Bipolar disorder

An information guide

REVISED EDITION

CAMH Bipolar Clinic Staff

camh
Centre for Addiction and Mental Health

Bipolar disorder

An information guide

REVISED EDITION

CAMH Bipolar Clinic Staff

camh
Centre for Addiction and Mental Health

Library and Archives Canada Cataloguing in Publication

Bipolar disorder : an information guide / CAMH Bipolar Clinic staff ; [contributors, Sagar Parikh ... [et al.]]. -- Revised edition.

Includes bibliographical references.
Issued in print and electronic formats.

ISBN: 978-1-77052-579-5 (PRINT)
ISBN: 978-1-77052-580-1 (PDF)
ISBN: 978-1-77052-581-8 (HTML)
ISBN: 978-1-77052-582-5 (EPUB)

1. Manic-depressive illness--Popular works. I. Parikh, Sagar V., author II. Centre for Addiction and Mental Health, issuing body

RC516.B567 2013 616.89'5 C2013-905614-9
C2013-905615-7

Printed in Canada

This publication may be available in other formats. For information about alternate formats or other CAMH publications, or to place an order, please contact Sales and Distribution:
Toll-free: 1 800 661-1111
Toronto: 416 595-6059
E-mail: publications@camh.ca
Online store: http://store.camh.ca

Website: www.camh.ca

Disponible en français sous le titre :
Le trouble bipolaire : Guide d'information

This guide was produced by CAMH's Knowledge and Innovation Support Unit.

3973f / 01-2014 / PM105

Contents

Authorship

Bipolar disorder is an often-complex disorder that requires many different types of knowledge and expertise to treat. Effective treatment is usually collaborative and multidisciplinary; so too was the writing of this guide. We have stated authorship as the "Bipolar Clinic Staff" to reflect our commitment to collaboration. For the record, the contributors to the guide include Sagar Parikh, MD, FRCPC; Carol Parker, MSW, RSW; Robert Cooke, MD, FRCPC; Stephanie Krüger, MD; Roger McIntyre, MD, FRCPC; Alice Kusznir, OT, MEd; and Christina Bartha, MSW, RSW. Additional input was provided by Lynnette Ashton, Mary Damianakis, Deborah Mancini and Lisa Zetes-Zanatta.

Acknowledgments

The authors would like to pay special tribute to our patients, clients and their families who, through their openness, have taught us so much. We would also like to express our sincere appreciation to the patients, clients and family members who gave so generously of their time in reviewing the manuscript and who provided their thoughtful comments and suggestions.

This revised edition was reviewed by Dr. Hagen Rampes.

Introduction

This guide is for people with bipolar disorder, their families and anyone who wants to understand the basics of this illness and its treatment and management. It is not a substitute for treatment from a doctor or mental health care provider, but it can be used as a basis for questions and discussion about bipolar disorder. This handbook covers many aspects of bipolar disorder and answers frequently asked questions. With respect to drug treatments, new medications are continually being developed, and some current medications may not yet have been available when this guide was published.

1 What is bipolar disorder?

Why is bipolar disorder called an "illness"?

Everyone has ups and downs in mood. Feeling happy, sad and angry is normal. Bipolar disorder (or manic-depressive illness, as it used to be called) is a medical condition in which people have extreme mood swings. Their moods may have nothing to do with things going on in their lives. These swings do not only affect mood, they also affect how people think, behave and function.

Bipolar disorder is no one's fault. It does not come from a "weak" or unstable personality. It is a medical disorder that can be treated.

How common is bipolar disorder?

You or someone you care about may have been diagnosed with bipolar disorder. You may now feel alone in facing the problems of the illness, but you are not alone. About one to two per cent of adults worldwide suffer from bipolar disorder. Men and women are affected equally.

When does bipolar disorder begin?

More and more, the first signs of bipolar disorder are being recognized in adolescence or early adulthood. Yet the younger the person is when the symptoms first develop, the less typical the symptoms may be. The symptoms may be mistaken for teenage distress or rebellion, so bipolar disorder is often not diagnosed until adulthood.

In some women, bipolar disorder may appear during pregnancy or shortly after it. Mania, or a "high," after pregnancy occurs in only about one mother in a thousand. Postpartum depression is more common (see pages 5–9 for symptoms of mania and depression). If you or someone you care about has developed depressive symptoms after giving birth, and these symptoms are severe or last more than two weeks, you or she should seek help.

