

BIPOLAR AFFECTIVE DISORDER



A GUIDE TO RECOVERY

THE ORGANIZATION FOR BIPOLAR AFFECTIVE DISORDERS
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OBAD...

***Helping people
with mood disorders
live better lives.***

*In Memory of
Enn Purdmaa*

*Whose words
have helped those with mood disorders
around the world.*

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OBAD is a registered, non-profit, consumer-driven organization that encourages the empowerment of people with mood disorders through education and support groups. Throughout the year we also sponsor seminars on the illness as well as public speaking engagements.

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THE ORGANIZATION FOR BIPOLAR AFFECTIVE DISORDER

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What is Bipolar Affective Disorder?

Bipolar Affective Disorder is an abnormal fluctuation in moods, varying between marked highs (mania) and lows (depression) with periods of stability.

Both men and women are affected equally, with the average age of onset said to be 28; yet children, adolescents and seniors can also be affected. Approximately three percent of the population is believed to have the disorder.

Bipolar refers to the two poles of the continuum with mania being the higher pole and depression being the lower pole. Affective means one's mood or emotions.

The dramatic fluctuation in mood is sometimes referred to as an episode or as a mood swing. The frequency, severity and length of the episodes vary from one individual to another. Without treatment and proper care, the frequency and severity of this chronic disorder can increase.

Individuals with bipolar disorder often spend many years seeking professional help and may get from three to four diagnoses from doctors before receiving a correct diagnosis. Early diagnosis is important as it can lessen the effects of the disorder on the individual. Individuals with bipolar disorder have an approximately 75-80 percent risk for alcohol and substance abuse. Marital fluctuation, chronic unemployment, and suicide are also prevalent.

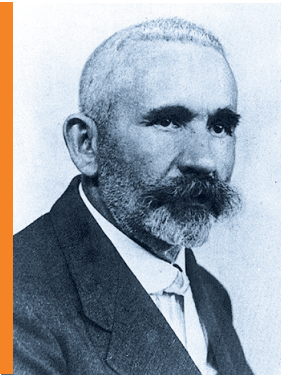
It is thought that the more episodes experienced by the individual before receiving a correct diagnosis, the more difficult it is to treat. Individuals who do not respond to treatment are said to be refractory.

**MENTAL
DISORDERS
AFFECT
ONE
IN FOUR
PEOPLE IN
ANY GIVEN
YEAR.**



The history of Bipolar Disorder

Bipolar Affective Disorder, sometimes referred to as manic-depression has existed since the beginning of recorded time. Aerates, in the second century A.D., first used the word mania to describe patients who would; 'laugh, play, dance night and day, and sometimes go openly to the market crowned, as if victors in some contest of skill'. He noted that they would later appear 'torpid, dull and sorrowful'. However, it was Theophile Bonet in 1686 who first connected the two distinct ends of the mood spectrum and coined the term manico-melancolicus.



Emil Kraepelin:
The father of manic-depression.

In the 1830's Falret and Baillarger isolated and identified symptoms that remain in many of today's books and journals. They also believed that what they considered a circular insanity had hereditary factors. They encouraged physicians to experiment with drug therapies in the hopes of finding a cure. In 1904, Emil Kraepelin, a German physician, developed a symptomatic classification for mania and depression. Kraepelin identified over 100 sub-types of Bipolar illness.

What causes Bipolar Disorder?

A specific cause for Bipolar Disorder has not been identified; there is no diagnostic test and as yet, no cure for this condition. There are a number of factors however, that contribute to its onset. They include physiology, heredity and the environment in which you live and work. Researchers have discovered that the increase or decrease of certain chemicals, called neurotransmitters, may be involved. These neurotransmitters assist the movement of electrical charges in the brain, from one cell to another.

NEURONS

There are many explanations as to how the chemistry of the brain affects our moods. Simply put, the brain needs certain chemicals in specific amounts to function *normally*. The condition known as bipolar is believed to result from an imbalance in these chemicals. The brain consists of many cells called neurons that communicate with other cells throughout the body.

Neurons are made of three major parts: the cell body, axon, and dendrite. To communicate messages, the neuron transmits electrical impulses that trigger chemicals to be released.

THE BRAIN AND NEUROCHEMISTRY

Chemicals (also known as neurotransmitters) such as norepinephrine, dopamine, serotonin, and others, are released into a region between two neurons called the synapse. Another neuron responds to the chemicals in the synaptic junction by excitement or with inhibition. Once the receiving cell has responded, the chemicals remaining in the synaptic junction are either broken down by mono-amine oxidase enzymes or taken up again by the transmitter cell.

Alterations in neuronal cell function can influence psychological behavior. Depression can be caused by decreased chemical levels, especially serotonin and norepinephrine. On the other hand, psychosis, schizophrenia, or other mental illnesses can be caused by increased chemical (mainly dopamine) activity in the synapse. Bipolar disorder may be caused by variable chemical extremes in the synapse, and shifting inside the neuron

HEREDITY

Observations have been made that both bipolar and unipolar disorders tend to run in families. Twin, adoption and family studies have shown a strong possibility of a genetic component to these conditions. This seems to be even more prevalent in Bipolar Disorder, where there seems to be a strong connection between the disorder in the individual and their biological parents. Inform your doctor of any family history of bipolar or other conditions such as alcoholism, drug dependence or post-partum depression. Include, if possible, the types of medications they were treated with and any side effects that may have been experienced. This information will be of immense benefit to your doctor and ultimately, you.

HUMAN GENOME AND THE SEARCH FOR BETTER TREATMENT

Recent breakthroughs in understanding the human genome have suggested that depression, bipolar disorder, schizoaffective disorder, and schizophrenia are all related; many different genes and chromosomes such as chromosome 13 and 22. Researchers believe that understanding the interactions within the genetic spectrum will lead to better therapy. This represents remarkable possibilities for the future understanding and for fighting bipolar illness.

The Spectrum - Mood Disorders

**BIPOLAR
AFFECTIVE
DISORDER IS
AN ABNORMAL
FLUCTUATION
IN MOODS
VARYING BETWEEN
MARKED HIGHS
AND LOWS
WITH PERIODS
OF STABILITY.**



Bipolar Affective Disorder is an abnormal fluctuation in moods, varying between marked highs (mania) and lows (depression) with periods of stability.

J. Hudson and H. Pope first proposed the affective spectrum concept. They theorized that individuals with an affective disorder (bipolar, unipolar, and schizoaffective disorder) tended to have many chronic symptoms of other disorders. They additionally discovered that substance abuse seems to be connected to the affective disorders.

DISORDERS LINKED TO MOOD DISORDERS

The following is a list of the disorders that are thought to be pathologically linked:

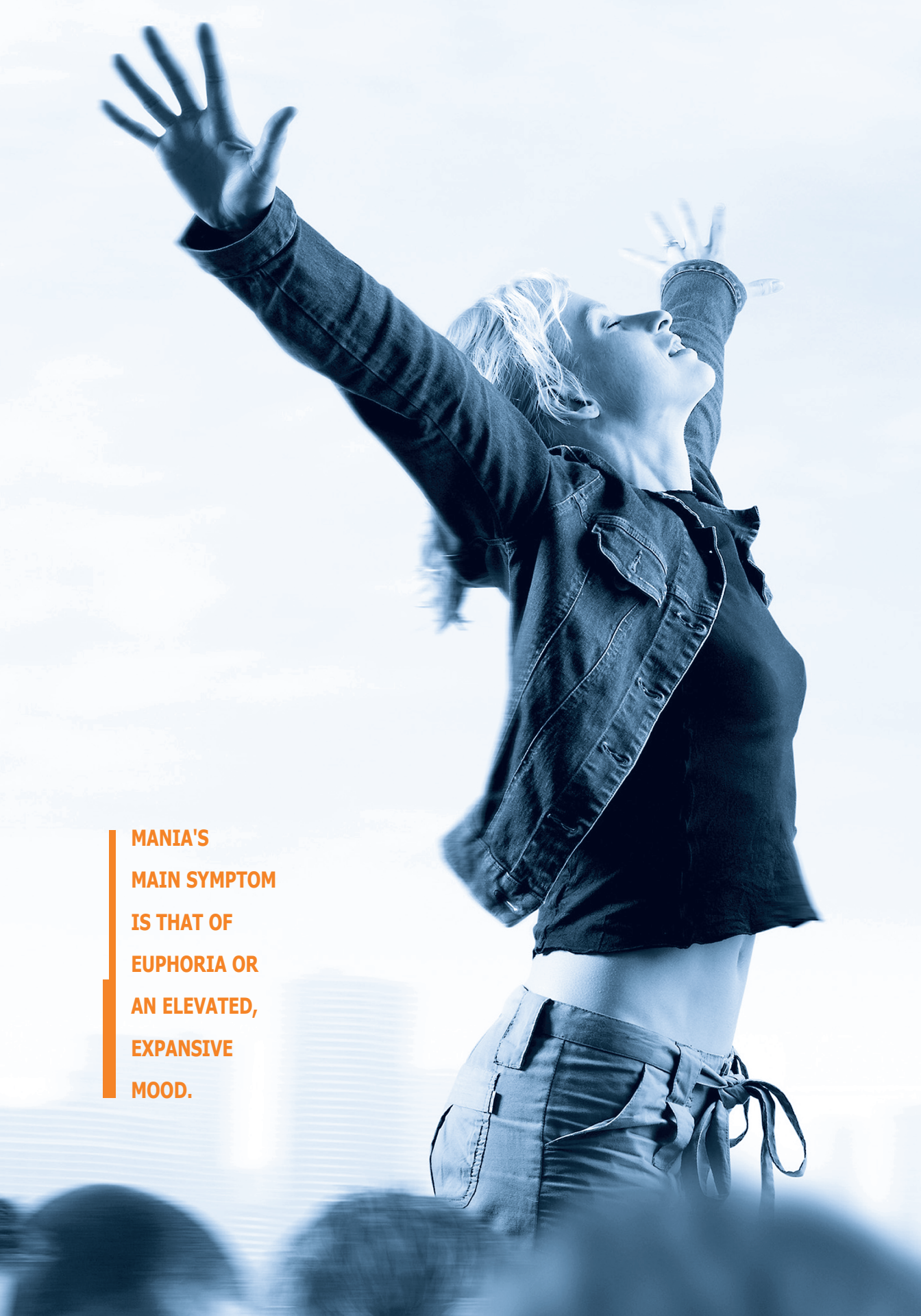
- affective disorders (bipolar, unipolar, and schizoaffective)
- attention deficit disorder (ADD & ADHD) (strong link)
- eating disorders; migraines
- obsessive-compulsive disorder (strong link)
- panic disorder (strong link)
- and pathological gambling

