CHAPTER 1

How This Book Can Help You Survive—and Thrive

Why Do You Need This Book?

- To understand the symptoms, diagnosis, and causes of your bipolar disorder
- To learn about effective medical and psychological treatments
- To learn self-management techniques to help you deal with mood cycles
- To improve your functioning in family and work settings
- To learn how treatment regimens and lifestyle strategies can be customized to your unique characteristics, symptoms, and life situation

Martha, 34, ended up in the hospital after storming out of the house where she lived with her husband and two school-age children and spending a disastrous night in a town over 2 hours away. Her problems had started about 2 weeks earlier, when she became unusually irritable with her husband, Eric, "slamming about the house," as he described it, and becoming easily provoked by the minor infractions of their children. She then began to sleep less and less and was increasingly preoccupied with many ideas for a tech start-up business she had been planning. Despite this intense focus, Martha was very easily distracted. She also began speaking very rapidly.

Her problems came to a head when she left the house in a fury shortly after dinner one night and impulsively took a bus to a gambling casino about

100 miles away. By her account, she met a man at a bar the same night and went to bed with him. The next morning she called her husband, crying, and explained what had happened. Needless to say, he was quite angry and drove to the casino to pick her up. He arrived at the agreed-upon place and time, only to find that Martha was not there. He returned home to find his wife dishevelled, sleep deprived, and angry. After sobbing for several hours, she finally agreed to go with him to be evaluated at a local hospital. She was admitted to the inpatient unit and given a diagnosis of bipolar I disorder, manic phase.

Bipolar disorder is a mood disorder that affects at least 1 in every 50 people—and as many as 1 in 25 by some estimates—and puts them at high risk for the kinds of problems in their family, social, and work lives that Martha suffered. People with bipolar disorder are also at high risk for physical illnesses such as cardiovascular disease, alcohol and substance use disorders, and suicide. Fortunately, there is much hope. With medications, psychotherapy, and self-management techniques, it's possible to control the rapid shifts in mood from manic highs to severe depressive lows (called *mood disorder episodes*), prevent future episodes from occurring, decrease the impact of environmental triggering events, and cope well in the job and social world. These may sound like pie-in-the-sky promises, but they reflect decades of research as well as the rich and hopeful stories of people with the disorder.

Whether you have already been diagnosed with bipolar disorder, think you might have it, or are concerned about a family member or friend who has it, this book will help you understand the disorder, learn to manage it effectively, and teach others how to cope with it. In the following chapters you'll find up-to-date information on the nature of the disorder, its causes, its medical and psychological treatments, and the lifestyle changes you can make to manage the disorder. You'll also learn how to adapt these treatment or self-management strategies to your individual circumstances. The information should be relevant to you whether you have been treated on an inpatient basis, like Martha, or on a continuous outpatient basis, which is becoming more and more common.

Understanding the Facts about Bipolar Disorder: Its Symptoms, Causes, Treatment, and Self-Management

The inpatient physician who saw Martha diagnosed her as bipolar very quickly and recommended a regimen of lithium, a mood-stabilizing medication, and risperidone (Risperdal), a second-generation antipsychotic (SGA) medication. After only a few days it was clear that she was responding well. But when her doctor made plans to discharge her, Martha had a litany of questions and worries about everything that was happening to her. Why was she being given "this death sentence" (her diagnosis) and "drugged and disposed of so quickly"?

Why was she being labeled manic, when most of what she had done, she felt, could be attributed to her personality or interpersonal style? "I've always been assertive and direct," she complained to her doctor, her husband, and almost everyone else she saw. "Since when is everything I do a mental illness?" Her doctor responded with sympathy but offered insufficient information to satisfy Martha. Under considerable pressure to get people in and out of the hospital quickly, he left her with a list of medications to take but little understanding of what had happened to her or what to expect once she got home.

If you were in Martha's position, in all likelihood you would find the hospital experience as confusing and frustrating as she did. In my experience, people with bipolar disorder and their family members usually are hungry for information about the disorder, particularly during or after a manic or depressive episode, even if the episode has not involved hospitalization. Of course, people with the disorder have an easier time assimilating information about it once they are over the worst of their symptoms. But even during the hospitalization, Martha and her husband would have benefited a great deal from some basic information: why her doctors suspected she had the illness, how the symptoms are experienced by the person with the disorder versus everyone else, the expected course of the illness over time, and what kinds of treatments would help. They would have benefited from knowing what to expect after she was discharged from the hospital, including her risks of cycling into new episodes. Without this information, it was difficult for Martha to put her experiences in context. As a result, she began to doubt the accuracy of the diagnosis and, by extension, the wisdom of complying with her prescribed treatments.