2 The clinical features of bipolar disorder

The episodes of bipolar disorder

Bipolar disorder is an episodic (that is, recurring) disorder. It typically consists of three states:

- a high state, called **mania**
- a low state, called **depression**
- a well state, during which many people feel normal and function well.

The manias and depressions may be either "pure" episodes (they have only typical manic or depressive symptoms) or they may be **mixed episodes** (they may consist of a mixture of both manic and depressive symptoms at the same time). Traditionally, mixed episodes have been associated with the manic phase of the illness, so terms such as "mixed mania" or "dysphoric mania" are often used to describe mixed states.

Types of bipolar disorder

Some people experience manic (or mixed), depressed and well phases during their illness. Such people are said to have **bipolar-I disorder**. A milder form of mania is called "hypomania." People who have hypomania, **depression** and intervals without symptoms, but no full manic phases, are said to have **bipolar-II disorder**.

Order and frequency of the various states

The manic/hypomanic, mixed and depressive states usually do not occur in a certain order, and their frequency cannot be predicted. For many people there are years between each episode, whereas others suffer more frequent episodes. Over a lifetime, the average person with bipolar disorder experiences about 10 **episodes** of depression and mania/hypomania or mixed states. As the person ages, the episodes of illness often come closer together. Untreated manias often last for two to three months. Untreated depressions usually last longer, between four and six months.

RAPID CYCLING

About 20 per cent of people with bipolar disorder have four or more (sometimes many more) episodes a year. People with four or more episodes a year are said to be having **rapid cycling**, which is a subtype of bipolar disorder that needs specific treatment. We don't know for certain what causes rapid cycling. Sometimes, its occurrence may be triggered by certain antidepressants, but how the antidepressant causes rapid cycling is not clear. Sometimes stopping the antidepressant may help the person to return to a "normal" cycling pattern.

3 The symptoms of bipolar disorder

Mania

Sometimes, a person may seem abnormally and continuously high, irritable or expansive for at least one week. If this change in mood is accompanied by other symptoms (see below) the person may be in a manic phase of bipolar disorder. *Not everybody who enters a manic phase feels happy or euphoric*. Instead, a person may feel very irritable, or may be terribly angry, disruptive and aggressive.

People in a manic phase do not have only mood symptoms. For a manic episode to be diagnosed, they must also have at least three of the following symptoms to an important degree:

- **Exaggerated self-esteem or feeling of grandeur:** People feel invincible or all-powerful; they believe they understand "how the world works" or how to save it. They may feel they have a special mission in life (e.g., that God has sent them or given them special powers).

- **Less need for sleep:** People feel rested after just a few hours of sleep. Sometimes they may not sleep at all for a few days or even weeks.

- **Increased talking:** People may talk very quickly, too loudly and much more than usual. They may like to tell jokes or rhyme words and may become angry when interrupted. They may keep switching topics and be unable to converse properly with others.

- **Flight of ideas or racing thoughts:** People easily lose their train of thought, and have trouble interacting because they are *easily distracted*. They may be impatient with others who cannot follow their fast thinking and changing plans and ideas.

- **Speeded-up activity:** People may socialize more than usual at work or school, or may be much more active, with seemingly boundless energy. In the early manic phase, they may be productive, but as symptoms worsen, people are more frantic in their activities and start many projects without finishing them.

- **Poor judgment:** People may not be able to control or plan how they act. They may take part in unusual and risky activities without realizing the harmful consequences (e.g., shopping sprees, bad business choices and bad decisions). They may become more sexually active and take less care in choosing their sexual partners. This increased sexual activity may lead to unwanted pregnancies, sexually transmitted diseases, guilt and disrupted relationships.

- **Psychotic symptoms:** People may experience symptoms of **psychosis**, such as **delusions** (beliefs that are not based in reality). They may also have **hallucinations**—most often, they hear voices that are not really there.

Hypomania

The symptoms of **hypomania** are less severe than those of mania, but may still be disruptive. People may feel happy and have lots of energy, but do not usually get into serious trouble. Hypomania may progress to a full-blown manic episode or a severe depression, and therefore needs treatment.

Mixed state

Some people do not always have "pure" manic or depressive episodes. Instead, they may experience episodes in which manic and depressive symptoms occur at the same time. This is called a "mixed state." For example, someone in a mixed state may think and speak very rapidly. At the same time, the person may be very anxious and have suicidal thoughts. Mixed states are hard to diagnose and are very painful for the individual.