Bipolar disorder can be difficult to treat if one has a secondary diagnosis such as alcohol or drug abuse, or an anxiety disorder. Anxiety disorders are often treated with antidepressants. For individuals who have a primary diagnosis of bipolar disorder, who experience mostly manic symptoms and who have a secondary diagnosis of anxiety disorder, the addition of an antidepressant may be contraindicated. For individuals who have a secondary diagnosis of alcohol or drug dependence, see the next section on Dual Diagnosis.

ENVIRONMENTAL FACTORS

DOES STRESS CAUSE BIPOLAR DISORDER?

Monitor yourself closely, as an increase in stresses could lead to an episode. Studies have confirmed that stress can precipitate manic and depressive episodes. The biochemical imbalance makes individuals more vulnerable to emotional and physical stressors such as lack of sleep, excessive stimulation, marital tensions and conflicts; or upsetting and traumatic life experiences. During times of stress, the brain chemistry lacks the mechanisms to function properly, triggering the onset or recurrence of an unwanted episode. Despite this reaction, the stress in and of itself is not the cause of the disorder.

A woman with blonde hair, wearing a dark denim jacket and a black crop top, is shown from the waist up. Her arms are raised high in the air, and she has a joyful expression with her eyes closed and mouth slightly open. She is surrounded by a crowd of people, whose heads are visible in the foreground, all under a bright, hazy sky. The overall mood is one of euphoria and celebration.

**MANIA'S
MAIN SYMPTOM
IS THAT OF
EUPHORIA OR
AN ELEVATED,
EXPANSIVE
MOOD.**

Mania

Mania can be extremely destructive and cause considerable impairment in social and occupational functioning. People are more likely to seek help when moderately depressed than when they are experiencing an episode of mania.

Mania's main symptom is that of euphoria or an elevated, expansive mood, often irritably based. Everyone has feelings of happiness, pleasure and joy, but, in someone with this disorder, the mood progresses along a continuum from loss of self-control and judgment, to psychotic thinking and behavior. Symptoms can affect emotions, thinking, and behavior.

Untreated, moderate to more severe mania can be extremely destructive and cause considerable impairment in social and occupational functioning. Individuals are not likely to seek help when manic and they may deny that there is anything wrong with them. This can lead to involuntary hospitalizations.

Some typical symptoms of mania are persistently euphoric or high states, irritability or excitability, appetite disturbance, decreased need for sleep, increased activity, increased sexuality, pressured speech or rhyming games, racing thoughts, loss of self-control and judgment, non-completion of tasks, financial extravagance, inflated self-esteem (grandiosity), impulsive behaviors, laughing inappropriately, creative or bizarre thinking, participating in risk taking activities, and increased or delusional religious thoughts or experiences.


Hypomania

Hypomania is a condition similar to mania but less severe. Symptoms are similar with elevated mood, increased activity, and decreased need for sleep and the like. However hypomanic episodes differ in that they do not cause significant problems in an obvious way as opposed to excessive symptoms of mania.

Depression

Everyone has feelings of sadness and disappointment. Depression's main symptom is that of intense, pervasive, persistent feelings of sadness, hopelessness and frustration that cause considerable impairment in social and occupational functioning. Untreated, moderate to more severe depression can lead to suicide attempts or psychotic thinking and behavior.

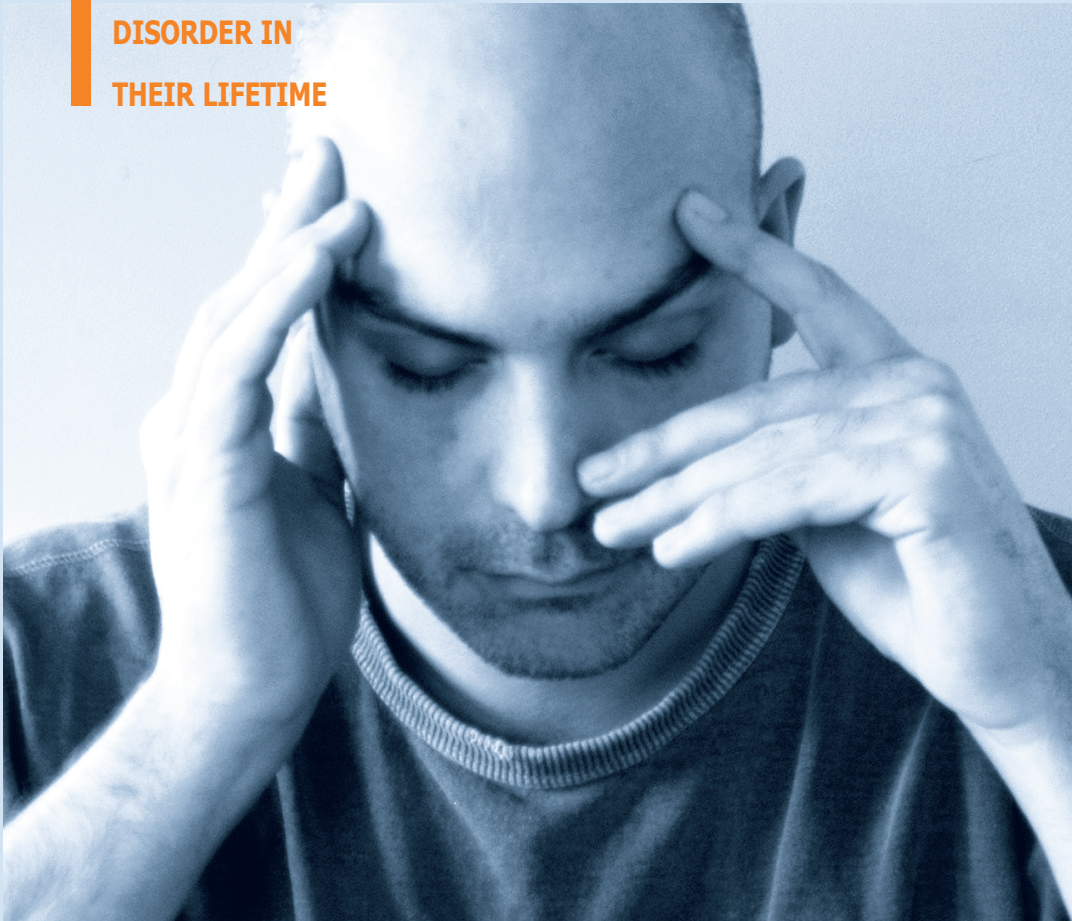
Some typical symptoms of depression are poor appetite and weight loss or marked increase in appetite and associated weight gain. Other symptoms include sleep disturbance, loss of energy, excessive fatigue or tiredness, slow speech and movements, change in activity level, loss of interest or pleasure in usual activities, decreased sex drive, diminished ability to think or concentrate, indecisiveness, withdrawal and isolation from family, decreased memory function and lack of concentration, disorganization, highly critical of self, low self-esteem, feelings of worthlessness or excessive guilt which may reach delusional proportions, recurrent thoughts of death or self harm contemplating or attempting suicide, and heightened or changed perceptions.



