunate to receive the support and input from many experts in the field of bipolar disorder, practitioners, and those who have been touched firsthand by the illness. They came together with the common goal of presenting a book that would help anyone who has a connection to this disease. Their desire to make a better future for them and others with the disease never waned. The International Bipolar Foundation came into being through their tireless work, vision and dedication.

We sincerely wish to thank our scientific advisory, honorary and advisory boards that have continued to support the foundation.

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

To your health,

The Founding Board

Lynn Hart-Muto

Karen Sheffres

Muffy Walker

Lisa Selbst Weinreb



# international bipolar foundation

*A world of hope, resources and support*

Founded by four parents with children affected with bipolar disorder, the International Bipolar Foundation is a not for profit organization whose mission is to improve understanding and treatment of bipolar disorder through research; to promote care and support resources for individuals and caregivers; and to erase stigma through education. services; and to erase associated stigma through public education.

[www.ibpf.org](http://www.ibpf.org)

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

## Research

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

## Care & Support

- **Outreach & Referral:** If you need a referral or feedback on a provider, we will send you the comments from our supporters
- **Ambassador Program:** Ambassadors surpass barriers of stigma, help others with bipolar disorder (or other mental illnesses), and further the mission of educating the public and erasing stigma
- **International Bloggers**
- **Awards:** HOPE Award is given to an individual or organization whose public efforts improve care, support and access to mental health treatment &/or champions to erase the stigma of mental illness and instills hope in families, communities and the nation. IMAGINE Award is given to a person who has bipolar disorder who sees beyond the illness and can imagine a future free of barriers, stigma, and discrimination. The recipient empowers others by sharing their story instilling hope and inspiration.

## Education

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

# How To Use This Manual

This book was created to assist anyone touched by bipolar disorder. It is written by a variety of authors with lived or expert experiences. The chapters contain helpful information on a variety of topics that arise in everyday life, as well as resources for dealing with specific issues facing those affected by this illness. Although the book is written for an American audience, most of the material is transferable to other countries and cultures. This book has also been translated into a variety of languages and has country-specific chapters addressing how bipolar is treated medically and culturally in that country.

It is our goal to provide new perspectives and helpful guides to healthy living, while recognizing the stigma and challenges of bipolar disorder.

The binder format allows you to continue to add any additional information so that this may become your ultimate reference book. Periodic updates will be posted at [www.ibpf.org](http://www.ibpf.org) which you can download and print for free.

For additional resources please visit our website at [www.ibpf.org](http://www.ibpf.org) or email us at [info@ibpf.org](mailto:info@ibpf.org).

**If you are in a crisis please call Suicide Hotlines: National Hopeline Network: (800) 784-2433 National Suicide Prevention Lifeline: (800) 273-8255 Suicide hotline, 24/7 free and confidential. National Youth Crisis Helpline: (800) 442-4673 International Suicide Information: [www.befrienders.org](http://www.befrienders.org)**

# The Authors



## **Ashley Aleem, B.A.**

Ashley Aleem, B.A. graduated from San Diego State University in 2008 with a Bachelor of Arts in Psychology. While an undergraduate student she volunteered as a peer advocate at San Diego Center for Children where she worked alongside severely emotionally disturbed youth. She also worked with San Diego County Independent Living as a residential supervisor to former foster females and as a case manager and daily living skills educator to transitioning and former foster youth within the community. She is currently pursuing a Master's degree in Clinical Mental Health Counseling at the University of San Diego. In July 2010, Ashley presented a proposal on a screening process for psychopathic violent offenders at the American Mental Health Counseling Association's national conference in Boston, Massachusetts. Since its inception in January of 2010, Ashley has been working with Exodus Central Connections, the treatment sector of the San Diego Behavioral Health Court Calendar, where she provide case management and rehabilitative services to severely mentally ill individuals involved in the criminal justice system.



## **Dr. Jennifer Bahr**

Dr. Jennifer Bahr, ND is a licensed naturopathic doctor practicing in San Diego, CA. She specializes in the treatment of mental health conditions with expertise in mood disorders and child/adolescent mental and behavioral health. Her unique perspective and training allows her to blend conventional and natural medicine to provide a truly individualized and integrative approach to whole body health.

Dr. Bahr also teaches endocrinology as well as diet and nutrition for mental health and addictions at Bastyr University California. She lectures extensively to the public on all topics related to mental health.

Dr. Bahr received her Doctor of Naturopathic Medicine from Southwest College of Naturopathic Medicine in Tempe, AZ. She received her Bachelor of Science in Physiology and Neurobiology from the University of Maryland. She is the Vice President and Legislative Committee Chair for the California Naturopathic Doctors Association, a member of the House of Delegates for the American Association of Naturopathic Physicians, and a member of the Pediatric Association of Naturopathic Physicians.



# The Authors



## **Colin Depp**

Colin A. Depp, PhD is an Associate Professor in the Department of Psychiatry at the School of Medicine of the University of California, San Diego (UCSD). He is a Staff Psychologist in the VA San Diego providing clinical services, training, and research functions in the ASPIRE Center, a residential treatment program for homeless returning Veterans. Dr. Depp is also the Deputy Director of the Education and Training Division of UC San Diego's Clinical and Translational Research Institute and he is a faculty member at UCSD's Sam and Rose Stein Institute for Research on Aging. Dr. Depp received his bachelor's degree from the University of Michigan and his doctorate in clinical psychology from the University of Louisville. He then completed a pre-doctoral internship at the Palo Alto Veteran's Administration and a National Research Service Award post-doctoral fellowship in the Division of Geriatric Psychiatry at UCSD.



## **Russ Federman, Ph.D., ABPP**

Russ Federman, Ph.D., ABPP, is Director of Counseling and Psychological Services at the University of Virginia and a Clinical Assistant Professor in the University's Department of Psychiatry and Neurobiological Sciences. He is a licensed psychologist, a Diplomate in Clinical Psychology through the American Board of Professional Psychology and an editorial board member of the Journal of College Student Psychotherapy. Dr. Federman writes a blog for Psychology Today called Bipolar You and is also co-author of the 2010 book – Facing Bipolar: The Young Adults Guide to Dealing with Bipolar Disorder (New Harbinger Publications). His 2011 journal article Treatment of Bipolar Disorder in the University Population (Journal of College Student Psychotherapy) was selected for the American College Health Foundation's, Stephen Weiss Writing Prize.

# The Authors



## **Karen Freeman, MS, RD, CSSD**

Karen Freeman is a Registered Dietitian and Certified Specialist in Sports Dietetics, and has been applying her nutritional expertise in academic, clinical and private practice settings for the past thirty years.

She specializes in weight management, eating disorders and sports nutrition for all age groups. In addition to her full time private practice, she is the Sports Dietitian for the San Diego Chargers football team. She has also worked with the San Diego Padres, San Diego Spirit women's soccer team, Los Angeles Raiders, New York Rangers hockey team, as well as high school, college and Olympic athletes.

Karen is a Clinical Instructor at the University of California, San Diego, Department of Family and Preventative Medicine where she teaches Sports Nutrition to medical students, and Sports Medicine Fellows.

Karen received her undergraduate degree in Dietetics at Buffalo State University College, New York, and a Masters degree in Nutrition and Public Health, with an emphasis in Exercise Physiology from Columbia University. Her Masters research at the University of California in San Francisco included the study of child and adolescent obesity.



## **Rob Friedman, M.D.**

Rob Friedman, M.D. is Board Certified in Child and Adolescent, as well as Adult Psychiatry. After graduating Magna Cum Laude with Distinction in Psychology from Duke University, Dr. Friedman received his medical

degree from The New York State Program at the Sackler School of Medicine in Tel Aviv, Israel, in 1985. He completed his Residency in General Psychiatry at Long Island Jewish/Hillside Medical Center in Great Neck, New York, followed by the completion of a fellowship in Child and Adolescent Psychiatry at the UCSD Medical Center in 1990. Since then, Dr. Friedman has been in private practice in San Diego. He is a founding partner, President and CEO of PsyCare, Inc., a behavioral healthcare provider group with seven offices throughout San Diego. Dr Friedman is an Assistant Clinical Professor of Psychiatry at the UCSD Department of Psychiatry, San Diego, providing clinical supervision to training child and adolescent psychiatrists. Dr. Friedman is a member of the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatrists.

# The Authors



## Ellen Frudakis

Ellen Frudakis was born in Northern California and raised in the foothills of Nevada County California. In 2004 she co-founded Impact Young Adults (IYA), a nonprofit organization that provides social activities and leadership development for young adults with mental illness. Since that time she has held the role of Copresident, helping to build the organization along with its next round of young leaders. A previous member of the Consumer Advisory Board, Ellen now serves on the Executive Board of the International Bipolar Foundation. Ellen is also the recipient of the International Bipolar Foundation's prestigious Imagine award Ellen received her Bachelor of Science degree in Human Services from Springfield College in 2005, graduating with honors and earning the Student Humanics award for representing the very principles of this degree program. She is currently in graduate school, working towards a Master of Arts Degree in Nonprofit Leadership and Management at the University of San Diego.



## Reverend Susan Gregg-Schroeder

Reverend Susan Gregg-Schroeder of California founded Mental Health Ministries in 2001 to provide media and print educational resources to help erase the stigma of mental illness in our faith communities. Susan's DVD set, *Mental Illness and Families of Faith: How Congregations Can Respond*, offers eight shows on a variety of mental health issues. There is also a downloadable resource/study guide and other print resources available in English and Spanish at [www.MentalHealthMinistries.net](http://www.MentalHealthMinistries.net).

Susan's shares her personal journey with clinical depression in her book, *In the Shadow of God's Wings: Grace in the Midst of Depression*. Susan works with several national groups including serving on the Advisory Committee for NAMI FaithNet, the American Association of Pastoral Counselors and the Board of Directors for Pathways to Promise.

# The Authors



## **A. Tom Horvath, Ph.D., ABPP**

Dr. Horvath is California licensed and a Diplomate in Clinical Psychology through the American Board of Professional Psychology and is the founder and president of Practical Recovery, a self-empowering addiction treatment system in San Diego. He is past president of the American Psychological Association's Society of Addiction Psychology (Division 50), the world's largest organization of addiction psychologists. He is the author of *Sex, Drugs, Gambling & Chocolate: A Workbook for Overcoming Addictions* (listed by the Association for Behavioral and Cognitive Therapies as a "Self-Help Book of Merit"). He is currently the President of Smart Recovery, an non-profit, science-base, self empowering addiction support group. In 1985 he founded Practical Recovery, which offers a self-empowering alternative to 12-step and disease-oriented addiction treatment.



## **Christi Huff**

Christi Huff was diagnosed with Bipolar II in 2005 after experiencing eating disorders and struggling with anorexia, bulimia and depression in college. Christi has worked on understanding her own illness and how to manage it by turning to social media sites for more information and support. In addition to holding a fulltime job as a paralegal, she is a partner and author of the website Ask A Bipolar and is a monthly blogger for International Bipolar Foundation. Her goal is to use her writing and support to help others. Christi wants others to know they are not alone and hopes her work can help break the stigmas.

# The Authors



## **Dr. Felice Jacka**

Associate Professor Felice Jacka is a Principal Research Fellow at Deakin University. She is recognised as a leading expert worldwide regarding the association between diet quality and the common mental disorders, depression and anxiety, in children, adolescents and adults. She is president of both the International Society for Nutritional Psychiatry Research (ISNPR) and the new Australian Alliance for the Prevention of Mental Disorders (APMD).



## **Tom Jensen, M.D.**

Dr. Jensen is a psychiatrist in private practice in San Diego. He specializes in general and neuropsychiatry treating children, adolescents and adults, but is especially esteemed for his work with patients with bipolar disorder. Dr. Jensen is the Medical Director for International Bipolar Foundation.

Tom Jensen graduated Summa Cum Laude from UCSD with a Bachelor of Arts in Chemistry. After obtaining his degree in Medicine from UCLA, Jensen did his residency at UCSD followed by a Child Psychiatry fellowship at Stanford University.

Throughout his career, Dr. Jensen has been a department chair, written several medical articles, been interviewed by news and radio, spoken to over 100 different organizations, been President of the San Diego Chapter of the American Academy of Child and Adolescent Psychiatry, held positions as both assistant and associate professor and has received several awards including the American Psychiatric Association (APA) Distinguished Fellow and a Special Presidential Commendation from the APA.

# The Authors



## **Kimberly Knox**

Multidisciplinary inventor and of note, a patient with Bipolar I.

Ms. Knox was educated around the world, completing her Bachelors degree in Philosophy of Art and Science at the Union Institute and University. Her patented inventions include US6476069, "Compositions for creating embolic agents and uses thereof" (11 patents), and (US61757086 pat. Pending) Moodwatch, among other notable contributions in chemistry, biofluid mechanics and biomechanical engineering, including awards and publications.

Her work in fine art and fine jewelry include bronze, fiberglas and fiberglas reinforced plasters, glass, gold, platinum and precious stones with a permanent installation in the collection of The Los Angeles County Natural History Museum. The integration-in fact a fusion-of science and art seem to almost compliment this complex mental condition.



## **Wendy McNeill**

Wendy McNeill is a Los Angeles native who moved to San Diego to attend the University of California, San Diego, where she graduated with a B.A. in literature/writing in 1995. Ever since, her professional and personal pursuits have been as an educator, writer, and mental health advocate. She currently is a tutor at San Diego Mesa College's Writing Center, where she has worked with students one-on-one for over ten years. Prior to her work at the college, Ms. McNeill was a recruiter and assistant to the clinic manager at the medical research study, the Women's Health Initiative at UCSD. Later, she worked in marketing for Prudential. In the non-profit world, Ms. McNeill served as the Editor-In-Chief of The Advocate, the NAMI (National Alliance on Mental Illness) newsletter, for four years. Ms. McNeill continued to serve NAMI as a Peer Mentor, an In Our Own Voice public speaker, and as a trainer for PERT, the Psychiatric Emergency Response Team with the SDPD. In addition, Ms. McNeill served on the NAMI Board for four years and is currently on the Board of MHA (Mental Health America.) Ms. McNeill continues to advocate for people with mental illness in her blog, Wendy's Whirl'd. She has been published in Our Stories: Things We Knew Now We Wish We Knew Then and bp magazine.

# The Authors



## **Thomas Meeks, M.D.**

Dr. Meeks is a board-certified psychiatrist with added qualifications in geriatric psychiatry. He worked for 7 years in the University of California, San Diego (UCSD) Department of Psychiatry in the Senior Behavioral Health clinic. He is now a staff psychiatrist in the VA San Diego Healthcare System. Dr. Meeks graduated from the Medical College of Georgia and then did his clinical training at Emory University in Atlanta, GA and at UCSD.



## **Anja Stevens**

Anja Stevens is a psychiatrist from the Netherlands. She is a member of the Board of the Dutch Foundation for Bipolar Disorders, chapter of ISBD, and a member of the Board of the Dutch Knowledge Centre for Psychiatry and Pregnancy. Her interests are bipolar disorder in general and, in particular, bipolar disorder and pregnancy. Her current research focuses on the influence of sleep disturbance in the perinatal period on postpartum psychopathology. She wrote, together with Fleur Schreurs, a book on postpartum psychosis and translated, together with Bart Geerling, Sharon Bracken's book 'Eli, the bipolar bear' to Dutch.

# The Authors



## **J. Anderson Thomson, Jr., M.D.**

Dr. Thomson is a board certified staff psychiatrist at Counseling and Psychological Services at the University of Virginia Student Health Services as well as a private practitioner in Charlottesville, Virginia. His work with Paul Andrews on an evolutionary view of depression was featured in the New York Times Magazine in 2010. He is the co-author of the 2010 book – Facing Bipolar: The Young Adults Guide to Dealing with Bipolar Disorder (New Harbinger Publications) as well as the author of Why We Believe In Gods: A Concise Guide to the Science of Faith (Pitchstone Publishing, 2011).



## **Muffy Walker, MSN, MBA**

Muffy Walker was born and raised outside of Philadelphia, PA. She currently resides in Rancho Santa Fe with her husband John C. Reed and their three sons. In 1983, Walker graduated with a Master's of Science in Psychiatric Nursing from the University of Pennsylvania. She worked in the mental health field for over 18 years until she moved to California when she obtained her MBA with a focus in marketing from the University of California-Irvine. Walker has owned several companies both for and not for profit and is the founder and President of International Bipolar Foundation (IBPF). After learning that her youngest son had Bipolar Disorder, Walker joined other mental health boards and ultimately started IBPF. She has served on a plethora of boards including Children's Hospital, Kids Korps USA, NeighborHelp, ChildHelp USA, and has dedicated the past 10 years of her life championing the education of the public about mental illness. Walker's interests include travel, tap dancing, community theatre, and Thai cooking.



# The Authors



## **Lisa Weinreb, J.D.**

Lisa Weinreb is a Deputy District Attorney in San Diego County and has been a prosecutor for 19 years. Ms. Weinreb is an adjunct Professor at California Western School of Law where she teaches Trial Practice, White Collar Crime, Culture and the Criminal Justice System and Advanced Criminal Prosecution. She has also been an instructor for the California District Attorneys Association, the National Institute for Trial Advocacy and the National District Attorneys Association. Ms. Weinreb received her Bachelors degree from the University of Texas at Austin and her Juris Doctor from California Western School of Law.

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

# What is Bipolar Disorder?

By Lisa Selbst Weinreb, J.D.

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

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

*There are  
27 million people  
worldwide  
who have  
bipolar disorder*

## Symptoms of Bipolar Disorder

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

### Mood Changes

Symptoms of mania or a manic episode include:

- A long period of feeling "high" or an overly happy mood
- Extremely irritable mood or agitation

Symptoms of depression or a depressive episode include:

- A long period of feeling worried or empty
- Loss of interest in activities once enjoyed



## Behavioral Changes

Symptoms of mania or a manic episode include:

- Easily distracted
- Rapid speech, racing thoughts
- Increasing goal-directed activities, such as taking on new projects
- Decreased need for sleep
- Having an unrealistic belief in one's abilities
- Behaving impulsively and engaging in high risk behaviors such as spending sprees or impulsive sexual activity

Symptoms of depression or a depressive episode include:

- Feeling tired or "slowed down"
- Having problems concentrating, remembering, and making decisions
- Being restless or irritable
- Change in eating, sleeping or other habits
- Thinking of death or suicide, or attempting suicide\*

National Institute of Mental health, [www.nimh.nih.gov](http://www.nimh.nih.gov)

\* Thoughts of suicide can occur in manic, depressive and mixed state episodes

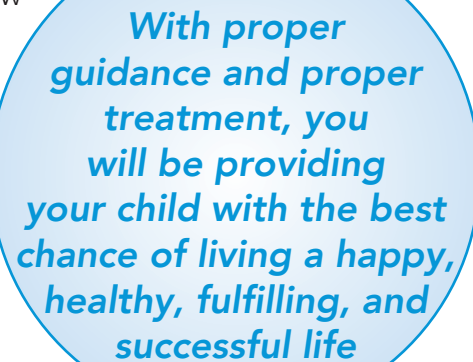
# Children and Adolescents with Bipolar Disorder

By Rob Friedman, M.D.

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

The entire topic of bipolar disorder in children and adolescents is a confusing one, even within the medical community. It is understandable then, that as a parent, you may be confused as well. Skepticism and disbelief are common initial reactions, sometimes with good reason.

On the other hand, it is important for parents to not allow their own confusion and fears to interfere with finding the proper help for one's child. With so much information readily accessible from the reliable resources referred to elsewhere in this guide, a little self-education can go a long way in helping your child and family. In this chapter, we will examine why there is so much confusion about bipolar disorder in children and adolescents, help clarify some of the issues surrounding this confusion, and attempt to provide some guidance for you and your family. With the correct information, you will be prepared to seek and obtain the most appropriate intervention and treatment for your child and family. With proper guidance and proper treatment, you will be providing your child with the best chance of living a happy, healthy, fulfilling, and successful life.



*With proper guidance and proper treatment, you will be providing your child with the best chance of living a happy, healthy, fulfilling, and successful life*

## Bipolar Disorder is a Brain Disorder

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

When one suffers from an illness of the brain, instead of resulting in measurable changes in blood pressure or blood sugar, it often results in less easy to measure changes in one's thoughts, feelings and behaviors. Just like in the examples above, these alterations in one's thoughts, feelings and behaviors, are often beyond one's control. We are raised however, to believe that we have the power and ability to



exercise control over our own thoughts, feelings and behaviors. When we don't, we are held accountable and there are consequences. This is reasonable in the absence of a brain illness. When there is an illness of the brain however, there are chemical, cellular and structural changes caused by the illness that, up until very recently, have been difficult to observe and measure. Since these changes are difficult to observe and measure, people have traditionally had a difficult time believing such changes were real. The belief that we should be able to control our thoughts, feelings and behaviors, coupled with the lack of evidence that anything was physically altered in the brains of people with disordered thoughts, feelings and behaviors, resulted in the bias and stigma that people with a brain or mental illness should somehow be able to have control over the abnormal thoughts feelings

and behaviors from which they suffer. This stigma becomes fueled by our own fears of not being able to control our own thoughts, feelings or behaviors while failing to make the distinction between a normally functioning brain, and a brain suffering from an illness.

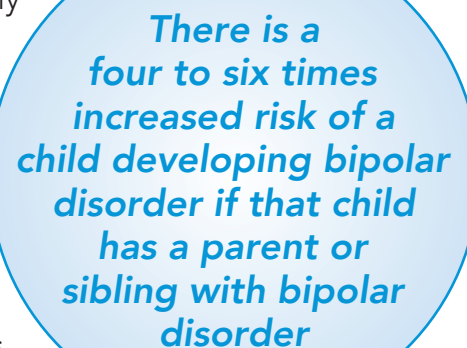
During the last two decades, however, with advances in technology and the development of sophisticated brain imaging techniques, the changes in the brains of people who suffer from mental illnesses are more able to be observed, measured and studied. While such scientific techniques are used in researching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

After years of research, although we still probably know relatively little about the functioning of the brain, there are some things we have learned about illnesses of the brain, such as bipolar disorder. We know that in bipolar disorder, there are often underlying genetic determinants found in the DNA inherited from one's ancestors that modulate the production and release of chemicals within and between our brain cells, which have an impact upon how the brain works. Depending upon which areas of the brain are affected, changes in one's thoughts,

feelings and behaviors can be the result. While there are likely many other chemicals involved, some of these chemicals are called “neurotransmitters.” Some of the commonly known neurotransmitters include Serotonin, Dopamine, Acetylcholine and Norepinephrine. Whether caused completely by genetics, or by an interaction between something in the environment and our genetically inherited DNA, the result can be structural and chemical changes in the brain that can change the way we think, feel and behave. When these altered thoughts, feeling and behaviors are recognized as abnormal, they are called “symptoms.” When there is a collection of symptoms that have a negative impact on one’s successful functioning, we call it an illness, a disease or a disorder. In the past, before we had a way to link these symptoms of impaired thoughts, feelings and behavior to the physical structure of the brain, we attributed them to the “mind” and understood them to be a result of a “mental disorder.” It would seem that much of the confusion and stigma surrounding these illnesses could be resolved if we began to understand these illnesses for what they are: illnesses of the brain, or Brain Disorders.

## **Genetics and the Environment**

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



***There is a four to six times increased risk of a child developing bipolar disorder if that child has a parent or sibling with bipolar disorder***

It is difficult to argue against the idea that people are responsible and accountable for their behavior. However, if we can understand that the child or adolescent whose behaviors are the result of, or at least influenced by an illness affecting his or her brain, through no fault of his or her own, it can help parents, siblings, teachers, friends and clinicians maintain a posture of empathy and compassion, while minimizing the tendencies toward frustration, anger and rejection. These negative emotions may ultimately become a part of the environmental stresses negatively impacting a child or adolescent with bipolar disorder, thereby possibly contributing to a less positive outcome for them and the family. In order to



successfully maintain such posture, much patience and self-control is required, highlighting the need for self care and supportive resources. It is important to understand that reaching such a level of equanimity may not always be possible to achieve and maintain, but it is helpful to recognize this as an idealistic goal to strive toward while parenting and interacting with children and adolescents with bipolar disorder.

## Diagnosing Bipolar Disorder in Children and Adolescents

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

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

In the past, bipolar disorder was called "Manic Depression" or "Manic Depressive Disorder." These terms are synonymous, but today, we refer to the condition as "bipolar disorder." Bipolar disorder is suspected when there are symptoms suggestive of a "manic episode" or "mania," as well as "depressive episodes," or "depression." These episodes can be mild, moderate or severe. When very severe, the depressive or manic episodes may be accompanied by misperceptions of reality, or "psychotic symptoms," such as delusional beliefs or hallucinations. One of the problems with recognizing and diagnosing bipolar disorder is that for

some period of time, a person appears to be manic, while at other times, that same person may appear to be depressed for a period of time, and at other times, that same person may have a normal, or “euthymic” mood for a period of time. This pattern is called Bipolar Disorder, Type I. If the manic episode is on the mild side, sometimes it is referred to as “hypomanic” as it may not have quite reached the diagnostic threshold of a full blown “manic” episode. Instead of being diagnosed with Bipolar Type I Disorder, one may therefore be diagnosed with Bipolar Type II Disorder. When there are mild depressive episodes alternating with hypomanic episodes, this is sometimes called “Cyclothymia.” When someone has symptoms suggestive of a bipolar disorder, but the symptoms do not fit any of the above subtypes, it may be categorized as Bipolar Disorder Not Otherwise Specified (NOS).

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

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





Let's take a closer look at the symptoms of both manic and depressive episodes.

**The symptoms of mania or manic episodes include:**

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

**The symptoms of depression or a depressive episode include:**

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

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

Many of the symptoms of ADHD, another disorder common in childhood, for example, overlap with the symptoms of bipolar disorder in children and adolescents. Impulsivity, hyperactivity and distractibility, the hallmark symptoms of ADHD, are a subset of the symptoms found in bipolar disorder. Irritability, as well as oppositional and defiant behaviors, is commonly present in children with ADHD as well as bipolar disorder. It is helpful to recognize that mood elevation, grandiosity,

a decreased need for sleep and an increase in sexual interest or behavior, are features strongly suggestive of bipolar disorder, as they are not generally part of the presentation of ADHD. Another clue is that the symptoms of ADHD are generally always present, while the symptoms of inattention, distractibility, hyperactivity and impulsivity, when present in Bipolar Disorder tend to fluctuate as the episodes of mania and depression fluctuate. However, since eighty five percent of children and adolescents with bipolar disorder are likely to also suffer from ADHD, this distinction is not always helpful.



Another dilemma that causes confusion in diagnosis involves drug and alcohol use, especially in adolescents. Sometimes the effects of drugs and alcohol can mimic the symptoms of the manic or depressive episodes of bipolar disorder. Other times, when a teenager is in the midst of a manic or depressive episode, they may be more likely to experiment with or use drugs or alcohol, adding yet another layer to the difficulty in accurately diagnosing

bipolar disorder in adolescents as well as young adults. One thing is very clear. The use of any illicit drugs and alcohol in the presence of bipolar disorder must be completely prohibited. Not only do they complicate the diagnostic picture, but their use is like adding “fuel to the fire” of a brain already impaired by a severe illness, and will undoubtedly worsen the symptoms and outcome of the illness. Anxiety Disorders, Major Depressive Disorder, Schizophrenia, Autism Spectrum Disorders, Post Traumatic Stress Disorder, and ADHD are some of the other common psychiatric conditions that can present with symptoms that may be confused with, or co-occur with bipolar disorder in children and adolescents.

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

Finally, if the above diagnostic challenges are not enough, the diagnosis of bipolar disorder in children and adolescents is not without further controversy. As mentioned above, in the last decade, there has been a dramatic increase in the diagnosis of childhood onset bipolar disorder. While some parents resist the identification of bipolar disorder in their children, other parents may seek such a diagnosis as a means of explaining their child’s behavior, when the issues may have more to do with behavior problems and parenting issues as opposed to bipolar

disorder. Still, other children may be diagnosed with bipolar disorder because of the presence of severe tantrums and outbursts along with other disruptive behaviors that warrant intervention, but there is no other diagnostic category that is a better fit in categorizing their symptoms. Researchers have recently begun examining the subset of children who may be given a diagnosis of bipolar disorder, but who lack clearly defined episodes of mania and depression. Perhaps some of these children overlap with ultra-rapid and rapid cycling presentations of bipolar disorder in children and adolescents, while others may present differently. There are some children who present with persistent and continuous severe irritability along with a low frustration tolerance, leading to frequent and severe emotional outbursts that are no longer developmentally appropriate for their age, and may be accompanied by additional symptoms of sadness, anxiety, distractibility, racing thoughts, insomnia and agitation. These children may be on a different developmental trajectory than children with classic bipolar disorder. They may be at risk for developing Depressive and Anxiety Disorders and not bipolar disorder when they reach adulthood. A new diagnostic entity called **Disruptive Mood Dysregulation Disorder** to identify and describe these children may be forthcoming. Regardless of the label, the children who manifest these symptoms, as well as their parents, siblings and others around them suffer greatly, and the impairments from which these children suffer are serious. A better understanding of these children, as well as effective interventions and treatments to improve the symptoms from which they suffer are clearly needed.

To summarize, not everyone who has “mood swings” suffers from bipolar disorder. Although challenging, a thorough assessment performed by a qualified and competent clinician can help clarify the issues related to the mood swings, and facilitate

the establishment of the correct diagnosis or diagnoses, which will lead to recommendations for appropriate interventions and treatment. If it turns out that your child is correctly diagnosed with bipolar disorder, it is very important that your child be treated effectively and appropriately. Untreated or incompletely treated bipolar disorder can lead to terrible consequences. There are very effective treatments available that may improve or control the symptoms of bipolar disorder and allow your child every opportunity to lead a full, productive and successful life.

*If it turns out that your child is correctly diagnosed with bipolar disorder, it is very important that your child be treated effectively and appropriately*

*There are very effective treatments available that may improve or control the symptoms of bipolar disorder and allow your child every opportunity to lead a full, productive and successful life*

## **Course and Outcome of Children and Adolescents with Bipolar Disorder**

New and ongoing research about bipolar disorder in children and adolescents is taking place and new information is being learned all the time. As of 2005, studies suggest that 40% to 100% of children and adolescents who suffer from

a manic episode will usually recover from that episode within one to two years. However, according to the Journal of American Academy of Child and Adolescent Psychiatry, of those who do not recover, up to 60-70% will experience a recurrence of an episode within 10-12 months (Journal of the American Academy of Child & Adolescent Psychiatry, Volume 44, Issue 9, Pages 846-871). In addition, many



of these young people will experience frequent fluctuations in their moods, most often with depressed or mixed episodes, on an ongoing basis, aside from the recurrent episodes. The factors associated with a worse outcome over time for these children and adolescents include an early age of onset, a long duration of the illness, mixed episodes, rapid cycling, the presence of psychotic symptoms, a lack of treatment, and poor compliance with medication treatment.

About 20- 25 % of children and

adolescents with Bipolar Disorder NOS and Bipolar Type II are likely to progress to the Bipolar Type I Disorder in adulthood. Between episodes, many of these young people experience what are called "subsyndromal" symptoms of bipolar disorder, or mood and behavioral symptoms that are beyond what would be considered normal, but not severe enough to reach the level of a full blown episode. For children and adolescents, 30% of the time, full blown mood shifts between mania and depression will likely occur one time or less per year, while 50% of the time, the mood shifts will likely occur more than five times per year. Almost 40% of the time, the mood shifts between depression and mania will occur more than 10 times per year, and in 24%, they will occur more than twenty times per year ("Four-Year Longitudinal Course of Children and Adolescents with Bipolar Spectrum Disorders: The Course and Outcome of Bipolar Youth (COBY) Study, American Journal of Psychiatry, Volume 166, Pages 795-804).

Bipolar disorder in children and adolescents is best understood as characterized by shifting episodes between mania and depression, while between these episodes, symptoms of depression, mixed symptoms of depression and mania, as well as rapidly changing moods are common.

The challenge for parents and clinicians is to be able to differentiate what may be a normally moody child from a child who has symptoms of a disorder that warrants treatment. Although not easy, this is an important task, as each year of untreated bipolar disorder in children and adolescents goes by, effective treatments becomes more difficult, and full recovery from symptoms becomes more difficult to achieve. Left untreated, many children with bipolar disorder grow up to become adults with bipolar disorder. Left untreated, this brain illness can lead to serious impairments in school functioning, work functioning,

**As each year  
of untreated bipolar  
disorder in children  
and adolescents  
goes by, effective  
treatments becomes  
more difficult**

interpersonal relationships, one's physical health and lifespan, as well as wreak havoc upon families, other loved ones and friends. It is not surprising that many people with bipolar disorder end up in jail. Bipolar disorder can result in premature death due to high risk behaviors, including the use of drugs and alcohol, as well as accidents, suicide, and the medical complications of poor physical health. One out of four people with bipolar disorder will attempt suicide, sometimes resulting in debilitating injuries, while one out of ten people with bipolar disorder will succeed in committing suicide.

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

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

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

The use of antidepressant medications, such as the SSRIs', including Prozac, Paxil, Zoloft, Celexa and Lexapro, while often helpful in treating depressive symptoms in children and adolescents, pose serious risks when used in attempting to treat depressive symptoms in the context of bipolar disorder in children and adolescents.

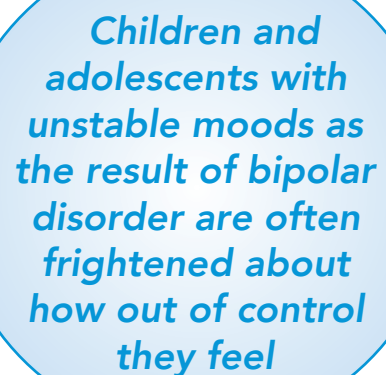
Activation, disinhibition, the triggering of a manic episode and the worsening of mood symptoms are not uncommon results. If these medications are to be used, caution and careful monitoring are required (see section on medication treatment).