Depression

Depression can take many forms, and it often comes out of nowhere. For a major depressive episode to be diagnosed, the symptoms must last for at least two weeks, and must be present most days and last most of the day. Symptoms of depression in bipolar disorder include at least five of the following:

Depressed mood: The mood state in depression differs substantially from normal sadness. In fact, many people experiencing depression say they cannot feel sadness, and many people cannot cry when depressed. Being able to cry again often means the depression is improving.

Marked loss of interest or pleasure in activities that used to be fun: When people have just begun to feel depressed or are mildly depressed, they can still enjoy things, and may also be distracted by pleasurable activities. When people are severely depressed, they lose these abilities.

Weight loss or weight gain: Many people lose weight when depressed, partly because they lose their appetite. However, one subgroup feels hungrier, and may develop a craving for carbohydrate-rich and fatty foods. This results in weight gain. Metabolism may also increase or slow down, depending on the type of depression; such changes in metabolism can cause either weight loss or weight gain.

Sleep problems: Sleep disturbance is common in depression. Many people suffer from **insomnia**: they have trouble falling asleep, wake up often during the night or wake very early in the morning. People do not see sleep as being restful, and they may wake up feeling exhausted. Other people oversleep, especially during the day; they are said to have "hypersomnia."

Apathy or agitation: Many people with depression develop slowed-down movement, speech or thinking. In severe cases, people with depression may be unable to move, speak and respond to their environment. For some people, the opposite happens, and they are very agitated. They are tormented by a severe inner restlessness—they cannot sit still, they pace, they may wring their hands. They may also show their agitation in other ways. People who feel agitated often feel very anxious, too.

Loss of energy: People experiencing depression find it hard to complete everyday chores. It takes them longer to perform at work or at home because they lack energy and drive.

Worthlessness and guilt: When depressed, people may lack self-confidence. They may not assert themselves, and they may be overwhelmed by feelings of worthlessness. Many people cannot stop thinking about past events. They obsess about having let others down or having said the wrong things—and they feel very guilty. In severe cases, the guilt may cause delusions; that is, people feel sure that they have sinned and need to be punished for their wrongdoings. Or they may believe that God is punishing them for their past mistakes.

Inability to concentrate or decide: These symptoms may be so bad that people cannot do simple tasks. They may have trouble deciding on very small matters.

Suicidal thoughts: People who are depressed often think that life is not worth living or that they would be better off dead. The risk of acting upon these thoughts is high, and many people do try to commit suicide when depressed.

Psychotic symptoms: Symptoms of psychosis in depression may include false beliefs about being poor or being punished for past sins. People may believe that they have a deadly disease, such as cancer. They may also hear voices (auditory hallucinations) or may see things that do not exist (visual hallucinations).

Depressive symptoms also often include:

- severe anxiety
- worries about small matters
- complaints about physical symptoms, including pain
- many visits to the family doctor for various physical symptoms.

Other symptoms of a bipolar episode

Some people with bipolar disorder may have problems with movement during their episodes. These disturbances of movement (motor symptoms) occur in up to 25 per cent of patients with depression and up to 28 per cent of patients with mixed or pure manic episodes. These motor problems—called **catatonic symptoms**—vary and may include extreme physical agitation, slowness, or odd movements or postures. Sometimes people can't be slowed down; others may move so little that they refuse even to open their mouth to eat, drink or speak. This is a serious risk to their physical health. In most cases, people become free of catatonic symptoms after specific treatment.

There is a risk that people with catatonic symptoms may be misdiagnosed, because these symptoms have been traditionally associated with schizophrenia, rather than bipolar disorder.

Comorbidity and its importance

A **comorbid disorder** is an illness or medical condition that occurs together with another illness or medical condition. Comorbid conditions can occur with bipolar disorder—they can start either before a bipolar illness or at the same time. Experts do not know why some disorders co-occur frequently with bipolar disorder and others do not. The severity of the comorbid condition may change over a lifetime, and its symptoms may also vary as the bipolar disorder changes.

For example, one of the most common comorbid conditions is **alcohol or other drug problems**. People with an alcohol problem may drink too much during mania, or they may experiment with other drugs, because they feel free and they are impulsive. They

may also use drugs during depressive phases, because they believe it helps them to feel less depressed. The same people may not abuse alcohol or other drugs during their well phase.

Psychiatric conditions that often co-occur with bipolar disorder:

- panic disorder
- obsessive-compulsive disorder
- binge eating disorder
- substance abuse
- attention-deficit/hyperactivity disorder
- borderline personality disorder

It is important to diagnose comorbidity in bipolar disorder. Comorbid conditions may cloud the clinical picture and complicate treatment of bipolar disorder. Also, the comorbid conditions are often so severe that they too need treating.