A major assumption of this book is that understanding the facts about your disorder will help you and your close family members accept, live with, and cope more effectively with it. Here are some important questions that often go unanswered because mental health providers simply don't have time or don't know the answers:

- "What are the symptoms of bipolar disorder?"
- "Who am I apart from my disorder?"
- "Where does ordinary moodiness end and bipolar disorder begin?"
- "Where did the illness come from?"
- "How do I know when I'm becoming ill?"
- "What triggers my mood cycles, and are the triggers different for the highs and lows?"
- "What can I do to minimize my chances of becoming ill again?"
- "How do I explain the illness to other people?"
- "What can I expect from my future?"

By the end of this book, I hope you'll have gotten useful answers to these questions, together with a more complete understanding of bipolar disorder, a new grasp of who you are and how bipolar disorder fits into your life, and a wealth of illness management techniques. I also hope to leave you knowing where to turn when the future brings new challenges and you need additional information and advice.

Effective prevention: Being able to put your illness in an informational context helps you prevent or at least minimize the damage associated with future recurrences and set appropriate goals for your immediate and long-term future.

Adjusting to the Aftermath of an Episode

Martha left the hospital with prescriptions for lithium and risperidone and an appointment to see a new doctor 2 weeks later. Upon discharge she agreed to follow the recommendations of the inpatient staff to continue taking her medications, but she knew little about what the medications were doing or exactly what was being medicated. She felt shaky, agitated, irritable, and mentally confused. She complained of physical pains that had no obvious source. These uncomfortable sensations were largely the result of continuing symptoms of her disorder, but in the absence of any information to the contrary, Martha assumed her confusion and pain were due entirely to the lithium.

She then noticed her mood start to drop, gradually at first. She felt numb, disinterested in things, tired, and unable to sleep even though she desperately wanted to. She began to spend more time during the day "sleep bingeing" to try to catch up from the night before. She awoke in the afternoon feeling worse and had difficulty with her usual responsibilities, such as making dinner or helping the children do their homework. She dreaded interacting with her neighbors. The idea of committing suicide crossed her mind for the first time. She felt guilty about the potential impact of her disorder on her children and wondered whether they would be better off without her.

Martha developed an upper respiratory infection, which kept her up late at night coughing. Compounding this stress, the neighbors were having work done on their house, and she was awakened from her fitful sleep by noise early in the morning. Her sleep became more and more inconsistent, and her daily and nightly routines—when she went to bed and when she woke up—began to change from day to day.

About a week after being discharged from the hospital, Martha's mood escalated upward again. Her thoughts began to race, and she started to think again about the tech start-up. Then, in what she later described as a flash, she decided that all of her problems—not just the mental confusion but also her cycling mood, her sleep disturbance, and her lethargy—were caused by lithium. Without checking with a physician or telling anyone, she lowered her

lithium dosage. When she saw no immediate negative results, she discontinued it altogether. She stopped her risperidone next. Martha became severely irritable again, began to sleep less and less, and ended up back in the hospital only 3 weeks after her discharge.

Martha's story is all too common. Because the nature of the disorder was not explained fully to her, she thought of the episode as a sort of "nervous breakdown" requiring only temporary medication. She did not know that the illness could be recurrent. In Chapters 2, 3, and 4, you will become familiar with the expected course of bipolar disorder and the various forms that mood recurrences can take. This knowledge will help you feel more confident about sticking to a treatment and self-management plan that may help stave off recurrences.

Martha also would have benefited from knowledge of the factors that we believe cause the cycling of bipolar disorder: a complex interplay of genetic background, individual neurophysiology, and life stress, as discussed in Chapter 5. Many people who have bipolar disorder burden themselves with guilt and self-blame because they believe their mood disorder is caused solely by psychological factors or even sheer weakness of character. Martha could have avoided such self-blame if she had known that her dramatic mood shifts were associated with changes in the function of nerve cell receptors or activity in the limbic system of the brain. Her experiences would have made more sense to her in the context of her family tree: her mother had severe depression and her paternal grandfather was hospitalized once for "mental anguish" and "exhaustion."