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

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

## **Knowledge is Power**

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



***Children and adolescents with unstable moods as the result of bipolar disorder are often frightened about how out of control they feel***

## References:

Hamrin, V. and DeSanto Iennaco, Psychopharmacology of Pediatric Bipolar Disorder, Expert Review of Neurotherapeutics;10 (7): 1053-1088 (2010).

Pavuluri, Mani N., Birmaher, Boris, Naylor, Michael W., Pediatric Bipolar Disorder: A Review of the Past 10 Years, Journal of the American Academy of Child and Adolescent Psychiatry, Volume 44, Issue 9, Pages 846-871, September, 2005.

Birmaher, Boris, MD, Axelson, David, MD, Goldstein, Benjamin, MD, Strober, Micael, Ph.D., et. al, Four-Year Longitudinal Course of Childhood and Adolescents with Bipolar Spectrum Disorders: The Course and Outcome of Bipolar Youth (COBY) Study, American Journal of Psychiatry, 166: 795-804 (2009).

Kowatch, MD, PhD, Monroe, CNS, Erin, Delgado, MD, Sergio, Not All Mood Swings Are Bipolar Disorder, Current Psychiatry, Vol. 10, No. 2, February, 2011.

[www.nimh.nih.gov](http://www.nimh.nih.gov)

[www.aacap.org](http://www.aacap.org)

# Treatment Modalities

By Thomas S. Jensen, M.D.

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

This chapter discusses the main components in a treatment plan, including medications, therapies and lifestyle choices. Major side effects and risks are discussed, however, it is impossible in a chapter of this nature to list every side effect for every medication. The focus is on the more common ones and the more serious ones. As a general rule, any of the medications discussed here can cause nausea, vomiting, headache, allergic reactions, sleepiness, or sleeplessness.

*Medications form the cornerstone for building a comprehensive and effective treatment plan for individuals with bipolar disorder*

With respect to the interactions of each of these medications, it is not possible to go into all interactions in this chapter. It is advised that consumers and family members use a "drug interaction" computer program any time a new medication is added, whether it is another psychiatric medication, an over the counter medication, or an antibiotic. There are many such programs online, such as [www.drugs](http://www.drugs). Always discuss all medicines, prescribed and over the counter, with your doctor and pharmacist.

## MOOD STABILIZERS

Within this category there are the Mood Stabilizers and the Anti-Psychotic (or Atypical) Mood Stabilizers, the later having different characteristics, advantages, and disadvantages from the more traditional Mood Stabilizers. In routine practice, monotherapy or using only one, is often not effective for acute and/or maintenance therapy. Therefore, most patients are given a combination of therapies.

- ❖ **Mood Stabilizers:** drugs for mood disorders include both lithium and a group of drugs developed to treat epilepsy called anticonvulsants.

Commonly used mood stabilizers:

- Lithium (<http://ibpf.org/lithium-still-cornerstone-long-term-treatment-bipolar-disorder>)

Anticonvulsants (brand/generic):

- Depakote (Epival)
- Depakene (Valproic Acid)
- Keppra (Levetirecetam)



- Klonopin (Clonazepam)
  - Lamictal (Lamotrigine)
  - Neurontin (Gabapentin)
  - Tegretol (Carbamazepine)
  - Topomax (Topiramate)
  - Trileptal (Oxcarbazepine)
  - Zonegran (Zonisamide)
- ❖ **Anti-Psychotic or Atypical Mood Stabilizers:** drugs for acute mania or mixed states, particularly severe forms of these states that threaten safety or place the patient in the hospital or at risk of hospitalization. Their advantages include that they can be rapidly introduced, rapidly adjusted, and often can, at the cost of some annoying side effects, bring the acute mania or agitation of a mixed state under control in 24 to 72 hours. For those who experience hallucinations, paranoia, delusions (false beliefs that things are happening that in fact, are not happening), or other symptoms of the inability to distinguish that which is real from that which is not (the definition of psychosis), the antipsychotic mood stabilizers are the best agents for addressing these psychotic symptoms.



Commonly used Atypical Anti-psychotic mood stabilizers:

- Abilify (Aripiprazole)
- Clozaril (Clozapine)
- Fanapt (Iloperidone)
- Geodon (Ziprasidone)
- Invega (Paliperidone)
- Latuda (Lurasidone)
- Risperdal (Risperidone)
- Saphris (Asenapine)
- Seroquel (Quetiapine)
- Zyprexa (Olanzapine)

## Side effects and risks of anti-psychotic mood stabilizers:

Some members of this class have a strong tendency to promote weight gain. At times this weight gain is marked and can lead to obesity and even Type II Diabetes.

Many of the medications in this class are highly sedating, which can be an advantage in that we can put the acutely manic patient to sleep and break the mania with them. This is a disadvantage in that daytime sedation can occur and this is not desirable.

Another disadvantage is that, in contrast to the more traditional mood stabilizers, there is no evidence that the antipsychotic mood stabilizers lengthen the time between cycles, and therefore likely do not improve the long-term course of the illness.

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

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

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

A very rare but very serious side effect is called Neuroleptic Malignant Syndrome, or NMS. NMS is a life threatening medical emergency. It is characterized by a rising body temperature to the point of being dangerous (it can climb above 104 degrees Fahrenheit). The muscles at the same time become very stiff, which probably generates some of the heat leading to the high temperature, though most of this heat is likely caused by the temperature regulating mechanism in the brain not working well. The prolonged muscle contractions can lead to popping of muscle cells which then release proteins called muscle enzymes into the blood. In sufficient quantities, these enzymes can more or less clog up the filtering elements of the kidneys and lead to kidney failure. The patient often becomes confused, and the blood pressure can begin to vary widely. This syndrome requires immediate treatment at the nearest hospital emergency room.

## **ANTI-DEPRESSANTS:**

Antidepressant refers to several families of drugs, which, as the name implies, are designed to combat depression. This family includes Selective Serotonin Reuptake Inhibitors (SSRI), Serotonin Antagonist and Reuptake Inhibitor (SARI), Serotonin-Noradrenaline Reuptake Inhibitor (SNRI), Norepinephrine-Dopamine Reuptake Inhibitor (NDRI), Tricyclic (TCA), and Monoamine Oxidase Inhibitors (MAOI).

The use of traditional antidepressants to treat bipolar depression is considered experimental, and none are FDA-approved for that purpose. There is no research to show that they have any greater benefit than taking a mood stabilizer (such as lithium or Depakote) alone. Many of the existing studies of their efficacy have focused mainly on people with unipolar rather than bipolar disorder.

Using antidepressant medication alone to treat a depressive episode is not recommended. The drugs may flip a person, particularly a person with bipolar I disorder, into a manic or hypomanic episode. Hypomania is a more subdued version of mania. Using antidepressants alone also may lead to or worsen rapid cycling in some bipolar patients. In rapid cycling, a person has 4 or more distinct episodes of mania/hypomania or depression over a 1-year period. And while they may “recover” more quickly from depression, they may be more prone to experience a relapse or the next phase of illness sooner and more often than people without rapid cycling.

Nevertheless, there are many different types of antidepressants used to treat depression in people with bipolar disorder. With antidepressants, it typically takes

three to four weeks for people to respond to treatment. Sometimes a doctor will try several different medicines before finding one that works for a patient. These medications include SSRIs such as Zoloft or Prozac, SNRIs such as Effexor, and novel antidepressants such as Wellbutrin. (WebMD)

Note: The FDA has determined that antidepressant medications can increase the risk of suicidal thinking and behavior in children and adolescents with depression and other psychiatric disorders. If you have questions or concerns, discuss them with your health care provider.

Commonly used anti-depressants:

- Anafranil (TCA: Clomipramine hydrochloride)
- Celexa (SSRI: Citalopram Hydrochloride)
- Cymbalta (SNRI: Duloxetine)
- Effexor (SNRI: Venlafaxine)
- Lexapro (SSRI: Escitalopram Oxalate)
- Luvox (SSRI: Fluvoxamine Maleate)
- Paxil (SSRI: Paroxetine Hydrochloride)
- Prozac (SSRI: Fluoxetine Hydrochloride)
- Desyrel (SARI: Trazodone)
- Wellbutrin (NDRI: Bupropion)
- Zoloft (SSRI: Sertraline Hydrochloride)

## NATURAL APPROACHES:

Two “natural” approaches have also been demonstrated in studies as useful for bipolar depression.

- ❖ **High dose omega-3 fatty acids** in the form of fish oil. The original studies done in the 1990s looked at doses in the 3 to 6 grams a day range (3,000 to 6,000 mg a day). There are two important things to note when buying fish oil. The better ones are “enteric coated,” meaning they don’t release the oil until it has already passed through the stomach. This can minimize unpleasant tastes if one burps after taking it. Some preparations, which tend to be expensive, are bottled in an oxygen-free environment so that the fish oil does not “oxidize.” This type of fish oil does not smell or taste like fish and can often be comfortably ingested as a liquid.
- ❖ **Inositol:** Inositol is sometimes referred to as “vitamin B8” and is sort of an unofficial B vitamin. It is also structurally similar to glucose. Inositol is present in large quantities in the membranes of nerve cells and is also involved in the functioning of serotonin neurons. Serotonin neurons are well known to play a role in depression.

*“Natural” approaches  
have also been  
demonstrated in studies  
as useful for bipolar  
depression*

## NON-MEDICATION APPROACHES:

There are non-medication but still biologic approaches to treating bipolar depression.

- ❖ **Electroconvulsive Therapy (ECT).** This involves using an electrical pulse, while the patient is anesthetized, to induce a seizure. Typically a series of 6 to 12 sessions is used. Often this puts the depressed person into a mania, and then additional mood stabilizers are used to treat the mania. (<http://ibpf.org/electroconvulsive-therapy>)
- ❖ **Transcranial Magnetic Stimulation (TCMS or TMS)** is a series of magnetic pulses applied to precise brain areas. (<http://ibpf.org/use-transcranial-magnetic-stimulation-treatment-mood-disorders>)
- ❖ **Deep Brain Stimulation:** Microelectrodes are inserted into a very specific nest of cells in the brain. Once the appropriate frequency and amplitude of the electrical impulses are found, this seems to treat the depression.
- ❖ **Sleep deprivation,** under medical supervision, can also help one get out of a depressed state. The reason this should only be done with a doctor prescribing it is that one can quickly go from depressed to a mixed or manic state following sleep deprivation.
- ❖ **Cognitive Behavioral Therapy (CBT):** is a psychotherapeutic approach that addresses dysfunctional emotions, maladaptive behaviors and cognitive processes and contents through a number of goal-oriented, explicit systematic procedures.
- ❖ **Dialectical Behavior Therapy (DBT):** is a therapy designed to help people change patterns of behavior that are not effective, such as self-harm, suicidal thinking and substance abuse. This approach works towards helping people increase their emotional and cognitive regulation by learning about the triggers that lead to reactive states and helping to assess which coping skills to apply in the sequence of events, thoughts, feelings and behaviors that lead to the undesired behavior. (<http://ibpf.org/debra-meehl-dialectical-behavior-therapy-dbt>)
- ❖ **Family Focused Therapy (FFT):** is a therapy where all family members are included, and consists of several stages, beginning with psychotherapy about the symptoms and etiology of bipolar disorder and the need for medication adherence. Families are taught to respond early to emergent symptoms and provided with training about the best coping responses. Light Therapy: Outside walks in the sunshine or the use of a full spectrum artificial light called a phototherapy light can be helpful. It is important to use the phototherapy light carefully and under the supervision of a psychiatrist, as overexposure to light can trigger a mania or a mixed state.



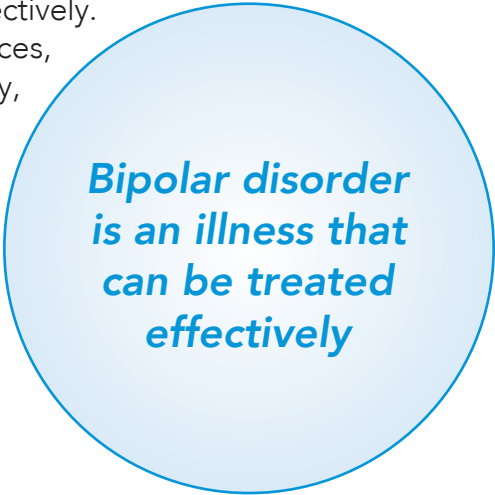
❖ **Interpersonal and Social Rhythm Therapy (IPSRT):** is a compelling adjunctive therapy for people with mood disorders, and it emphasizes techniques to improve medication adherence, manage stressful life events, and reduce disruptions in social rhythms. IPSRT teaches patients skills that let them protect themselves against the development of future episodes.

❖ **Lifestyle Choices:**

- It is very important not to repeatedly go on and off your medications, as sometimes the drugs don't work the second time around after being discontinued. This is particularly important in a difficult to treat form of the illness and if multiple medications were tried before you became stable. You can lose your response and have few alternatives available, all because the medication was stopped.
- Maintaining a sleep pattern of going to bed at the same time every night and getting up at the same time every morning is important. (<http://ibpf.org/circadian-clocks-bipolar-disorder>)
- Drugs of abuse are very destabilizing. This is true for all drugs of abuse, including Cannabis. Of the two general categories of Cannabis, Cannabis Sativa (the stimulating variety) is far worse than Indica (the sedating variety) though Indica is well known to induce depression with chronic use. Stimulant abuse including cocaine is very destabilizing as is the club drug Ecstasy. Even alcohol can trigger depression. In general, if you have bipolar disorder, it would be best to not use any substances.
- Adequate nutrition is very important (see chapter X) (<http://ibpf.org/advanced-nutrient-therapies-bipolar-disorders-dr-william-walsh>)
- Regular aerobic exercise, preferably in the morning and outside to get the sunlight in the winter, seem to help keep the biologic clock regulated and the mood stable.
- Mindful Meditation & Yoga: (<http://ibpf.org/mindful-meditation-bipolar-disorder-can-it-help>) (<http://ibpf.org/yoga-and-mood-disorders>) (<http://ibpf.org/meditation-medication-magic>)

Bipolar disorder is an illness that can be treated effectively. With optimal treatment and proper lifestyle choices, most bipolar individuals can lead happy, healthy, productive lives.

The key is to seek optimal treatment, comply with recommendations, don't stop your medications, and make healthy lifestyle choices.



***Bipolar disorder  
is an illness that  
can be treated  
effectively***



# Suicide and Bipolar Disorder

By Dr. Tom Jensen, M.D.

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

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

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

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



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

Another important multiplier is firearm possession. Suicide by firearm is extremely common, especially in young people. Most self-inflicted gunshot suicide attempts are not survived, or if they are, it is with severe brain damage. In fact, we know



that if we were given a large grant to reduce the number of suicide deaths in a community, the most effective thing we could do would be to provide trigger locks and gun safes.

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



over the past two decades is that half of the people with bipolar disorder also have an anxiety disorder (generalized anxiety, panic disorder, phobias, Obsessive Compulsive Disorder). This anxiety also appears to be a risk factor for suicide. Please review the Medication Treatment chapter regarding how to reduce anxiety through cognitive therapy and medications, and take note that some medications commonly used for anxiety can cause mixed states.

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

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

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

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

It is so important that those with bipolar disorder seek treatment with psychiatrists who are skilled at treating this illness. Sadly, it is not safe to assume that all psychiatrists treat this illness well. In order to find a physician where you reside, it may be helpful to go to the consumer support groups or call them and ask "who is the best?" In this illness, where the mood can pivot on a dime, the psychiatrist needs to be responsive when you need to speak with him or her.

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

There are also specific psychotherapy interventions that can be performed by a therapist or psychiatrist. The therapy of bipolar illness should typically include the following elements: patients, and if possible family members, should learn how to recognize depression, mania or hypomania, and mixed states. It is best if a mood chart is used to spot seasonal and other patterns. Also, charting the mood helps a person recognize that it is the illness making them feel badly, not just the events in their daily life. (See mood chart in the reference section) Once a person knows how to identify specific mood states, they can then receive cognitive behavioral therapy to learn skills to deal with the feelings and distorted thoughts in each mood state. The therapist can also work with the patient and their family to make the home safer. In addition, the family can implement strategies to lessen social isolation and help their bipolar loved one to find one's gift, and applying it so as to gain a sense of usefulness and worth. The therapist can also monitor and encourage medication compliance. Since, noncompliance with medications is a common dilemma with people with bipolar disorder, which in turn can lead to suicidal thoughts.


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

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

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

1. Name and numbers of psychiatrist and therapist to call.
2. Phone numbers for suicide or mental health hotlines in your area.
3. A reminder that calling 911 is a safe thing to do if one is feeling suicidal and is having trouble accessing the psychiatrist or therapist.
4. Name and directions of the chosen hospital or emergency room.
5. Insurance Information to take it with you if you need to go to the ER or the hospital.
6. Written list of all medications.
7. A list of "reasons to live" and "why suicide thoughts are distorted" to reference when one is thinking of suicide.

Suicide is NOT the way to deal with this illness. Bipolar disorder is treatable, and new advances are made every year. In order to guard against a suicide attempt, there are practical things that you and your support group can do. Be your own advocate and make sure that the suicide prevention ideas you have read about become a part of yours or the ill person's treatment. Also, though the person believes that he/she will never get better, remember that we are developing new ways to treat this illness everyday and most importantly, don't give up.



***Bipolar disorder is treatable, and new advances are made every year***

**If you are in a crisis please call Suicide Hotlines: National Hopeline Network: (800) 784-2433 National Suicide Prevention Lifeline: (800) 273-8255 Suicide hotline, 24/7 free and confidential. National Youth Crisis Helpline: (800) 442-4673 International Suicide Information: [www.befrienders.org](http://www.befrienders.org)**

# Throwing Water On A Grease Fire:

## THE RISKS OF SUBSTANCE USE FOR THOSE WITH BIPOLAR DISORDER

By

Russ Federman, Ph.D., ABPP - University of Virginia

J. Anderson Thomson, Jr., MD - University of Virginia

Tom Horvath, Ph.D., ABPP - Practical Recovery, San Diego, CA

If you have bipolar disorder but you abstain from alcohol and other substances, you may not need to read this chapter! Use of substances (including cannabis, alcohol, cocaine, heroin, etc.) generally complicates the experience of bipolar disorder. This chapter will explain why abstaining is the simplest and safest course of action. However, we will also provide information about when you may consider moderation as a potential option.

### Two Case Examples:

#### FRANK

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

#### GABRIELLE

Gabrielle's mood instability initially emerged around age 12. Her moods were often dark and stormy characterized by strong irritability and frequent acting out. By high school, pot was a daily part of life. It softened the painfulness of her depressed mood and also took the edge off of some of her irritability. She did reasonably well with her high school grades, but chose to pass on going to college. Instead she found she was able to support herself through retail clothing sales. At age 20 one of her co-workers gave her some Oxycontin. She was curious, tried it and liked it a lot. The guy who supplied the Oxycontin to Gabrielle's coworker soon had

Gabrielle converted to heroin. It worked, or at least so she thought. She no longer worried about where she was going with her life. She only had to worry about how she would come up with money for more heroine. After losing her job and winding up on the street, her family intervened and Gabrielle was hospitalized for heroine detox and substance dependency treatment. The intervention was partly effective as she finally stopped opiates, but she continued with her intermittent use of pot.

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

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

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

## **The Cost-Benefit Analysis**

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

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

We need to acknowledge that the goals each had (to fit in, to relax) are reasonable goals, and worth pursuing. Our work with bipolar individuals suggests that substance use is often related to one or more of the following factors: desires to 1) calm elevated energy or agitation, 2) lessen depression, 3) deal with the boredom of mid-range mood, and 4) instigate, increase or prolong the intensity of the "up"

feeling of hypomanic mood. There is nothing surprising or abnormal about wanting to feel calm, up (or more up), not down and not bored.

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

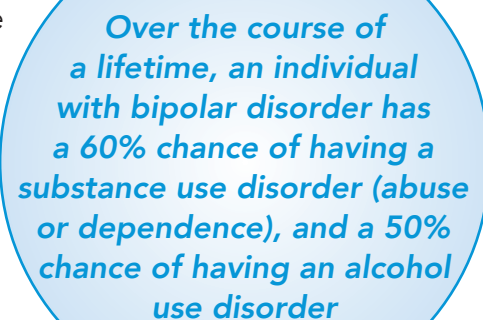
Perhaps you are thinking: “I see the risks here. I won’t let that happen to me. I’ll be careful.” To reiterate, the simplest way to “be careful” is to abstain from substance use. However, it is up to you to decide how much “margin for error” you want to have. Although there are some aspects of bipolar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

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

## **The Relationship Between Substance Use and Bipolar Disorder**

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

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



**Over the course of a lifetime, an individual with bipolar disorder has a 60% chance of having a substance use disorder (abuse or dependence), and a 50% chance of having an alcohol use disorder**

use disorder, with the others having other substance use disorders involving marijuana, opiates, stimulants, etc.

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

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

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

## Hepatitis C

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

Having Hepatitis C makes treating bipolar disorder more difficult. The most common substance misuse problem with bipolar patients is alcohol, and patients

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

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

## **Jail Time**

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

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

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

So if substance use causes so many problems for those with bipolar disorder, why do they do it? The explanation is self-medication: because mood regulation is so difficult at times, substances are used to accomplish this task. There is evidence to suggest that substance use does occur in an effort to cope with some bipolar symptoms, and that some relief may come of this effort, at least initially. Of course,



if the “medication” seems to be working, it is easy to assume that it will continue working with continued use. Here’s where there’s risk to encounter substantial problems.

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

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

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

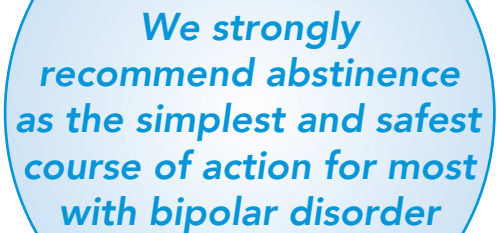
Perhaps substance use in anyone requires little explanation: we use substances because we want to! Many individuals vividly describe their substance experiences as fun, pleasurable, calming, exciting, exhilarating, “a chemical glimpse of paradise” and so forth. Weighed against these pleasures are the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

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

Your relationship with substances falls somewhere on this continuum:  
Abstinence ➡ Moderate Use ➡ Abuse ➡ Dependence

For reasons which we will explain, we strongly recommend abstinence as the simplest and safest course of action for most with bipolar disorder.

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



***We strongly recommend abstinence as the simplest and safest course of action for most with bipolar disorder***

### **Here's Why:**

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

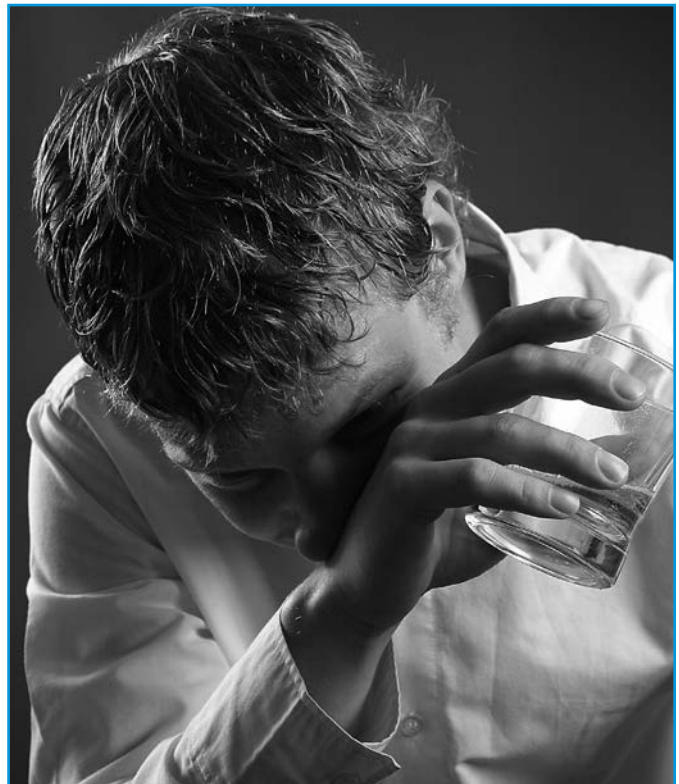
One of the stronger influences during this stage of development entails the need to fit in and establish strong interpersonal connection. This is pivotal because to be successful in gradually lessening ties to one's family unit, new connections are needed to move towards. This need to belong and be accepted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

You might perceive this data differently and say "Wait, what about the 40% who report not using alcohol?" We agree, that's a substantial figure. But much more powerful, is the fact that students "perceive" that nine out of ten students do drink. In other words, abstinence is not a perceived norm in the university population. When we reflect upon the importance of fitting in, it makes sense that many students will want to behave in a manner that's consistent with what they perceive their peers to be doing. Making alternative choices is far more difficult. For instance, going

to a fraternity party and adhering to a one or two drink limit is a hard choice when most in attendance are having many more. And when a student's peers are among those who are not doing well with moderation, then group affiliation can become a slippery slope towards a student's own excessive drinking. By choosing to form close connections with a group of peers who drink, the student greatly increases his or her own substance use risks. Combine that with a genetic predisposition towards bipolar disorder and you've got a recipe for the kinds of dual diagnoses problems that we listed earlier in this chapter.

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

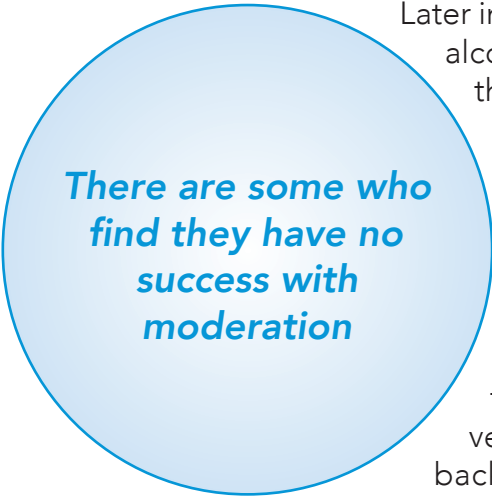
Let's shift a bit and consider the realities of a 42 year old named Keith who has lived with his bipolar disorder for the last 20 years. Keith is married with two children in their early teens. He is employed as a mid-level administrator in the health insurance industry. From ages 20 through 24, he experienced a fair amount of mood instability, largely fueled by frequent and excessive alcohol use as well as intermittent pot smoking. After one hospitalization and two subsequent medical withdrawals from college Keith "got it" that substance use was his nemesis. In fact, he found that once he was able to stay away from alcohol and pot, his instability became less severe and more infrequent. As he progressed with his sobriety he would still occasionally dip into a moderate depressive funk which created some impairment. He would also go through periods of elevated mood where everything was moving too fast for comfort. The difference at his stage of life was that Keith was connected to a strong, healthy and enduring support system. His wife understood the realities of his disorder as did his employer. He also had seen the same psychiatrist over the last 10 years time and all involved through key roles in his life were able to make necessary adjustments as needed. The impact of Keith's bipolar disorder wasn't inconsequential, but at the same time it didn't turn into a major disability. It was an ongoing factor that he had learned to manage.



Keith generally refrained from drinking but sometimes he and his wife had a glass of wine with dinner. He liked the wine for its flavor and the way it enhanced his meal. He rarely felt the desire for more than a glass or two. And on those isolated occasions where he went beyond that limit, he usually paid for it by having difficulty awakening in time to arrive at his office when his work day started. If Keith were being honest, he would acknowledge that his occasional slips into too much alcohol were never worth it. At these times he would feel fatigued, cranky and on edge for much the following day. He hated it. And he also rarely found that there was anything extraordinary about his alcohol-related experience from the night before.

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


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



***There are some who find they have no success with moderation***

Later in life, the risk of bipolar destabilization from moderate alcohol use is much less due to the many other factors that augment stability and have us less vulnerable to the seduction of social conformity and excitement seeking. There is one very important caveat here: there are some who find they have no success with moderation. It seems that every time they drink they get drunk. Even just a little alcohol consumption stimulates cravings for more.

And once that train has left the station it becomes very difficult to get things back on track without the destructive consequences of relapsing into excessive use. Where you fit on this continuum is something you will each need to discover. And again, if you're at an earlier point in the lifecycle, then the very process of discovery is also fraught with danger. Instead, you'll find that abstinence is your best friend.



***Instead, you'll find that abstinence is your best friend***

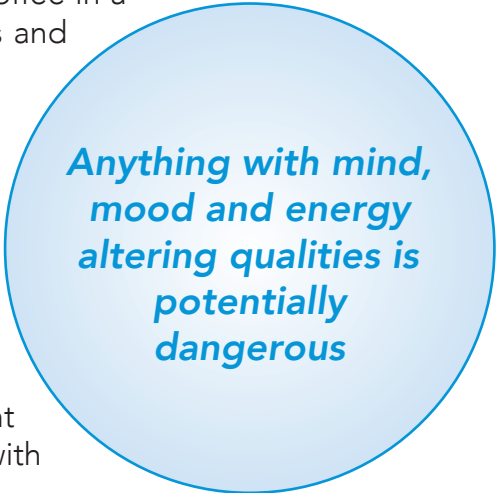
Thus far, most of our discussion has organized around alcohol use. This is purposeful. When we broaden the focus to include the wider range of popular drugs (stimulants, opiates and hallucinogens) then we are back to the slippery slope and our advice is that of strong caution. But

we also don't want to excessively generalize with excessive rigidity. Let's parse the issues with more specificity.

## Stimulants

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

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



***Anything with mind,  
mood and energy  
altering qualities is  
potentially  
dangerous***

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

## Opiates

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

## Hallucinogens

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

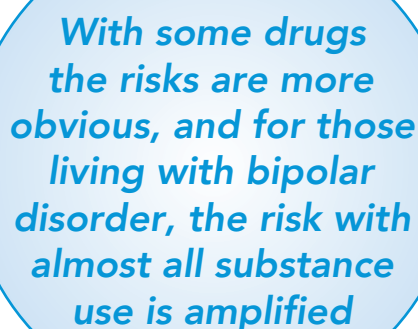
## Cannabis (marijuana)

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

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

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

For the average, mentally healthy person who is not bipolar, the occasional use of cannabis may be no big deal. But for the individual with bipolar disorder, the picture is different. There are the risks that occasional use will become more frequent as well as the risk that even occasional use may still have negative impact upon mood stability. We've simply seen the same outcome again and again within the bipolar population. When people with bipolar disorder get high on cannabis they experience stronger mood variability than if they abstain. And once they get a handle on abstinence, they generally experience more sustained psychological well-being.



***With some drugs the risks are more obvious, and for those living with bipolar disorder, the risk with almost all substance use is amplified***

It may seem that the information you're receiving within this chapter begins to sound like a broken record. All substance use carries risk. With some drugs the risks are more obvious, and for those living with bipolar disorder, the risk with almost all substance use is amplified. Perhaps our experience is similar to ER physicians who speak out against motorcycle use. What they see is the death, injury and dismemberment caused by motorcycle accidents. Many of those riders thought "it will never happen to me." We can only hope that all individuals with bipolar disorder will understand the risks we are pointing to in order to reduce their own risks of truly negative outcomes.

We'll conclude with a real life story which demonstrates the many of the risk and reward issues discussed throughout much of this chapter.

## Beth's Bipolar Disorder and Summer Camp: A Corrective Combination

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

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

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

## References

- American College Health Association (2010). National College Health Assessment II, Fall 2010 Reference Group Data Report. [http://www.acha-ncha.org/docs/ACHA-NCHA-II\\_ReferenceGroup\\_DataReport\\_Fall2010.pdf](http://www.acha-ncha.org/docs/ACHA-NCHA-II_ReferenceGroup_DataReport_Fall2010.pdf)
- Baethge, C., Hennen, J, Khalsa, H.K., Salvatore, P, Mauricio, T. and Baldessarini, R.J. (2008): "Sequencing of substance use and affective morbidity in 166 first-episode bipolar I disorder patients." *Bipolar Disorders*. 10:6. 738-741
- Bhattacharya, R., Shuhart, M. (2003): "Hepatitis C and Alcohol." *Journal of Clinical Gastroenterology*. 36: 242-253.
- Frederick K. Goodwin and Kay Redfield Jamison. (2007): *Manic Depressive Illness: Bipolar Disorders and Recurrent Depression. 2nd Edition*. New York, New York: Oxford University Press.



- Matthew, A.M., Huckans, M.S., Blackwell, A.D., Hauser, P. (2008): "Hepatitis C Testing and Infection Rates in Bipolar Patients With and Without Comorbid Substance Abuse Disorders." *Bipolar Disorder* 10: 266-270.
- McDermott, B.E., Quanbeck, C., Frye, M.A. (2007): "Comorbid substance use disorder in women with bipolar disorder associated with criminal arrest." *Bipolar Disorders*, 9: 536-540.
- Baillargeon, J., Binswanger, I.A., Penn, J.V., Williams, B.A, Murray O.J. (2009): "Psychiatric Disorders and Repeat Incarcerations: The Revolving Prison Door." *American Journal of Psychiatry*. 166: 103-109
- Onyike, C.U., Bonner, J.O., Lyketsos, C. G., Treisman, G.J. (2004): "Mania During Treatment of Chronic Hepatitis C with Pegylated Interferon and Ribavirin," *American Journal of Psychiatry* 161: 429-435.
- Quanbeck, C.D., Stone, D.C., Scott, C.L., McDermott, L.L., Frye, M.A. (2004): "Clinical and Legal Correlates of Inmates with Bipolar Disorder at Time of Criminal Arrest." *Journal Clinical Psychiatry* 65: 198-203.
- Sublette, E.M., Carballo, J., Moreno C., Galfalvy H.C., Brent D.A., Birmaher B., John Mann J., Oquendo M.A. (2009): "Substance Use Disorders and Suicide Attempts in Bipolar Subtypes." *Journal of Psychiatric Research* 43: 230-238.
- Tollivar, B.K. (2010): "Bipolar Disorder and Substance Abuse." *Current Psychiatry* 9: 33-40.