**DEPRESSION'S
MAIN SYMPTOM
IS THAT OF
INTENSE, PERVASIVE,
PERSISTENT FEELINGS
OF SADNESS,
HOPELESSNESS, AND
FRUSTRATION.**

Classifications of Bipolar Disorder

**MORE THAN
TEN PERCENT OF
THE POPULATION
WILL HAVE A MOOD
DISORDER IN
THEIR LIFETIME**



BIPOLAR I

Individuals diagnosed with Bipolar I have experienced at least one manic episode and almost always have experienced depression. They may have experienced psychotic symptoms (delusions, hallucinations) during either a manic or depressive episode.

BIPOLAR II

At their most severe, individuals diagnosed with Bipolar II experience moderate mania (hypomania), but they have not experienced psychotic symptoms (delusions and hallucinations) during either a manic or depressive episode.

RAPID CYCLING

Drs. Ronald Fieve and David Dunner first coined the term *rapid cycling* to refer to individuals who experience four or more episodes, in any combination of manic, hypomanic, mixed, or depressive episodes in a one year span. Approximately five to 15 percent of individuals with bipolar disorder will experience rapid cycling. It is thought that some antidepressants can contribute to rapid cycling. This form of bipolar disorder generally responds better to anticonvulsant drug therapy than to lithium therapy. Electro-convulsive therapy may be another treatment option for individuals with this form of the disorder.

MIXED STATES

There are a small percentage of patients who seem to be trapped in the transitional phase where mania switches to depression, and as a result, simultaneously display symptoms of both depression and mania. These individuals are said to be in a *mixed state*. Correct diagnosis is important to ensure proper treatment. Though this condition is statistically small, it is one of the most common problems seen at hospitals.

CYCLOTHYMIA

Cyclothymia is a milder form of Bipolar Disorder. Cycles of depression and hypomania are shorter, irregular, and less intense. Episodes typically last for days rather than weeks. Mood states can change rapidly so that an individual can experience a distinct change in mood from day to day.

DUAL DIAGNOSIS

Dual diagnosis is defined as having a severe mental illness associated with dependence on alcohol or other substances. There are two subgroups of patients: major substance abuse disorder coupled with another major psychiatric disorder; and abuse of alcohol and or other drugs in ways that affect the course of treatment of the mental disorder.

Surveys have shown that one third of dual diagnosis psychiatric patients will abuse or depend on alcohol, and that one third of individuals suffering from alcohol abuse will be additionally diagnosed with a psychiatric disorder. 50 percent of individuals who abuse drugs other than alcohol will be dually diagnosed.

For individuals who experience mania, the lifetime risk for developing alcoholism is greater than the general population, while major depression carries a risk. Individuals who are dually diagnosed may have a slower rate of recovery than individuals without major substance abuse. Currently, there are few comprehensive, integrated, recovery programs for these individuals, although research is continuing. A moderate lifestyle will help control the illness.



Unipolar Disorder or Major Depressive Disorder

**DEPRESSION
IS A SERIOUS MEDICAL
CONDITION THAT CAN
BE TREATED**

Unipolar Affective Disorder is an abnormal fluctuation in moods, alternating lows (depression) with periods of stability. Unlike bipolar disorder, individuals with unipolar disorder do not experience the high end of the continuum (mania). Although unipolar disorder usually occurs in adulthood, adolescents and seniors can also be affected but it is more difficult to recognize and diagnose in these groups.

The symptoms for unipolar disorder are the same as for bipolar disorder depression, with the following sub-types: melancholia, psychotic depression and dysthymic disorder.

PSYCHOTIC DEPRESSION

This is also a very severe class of depression with the same symptoms as melancholia, but also including psychotic symptoms such as hallucinations or delusions.

DYSTHYMIC DISORDER

This is a long-term mild depression that lasts for at least two years. It can be debilitating, spanning several decades, and having an adverse effect on personality.



Seasonal Affective Disorder

This disorder is marked by the seasonality of the symptoms that sets it apart from all the other mood disorders. Individuals with this disorder experience an assortment of symptoms at the same time of year.

The majority of people will suffer during the long winter months when the hours of darkness exceeds the hours of daylight. These people are said to have *Winter SAD*.

For the individual, the feelings – or symptoms – might be subtle, or intensely obvious. Symptoms may include months of depression, fatigue, weight gain

Treatment for this particular mood disorder can include antidepressants or light therapy. Light therapies can help alleviate SAD. Light therapy/phototherapy uses light that simulates the sun during long periods of darkness.

Excess use of light therapy can cause rapid cycling and manic states in some bipolar individuals.

Anxiety and Panic Disorders

Many people with mood disorders also suffer from anxiety. Although anxiety disorders can leave their victims virtually disabled, they are among the most common and treatable forms of mental disorders. You do not have an anxiety disorder if you experience brief anxiety over a specific stressful event like speaking in public. This is called *reactive anxiety*.

PHYSICAL (SOMATIC) SYMPTOMS OF PANIC DISORDER

- | | |
|-------------------------|--------------------------------|
| - Shakiness | -Dizziness |
| - Muscle aches | -Fatigue |
| - Sweating | -Racing heart |
| - Cold and clammy hands | -Dry mouth |
| - Apprehension | - Irritability |
| - Nervousness | - Feeling of a loss of control |

THERE ARE SEVERAL TYPES OF ANXIETY DISORDERS

PHOBIAS WITH PANIC ATTACKS

Phobias are experienced as a dread, or panic, that overwhelms the sufferer when they are faced with a feared object, situation or activity. Many common phobias are familiar such as a fear of snakes, enclosed spaces (claustrophobia), airplanes, and heights. Other phobias are not as well known such as agoraphobia: the fear of being in public like a shopping mall or a concert with no avenue of escape. Agoraphobia can be debilitating, completely isolating an individual in his/her own home.

PANIC DISORDER

Panic disorders are distinguished by an intense overwhelming terror with no apparent cause. The fear is often accompanied by physical symptoms such as a racing heart, sweating, hot or cold flashes, choking or smothering and feelings of unreality. If the symptoms are severe, the individual will often believe that they are about to have a heart attack, or even die. The attacks are short in duration, lasting about one hour. They can, however, be frequent.

POST TRAUMATIC STRESS DISORDER

This disorder can affect anyone who has survived a severe and extreme physical or emotional trauma. Rape victims, survivors of war, and crime victims may develop this disorder. Some individuals find themselves re-experiencing the traumatic event through nightmares, night terrors or flashbacks. Others become emotionally numb.

WHO SUFFERS?

Anxiety disorders are more common in women than men. Obsessive Compulsive Disorder, however seems to be equally common in both. Often the first symptoms are experienced during adolescence or early adulthood. The exceptions to this are phobias that generally begin in childhood and disappear as the child ages.

Treatment for anxiety disorders

These disorders can be treated successfully by a combination of drug therapy and behavioral treatments, including exposures to feared stimuli and cognitive intervention.

Depending on the disorder, medications from the benzodiazapine class of drugs, such as Rivotril and Ativan are usually the first line of defense.



How is Bipolar Affective Disorder treated?

Effective treatment for bipolar disorder is often a combination of several components that include:

MEDICATION THERAPY

Medication is key in the treatment of bipolar disorder. Approximately 75 to 80 percent of all cases can be effectively treated with drug therapy. In the remaining 20 percent, drug therapy can significantly reduce the impact of the disorder. Although some individuals with a milder form of the disorder may choose not to use maintenance drug therapy, most individuals do require medications to stabilize and maintain their wellness.

PSYCHOTHERAPY

Individuals with bipolar disorder often experience considerable impairment in social and occupational functioning. Other secondary problems associated with the disorder include unemployment, legal and financial difficulties plus marital problems. Psychotherapy can effectively help the individual overcome the consequences of the disorder.

CREATE A MOOD CHART

Bipolar disorder is a cyclic disorder, meaning episodes may be seasonal, or they may follow a pattern of some sort. By charting your moods over a period of time, you will gain insight into what may be times of concern. This will allow you to take a proactive approach to your treatment plan, e.g., you become depressed in the winter, so you may want to add an antidepressant in late fall. There are any number of items you can track in addition to your mood. You could make notes on when you have taken your pills, how much sleep you have been getting, and any outside factors that may be influencing your mood. The more information you have on your condition, the greater your chances of keeping the severe episodes to a minimum.

Types of Therapy

A SENSE OF
COMMUNITY AND
HOPE THROUGH
INFORMATION AND
EDUCATION AND
SUPPORT.



IFIT – INTEGRATED FAMILY AND INDIVIDUAL THERAPY

This is a relatively new method for treating bipolar disorder. IFIT involves helping the individual's family to understand the vulnerabilities that bipolar patients have, even to minor changes in their daily routines. Emphasis is placed on the patient keeping track of their regular daily routines. Family members are encouraged to assist the individual with maintaining their regular social rhythms. Families are taught to watch for pending episodes, and learn when and how to intervene.