4 What causes bipolar disorder?

Several factors are involved in causing bipolar disorder, and the precise mechanism is not known. However, there is strong evidence that biological factors, including genetics, play an important role. This does not mean that a person has to inherit the genes: the genes involved may be altered when a person is conceived.

Genes are the blueprint for all the body's cells and their contents. Scientists believe that changes to genes can lead to faulty proteins being produced within brain cells, which may then result in bipolar disorder. Researchers today are looking at genes themselves, as well as various proteins that may be affected in bipolar disorder. These include:

- proteins involved in making **neurotransmitters** ("chemical messengers" in the brain)
- proteins that use neurotransmitters to make cells do something.

We do know that bipolar disorder is not caused by too much stress or difficult family relationships. However, these factors may **trigger** an episode in someone who already has the illness. Nor is bipolar disorder a simple imbalance of neurotransmitters, such as serotonin or dopamine. Yet neurotransmitters may be affected during a flare-up of the illness.

What is a trigger for a bipolar episode?

Not all episodes can be related to any particular **trigger**, but many can. Triggers are situations that can provoke either mania or depression in someone who has already had an episode of illness. Feeling very stressed or continually losing sleep is an example of this kind of trigger. Other triggers are chemical, and include antidepressants that work "too well" and result in mania; common medications, such as steroids (for instance, prednisone used for treating asthma, arthritis, etc.); and street drugs, such as cocaine and amphetamines.

5 Treatments for bipolar disorder

Treatment of bipolar disorder includes biological treatments (e.g., medications) and psychosocial treatments (e.g., **psychoeducation**, **psychotherapy**). Often both types of treatment are needed, but usually biological treatment is needed first to bring symptoms under control.

Biological treatments

Because bipolar disorder is an illness with a strong biological component, the main forms of treatment are biological. These consist mainly of medications, but also include other treatments, such as **light therapy** (spending time every day under a specially designed light box) **electroconvulsive therapy** (ECT) and **transcranial magnetic stimulation** (TMS), which is being researched as an alternative to ECT.

MEDICATIONS

Some of the information in this section is summarized from the CAMH pamphlet series *Understanding Psychiatric Medications*. The pamphlets are designed to help people better understand and make

choices about psychiatric drugs. They discuss what the drugs are used for, the different types and names of drugs, their effects and their place in the treatment of mental health problems. An online version is available at www.camh.ca.

Medications are the cornerstone of treatment in bipolar disorder—they are needed to restore and promote wellness, and to prevent the return of symptoms. Several types of medications are commonly prescribed for bipolar disorder. Finding the right medication and the right dose for you will require monitoring and discussion with your doctor.

Bipolar disorder symptoms tend to return if the disorder is not treated. Most people who are untreated will experience another episode within a couple of years. Medications not only treat symptoms but also prevent their return. People are much more likely to stay well if they remain on medications. Recommendations for maintenance, or longer-term, treatment depend on the type of illness. For some people, who have a mild single episode that is not very impairing, staying on medications for one or two years may work. For most other people, longer-term treatment is recommended. In many cases, treatment may be indefinite. Bipolar disorder is potentially a chronic medical condition.

Sometimes, people with bipolar disorder may feel well for a long time. When this happens, it is possible that the illness has entered into a quiet period. Or it may mean that the medication is successfully preventing symptoms. In either situation, it is important to keep taking medication. If a person ends the treatment, there is an 80 per cent risk of **relapse** within two years. Relapse may occur even after many years of stability.

Some people worry about becoming addicted to medications, or experiencing a change in personality. The main treatments for

bipolar disorder are mood stabilizers, antidepressants and antipsychotics. These medications are not addictive and there is no evidence that they change personality. However, some anti-anxiety drugs carry a risk of addiction if taken regularly for more than a few weeks.

Some of the medications used to treat bipolar disorder may have side-effects. Many of these side-effects lessen with time, and others can be relieved with help from a doctor. The doctor will monitor side-effects and the medication dose, and will sometimes make other checks. With these checks in place, the risk for long-term physical complications from the medications is low. The risks of living with untreated bipolar disorder are much greater.

Medications for bipolar disorder fall into two broad categories—mood stabilizers and adjunct medications. **Adjunct medications** are other medications that can be used to treat specific symptoms, such as depression, poor sleep, **anxiety** and psychotic symptoms. Adjunct medications include antidepressants, **anxiolytics** (anti-anxiety medications), and antipsychotics (formerly called neuroleptics). These medications are often only used for the short term, until the mood stabilizers take their full effect. However, they can also be used in combination with mood stabilizers as longer-term treatments for bipolar disorder.