# Pregnancy & Bipolar Disorder:

## Taking Care of Both of You

By Depression & Bipolar Support Alliance (DBSA)

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

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



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

### What is Postpartum Depression?

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

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

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

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

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

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

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

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

## What Might Increase my Risk for Postpartum Depression?

Although postpartum depression can affect any woman who has recently given birth, there are some factors that may increase your chance of having postpartum depression, such as:

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

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

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

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

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

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

## What are my Treatment Options?

### MEDICATION

Some mothers decide with their doctors that medication is the best choice of treating their postpartum depression. Some medications may pass into breast milk, but others are less likely to do so, and your doctor should have the information to help you decide which medication is best for both you and your baby. If you have to stop breastfeeding, it doesn't mean you aren't a good mother; it means you are taking care of yourself in order to be the best possible mother.

Some medications may have side effects, such as dry mouth, light-headedness, sexual dysfunction or weight gain. Sometimes side effects go away on their own; other times it helps to change medication. Don't become discouraged if you experience side effects—discuss them with your doctor and find out what other options you have. There are many different medications available to treat depression. All of them work, they just don't work the same on everyone. If one medication causes side effects or does not relieve your depression, another may work well and have fewer side effects. Don't give up. Never stop taking your medications or change your dosage without first discussing it with your doctor. Check with your doctor before using herbal, natural or over-the-counter remedies, because sometimes they can interfere with prescribed medication.

## **PSYCHOTHERAPY**

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

## **How Might this Illness Affect my Family?**

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

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

## **What can Families do to Help?**

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

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

## What is Postpartum Psychosis?

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

## What if I was Already Diagnosed and Treated for Depression or Bipolar Disorder Before I Became Pregnant?

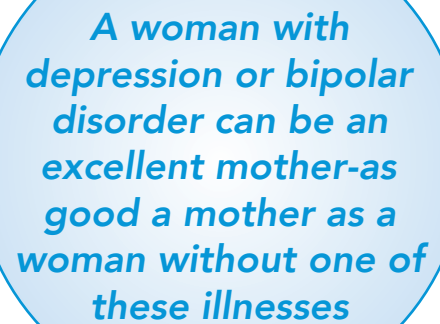
A woman with depression or bipolar disorder can be an excellent mother—as good a mother as a woman without one of these illnesses. But a woman with a prior history of depression or bipolar disorder is at an increased risk to develop postpartum depression (1 in 4 develop postpartum depression) compared to a woman with no prior history (1 in 10 develop postpartum depression).

Be the best mother you can by staying aware of your own moods, working with your doctor to monitor your illness, planning appropriate treatment during pregnancy, sticking with the treatment plan you are given and making sure you have a support network in place before the baby is born. Your support network may include a support group you attend, your family and friend, health care providers or other new moms.

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

## How do Support Groups Help?

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



*A woman with depression or bipolar disorder can be an excellent mother—as good a mother as a woman without one of these illnesses*

## What are Some Things I Can Do to Stay Healthy?

- Keep appointments with all your health care providers and stick with your prescribed treatment plan.
- Learn all you can about postpartum depression and its treatment.
- Keep track of your moods, things that cause you stress, and your response to treatment in a journal. This may help you spot future episode earlier.
- Share your thoughts and feelings with others.
- Set realistic expectations for yourself. Work on accepting yourself as you are.
- Don't skip meals, even if your appetite and energy are low. Eat a variety of foods to get the nutrients you need. Talk to your doctor about taking vitamin supplements.
- Look for opportunities to be physically active. Even walking or climbing stairs can help improve your mood and health.
- Develop stress reduction techniques, or ask your doctor about or therapist to recommend some.

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

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

Reproduced with permission of the Depression & Bipolar Support Alliance (DBSA) brochure. Brochures are available at [www.dbsalliance.org](http://www.dbsalliance.org) or by calling 1800-826-3632.

# Stigma & Mental Illness

By Muffy Walker MSN., MBA

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

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

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


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

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

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

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

Four of the 10 leading causes of disability worldwide are mental disorders.



**Four of the 10 leading causes of disability worldwide are mental disorders**

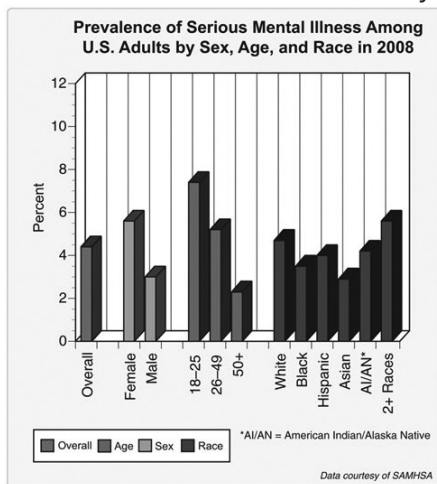


According to the 2005 National Comorbidity Survey Replication study, approximately 1 in 3 Americans experience a mental health disorder in any given year. This translates to over 75 million individuals. Nearly half of Americans will experience a mental health disorder at some point in their lifetime.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

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

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

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



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

the result of chemical imbalances in the brain. These imbalances may be inherited, or may develop because of excessive stress or substance abuse.

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

**It is sometimes easy to forget that our brain, like all of our other organs, is vulnerable to disease**

*When I was twelve I invited my friend to come over for a play date. His father said no, they were going to his Grandmother's. A few minutes later another boy invited him to play. The father said yes, and off they went. Court R.*

The effects of stigma are especially painful and damaging to one's self-esteem. It leaves people with mental illnesses feeling like outcasts from society. Whether the perceived stigma is real or not, it is the subjective interpretation that affects the person's feelings of belonging.

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

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

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

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

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

## **Myths:**

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

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

*Yes, they discriminate against us; They don't count on us; Our society in Iran has no capacity for us; I mean there is no cultural understanding in our society; They ridicule, insult and harm us; I wish they could understand that psychiatric patients are like other patients, like patients with cancer or cardiac disease and that they can live their lives. (15)*

- Myth #2:** People with a severe mental illness, such as schizophrenia, are usually dangerous and violent.
- Fact:** Statistics show that the incidence of violence in people who have a brain disorder is not much higher than it is in the general population. Those suffering from a psychosis such as schizophrenia are more often frightened, confused and despairing than violent.
- Myth #3:** Mental illness is the result of bad parenting.
- Fact:** Most experts agree that a genetic susceptibility, combined with other risk factors, leads to a psychiatric disorder. In other words, mental illnesses have a physical cause.
- Myth #4:** Depression results from a personality weakness or character flaw, and people who are depressed could just snap out of it if they tried hard enough.
- Fact:** Depression has nothing to do with being lazy or weak. It results from changes in brain chemistry or brain function, and medication and/or psychotherapy often help people to recover.
- Myth #5:** Schizophrenia means split personality, and there is no way to control it.
- Fact:** Schizophrenia is often confused with Dissociative Identity Disorder (previously called multiple personality disorder). Actually, schizophrenia is a brain disorder that robs people of their ability to think clearly and logically. The estimated 2.5 million Americans with schizophrenia have symptoms ranging from social withdrawal to hallucinations and delusions. Medication has helped many of these individuals to lead fulfilling, productive lives.
- Myth #6:** Depression is a normal part of the aging process.
- Fact:** It is not normal for older adults to be depressed. Signs of depression in older people include a loss of interest in activities, sleep disturbances and lethargy. Depression in the elderly is often undiagnosed, and it is important for seniors and their family members to recognize the problem and seek professional help.
- Myth #7:** Depression and other illnesses, such as anxiety disorders, do not affect children or adolescents. Any problems they have are just a part of growing up.
- Fact:** Children and adolescents can develop severe mental illnesses. In the United States, one in ten children and adolescents has a mental disorder severe enough to cause impairment. However, only about 20 percent of these children receive needed treatment. Left untreated, these problems can get worse. Anyone talking about suicide should be taken very seriously.

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

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

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

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

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

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

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

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

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



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

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

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

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

## Challenging stigma

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

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

- The You KNOW Me Alaska anti-stigma campaign uses of a popular Alaskan Iditarod musher as a spokesperson for television ads, trading cards, newspapers, posters, and radio. [www.mhtrust.org](http://www.mhtrust.org)
- "On June 11, 2009 Wayne Cho completed a 8207 km cross-Canada run to raise awareness for anxiety and depression. These debilitating illnesses affect a great number of people and can cause great physical/mental/emotional harm to not only the affected individuals, but also to those closest to them. Wayne Cho has battled an anxiety disorder for many years and knows all-too-well the stigma to which people suffering from mental illness are subjected. His journey to achieve his dreams, the people that he has met along the way, and the millions more people that are affected by mental illness worldwide have inspired Wayne to challenge the stigma surrounding these disorders."
- Actress Glenn Close has a campaign called BringChange2Mind with a PSA directed by Ron Howard: <http://www.bringchange2mind.org/>

- Fidgety Fairy Tales—The Mental Health Musical is an original 40-minute musical produced by the Minnesota Association for Children’s Mental Health (MACMH) [www.macmh.org](http://www.macmh.org)
- In Our Own Voice (IOOV) is a unique informational outreach program, developed by the National Alliance on Mental Illness (NAMI), that offers insight into the recovery that is possible for people with severe mental illnesses. The program aims to meet the need for consumer-run education initiatives, to set a standard for quality education about mental illness from those who have been there, to offer genuine work opportunities for consumers, to encourage self-confidence and self-esteem in presenters, and to focus on recovery and the message of hope. [www.nami.org](http://www.nami.org)
- The Iris the Dragon book series was developed in 2000 by Gayle Grass in Ontario, Canada. It was created to help reduce the negative attitudes that are associated with mental illness and to generate understanding and awareness of mental health problems in children. [www.iristhedragon.com](http://www.iristhedragon.com)
- Developed in Andalusia, Spain, in September 2007, 1 de cada 4 (1 in 4 in English) is a campaign to increase public awareness of mental illnesses in order to reduce the stigma and discrimination experienced by people with mental illness. [www.1decada4.com](http://www.1decada4.com)
- SANE StigmaWatch, an initiative of the national mental health charity, SANE Australia, monitors the Australian media to ensure accurate and respectful representation of mental illnesses. It does this through monitoring, correcting, and logging media misrepresentation of mental illnesses. [www.sane.org](http://www.sane.org)
- Mind (National Association for Mental Health) provides information on a national level for England and Wales. Their activities promote the values of autonomy, equality, knowledge, and participation in the community for all people, especially those with mental illnesses. The group actively campaigns to improve the policy and attitudes of governing bodies in the United Kingdom, and has developed highly successful local-level initiatives for consumers of mental health. <http://www.mind.org.uk>



**MASS MEDIA** “Mass media is, far and away, the public’s primary source of information about mental illnesses.” ---Survey of public attitudes, Robert Wood Johnson Foundation

## Why should we be concerned?



Mass media are those sources that reach vast audiences on a daily basis and include television, film, radio, newspapers, advertising, and the Internet:

- the average American watches 4 hours of TV each day
- 1.36 billion movie tickets were sold in 2008
- 1.71 million DVDs were rented and over one billion sold in 2007
- the average Internet user spends 61 hours/month on the Internet (February 2009) (8)

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

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

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

Journalists in all forms of media play an increasingly important role in shaping public understanding and debate about health care issues. The Rosalynn Carter Fellowships for Mental Health Journalism program, created in 1996, is part of a national effort to reduce negative attitudes and discrimination associated with mental illnesses. The fellowship program aims to increase accurate reporting on mental health issues; help journalists produce high-quality work that reflects an understanding of mental health issues through exposure to well-established resources in the field; and develop a cadre of better-informed print and electronic journalists. (11)

Unfortunately, a joint study by Indiana University and Columbia University researchers found no change in prejudice and discrimination toward people with serious mental illness or substance abuse problems despite a greater embrace by the public of neurobiological explanations for these illnesses. (12)

Recent research has found that:

– 48.6 percent of the public are unwilling to work closely on a job with someone with depression

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

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

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

- The percentage of people associating mental illness with violence has doubled since 1956. (13)

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

"Often mental health advocates end up singing to the choir," Pescosolido said. "We need to involve groups in each community to talk about these issues which affect nearly every family in America in some way. This is in everyone's interest."

The research article suggests that stigma reduction efforts focus on the person rather than on the disease, and emphasize the abilities and competencies of people with mental health problems. Pescosolido says well-established civic groups -- groups normally not involved with mental health issues -- could be very effective in making people aware of the need for inclusion and the importance of increasing the dignity and rights of citizenship for persons with mental illnesses. (14)



## Combatting Stigma:

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

1. In a recent survey by the American Psychiatric Association, 79% percent of those surveyed believed that seeking and receiving support from family and friends reduced feelings of stigma.
2. Share your experience with mental disorder. Your story can convey to others that having a mental disorder is nothing to be embarrassed about.
3. Help people with mental disorder reenter society. Support their efforts to obtain housing and jobs.
4. Watch the language you use:
  - don't use generic labels: "retarded", "our mentally ill"
  - don't use psychiatric diagnoses as metaphors: "schizophrenic situation"
  - don't use offensive words: "psycho", "loony", "crazy", "wacko", "slow", "crackpot"
  - don't refer to a person as a diagnosis: "he's bipolar", instead say, "he has bipolar disorder"
5. Document stigma in the media whenever possible
6. The media also offers our best hope for eradicating stigma because of its power to educate and influence public opinion, so remember to thank journalists when they get it right.
7. Send letters, make phone calls, or e-mail the offending parties
8. Ask your local, regional, and national leaders to take a stand
9. Support efforts to actively expose stigma in the media
10. Educate yourself - the elimination of stigma begins with you
11. Volunteer, join the IBPF anti-stigma campaign in October every year named "Say It Forward". Check our website in September for details.

## References

- (1): (Healthline Network Inc., 2007)
- (2): About.com
- (3): Link & Phelan, 2001
- (4): MHA Colorado
- (5): Canadian MH Assoc Ontario
- (6): Lacondria Simmons: <http://www.med.upenn.edu/psychotherapy/Stigma.html>
- (7): Link, Mirotznik, & Cullen, 1991; Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001; Perlick et al., 2001; Sirey et al., 2001; Struening et al., 2001
- (8): Bryant, J. & Thompson, S. (2002). Fundamentals of Media Effects. McGraw-Hill. Gerbner, G., Gross, L., Morgan, M., & Signorelli, N. (1980). The "Mainstreaming" of America. Journal of Communication, (30), 10-29.

- (9): Wahl, O., Wood, A., & Richards, R. (2002). Newspaper coverage of mental illness: Is it changing? *Psychiatric Rehabilitation Journal*, Vol. 6, 9-31.
- (10): Don Diefenbach (2007). *Journal of Community Psychology*, Vol. 35, 181-195.
- (11): [www.samhsa.org](http://www.samhsa.org)
- (12): Pescosolido, B.A., J.K. Martin, J.S. Long, T.R. Medina, J. Phelan, B.G. Link. 2010. "A Disease Like Any Other?" A Decade of Change in Public Reactions to Schizophrenia, Depression and Alcohol Dependence." *American Journal of Psychiatry* 167(11):1321-1330.
- (13): Link, B.G., Phelan, J.C., Bresnahan, M., Stueve, A. & Pescosolido. B.A. (1999). Public conceptions of mental illness. *American Journal of Public Health*, Vol. 89, 1328-1333.
- (14): Pescosolido, B.A., J.K. Martin, J.S. Long, T.R. Medina, J. Phelan, B.G. Link. 2010. "A Disease Like Any Other?" A Decade of Change in Public Reactions to Schizophrenia, Depression and Alcohol Dependence." *American Journal of Psychiatry* 167(11):1321-1330.
- (15) GHANEAN, H., NOJOMI, M., JACOBSSON, L.. Internalized stigma of mental illness in Tehran, Iran. *Stigma Research and Action, North America*, 1, Feb. 2011.

***HERE'S TO YOUR HEALTH!***



# Bipolar Disorder And Aging

By Thomas W. Meeks, M.D.; Colin A. Depp, Ph.D.

## How common is bipolar disorder in later life?

Bipolar disorder is uncommon in later life according to studies of community prevalence, such as the Epidemiological Catchment Area (ECA) Survey (Regier et al., 1993). The lifetime prevalence of bipolar disorder in the ECA was 0.4% among persons aged 45 to 64 and 0.1% among persons older than age 65 (compared to 1.4% among persons aged 18-44). Other community surveys indicate the prevalence of bipolar disorder among persons older than age 60 ranges between 0.1% and 0.5% (Hirschfeld, 2003; Unutzer et al., 1998). Although these data suggest that bipolar disorder is less common among older than younger age groups, these studies should be interpreted with caution as these studies did not typically include people in assisted living situations. It is also notable that within mental health settings, bipolar disorder is a relatively common diagnosis among samples of older adults, accounting for between 8 and 10% of all diagnoses (Depp & Jeste, 2004). The reported rates may also be lower in older adults in part because bipolar disorder is associated with increased rates of suicide and chronic medical conditions, both of which decrease the number of persons with bipolar disorder who live on into their later years. Of course, many people may wonder, "What exactly is an older adult?" Medical literature typically defines the term "geriatric" or "elderly" as age 65 and above. There is really no biological reason to choose this age over, say, 60 or 70, but this has been a convention derived from the national standards for retirement age. People on an individual level obviously age at different rates; some healthy 70 year-olds may have better functioning bodies and minds than some 40 year-olds in ill health.

## What happens to people with bipolar disorder as they age?

When compared to research on other psychiatric disorders, such as later-life depression or schizophrenia, there is little known about the course of bipolar disorder in older adults (Charney et al., 2003). The majority of data on later-life bipolar disorder has come from hospitalized people and anecdotal data (Depp & Jeste, 2004). Early observations were that the long term course of bipolar disorder involves a reduction in symptoms and improvement in functioning, which, in some ways, is what separated bipolar disorder from early conceptions of schizophrenia (Kraepelin, 1921). Other observations provide stark contrast, with the 'kindling' theory proposing that inter-episode recovery periods tend to shorten with age, consistent with the idea that bipolar disorder follows a progressively declining course (Post et al., 1986). Kindling implies that each mood episode actually changes the brain in a way that makes future episodes happen sooner and more severely—a "snowball effect" of sorts. Unfortunately, there is little data to confirm either supposition about the long-term course of bipolar disorder.

However, what is known is that most older people who have bipolar disorder have lived with the illness for many years, as the mean age of onset is between age 20 and 25. These individuals would be referred to as "early-onset." The cut-off

between “early-onset” and “late-onset” is often age 50, but varies from study to study (Depp & Jeste, 2004). It is more common that “late-onset” individuals experience neurological illnesses, such as a stroke or progressive dementias. In fact, having a first depressive or manic episode after age 50 is certainly the exception rather than the rule. If someone first shows signs consistent with bipolar disorder after age 50, there should be a thorough work-up, including a CT or MRI of the brain, to ensure that the symptoms are not due to a medical/neurological disorder or due to substances (illicit drugs, alcohol, or prescribed medications). In general, there are probably more similarities than differences between early- and late-onset patients, but some differences are worth noting. For instance, late-onset patients more often attain functional milestones such as employment and marriage prior to the illness starting and are less likely to have first-degree relatives with bipolar disorder. It should be noted that some seemingly “late-onset” cases may actually be instances of years of misdiagnosed or undiagnosed bipolar disorder, or instances in which the first manic or hypomanic episode occurs more than a decade after the first episode of major depression. Ageist bias may also prevent proper screening for certain symptoms of mania such as impulsive sexual activity and other risk-taking behaviors. Comparing younger and older persons with bipolar disorder, older people may experience less severe symptoms of mania, as identified in a study of people hospitalized for mania (Young & Falk, 1989). According to a large survey, community-dwelling older adults report experiencing more depression- and mania-free days (Calabrese et al., 2003).

### **What other health problems do older adults with bipolar disorder face?**

On balance, older adults experience a much greater degree of medical burden. Most notably, the risk of diabetes and cardiovascular disease is several times higher in older adults with bipolar disorder compared to older adults without psychiatric illnesses (Kilbourne et al., 2004). Risk factors for co-occurring medical disorders include poor health habits (e.g., smoking and physical inactivity), diminished access to medical care, and side effects of medications such as atypical antipsychotics. On a more positive note, older adults with bipolar disorder are less likely to have met criteria for substance use disorders within their lifetimes; prevalence for any substance use disorder among younger adults with bipolar disorder is about 60%, whereas among older adults estimates range from 20 to 30% (Cassidy et al., 2001). This is notable because co-occurring substance use disorders add greatly to the disability associated with bipolar disorder.

With the current epidemic of Alzheimer’s disease, the public is becoming increasingly aware of the importance of cognitive disorders among older adults. As a point of clarification, many people confuse the terms “dementia” and “Alzheimer’s disease.” Dementia (which may be renamed neurocognitive disorder in the upcoming DSM-5) is the broader term that describes any progressive, irreversible dysfunction in memory, language, decision-making, and other cognitive skills that impairs someone’s life functioning. Alzheimer’s disease is a specific (and the most common) type of dementia whose cause is not fully understood but appears to be related to certain genetic and environmental factors that cause

excessive brain deposits of a protein called beta-amyloid. Cognitive impairments are more prevalent in older adults with bipolar disorder compared to younger adults. In one study, it was estimated that about 50% of persons older than age 60 with bipolar disorder display clinically significant cognitive impairment, even when not depressed or manic (Gildengers et al., 2004). It is unclear at this point if cognitive impairments worsen at a more rapid rate than that expected from the normal course of aging, with data mixed as to whether this may be the case (Gildengers et al., 2009; Schouws et al., 2012).

What is clear is that whenever there is concern about changes in an older person's memory/cognition, further evaluation, often by a neurologist or geriatric psychiatrist, is recommended rather than accepting such changes as part of normal aging or as part of the normal course of bipolar disorder. It is also important to keep in mind that declining cognition could destabilize an otherwise stable course of bipolar illness. Problems with memory or planning can impair ability to adhere to treatment recommendations, and changes in mood, sleep, and behavioral control are common in dementia. Medical comorbidity and cognitive impairments frequently become important factors in the care of older people with bipolar disorder and often necessitates coordination with primary care providers and family members.

### **What else could it be? Bipolar imposters**

Older adults on average take more prescription medications than younger adults, which creates increased potential for medication-induced mood symptoms as well as medication interactions. Medications that can cause symptoms which mimic bipolar mania include antidepressants, steroids such as prednisone, thyroid supplements, and medications for Parkinson's disease. It should be noted that some people who do go on to develop true bipolar disorder have their first manic or hypomanic episode while taking an antidepressant but then have further episodes independent of any medication. Prednisone, a steroid used to treat disorders associated with inflammation like rheumatoid arthritis, emphysema, and lupus, may cause manic, depressive, or psychotic symptoms, especially when prescribed in high doses. Despite the decreased rates compared to younger adults, a substantial number of older adults also suffer from substance use disorders such as alcoholism and prescription drug abuse. Substances of abuse can cause symptoms that mimic bipolar disorder, but cause-and-effect is not always clear. Many persons with true bipolar disorder also battle substance abuse and may continue to have bipolar symptoms even if they recover from their addiction (see section on substance abuse and bipolar disorder).



Several medical (especially neurological) conditions can cause a cluster of symptoms that mimic bipolar disorder. These include strokes, overactive thyroid, brain tumors, multiple sclerosis, and frontotemporal dementia. Stroke (damage to the brain caused by lack of blood flow, usually due to a clot or hemorrhage) is an interesting

example of a medical illness that can cause mood difficulties. Depression after strokes is fairly common, with about 1 out of 3 persons experiencing significant depression symptoms after a stroke. A stroke may obviously cause significant life stress if it results in a new disability, such as impaired ability to walk or speak, but strokes can cause mood symptoms not only for this reason, but also because they may directly impact the brain in regions responsible for mood regulation. While the effects of strokes on speech/language or movement are more obvious, the damage to emotional control from a stroke is often more subtle, and thus people may not link changes in their mood to having suffered a stroke.

While less common than depression, symptoms that resemble mania (e.g., elevated mood, impulsivity, rapid speech, decreased sleep, and irritability) may also occur in up to 1-2% of persons who suffer a stroke. Mania caused by a stroke appears to be more common if the stroke occurs in the right side of the brain (which in turn usually affects the left side of the body) and may be more common if the affected person has a family history of bipolar disorder, suggesting an underlying genetic susceptibility. Strokes should be considered as a potential cause of late-onset mania, especially if someone has notable stroke risk factors such as diabetes or high blood pressure (Santos et al., 2011). On the flip side, however, older adults with early-onset, long-standing bipolar disorder are actually at increased risk for cardiovascular disease and stroke because of elevated rates of diabetes, high cholesterol, high blood pressure, and obesity in bipolar disorder. This is to say, the cause and effect can go both ways: strokes can cause mood symptoms similar to bipolar disorder, but bipolar disorder (and some of its medication treatments) is associated with increased risk for strokes.

## **How does treatment differ for older adults?**

There are few systematic studies of interventions for bipolar disorder specifically among older adults. This lack of treatment research is even more notable for older adults age 75 and above. As occurs with many mental health disorders, treatment recommendations for older adults with bipolar disorder are largely extrapolated from studies conducted among young and middle-aged adults. Yet, as life expectancy in general and more specifically in bipolar disorder increases, the number of persons with bipolar disorder in late-life will grow significantly. Studies that evaluate treatment options in bipolar disorder among this burgeoning geriatric population will therefore become even more paramount in importance.

### **Lithium**

Medications remain the cornerstone of treatment for bipolar disorder in older adults. Lithium, arguably the most tried and true mood stabilizer, poses unique challenges for use in the geriatric population. Older adults have important changes in how they absorb, distribute, and eliminate medications in the body. A fairly common age-related change is a decrease in the efficiency of eliminating medications from the body, a function usually performed by the liver and/or kidney. Lithium is not processed in the liver but rather is primarily eliminated via the kidney. The kidneys predictably have a decline in functioning with aging, even in the absence of any specific disease affecting them. Additionally, treatment with

lithium for decades into late life can at times accelerate age-related declines in kidney function, due to the damaging effects of long-term lithium use on the kidney in a subgroup of individuals. Several medical conditions that become more common with aging, such as high blood pressure and diabetes, may also impair kidney function. Medications used to treat hypertension, such as certain diuretics (“water pills”) and “ACE inhibitors” (e.g. lisinopril), may interfere with the kidney’s elimination of lithium, causing an elevated lithium level. Other common medications that can raise lithium levels are non-steroidal anti-inflammatories (NSAIDs) used for pain relief—the most commonly used are ibuprofen (Motrin, Advil) and naproxen (Alleve).

These phenomena in the kidney often cause a lithium dose that yields a safe and effective lithium blood level in younger adults to yield an elevated, intolerable or even toxic lithium level among older adults. Troublesome side effects that may occur even at therapeutic lithium levels in older adults include cognitive complaints, tremor, worsening urinary frequency or incontinence, impaired balance, lowered thyroid functioning, and weight gain. Symptoms of lithium toxicity include poor muscle coordination, confusion, and pronounced tremors—this is a medical emergency that is managed usually in the hospital by discontinuing lithium and hydrating the affected person with IV fluids, but occasionally may require temporary dialysis to remove excess lithium from the body. In fact, even at a “normal” blood level, the bodily systems of older adults (including the brain) are generally more sensitive to the effects of lithium. This may be in part related to age-associated changes in the integrity of the “blood-brain barrier,” which regulates what compounds in the general blood stream are allowed access to the blood that nourishes the brain. These phenomena have led geriatric psychiatrists to prescribe lower doses of lithium as well as to shift the target lithium blood level from 0.8-1.2 down to 0.5-0.8 mEq/L for most older adults. In addition to usual laboratory monitoring, older adults treated with lithium should have an EKG (electrocardiogram) checked as lithium can affect electrical conduction in the heart.

Despite these challenges, lithium may be very helpful for some older adults with bipolar disorder, including those who have preferentially responded to lithium over other mood stabilizers as younger adults and those with more “classic” bipolar disorder (euphoric mania without mixed depressive-manic episodes or rapid cycling). In a large recent government-sponsored study on bipolar treatments entitled STEP-BD (Systematic Treatment Enhancement Program for Bipolar Disorder), when adults aged 60 and above were compared to younger adults, lithium use was less frequent but not uncommon (30% of geriatric cases vs. 38% of younger adult cases), and the average dose was about 1/3 lower for older adults. Interestingly, older adults were twice as likely to recover compared to younger adults when treated with lithium (D’Souza et al., 2011).

Lithium is also the only medication shown to have definite protective effects against suicide in bipolar disorder. Because completed suicides are a major mental health concern in older adults, especially older Caucasian males, lithium deserves consideration for older adults with bipolar disorder and prominent suicide risk



factors. Additionally, there are some theoretical benefits of lithium for older adults, who are more susceptible to diseases of brain degeneration, such as Alzheimer's disease. Lithium is being studied for its "neuro-protective" properties, that is, molecular actions that may prevent nerve cell death. This is still experimental at this stage, however, and high lithium levels actually impair thinking and memory, especially among older adults. On the whole, with all other factors being equal, ease of use favors other mood stabilizers over lithium as first-line agents among older adults with bipolar disorder. However, all other factors are often not equal, and lithium may be very beneficial for a substantial portion of older adults, such as those who have responded well to lithium earlier in life, those with classic euphoric mania, those at high risk for suicide, and those without prominent medical issues that affect kidney function.

### **Valproic acid**

Valproic acid (or its related slow-release formulation, divalproex [Depakote]), originally approved to treat seizures, has become a common alternative to lithium as a mood stabilizer in bipolar disorder. Valproic acid may be more effective than lithium for certain variants of bipolar disorder, such as rapid cycling or mixed manic-depressive episodes. There is some suggestion that it may also be more effective than lithium in bipolar disorder associated with an underlying neurological abnormality or substance abuse. Overall, efficacy and tolerability have made valproic acid a common first line mood stabilizer in late-life bipolar disorder.

Some special consideration should be given when prescribing valproic acid to older adults, however. With increasing age, levels of the blood protein albumin tend to decline. This is relevant because valproic acid binds to albumin; when there is less albumin available or when other drugs such as warfarin (Coumadin) and aspirin "push" valproic acid off of albumin, this leaves more free levels of valproic acid in the blood. The free (i.e. not protein-bound) form of the drug is the one that exerts both beneficial and adverse effects. Routine labs to check for blood levels of valproic acid do not account for a possible shift to a higher proportion of free drug that may occur with aging or complex medication regimens. This may lead to situations in which older adults benefit from a relatively low total valproic acid blood level or in which side effects emerge at a seemingly low valproic acid level. Checking a more specialized lab, the free valproic acid level, in these cases could help older patients and doctors to aim for a more precise valproic acid dose. Therapeutic effects are often seen for older adults at total valproic acid levels of 65-90 mcg/ml or 6-22 mcg/mL of free valproic acid.

Some common side effects of valproic acid include nausea, sedation, tremor, weight gain, and thinning hair. Other uncommon but serious adverse effects include liver toxicity, pancreatitis, and low blood platelets (which can lead to poor blood clotting). Some evidence suggests liver and pancreas side effects are less common with increasing age. An infrequent and often unappreciated cause of confusion in older adults taking valproic acid is a side effect of increased urea (a "waste product" that may affect brain function when it accumulates). Urea levels can also be measured with a special laboratory test.

## Other anticonvulsants

Other anti-seizure medications that were discovered to have mood stabilizing properties include carbamazepine (Tegretol) and lamotrigine (Lamictal). Carbamazepine, like valproic acid, may be useful for bipolar syndromes more often resistant to lithium, such as those with rapid cycling or associated underlying neurological disorders. Carbamazepine tends to be somewhat harder for older adults to tolerate than valproic acid, largely because of neurological side effects such as tremor, dizziness, incoordination, double vision, and cognitive impairment. Carbamazepine can lower blood levels of many medications, so drug interactions are important to consider when using it among older adults. Other side effects that occur in all ages but may be even more problematic in older adults are lowered blood sodium levels, rashes, altered electrical conduction in the heart, and suppression of the bone marrow's production of blood cells. Lowered sodium levels can cause confusion, lethargy, seizures and even coma, and may be more common when carbamazepine is given to older adults taking SSRI antidepressants or diuretics.

Lamotrigine has been an important addition in the treatment of bipolar disorder because of its relative strength in preventing depressive episodes, without the apparent risk of inducing mania or rapid cycling observed with conventional antidepressants. Lamotrigine appears to have good tolerability for most older adults. For instance, cognitive side effects appear less likely in comparison to many other anti-seizure medications. Rash, as in all age groups, is the most important side effect to monitor. Medication interactions with other anti-seizure medications are important to keep in mind as well. For instance, valproic acid increases blood levels of lamotrigine, while carbamazepine decreases lamotrigine levels.

## Antipsychotics

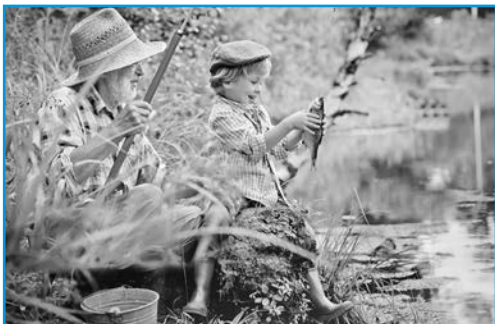
As the name implies, antipsychotic medications have traditionally been developed for treatment of psychotic disorders such as schizophrenia. However, psychosis is often evident in severe manic and depressive episodes, and antipsychotics have a long history of use in bipolar disorder. Research has also shown that antipsychotics may act as long-term mood stabilizers, anti-manic agents, and antidepressants in bipolar disorder even without psychotic symptoms. Most research in bipolar disorder has examined the newer, so-called "atypical" antipsychotics, although the older, "typical" drugs, such as chlorpromazine (Thorazine) and haloperidol (Haldol), have been used for decades, especially in the treatment of manic agitation.