LIFE-STYLE MODIFICATIONS

Many individuals find that they have to make changes to their life-styles that include making healthy choices for living. These include a healthy diet, regular exercise, adequate sleep, and abstaining from drugs and/or alcohol.

EDUCATION

Education is crucial for both the affected individuals and their families. It is important to be proactive and to make informed, educated decisions regarding your mental health. Education also helps to expedite the natural process of grieving within the family unit.

SELF-HELP

Joining a peer support or self-help group is often a necessary component of an effective treatment program. In Canada, contact any mood disorders group in your area. In the United States, contact NAMI or the Depression Bipolar Support Alliance (DBSA).

Psychological Treatment

PSYCHOTHERAPY

Individuals with Bipolar Disorder often experience considerable impairment in social and occupational functioning. Other secondary problems associated with the disorder include unemployment, legal and financial difficulties plus marital problems.

Psychotherapy can effectively help the individual overcome the consequences of the disorder.

While mood disorders have their origins in biochemical systems of the brain, there is often psychological conditions and fallout that accompany the primary illness. These auxiliary psychological problems are commonly dealt through a number of different treatment modalities.

Often depression can be helped by therapists who are sympathetic and supportive. This type of therapy developed by psychologist Carl Rogers is a philosophy embedded in many forms of therapy. Others include Cognitive Behavioral Therapy, Interpersonal, Social Rhythm, and Family Focused Therapy.

COGNITIVE BEHAVIORAL THERAPY

Cognitive Behavioral Therapy (CBT) assists individuals in challenging and modifying negative thought patterns. These negative thoughts often lead to inappropriate behaviors that impact negatively on people's lives. CBT Talk Therapy sets in motion a corrected set of ideas that are more rational and realistic; creating a more positive outlook on life. It also helps deal with the issues surrounding a mood disorder.

INTERPERSONAL THERAPY

Relationships may be difficult to maintain and nurture while one has a mood disorder. Through therapies such as Interpersonal and Social Rhythm Therapy, relationships can be maintained and developed. Interpersonal Therapy concentrates on personal relationships that the consumer has with others. Through therapy the therapist works with the individual to find a way of nurturing their relationships with an emphasis on maintaining close personal relationships. Having good relationships regulates the consumer's life and lessens interpersonal stress.



SOCIAL RHYTHM THERAPY

Social Rhythm Therapy focuses on daily routines including sleeping, eating and working. Regular sleep patterns are said to be one of the most important components in maintaining mental health in those with a mood disorder; alongside eating well and compliance to medication. Research has shown that people with Bipolar Disorder are more prone to episodes when their daily schedules are disrupted.

Researchers have also concluded that drug therapy combined with interpersonal and social rhythm therapy helped to prevent further manic and depressive symptoms.

FAMILY FOCUSED THERAPY

Family focused therapy is an integral part of a family dealing with a loved one with a mood disorder. Often the illness affects the entire family: from its daily routine to the core of family beliefs about mental illness. The family therapist helps educate the members about Bipolar Disorder and depression. The role of therapist for the family is often that of a facilitator to help communication between family members and sets about providing skill sets so families can solve problems unique to their situation. Ultimately, therapy should help alleviate stress among family members and restore a sense of normalcy through support and education.

Research has shown that with proper drug therapy and psychological therapy will help to prevent episodes and/or symptoms. Psychological therapy is not a sign of weakness but rather a sign of strength in being proactive while dealing with a serious mood disorder.

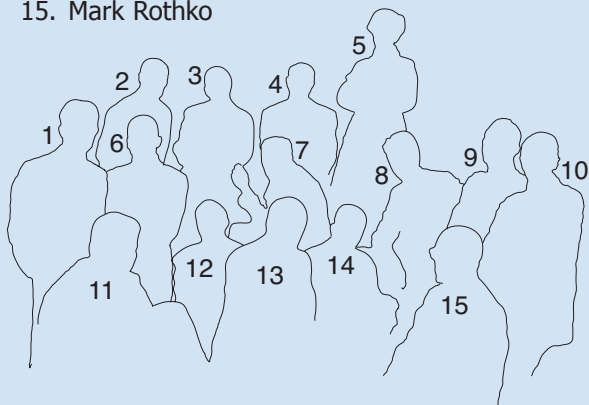
What's right with this picture?

The vanguard of American art post WWII let New York overpower Paris - and greatly influenced the rest of Europe.

The Abstract Expressionist movement painters gathered for a Life magazine group photo in 1951. Not surprisingly, eight of 15 of the Abstract Expressionists had Bipolar Disorder.

Bipolar people tend to be in the forefront of change in many disciplines: "Blessed are the cracked for they let the light shine through."

1. Richard Pousette-Dart
2. Willem De Kooning
3. Adolphe Gottlieb
4. Ad Reinhardt
5. Hedda Sterne
6. Willem Baziotes
7. Jackson Pollock
8. Clyfford Still
9. Robert Motherwell
10. Bradley Walker Tomlin
11. Theodore Stamos
12. Jimmy Ernst
13. Barnett Newman
14. James Brookes
15. Mark Rothko





Medication Therapy

MOOD STABILIZERS

Mood stabilizers, like Lithium, and certain antiepileptics, such as Tegretol, Epival, Neurontin and Lamictal, can be used to treat Bipolar Disorder by altering the elements in the cell, which stabilizes nerve impulse transmission and chemical release. Neuronal excitability is diminished by these medications by decreasing impulse transmission and returning body movements to a more organized smooth state, relaxation, or sleep. These medications decrease the spread of the neuronal activity, reorganizing impulse formation, chemical release or response, synaptic response, or receiver cell response, so that messages are acted upon appropriately.

LITHIUM *Lithium* was the first of the mood stabilizing drugs. Lithium is a naturally occurring salt that was discovered in 1817 by a Swedish chemistry student. *Lithium* was found in mineral rocks, natural brines and mineral waters, and in some plant, animal and human tissues. In the mineral waters of European and American spas in the 19th and 20th centuries, *lithium* was found to be an agent that promoted physical and mental health. In the late 1940's *Lithium Chloride* was used as a popular salt substitute for people on salt-free diets. In 1949, John E. Cade, an Australian psychiatrist, first discovered the mood stabilizing effects of lithium. In 1957, Mogens Shou furthered Cade's discovery, and campaigned for the use of lithium as a mood stabilizer, which led to the acceptance of *lithium* as a safe treatment for bipolar disorder.

Why *lithium* works remains unclear. Studies show that 70 to 80 percent of patients with mania respond to *lithium*, and do so in a relatively short time frame (10 to 21 days). The addition of an antipsychotic or secondary agent is often necessary to curtail a florid manic episode. Although beneficial, *lithium* can be potentially toxic and harmful. If blood levels are taken regularly and there is close supervision, toxicity is far less likely to occur.

EARLY SIGNS OF TOXICITY INCLUDE:

- increased trembling
- weakness
- blurred vision
- vomiting
- slurred speech
- poor coordination

COMMON SIDE EFFECTS OF LITHIUM INCLUDE:

- drowsiness
- tiredness
- increased thirst
- stomach upset
- headache
- sleep disturbances

These should subside as your body adjusts to the medication.

If these symptoms persist or become bothersome, inform your doctor.

Notify your doctor if any of these symptoms become severe.

Consult your pharmacist for any drug interactions, including over-the-counter drugs.

ANTICONVULSANTS

CARBAMAZEPINE

LAMOTRIGINE

DIVALPROEX

NEURONTIN

Another classification of drugs that have been found to be helpful in the treatment of mood disorders is anticonvulsants (*Carbamazepine, Lamotrigine, Divalproex, and Neurontin*).

These were first used to control seizure disorders. Anticonvulsants are effective in treating refractory (difficult to treat) Bipolar Disorder, rapid cycling and mixed states. Anticonvulsants can be used in conjunction with lithium therapy to augment treatment. Although they primarily reduce the symptoms of mania, they also decrease the effects of depression.

Discontinuation of an anticonvulsant involves careful and gradual reduction over several weeks or more. Abruptly discontinuing this medication may precipitate a seizure. Regular blood tests are required to monitor the levels of the medication to ensure that a therapeutic level is maintained and to monitor potential toxicity.

Rarely, *Epival* can interfere with blood clotting. Watch for unusual bruising and bleeding, and report it to your physician promptly. (*Epival* also has the very rare adverse effect of liver damage, especially if taken with other anticonvulsants, and bleeding).