Knowing about the biological causes of your disorder will also clarify why consistency with your medications is essential to maintaining good mood stability. Martha knew that she needed to take medications, but not why. Chapters 6 and 7 deal with medication treatments for bipolar disorder. Many drugs are available

PERSONALIZED CARE TIP:

Communicating with your physician

You will feel more effective in managing your disorder if you can openly communicate with your physician about which medications are most effective for you, their side effects, and the mixed emotions you may feel about taking them. Not everyone responds the same way to different medications. You may be having unusual reactions to a given medicine that could be corrected by adjusting your dosage or switching to a different drug. You may also harbor fears that the medications will cause long-term damage to your kidneys or that they will kill brain cells. These are all understandable concerns that your doctor should address.

nowadays, in various combinations and dosages. Doctors have to be constantly updated on which treatments to recommend to which patients, since the accepted treatment guidelines for this disorder change so rapidly.

Self-Management Strategies

Beyond taking medications and meeting with a psychiatrist, there are good and bad ways to manage your disorder. Self-management involves learning to recognize your individual triggers for episodes and adjusting your life accordingly. This book will teach you a number of self-management tools that will probably increase the amount of time that your moods remain stable. For example, Martha would have benefited from sleep–wake monitoring, or staying on a regular daily and nightly routine, including going to bed and waking at the same time, strategies described in Chapter 8. Likewise, keeping a mood chart (also covered in Chapter 8) would have provided a structure for tracking the day-to-day changes in her moods and revealed how these changes corresponded with fluctuations in her sleep, inconsistency with medications, and stressful events. Recall that Martha's worsening mood was precipitated by a respiratory infection and the appearance of neighborhood noise, which were stressful and disrupted her sleep–wake patterns. In addition to recognizing these events as triggers, Martha and her husband could have developed a list of early warning signs that would alert them to the possibility of a new episode of mania. In Martha's case, these signs included irritability and a sudden and unrealistic interest in developing a tech start-up. Chapter 9 provides a comprehensive overview of possible early warning signs of mania.

When Martha first started becoming depressed, certain behavioral strategies might have kept her from sinking further into depression, including behavior activation exercises and cognitive restructuring techniques, introduced in Chapter 10. She would have had the support of knowing that suicidal thoughts and feelings—a common component of the bipolar syndrome—can be combated through prevention strategies involving the support of close friends and relatives, counseling, and medications, as described in Chapter 11. She would have understood some of the differences between women and men during the depressed phase (for example, the role of the menstrual cycle), and how to manage some of the health complications that affect women who take mood-stabilizing medications, as discussed in Chapter 12.

Finally, many people with bipolar disorder worry that their children will develop the disorder. Raising children under these circumstances can feel like there is a sword hanging over your head. Martha worried constantly about Kirsten, her 14-year-old, who had hit adolescence with a vengeance, with unpredictable hours, irritability, withdrawal, sleep problems, and a deterioration in her academic performance. Was this a reaction to her mother's illness or the beginning of her own illness? In Chapter 14, you'll learn how to recognize early warning signs of

bipolarity in your children as well as some useful strategies for obtaining a diagnosis and, if warranted, early interventions.

Coping Effectively in the Family and Work Settings

Martha spent 5 more days in the hospital but this time was discharged with a clearer follow-up plan. She met the physician who would see her as an outpatient to monitor her medications and blood serum levels. The inpatient social work team also helped arrange an outpatient appointment with a psychologist who specialized in the treatment of mood disorders. This time, she felt better about the hospitalization experience but was quite wary of what would happen once she was back at home.

After her discharge, Martha spoke with close friends about what had happened. They were sympathetic but said things like "I guess everybody's a little bit manic–depressive" and "Maybe you were just working too hard." When she disclosed to one friend that she was taking lithium, the friend said, "Don't get addicted." Although she knew her friends were trying to be supportive, these messages confused her. Was she really ill or just going through a tough time? Were her problems really an illness or just an extreme of her personality? Hadn't the physicians told her that mood-stabilizing medications were meant to be taken over the long term?

Martha's husband, Eric, seemed unsure of how to relate to her. He genuinely cared about her and wanted to help but frequently became intrusive about issues such as whether she had taken her medications. He pointed out minor shifts in her emotional reactions to things that formerly would have escaped his notice but which he now relabeled as "your rapid cycling." Martha, in turn, felt she was being told that she was "no longer allowed to have normal emotional reactions." She told him, "You can't just hand me a tray of lithium every time I laugh too loud or cry during a movie."