Recent years have seen increasing debate over how much better (if at all) atypical antipsychotics are than older, typical versions. Both types have relative pros and cons in older adults. Typical antipsychotics tend to cause more neurological side effects, such as tremors and stiffness resembling Parkinson's disease as well as writhing or jerking movements called tardive dyskinesia. Older adults are more susceptible than younger adults to both Parkinson-like effects and tardive dyskinesia when prescribed antipsychotics. Another antipsychotic side effect more common with typical agents is elevation of the hormone prolactin. Increased

prolactin blocks the effects of the sex hormones estrogen and testosterone, which are already on the decline in older adults. This could worsen bone loss and osteoporosis as well as sexual functioning, two issues often problematic for older adults. Certain typical antipsychotics strongly block a brain chemical messenger called acetylcholine. Decreasing the functioning of acetylcholine is particularly troublesome in older adults because this may worsen certain symptoms already common in aging, such as memory impairment, trouble urinating, blurry vision, and constipation.

“Atypical” antipsychotics have traditionally been defined by their decreased likelihood of causing neurological side effects in comparison with typical antipsychotics. While this is true, enthusiasm for the use of atypical antipsychotics has declined somewhat as another set of side effects has emerged with the atypical drugs, namely adverse effects on body metabolism. Drug-induced changes in metabolism with atypical antipsychotics include elevated blood sugar, elevated lipids/cholesterol, and weight gain. Older adults already have increased rates of diabetes and high cholesterol, so these drugs should be used with caution in this population. Nevertheless, some evidence suggests effects on weight and lipids/cholesterol may not be as common in older adults as in younger adults, and atypical drugs vary in how likely they are to cause metabolic side effects (Mathys et al., 2009). An important advantage of atypical antipsychotics over typical agents is the better library of evidence supporting their acute and long-term benefits in bipolar disorder. This is particularly true for bipolar depression, for which quetiapine (Seroquel) and olanzapine in combination with fluoxetine (Symbyax) are the only medications of any class FDA-approved for the acute treatment of bipolar depression.

Special mention of another apparent age-related side effect of antipsychotics bears mentioning here. All antipsychotics (typical and atypical) have warnings about increasing the risk of death and stroke in older persons with dementia. The rates of death and/or stroke increased by 1-2% in the initial 12 weeks of treatment with an antipsychotic in studies looking at whether these drugs improved behavioral and psychological symptoms associated with dementia, such as aggression and agitation. While most older adults with bipolar disorder do not have dementia, this



could be an emerging clinical problem as persons successfully treated with antipsychotics for bipolar disorder grow older. Additionally, it is not clear whether the risk of stroke and death is specific to the diagnosis of dementia or is a broader risk associated with antipsychotic treatment among older adults, independent of diagnosis. Antipsychotic use requires a careful individualized assessment of risks and benefits of the medications

by physicians and patients. The potential benefits of antipsychotics for bipolar disorder are, on the whole, considerably better established than for dementia-associated behavior changes. Other potential risks of antipsychotics of particular relevance to older adults include impaired balance, falls, drops in blood pressure upon rising, and electrical abnormalities in the heart.

## Antidepressants

The use of antidepressants in bipolar disorder is generally controversial, regardless of age, because of risks of medication-induced mania or rapid mood cycling. Nonetheless, antidepressants are often prescribed to older adults with bipolar disorder for either the acute or maintenance treatment of bipolar depression. Their use is probably most reasonable in the following situations: acute depression not responding to adequate mood stabilizer treatment, absence of rapid cycling or mixed depressive-manic symptoms, and/or bipolar illness historically characterized by prominent depression and relatively brief periods of mania or hypomania. As previously mentioned, lamotrigine and atypical antipsychotics are probably better alternatives for maintenance and acute treatment of depression, respectively, if side effects do not prohibit their use. One bright note about antidepressant use in older adults is that, in contrast to reports of more suicidal thinking/behavior in a small portion of persons under age 25 taking antidepressants, these medications on average actually decrease suicidal tendencies in adults age 65 or older.

When using antidepressants for older adults with bipolar disorder, selective serotonin reuptake inhibitors (SSRIs) and bupropion (Wellbutrin) are reasonable first choices. Among the SSRIs, sertraline (Zoloft) and escitalopram (Lexapro) are good options for older adults because they have relatively few interactions with other medications used for common health conditions. Citalopram (Celexa) also has few medication interactions, but recent data suggest it may predispose older adults to electrical conduction problems in the heart at doses over 20 mg per day. Fluoxetine (Prozac) and paroxetine (Paxil) can be helpful in some cases but are not common initial choices for older adults; they both can interfere with the liver's metabolism of certain other medications, and paroxetine is somewhat anticholinergic, which can impair memory functions. Common initial side effects of SSRIs include nausea, diarrhea, anxiety, fatigue, insomnia, headache, and sexual dysfunction (inability to reach orgasm, for instance). Most of these side effects are mild-to-moderate and dissipate over time. A notable exception is sexual dysfunction, which is often a more persistent side effect. Ageism should not make affected persons or their treatment providers insensitive to the possible impact of sexual side effects on older adults. Less often, SSRIs may be associated with lowered sodium levels, accelerated loss of bone mass, and gastrointestinal bleeding in older adults.

Bupropion has a potentially lower propensity to cause mania than other antidepressants, does not cause weight gain, may help fatigue, and does not have sexual side effects, but tremors, anxiety, insomnia, and agitation can be limiting side effects. Bupropion (especially short-acting formulations) should be used very cautiously in persons susceptible to seizures. Other antidepressants include serotonin-norepinephrine reuptake inhibitors, such as venlafaxine (Effexor), desvenlafaxine (Pristiq), and duloxetine (Cymbalta). These may be helpful for persons with chronic pain co-occurring with bipolar disorder, although blood pressure should be monitored for elevation on venlafaxine in particular. Mirtazapine (Remeron) is a unique antidepressant that boosts serotonin and norepinephrine levels in an indirect way. Notable common side effects include weight gain and sedation, which can be used to a person's benefit if loss of appetite and insomnia

are problematic symptoms of depression. Mirtazapine also does not appear to cause sexual side effects and may actually help with nausea/stomach upset. Older medications such as tricyclic antidepressants (TCAs) and monoamine oxidase inhibitors (MAOIs) are seldom used among older adults with bipolar disorder. TCAs may be more likely to induce mania than other antidepressants, and they are difficult for older adults to tolerate. Possible side effects of TCAs include constipation, dry mouth, sedation, difficulty urinating, heart arrhythmias, and memory impairment. MAOIs have multiple medication interactions and dietary restrictions, which, if violated, can cause very high blood pressure, stroke, and even death. However, when other treatments fail, they sometimes can be helpful for bipolar depression.

### **Electroconvulsive therapy (ECT)**

Few topics in modern medicine incite more controversy and divisive opinions than electroconvulsive therapy (ECT). A comprehensive review of ECT is beyond the scope of this text. Unfortunately, media dramatization, unfounded stereotypes, and certain organizations have led many people with severe, chronic, difficult-to-treat mood disorders to refuse ECT before getting medically reliable information on its risks and benefits. ECT is primarily used in the treatment of medication-resistant or very severe depression (including bipolar depression), but it is also effective in treating mania. ECT has a long history of mostly well-intentioned but admittedly occasionally inappropriate use in psychiatry. Any past abuses, however rare, are condemnable but should not prevent suffering patients from an accurate appraisal of whether ECT might be a viable treatment alternative for them. Modern medical procedures and technology have streamlined ECT to make it quite tolerable (more so than medications for some people), and most states have very strict legal guidelines about safe and ethical use of ECT.

Media portrayals of ECT have usually painted a picture of it as a punishment for “bad behavior” and/or as a painful, traumatic experience in which patients thrash about or scream in agony. I have personally never known anyone (a patient’s family member or a medical trainee) witness ECT for the first time that was not entirely underwhelmed when they saw it first-hand. The actual electrical stimulus applied to the brain lasts on the order of seconds and the induced seizure on the order of 1-2 minutes. For decades, patients receiving ECT in the US have been under anesthesia and thus unaware when the actual procedure is being done. It is not punitive and patients typically have no recall of the procedure or of the minutes-to-hours surrounding the procedure. Additionally, there is no thrashing about—that, in fact, did occur with early ECT, but modern methods have long used a muscle blocker which prevents the therapeutic seizure activity that happens in the brain from causing any jerking movements in the body. The most invasive aspect of ECT is typically a short-term IV line to administer the anesthetic and muscle blocker. ECT has been used safely and effectively among older adults with a wide variety of medical illnesses. In fact, some evidence suggests older adults with melancholic or psychotic depression may be among the most robust responders. ECT, however, is not without possible side effects. Rates of death are very low, but not zero. Risk of death appears similar to that for other minor procedures requiring general

anesthesia and is roughly comparable to the risk of death during childbirth. Medical problems which may complicate the use of ECT and increase the risk for adverse outcomes include unstable heart disease and a brain mass/tumor. Probably the most concerning possible side effect for most people is cognitive impairment, specifically memory loss. This is particularly relevant for older adults, who are more prone to memory impairments. Patients commonly report trouble remembering some events in the weeks to months before and after ECT, although this usually resolves. In fact, many people have improvements on tests of cognition with ECT because the mood disorder itself was already severely impairing their memory and concentration. Certain techniques during the ECT procedure can help spare memory and this can be inquired about prior to the treatment.

ECT typically is given 3 times a week, for an average of 8-12 total treatments. Some people are maintained on medications during ECT, although anticonvulsants such as valproic acid and lamotrigine can interfere with the ability to induce a seizure, and lithium may lead to more confusion immediately after ECT is given. Medication regimens thus have to be individualized for each person. Almost always, however, some mood stabilizing medication is continued, started, or re-initiated once ECT is done, as ECT does not “cure” bipolar disorder. Its effects may be pretty long-lasting, and many people only need one course of treatment in their lifetime. Others may have recurrent bouts of mania or depression that respond better to another course of ECT than to medications. Less frequently, persons with bipolar disorder may have chronic symptoms that are unresponsive or inadequately responsive to any treatment other than ECT. In such cases, after finishing a round of successful ECT, future treatments can be gradually spaced apart to one treatment every few weeks to months in what is called “maintenance ECT,” meaning ECT for these persons is used not only to treat severe acute mood episodes, but is also used less frequently over the long-term as the primary treatment method.

### **What is the role of psychotherapy in late-life bipolar disorder?**

Psychotherapy as an adjunctive treatment is increasingly seen as a viable method of improving patients’ chances of remaining euthymic and improving overall functioning (Scott & Colom, 2005). There are now several evidence-based models of psychotherapy that have empirical support, including cognitive-behavioral therapy, psychoeducation, family focused therapy, and interpersonal and social rhythm therapy. None of these treatments have been adapted specifically for older adults, but older adults with other psychiatric illnesses often do respond well to psychotherapy when a few modifications are made. Adaptations for older adults may include holding briefer sessions, providing written review of session content to increase retention, and involving supportive persons in therapy (Araon et al., 2003). Another important target for psychosocial treatment in later life bipolar disorder is medication adherence. Although older adults are more likely to be adherent to medications than their younger counterparts, older adults are more likely to endorse unintentional non-adherence (e.g. forgetting, misplacing medications). As such, interventions such as Medication Adherence Skills Training (MAST-BD) focus on compensation for cognitive impairments that may interfere with regular medication taking, such as reminders, pill boxes and pairing activities with medications.

Because older adults with bipolar disorder often have diverse needs, spanning financial, transportation, medical, and social realms, an important clinical task is to broker engagement with social service agencies serving seniors. Knowledge of community services is thus necessary. Given that social isolation is among the most potent predictors of recurring depression among older adults, mutual support organizations can be an incredible resource for people with bipolar disorder. The Depression and Bipolar Support Alliance ([www.dbsalliance.org](http://www.dbsalliance.org)) and the National Alliance for Mental Illness ([www.nami.org](http://www.nami.org)) are the largest such organizations, with thousands of chapters operating across the United States. Unfortunately, for reasons that are unknown, older adults typically underutilize mutual support groups.

## Conclusions

More and more persons with bipolar disorder are enjoying the increases in longevity that the general population has already experienced for many years. Nonetheless, aging with bipolar disorder presents some unique challenges, such as increased rates of some medical disorders, cognitive impairments, and frequent need for adaptation of medication and psychosocial treatments. Later-life bipolar disorder has been markedly understudied, and much remains to be learned. Important areas of research include changes in the course of the illness, differences in symptom presentation, the effectiveness of treatments developed for younger adult populations, and the interaction between bipolar disorder and cognitive disorders. There are important positive aspects of aging that are relevant to bipolar disorder, such as better treatment adherence, age-associated improvements in emotional regulation, and, according to many cultures, increasing wisdom. Along those lines, perhaps it is best to conclude this discussion about the effects of aging on bipolar disorder with the thoughts of someone who has experienced it first-hand.

## An Interview with David a 69 year old man with bipolar disorder

David was born in Massachusetts in 1943. He first started experiencing symptoms of bipolar disorder in his early 20s. The illness was recognized by an internist whose mother had the illness. David was first hospitalized at age 24, but states "While watching other patients playing volleyball while under meds I vowed not to return." Some of his life time achievements include obtaining an M.B.A. degree and starting five small businesses. David remarked that he was fired from many jobs, but at the same time kept climbing the "corporate ladder". He has been married for 40 years, and, of his wife, he says "She must be a saint to put up with the heartaches and headaches caused by my BD."

### **Q. What has changed about bipolar disorder since it first started for you?**

The illness does not change. My experience of it has changed by learning the nuances of it as the illness cycle keeps repeating.

It is chronic and learning my triggers took time. I still am not as proficient as I need to be to fend off severe mood changes. However, I have learned to somewhat lessen them.

**Q. What it is like to manage BD in the context of the other good and bad parts about older adulthood:**

As long as I am busy I can mostly keep depression away or, at least, minimized. Among these activities I have learned to keep healthy by trying to help other people. This counters my feeling like a "victim / loser" which is part of my downward spiraling depressive pattern.

Managing BD is paramount so I can remain calm and logically face the challenges of getting older. I can become depressed when focusing on my failed prostate cancer operation and my failing kidneys whose demise started with taking Lithium for 13 years before I educated myself on the hazard of taking it. Of course, when I started with Lithium, it was the "only game in town".

**Q. Reflecting on your experience with bipolar disorder, what "wisdom" can you share?**

Assemble a team you can trust if you can afford it- Med management (Psychiatrist) and Psychologist. Meds may take time to work as your body is a laboratory. 100 years from now the treatment we receive will be considered barbaric.

While you are well create an agreement with someone who sees you often that they will make you aware when your behavior deviates from your own "normal (not necessarily society's standards)". This is a concept of gaining feedback through your "mirror".

Realize that you can't throw a baseball 100 miles/ hour but you could not do that when you were 20. That is, the "good old days" are over - if they ever did exist.

Don't isolate. A group such as DBSA allows you to see that you are not alone on the path you are on. Listen to member stories. Somehow a group has wisdom that you may not find on your own.

If you believe that people will stigmatize you if they know you have BD - So, what else is new? - Try telling someone. When I do so I have been surprised by the number of people who say they have someone they know with the illness.

We are not weak. It takes more strength to live with BD than the average person comprehends.

Try to stay in the moment. Learn to take a deep breath. Don't panic! A little humor helps.

Suicide is a permanent solution to a temporary problem. Take a walk or whatever gets you out of listening to the tape that keeps replaying in your brain.

You can't drive forward while looking through a rearview mirror.

A special acknowledgment to David Z. who volunteered his time so that his personal experience might benefit others.



## References

- Arean, P., Cook, B., Gallagher-Thompson, D., Hegel, M., Schulberg, H., & Schulz, R. (2003). Guidelines for conducting geropsychotherapy research. *American Journal of Geriatric Psychiatry*, 11(1), 9-16.
- Ayalon, L., Arean, P., & Alvidrez, J. (2005). Adherence to antidepressant medications in black and latino elderly patients. *American Journal of Geriatric Psychiatry*, 13(7), 572-580.
- Bearden, C. E., Hoffman, K. M., & Cannon, T. D. (2001). The neuropsychology and neuroanatomy of bipolar affective disorder: A critical review. *Bipolar Disord*, 3(3), 106-150; discussion 151-103.
- Calabrese, J. R., Hirschfeld, R. M., Reed, M., Davies, M. A., Frye, M. A., Keck, P. E., et al. (2003). Impact of bipolar disorder on a u.S. Community sample. *J Clin Psychiatry*, 64(4), 425-432.
- Cassidy, F., Ahearn, E. P., & Carroll, B. J. (2001). Substance abuse in bipolar disorder. *Bipolar Disord*, 3(4), 181-188.
- Charney, D., Reynolds, C., Lewsi, L., Lebowitz, B., Sunderland, T., Alexopoulos, A., et al. (2003). Depression and bipolar support alliance consensus on the unmet needs in diagnosis and treatment of mood disorders in late life. *Archives of General Psychiatry*, 60, 664-672.
- Depp, C., & Jeste, D. V. (2004). Bipolar disorder in older adults: A critical review. *Bipolar Disord*, 6(5), 343-367.
- D'Souza, R., Rajji, T.K., Mulsant, B.H., & Pollock, B.G. (2011). Use of lithium in the treatment of bipolar disorder in late-life. *Curr Psychiatry Rep*, 13, 488-92.
- Gildengers, A., Butters, M., Seligman, K., McShea, M., Miller, M., Mulsant, B., et al. (2004). Cognitive functioning in late-life bipolar disorder. *American Journal of Psychiatry*, 161(4), 736-738.
- Kilbourne, A. M., Cornelius, J. R., Han, X., Pincus, H. A., Shad, M., Salloum, I., et al. (2004). Burden of general medical conditions among individuals with bipolar disorder. *Bipolar Disord*, 6(5), 368-373.
- Kraepelin, E. (1921). *Manic-depressive insanity*. Translated by rm barclay. New York: Arno Press.
- Mathys, M., Blaszczyk, A., Busti, A. (2009). Incidence of abnormal metabolic parameters and weight gain induced by atypical antipsychotics in elderly patients with dementia. *Consult Pharm*, 24, 201-9.
- Post, R., Rubinow, D., & Ballenger, J. (1986). Conditioning and sensitisation in the longitudinal course of affective illness. *British Journal of Psychiatry*, 149(191-201).


- Regier, D., Narrow, W., Rae, D., & al., e. (1993). The de factor us mental and addictive disorders service system: Epidemiologic catchment area prospective 1-year prevalence rates of disorders and services. *Archives of General Psychiatry*, 50(85-94).
- Sajatovic, M. (2002). Treatment of bipolar disorder in older adults. *International Journal of Geriatric Psychiatry*, 17, 865-873.
- Santos, C.O., Caeiro, L., Ferro, J.M., & Figueira, M.L. (2011). Mania and stroke: a systematic review. *Cerebrovasc Dis*, 32, 11-21.
- Schouws, S.N., Stek, M.L., Comijs, H.C., Dols, A., & Beekman, A.T. (2012). Cognitive decline in elderly bipolar disorder patients: a follow-up study. *Bipolar Disord*, 14, 749-755.
- Scott, J., & Colom, F. (2005). Psychosocial treatments for bipolar disorders. *Psychiatr Clin North Am*, 28(2), 371-384.
- Unutzer, J., Simon, G., Pabiniak, C., Bond, K., & Katon, W. (1998). The treated prevalence of bipolar disorder in a large staff-model hmo. *Psychiatr Serv*, 49(8), 1072-1078.
- Young, R. C., & Falk, J. (1989). Age, manic psychopathology, and treatment response. *International Journal of Geriatric Psychiatry*, 4, 73-78.



# Healthy Family Life and Relationships

By Ashley Aleem

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



***Building and maintaining supportive relationships is a critical part to our overall well***

## The Importance of Supportive Relationships

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

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

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

## Improving the Bonds Within Your Family

When we are struggling with our mental health, our relationships often suffer. The ones we are closest to, such as spouses, children, parents, and siblings, are pushed away. We become detached, and this often drives us further into an unhealthy state.

When stress and anxiety increase, we lash out, isolate, or shut down. This only fuels the stress and instigates anger and resentment in our loved ones. Instead, reaching out and connecting with those nearest to us will help fight the stress and strengthen our bonds. Supporting our loved ones when they are struggling and allowing them to be there for us will improve the bonds within the entire family.

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

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



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

## **Education About Bipolar Disorder**

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

Strongly consider educating your spouse about your mental health diagnosis. Although it is natural for a couple to have periods of decreased communication and intimacy, it is more likely that these periods will be exacerbated by the symptoms of bipolar disorder. Engaging your significant other in a discussion about your diagnosis may assist in alleviating the negative effects it may have on

the relationship. Providing literature on bipolar disorder will be beneficial, although explaining your experience in your own words might be most powerful. If possible, and if your spouse is willing, consider inviting him/her into a therapy session so he/she may gather information from a mental health professional. Ongoing couples counseling can also assist in resolving concerns and increasing the bonds between spouses.

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

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

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

## **Your Impact on Others**

When we are in the midst of our mental health disorders, we are often ignorant of our impact on others. Our perception of ourselves is skewed, and our beliefs and behaviors are often irrational. We say and do things we would not normally do. We do not understand why others do not see or think as we do. It baffles us that others do not agree with us unconditionally. Then, when we are well, we are often overcome with feelings of regret, guilt, and resentment. And we cannot understand why they cannot forgive us. Why can't they just be there for us, support us, love us?

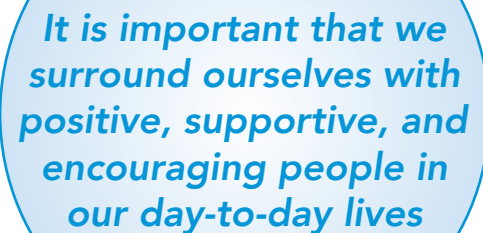
We may have acted in a way, which was harmful to them. Just as we were troubled by our minds, so were they, by our actions. As we became fearful, angry, and confused, so did they. We cannot combat our mental health symptoms overnight. Nor can they forgive and forget so easily. We ask them to understand, to be patient, to give it time. We must do them the same return favor. Relationships are reciprocal.

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

## Developing Healthy Friendship

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

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



*It is important that we surround ourselves with positive, supportive, and encouraging people in our day-to-day lives*

## Selecting a Romantic Partner

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

yourself: are you infringing on your partner's personal rights or needs? Are you disregarding their feelings or requests? If you do not show respect for your partner, you cannot expect to receive any in return. You cannot expect this relationship to stand the test of time.




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

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

As an individual diagnosed with a mental health disorder, it is important that you receive support and advocacy from those closest to you, especially your romantic partner. Explain to your partner the nature of your bipolar disorder and what it entails for you personally. Educate your partner on the importance of following a medication regimen and seeing a mental health professional on a regular basis so that they can support you in following through with these tasks. You might want to discuss your personal struggles, such as what a manic or depressive episode looks like for you, so that they can know what to expect and how to help during these times. Based on your comfort level with disclosure, it might be helpful to break up this discussion into several smaller conversations. Utilize your therapist or counselor to assist you in the process by discussing your plans beforehand and debriefing the



experience afterwards. Throughout this important discussion with your new romantic partner, gauge his/her response for signs of understanding, compassion, and support. If you do not feel like this person respects you or regards you less for having this diagnosis, then he/she might not be worth your time. If they call you names, degrade you for your struggles, or discourage your efforts toward self-care, it might be best for you to withdraw from the relationship. Again, refer to your outside support system for assistance if you need it. If, however, while having this discussion, you feel your partner is engaged and interested, that he/she is willing to learn about bipolar disorder and to support and comfort you in your struggles, then congratulations. You have found a romantic partner with the foundational makings for a long-term relationship.



*The key is to expecting and accepting the bad times as well as the good*

## **Maintaining the Relationship**

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

## **Staying Involved**

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

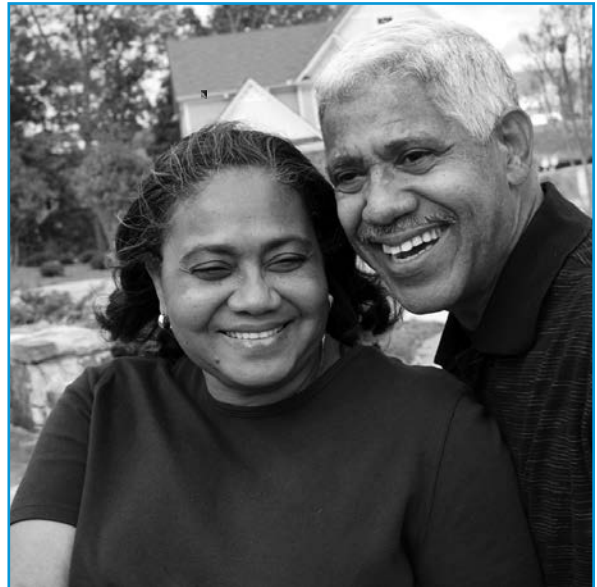
## **Expressing Emotions and Keeping Open Communication**

Everyone experiences a range of emotions on a continuous basis. Some days you're feeling much more positive than others, and some days you will feel down and upset. In a healthy relationship, you should be permitted to discuss your concern as well as your excitement. If you have established mutual respect, you should be able to easily vent about frustrations without feeling shut down or ignored. It is particularly important to voice emotional reactions around the status of the relationship. Verbalize your doubts and annoyances in a respectful manner, with the intention of reaching a resolution. Also, do not neglect to articulate your satisfaction with the positive experiences you share. Sharing positive and negative

emotions equally will help you express your respect and appreciation for your partner, as well as allow you to discuss upsetting matters more effectively. For example, if you express excitement about the gift your partner gave you, it will be easier to voice your hurt around not being acknowledged for the gift you gave him/her.

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

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



## Resolving Conflicts

When emotions are stifled and matters of concern are ignored, the issue is likely to swell inside you and eventually explode. When this happens, the best thing to do is confront the conflict directly. Open the lines of communication with genuine concern and understanding. Listen to your partner's opinions and consider them as best you can. Respond as calmly as possible. Articulate your concern and present a possible solution. For example, if you feel your partner doesn't spend enough time with you, first listen to his/her reasoning. Maybe he/she feels overwhelmed at work, so he/she doesn't arrive home until late at night and then simply wants to go home and sleep. Really listen to their perspective. Consider their experience wholeheartedly. Then respond with a proposed solution. Maybe you could plan an outing on a weekend night when he/she feels rested and can give you the

attention you desire. Or maybe you can offer to just listen to your partner vent about their frustrations at work in an effort to soothe his/her anxieties. Request your partner's input after providing a suggestion. This might be a back-and-forth process before a solution is achieved, but it will be well worth it if you wish to maintain the relationship. When experiencing a bumpy road with your mood, you may suggest discussions at a later date when you are better equipped to handle it.


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

## Preserving Individuality

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

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

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



***it is important that  
you tend to your own  
self-care to prevent an  
increase in mental health  
symptoms***



of your partner, as this maintains your individual identity.

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



# Supportive Nutrition

By Karen Freeman, MS, RD, CSSD

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

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

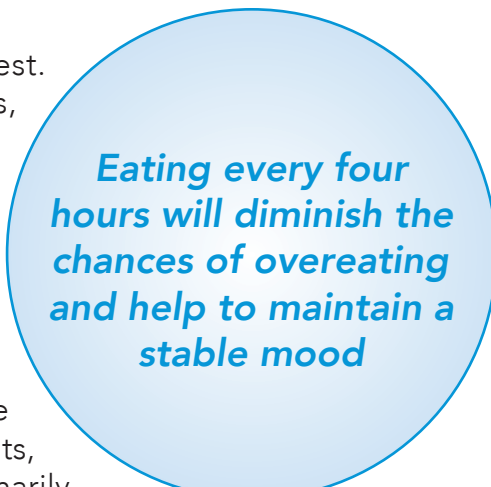
## Timing of Meals is to be on a Regular Schedule

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

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

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

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



***Eating every four hours will diminish the chances of overeating and help to maintain a stable mood***

meals consisting of carbohydrates, proteins and fats to ward off hunger for 3-4 hours.

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

FOOD	NUTRIENT TYPE	# OF HRS TO DIGEST
2 slices of toast	carbohydrate	1
1 egg with a sprinkle of cheese (feta) ~ 1oz.	protein & fat	2
1 - 2 oranges	protein & fat	2
1 cup of decaf coffee	carbohydrate	1

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

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

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

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

**Emotional factors may affect feelings of hunger, such as feeling less hungry during manic phases and more hungry during depressed mood states**

## How Much Protein and Carbohydrates Do We Need?

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

Vegetables, grains, beans, legumes, and lentils, all grow from the ground and are therefore mostly carbohydrates. They all contain protein as well, from 2-8 grams per  $\frac{1}{2}$  cup cooked serving. An example of the protein power of combined vegetables can be taken from ethnic meals where food combining is a mainstay of the daily intake. Mexican cuisine routinely consists of rice and bean dishes. If rice (white, brown or mixed) is mixed with beans (i.e.: red, black, kidney, pinto) each incomplete in its protein content, the combined result is a complete "8" of all the essential amino acids.

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

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


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

1. To get weight in kilograms (kg.), divide weight in pounds by 2.2.  
 $130/2.2 = 60$  kgs.
2. To calculate the recommended grams of protein, multiply weight in kilograms by 1.5 which is the mid range of the higher protein recommendation:  
 $60 \text{ kg} \times 1.5 \text{ gms protein} = 90$  gms. of protein.
3. To estimate how many ounces of protein 90 grams is equivalent to, simply move the decimal point over one place to = 9.0oz. of protein.


8 oz. of protein per day is equivalent to 1 serving of broiled fish from your favorite restaurant, 3 oz of protein looks like a deck of cards, and 1oz. serving example is 1 cheese stick size.



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



<b>Sedentary life style, minimum movement each day</b>	= 1 - 2 g/kg of ideal body weight
<b>Light activity, housework, leisure walking, activity for everyday living</b>	= 2 - 3 g/kg of ideal body weight
<b>30 – 60 minutes of regular exercise each day</b>	= 3 - 4 g /kg of ideal body weight
<b>1 hour of exercise/ day</b>	=5 g /kg of ideal body weight
<b>2 hours of exercise/day</b>	= 8 g /kg of ideal body weight
<b>3 + hours of exercise/day</b>	= 10 g /kg of ideal body weight



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

### **Food Selection Guidelines**

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

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

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

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

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

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

\* saturated fat

## Sample Menu for:

130 lb. female, light exercise at 30 minutes/day  
carbohydrate needs are 3-4 gm/kg body weight = 180 – 240 gms and  
protein need are 1.2 – 1.5 gm/kg = 7 – 9 oz protein (=72 – 90 gms)

### 9 AM

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

### 10 AM

1 slice squaw toast  
1 T almond butter

### 12:30 PM

1 banana  
1 cup cottage cheese

### 3 PM

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

### 5:30 PM

1 tortilla  
1 cup pinto beans  
1/2 cup rice  
1 oz cheese  
1 cup green beans  
salsa

### 8:30 PM

8 oz. nonfat milk and 3 cookies

### TOTAL:

Protein	96g	21%
Carbohydrates	266g	59%
Fat	40g	20%

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

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



- Calorie balance is important to maintain a healthy, normal body weight, as well as eating more healthful fats from food groups recommended by the 2010 Dietary Guidelines for Americans (DGA).
- The ratio of total fat intake is not as important as type of fats.
- Omega-3 fatty acids are beneficial and should be included in the diet at least twice weekly.
- Trans fats are unhealthy and should be kept to a minimum in the diet because they decrease HDL cholesterol and increase total cholesterol (19).

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

Some practical ways to incorporate “healthy” fats in our diet include the following:

- add 10 – 20 nuts to low-fat yogurt, or as a “dressing” addition to salads, while drizzling the actual oil and vinegar dressing (vs.) pouring.
- drizzle vs. pour all fats.
- add  $\frac{1}{2}$  -  $\frac{1}{4}$  of an avocado to enhance flavors of salads and/or sandwiches.
- include natural nut butter sandwiches as a meal option.

## Omega-3 Fatty Acid Supplements and Other Supplements

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

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



The chart below, from the 2010 Dietary Guidelines for Americans, provides a good estimation of the n-3 fatty acid content of fish:

### ESTIMATED EPA AND DHA AND MERCURY CONTENT IN 4 OUNCES OF SELECTED SEAFOOD VARIETIES

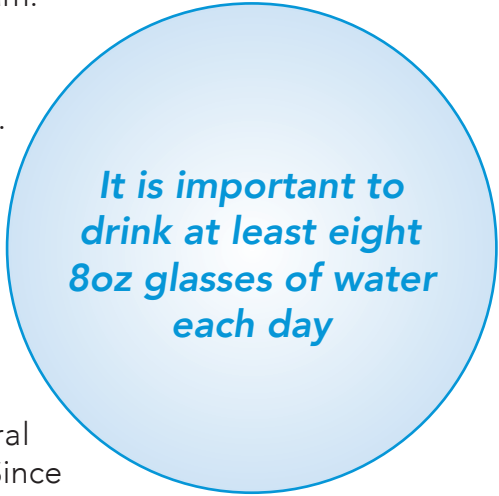
Common seafood varieties	Epa + dha mg/4 oz	Mercury mcg/4 oz
Salmon: Atlantic Chinook, Coho*	1,200 - 2,400	2
Anchovies, Herring and Shad	2,300 - 2,400	5 - 10
Mackarel: Atlantic and Pacific (not King)	1,350 - 2,100	8 - 13
Tuna: Blue fin, and Albacore	1,700	54 - 58
Sardines: Atlantic and Pacific	1,100 - 1,600	2
Oysters: Pacific	1,550	2
Trout: Freshwater	1,000 - 1,100	11
Tuna: White (Albacore) canned	1,000	40
Mussels	900	NA
Salmon: Pink and Sockeye	700 - 900	2
Squid	750	11
Pollock: Atlantic and Walleye	600	6
Crab: Blue, King, Snow, Queen and Dungeness	200 - 550	9
Tuna: Skipjack and Yellowfin	150 - 350	31 - 49
Flounder, Plaice, and Sole (Flatfish)	350	7
Clams	200 - 300	0
Tuna: Light canned	150 - 300	13
Catfish	100 - 250	7
Cod: Atlantic and Pacific	200	14
Scallops: Bay and Sea	200	8
Haddock and Hake	200	2 - 5
Lobsters: Northern, American	200	47
Crayfish	200	5
Tilapia	150	2
Shrimp	100	0
<b>Seafood varieties that should not be consumed by women who are pregnant or breastfeeding</b>		
Shark	1,250	151
Tilefish: Gulf of Mexico	1,000	219
Swordfish	1,000	147
Mackarel: King	450	110

## Exercise

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

## Drink Water

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



*It is important to  
drink at least eight  
8oz glasses of water  
each day*

## And Other Supplements?

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

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

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

Vitamin D is essential for calcium absorption and has been shown to enhance our body's natural immunity. Those of us with limited exposure to natural sunlight

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

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

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

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

## Alcohol

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

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

## Caffeine

Caffeine mildly stimulates parts of the body and brain. It increases heart rate and blood pressure and is never recommended for individuals with bipolar disorder. It interferes with sleep by leading to disturbing sleeping patterns and causes irritability, anxiety, nervousness, upset stomach, headaches and difficulty concentrating. It takes 3-4 hours for caffeine to be eliminated from the body.