People with bipolar disorder often require more than one medication. The treatment of other chronic medical conditions such as diabetes or epilepsy often requires a combination of medications.

Mood stabilizers

Mood stabilizers are medicines that help reduce mood swings. They also help prevent manic and depressive episodes. The oldest and most studied of the mood stabilizers is lithium, a naturally occurring element in the same chemical family as sodium. Many

drugs that were first developed as anticonvulsants to treat epilepsy also act as mood stabilizers. These include carbamazepine (Tegretol), divalproex (Epival) and lamotrigine (Lamictal). Gabapentin (Neurontin) and topiramate (Topamax) are also anticonvulsants that may act as mood stabilizers, although they are usually only given in addition to other medications.

Some people may be prescribed more than one type of mood stabilizer to take in combination.

How mood stabilizers work is not fully understood; however, it is thought that the drugs work in different ways to bring stability and calm to areas of the brain that have become overstimulated and overactive, or to prevent this state from developing.

The side-effects of mood stabilizers vary depending on the type of medication. With some medications, side-effects are kept to a minimum through regular monitoring of the level of the drug in the blood. Some people experience no side-effects. Others may find the side-effects distressing. Side-effects usually lessen as treatment continues. If side-effects are not mild and tolerable, let your doctor know as soon as possible.

LITHIUM

Lithium (Carbolith, Duralith, Lithane, Lithium Carbonate, Lithium Citrate) is found in nature in some mineral waters and is also present in small amounts in the human body. Lithium is used to treat mania and to prevent further episodes of mania and depression. There is increasing research evidence that lithium protects brain cells from the inflammation that occurs in the brains of people with bipolar disorder.

Common side-effects of lithium include increased thirst and urination, nausea, weight gain and a fine trembling of the hands. Less

common side-effects can include tiredness, vomiting and diarrhea, blurred vision, impaired memory, difficulty concentrating, skin changes (e.g., dry skin, acne) and slight muscle weakness. These effects are generally mild and fade as treatment continues. If, however, any of these effects are severe, they should be reported to your doctor immediately. Thyroid and kidney function can be affected by lithium in some people, and must be monitored regularly by your doctor.

DIVALPROEX, VALPROIC ACID OR VALPROATE

The differing names for this anticonvulsant medication reflect the various ways it is formulated. Divalproex (and its various forms) is used when people have frequent mood swings or when they don't respond to lithium. Brand names include Depakene and Epival.

Common side-effects of divalproex include drowsiness, dizziness, nausea and blurred vision. Less common side-effects are vomiting or mild cramps, muscle tremor, mild hair loss, weight gain, bruising or bleeding, liver problems and, for women, changes in the menstrual cycle.

CARBAMAZEPINE

Carbamazepine (Tegretol) is another anticonvulsant. It is used for mania and mixed states that do not respond to lithium or when the person is irritable or aggressive.

Common side-effects of carbamazepine include dizziness, drowsiness, blurred vision, confusion, muscle tremor, nausea, vomiting or mild cramps, increased sensitivity to sun, skin sensitivity and rashes and poor co-ordination.

A rare but dangerous side-effect of carbamazepine is reduced blood cell counts. People who take this drug should have their blood monitored regularly for this effect. Soreness of the mouth, gums

or throat, mouth ulcers or sores, and fever or flu-like symptoms can be a sign of this effect and should be reported immediately to your doctor. If carbamazepine is the cause of these symptoms, they will go away when the medication is stopped.

Oxcarbazepine (Trileptal), a closely related drug, may have fewer side-effects and drug interactions than carbamazepine, but is not as well studied for bipolar disorder.

LAMOTRIGINE

Lamotrigine may be the most effective mood stabilizer for depression in bipolar disorder, but is not as helpful for mania.

The starting dose of lamotrigine should be very low and increased very slowly over four weeks or more. This approach decreases the risk of a severe rash—a potentially dangerous side-effect of this drug.

Common side-effects of lamotrigine include fever, dizziness, drowsiness, blurred vision, nausea, vomiting or mild cramps, headache and skin rash. Although it is rare, a severe skin rash can occur with lamotrigine. Any rashes that begin in the first few weeks of treatment should be reported to your doctor.

Antidepressant medications

Antidepressants are medications that were originally found to be useful in treating depression, and more recently have often been found helpful to treat anxiety disorders.