Most of the common side effects of anticonvulsants should subside as your body adjusts to the medication. Notify your doctor if seizures occur or if you develop vomiting, weakness, depression, skin rash, or yellowing of the eyes or skin while taking this medication. Anyone using an oral contraceptive birth control should be cautious when taking an anticonvulsant drug. The combination of these two drugs can decrease the effectiveness in preventing unwanted pregnancies. Anticonvulsant drugs should not be used during pregnancy unless clearly needed. Discuss the risks and benefits with your doctor. Small amounts of these drugs appear in breast milk. Consult with your doctor before breast-feeding. Inform your doctor if you have any diseases of the liver, kidney, brain or blood prior to using an anticonvulsant. Be sure to mention if you are taking nonprescription or prescription medication that may cause drowsiness such as tranquilizers, sleeping pills, antihistamines, pain medication (narcotic containing) or cough-and-cold products. Use of alcohol or other sedative type medications can lead to extreme drowsiness.

CARBAMAZEPINE

ALTHOUGH VERY RARE, TEGRETOL (*CARBAMAZEPINE*) HAS POTENTIALLY SERIOUS SIDE EFFECTS THAT INCLUDE:

- hepatitis
- cardiovascular complications
- potential hematological disorders
- massive hepatic cellular necrosis with total loss of intact liver tissue
- vomiting
- blurred vision
- slurred speech

DIVALPROEX

COMMON SIDE EFFECTS INCLUDE:

- dizziness
- drowsiness
- loss of motor coordination
- nausea
- stomach upset
- headache
- sleep disturbances

COMMON SIDE EFFECTS OF EPIVAL INCLUDE:

- drowsiness
- dizziness or vision changes
- weight gain or loss

LAMOTRIGINE

SIDE EFFECTS OF LAMOTRIGINE:

As a new anticonvulsant/antiepileptic, psychiatrists began titrating (raising the dose) of Lamotrigine too fast, which made some patients vulnerable to Stevens-Johnson syndrome, a rare yet potentially fatal skin rash. One in 1000 patients contract Stevens-Johnson, but the results are seldom fatal if the drug is promptly discontinued.

Lamictal has taken its place as a valuable pharmaceutical tool that is now slowly titrated with far fewer incidence of Stevens-Johnson. If you do experience rashes, particularly around mucous-producing areas of your body, contact your doctor immediately.

ANTIDEPRESSANTS

Mood stabilizers are more effective in the treatment of the mania symptoms rather than of depression. Antidepressants may be prescribed to augment mood stabilizers for symptoms of depression.

THE MAIN CLASSIFICATIONS OF ANTIDEPRESSANTS:

- Noradrenergic and Specific Serotonergic Antidepressants
Remeron, Pristiq
- Selective Serotonin Noradrenergic Reuptake Inhibitors *SSNR'S*
Effexor, Wellbutrin, Cymbalta
- Selective Serotonin Reuptake Inhibitors *SSRI'S*
Prozac, Paxil, Zoloft, Celexa, Luvox
- Tricyclics *Elavil, Norpramin, Tofranil, Pamelor, etc.*
- Monoamine Oxidase Inhibitors *MAOI'S Parnate, Nadril*

For many years, doctors prescribed Tricyclics as the treatment of choice despite their many side effects such as dry mouth, lethargy, blurred vision, and constipation. Tricyclics work by redirecting excitatory chemicals for use in the synapse to stimulate or excite other neurons. For those individuals who did not respond favorably to tricyclic drug therapy, doctors turned to the MAOI's. MAOI's work by blocking enzymes that break down chemicals, allowing further activity or excitement to occur in the synapse. Dr. Nathane Kline first discovered the antidepressant properties of MAOI's, when he noticed an increase in mental alertness, and a mild sense of elation, in patients he was treating for tuberculosis. Regardless of their effectiveness in the treatment of depression, MAOI's require some caution because of possible and sometimes serious adverse effects on blood pressure.

Certain foods can increase this risk, so there are many dietary restrictions. These restraints may decrease the desirability of this classification of drug.

If you are prescribed a MAOI, you will be given a list of foods, beverages and other medications to avoid. A secondary generation of antidepressants, called SSRI's, were developed to help those who did not respond well to Tricyclics. SSRI's increase the level of serotonin in the brain. *Prozac, Paxil, Celexa, Luvox, and Zoloft* are now considered standard therapy due to their high level of tolerability and safety. SSRI's are also used in the treatment of panic, obsessive-compulsive, and eating disorders. Antidepressants are often prescribed for six months to a year, to guard against a relapse. Discontinuation involves careful and gradual reduction. Abruptly stopping medication can lead to withdrawal symptoms such as intense restlessness, anxiety and gastro-intestinal distress. For individuals with bipolar disorder, the use of antidepressants can precipitate a manic episode if there is no mood stabilizer present and supervision by a physician.

**PROZAC, PAXIL, CELEXA,
LUVOX, ZOLOFT**

COMMON SIDE EFFECTS OF ANTIDEPRESSANTS INCLUDE:

- drowsiness
- weakness and fatigue
- blurred vision
- difficulty urinating
- constipation

ANTIPSYCHOTICS

Recently, *atypical* antipsychotics such as, *Seroquel*, and *Zyprexa* have been prescribed as supplements to mood stabilizers: to control hallucinations and delusions in severe mania or psychotic depression. Antipsychotic medications work by blocking the flow of the neurotransmitter dopamine (and some by blocking dopamine and serotonin). By changing the flow of these neurotransmitters, medications can reverse some of the symptoms of the disorder.

Antipsychotics can have severe side effects, especially in higher doses or after long term use. Side effects include influences on the nervous system, which in turn results in tremors, rigidity, or restlessness.

Other common side effects include dry mouth, weight gain, drowsiness, blurred or double vision, and sensitivity to light.

If any severe side effects do occur, contact your doctor. It is important not to stop taking your medication without your doctor's knowledge.

ATYPICAL ANTIPSYCHOTICS For Bipolar Disorder

Antipsychotic medications have been a treatment for Bipolar Disorder since the 1960's. A study published on the use of Clozapine for non-responsive bipolar patients (1) paved the way for investigations into the usefulness of atypical antipsychotic medications, or second-generation anti-psychotics (SGA's) for bipolar patients. The patient benefit was so substantial, the authors suggested bipolar patients seemed to benefit more than people with schizophrenia. Single treatment options (monotherapy) are rarely successful for treating bipolar disorder, including: mania; bipolar depression; prevention of mania and bipolar depression. Thus, SGA's are often co-prescribed.

Medication research is either focused on effective treatments, or equally important, reducing side effects. The potential benefits of a medication are usually greater than the potential for side effects. For most psychiatric medications, the intended benefits frequently take days to weeks to occur; yet side effects arrive earlier, and often diminish with time. The SGA's can be used ideally short term or long term (months to years). The short-term use would be to treat an episode of mania, mixed state or depressive phase; and the long-term use to prevent those phases.

The addition of SGA's to mood stabilizers (*Lithium*, *Carbamazepine*, *Valproate* or *Lamotrigine*) augments their effect when mono-therapy is ineffective (2). All SGA's are established first line treatments for mania. Two SGA's (*Quetiapine* or *Seroquel XR* and *Aripiprazole*) have been proven to be effective against the depressive phase, with or without psychosis (3,4). Some bipolar patient's require SGA's for maintenance, or taken on a long-term basis to prevent depression and mania. The American Psychiatric Association's Bipolar Guidelines (5), and the Canadian Mood and Anxiety Trial Network (CANMAT) Bipolar guidelines (6) support these recommendations.

Atypical antipsychotic medications, as opposed to older antipsychotic medications, reduce neurological side effects and cognitive dulling. This is their principal advantage over typical antipsychotic medications. Examples of older anti-psychotics include *Haldol*, *Chlorpromazine*, *Loxapine* etc. Advantages over the older antipsychotic medications also include: improved sleep; better cognition (improved memory, concentration, judgment, and reduced impulsivity); and evidence for mood stability. The neurological side effects mostly eliminated by SGA's include: Tardive Dyskinesia (abnormal involuntary movements such as tongue writhing, increased mouth and rarely limb movements, potentially permanent); and acute neurological side effects including: dystonia (tight muscles in jaw or face); tremors, and akathisia. The side effects of dry mouth, hypotension (low blood pressure) blurred vision, constipation, and sedation occur with typical antipsychotic medications and SGA's in varying amounts.

These neurological side effects initially compelled psychiatrists to prefer benzodiazepines (Diazepam, Clonazepam, Lorazepam, etc.) for mania and hypomania management. Although used mostly on inpatient units for mania, they continue to be safe and effective interventions.

The primary concern or side effect from SGA's is the potential for inducing the metabolic syndrome (weight gain, diabetes, elevated lipids of cholesterol and triglycerides). *Clozapine* and *Olanzapine* share the greatest risk of these side effects, with *Quetiapine* and *Risperidone* being less risky. With the introduction of *Ziprasidone* and *Aripiprazole*, the risk of metabolic side effects is reduced even more.

Olanzapine emerged as the first atypical antipsychotic medication approved for treating bipolar disorder. To achieve this approval, a medication must go through rigorous studies proving its effectiveness and safety. All other SGA's have undergone studies for approval for treatment of mood disorders.