Therefore, to cut back and eliminate caffeine consumption, do so gradually and try using some of these tips:

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

## Is my diet related to my mental health?

*Felice Jacka, M.D.*

The idea that what you eat may actually impact on your mental health symptoms is a relatively new one. While there were some older studies that looked at factors such as protein or various supplements in mood disorders, these were often not particularly scientifically sound. More importantly, nobody eats just individual nutrients (such as folate)! We eat diets that have many, many vitamins, minerals, macronutrients (carbohydrates, fats, proteins) and other compounds and they all work synergistically together. So there is little point in examining single nutrients or food components when we want to understand the relationships between diet and health.

When we eat food, nutrients combine in a multitude of ways that have complex effects on the body and brain. Because of this, it was recognised that researchers needed to take the whole diet of people into account when looking at the relationships between food and mental health. This particularly field of research really began to gain traction in 2009 and has since generated many, many studies investigating the important question, ‘is my diet related to my mental health?’

So what do we know now that we didn’t know before 2009? The studies that have examined the relationship between diet and mental health in many different countries and age groups have come to very similar conclusions.

Firstly, it is very clear that the ‘quality’ of our diets is related to whether or not we have a clinical depressive or anxiety disorder, and is also related to our level of symptoms. So we know that people, on average, who have diets higher in ‘nutrient-dense’ foods (these are foods such as vegetables, fruits, good quality meats and fish, wholegrains, and legumes) are less likely to have a mood or anxiety disorder (including bipolar disorder). Similarly (although not the same thing), people who eat a lot of ‘junk’ foods, containing poor quality carbohydrates – that is, lots of sugar and white flour – and saturated and/or trans fats are also more likely to have a mental disorder. This seems to be the case in adults, adolescents, and even in very young children. These studies have shown the same thing from countries

around the world: China, Japan, Australia, the UK, the USA, Norway, Spain and many European countries.

But what explains the relationships that we see? We know that people with mental disorders eat differently to those who are not affected. People with depressive symptoms or those who are more anxious, seem to be particularly attracted to sweet fatty foods. Why is this? And does this explain the associations that we see between food and mood?

These are very important questions. The answer to the first question – why are people with depressive or anxiety symptoms attracted to sweet and fatty foods – is quite straightforward. Simply speaking, these foods actually make us feel less stressed and anxious when we eat them! Many studies done using rats tell us that sugar and fats actually calm down the stress response. Unfortunately, a bit like smoking and drinking alcohol, the long-term effects of eating these sorts of foods appear to be the opposite of the short-term effects. In the long-term, these foods seem to actually increase the risk for these symptoms. The other thing to consider with these foods is that they are highly addictive. When rats are allowed to eat 'junk' foods as much as they want, then have the foods removed, they display all the signs of withdrawals. At the same time, scientists can see changes in the rats' brains that are associated with the 'reward' systems – the parts of the brain that are activated in response to drugs of addiction!

The answer to the second question, whether or not the tendency for people with mood and anxiety disorders and symptoms to have poorer diets explained by the calming effects of unhealthy foods, the answer is 'partly'. However, the many studies that have sought to tease apart cause and effect find that this only explains part of the relationship. Even after taking this fact into account, there is still evidence that unhealthy diets increases the risk for mood and anxiety disorders, while healthier diets are protective. So what else could explain these associations?

While it is true that people from poorer backgrounds or with less education are more likely to have poor diets, and also more likely to have a mood or anxiety disorder, this fact doesn't seem to explain the relationships that we see. The fact that people who eat well are also more likely to do more exercise, or less likely to smoke, doesn't explain the relationships either. So how do these relationships work? How does food exert an influence on mental health?

Well, a lot of work (again, mostly in animals) tells us that unhealthy foods, high in fat and sugar, have a very potent and detrimental impact on our brains, our immune systems, our stress-response systems and our health – both mental and physical. These interactions are complex but, simply put, such foods can shrink parts of the brain that are seen to be important in psychiatric illness – the hippocampus; they increase the activation of our immune systems, which we know is a key factor in mood disorders in particular; they increase oxidative stress (antioxidants in healthy foods do the opposite); and they activate the stress response system over the long term. Each of these are key factors in mood and anxiety disorders.

So, is it possible to improve your bipolar illness by improving your diet? Well, the answer is that we don't know for sure yet. The first study to assess whether

improving diet results in improvements in symptoms of major depression is currently underway and we won't know the answer to this important question for another year or so. However, a few recent studies have shed some light on whether or not improving diet can result in reducing the risk for depression.

In the first big study, conducted in Europe and involving thousands of people with risk factors for heart disease (with elevated blood pressure, overweight, diabetes and/or other risk factors), participants were put into three groups. The first group – the control group - were told to adhere to a 'low fat' diet. The other two groups were encouraged and supported to switch to a form of a Mediterranean diet. There is a lot of evidence to suggest that the Mediterranean diet is a particularly healthy way of eating. It promotes high intakes and a wide range of vegetables and fruits, as well encouraging the consumption of fish, legumes (lentils, chickpeas, beans), nuts and wholegrains. One of these groups was also told to use extra olive oil and the other group was encouraged to have a big handful of raw nuts (almonds, walnuts, hazelnuts) every day.

The people participating in this big study were then followed to see whether one group had fewer cardiovascular events (such as heart attacks). The answer was clear – those in either of the two Mediterranean diet groups had a lower risk for such events compared to those in the low-fat diet group. What they also found was that following this diet, particularly if the participant already had diabetes, seemed to prevent new cases of depression occurring! This was particularly evident in the group told to eat extra nuts every day. Nuts are very high in antioxidants and this may have been an important factor in the protective effect.

Similarly, another recent study in older adults sought to prevent people with symptoms of depression going onto develop a clinical depressive disorder. One group of participants received a form of psychotherapy, while the other group received detailed dietary counselling. The study leaders did not anticipate that dietary improvement would result in any improvements in mental health; they'd chosen a dietary intervention because they didn't know that diet was relevant to mental health! Needless to say, they were very surprised and pleased to find that both interventions – psychotherapy AND dietary improvement – were very helpful in preventing the occurrence of a clinical mood disorder.

The final piece of evidence that is of relevance to those suffering from bipolar disorder is the studies showing some improvements in symptoms from the consumption of omega-3 fatty acids (fish oil). There are several such trials now and, although the results aren't always consistent, there does seem to be evidence that fish oil can be helpful for people with bipolar disorder.

Taken together, the evidence from around the world showing that diet quality is related to the risk for mood and anxiety disorders, the extensive work done in animals to show a noxious impact on the brain, immune system and stress response system of unhealthy foods, and the new studies showing prevention of depressive illness using dietary improvement and the treatment of symptoms using fish oils, all suggest that diet is important and relevant to symptoms of mental illness. As such, improving one's diet and making all attempts to continue a healthy diet, may be particularly helpful and important for people with bipolar disorders.

## Summary

- Assess what you “like” to eat and work with a balance to honor your preferences. Sometimes choosing food you think you “should” eat can be less healthy.
- Human bodies get hungry approximately every 4 hours. If you feel hungry and it has been almost four hours since your last meal, you are probably hungry and it is time to eat.
- Eat to satisfy your appetite. Appetite normally and naturally varies so it is normal to feel hungrier on some days and less hungry on others.
- Deprivation is a setup for overeating. Include your favorite food and enjoy social obligations and appointments. Getting overly hungry hurts. Avoid it when possible and nurture yourself.
- Limit total fat intake and allow for small amounts of healthy fats such as Monounsaturated fats: nuts, natural nut butters, seeds, avocado, tofu and olives as well as Omega-3 fatty acids: fish, flax seeds, walnuts and canola oil.
- Minimize Saturated Fats which are fats in and from meats, poultry and lard. Avoid trans-fats such as fried food, hydrogenated oils and sweets.
- Maintain a healthy protein intake and eat what you need per day: 4-6 oz. for woman and 7-10 oz. for men.
- Carbohydrate intake must be adequate to maintain energy and exercise needs. Fruits & Vegetables (10+/day); Lentils, beans, potatoes, rice, whole grains (4+/day.)
- Increase fiber intake to 35+ grams per day.
- Include low fat dairy products, such as nonfat milk and yogurt, for bone health and to help maintain normal weight.
- Drink Water! Often we feel hungry when we are actually thirsty. Limit or avoid liquid calories and caffeine containing beverages. Water is the #1 nutrient.
- Move about more and/or start an exercise program.
- Think before you drink alcohol. Alcohol is a diuretic and can cause dehydration, is a depressant, slows respiratory rate and is caloric. It is contraindicated with bipolar disorders.

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



# Natural Treatments

By Dr. Jennifer Bahr

Over 100 years ago Thomas Edison was quoted as saying “The doctor of the future will give no medicine but will interest his patients in the care of the human frame, in diet and in the cause and prevention of disease.” Long before that, Hippocrates, the father of modern medicine said “Let food be thy medicine and medicine be thy food.” Both of these are coming to fruition as people are seeking out natural alternatives for almost everything these days, especially our foods and medicines. As a naturopathic doctor, I am thrilled to see this trend and hope that it continues. Many chronic diseases are the result of a poor diet and lifestyle, or can be managed well with natural therapies. Mood disorders are no different. I do, however, have some reservations about how the word “natural” can be misleading and assumed to be healthy and safe. But before we get into the meat of specific treatments and their safety (or non-safety) for various aspects of mood disorders, I want to discuss some important relevant background information anyone using natural therapies should keep in mind.

To start off, I may have just used a term you may be unfamiliar with – naturopathic doctor. If you are like many people, including myself before I went to naturopathic medical school, you have probably never even heard of this type of doctor. Naturopathic doctors (NDs) are trained in 4 year, graduate-level residential naturopathic medical schools after completing 4 years of undergraduate education. We are taught the same biomedical sciences such as anatomy, physiology, biochemistry, pathology and even pharmacology as your MD or DO. In many cases we are actually taught by an MD. Where our training differs is the focus of treatment. We follow a therapeutic order and philosophic principles, which I will describe next as they are relevant to this chapter, that guide the use of natural therapies to stimulate the body to heal. The types of treatments NDs learn are clinical nutrition, botanical medicine, homeopathy, hydrotherapy, mind-body medicine, environmental medicine, naturopathic manipulative therapy, and in some schools, acupuncture and bio/neurofeedback. All NDs are trained as primary care doctors, but some will choose to focus on a particular body system or area of concern, such as mental health. Those of us who do have a specific area of expertise will still treat the whole person with naturopathic methods, not just the disease itself. This is especially important in mental health, where there are often physical concerns that are highly related to the mental health concerns.



## The Naturopathic Approach

At the foundation of naturopathic medicine are six principles and a therapeutic order that guides treatment. I have found that in choosing the best natural methods to use, even at home, these principles should always be followed. For that reason I feel it is pertinent to discuss them first.

***Primum non nocere: First do no harm***

As I mentioned above, just because it is natural, does not mean it is safe. Ephedra is a great example of this. Once widely sold in diet supplements, it ended up being over-used or even abused, and contributed to the early death of young athletes or those trying to lose weight. Before you begin any type of diet, lifestyle change, supplement or medication regimen, first ask yourself if it will do any harm. Keep in mind though that sometimes in mental health leaving a condition untreated causes more harm than using a medication with unpleasant side effects.

***Vis medicatrix naturae: The healing power of nature***

With naturopathic medicine, the focus is on the healing power of nature, including the healing power within our bodies. We have an amazing, innate capacity to heal, especially when given the right tools to do so. Natural treatments should focus on this healing power more so than on brute force.

***Tolle Causam: Identify and treat the cause***

When possible, the cause of the illness should be sought out and identified. In mood disorders, things such as dietary insufficiencies of both macro and micronutrients, hormone imbalances, and lifestyle can be the cause of symptoms, or make symptoms more challenging.

***Tolle Totum: Treat the whole person***

Treating the whole person is especially vital in mental health challenges. The brain and the body are not disconnected and shouldn't be treated as if they are. What affects one, affects the other. Unfortunately, in the modern era of overspecialization in our doctors this principle of interconnectivity can be lost.

***Docere: Doctor as Teacher***

Doctors are informed guides to help you make decisions about your health. Using diagnostic tools and extensive medical knowledge they can empower you to set health priorities and goals, and then mentor you as you navigate your way toward health.

***Prevenere: Prevention is the best medicine***

When possible, it is always better to prevent illness before it starts. This principle focuses primarily on lifestyle choices that establish the conditions for health.

The last point is a perfect segue into the therapeutic order, because it is the first step that is vital to all treatments. Like the principles of naturopathic medicine, the therapeutic order can be used to help you make the best decisions for your health. As we go through naturopathic approaches to mood disorders and their common co-occurring conditions we will be using the therapeutic order as a guideline. Some therapies or methods can be broadly applied to most chronic conditions. Where this is true it will be noted. Some therapies discussed can be used with relative safety in mood disorders, others will be discussed as natural medicines that should be avoided with certain diagnoses. Regardless of these notations about broad use and levels of safety, any changes you make to your diet or natural supplements should be discussed with your doctor(s).

## THERAPEUTIC ORDER

- 1. Establish conditions for health.** This is the area we will focus heavily on as it is relevant to all conditions, mental health or otherwise. Ensuring this step is in order will make other treatments, natural or conventional, work more effectively and in some cases may reduce the need for some drugs. In order to establish the conditions for health we will focus on aspects of lifestyle such as sleep, exercise, mindfulness, social relationships and diet.
- 2. Stimulate and support the self-healing process.** To accomplish this, NDs will use therapies that have been around for centuries to amplify signals to the body and brain that establish natural rhythms or biochemical processes, or to stimulate the body to heal itself. These therapies may include homeopathy, hydrotherapy or light/dark therapy.
- 3. Correct areas of imbalance.** With this step we aim to ensure that the mind and body are integrated, hormones (especially thyroid in mood disorders) are being produced and utilized optimally, and biochemical pathways are functioning optimally. Temporary high doses of nutrient cofactors (vital nutrients needed to produce energy, hormones, and neurotransmitters), hormone supplementation, neuro/biofeedback and meditation can be helpful in this stage.
- 4. Apply pathology-centered natural care.** Pathology-centered natural care aims to suppress symptoms of an illness. Very high doses of vitamins (the orthomolecular approach), botanical or herbal medicine, and specific nutrient supplementation in the case of a known deficiency are common approaches for mental health conditions. These methods are rarely healing, and as such, would need to be used long term and monitored regularly unless the first 3 areas above are addressed. The approaches used in this step will almost universally have cross-reactions, the same action as, or interferences with conventional drugs. They may also cause complications in your condition even if used alone. None of these types of natural treatments should be used without the help of your doctor.
- 5. Apply pharmacologic intervention.** Naturopathic medicine is not fundamentally opposed to the use of conventional drugs. Sometimes the use of pharmacology is necessary and saves lives. Until the work of eliminating the stigma associated with mental illness makes it easier to seek treatment early, this will unfortunately be where most people will start their journey to recovery and will have to work backwards or through several stages at once. The more we are able to talk about mental health challenges, and the safer it feels, the more we can focus on early warning signs and less intensive interventions at the beginning of treatment. Until then, you or your loved one will likely start with a conventional drug. This does not mean you can only use pharmaceuticals or will have to be on them for the rest of your life.

### Naturopathic Therapeutic Order

1. Establish conditions for health
2. Stimulate and support self-healing process
3. Correct areas of imbalance
4. Pathology-centered natural care
5. Pharmacology intervention
6. Surgery



- 6. Recommend surgery or major procedures.** Surgeries for mental illness are thankfully a thing of the past, but major procedures such as electroconvulsive therapy are not. Much like the conventional model, this would only be recommended as an absolute last resort and would be referred to a specialist to conduct it.

## Working with a Doctor

I am sure you are eager to read about the therapies you can use at home, but while I still have your attention I want to make sure I emphasize the important role your doctors play, even with the use of natural medicines. Nothing I can give you in this chapter is as specific and individualized to you as a healing treatment should be. Without a detailed history, a keen understanding of your or your loved one's unique experience of depression, anxiety or mania, or diagnostic work ups for nutritional deficiencies, hormonal imbalances, or underlying physical ailments manifesting with mood dysregulation, none of these treatments will be as effective. And as I have already and will continue to emphasize, not all natural treatments are safe to use without medical guidance.

The most important thing you can do to take control of your health and moods is to be honest and open about them. Be honest with yourself about what you eat, how you live, your mood triggers, your sleep, etc. There are many valuable tools at the end of this book you can use to help with this. There are also smart phone apps you can download to help track these things. You should also be honest with your doctor about your treatment goals, dietary supplements you are taking, and discontinuation of any medications. All of your doctors have your health and best interests at heart, but they can't help you as well if they are only working with part of the information. And finally, make sure your doctors talk to each other so that they can come up with the best treatment plan, and not use anything that will negate the therapeutic effect of something else you are taking.

If you are hoping to try to use natural treatments to reduce or eliminate the need for medication there are several types of healthcare providers you can work with. I am writing this chapter from a naturopathic perspective because that is how I was trained. There are also MDs (medical doctors) or DOs (osteopathic doctors) that have received additional training in homeopathy, functional medicine, or integrative medicine that will utilize similar approaches to treatment. Some acupuncturists work with mental health conditions, however they often use a combination of herbs and needling based on principles of traditional Chinese medicine. Please note that not all states protect the title of "naturopath" to those who can be legally licensed to provide care to patients. There are some online schools that provide courses in naturopathy, herbal medicine, nutrition or homeopathy, but their graduates are not eligible to be licensed, which means they are not regulated or held to any standards of safety. If you have questions about how to determine if someone you are considering working with is a licensed doctor visit your state or national medical/osteopathic society or naturopathic association.

## Establish Conditions for Health

Treatments do not always have to be something that you put into your body, they can be related to how you live your life, and sometimes what you don't put into your body. Lifestyle treatments can be related to sleep, diet, exercise, social relationships, mindfulness, and the patterns/routines of daily life. These can and should be broadly applied regardless of your diagnosis (including those who have a physical health diagnosis, or even no diagnosis at all).

### Sleep

Regardless of your health concern, sleep is vital. Health news reports are littered with evidence that our current lifestyle is reducing our ability to get this much-needed aspect of general health. We are constantly bombarded with artificial lights that negatively impact our natural biological clock. Top that with poor food choices that impact our blood sugar and therefore energy regulation, and relatively high levels of stress in our go-go lifestyles, and you have a recipe for poor sleep.

Researchers have yet to identify exactly why we need to sleep, but studies in sleep deprivation give us some insight into the effects of not getting enough zzz's. One small study conducted a simple 24 hour sleep deprivation in adults with no major health concerns and found that stress hormones were increased while cognitive function and memory were decreased<sup>1</sup>. Other studies have shown that even fragmented sleep for a single night affects some hormone production and can contribute to increased eating with lower feelings of fullness the following day<sup>2</sup>. To make a long story short, we need to sleep to maintain a healthy body and brain.

Disordered sleep, whether insomnia or hypersomnia (too much sleep) is very common among those with mood disorders. Good sleep hygiene practices can be helpful in establishing an environment that is more conducive to sleep. This includes establishing a nightly routine to signal your brain that it is time to prepare for sleep. An ideal nightly routine would include turning lights down, turning off all screens, and engaging in calm, quiet activities such as reading. It also includes setting a daily routine in which you wake up at the same time, even on weekends, and don't nap. Caffeine should be avoided after 2pm, but keep in mind that the effects of caffeine can linger as long as 12 hours depending on how quickly your body processes it. Finally, use your bed only for sleep and sex. This means that if you have difficulty falling asleep you should get up and do something else, preferably boring and without a lot of light, and return when you feel sleepy again. For those of you who are attached to your smart phone or tablet and use them exclusively for reading, it would be wise to invest in a library card or older model e-reader without the backlit screen. Trying to read to induce sleep on a backlit screen is counterproductive.

More information on specific, non-lifestyle related treatments for disordered sleeping will be given in later sections.

### Diet

The same hectic, non-stop lifestyle that can interfere with sleep also often interferes with diet. Our diet is where we obtain all of the vital nutrients and cofactors that are responsible for the normal production of energy, hormones, and neurotransmitters.

We are always looking for the magic bullet or the specific diet that will solve our problems. Should you eat high carb and low fat? What about high protein? Vegetarian? Vegan? Gluten free? Dairy free? There is the Paleo diet, the Atkins diet, the South Beach Diet, The Zone, the Ketogenic diet, the Blood Type Diet, the Feingold diet, and on and on and on. You have probably tried one or more of these diets at some point. The problem is that all of our bodies are different and will respond differently based on our metabolism and nutritional needs.

Dietary focus should be on having a diet rich in vitamins, minerals, and with a healthy balance of carbohydrates, proteins and healthy fats (very important for brain function). The chapter on nutrition goes into great detail about how to accomplish this, so I will not duplicate the effort here. Instead, I will focus on the five most common dietary missteps that are associated with a large majority of chronic diseases.

- 1. Sugar.** We all love sugar, it is encoded in our DNA. But sugary foods are often high in calories and low in nutrients. Sugar is also associated with inflammation throughout the body and the brain, and this inflammation is correlated to many chronic conditions. Reducing or eliminating sugar from your diet is an excellent first step toward establishing conditions for health. Keep in mind, alcohol and refined grains such as white bread and pastries count as sugar even if they don't taste sweet to you right now. Eliminate sugar for a month and then see how sweet they really are!
- 2. Artificial sweeteners.** These are just as problematic as sugar. The research is inconclusive about how these chemicals affect our brains, but there is strong evidence regarding how they affect our appetite and weight. If you think about it, it makes sense that consumption of diet sodas would lead to increased caloric consumption overall because you usually drink soda with junk food. In fact, the San Antonio Heart Study examined this correlation and found that those who consumed artificially sweetened beverages had a significant increase in risk and rates of obesity, even when they started at normal weights<sup>3</sup>. While obesity is not a direct contributor to mood disorders, it is a common co-occurring condition and a frequent side effect of anti-depressants and mood stabilizers.
- 3. Highly processed foods.** Just like sugar, we all love fatty, greasy foods. Hi fat foods served our ancestors well to store fat in preparation for times of scarcity, so we inherited the taste for them. In our current environment of abundance, this taste doesn't serve us as well, and leads to the overconsumption of readily available junk food. These foods are very high in calories and unhealthy fats (mostly trans fats that make cell membranes less fluid), and very low in nutrients. Eating "junk food" every once in awhile is fine, but eating it regularly leads to obesity, inflammation, insufficient nutrient status, mood changes, digestive problems, and migraines just to name a few. Anyone with a chronic condition can probably attest that when they eat junk food, their chronic symptoms get worse. I always suggest that my patients shop on the outside edges of grocery stores. This is where you will find fruits, veggies, proteins and grains that are in their original,

non-processed form. The more foods you can eat that are recognizable in nature, the better.

- 4. Eating foods we are sensitive to.** Not everyone has a food sensitivity (sometimes called food allergies), but a lot of us do. Eating foods that we are sensitive to can be related to a whole host of things, including mood disruption, difficulty concentrating, skin conditions, headaches, digestive complaints. Do these sound familiar? Probably, because they keep being mentioned as things that can be associated with inflammation, which eating foods you are sensitive to can cause. The most effective and accurate way to uncover food allergies is by elimination and challenge. What this means is that you would eliminate all foods that have been identified to cause sensitivity or allergies in the general population, and then after a period of 1-2 weeks, reintroduce the foods one at a time. This is a very slow and tedious process, but it can be worthwhile if you have reactions after eating foods, but can't identify which specific foods they are. The most common food sensitivities are wheat/gluten, dairy, corn, soy, eggs, nightshade vegetables (like tomatoes, eggplant, and peppers), citrus fruits, garlic, and yeast. There are some blood tests that can be run to check for IgE (immediate response) and IgG (delayed response) allergies to food, however their accuracy is somewhat debated. Despite that, people often find improvement in their health when they remove foods that are found using one of these tests.
- 5. Pesticides on foods.** Organophosphate pesticides are present on all conventionally grown produce. These chemicals have been found to be associated with adverse neurodevelopment (including behavioral issues) and cognitive issues. They are also associated with insulin resistance, which is a concern if you are taking medications that are also associated with insulin resistance, such as the neuroleptic drugs. Some symptoms associated with a high body burden of these pesticides in otherwise healthy people are poor cognition, poor attention, short-term memory loss, depression, fatigue, numbness, balance or coordination issues, thyroid dysfunction, and disruption in sexual interest<sup>4</sup>. Do any of those overlap with a mood disorder? You bet. Consumption of pesticides have not yet been shown to be associated with the onset of a mood disorder, but why risk worsening of your symptoms by adding something to your body that on its own causes the symptoms you have? Of course, eating only organic foods can be cost prohibitive, so I suggest that my patients use the guides published by the Environmental Working Group each year. These guides give the dirty dozen, which are the most likely to retain pesticides that you will ingest, and the clean 15, the least likely to do so. In general, the thicker or tougher the skin is, the less likely it will be to affect you. If you throw away a peel, it is probably safe to buy conventionally grown and save some money. Just remember to wash the skin before you cut through it.

### **Exercise**

It has been said that exercise is the most effective but least used antidepressant and anti-anxiety treatment. In general, to live a healthy lifestyle you should aim to get at least 30 minutes of cardiovascular exercise (where your heart rate gets between

65-85% of the maximum predicted heart rate) and 15-20 minutes of resistance or strength training exercise at least 3 days a week. To calculate your target heart rate, subtract your age from 220 and then multiply by .65 for the low end, and .85 for the high end. For a 35-year-old person you would have the following equation:

$$\begin{aligned}220 - 35 &= 185 \text{ (predicted max HR)} \\185 \times .65 &= 120.25 \text{ (low end of cardio training HR)} \\185 \times .85 &= 157.25 \text{ (high end cardio training HR)}\end{aligned}$$

Based on the calculation a 35-year-old person would aim to keep their heart rate between 120 and 160 beats per minute for at least 30 minutes. Strength training can be done using body weight for resistance, stress bands, or weights. This is recommended for most health conditions, but you should always check with your doctor before beginning a new exercise program. Some conditions may have specific limitations.

Some studies have shown a correlation between depression and periods of lower exercise frequency and mania with higher frequency of exercise, however this does not mean more exercise causes the mania. In my practice, it has been my observation that regular, and specifically morning exercise, is effective for helping to maintain mood stability. Part of that is likely related to consistent timing of daily routines and improved sleep with regular intense exercise.

If you are drawn to more intense forms of exercise, keep in mind that more does not always mean better. Your body needs time to recuperate. Going far beyond your limits can cause increased inflammation rather than decreasing it, and can be counter productive as it could lead to injury that will disrupt your exercise routine entirely.

If you are new to exercise, start slowly and choose something that is fun for you so you are more likely to stick with it. The goal in exercise with bipolar disorder is routine and consistency, so starting with an intense program you are unlikely to maintain more than a few weeks will be less effective than a moderate program you can stick with and build on as your fitness improves. Yoga is an activity that has been demonstrated to improve attention and decrease self-report of feelings of depression and anxiety<sup>5</sup>. Yoga can vary in intensity from recuperative (very gentle) to the more intense versions at higher temperatures. Find what works best for you.

Finally, exercise doesn't have to be in a gym! You can find active hobbies that count as exercise, such as wood working, gardening, or hiking. In fact, the benefits of exercise can be enhanced by being outdoors. Time in nature has been shown to reduce cortisol levels (highly associated with stress), improve an overall sense of wellbeing, and even reduce symptoms of ATTENTION DEFICIT HYPERACTIVITY DISORDER, even without exercising.

### **Social Relationships**

Social interaction is covered in more detail in a later chapter, so it will not be covered in detail here. I do want to point out briefly that healthy relationships are vital to overall health and treatment outcomes. Medications, diet, or herbs cannot give you less anxiety if you work in an incredibly stressful environment

with an abusive boss. It may help reduce your anxiety by blunting it, but it will not remove it. Additionally, a recent study showed that treatment adherence to mood stabilizers is improved where the patient has strong social support as well as strong beliefs that their health outcomes could be influenced by others<sup>6</sup>. Although this study has not been done regarding natural therapies, I have found the same to be true in my practice and in that of my colleagues throughout the US. The bottom line for those with a mood disorder is to surround yourself with healthy relationships and people who are living how you want to live. For those who love someone with a mood disorder, support them in their choice of healthcare and they will be more likely to stick with it, leading to better outcomes.

### **Daily Routines**

Throughout this book, the need for consistent routines is emphasized. In many ways bipolar disorder is really a disorder of circadian rhythms. The natural sleep/wake cycle is altered. By maintaining consistent routines primarily through sleep/wake times, night time routines, regular healthy meals, and morning exercise as described above we can help to maintain a more effective circadian rhythm. Consistent routines amplify and reinforce the cycle that we wish to maintain.

### **Mindfulness**

Entire books can and have been written on mindfulness. Mindfulness is an effective tool to ensure that all of the aspects of lifestyle enumerated above can be accomplished. It can help to establish and maintain your nightly routine by giving you the skills to slow down. It can help you manage your sugar, alcohol or junk food cravings by helping you to identify the feelings that you may be having that trigger cravings. It can help you to become more aware of your feelings related to triggers and slow your reactions to them. This can in turn help to improve your relationships. Exercise itself can be incorporated into mindfulness, and mindfulness can help you maintain your motivation for exercise. Some professional athletes or entrepreneurs have even attributed their mindfulness practice to their success in sports or business because of the focus and concentration it gives them.

Meditation and mindfulness are almost always thought of as one and the same. This often conjures up images of people sitting still for 30 minutes trying not to think or feel anything. This couldn't be further from the truth. Mindfulness is actually a keen awareness of the things that you are experiencing without judgment. Mindfulness is experiencing the details of life in an intentional way without distraction. Trying mindful eating is often an effective first exercise. To do this you would begin by eating without distractions of TV, conversation, music, or anything. You would engage all of your senses as you slowly take a bite. What does your food look like? Feel like? Smell like? What are the sounds it makes as you chew? What are the nuances of its flavor? Can you pick out individual spices? Where do you feel the food inside your mouth? How does it feel as you swallow? Mindful eating slows the process down, brings greater awareness to our appetite and emotions, and often leads to less overeating and more enjoyment of healthier foods.

For those interested in even greater exploration of mindfulness there are programs that you can take. One in particular was developed by John Kabat Zinn and others

for the purposes of helping with pain in a hospital setting. The 8-week Mindfulness Based Stress Reduction (MBSR) course is now offered to communities and hospitals throughout the US. I recently found a free online version that can be done in your home, however you will miss out on some of the group dynamic and interaction so it may be best to undertake the online version with a friend. There are also books that you can read to help guide you through various types of meditations that you might find helpful to cope with more challenging moments. One of my favorites is *The Mindful Path to Self-Compassion* by Christopher K. Germer.

## **Stimulate and Support the Self-Healing Process**

The body has an amazing ability to heal itself, as does the mind. Doubt the truth in that? Next time you have a cold or a cut, watch and see what your body does even if you don't do anything. Sometimes all we need to do is establish the conditions for health to alleviate our symptoms. In mood disorders, that is not often the case. Instead, our systems need some support or extra stimulus to heal. The three methods I have found to be the most effective in mood disorders are hydrotherapy, homeopathy, and light/dark therapy.

### **Hydrotherapy**

Hydrotherapy is what it sounds like – the therapeutic use of water – however it is so much more. In fact, some of my teachers argued that it is a bit of a misnomer and should really be called *thermotherapy*, or heat therapy. After all, therapeutic treatments using water are really focused on the transfer of heat through the deliberate application of cold or hot water. This can be done using steam rooms, cold plunge baths, ice, or wet towels (the most accessible and most common method).

Some of you may be familiar with the more sordid history of psychiatry where “hydrotherapy” was used as a method of scaring willful or psychotic patients into submission. In these cases a doctor would simulate drowning or cause extreme discomfort. I bring this up only to reassure you that this is NOT the type of hydrotherapy I am discussing.

I see modern day hydrotherapy as it is used by naturopathic doctors to be a therapy that is amplifying our body's natural processes. The systematic application of hot and cold cloths helps to increase nutrient delivery and waste removal from tissues, reducing inflammation, improving circulation and the immune system, and generally helps to alleviate stress. The way that hydrotherapy amplifies these things is by creating what I liken to a pump throughout your circulatory system. The heat causes dilation of the blood vessels and brings more blood to the surface by dilating those closer to the surface and constricting those deeper down. Alternating with cold then does the opposite, constricting the surface vessels and dilating the deeper vessels, thus shunting the blood that was just drawn to the surface back down to the internal organs. Blood and lymph work to deliver nutrients and remove wastes, and this pumping action helps to amplify that.