Antidepressants are thought to work primarily by affecting the concentration of chemicals called neurotransmitters in the brain. Key neurotransmitters that are affected include serotonin, norepinephrine, and dopamine. While antidepressants can be used in bipolar disorder during depression episodes, they must be used with caution

since they can also cause a switch into mania and may precipitate a **cycle** of frequent mood episodes (rapid cycling).

There are several classes of antidepressants; within each class there are many individual medications. The different types of antidepressants are listed below in the order in which they are most commonly prescribed.

SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIs)

This group of drugs includes fluoxetine (Prozac), paroxetine (Paxil), fluvoxamine (Luvox), citalopram (Celexa), escitalopram (Cipralex) and sertraline (Zoloft). SSRIs are usually the first choice for treatment of depression and anxiety problems.

SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIs)

This class of medications includes venlafaxine (Effexor), duloxetine (Cymbalta) and desvenlafaxine (Pristiq).

NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIBITORS (NDRIs)

The medication available in this class is bupropion (Wellbutrin, Zyban). When used to treat depression, it is often given for its energizing effects, in combination with other antidepressants.

NORADRENERGIC AND SPECIFIC SEROTONERGIC ANTIDEPRESSANTS (NASSAs)

Mirtazapine (Remeron), the medication available in this class, is the most sedating antidepressant.

CYCLICS

This older group includes amitriptyline (Elavil), maprotiline (Ludiomil), imipramine (Tofranil), desipramine (Norpramin), nortriptyline (Novo-Nortriptyline) and clomipramine (Anafranil).

Because these drugs tend to have more side-effects than the newer drugs, they are not often a first choice for treatment.

MONOAMINE OXIDASE INHIBITORS (MAOIs)

MAOIs, such as phenelzine (Nardil) and tranylcypromine (Parnate), were the first class of antidepressants. MAOIs are effective, but they are not often used because people who take them must follow a special diet. A newer MAOI, moclobemide (Manerix), can be used without dietary restrictions; however, it may not be as effective as other MAOIs.

ANTI-ANXIETY MEDICATIONS

Anxiety is common in bipolar disorder. Sleep disturbance is also very frequent during an acute episode. **Benzodiazepines**, a family of medications with mild sedating ability, are often prescribed. Many types of benzodiazepines are available in Canada. All benzodiazepines work the same way; however, the intensity and duration of their effects vary. Benzodiazepines may be used for short periods without causing addiction.

The benzodiazepines most commonly used to treat anxiety are clonazepam (Rivotril), alprazolam (Xanax) and lorazepam (Ativan). Clonazepam is particularly useful for treating the excessive energy and reduced sleep of hypomania.

Benzodiazepines used for the treatment of insomnia include lorazepam (Ativan), nitrazepam (Mogadon), oxazepam (Serax), temazepam (Restoril), triazolam (Halcion) and flurazepam (Dalmane).

Another drug used for insomnia is zopiclone (Imovane). This drug is similar to benzodiazepines and has similar side-effects. Zopiclone may have less abuse potential than some benzodiazepines; however, people can still become addicted to this drug.

Antipsychotic medications

Antipsychotic medications are commonly used in bipolar disorder. These medications have powerful sedating effects, which help control mania, and can treat psychotic symptoms such as delusions of grandeur or persecution, and hallucinations. Antipsychotic medications are generally divided into two categories: first generation (*typical*) and second generation (*atypical*). Most people who take antipsychotics over a longer term are now prescribed the second-generation drugs.

SECOND-GENERATION (ATYPICAL) ANTIPSYCHOTICS

Medications available in this class include risperidone (Risperdal), quetiapine (Seroquel), olanzapine (Zyprexa), ziprasidone (Zeldox), paliperidone (Invega), aripiprazole (Abilify) and clozapine (Clozaril). Clozapine is exceptional in that it often works even when other medications have failed; however, because it requires monitoring of white blood cell counts, it is not the first choice for treatment.

FIRST-GENERATION (TYPICAL) ANTIPSYCHOTICS

These older medications include chlorpromazine (once marketed as Largactil), flupenthixol (Fluanxol), fluphenazine (Modecate), haloperidol (Haldol), loxapine (Loxapac), perphenazine (Trilafon), pimozide (Orap), trifluoperazine (Stelazine), thiothixene (Navane) and zuclopenthixol (Clopixol).