Quetiapine or *Seroquel XR* is the most frequently prescribed SGA for bipolar disorder in Canada. It is sedating and thus very helpful for patients who are very agitated and/or experiencing insomnia.

Insomnia is the symptom I see as the most important signal of illness for all mood disorders, and any treatment that addresses it, is an important treatment. Every expert in bipolar disorder recognizes depression as the most important part of the syndrome to address, and *Seroquel XR* has the most evidence as a single SGA medication to treat it, a considerable advantage over all other SGA's. *Seroquel XR* also has the least potential to produce neurological side effects compared to *Olanzapine* or *Risperidone*. *

ANTIANSIETY AGENTS

Antianxiety agents such benzodiazepines (*Rivotril*, etc.) have been used as an adjunct to mood stabilizers to create calming effects or sedation. They decrease the transmission of the nerve signals by blocking the chemicals, especially dopamine, at targeted receptor sites. They offer relatively quick relief from often very disturbing and agonizing symptoms, while the individual waits for the other medications to take effect and control other manic or depressive symptoms.

As antianxiety agents are habit-forming and have potentially serious side effects, both patient and doctor must carefully weigh the benefits and risks of using these drugs.

* **Dr. Chris Gorman**, *The Optimal Performance Doctor*

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Treatment Resistance



WITH CONTINUAL
MONITORING AND
ACTIVE INVOLVE-
MENT ON THE
PATIENT'S PART,
TREATMENT
RESISTANCE CAN
BE OVERCOME.

WHEN DRUG THERAPY FAILS

Most individuals will experience improved quality of life after they begin drug therapy. However, just as the disorder is experienced differently, the treatment is highly individual. No single treatment will be effective for all people at all times. Some individuals require additional or different medications. It is estimated that 20 percent of treated individuals will not respond to the first treatment tried. Managing the disorder is a life-long process and requires continuous monitoring. For any treatment to work, you must be actively involved.

WHAT IS TREATMENT RESISTANCE?

Treatment resistance is a lack of satisfactory response after a period of time, often after several different options have been tried. There are many reasons why some treatments fail, or appear to fail.

SIDE EFFECTS

Most medications used to treat mood disorders have side effects. Reaction and tolerance to side effects differs from one individual to another. Some side effects will diminish after several weeks of treatment. Some side effects may become intolerable, making the treatment worse than the condition. Sometimes a reduction in the dosage can improve the unwanted side effects. The decision to alter medication must be made in partnership with your mental health professional.

INSUFFICIENT DOSAGE

Due to the physiological differences among individuals, dosages required to reach therapeutic levels in one person may be different in another. Inadequate levels of the drug may contribute to a feeling that the medication is not working. Increasing the dosage with your doctor's approval might rectify this.

INADEQUATE TIME

During the initial stages of treatment, the treatment may appear to fail. The reality may be that the body has not attained *therapeutic levels* of the medication. Medications can sometimes take at least a month of continued use to reach appropriate levels in the body.

NONCOMPLIANCE

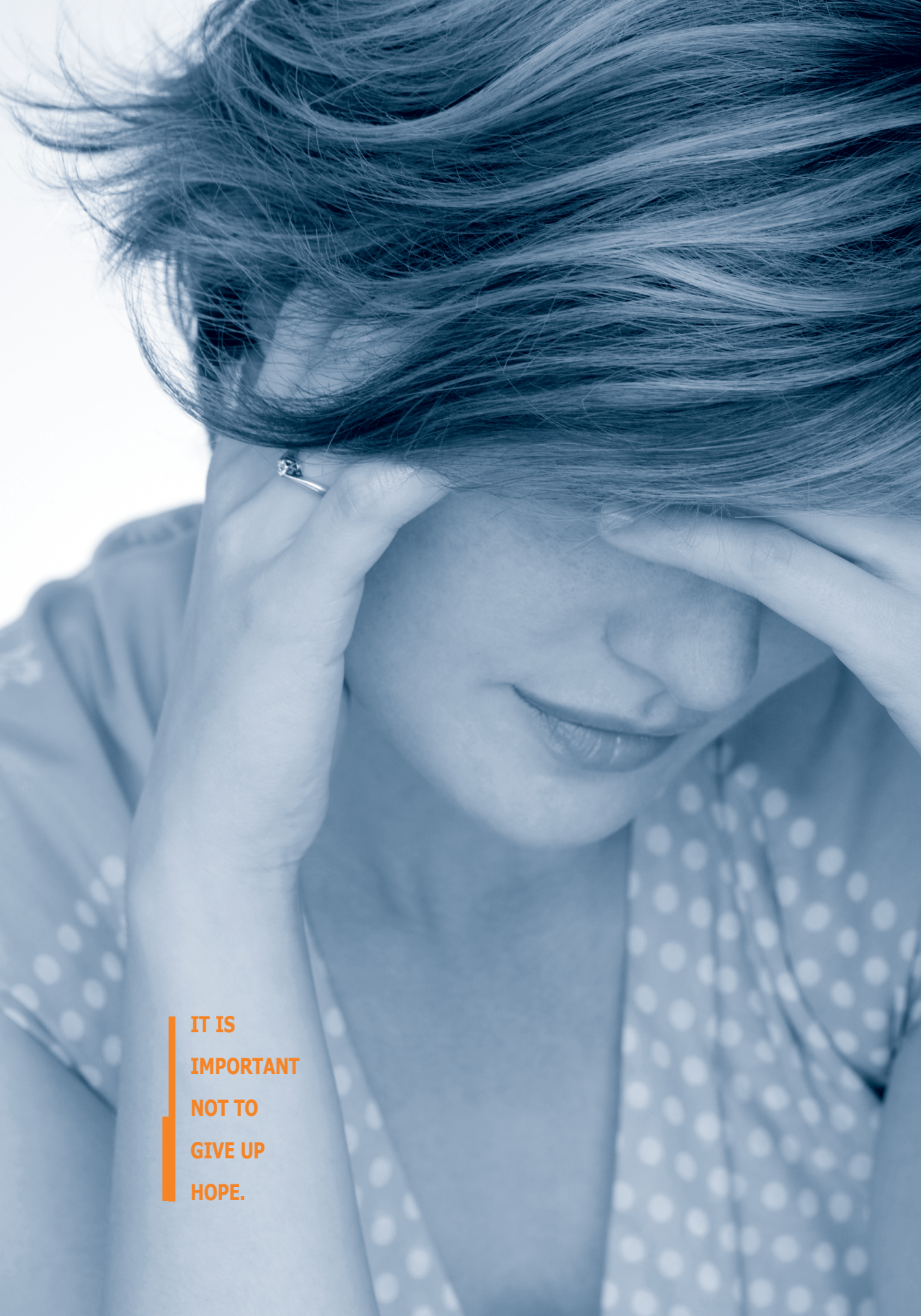
The most common reason for treatment failure - is when individuals do not follow the regimen established by their doctor. Medication noncompliance can be a consequence of the disorder, since confusion, distractibility and memory impairment are common in Bipolar Disorder. Sometimes, if there is a breakthrough manic episode, the individual will feel a false sense of security, believing he/she is cured. This is not the case. If a breakthrough depression occurs, hopelessness may be experienced, leaving the individual feeling, 'what does it matter'. Their thinking may be impaired. They need to be encouraged to continue with their medication and to contact their doctor. Some people find that using a dosette (a pill scheduler) helps them to remember to take their medication.

ADVERSE DRUG INTERACTIONS

Individuals who are taking medications for other conditions may experience an adverse drug interaction when mixed with a psychiatric drug. This can lead to an intolerable side effect of the combined drugs, or a decrease in the amount of mood stabilizing drugs in the bloodstream, preventing them from reaching therapeutic levels. Always inform a doctor or dentist of your current medications.

NON-RESPONSE

A small number of individuals may not respond to a particular medication. It is important not to give up hope. There are a multitude of alternative treatment strategies. If one doesn't work for you, try another.



IT IS
IMPORTANT
NOT TO
GIVE UP
HOPE.



Electro Convulsive Therapy

Electro convulsive therapy (ECT) is a treatment option for individuals who are not responding adequately to drug therapy in the treatment of Bipolar Disorder and other psychiatric disorders. ECT is the brief application of electric stimulus to the brain that results in a seizure.

Current studies have shown that ECT and lithium are equally effective for acute mania. It also appears that if ECT is used for an acute episode of mania, followed by lithium maintenance, there is a decreased risk of relapse, as opposed to treatment with lithium treatment alone.

In studies of ECT as a treatment for depression, ECT clearly immediately reduced the symptoms of depression for the short term, where antidepressant therapy failed. However, relapse rates in the year following ECT are likely to be high, unless maintenance antidepressants are used. ECT has also been shown to be a highly effective treatment for delusional depression. Its effectiveness is superior to antidepressant or antipsychotics administered alone. It is as effective as taking a combination of an antidepressant and an antipsychotic.