Hydrotherapy is something that you can do at home and is usually more effective in the early stages of any condition. It can be helpful in the early stages of depression,

anxiety, or mild mania as a method to have purposeful relaxation. It can also be very helpful with pain and other chronic conditions. Despite this, hydrotherapy is not broadly applicable. The methods used can be either stimulating or relaxing to the system. In general, the longer you apply the hot or cold, the more relaxing it is, and the shorter, the more stimulating. Additionally, the greater the temperature difference (never to the point that you would scald someone) of the water or applications to your body temperature, the more stimulating it would be. Finally, you would not want to apply heat for a long time to an already inflamed area.

Hydrotherapy can be done with the full body or localized to a specific area of pain or trauma. For mood disorders in early stages I find what is called constitutional hydrotherapy to be helpful, although I would not use it as a stand alone treatment. To do constitutional hydrotherapy it takes about an hour, requires a decent amount of equipment, and someone to perform it. It is best done in an office setting. For a simpler version you can easily do at home you can perform alternating hot and cold showers. For an average 10-minute shower you would begin with 3 minutes of hot water followed by 30 seconds of cold and repeat two more times. The hot water should be hotter than an average shower but not so hot that it will scald the skin. Similarly, the cold water should be as cold as you can stand it without being painful. Alternating hot and cold showers should always end on cold, even in the winter. You will be surprised how quickly you warm up when ending on cold, and how much longer you retain the warmth than with regular showers. Most people report that they feel more energized when they end their showers with a cold blast as well.

## **Homeopathy**

Homeopathy is a system of medicine that uses small doses of single substances found in nature to stimulate the body to heal. It is based on a centuries old principle of like cures like that was first posited by Hippocrates, the father of modern medicine. The exact mechanism in which homeopathy stimulates healing is unknown, however the current research suggests that nanoparticles<sup>7</sup> of the original substance are created during the process followed to make a homeopathic preparation.

For homeopathic treatment to be effective for serious conditions a skilled practitioner and diagnostician needs to be involved. Homeopathic remedies are prescribed based on the unique, characteristic symptoms that each individual experiences with their illness. Everyone reading this has or knows someone with a mood disorder. If you were all to share your stories there would certainly be some common themes. This is what leads to your medical diagnosis. But I am certain you would notice some subtle, and some not to subtle differences in how you experience episodes of mania or depression. Some people find it more pleasant with increased social engagement and more effective work. Some find it irritating with increased anger and agitation. Others find it scary with auditory or visual hallucinations or incredibly risky behaviors. Some are driven to think of or even attempt suicide because of their symptoms, while others never reach that point, even if their symptoms are as severe. Similarly, you will also not all have the same physical symptoms associated with the condition. Some may get migraines every



time they get depressed or manic. Some may get specific aches and pains. Others may have digestive complaints. Being able to gather all of this information, sort through the things that place you or your loved one in a diagnostic category, and then sorting out the aspects that are unique and specific to you is the job of a homeopathic practitioner.

The reason this is so important is that these unique symptoms are what guide the selection of a remedy to help you heal as a whole person. There are over 3,000 homeopathic remedies to select from, and each has specific indications based off of individual presentation. It is the most individualized medicine that I have seen thus far. For that reason, it would be impossible to give examples of homeopathic remedies to use for mood disorders. Any given remedy listed would only work if your depression, anxiety, or mania symptoms were exactly those that the remedy is indicated for.

This complex and often poorly understood form of medicine can be incredibly powerful when done well. There is evidence that it is in no way inferior to the use of Fluoxetine (Prozac)<sup>8</sup> and that it is more effective than stimulant medications for attentional issues<sup>9</sup>. In my practice, I have seen a well-prescribed remedy be so effective that a suicidal patient had a significant reduction in her suicidal thinking and behavior before she was even seen in the emergency room, so much so that she was sent home immediately after her evaluation with no concerns for her safety. For a more detailed example of how homeopathy is used and the types of results that can be possible, see the case example at the end of this chapter.

### **Light/Dark Therapy**

As described in the section on establishing conditions for health, bipolar disorder is in many ways a disorder of circadian rhythm. When maintaining consistent daily routines isn't enough to keep moods stable, sometimes we need to amplify the sleep and wake cues. This is where light and dark therapy comes in.

Our circadian rhythm is primarily dictated by hormones that fluctuate throughout the day including cortisol and melatonin. Hormone regulation is affected by many things, including what we eat. This will be discussed more in a later section. The production of melatonin requires a complex mechanism involving light input from the eye to an area of the brain called the hypothalamus and more specifically, the suprachiasmatic nucleus. When we use light and dark therapy we are amplifying these signals that would occur in nature if we didn't use artificial lighting. This is also why some people will notice an improvement in their sleep patterns after having gone camping for a week that will last well past their return to their usual daily life. When we camp we reduce our artificial light exposure that is coming directly into our eyes and are often able to sleep earlier as the sun sets. This really only applies to more rustic camping, not to RV camping.

Note that this subsection is called light/dark therapy. Often people will think to use light therapy when they are depressed because of news stories they have read or because it worked for a friend. They go online, find a place to order a light with the more therapeutic wavelengths (typically blue), and then sit in front of it for however long they can muster, all without direct supervision from a medical professional. This can be dangerous to do if you have or are susceptible to bipolar disorder.

People who have this condition can sometimes have a mania triggered if light therapy is used alone without the accompanying dark therapy. Basically they are amplifying only half of the signal to the brain.

To more safely and completely amplify signals for our circadian rhythm, we need to block the same light wavelengths at night that the morning light provides in abundance. The easiest way to accomplish this is by wearing sunglasses that block blue wavelengths for an hour or two before bed, even indoors. I have found patients with bipolar disorder who have clear evidence of a delayed sleep phase demonstrated with 24 hour salivary cortisol testing do quite well normalizing their sleep patterns when this method is adhered to strictly and monitored.

## **Correct Areas of Imbalance**

Sometimes setting the stage for optimal health and working with the body's innate ability to heal still falls short. Sometimes this is due to medications that are being used to treat the condition. Other times it is because of the length of time that the body has been exposed to less than optimal conditions. In these cases, we need to use more overt methods to bring the body back into balance.

## **Hormones and Mood Disorders**

The most important hormone to discuss as it relates to mood disorders is thyroid. What we typically call thyroid hormone is actually made up of several different hormones. The most common hormones that we monitor are thyroid stimulating hormone (TSH), thyroxine (T4), and triiodothyronine (T3). Symptoms of a low functioning thyroid include depression, weight gain, constipation, lethargy/fatigue, dry skin, and hair loss. Symptoms of a high (meaning too high) functioning thyroid are agitation, anxiety, weight loss and restlessness. There are several things that can contribute to a poorly functioning thyroid, including the use of lithium as a mood stabilizer.

In my practice I have found that it is incredibly important to monitor thyroid hormone levels in anyone who is experiencing mood instability. For some people, appropriate thyroid hormone replacement alleviates their symptoms entirely. For others, thyroid hormone is not needed, but nutritional cofactors to help with the conversion to the more active form of the hormone can be beneficial. In general, my experience has taught me that no matter what type of treatment used, natural or conventional, nothing is as effective if the thyroid is not functioning optimally.

You must have a blood test to assess your thyroid function before undertaking any treatment. To get the broadest possible understanding of function your doctor will likely order TSH, T4 and T3. If you use hormonal contraceptives you should have the free form of T4 and T3 assessed. Occasionally doctors will also order reverse T3 to assess the conversion of active hormone to this relatively inactive form. And finally, should there be any suspicion of autoimmune causes for thyroid abnormalities, thyroid antibodies would be checked as well.

## **High Dose Nutrients**

There are pro and con arguments for almost everything these days, and even something as seemingly innocuous as multivitamins has not been spared. Some

say that multivitamins are a waste of money and only give you “expensive urine.” This may be true for some of us, but not for others.

Those of us with “clean” healthy diets that we have maintained for a long time will often get most of the nutrients we need from our food if we are conscientious about eating a wide variety of fruits and vegetables. If you are one of these people and you have good energy, go to sleep and wake up easily, and have regular healthy bowel function, you may not gain as much benefit from a multivitamin. If you struggle more with any of these things, using a multivitamin may help to ensure that you are getting not just adequate, but optimum levels of nutrients.

For those of us who have been eating poorly and have more systemic inflammation, this may also be true but not why you think. More inflammation often leads to reduced absorption of nutrients from your food. So even if you have cleaned up your diet, your gut may take a significant amount of time to repair. In these cases, even a multivitamin will not be enough to increase absorption. These cases may indicate the short-term use of IV nutrient therapy. This allows us to bypass the limitations of absorption and deliver the nutrients directly to the bloodstream where they can then be delivered to the tissues to do their work.

Nutrients are used in our biochemical pathways that produce energy, hormones, and neurotransmitters. Let’s look at the production of melatonin as an example. As described earlier, melatonin requires light signals from the eye to specific areas of the brain to regulate its production. But the precursors that melatonin is made from must be present. Tryptophan is an amino acid found in many dietary proteins. This amino acid undergoes a transformation through the use of enzymes, vitamins and minerals to produce serotonin and eventually melatonin. Along this process the enzymes require nutrients, called co-factors, in order to function. For this process, the nutrients that are required include vitamins C, B1, B3, B5, B6, and folate, zinc, calcium, magnesium, and iron. Some of these vitamins are needed for what is called the “rate-limiting step” or the step in the process without which everything slows down dramatically or stops. Without adequate nutrition we will be less able to produce energy and other substances that help to regulate sleep and mood. With optimum nutrition, we will produce them with more consistency.

There are better forms of some vitamins, and fat-soluble vitamins (A, D, E and K) should not be taken in high doses without talking to a doctor first. These vitamins are stored in fat cells, so it is possible to over dose them. Consult with your doctor about the best form and combination to take if you are considering vitamin therapy.

## **Neuro/Biofeedback**

Neurofeedback utilizes computer programs to help you train your brain’s activity. It focuses on alpha, beta, delta, gamma, and theta waves. Alpha waves are associated with awake but relaxed states, beta with fully awake and alert, gamma with processing and learning, delta with deep sleep, and theta with extreme relaxation. Those with more anxiety tend to have a high ratio of beta waves compared to alpha and theta whereas those with depression tend to be the reverse. Neurofeedback has been shown to be effective for treating both of these conditions as well as ATTENTION DEFICIT HYPERACTIVITY DISORDER, dementia,

and general concerns with focus. It has not been shown to be effective for mania or bipolar disorder as a full condition.

Using neurofeedback, you are learning how to identify and create certain states within your brain. This needs to be done using high tech equipment not readily available for home use, with a skilled technician. Your training would be designed based on results from a study called a qualitative electroencephalograph (QEEG). Training typically involves a 20 – 30-minute session in which you have sensors applied to your scalp with an electrolyte paste to allow for transmission of data. These sensors are connected to a program that will allow you to watch a movie, listen to music, or play a game based on keeping your brain waves within a certain range. Maintaining your brainwaves within that range allows for smooth playback while going outside of the target range causes pauses or skips. Training typically requires at least 20 sessions that become more challenging as you improve your control.

Biofeedback works similarly but with physical parameters. Typically with biofeedback you are learning to identify and control emotional or physical responses based on physical signs. These can include galvanic skin response which measures sweat on your skin, temperature, pulse and breathing rates. This can be a great tool to help bring awareness to your body and even bring you back to your body in emotionally charged states. It can be helpful in mitigating triggers for anxiety and depression, but again, is not as effective in mania.

## Apply Pathology-Centered Natural Care

As described earlier, this type of care is meant exclusively to suppress symptoms. Using treatments in this section should never be done without the guidance of a doctor, even if you can buy them without a prescription. If you are working with one doctor for natural treatments and another for prescription medications, you absolutely need to make sure that both doctors know everything you are taking as most of these things either need testing or have interactions with medications. There are many types of natural treatments that can be used to suppress symptoms. This is not meant to be an exhaustive list, but an overview of the types of treatments there are and how they should be used.

### Specific Nutrient Supplementation

Taking single vitamins should only be done when there is a known deficiency. Lab tests can be done to determine your specific needs. Some medications can have side effects that cause nutrient deficiencies. For example, most oral contraceptives cause a deficiency in B6, which can lead to symptoms of low energy, lack of focus, and depression.

**Vitamin D.** We produce vitamin D through exposure of our skin to the sun. It is important for structural integrity of our bones, functioning of our immune system, and maintenance of our mood. Low vitamin D is associated with depressed mood. Vitamin D is a fat-soluble vitamin, so it should always be tested before you begin taking a supplement.

**Vitamin B12.** This vitamin is available almost exclusively from animal products or nutritional yeast. Strict vegans will likely need to supplement

this vitamin. Deficiencies of B12 are highly correlated with mood instability, including both mania and depression as well as mixed states. It is absorbed exclusively in the terminal section of the small intestine. Conditions such as Crohn's disease that cause significant inflammation of the small intestine will impair or destroy your ability to absorb B12 from your food. B12 is best taken sublingually (meaning you let it absorb under your tongue) or by intramuscular injection. Oral doses are poorly absorbed<sup>10</sup>.

**L-Tryptophan.** This amino acid is sometimes given in supplement form to aid in sleep and improve mood in depressed patients. Some people who have bipolar disorder may benefit from tryptophan in both mania and depression, however this is not always the case. As described above, tryptophan is a precursor to serotonin. Giving more of the precursor "feeds the pathway" so to speak, and will typically end with an increase of serotonin. As discussed in the medication chapter, the use of serotonin modulating drugs without the presence of a mood stabilizer can cause mania or worsen the course of treatment. The same is true with any natural substance that alters the amount of serotonin in your system<sup>10</sup>.

**Omega-3 Fatty Acids.** Studies have been done that suggest high doses of omega-3 fatty acids can be beneficial in mood disorders. These are typically found in highest concentration in fish oil, but is also present in flax, hemp and chia seeds. There are several types of omega-3's, but eicosapentaenoic acid (EPA) has been studied the most in relation to mood disorders. EPA is anti-inflammatory and protective for the nerves but can also be a blood thinner. The doses that were found to be effective for mood control were very high, up to almost 10g for studies on bipolar disorder. This dose could amplify the blood thinning effects of any anti-coagulant drugs and could be problematic if you are undergoing any type of surgical procedure<sup>10</sup>.

**Magnesium.** Biochemically, magnesium has very similar effects in the body to lithium. This has led some researchers to theorize that magnesium supplementation could be an effective mood stabilizer. Magnesium is the most common deficiency in the standard American diet, however not everyone will have a deficiency, and doses used for mood stability are typically higher than recommended daily allowance. Magnesium is also sometimes used for anxiety and insomnia as it tends to have a calming or sedative effect. High doses of magnesium may cause diarrhea and intestinal cramping<sup>10</sup>.

**Zinc.** Some studies suggest a strong correlation of zinc deficiency with eating disorders, anxiety and depression<sup>11</sup>. There is some work being done to explore zinc supplementation to aid in treatment resistant depression<sup>12</sup>.

**Selenium.** This mineral is a cofactor in the production of triiodothyronine or T3, the more active form of the thyroid hormone. As you may recall, lower thyroid activity is associated with depression. Supplementing

selenium during pregnancy has also been shown to be correlated with lower rates of post-partum depression<sup>13</sup>.

**SAMe.** S-adenosylmethionine, better known as SAMe made the news over a decade ago as it was purported for its natural antidepressant and anti-anxiety effects. Claims were made that it was used instead of SSRIs throughout England. These claims are not untrue, however this supplement should be used in extreme caution or completely avoided in bipolar disorder as it can cause hypomania.

## Botanical Medicine

Botanical medicine, also called herbal medicine, is the use of plants medicinally. This class of natural medicine is readily available without prescription but should ALWAYS be considered a drug. Many drugs are actually made from the medicinally active parts of plants. Botanical medicine works by introducing an active agent to your body that is causing it to do something that it wouldn't do on its own, just like a pharmaceutical drug does. Plants often have interactions with pharmaceuticals. These should always be discussed with a doctor before taking them. I almost always avoid the use of botanical medicine in my patients with mood disorders and find that when I address the first three steps in the therapeutic order, they aren't needed. I will not give doses for any herbs in this section because I want to ensure you talk to a trained professional about this – that is how seriously I take their use.

The advantage of using plants over their pharmaceutical counterparts is that many people find them to be gentler and with fewer side effects. Herbal extracts of medicinal plants can be given as a single substance or combined for your individual presentation. In using plants, you get additional benefits from them as well, including other active constituents that work synergistically with the specific action you are looking for, and some small additional nutrients from the plant as well.

Plants are designated based on how they affect the body. The plants that are most commonly used in mood disorders are classified as nervines, sedatives and adaptogens. Nervines modulate the nervous system and are typically calming. They can be useful in helping withdraw from recreational or prescription drugs. An example of a gentle nervine is *Avena sativa* (milky oat seed). Sedatives are commonly used in anxiety, hypomania, and insomnia. They are calming, and as the name describes, mildly sedating. They can amplify the effects of medications that are being used for the same purpose, such as benzodiazepines. Sedative plants include *Eshscholzia californica* (California poppy) and *Piper methysiticum* (Kava kava). Clinical report suggests that some of the stronger sedatives such as Kava kava may be associated with causing severe depression in those with bipolar disorder. Finally, adaptogens modulate the stress response systems. They typically help reduce anxiety, increase focus and attention, and improve sleep. Examples of this include *Eleuterococcus senticosus* (Siberian ginseng), *Withania somnifera* (Ashwaganda), and *Rhodiola rosea* (rose root). Adaptogens can be energizing and should be used with extreme caution in bipolar disorder as they may cause mania.

I can't leave this section without mentioning the most famous herbal medicine for improved mood – *Hypericum perforatum* (St. John's Wort). This herb is effective for depression because it increases the serotonin levels in your system, just like an SSRI does. The herb should never be used in someone with bipolar disorder without the presence of a mood stabilizer. Just like taking an antidepressant alone, taking this herb alone can cause hypomania or make your treatment outcomes worse. It can also cause a very elevated level of serotonin that leads to toxicity, called serotonin syndrome.

### **Orthomolecular medicine**

This system of medicine developed by Linus Pauling incorporates the use of very high doses of vitamins for treatment of mental illness. It is most famous for the treatment of schizophrenia, but has also been used for mood disorders. It commonly uses doses of niacin and vitamin C that can cause significant "flushing" in which the skin becomes uncomfortably red and hot and stools become very loose. Some people find great relief using this method, however they have to take the vitamins long term. They typically find that the symptoms return as soon as they discontinue the high doses.

## **Apply Pharmacologic Intervention**

Sometimes, natural treatments are not enough to regain stability for someone who has gone untreated for a significant period of time or who has very severe symptoms. In these cases, pharmaceutical intervention is indicated and can be absolutely life saving. Some people find that they have no side effects from the drugs and can live happy, productive lives. It is not my practice as a naturopathic doctor to ever dissuade these people from using their medications. My goal is to help people find health and live happy, productive lives, and being on medications can be the way for some people to find that. Others find the side effects of medications less tolerable than the condition itself. For these people, natural medicines, and especially the naturopathic approach, can be very effective at helping to heal and maintain stability while slowly and safely reducing or eliminating the need for pharmaceuticals.

## **Common Co-Occurring Conditions**

One of the tenets of naturopathic medicine is to treat the whole person. This is why if you see a naturopathic doctor who specializes in one area, they will still ask about all of your symptoms. This is especially important in psychiatric conditions where there are often multiple physical concerns as well. Unfortunately, the more our medical system lends itself to expertise in body systems, the more divided our treatment becomes. We end up seeing our psychiatrist, our gastroenterologist, our endocrinologist, and our neurologist for things that could all be related.

### **Migraines**

I read a statistic somewhere long ago that there is approximately a 50% coincidence of migraine headaches and bipolar disorder. A study published over 30 years ago in *The Lancet* showed that 93% of children with severe frequent migraines recovered by identifying and removing food allergens<sup>14</sup>. I have seen this to be effective time and again, including in my own health. And, as stated previously, removing

food allergies can also be very effective for mood stability, focus and attention. It also tends to clear up other aches and pains and skin conditions as well due to decreased system-wide inflammation.

Homeopathy, hydrotherapy, acupuncture and biofeedback can all be very effective for treating migraines. All but hydrotherapy require a professional to work with (after initial training biofeedback will not require appointments with a professional). The most commonly used hydrotherapy treatment for migraines is to place the feet in a hot bath and an ice pack on the head or neck for about 10 minutes at a time.

The primary nutrient deficiency associated with migraines is magnesium. As you may recall, magnesium can also be effective for mood stability and for constipation as well. Magnesium deficiency may be a strong consideration if you experience both migraines and a mood disorder.

Botanical medicines that are commonly used in natural migraine formulas are *Tanacetum parthenium* (Feverfew) and *Petasites hybridus* (Butterbur). These plants have both been studied and show moderate efficacy in the prophylactic treatment of migraines. I have never found them to be effective for the treatment of an active migraine.

### **Metabolic Syndrome**

This all too common condition in the US is very prevalent in the mental health population, made even worse by medications that contribute to it such as anti-psychotics. Even without medications, there is a high rate of what is called reactive hypoglycemia in people with mood disorders. In reactive hypoglycemia, blood sugar drops very quickly after eating a meal, leading to fatigue, concentration issues, irritability, and headaches. When we feel this way we are often prompted by internal cues to seek out more food which leads to a consistent pattern of overeating.

Metabolic syndrome is considered a precursor to diabetes and is made up of 5 risk factors. These are central/abdominal obesity, high triglycerides, low HDL (also called the “good” cholesterol), high blood pressure, and high fasting blood sugar (or being on medication for previously high blood sugar).

Metabolic syndrome is best managed with lifestyle changes such as sleep and exercise and strict low carbohydrate diets that include healthy fats. Sometimes initial supplementation of minerals and herbs can help to regulate blood sugar while you are adapting to your new regimen. The most common and effective supplements are chromium picolinate, cinnamon, and green tea. The first two help to stabilize blood sugar and decrease insulin resistance. Green tea has been shown to help increase metabolism and to reduce a blood sugar spike after meals.

### **Insomnia**

Insomnia can be a significant challenge, especially in mood disorders. When lifestyle and diet aren't helpful enough, homeopathy, hydrotherapy or light/dark therapy are often helpful. On occasion, the insomnia is bad enough to consider using a temporary supplementation of melatonin an hour before bedtime. Adaptogenic



herbs can be helpful in reestablishing good sleep patterns. Sedative or hypnotic herbs such as those mentioned previously as well as Valerian root can be used to induce sleep. All of these natural therapies should be discussed with a doctor before using them as all can have interactions with or amplify the effects of your prescription medications.

## **Substance Use Disorders**

Alcohol and recreational drug use is a common coping mechanism for those with mental health concerns. There is some debate as to whether the substances cause the illness, or the illness causes the substance use. Regardless, if your goal is to establish a healthy body and brain, reducing substance use is a vital part of that. This can be very challenging though, because the substances are not only addictive, they also often help to reduce the perceived severity of the mental or emotional challenges.

The vast array of substances and what they do to the body make it impossible to cover in depth in this chapter. Each causes specific nutrient depletions in the body that will likely need to be replaced by IV nutrient delivery or very high doses of oral vitamins. Hydrotherapy is effective for helping aid your body in the detoxification process because it increases delivery of nutrients required for the process as well as removal of wastes. High fiber diets also help to hasten the removal of detox products from the body. Homeopathy can also be very effective for the symptoms of withdrawal from drugs. Sometimes additional supplementation of herbs may help reduce cravings or side effects of withdrawal such as insomnia or agitation.

## **Conclusion and Resources**

Natural treatments can be very effective for managing and aiding in recovery from mental health conditions. Before I end with a case example that exemplifies the principles and process I have described above, I want to reemphasize the importance of safety when seeking natural alternatives to medications. Remember that many natural treatments behave as drugs would in your body. Working with a medical professional is the best way to ensure that you are getting natural treatments that are not only safe, but also likely to be effective and specific for you. To find a qualified professional, visit your state or national professional association websites for referrals. Naturopathic doctors, functional medicine doctors, and integrative mental health doctors are great places to start. Many of these doctors keep blogs on their websites that give helpful tips for managing your health.

## **A Case Example**

In this case example the name, age, and other identifying information has been changed for the privacy of the patient.

Emily was 21 when she was first diagnosed with bipolar disorder. She had been undergoing a very high level of stress in her senior year of college and was preparing to take her LSAT to apply to law school. She had always experienced ups and downs, but never sought out medical help because the ups helped her study more and the downs were never something she couldn't push through, until then. The high level of stress and lack of sleep finally got the best of her and she

couldn't stop crying. She sought help from her MD and was accurately diagnosed with bipolar disorder. Her doctor prescribed a mood stabilizer, and after a week added an antidepressant. Her moods felt better and she finished college and was accepted to law school. She continued to take her medication consistently because she was worried about the stress of law school "getting to her" like it had before.

When Emily decided to pursue natural treatment it was because of the side effects she was getting from the medication. She had no sex drive, felt "foggy headed" and had gained over 50 pounds. She had started trying to eat better by following a low fat diet and running daily, but the weight just wouldn't come off. She was also concerned about the long term ramifications of her medications, including the effects it would have on a baby should she decide to become pregnant, and was hoping to get off of the drugs if possible. Despite all of this she was open to staying on her medications if that was best.

A full intake showed that she had signs of hypothyroidism including lethargy, weight gain, constipation and dry skin. She also shared that she had debilitating migraines up to four times a week. Lab testing showed that she did in fact have hypothyroidism and metabolic syndrome as well. A food allergy panel suggested that she had sensitivities to coffee, dairy, wheat, and baker's yeast.

Her treatment plan started aggressively as she had a high level of commitment and enthusiasm. It began with an exercise prescription to reduce the amount of running she was doing to 20-30 minutes 3 days a week and substitute weight training on alternate days. Some studies suggest that long cardio sessions will actually reduce thyroid hormone and therefore metabolism as well, whereas weight training does the opposite. She found a positive impact on her weight and energy levels within the first 2 weeks of the change in her exercise routine.

She was also started on a thyroid hormone replacement and a low carbohydrate allergy elimination diet. This meant she avoided all of the common missteps in diet described earlier in the chapter as well as all grains, most fruits, and her food sensitivities. Emily's diet felt restrictive at first while she adapted, but she soon found that she felt much better eating primarily proteins and veggies. She was even able to eat out with friends from time to time.

The final piece of the equation was the homeopathic remedy. Emily spent 4 hours sharing all of her symptoms and medical history. The recap of the symptoms she experienced confirmed her existing diagnosis of bipolar 2 disorder. At the time of her initial intake she was feeling more depressed than hypomanic. She had recently experienced the loss of a significant relationship and found that the only thing that could keep her from having outbursts of tears was to stay very busy with work. Any time she found herself unoccupied she would burst into "hysterics" and she would have suicidal ideation that would last just a few minutes until she was able to make herself work again. As long as she was working she was fine and had no thoughts of death. When she would cry, having someone console her made her angry and she would stiffen against any offered hugs. Her migraines would also get worse during this time, and were described as feeling like a steel spike was being driven through her skull right above her eye. These specific symptoms of her depression and migraine were unique to her, meaning that not everyone with depression and

migraines will feel them the same way, and indicated the homeopathic remedy *Ignatia amara*. Emily had some traumatic experiences in her past as well, so she was referred to a therapist for talk therapy.

Emily did well on that remedy for a few months, having to change the potency, or preparation a few times. Eventually her symptoms changed and a different remedy was indicated. She had several remedies and several ups and downs with her aggressive diet and exercise plan over the subsequent 2 years. She noticed that as she continued with homeopathic treatment she was able to eat more of the foods she was sensitive to without triggering as many migraines or mood episodes. If she went overboard and started having more severe or more frequent migraines, she removed the foods she is sensitive to from her diet again and almost immediately saw an improvement in her migraines and her moods.

After a few months of steady improvement with her natural treatment plan, we worked with Emily's psychiatrist to slowly reduce her medications. After about 1 year she was able to fully discontinue her prescription medications. She did have a few episodes after discontinuing her medication, but by that time she had learned what her triggers were, how to cope with the symptoms, and when to call for a change in her homeopathic remedy. She was able to avoid hospitalization.

Now Emily tries to maintain her initial diet and exercise routine but doesn't have to be as strict with it. She will go back to the strict schedule every once in awhile when she feels that she is starting to slip. She maintains a solid sleep routine and is focusing more on mindfulness with her eating and emotional responses. She calls every once in awhile when the skills she has learned for her lifestyle aren't quite enough and she needs a "tweak" in her homeopathic protocol. Overall, Emily is feeling great with consistent energy, healthier weight, successful and fulfilling work, and healthy relationships.

## Works Cited:

- 1 – Joo, E.Y., Yoon, C.W., Koo, D.L., Kim, D., Hong, S.B. (2012). Adverse Effects of 24 Hours of Sleep Deprivation on Cognition and Stress Hormones. *Journal of Clinical Neurology*. DOI: 10.3988/jcn.2012.8.2.146
- 2 – Gonnissen, H.K., Hursel, R., Rutters, F., Martens, E.A., Westerterp-Plantenga, M.S. (2013). Effects of sleep fragmentation on appetite and related hormone concentrations over 24 h in healthy men. *British Journal of Nutrition*. DOI: 10.1017/S0007114512001894
- 3 – Fowler, S.P., Williams, K., Resendez, R. G., Hunt, K.J., Hazuda, H.P. & Stern, M. P. (2012) Fueling the Obesity Epidemic? Artificially Sweetened Beverage Use and Long-term Weight Gain. *Obesity: A Research Journal*. DOI: 10.1038/oby.2008.284
- 4 – Pizzorno, Joe (March 2013). Assessment and Intervention of Persistent Organic Pollutants and Glutathione Depletion. California Naturopathic Doctors Association MM14: Environmental Medicine and Oncology in Primary Practice. Lecture conducted in San Francisco, CA.

- 5 – Woolery, A., Myers, H., Sternlieb, B., & Ztelzer, L. (2004) A Yoga Intervention for Young Adults with Elevated Symptoms of Depression. *Alternative Therapies in Health and Medicine*. DOI: 10(2):60-63.
- 6 – Chang, C.W., Sajatovic, M., & Tatsuoka, C. (2014). Correlates of attitudes towards mood stabilizers in individuals with bipolar disorder. *Bipolar Disorders: An International Journal of Psychiatry and Neurosciences*. DOI: 10.1111/bdi.12226
- 7 – Bell, I., Koithan, M. (2012). A model for homeopathic remedy effects: low dose nanoparticles, allostatic cross-adaptation, and time-dependent cross-sensitization in a complex adaptive system.
- 8 – Adler, U.C., Paiva, N.M.P., Cesar, A.T., Adler, M.S., Molina, A., Padula A.E., Calil, H.M. (2011). Homeopathic Individualized Q-Potencies versus Fluoxetine for Moderate to Severe Depression: Double-Blind, Randomized Non-Inferiority Trial. *Evidence-Based Complementary and Alternative Medicine*. DOI: 10.1093/ecam/nep114
- 9 – Frei, H., Everts, R., von Ammon, K., Kaufmann, F., Walther, D. (...), Thurneysen, A. (2005). Homeopathic treatment of children with attention deficit hyperactivity disorder: a randomized, double blind, placebo controlled crossover trial. *European Journal of Pediatrics*.
- 10 – Gaby, Alan. (2011) *Nutritional Medicine*. Fritz Perlberg Publishing, Concord, NH.
- 11 – Cope, E.C., Levenson C.W. (2010) Role of zinc in the development and treatment of mood disorders. *Current opinion in clinical nutrition and metabolic care*. DOI: 10.1097/MCO.0b013e32833df61a.
- 12 – Dye, John (2010). *Naturipathic Treatments for Mental Illness*. Delivered at Southwest College of Naturopathic Medicine, Tempe, AZ.
- 13 – Mokhber, N., Namjoo, M., Tara, F., Boskabadi, H., Rayman, M.P., Ghayour-Mobarhan, M. , (...) Ferns, G. (2011). Effect of supplementation with selenium on postpartum depression: a randomized double-blind placebo-controlled trial. *Journal of Maternal-Fetal and Neonatal Medicine*. DOI: 10.3109/14767058.2010.482598
- 14 – Egger, J., Wilson, J., Carter, C.M., Turner, M.W., Soothill, J.F. (1983). Is migraine food allergy? *The Lancet*. DOI: 10.1016/S0140-736(83)90866-8



# Mental Illness and Families of Faith

By Reverend Susan Gregg-Schroeder

## Introduction

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

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

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

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

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

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

It was my senior pastor who stood by me, who believed in grace and who believed in me. With his support, I finally decided to openly acknowledge my depression.

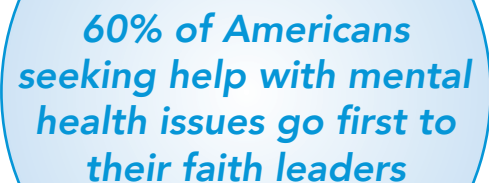
I wrote an article for our church newsletter entitled, "The Burden of Silence." My senior pastor wrote an accompanying article about the ignorance associated with mental illness. Our parish nurse set up an informational meeting on depression, and we had a turn-away crowd of over 130 people. Seeing such a great need, a depression support group was started, led by a professional counselor.

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

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

## Background

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



**60% of Americans seeking help with mental health issues go first to their faith leaders**

There are a number of reasons why these needs are not being met. Clergy do not receive adequate education about mental illnesses in seminaries. Some faith groups see mental illness as a moral or spiritual failure. Congregations are made up of individuals who mirror the stigma we find in society as a whole. Even if people are aware that someone is struggling with mental illness, they may not know what to do or say.

The needs of families coping with mental illness are documented in the book, *Families and Mental Illness: New Directions in Professional Practice* (Marsh, New York: Praeger, 1992.) The needs fall into eight categories:

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

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

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

Hospitality is a core value of major religions: Muslim, Jewish and Christian. The words hospital, hospice and host are derived from hospitality. In Christianity, hospitality is literally extending our hand to another, touching another and getting close enough to recognize our mutual vulnerability to things in this life.