At other times Eric became angry and criticized her for the deterioration in her care of the children. Indeed, she didn't have enough energy to take them to their various activities or get them to school on time. She didn't feel up to the social demands of being a parent. "You aren't trying hard enough," Eric said. "You've got to buck up and beat this thing." At other times he would tell her she shouldn't take on too much responsibility because of her illness. Martha became confused about what her husband expected of her. What neither understood was that most people need a low-key, low-demand period of convalescence after a hospitalization so that they can fully recover from an episode of bipolar disorder.

Her children eyed Martha with suspicion, expecting her to burst into irritable tirades, as she had done prior to her first hospitalization. She began to feel that her family was ganging up on her. The family stress during the aftermath of her episode contributed to her depression and desire to withdraw.

Given the economic pressure her family was under, Martha decided to immediately return to her part-time computer programming job but felt

unable to handle the long commute. When she arrived at work, she stared at the computer screen. "The programs I used to know well now seem like gobbledygook," she complained. She finally told her boss about her psychiatric hospitalizations. He seemed sympathetic at first but soon began pressuring her to return to her prior level of functioning. She felt uncomfortable around her coworkers, who seemed edgy and avoidant as they "handled me with kid gloves." The shifts in work schedules, which had been a regular part of her job before, started to feel like they were contributing to her mood swings.

Martha had significant problems reestablishing herself in her home, work, and community following her hospitalization. People who develop other chronic medical illnesses, such as diabetes, cardiac disorders, multiple sclerosis, or cancer, also can have trouble relating to their partner, children, other family members, friends, and coworkers. When you reenter your everyday world following a mood episode, even well-intentioned family members don't know how to interpret the changes in your behavior (for example, your irritability or lack of motivation). They often mistakenly think that you are acting this way on purpose and could control these behaviors if you only tried harder. As a result, they become critical, evaluative, and judgmental. They may also mistakenly think you can't take care of yourself and try to do things for you that you are more than capable of doing yourself. For example, they may try to actively manage your time, direct your career moves, telephone your doctors with information about you, constantly question you about your medications, or become vigilant about even the most minor changes in your emotional state.

In the workplace you may find your employer initially sympathetic but impatient. Your coworkers may be guarded, suspicious, or even scared. In addition, you may feel that you can't concentrate as well on the job as you did before you became ill. These difficulties are all a part of the convalescent period that follows an episode. In all likelihood, your concentration problems will diminish once your mood becomes stable. But it can be quite upsetting to feel like you're not functioning at the level at which you know you can.

As you are probably aware, bipolar disorder carries a social stigma not associated with medical illnesses. Even though bipolar disorder is clearly a disorder of the brain, and its genetic and biological underpinnings are well documented, it is still treated as a "mental illness." Many people still erroneously believe it is related to your personal choices or morals. As a result, you may feel alienated from others when they find out about your disorder.

On the hopeful side, there is much you can do to educate your family, coworkers, and friends about the nature of your illness. Certainly, people will respond to your disorder in ways that you will find uncomfortable, but their reactions will vary, at least in part, with how you present it to them. Chapter 13 is devoted to exploring ways of coping effectively in the family and workplace. You'll learn how

to talk to your family, friends, and coworkers about your disorder so that they know how best to help you and don't force their misconceptions on you (as was the case for Martha). You'll learn specific strategies for communicating effectively and solving problems with your family so that disagreements about the disorder don't escalate into unproductive and stressful arguments.

Effective prevention: One objective of this book is to familiarize you with the role of family and other social factors in contributing to, or ameliorating, the cycling of your bipolar disorder.

Martha: Epilogue

Martha's first year after her two hospitalizations was quite difficult, but now, several years later, she is doing much better. She found a psychiatrist with whom she feels comfortable. She is taking a regimen of lithium, lamotrigine (Lamictal), and a thyroid supplement. Her mood and behavior still shift up and down—for example, she reacts strongly to disagreements with her husband and still has periods of feeling down or unmotivated—but her symptoms are no longer incapacitating. In part due to her willingness to commit to a program of mood-stabilizing medications, she has not needed the intensive inpatient treatment she received initially.

Martha and Eric have improved their relationship. They regularly see a marital therapist, who has helped them distinguish how the disorder affects their relationship, how conflicts in their relationship affect the disorder, and what problems in their family life are unrelated to her illness. Together they have developed a list of the signs of her oncoming episodes and what steps to take when these signs appear (for example, calling her physician for an appointment to get her medications adjusted and, hopefully, prevent a hospitalization). Her children have become more accepting of her moodiness, and she has become more enthusiastic about parenting. For Kirsten, her 14-year-old, Martha engineered an evaluation with a child psychiatrist at the same facility where she got her treatment. The psychiatrist concluded that Kirsten had developed a mild depression, probably related to events in her family life and a boyfriend with whom things had not worked out. Individual therapy was recommended and was successful.