ECT should be administered to individuals where it is clearly indicated. Risks and benefits must be weighed carefully against the risks of other treatment options. Doctors with experience with ECT will consult with patients in the most severe cases and will discuss the outcomes of this procedure. The procedure is generally performed in the recovery room of a hospital or in a specialized room. An intravenous tube is inserted to provide any medication that may be required during the procedure. Your vital signs are taken initially and throughout the procedure. You are given a general anesthetic. Electrodes are then applied to your head with conducting jelly and a brief shock is administered.

ECT should be administered to individuals where it is clearly indicated. Risks and benefits must be weighed carefully against the risks of other treatment options. Over the years, safer methods of administration have been developed, including short-acting anesthetics, use of muscle relaxants, and adequate oxygenation.

Lifestyle Considerations

Many people will continue to lead successful and fulfilling lives after treatment. Revolutionary medications used to treat this disorder, combined with community supports, have decreased the effects of the disorder.

Some individuals may experience grief and loss over their perceived selves prior to treatment. Most individuals experience feelings of denial: 'I am fine, I don't need medication' or 'I felt better prior to treatment', 'I cannot tolerate the side effects of medication'. These are all part of the natural process that leads to acceptance.

Being diagnosed with Bipolar Disorder is like having any other serious medical condition. It means being more careful in how you live your life. A healthy diet, regular exercise, proper sleep, prescribed medications, limited alcohol and drug use, and a reduction of stress, are not just words, but words to live by.

MEDICATION COMPLIANCE

One of the ironies of the medications taken to improve our functioning is that the side effects sometimes make us feel physically worse than the illness itself. What you need to know is there are many different types of medications available. You don't have to live with a side effect that makes your quality of life unacceptable. If you are experiencing this type of reaction, talk to your doctor. They will be able to change medications or reduce the dosage to make the side effects more manageable. Too many people stop taking medications for this reason.

LIMIT ALCOHOL AND DRUG USE

Research has shown that continued abuse of alcohol and/or a dependence on street drugs even marijuana could alter the course of the illness. If you need help in dealing with this problem, there are agencies and groups available.

THERE ARE
MANY DIFFERENT
TYPES OF
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YOU DON'T
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WITH SIDE
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FITNESS

Regular exercise should be a part of your daily living. Exercise increases your metabolism by increasing oxygen intake. The resultant increase in endorphins enhances one's feeling of well being. Moderate exercise such as walking, cycling, or swimming will help you maintain mental health. Try to include 45 minutes per day of activity. Fresh air, sunshine, and social interactions are added benefits.

NUTRITION

A balanced intake of food includes protein at each meal, ten fruits or vegetables per day, and two carbohydrates. Try to eliminate junk food. Keeping your weight down can be a challenge since many of the bipolar medications cause weight gain. Water intake is especially important as an adequate supply can combat fatigue. Aim for six to eight glasses a day.

MONITOR SLEEP

Normal sleep occurs with fatigue and reduced stimulation. If excessive electrical impulses are triggered, disorganization, increased chemical release, and altered brain functioning occurs-resulting in sleeplessness (insomnia). In Bipolar Disorder, loss of sleep can precipitate or exacerbate an episode of hypomania, or more severe mania.

Some researchers believe that losing a single night of sleep, for any reason, may be enough to trigger mania. The likelihood of a manic episode could be reduced by following very regular daily routines and involving family members. It is critical to monitor your sleep and ensure that you are receiving adequate sleep every night. For most individuals this means approximately six to eight hours. Recent findings cite nine to ten hours sleep as optimal. Similarly, if you are sleeping too much, this could be contributing to an episode of depression.

10 STEPS FOR A BETTER SLEEP

1. Schedule a relaxing period before going to sleep to separate your body and mind from the day's hassles.
2. Use your bedroom primarily for sex and sleep; not as an all-purpose activity arena.
3. Your bed should be comfortable, large enough, in a quiet, dark room and at the right temperature.
4. Keep a regular schedule, going to bed and getting up at the same time each day. Don't go to bed until you feel sleepy.
5. Be consistent about taking naps. Take one regularly or not at all.
6. Exercise regularly in the morning or early afternoon, but do not engage in a strenuous activity late in the evening. A relaxing, mild physical activity might be helpful close to bedtime.
7. Assess your caffeine intake, and avoid caffeine after 2 p.m. Smoking close to bedtime or at night causes further sleep disruption.
8. Don't use alcohol or street drugs as sedatives. While they might help you initially fall asleep, they lead to sleep disruption and deprive you of deep sleep, at times for years after stopping heavy use.
9. If you feel hungry in the evening, have a light snack or a glass of milk. Heavy meals close to bedtime can result in discomfort and further sleep disturbance.
10. Above all, don't try too hard. If you can't fall asleep, don't lie in bed anxious and frustrated. Leave your bedroom to read, watch television, or do something else to relax. Go back to bed only when you feel sleepy again.

Coping Strategies

BUILD A THERAPEUTIC PARTNERSHIP WITH YOUR DOCTOR

Historically speaking, it hasn't been long since bipolar patients were literally bound and chained in what were no more than prisons for the mentally ill.

Pioneering humane physicians such as France's Dr. Pinel stepped forward to end the brutality. Meanwhile London's notorious Bedlam asylum charged the public admission to view the barbaric conditions mental patients were subjected to.

Only the last century saw actual patient-physician relationships develop. Unfortunately, these arrangements were almost always one-sided with the psychiatrist dominating therapeutic relationships. An unhealthy scenario saw doctors stepping into the unwelcome role of all-knowing parent to the ever-compliant patient.

PARTNER WITH YOUR DOCTORS

The keynote of the recent World Bipolar Conference in Pittsburgh heralded the emergence of a *collaborative empiricism* between Bipolar patients and their clinical caregivers – a partnership in treatment.

The tenets of collaborative empiricism ensure a closer working relationship between bipolar sufferers and their physicians. The patient and the doctor are in fact partners in treatment. Moreover, bipolar patients are more likely to influence their particular pharmacological regimen.

The progress that individuals make in therapy is contingent upon a positive therapeutic relationship. This may be even more important than the type of therapy used.

You can't do this alone, but you are the only one that can help yourself. Sounds contradictory, but it's true. Unless you take the steps to inform yourself about your condition, you will be forever subject to its whims. And one of the very best ways to inform yourself is through peers that have been there, done that.

This is the basis for Alcoholics Anonymous (AA) and other successful peer support programs. Once you talk with others who have had all the questions and fears that you have, you begin to advocate for yourself. Your rights as a person do not change with a diagnosis, but the methods to ensure them often do.

PERSISTENCE

The patient is willing to make a commitment to work at getting better.

UNCONDITIONAL POSITIVE REGARD

A doctor does not treat the patient in a judgmental way.

INSIGHT

The patient is able to understand how his/her disorder, attitudes and behaviors affect his/her life.

RAPPORT

The patient and doctor seem to *click* with one another.

SYMPATHY

A sympathetic doctor tries to understand the situations and feelings through the patient's eyes.

HONESTY

The patient is able to discuss his/her symptoms and/or situation.

GENUINENESS

The doctor has an honest and interested approach towards the patient.

MOTIVATION

The patient has a desire to feel better and improve his/her situation.

TRUST

The patient views that therapeutic relationship as helpful and the doctor finds the patient interested in changing.

CONFIDENTIALITY

A doctor keeps what is said in therapy between himself and the patient, except when the patient or others are in danger.

Personal Survival Tips

BUILD A STRONG SUPPORT SYSTEM

It is important to build a strong support system. This means surrounding yourself with individuals who have your best interests at heart; individuals you trust and respect. For your support system to work, you must be willing to hear and accept their support and judgments regarding your mental health. At times you might not be well enough to distinguish whether you are in the midst of an episode.

ADD STRUCTURE TO YOUR LIFE.

TIME MANAGEMENT

Due to the nature of this condition it is very important to add structure to your life. This includes regular sleep and wake times, scheduled meal times, exercise and social activities. Try to avoid 'overbooking' your life. When individuals are manic they often underestimate the time it takes to complete a task or project and the pressure to perform increases. When depressed, individuals often lack the energy or ability to maintain a regular schedule. This is a vicious circle; the less you accomplish, the worse you may feel. Try to focus your energies. Remember, if you get sick, you accomplish nothing.

PREPARE A BUDGET LEARN TO LIVE WITHIN YOUR MEANS

FINANCIAL MANAGEMENT

If you are on a fixed or limited income, you may want to take advantage of budgeting and financial management services offered by various community agencies. They can help you live within your means, and reduce the trauma and stress of unpaid bills.

MAKE FINANCIAL DECISIONS BEFORE EPISODES OCCUR

If you have a history of excessive spending during episodes, you may want to explore the possibility of someone else managing your finances. You may also wish to put limits on your spending by decreasing your credit card and bank withdrawal limits. Recovering from an episode of mania is difficult enough without the added stress of financial loss.