Major religions share the conviction that we are called to care for those who suffer in this world. Both the Hebrew Scriptures and the New Testament contain many stories of people being called to reach out to those in need. The great prophets share a similar message that God asks us to be faithful, to love one another, to reach out to those who are broken and to seek justice for all God's people.

## **Treatment Options**

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

Studies are increasingly demonstrating the relationship between the physical, mental, emotional and spiritual dimensions of our lives. We know that support from family members, friends and a person's community of faith are a very important part of a person's treatment and recovery. People are more likely to comply with



their medication therapy or participate in psychotherapy if they can envision hope for the future.

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

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

***A person's spirituality or religious views can be of great benefit in the treatment and healing of many illnesses, including mental illness***

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

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

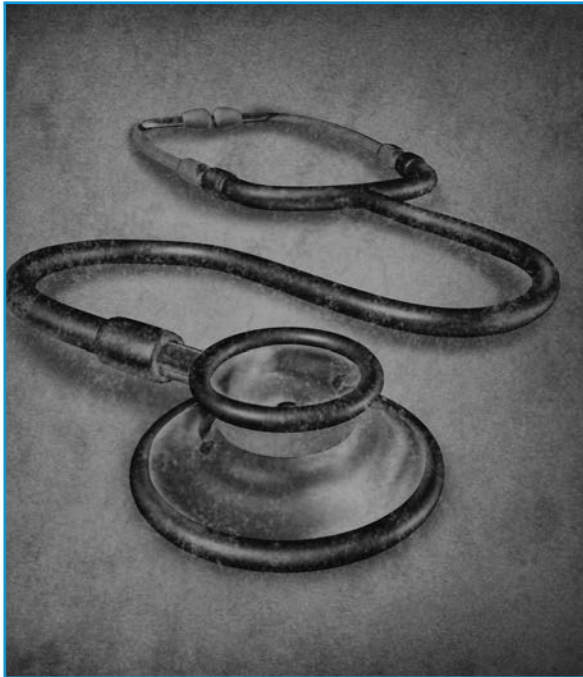
Mental illness goes back as far as recorded history and has been known by many names over time. As with all faith traditions, beliefs about mental illness cover a wide range of theologies from biblical literalists who view mental illness as a moral or spiritual failure, to persons who understand mental illnesses as brain disorders that did not have a name and were not understood by persons living 2000 years ago. Most ancient societies regarded mental illness as a religious problem involving the health of one's soul. There were elements of magic and mysticism in the rituals performed to cure persons with a mental illness.

With monotheism, as articulated by ancient Judaism, there was a shift in how mental illness was understood. While still almost completely religious in nature, mental

illness became a problem in the relationship between an individual and God- a condition associated with the soul. The Hebrew and Christian scriptures are full of stories and laments of persons suffering from so-called demon possession, visions or hallucinations, depression and other forms of mental illness.

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

Islam began to spread across Asia, Africa and southern Europe about a thousand years later. Like Judaism, the Qur'an frequently talks about the spirit or the soul.



But there was not the conception that mental illness was a punishment from God. Those suffering from mental illness were thought to be possessed by supernatural spirits, but these jinn (genies) were not seen as good or bad.

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

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

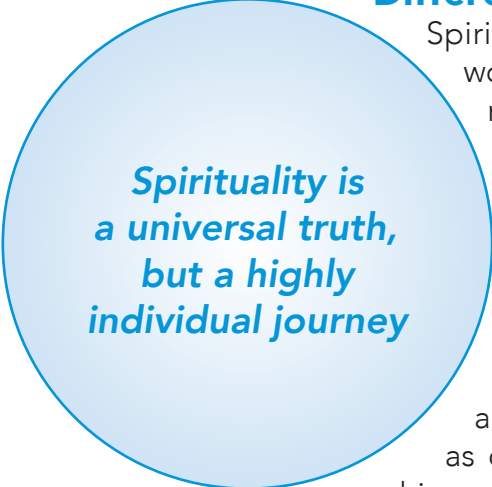
With the age of Enlightenment in about 1750 and the introduction of the science of psychology, attention was directed to the mind. Psychoanalysis looked at such things as unhappy childhood experiences or other conflicts arising from the unconscious mind. Followers of Freud viewed spirituality as superstition and the church's influence all but disappeared. The split with the church was complete. Mental illness was no longer a spiritual issue associated with the health of a person's soul. It was a problem with the mind or one's thinking.

Insane asylums were opened and an era of so-called moral treatment began. From 1750 to about 1950, persons with a serious mental illness were put in an asylum or other locked facility. Treatment in the early asylums was very poor, often secondary to prisons. Some early forms of treatment included lobotomies and a primitive form of electro convulsive therapy or ECT.

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

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

### Differences Between Spirituality and Religion



***Spirituality is  
a universal truth,  
but a highly  
individual journey***

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

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

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

Psalm 88 portrays the experiences of a depressed person from an emotional spiritual perspective. The words of the psalmist describe many of the symptoms of depression; sadness, isolation, anger, abandonment, mistrust, spiritual emptiness and hopelessness.

*You have put me in the depths of the Pit, in the regions dark and deep.*

*Lord, why do you cast me off? Why do you hide your face from me?*

Mental illness affects all aspects of our life including our spiritual well-being. It strikes at the very soul of our being, making us feel cut off or separated from God's love and acceptance. It is like a thief in the night. It steals a person's sense of self worth, their hopes and dreams for the future and it feels like it will always be this way. Mental illness challenges our core beliefs and values, and we often feel unworthy of God's love and acceptance. We feel alienated from God. We feel alone, helpless and hopeless in the dark despair of our illness.



**Mental illness affects all aspects of our life including our spiritual well-being**

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

### **Integrating Spirituality into the Treatment Process**

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

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

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

*The President's New Freedom Report on Mental Healthcare in America (2003) states that our current delivery system for mental health services is in shambles and only a total "transformation" of the system will benefit consumers. From a theological perspective, transformation refers to a spiritual process of growth and change.*

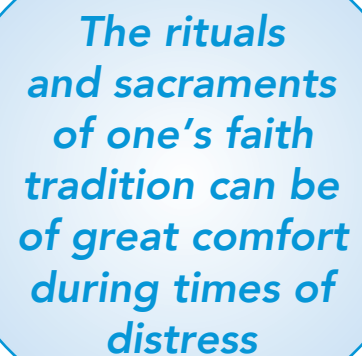
The commission for this report, which was made up of some of the most respected mental health professionals in America, asks for more coordination of services and providing treatment through community-based groups rather than institutions. It also calls for assisting persons to reintegrate into being successful and productive members of society through such means as job training and community support. Our faith communities can be an integral part of this process.

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

## Spiritual Care

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

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



**The rituals  
and sacraments  
of one’s faith  
tradition can be  
of great comfort  
during times of  
distress**

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

Because faith leaders are respected by their congregations, they can model an acceptance that will help diminish the stigma associated with mental illness. This is easier if mental illness is treated like any other physical illness in sermon illustrations and in small group educational settings. By including persons with mental illness in pastoral prayers and liturgies, clergy are helping to educate the congregation that mental illness is not caused by lack of faith or spiritual commitment.

Pastoral care needs to include visitation to persons and families struggling with mental illness as with any other physical illness. Devotional material from a faith tradition can be given to individuals in a counseling setting. Scripture and other

resources from a faith tradition can bring comfort to persons in a psychiatric hospital, group home or other setting.

## The Ministry of Presence

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

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

## The Journey Continues

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

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



But the unconditional presence of the holy was revealed to me through my pastoral counselor. While everyone else was trying to “fix” me in some way, my counselor accepted me as I was. While others were looking for a cure, my friend offered care. He was vulnerable enough to enter into my dark place without judgment. He modeled for me an image of a God who surrounds us and holds us in a caring presence. He modeled an unconditional acceptance that I had never felt. In my feelings of worthlessness, he held on to a faith that I was loved as a child of God, just as I was. He became a lifeline to hope.

I now preach the importance of being in relationship with other people and with our faith community as one of the gifts that allowed me to gradually emerge from my deepest darkness and discover the most important gift of the shadow, the gift of hope. Medications may stabilize symptoms. *But it is relationship and love that heal the soul.*

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

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

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

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

*You are patient with us.  
You are protective of us  
You are present with us  
until such time that we are able  
to ask for what we need.  
Thank you, Spirit God,  
for your healing taking place within  
before we are even aware  
of how broken we have become.*



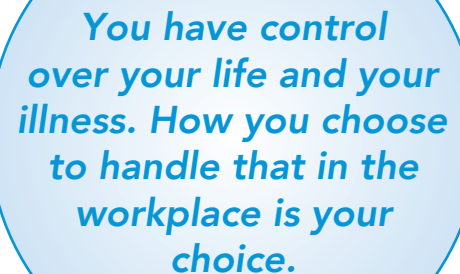
# Bipolar Disorder in the Workplace

Do you or do you not tell your employer about your disease? That is a question that many people with bipolar disorder ask themselves. Whether to disclose your illness directly to your supervisor is a very personal question. Some people have had very positive experiences while others have not.

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

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

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



***You have control over your life and your illness. How you choose to handle that in the workplace is your choice.***

**A Day at the Office** By Christi Huff

&

**Bipolar in the Workplace** By Wendy McNeill



## A DAY AT THE OFFICE

By Christi Huff

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

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

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

Some days I am more focused than others, and get a million things done. Other days it takes me almost an entire day to just read through a small stack of documents. You see, as a paralegal, I have to log a certain number of billable hours within my work day. All those ups and downs and distractions makes it difficult to get those hours at times, so in order to not just get the required work done, but to make up those required hours, I have to get the work done at home. You can imagine then how that affects my life outside of work. My fiancée frequently has to do things alone or not at all because I have to work. I miss out on events with my friends and other social interactions because I am always working. Not having any time to

socialize makes me feel secluded and feeds into my depression, making some of the symptoms of bipolar disorder worsen. Being at home so much gives me even more opportunity to start getting lost in my own thoughts while ruminating, which can either send me into further depression or can start causing hypomania because I begin to obsess over a project or new idea that launches a whole list of new ideas that must be started immediately. Those ruminations distract me from getting my work done at home, leading to a lot of frustration and the desire to just give up.

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

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

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


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

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

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

Does this mean that nobody should tell their employer about their bipolar disorder? Of course not. Every employer is different, just like every job is different. I believe the decision to tell one's employer should definitely be a decision based on their

own relationship with their employer and their own comfort level. In the meantime, targeting employers in our advocacy should become a priority so that this type of a decision does not have to be made by individuals with bipolar disorder, or any other mental illness, and we don't have to continue working around the clock battling the "Bipolar Coaster" just to keep up.



*Every employer is  
different, just like every  
job is different*

# Bipolar in the Workplace

By Wendy McNeill

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

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

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

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

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

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

But it has been quite a journey up until this point. If I am to judge myself through

“society’s” eyes, one might call it a journey filled with mediocrity and defeat, as I have come not even close to having a “real career.” In the context of my life, however, in the context of my struggles, what I see is a journey of determination, grit, doggedness, and the pursuit of happiness in spite of a mental illness.

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

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

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

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

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

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

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

Laura took me under her wing. She had me meet her at the office, and then she took me for a long walk around the campus. She told me about her neighbor’s daughter, an eerily similar story. The young girl was going to college, but living at home. She started talking faster, making all kinds of plans. Then she started rearranging the furniture in the house (including the piano.) When she started

swimming in the pool in the middle of the night, her parents knew that she needed help. She was taken to the psychiatric ward and diagnosed bipolar. She was like me, nineteen years old. Laura told me this story, and then she told me her plan. I could keep my job if I agreed to see a counselor at psychological services. We also agreed to cut my workload in half, so I would publish two papers a month instead of one a week.

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

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

***It is important to remember that the notion of success is individual, and every person with bipolar disorder is going to experience it differently***

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

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

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

Now, my immediate supervisor, who I knew through the mental health community, knows that I have bipolar disorder, but the President and Founder do not, and I intend to keep it that way. I think I want to be in one organization where I am not viewed as someone with a mental illness. Even in an environment that supports people with mental illness, I think a supervisor's attitude changes when she hears about a mental illness. She may think, "Wow, she's so normal for someone who

has bipolar disorder!" I think even enlightened people, or people in the mental health field, feel this way. I think the bias in our culture is so strong that even the most well intentioned person can have this reaction. So in this one instance, I have protected my anonymity, although I am "out" in every other area of my life.

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

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

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

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

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

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

And dare I say it, a success.





# Going to College with Bipolar Disorder

By Russ Federman, Ph.D., ABPP

## The Desire to Leave the Diagnosis Behind

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

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

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

## Considering the Best Choices for a College or University

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

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

## Close to Home or a More Distant School?

When deciding near or far, we look to the student's recent history of stability as an indicator of the kind of support network that will be necessary at college.

If relatively stable for the last year or two without hospitalizations or frequent medication changes, then perhaps being close to home is not so important. With a good track record of sustained stability, attending schools that are several hours or even several states away from home should not arouse concern.

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

## **Mental Health and Psychiatric Resources at Today's Colleges**

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

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

For any student the choice of where to go to college is crucial. For students with bipolar disorder, it's imperative to investigate the scope of services available through a college's counseling center before making any commitment to attend. If those resources are minimal or without a clear psychiatric component, then one should also make sure good psychiatric services are accessible in the nearby community.

This isn't to say that mental health treatment resources should be the primary criterion for



college selection; but for bipolar students, it really should be high up on the list of priorities. Clearly a bad choice would be to attend a college where access to psychiatric services was limited, both at the college and in the local professional community. Simply put, excellent treatment resources should always be readily accessible for those with bipolar disorder.

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

### **Important Preparatory Steps Before Arriving at School**

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

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

Students should be aware that their medical records belong to them and they have a right to receive copies at any time. During late adolescence and young adulthood, when students are likely to be on the move, it's actually recommended that they maintain a notebook of their medical records so that they're able to bring

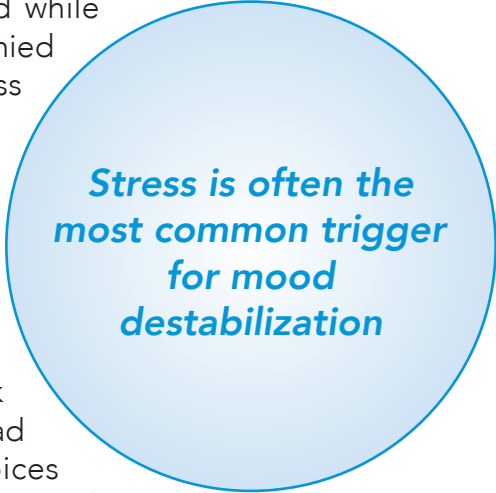
copies of records with them when transitioning to college, graduate school, a first job, employment relocation, or whatever may come next.

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

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

While considering all these choices, strong feelings of anticipation and excitement are perfectly normal. Why not just dive in and fully immerse yourself?

Simple - doing so activates a lot of intensity. And while intensity can feel pleasurable, especially if accompanied by mild to moderate hypomania, it is nonetheless stressful. For students with bipolar disorder, the stress of intense engagement is not necessarily their friend. In fact, stress is often the most common trigger for mood destabilization.



***Stress is often the  
most common trigger  
for mood  
destabilization***

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

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

## **The Potential Pitfalls of University Life**

If the symptoms of bipolar disorder did not emerge until sometime around age 35 or 40, the effective management of mild to moderate symptoms would be a much easier undertaking. Consider the reality that by middle-age, important maturational adjustments such as relying upon structured daily routines, employing good sleep hygiene, significantly limiting drug and alcohol use and more generally refraining from impulsive, risky behavior, are all choices that one has come to value in the broader context of a stable lifestyle.

Once these life skills have been achieved, many of the factors precipitating bipolar destabilization are rendered far less potent. That is precisely why we often see an improvement in mood and overall functioning as individuals with bipolar disorder transition out of early adulthood and progress towards later lifecycle stages.

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

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



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

Why not? For the individual with bipolar disorder, good stable sleep can be as effective (if not more so) than prescribed medicine. It's often

the case that inadequate sleep and/or inconsistent sleep patterns are some of the most common precipitates of bipolar mood destabilization. Similarly, research is showing that frequent and excessive use of psychoactive substances is a potent destabilizing influence for those with bipolar disorder (Baethge, C., Hennen, J, Khalsa, H.K., Salvatore, P., Mauricio, T. and Baldessarini, R.J., 2008). On the other hand, it's also common that most college students with bipolar disorder report that substance use is something they have struggled with. The third part of the terrible triad is stress. Stress usually worsens psychiatric disorders. Stress makes people feel worse even when they are free of any psychiatric diagnosis. For those

with bipolar disorder the combination of high stress, substance use and poor sleep habits is quite simply like introducing a lit match to gasoline. The outcome isn't good.

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

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

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

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

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



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

Late adolescence is a time of striving towards goals and ideals. Going to a good school, finding a fulfilling major, connecting with a wonderful love partner, developing options for gratifying and rewarding employment are dominant themes

for the late adolescent and young adult. As we progress through the lifecycle we all have to accept some modifications of our hopes and dreams. An ideal life exists in fairytales and movies. It doesn't exist in our lived realities. For most, these modifications of hopes and dreams typically occur somewhat later in life, when it gradually becomes clear that adolescent fantasies and adult realities aren't a close match.

But the college student with bipolar disorder needs to adjust expectations at an earlier age. The predominant lifestyle norms of university life won't work for the bipolar student. Indeed they're a recipe for instability. In order to work with this,

the bipolar student needs to try to embrace his or her diagnosis; not because it's desirable, but because it's real and to some degree, unchangeable. Denial won't make it go away. Denial of the bipolar disorder will temporarily allow students to do what they want. But when such choices disregard aspects of bipolar stability then there's the inevitable price to pay for brief forays into denial and temporary wish fulfillment.



***The bipolar student  
needs to try to embrace  
his or her diagnosis***

The necessary psychological adjustment for the bipolar student entails letting go of their ideal self - that person the student was striving to become - and accepting the realities of living with the bipolar diagnosis.

This adjustment is a painful one and it usually isn't achieved quickly. Just as with the process of grief, it needs to be revisited again and again in order to gradually be replaced with a deep sense of acceptance. It actually is a process of grief: grieving the loss of that person that one wants to be.

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

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

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



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

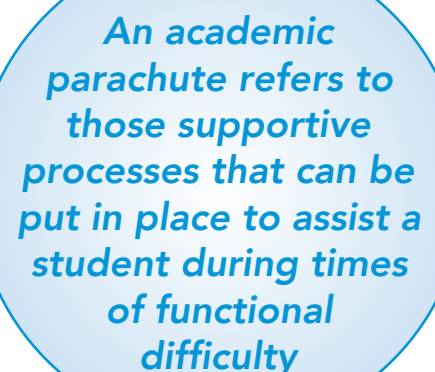
Think of a sprained ankle. Once an ankle is badly sprained it makes the ankle more susceptible to future sprains. Each successive sprain lowers the threshold for the kinds of physical stresses that will lead to subsequent sprains. The brain is not all that different. Vulnerabilities towards bipolar instability,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

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

## **The Appropriate Use of Academic Parachutes**

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

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



***An academic parachute refers to those supportive processes that can be put in place to assist a student during times of functional difficulty***

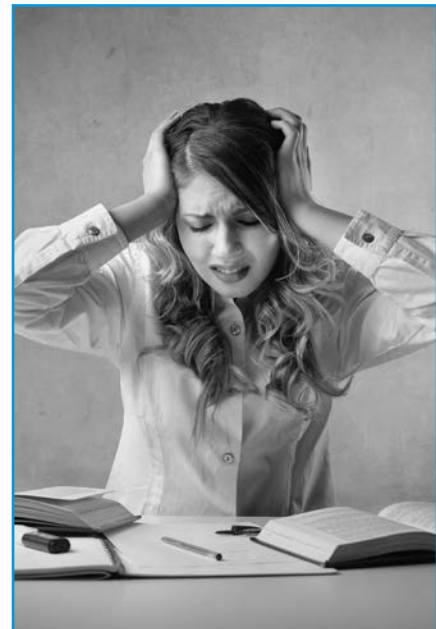
Most universities have an office that serves students with physical, psychiatric and learning disabilities. Typically this office is referred to as Disability Support Services; though on some campuses it may have a different title. The Americans with Disabilities Act requires that institutions of higher education provide assistance and necessary accommodations to students with diagnosed disabilities. Clearly no college student wants to consider themselves as having a "psychiatric disability," but there are times when bipolar symptoms can be just as disabling as any other

condition. If a student was in a wheelchair due to cerebral palsy, there wouldn't be much question as to whether some special assistance would be needed for that student. His or her classrooms would all need to be wheelchair accessible. If a student's arms were affected, it would also make sense that student receive copies of comprehensive class notes. In other words, some accommodations would need to be made to assist the student to participate equally in the educational process along with other nondisabled students. Why should bipolar disorder be viewed any differently?

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

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

A student's academic dean can also be an effective advocate when communicating with professors around issues of disability-related performance difficulties. A good example involves medically excused late course drops. Most schools have an initial period of time each semester where students can add or drop courses without consequence. Occasionally a student may recognize that his or her performance in a particular course is more negatively impacted than performance in other courses; however, it's not uncommon that for the bipolar student, course-specific performance deficiencies may not become apparent until after the last date to drop a course. In these instances, when accompanied by appropriate medical documentation, academic deans can sometimes play an important role in facilitating exceptions to standard course drop policies.



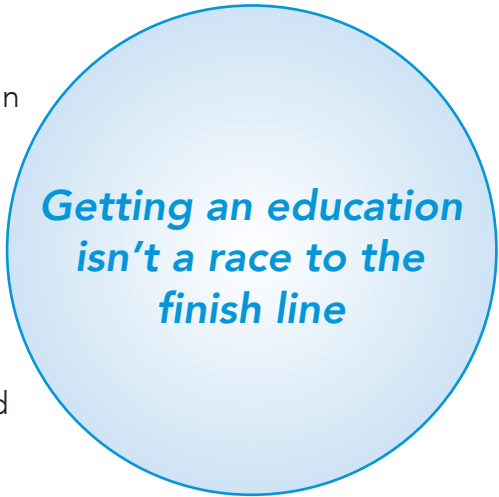
Beyond the helpful advocacy roles provided by others, one of the best strategies is for a student to meet with professors and share the realities of his or her bipolar condition. It's even more helpful when this is done proactively, early in the semester, rather than waiting until the point where it feels like the semester is a lost cause. In most instances university professors are more than willing to be flexible and supportive of students as long as they perceive the student's sincerity and all claims are backed up by appropriate documentation.

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

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

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

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



**Getting an education  
isn't a race to the  
finish line**

## **Conclusion**

We've often heard the phrase uttered by adults, "My college years were the best years of my life!" Typically when such is expressed we're seeing some degree of retrospective distortion. No doubt, the college years do involve some wonderful

experiences. But if the truth be told, they are also years of high stress and high complexity.

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

## References

- Post, R. 2007. Kindling and sensitization as models for affective episode recurrence, cyclicity, and tolerance phenomena. *Neuroscience and Biobehavioral Reviews*. 31:6. 858-873
- Baethge, C., Hennen, J, Khalsa, H.K., Salvatore, P, Mauricio, T. and Baldessarini, R.J. 2008. Sequencing of substance use and affective morbidity in 166 first-episode bipolar I disorder patients. *Bipolar Disorders*. 10:6. 738-741
- Activeminds.org, Active Minds is the leading nonprofit organization that empowers students to speak openly about mental health in order to educate others and encourage help-seeking. We are changing the culture on campuses and in the community by providing information, leadership opportunities and advocacy training to the next generation.



# Social Interaction

By Ellen Frudakis

Social interaction is a basic human need. Whether you have bipolar disorder or not, everyone needs to have opportunities to socialize. Social interaction can be fun, leading to friendships, and/or provide us with a deeper appreciation and sense of who we are. I have bipolar disorder and have experienced this first hand. Social interaction has brought me a feeling of belonging, friendship, laughter, and joy.

At times, it gave me an escape from the challenging aspects of this illness and a belief in the possibility of recovery. I have also seen this occur for many of the young people who have joined Impact Young Adults (IYA), a nonprofit organization that I co-founded that provides social activities and leadership experiences for young adults with mental illness.

***Social interaction can come in many different forms***

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

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

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

***People need to have access to positive experiences and people in order to create a life they can be proud of***

# Realizing the Needs and Benefits of Social Interaction

Some of the many benefits of ongoing social interaction are:

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

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

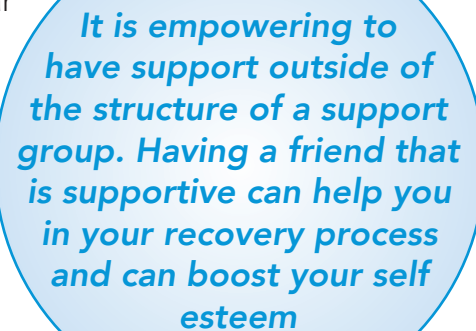
Joe is someone I know with bipolar disorder. He once told me that the hardest question for him to answer from strangers and acquaintances is "How are you doing?" Unless it is a friend or someone he feels is accepting of him, he has trouble answering this question because he feels that most people will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

**FRIENDSHIP** At a basic level, a friend can offer a feeling of connection and belonging. Janet, one of the members of IYA, says that friendship also opens doors to new experiences, exposing her to interests that she wouldn't have pursued on her own. Prior to one of her friendships, for example, she had not been interested in art. Then one of her friends introduced her to painting, which has now become a huge part of who she is. She considers this interaction to have altered her reality, bringing fresh energy and ideas into her daily life. Janet tells me that human interaction is so important to all of us, especially those of us with mental illness, because our number one way to cope when things are tough is to retreat. Her experience with friends has helped her change this, and she says that she no longer feels as alone as she had felt in the past.



**FUN** This is also an important part of social interactions. Recently, another one of the members of IYA, Scott, said that going on the IYA overnight trips make a big difference in his life. Specifically, he enjoys getting to spend time with friends, staying up late talking and making jokes. Scott expressed that one of the best things about it was not just the fun he had at the time but that it improved his mood for several days afterwards. He followed up this statement by saying that it made him feel like he is more than his illness and that he belongs somewhere.

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



*It is empowering to have support outside of the structure of a support group. Having a friend that is supportive can help you in your recovery process and can boost your self-esteem*

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

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

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



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

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

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

- **LIFESTYLE** When your ability to function gets handicapped by this disorder, it can affect your lifestyle, making the usual meeting places for meeting people less likely to occur in your life. Common ways of meeting new people include work, school, or through other friends. As an individual

begins treatment or is managing symptoms, those outlets can become inaccessible. I, like many others with this illness, have gone through periods when I was unable to work or attend school.

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

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

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

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

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

- **LOW SELF-ESTEEM** It is very common for self-esteem to develop with the onset of bipolar disorder. For me, losing the ability to trust my mind made

me feel like I was losing control of my life. Ultimately, I lost my sense of self. Before the onset I could say to myself with confidence, "I am a good student, I am a thoughtful friend, I am a talented artist." But bipolar disorder attacked and invalidated everything I thought I knew about myself and turned my life upside down. It was hard to put myself out there when I didn't feel good about myself. The risk was too great. I could be misunderstood, rejected, or worse... ridiculed. No one I know is up for that, whether they have a diagnosis or not.

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

- **LIMITED BUDGET** Many of the people I know with mental illness have a lower level of income compared to others without the disorder. This may be because they have had to go on disability due to the severity of their symptoms, or if they are able to work, sometimes they cannot work full-time. This limits the amount of money available to spend on fun activities. For some, a trip to the movies is way over their budget. I have listed many social options in the How-to section at the end of this chapter that are low to no cost.
- **STRESS** Stress is like lighter fluid for the fire that is this illness. Stress puts pressure on a system that is prone to ups and downs. That is why people with bipolar disorder have to be careful during periods of high stress and make sure they are getting the support they need, or limiting situations that add to their stress. Sometimes this means that a social life has to take a back seat to treatment, and that's ok... it will be there when you are ready. Hopefully, if you have already started to make friends, they will understand if you aren't available for the time being.

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

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

## How To

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

### ONLINE RESOURCES

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

- **Online Support Groups** – Some online support groups are message boards where people can “post” how they are feeling or ask a question that others can respond to. Others are more like chat rooms, where people all log in at the same time and are led by a facilitator. Some national organizations like DBSA (Depression Bipolar Support Alliance, <http://www.dbsalliance.org>) offer online support groups, like the chat room example.
- **Meetup.com** (<http://www.meetup.com>) – This is a website that lists groups of people that get together with specific interests. There are groups for everything! Just to name a few that I have seen: cooking, art, hiking, spirituality, and even politics. If you name it, you can probably find it. These groups are run by everyday people who started out looking for something to do, just like you. If you don't see one you like, start a new one!
- **Facebook/LiveJournal** – These are just two examples of many websites that have online communities that you can join – some of which may announce in-person events that you can find out about. This is one way you can connect with the people who live in your area.

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

### IN-PERSON OPPORTUNITIES

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

- **Religious Institutions** - If you believe in some form of higher power you can attend a religious service. There are many different types of religious institutions, from traditional Christian, Buddhist, Jewish, or Muslim congregations to Unitarian Universalists or other diverse groups that gather together. If this appeals to you, it can be a great way to get started.

- **Mental Health Related** - If you are insecure about being around others because you worry that they won't understand your illness, or if you are still experiencing symptoms that make it difficult to connect with others, try reaching out to mental health communities first. This can be less intimidating.
- **In-Person Support Groups** - Whether the group is led by a therapist or is a peer-support model, either can be good for you in multiple ways. First, they get you out of the house and around others. Second, they give you a chance to get support and understanding for what you are going through from people who know about it firsthand. Generally, you are not required to share, especially if it's your first time. So, just sit back, listen, and learn what it is all about. The following organizations are generally peer-led and have locations and meetings all over the United States. Check them out online to find more information.
  - DBSA (Depression and Bipolar Support Alliance):  
<http://www.dbsalliance.org>
  - NAMI (The National Alliance on Mental Illness):  
<http://www.nami.org>
  - If you have a dependency issue, support groups like AA, NA, or SMART Recovery (<http://www.smartrecovery.org/>) may also be good options.
- **National and International Mental Health Organization** - Some have been mentioned previously for their support groups but also offer other types of education programs and community events for anyone facing challenges related to mental illness. Call your local office to see if they know of activities in your area.
  - International Bipolar Foundation:  
<http://www.ibpf.org>
  - NAMI (The National Alliance on Mental Illness):  
<http://www.nami.org>
  - RI (Recovery Innovations):  
<http://www.recoveryinnovations.org>
- **Mental Health Clubhouses** - These are places where people with mental illness can go during the day to find support and structure. Some have support groups and social activities. Others offer job rehabilitation programs and job placement. Many times lunch is available for a minimal fee. The best thing about the one I attended was a support group for young people. I was able to meet others my age going through similar challenges.

- **Impact Young Adults** - This is a consumer-led social activity and leadership experience program for young adults with mental illness in San Diego, California. (<http://www.impactyoungadults.org>)
- **Compeer** Compeer provides one-to-one supportive friendships and mentoring relationships with volunteers for adults and youth in mental health recovery. It is not available in all areas, so check their website for more information. (<http://www.compeer.org>)
- **Parks and Recreation Clubs** - Some communities have Parks and Recreation departments that focus on providing fun activities in their area. Some even offer specific programs just for people with disabilities.
- **Volunteer** - Volunteering is a great way to get connected in your community and be involved with a cause you are interested in. For example, if you like the beach you might try volunteering for a beach clean-up event. If you love art, see if there are any local galleries that need volunteers to help out. Sometimes you can find people or agencies that keep track of all the organizations that need volunteers in your area. This can make it easier to find something that interests you without having to ask around or contact each organization individually.
- **Neighbors** - Not everyone knows their neighbors these days, but chances are you have passed them as you come and go from your home or apartment. Start off slowly by saying hi and asking how their day went. This may lead to longer conversations here and there, and slowly you might find that you are building a relationship with them. If you feel comfortable, ask them if they would like to go to a movie or on a walk with you.
- **Education/School**
  - Take a no cost / no credit course through your local Community College District. This can take the pressure off if you are unable to make a semester-long commitment but want to try something new.
  - Take an arts or crafts class at a local art studio.
  - Join a book club. If you are a book lover this is a great way to get involved with others with similar interests.
  - Join a writing group. I have a good friend who joined a writing group with a few people she has met over the years. She loves to write, and it gives her deadlines that help her accomplish what she might not get done on her own.
- **Politics** - If you are interested in politics and want to be around others like yourself, you can generally find a local group that organizes rallies or supports political candidates running for office. This is a great way to build skills and also meet people who share similar interests with you.

- **Family** - Spending time with members of your family can be a safe and less intimidating way to socialize with people you already know. If this is not a healthy option for you, do not feel bad. There are plenty of other ideas listed here to choose from.
- **Interaction with animals** - If you are an animal lover, this can be a good way to get yourself out there. Many local animal shelters look for people to help out. This way, you can be around animals and other people who like them as much as you.

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

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

When you are ready, I invite you to come join in the fun of social interaction.

# How to Travel Smart

By Kim Knox

## Choosing Calm over Chaos

Travel is a word that can invoke veiled images of far away lands, new sights, smells, tastes and sounds; of stolen time rich with untold adventure... or at least that's how travel is often glamorously portrayed in the movies. Could it be your travel experiences, and mine, have sometimes fallen short of the perfection of a Hollywood tale?

The authors at Wikipedia note...

"... the word 'travel' comes from the Middle English word *travailen*, *travelen* (which means to torment, labor, strive, journey) and earlier from Old French *travailler* (which means to work strenuously, toil).

In English we still occasionally use the words *travail* and *travails*, which mean struggle."