Newer medical treatments

Many of the newest medications used as mood stabilizers for bipolar disorder were first developed as anticonvulsants (epilepsy treatments). They include divalproex, carbamazepine, oxcarbazepine, lamotrigine, topiramate and gabapentin. There is variable evidence for the effectiveness of these medications; divalproex and lamotrigine have been investigated more thoroughly than the others.

Two other drugs, ketamine and scopolamine, administered intravenously are being investigated for their antidepressant effect in bipolar disorder.

It is helpful to ask your doctor about new and emerging treatments for bipolar disorder. In some university medical centres, it is also possible to participate in clinical trials of new treatments.

ELECTROCONVULSIVE THERAPY

Electroconvulsive therapy (ECT), also referred to as "shock therapy," is perhaps the most controversial and misunderstood of psychiatric treatments, due in part to sensationalized and misleading depictions of the treatment in the popular media. In fact, ECT is a highly effective and safe treatment for both the depressive and manic phases of bipolar disorder, and is sometimes used as a long-term **maintenance treatment** to prevent recurrence of illness after recovery.

ECT does not resemble the shock therapy portrayed in films such as *One Flew over the Cuckoo's Nest*. Now patients are given muscle relaxants and a general anesthetic before a mild electrical current is administered to one or both sides of the brain. There is minimal visible movement in the patient during the procedure. Usually the treatments are administered three times a week over three to four weeks, for a total of eight to 12 treatments. For longer-term maintenance treatment, the treatments may be spread out, for example, once a month, and continued for as long as the patient and doctor feel is appropriate. ECT is usually given to hospitalized inpatients, but outpatients can receive ECT as well.

Side-effects

Patients may have a headache or jaw pain on awakening after ECT, usually requiring only a mild painkiller such as acetaminophen

(Tylenol). Some loss of recent memory or problems with concentration usually occur during treatment (e.g., patients may not recall what they had for supper the night before the treatment), but these symptoms improve quickly after the course of ECT is finished, over a few weeks. Some patients report mild memory problems persisting much longer after ECT treatment has been completed.

Uses of ECT in bipolar disorder

ECT is the most effective and possibly the fastest-acting treatment for severe depression, and is particularly helpful for people who are highly agitated or suicidal, or those with psychotic or catatonic symptoms. Some people receive ECT early in their episode of illness because of the urgency of their situation or their particular symptoms, while for other patients ECT may be used only after various medications have failed. ECT works well for severe mania as well.

While ECT is highly effective at ending an episode of depression or mania, the benefits may not last more than a few weeks or months following treatment. Therefore after a course of ECT, patients usually start or continue treatment with mood stabilizers and/or other medication. Maintenance ECT may be used when medications have not prevented a recurrence of the illness, or for patients who cannot tolerate the side-effects of medication.

TRANSCRANIAL MAGNETIC STIMULATION

Transcranial magnetic stimulation (TMS) involves a series of short magnetic pulses to the brain to stimulate nerve cells. TMS is being tested, but its effectiveness has not yet been proven. TMS is being investigated as an alternative treatment to ECT, but its effectiveness is not yet proven. Unlike ECT, the treatment is carried out without the need for an anesthetic or muscle relaxant.

COMPLEMENTARY AND ALTERNATIVE TREATMENTS

Some people with bipolar disorder seek non-conventional treatments, often as an adjunct to complement conventional treatments rather than as an alternative. Examples of complementary treatments include herbal medicines, acupuncture, homeopathy, naturopathy, meditation, yoga and Ayurveda. A number of nutritional supplements and vitamins are also available.

Many of these treatments have not been thoroughly tested. St. John's wort has been shown to have some antidepressant effect for mild to moderate **unipolar depression** (depression without mania). In people with bipolar disorder, however, there is the possibility that it may cause a switch from depression to mania. St. John's wort may also interact with a number of conventional medications.

If you are interested in herbal remedies, it is important to talk to your doctor. It is helpful to have a doctor who is knowledgeable about complementary and alternative therapies, because these can interact with other medications you may be taking.

Omega-3 fatty acids (found in fish oils and some other foods) are anti-inflammatory, and diets high in omega-3 are linked with lower rates of depression. There is some evidence that omega-3 fatty acids may be helpful in bipolar depression.

Some people find that practices such as yoga, tai chi and meditation can aid with the control of anxiety and depression.

Physical activity

Physical activity or exercise has been shown to have antidepressant effect. Regular physical activity—even just walking for 30 minutes a day—has profound effects for physical and mental health. Exer-

cise has also been shown to increase the size of the hippocampus, a part of the brain concerned with memory.