Martha has had frustrations in the workplace and finally came to the conclusion that "I'm just not a nine-to-fiver." She decided to try freelance work, which, although not as financially lucrative as her job, has reduced her stress and given her predictable hours.

Martha now has a better understanding of the disorder and how to manage it. For example, by keeping a mood chart she has learned to distinguish—for herself as well as for other people—between her everyday, normal mood swings and the more dramatic mood swings of her bipolar illness. She has learned to maintain a regular sleep–wake cycle. She recognizes that keeping

her disorder well controlled is the key to meeting her own expectations of herself. She is now more comfortable trusting and enlisting the support of her husband and, especially, a close friend when she feels depressed or suicidal.

Martha recognizes that her disorder is recurrent but also feels that she is more in control of her fate. In summing up her developing ability to cope with the disorder, she said, "I've learned to accept that I've got something biochemical that goes haywire, but it's not the sum total of who I am. If I could change one thing about myself, it'd be other people's moods and how they affect me, even when it's their problem and not mine."

Above all, this book is about hope. If you've just been diagnosed with bipolar disorder, or even if you have had many episodes, you probably have fears about what the future holds. Martha's story—while perhaps representative of only one form of the disorder and one type of life situation—captures some of the ways that people learn to live with bipolar illness. ***A diagnosis of bipolar disorder doesn't have to mean giving up your hopes and aspirations.*** As you will soon see, you can come to terms with the disorder and develop skills for coping with it and still experience life to its fullest.

How This Book Is Organized

This book is divided into three sections. In the remaining chapters (2–4) of this section, "The Experience and Diagnosis of Bipolar Disorder," you'll learn about the symptoms and recurrent nature of the disorder from your own vantage point as well as that of your relatives and the physician who makes the diagnosis. You'll become familiar with the behaviors considered to be within the bipolar spectrum and learn what to expect from the diagnostic process. Chapter 4 offers you tips on how to cope with the diagnosis and addresses the question many people ask themselves: "Is it an illness or is it me?"

In Part II, "Laying the Foundation for Effective Treatment," Chapter 5 provides an overview of the genetic, biological, and environmental determinants of the disorder. You'll come to see how the disorder is not *just* about biology or *just* about environment, but an interaction of the two. Chapter 6 discusses medications for treating the biological aspects of the disorder (mood stabilizers, SGAs, antidepressants) and newer, alternative treatment approaches, including their effectiveness, how we think they work, and their side effects; and the role of psychotherapy in helping you cope more effectively with mood swings and their triggers. Chapter 7 deals with the issue of accepting and coming to terms with a long-term regimen of medications. For people with bipolar disorder—and many other recurrent illnesses—taking medications regularly and over the long-term poses many emotional and practical challenges. In this chapter you'll learn why taking medica-

tions consistently is so important and why some of the common arguments for discontinuing them (for example, "I don't need to take pills when I feel well") are erroneous.

Part III, "Practical Strategies for Staying Well," starts with tips to help you manage moods and improve your daily life (Chapter 8), strategies for derailing the upward cycle into mania (Chapter 9), and ways to recognize and handle depression (Chapter 10). I devote a special chapter to dealing with suicidal thoughts and feelings (Chapter 11), which, for many people with bipolar disorder, are a constant source of pain. You'll learn ways to get help from others when you're suicidal and some things you can do to manage these feelings on your own.

Chapter 12 contains a wealth of up-to-date information and advice just for women, on topics including how bipolar disorder affects and is affected by the reproductive cycle, how to have a healthy pregnancy and postpartum period in the context of mood symptoms and medications, and how bipolar disorder and its treatments affect women's health in unique ways. Chapter 13, "Succeeding at Home and at Work: Communication, Problem-Solving Skills, and Dealing Effectively with Stigma," is designed to help you handle the family, social, and work stress that usually accompanies the disorder and to educate others about the challenges you face. Finally, Chapter 14, "'Does My Child Have Bipolar Disorder?': How Would You Know and What Should You Do?," is brand new to this third edition. It explains how to get a good psychiatric evaluation for your child and what to do with the information once you receive it. In that chapter you'll learn about the current options for treatment (which are not only medicinal), as well as what we do and don't know about the future course for children who obtain early diagnoses. My hope is that you'll come away from this chapter with a clear set of steps you can follow to obtain help for your child.