So where's the fun in that? Even today, with all of the modern conveniences, travel can still be rough. A 99-year-old woman in a wheelchair might get frisked during a TSA inspection. The Transportation Security Administration alone can cause undue travel stress.

And the uncertainties and challenges do not stop there. Regardless of your experience with travel, it is a different thing entirely when you add on a layer of anxiety-laced bipolar disorder.

My name is Kimberly Knox, a bipolar I patient and your tour guide on this adventure called, 'How to Travel Smart.' From my personal travel experience, and the experience of other bipolar peers, it appears that the principle problems stem from anxiety, fueled in addition by some degree of either depression, mania, or worse still, rapid cycling.

But there's good news. You can take some sensible, rather simple steps to create the best possible travel scenario. And two words say it all: plan ahead.

## Preparing to Travel

Best case scenario: You've had bipolar long enough to know the difference between it and you, and you are on medication that controls it reasonably well. If not, you're still fit to travel; you're just juggling a few more balls than someone who has settled into some routine.

**Make all of your travel arrangements as far in advance as possible**, and in as much detail as possible. This will simplify your trip and keep your mind uncluttered. Print everything out. Make files. Be organized. And remember, travel agents are not yet extinct! For a modest fee, you can team up with an expert to handle your trip details. Book your flights open-ended so that you can make changes to your



schedule as you need. And contact your insurance company to find out what you are already covered for and what you may need to buy specifically for your journey. The key here is to avoid the build up of stress, which can fuel anxiety and exacerbate your illness.

**Travel with a friend, or hire an escort.** Preferred Travel Helpers is just one of many organizations who provide expertly trained staff to accompany you throughout your trip, with varying degrees of expertise to make your trip completely comfortable and worry-free. Though I don't have any personal experience, this firm is fully insured, their website is informative and friendly. Rates vary depending upon your needs. [www.preferredtravelhelpers.com](http://www.preferredtravelhelpers.com)

**Travel references:** Information services such as TSA (Transportation Security Administration) offer [www.tsa.gov/traveler-information/what-know-you-go](http://www.tsa.gov/traveler-information/what-know-you-go). Tips for Traveling Abroad is another useful government publication: [http://travel.state.gov/travel/tips/tips\\_1232.html](http://travel.state.gov/travel/tips/tips_1232.html)

**Get yourself "in shape" for your trip.** This important step includes all the things that do a body good -- eating nutritious food, drinking plenty of fluids and getting reasonable amounts of sleep and exercise. Your body and your mind react far better when they are not being asked to perform at the edges of their limits all the time. You're safe—now is the time to gently push yourself.

For every bit of pushing or extending you do in your relaxed pre-trip state, the more resilient you will feel on the road.

**Talk to your doctor and your therapist well in advance of your trip.** Share details about the destination, your trip goals, any known challenges and your concerns. For example, if you know you're sensitive to altitude and you're preparing for a hike into the Andes, talk to your doctor about taking Diamox (Acetazolamide). If you're boarding a ship, perhaps you'll need something to prevent motion sickness. Is it advisable to take an aspirin on your long flight? Do you need something to help you sleep? Perhaps ask about melatonin.

In addition, your doctor may prescribe a medication(s)<sup>1</sup> you can take in the event you need some extra help (a PRN, or 'as needed'), and if not, don't be shy: Ask. There are many medications that can be helpful, and your doctor will know which will work best with whatever you are already taking.

Your therapist will be able to arm you with coping strategies to help you deal with challenging situations. The more your therapist knows you and your disorder, the more helpful this kind of pre-planning and support will be.

**Time differences and medication.** The word from UCSD's Michael McCarthy, MD., PhD in psychiatry, and who has written extensively on the effects of travel and illnesses, take your medications at the same time. 9:00 pm in America, 9:00

---

1 The term "medication" throughout may also mean "supplement".

pm in Europe. The therapeutic levels really won't be affected, and that includes lithium.

**Check and double check that you pack your medications.** Not in your suitcase but in your carry-on bag. DO NOT CHECK THEM in case you need them during the flight, experience any travel delays, or heaven forbid your luggage gets lost.

Pack enough for your entire trip... and a little more. If for any reason you have to obtain more, call your doctor's office and ask them to send the order to your local pharmacy abroad. (In other countries, many prescriptions are actually sold over-the-counter, so check that option too). But bottom-line, take what you'll need, plus a "cushion" of a few extra days of medication in case of an emergency.

**Focus completely on whatever you are doing at the moment.** This is a calming practice called 'mindfulness.' It's both broad and narrow; internal and external. Try to appreciate every movement and component of each activity, even if it's brushing your teeth. Ritualize whatever you do—keep a schedule of even your simplest activities-- and you will enjoy a sense of control. I believe that it is quite impossible to have a panic or anxiety attack if you are completely in the moment. In a nutshell, mindfulness and all its benefits can be accomplished if you stay centered and uncluttered. (This is more than just a travel tip!). Also, as you read through this chapter, do try the EFT (Emotional Freedom Technique), or "Tapping".

## The Ultimate Preparation

Now is the time to get in the habit of tracking your moods, your medication(s), and integrate some meditation or relaxation exercises into your life. This is best done several weeks in advance of your trip, and in fact should be a part of your daily life, but even the day of, and through your adventure, this will help immensely.

Two tools may serve you well. One is a new mobile app called MOOD WATCH that gives you life-changing data in the palm of your hand. You can download the app on your iPhone, iPad, iPod Touch or Android devices for just 99 cents and is available in 11 languages. (visit [www.MoodWatchapp.com](http://www.MoodWatchapp.com)). Another similar tracking app is the T2Tracker created by the US Department of Defense to help returning soldiers with PTSD (Post-Traumatic Stress disorder), and it is free. <http://t2health.org/apps/t2-mood-tracker#.UdNd9IOAFZo> The details and instructions for Mood Watch are in the references section.

## Tapping

For some additional peace of mind during travel, you might consider trying my "bonus tip." It's called Tapping or EFT: Energy Freedom Technique <sup>2</sup>. Amazing, deep, effective, fast, and specific information is also available in the reference section.

---

2 Emotional Freedom Techniques, Craig, G (nd). EFT Manual (pdf). Retrieved 2013-06-26.

## MedJet Assist

And finally, one less worry is always a good thing. I recommend you check out MedJet Assist<sup>3</sup>.

This is about physical safety, and the only thing it has to do with bipolar is this: you will have one less worry. If you or any of your family become seriously sick or injured, for next to nothing, your fears are gone. *MedjetAssist.com*. They do NOT cover psychiatric illnesses, but they DO cover everything else. Rain or shine, 24/7, all around the globe. If you are hospitalized more than 150 miles away from your home and require continued in-patient care, Medjet will arrange for air-medical transfer to the hospital of your choice in your home country. This is an unbelievable service, and it's real. Place one more worry behind you, whether it's for your family or yourself. The flat-rate membership fees are amazingly affordable both for individual and family plans. This is a MUST HAVE in your travel kit. Look it up: *MedjetAssist.com*, and use the discount code: TRAVL for an International Bipolar Foundation 2% discount on all fees and products.

## MedFlash

MedFlash can be a lifesaving tool for travelers as you never know when you will be incapacitated or injured.

MedFlash is the next generation of PHR (personal health record) and is much more than an electronic filing cabinet. In fact, it's not a PHR at all. It's an Electronic Personal Health and Wellness Manager (ePHM) that delivers a highly personalized and interactive health and wellness experience that puts the member – the customer in control.



### **MedFlash offers many exciting features:**

Portability for on-the-go or emergency access:

This remains a critical component in any PHM system, but unless it's portable, its value is severely limited.

MedFlash offers multiple ways to enter and access the health profile data stored inside the ePHM, including web portals, smart phone applications and an encrypted USB drive along with a 24/7/365 emergency hotline.

In an instant, ePHM's provide paramedics and emergency room staffs with access to the information they need to properly provide care when a traveler is incapacitated or unresponsive. This flexibility also allows MedFlash to easily transport information between their primary care and specialty care physicians.

Internet access:

MedFlash also connects members to a wealth of trusted medical information available from multiple sources along with 24/7 access to clinical/nursing support through our Fone Med Program.

Again, use the ordering code TRAVL for your discount.

---

3 As an affiliate with MedJet Assist I was able to secure the 2% discount code.

## Ready to Launch

So your departure date is finally here. You are ready to launch.

We all know airports have the potential to be crowded, noisy places. Your goal is to have a plan. First of all, travel as lightly as you possibly can so your luggage doesn't overwhelm you physically and mentally. Take your time, ask for help and be prepared to tip. There are people in place to assist you.

If you feel unsteady on your feet-- whether from extreme anxiety or any other reason-- do not hesitate to seek assistance. Assistance can be just a matter of using a cane to help with your balance and as a sign to let those around you know that you require some assistance. It is as much for other people as it is for you. Keep in mind, a cane isn't your only option depending on your level of instability. Nearly all airlines offer a wheelchair service, and if you like, you can request it when you make your reservations. Also note that if you do ask for wheelchair assistance you must comply completely with everything you are requested to do. The airline wants things to go well for you and everyone around you.

## Airborne

Once you are airborne, there are several things you can do to stay relaxed at 30,000 feet and to reduce the effects of jet lag. This is my own formula, which I've found to be truly effective trip after trip.

- Let's assume you have read this entire chapter and have implemented the tips wisely. You should be well-rested, nourished and organized. You've packed your meds and some snacks in your carry-on, and a cane if you need it (high anxiety types). You know what to expect-- any stops, plane changes, flight times and the local arrival time at your destination. You are looking forward to your trip!
- On longer flights, by all means sleep when you're sleepy, but shoot for the longest leg of the flight. Consider the time it'll be when you arrive, because you'll want to adapt to the swing of things as quickly as you can once you're there.
- Kudos to you if you're an easy sleeper, but if not, ask your doctor to prescribe a sleep aid. What you want are good REM cycles. Go light on coffee or other caffeine beverages.
- As some medical research shows, taking one aspirin can help prevent the development of blood clots during long periods of sitting. Ask your doctor whether this is advisable for you.
- Move your body. Tricky business these days with airline regulations and limited space, but do as much as you can. Visit the restroom! There are in-seat exercises the airlines often have instructions for. Moving is good, especially for your legs.
- Set your watch to the new local time as soon as you're on your final flight. As funny as this sounds, set your head too. Refer only to the new time zone and completely buy into your new reality.

For a little different approach, David J. Miklowitz, author of The Bipolar Disorder Survival Guide writes on jet lag:

“One way to combat this travel disruption is to gradually adjust your internal time clock to the new place you’re going, before you actually leave. So, over the course of a week before you travel to a later time zone, go to bed an hour earlier than usual, then an hour and a half, and then 2 hours earlier, and so forth. By the time you arrive, it may be easier to adjust to the hours of the new time zone. This procedure usually works best if you’ll be in the new time zone for more than a few days.”

Jet lag is one of those maladies that has as many cures as hiccoughs, and probably all about as effective.

## After You Land

Slowly take in your new world-- the sights, the sounds, the smells. This is the perfect time to practice mindfulness, to be fully in the moment as you explore a different environment. Remember, whatever time it is there is YOUR time. If it’s siesta time, go for it, but avoid oversleeping. A nap is a nap!

Now comes the easier part—enjoying yourself. Keep to the Mood Watch program which will keep you on course—your meds will be correct, you’ll stay focused and centered and mindful, enjoying a little grounding meditation as part of your daily rituals... just like brushing your teeth, but a good deal more focused on keeping you able to enjoy yourself!

Let’s face it, living with a mood disorder is challenging, but it has no right nor should it have the power to keep us from traveling and exploring our world. Ernest Hemingway said it so beautifully, “It is good to have an end to journey toward; but it is the journey that matters, in the end.”

Enjoy your journey!  
Kimberly Knox

## Resources:

TSA (Transportation Security Administration): [www.tsa.gov/traveler-information/what-know-you-go](http://www.tsa.gov/traveler-information/what-know-you-go)

Tips for Traveling Abroad: [http://travel.state.gov/travel/tips/tips\\_1232.html](http://travel.state.gov/travel/tips/tips_1232.html)

MoodWatchApp.com, available in 11 different languages and endorsed by NAMI (National Alliance for Mental illness) and the International Bipolar Foundation

## Instructions on how to use Mood Watch:

MOOD WATCH lets you easily track your moods and biofeedback for a clear picture of how to improve your mental health and overall well-being. Simply respond to the following questions on your iPhone or iPod touch.

- Overall, how are you feeling? (Choose from Excellent, Great, Good, Fair Not So Good or Terrible.)
- How many hours of sleep last night?
- Quality of sleep? (Choose from Excellent, Good, Fair or Poor )



*(A wrist blood-pressure/pulse monitor)*

From here, you'll have a little biofeedback exercise, and one that's well worth doing. Your mind has more to do with your body than you might think, and you'll see the proof here.



Any blood pressure monitor will do. For example this wrist monitor is small, inexpensive (under \$20.00), and if you're consistent in the way you use it, it's accurate. Just strap it on and record your pulse and pressure. Remember, be consistent. Keep the monitor at heart-level and avoid talking, laughing or fidgeting and uncross your legs. Now record the numbers in MOOD WATCH. Then, meditate for between 3 and 5 minutes, focusing on your breath... slow deep breath in, longer exhale out. Practice will make meditating easier as you learn to relax and note how you feel better.

Finally, take your pressure and pulse again and record the numbers after meditating. You will likely notice a significant difference. If not, you will likely with practice. (Don't forget to pack your blood pressure cuff!

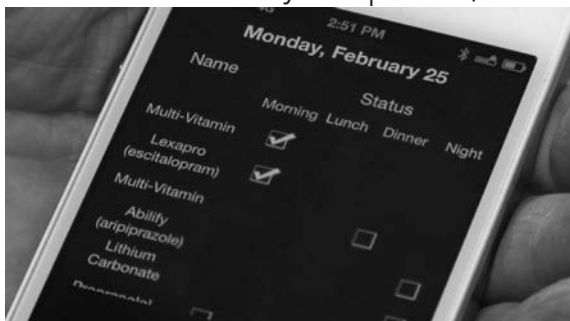
Doing this step regularly will help you lower or stabilize your baseline pulse and pressures so that regardless of your mental state, your body will maintain an even keel. This is biofeedback. It takes practice, but it is both doable and incredibly rewarding. Having the ability to check your vitals will reassure you that things are not nearly as bad as they might feel when anxiety is creeping up. You will quickly learn that you have more control—even subconsciously—over your body than you imagined.

Now, go on to evaluate your mood components guiding the buttons with your finger. You can rate your levels in seconds:



- What is your level of anxiety?
- What is your overall mood? High or low?
- What is your level of calmness? Calm or agitated?
- What is your level of focus or mindfulness? High or low?
- And what is your level of energy? Physical and emotional.

All of these components can be customized to fit you personally. For example, tap on Energy and change it to Exercise, if you'd prefer to track that component. You can also change the secondary component, or how it's scored.

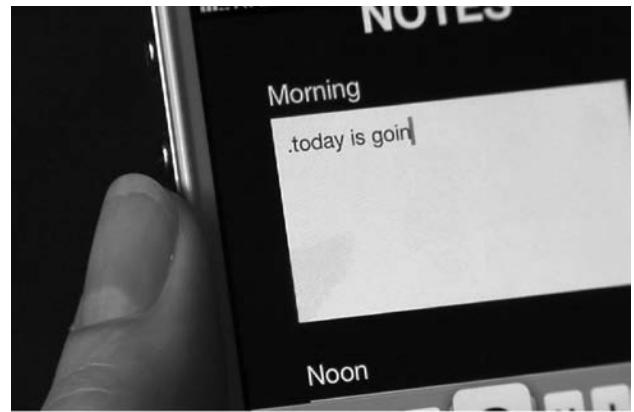


You have a tremendous amount of flexibility.

Once you've rated your mood components, there's a space—morning, noon, and evening—to make important notes about how you feel or how your day is going. These turn out to be invaluable later on down the line when looking

at all of your information at one time.

You can also keep quick and easy track of your medications and supplements, the dosages and whether you've taken them. Three of four subtle but effective alarms double to remind you to fill out your chart and take your medications or supplements.



MOOD WATCH takes all of your personal details, compiles and displays them in a Chart on the app. You get a personal picture of your moods over a week's time.



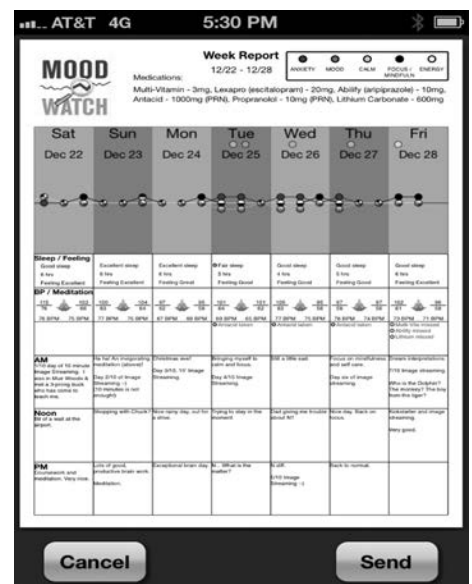
The Week Report is even more revealing. It includes your mood chart, and also sleep, blood pressure, meditation, your meds and your notes.

When seen together, the data are amazingly revealing and helpful in figuring out what action you can take to feel better. For example, you may discover that you need to get more sleep... or less sleep. Perhaps you forgot your medication, or are taking too much. And you can see what happens to your vitals and your mood when you meditate.

The Weekly Report can be emailed or printed out on standard-sized paper for easy reference. Consider sharing your data with your doctor. MOOD WATCH can be the window to improved mental health and a happier life.

T2Tracker: <http://t2health.org/apps/t2-mood-tracker#.UdNd9IOAFZo>

MedjetAssist.com





Emotional Freedom Techniques, Craig, G (nd). EFT Manual (pdf). Retrieved 2013-06-26

Tapping is a mystery. How it works is a mystery, but it works. Imagine a life free from anxiety, agitation, fear, worry... when you tap, you release these energies and make room for calmness, joy, contentment, mindfulness, and energy. It only takes a few minutes. A MUST TRY!

Let me tell you how I was taught: Standing up or sitting down, doesn't matter, you're just going to be focusing for a few minutes. Get centered (focus inside) and focus on what's getting to you. Could be a pain you want to resolve--physical, emotional, could be generalized anxiety, could be sadness, could be anything, truly.

We're about to start, so think of your problem--let's call it anxiety--and rate your level of anxiety on a scale of 1 to 10, 10 being the most anxious, one being no anxiety, and don't play the game if you don't have any anxiety. Choose anything else.

Alright, so you're centered, and you have your problem in mind. Take your dominant hand and make gentle karate chops into the palm of your other hand – nothing crazy.

Let's say you're at a seven. Start chopping into your hand and repeat the phrase, "Even though I have this anxiety, I love and accept myself completely." You repeat that phrase 3 to 5 times as you are chopping. (Pick a number and be consistent: 5)

For the next section, take both of your hands to the very crown of your head--the very top. Tap the top of your head with both hands saying, "anxiety". Repeat this word 5 times. That's right, just that word, while you're tapping.

Move to the inside corners of your eyebrows just above your nose. Tap your fingers, two fingers each hand, on the bone at the inside corner of your eyebrows. As you are tapping, continue saying, five times, "anxiety".

Go to the outside corners of your eyes, tapping on the orbit (bone), again saying, "anxiety", 5 times.

Now follow the orbit edge down to the center of your eyes--just below your eyes. Tap there on the bone again, and as you're tapping, say 5 times, "anxiety".

Now with one hand move your fingers down below your nose and above your upper lip. There, saying 5 times, "anxiety" as you tap.

Next, move your fingers to just below your lower lip, centered, and the top of your chin. Tap there, 5 times, saying, "anxiety".

Okay, homestretch! Both hands at the sides of your neck, slide your fingers down

to your collarbone, and down another 2 inches, there on your chest, tap and say, 5 times, "anxiety".

And the final tap: on either side of your body reach one arm around and underneath your arm, tap the side of your body as you say, 5 times, "anxiety". And you're finished!

Now, take a deep breath, relax, and centering yourself again, rate your level of anxiety. I think you'll be astounded to find that your level of anxiety really did go down and you really do feel different.

This technique is so incredibly effective it defies any feeble explanation. Just try it.

Tap away!

## References

Miklowitz, D.J., (2011) *The Bipolar Disorder Survival Guide*, "OK, Now That I'm Going to Bed on Time, How Do I Fall Asleep?" 175 – 176.

McCarthy, M.J., Welsh, D.K. Cellular Circadian Clocks in Mood Disorders, *J Biol Rhythms* 2012 27: 339 DOI: 10.1177/0748730412456367



# The Caregiver

By Muffy Walker, MSN, MBA

Putting baby locks on the kitchen cabinets to protect my toddler was one thing, but locking away the steak knives from my seven-year-old was not something I ever imagined would be necessary. I also never imagined that I would need to use my skills as a psychiatric nurse on my own child.

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

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



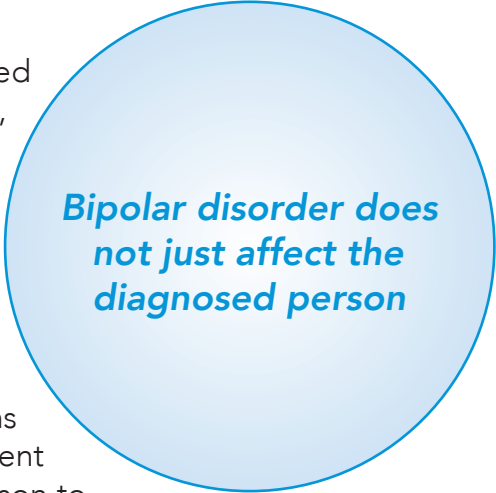
Even with medical training, my husband and I were ill prepared for the frustration we experienced trying to steer our way through the mental health system, the fear we encountered not knowing what the future held for our youngest son, and the lack of understanding and support we met on a daily basis.

Our lives changed dramatically. We read every book printed, searched the internet for any clue offering help or hope, sought multiple opinions from varying disciplines (psychiatrists, psychologists, neurologists, etc.), and clicked on every available website.

I quit my job and dedicated my waking hours to learning more, helping my son, and emotionally supporting my family. We looked into alternative schools and ultimately sent him to 4 different schools. We used mood charts, star charts for good behavior, practiced Ross Greene's "3 basket approach", and hired a mentor as we learned that author Danielle Steele did for her son, Nick Traina. We went to family therapy, individual therapy, and social skills groups.

The first 10 years were particularly difficult. We walked around as if on egg shells. We chose our words carefully so as not to upset Court; learned to disguise his many pills in pudding; in order to monitor his sleep we allowed him to stay in our room; repaired multiple broken windows, and sheltered our two other boys from Court's untempered profanity.

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



***Bipolar disorder does not just affect the diagnosed person***

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

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

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

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

When my son was 9, we allowed a television station in Los Angeles to interview us. After telling a co-worker what I had agreed to, she sent me a scholarly paper about children with AIDS, advising parents not to be public about it. I understood her

concern, but chose not to succumb to the unjust negative stigma associated with the biochemical brain disorder with which my son was born.



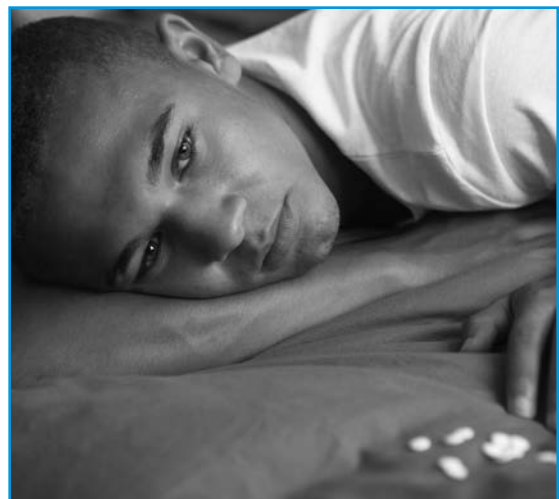
As I continued to talk openly about his disorder, people I had known for years, began secretly sharing with me that someone in their family was also diagnosed with bipolar disorder. Strangers called or emailed me, confiding that their son or daughter, mother or uncle also had bipolar disorder.

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

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

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

Not only is healthcare coverage more limited than for other illnesses, there is the issue of getting someone to treatment when he or she may not want to go. A person who is in a manic phase (up) may refuse to seek treatment and may even discontinue his medication. The medications are powerful and have unpleasant side effects. Someone in a depressed phase (down) may feel so helpless and worthless that getting help seems not to be an option. Furthermore, most of the medications used to treat bipolar disorder are powerful, have unpleasant side effects and may thwart their "high" feelings. Because there is not yet a cure for bipolar disorder, these medications must be taken for life, which is a scary prospect for most people.



For caregivers, coping with someone with bipolar disorder takes a heavy emotional toll and strains the relationship, often to the breaking point. An added burden is the stigma of mental illness, which leaves families feeling frightened and isolated, unaware that many other families share their experience.

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

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

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

- **Educate yourself** (congratulations - you're already on the right path by reading this). Visit our website for downloadable educational brochures, videos, other web links, and suggested reading. [www.ibpf.org](http://www.ibpf.org)
- **Seek treatment** from a reputable, board certified psychiatrist. Ask for referrals from your pediatrician, friends and mental health organizations. As a family caregiver, you can help by scheduling appointments, keeping track of medications and making sure they are taken as prescribed, and report any mood changes to the clinicians.
- **Meet with your loved one's clinician.** Although clinicians are bound by laws of confidentiality, you can ask to go with your family member to the appointment.
- **Establish an atmosphere** where symptoms, medications and concerns can be discussed freely. Understanding the early phases of the illness will help everyone seek appropriate help when it is needed. Sometimes, those with bipolar illness aren't aware when they are depressed or manic, although it is quite obvious to the caregiver. Pointing out when it is time to see the doctor or re-evaluate the medication needs to be done in an open, accepting way. Watch for triggers, and watch the behavior for clues of an upcoming change of mood or frame of mind. You are in the best position to recognize this.
- **Consider a contract** that you and your loved one with bipolar disorder agree on when he or she is calm, stable, and lucid. If the person is 18 years of age or over, you will generally not be able to learn much about his treatment because of HIPAA (The Health Insurance Portability and Accountability Act). Write out a statement describing agreed-upon treatment plans that you can show to your loved one when he or she is no longer rational or is refusing treatment.

- **Prepare a resource list**, even if you don't think you need the service, (example) Psychiatric Emergency Response Team (PERT) in your area.
- **Enlist support and build a network.** This is extremely important, not only to help you with the day –to- day stressors and limit your isolation, but also to learn what is “normal.”
- **Look into a Special Needs Trust.** Wikipedia defines this as, “A special needs trust is created to ensure that beneficiaries who are disabled or mentally ill can enjoy the use of property which is intended to be held for their benefit.” In addition to personal planning reasons for such a trust (the person may lack the mental capacity to handle their financial affairs) there may be fiscal advantages to the use of a trust. Such trusts may also avoid beneficiaries losing access to essential government benefits.
- **Let your family member know that you care.** According to Dr. Andrea Bledsoe of Everyday Health, here are some things TO SAY and NOT TO SAY to someone with bipolar disorder:
- **Please don't say:**
  1. You're crazy.
  2. This is your fault.
  3. You're not trying.
  4. Everyone has bad times.
  5. You'll be okay — there's no need to worry.
  6. You'll never be in a serious romantic relationship.
  7. What's the matter with you?
  8. I can't help you.
  9. You don't have to take your moods out on me — I'm getting so tired of this.

**Some of the best words of encouragement include:**

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



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

**You must take care of yourself**

When you take on the role of caregiver, you add more than just one new hat to your repertoire. Now you are "nurse," "doctor," advocate, case manager PLUS your previous roles as wife, mother, father, sibling.

**Caregivers' stress hormone levels were 23 percent higher than those of their non-caregiving counterparts**

Where there's caregiving, there's stress — that feeling that comes from having too many demands on your time. Chronic tension suppresses your immune system, making you more susceptible to illness. Research shows that caregivers' stress hormone levels were 23 percent higher than those of their non-caregiving counterparts. They also had lower levels of disease-fighting antibodies. This is why it is crucial to find ways to take stress-relieving breaks.

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

1. **Exercise daily**, even if for only 20-30 minutes a day.
2. **Get adequate rest and sleep.** Adhering to a healthy sleep schedule may be difficult with all you are now dealing with. Here are some helpful hints to get those much needed Z's: **Avoid** paying bills, having difficult discussions, or other stressful events in the evening. Try scheduling them early in the day.

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

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

**Smooth on some lavender cream** or put essential oil on a cotton ball near your pillow. Research shows that the scent of lavender eases anxiety and insomnia.

**Listen to soothing music** and turn off the TV and video games an hour before going to bed.

- Make love, not war.** Research shows that sex actually helps induce a sleepy state by releasing endorphins.
- Try some slow, deep breathing.** This type of breathing relaxes your body, oxygenates your blood and reduces the stress you feel.
3. **Eat nourishing foods.** Try to avoid caffeine, sugar, and processed foods. Avoid alcohol. Many believe alcohol helps them relax and sleep, however, alcohol disrupts the sleep cycle causing a nonrestful sleep.
  4. **Enjoy some “me” time.** Plan ahead for some “me” time, whether it’s a walk with your dog, lunch with a good friend, or curling up with a good book. “Me” time can be very restorative.
  5. **Acknowledge and understand your negative emotions.** Guilt, anger, isolation and resentment are normal feelings often associated with the caregiving process. If you notice yourself feeling this way, take a step back and remind yourself that these are part of the normal process.
  6. **Laugh.** Enjoying a good belly laugh helps the body relax, raises your blood oxygen levels, produces endorphins, stimulates your internal organs, and boosts your immune system. Know a good joke?
  7. **Give yourself a pat on the back.** You aren’t doing this to win a caregiver award but at the same time, you may not have realized how taxing it would be. If your loved one with bipolar disorder does not show his or her appreciation, don’t take it personally. Appreciate your own efforts and how they’re helping.
  8. **Find support.** Whether you seek support from your church, a professional therapist, or simply check in with a cheery friend, support is essential. Caring for your loved one is not a one-person job, although we tend to think it is. Connect with others who are in the similar situation. Support groups can work wonders for your morale. Your situations always seem so much worse until you are in the company of those going through the same thing.
  9. **Redefine your priorities.** Taking care of someone with bipolar disorder may leave you with little time and energy for yourself. Adjust your expectations of yourself and explain to others why your time and focus on them may need to change.
  10. **Arrange respite care:** <http://www.caringtoday.com/arrange-respite-care/respite-resources>.

11. **Consider Supplements.** Low serotonin levels have been linked to low spirits, says Marie-Annette Brown, PhD, RN, of the University of Washington. Getting 400 micrograms of the B vitamin folic acid; 50 milligrams each of B1, B2 and B6; and 400 international units of vitamin D every morning has been shown to boost serotonin and, as a result, people's mood and energy. In Dr. Brown's research, combining these supplements with daily exercise and exposure to natural light helped women overcome depression.
12. **Have hope.** Remember, bipolar disorder is treatable and in most cases can be stabilized. Be prepared for the condition to worsen and/or improve at times. We won't give up hope.

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

# Medication Chart

Start Date	Name of Medication/ Vitamin	Who Prescribed	Dosage	Frequency (morning and night, with food?)	Side Effects

Please use this chart for all the medications you are taking. Include all vitamins, over-the-counter and any homeopathic medications you may be taking, no matter what the reason. Keep this chart with you and share it with all of those on your treatment team including your pharmacist.

# Color Mood Chart

**ENERGY**  
**JOY**  
**ALERT**

Yellow

**CALM**  
**RELAXED**  
**CONFIDENCE**

Blue

**SAD**  
**TIRED**  
**CONFUSED**

Red

**NORMAL**  
**SAFETY**  
**HEALING**

Green

**STRESSED**  
**TENSE**  
**WORRY**

Black

**HAPPY**  
**ENERGIZED**  
**PEACEFUL**

Purple

**ENTHUSIASM**  
**EXCITED**  
**CREATIVITY**

Orange

**NERVOUS**  
**ANXIOUS**  
**IRRITATED**

Gray

# Medication Side Effect Checklist

- Blurred vision
- Changes in weight
- Swelling of hands and feet
- Dizziness
- High or low blood pressure
- Headaches or migraines
- Changes in menstruation or breasts
- Change in sexual functions
- Dry mouth
- Excess saliva
- Constipation
- Diarrhea
- Nausea

- Changes in urination patterns
- Muscle stiffness
- Trembling of muscles
- Trembling of tongue
- Tics or abnormal movement
- Tremors
- Decrease in muscle strength
- Jittery
- General fatigue

- Memory loss
- Difficulty in concentrating
- Anxiety
- Agitation
- Thoughts of suicide

**If you experience any of the above side effects from your medication, please contact your treating physician.**

# Exercise Journal

Use this form to log your daily exercise to keep you motivated. Make multiple copies to use in order to maintain a consistent exercise program.

WEEK OF \_\_\_\_\_

<b>MONDAY</b>	
<b>TUESDAY</b>	
<b>WEDNESDAY</b>	
<b>THURSDAY</b>	
<b>FRIDAY</b>	
<b>SATURDAY</b>	
<b>SUNDAY</b>	

# Food Log

DATE \_\_\_\_\_

BREAKFAST	
LUNCH	
DINNER	
SNACK	

Use this form to log your daily food intake to encourage healthy eating habits. You may want to make multiple copies to use in order to maintain a consistent health food plan.



# Doctor Contact Sheet

## Primary Care Doctor

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

## Psychiatrist

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

## Therapist

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

## Other

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

# Questions For Your Doctor

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

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

6. \_\_\_\_\_

The mission of International Bipolar Foundation is to improve understanding and treatment of bipolar disorder through research; to promote care and support resources for individuals and caregivers; and to erase stigma through education.

**[ibpf.org](http://ibpf.org)**