EMPLOYMENT ISSUES

One of the most common questions asked during our meetings is, “Should I tell my new or existing employer about my condition?”

To be honest, there is no easy answer for this question. In numerous discussions over this issue, we have had many different real life examples. Sometimes people are fired or set up for failure. Other times employers are understanding and try to assist you as best they can.

EMPLOYMENT RAISES SELF-ESTEEM

This is a very tough choice for an employer to make, especially a small business owner, where they rely on everybody to get the job done. If your condition will require you to miss a significant amount of time, they don't always have the luxury of an available replacement.

The best advice we can offer is to try and find a job that allows for some flexibility to accommodate your condition.

The next most frequently asked question is, “Should I tell my co-workers about my condition?” We at OBAD are trying to remove some of the stigma surrounding mental illness but they are still very much alive. If you choose to tell a co-worker, you will open yourself up to a wide variety of not-so-pleasant gossip. Because we are only human, we want to share our troubles with others, but, with our condition, we are vulnerable to society's preconceived notions. Work can increase our self-esteem and make us a part of the community in which we live. Know your limitations. Find a career that is able to accommodate your unique *gifts*.



Coping Methods for the Family

THINGS TO CONSIDER:

No one is to blame and you cannot cure a mental disorder in a family member.

Despite medication compliance, episodes may occur. It may take some time to find the right medications and dosages. Additionally, the symptoms of the disorder may change over time, requiring medication adjustments.

Despite your efforts, the symptoms may get worse.

Separate the person from the disorder. Love the person, hate the disorder; separate the medication side effects from the disorder/person.

It is not okay for you to neglect your needs. Take care of yourself, ensuring you have a rich and fulfilling life. Do not shoulder the whole responsibility for your family member. You may have to assess your emotional commitment. There is nothing to be ashamed of if someone in your family has a neurological chemical brain disorder.

EMOTIONAL HELP THROUGH THE FAMILY

It is natural to experience many strong emotions such as denial, grief, guilt, fear, anger, sadness, hurt, and confusion. Healing occurs with acceptance and understanding. Allow your affected family member, and other family members, to go through their grieving processes at their own pace. This is also true for you.

You may have to re-evaluate your expectations. Your family member's successes may be experienced differently from others, but, recognizing that a person has limited capabilities should not mean that you should expect nothing of them. It is important to set boundaries and clear limits.

Do not be afraid to ask if your family member is contemplating suicide. Remember that suicide attempts are a cry for help. Often the individual is trying to escape from the consequences of the

disorder and they feel hopeless. Their thinking and judgment at this time may be impaired: they may not understand that they are seeing the world through the symptoms of their disorder. Do not put up a barrier to open communication.

Remember that irritability and unusual behavior can be a symptom of the disorder: do not take it personally.

Allow your family member the dignity to make his or her own choices: do not patronize, but encourage.

**LEARN HOW TO
PREDICT THE CHANGES
IN YOUR MOODS**

RECOGNIZE PENDING EPISODES

To minimize the effects of mania and depression, and the consequences, it is important to identify pending episodes. Early recognition can prevent severe impairment in social and occupational functioning. Potential harm to relationships and the family unit can be minimized. Recognizing and treating episodes in their early stages can allow individuals to lead a healthy, productive life.

Even though your family member may be medicated, prescription drugs may not eliminate all episodes of mania or depression. You can help your family member by recognizing marked changes in their behavior.

Factors that could exacerbate a pending episode may be related to the environment, stress, or an unhealthy lifestyle.

An increase or change in usage of mood-altering substances, through the use of stimulants and depressants such as caffeine, smoking, alcohol, prescription drug abuse, and illegal narcotics, may also indicate a problem exists.

Please do not judge your family member: it is common to abuse these substances in an attempt to decrease the effects of the disorder. However the use of these substances will defeat the purpose of the prescribed medications, decreasing their effectiveness, and potentially creating an unwanted mood swing.

What to do in a Crisis

LISTEN

Let the person unload despair and ventilate anger. If given the opportunity to do this, he/she will feel better. This is a cry for help.

BE SYMPATHETIC

A non-judgmental, patient, calm acceptance of the situation will get you faster results. Do not hesitate to ask if they are feeling suicidal. You are not putting ideas in their head. You are doing a good thing for them. You are showing them you are concerned, that you take them seriously, and that it is okay for them to share their pain with you. Do not trivialize their problems. Simply talking about how they are feeling will give them relief from loneliness and pent-up feelings. It will confirm a feeling of being understood.

**THERE ARE THREE
CRITERIA TO 95 %
OF ALL SUICIDAL
PEOPLE**

ASSESS THE SITUATION

PLAN -

Have they thought about how they would accomplish their goal?

MEANS -

Do they have the ability to carry out their plan?

TIME SET -

Have they thought about when they would do it?

Family Matters

MONITOR BEHAVIOR

BE PROACTIVE

Monitor behavior without being intrusive. Be discreet. Individuals who are experiencing symptoms of mania will probably deny that there is anything wrong with them. People in depression will often isolate themselves from the family. They need to know you still love them.

Monitor any reckless or endangering activity. Pay attention to any extravagant expenditures or excessive shopping sprees. This could indicate a potential manic episode. Listen carefully to word choices to determine an impending episode.



If you notice rapid speech, this could be hypomania. It is important to acknowledge the symptoms you see, and confront the family member with how they are feeling to find out if there is a problem or if it is just a normal fluctuation in mood.

Know when to get help. Don't go it alone if they have taken an overdose. Ask what and how much and contact your local poison control centre. If the poison control centre indicates medical assistance is required, either transport them to your nearest hospital or call for an ambulance.

If there is a possibility that they are manic, point out the fact that they may be having an episode by using examples of how their current behavior has changed. Ask them if they have been taking their medication as prescribed.

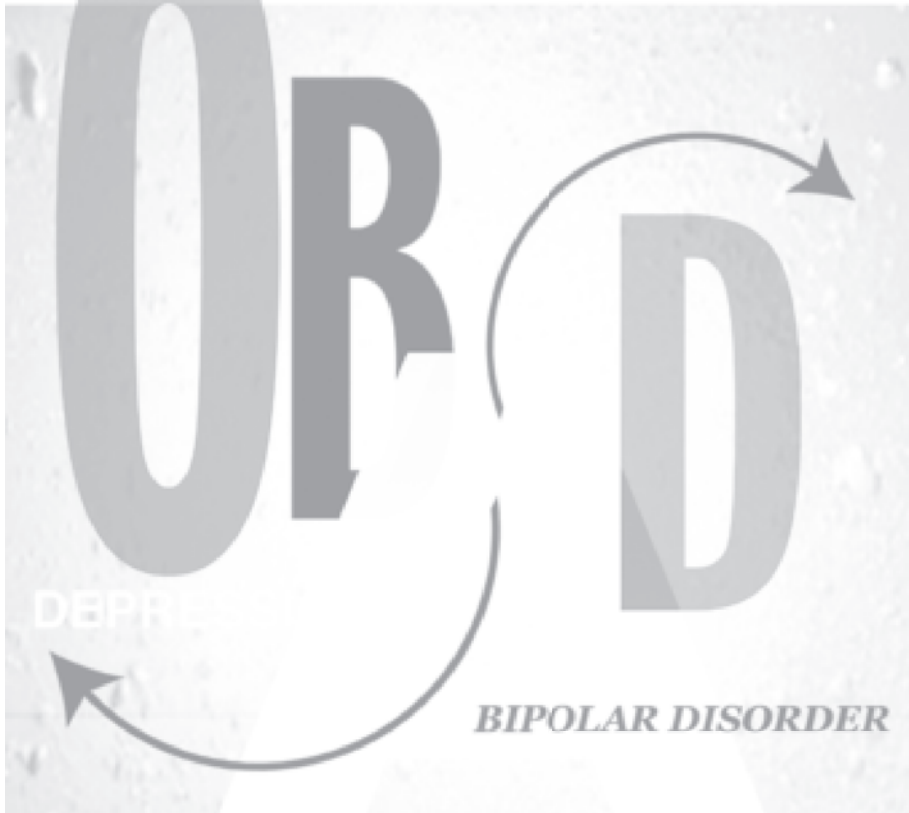
Encourage them to seek professional help. Remember that when someone is feeling manic, they are often unaware that there is anything wrong. They may react in a defensive way towards you. Let them know you are concerned. If you suspect they are delusional or are hallucinating, please contact your nearest hospital.

MAINTAIN A CLOSE RELATIONSHIP

Tell your family member how much you love them and mean it. Give them a hug when they need one. Treat your family member with dignity and respect. Include your family member at family gatherings or outings but recognize that sometimes your family member may not feel able to attend because of symptoms associated with the disorder or their medications. If your family member does not live at home, contact them by telephone on a regular basis. Offer assistance. If they do not have transportation, offer to go shopping with them or to help do their laundry. Prepare frozen dinners that can be re-heated.



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