Psychosocial treatments

Psychosocial treatments include psychoeducation, psychotherapy, support groups and rehabilitation.

PSYCHOEDUCATION

Psychoeducation is a process through which people learn about bipolar disorder, and also have an opportunity to talk about their feelings related to living and coping with the disorder. For example, it is common for people learning about their illness to experience strong feelings of fear or denial. Often, talking openly about these feelings helps people to deal with them and better adhere to a treatment plan that makes sense to them. Psychoeducation can occur in groups or in individual counselling with a doctor, social worker or other mental health care provider. When psychoeducation is offered in a group format it is usually time-limited (8 to 12 sessions) and each session focuses on a different aspect of managing bipolar disorder (for example, signs and symptoms, stress management and problem solving).

Psychoeducation also helps family members or partners understand what the affected person is going through. They learn about the symptoms of bipolar disorder, its treatment, what they can do to be helpful, and the limitations to the help that they can offer. The family can meet with the treating doctor, or attend a family support and education group.

Finally, psychoeducation helps people with bipolar disorder and their families to deal with their concerns about the stigma of mental illness. Although public education in recent years has raised awareness, there are still many people who do not understand mental illness, and feel uncomfortable when it is discussed. It is important that people with bipolar disorder, along with their families, have a safe place to discuss this issue and decide what information they wish to share outside of the family.

PSYCHOTHERAPY

Psychotherapy is a general term used to describe a form of treatment that is based on talking work done with a therapist. The aim is to relieve distress by discussing and expressing feelings, to help change attitudes, behaviour and habits that may be unhelpful, and to promote more constructive and adaptive ways of coping. Successful psychotherapy depends on a supportive, comfortable relationship with a trusted therapist. Psychiatrists, social workers, psychologists and other mental health providers are trained in various models of psychotherapy and work in hospitals, clinics and private practice.

There are many different models of psychotherapy. They fall into two general categories: **short-term** and **long-term**. Short-term therapies are structured and focus on current, rather than childhood, issues. On average, the treatment lasts for between 10 and 20 sessions. In short-term therapies, the therapist takes an active role in guiding the discussions. Long-term therapy is less structured, and can last for a year or more. The person has the opportunity to talk about a variety of concerns related to both past and present-day issues. In this model, the therapist is less directive and gives minimal advice, guiding the client instead toward his or her own answers. Psychotherapy is a very helpful treatment. For bipolar disorder, though, it only works as

an add-on to medications, not as a substitute. Every patient should get some supportive therapy that involves not only managing medication, but also dealing with the various problems that a person with bipolar disorder may experience. Practical suggestions and emotional support are the main features of supportive therapy.

Cognitive-behavioural therapy

Cognitive-behavioural therapy (CBT) is an example of a short-term structured psychotherapy that has worked well for many other disorders. It is based on the idea that deeply held beliefs or thoughts influence how we look at ourselves and the world, and have a strong influence on our mood and behaviour. For instance, if we are depressed and think no treatment will help, then we might not bother to seek treatment. This almost guarantees that we will feel worse. Cognitive therapy attempts to identify and change such thoughts and to improve mood and functioning. It is now being tested in bipolar disorder. The early results are promising, both in preventing future episodes and in treating depression.

Anxiety is common in bipolar disorder, and cognitive-behavioural therapy may be very helpful for more severe anxiety problems, such as panic attacks. It may in fact be needed, because the antidepressants that are also sometimes used to treat anxiety disorders may provoke manic episodes.

Insight-oriented or psychodynamic psychotherapy

Insight-oriented or psychodynamic psychotherapy is an example of a long-term, unstructured psychotherapy. This therapy reduces distress by helping a person gain insight into the underlying motives of his or her overall behaviour. While this is not a specific treatment for bipolar disorder, it can be very helpful because increased self-knowledge and awareness leads to more effective management of the illness.

Group therapy

Historically, **group therapy** has been used successfully to provide elements of support and psychoeducation. Cognitive therapy may also be provided in a group. However, group cognitive therapy has not yet been tested for people with bipolar disorder.

Family and couple therapy

Family and couple therapy can help address problems that may have existed before the illness and have become highlighted, or to deal with issues that have arisen as a result of the illness. The timing, however, is very important. During an acute episode, the family or spouse should be given only support and education. Formal family or marital therapy should wait until the person is more stable.

PEER SUPPORT GROUPS

Peer support groups can be very important to treatment. A peer support group is a group of people who all have bipolar disorder. These people can accept and understand one another, and can share their struggles in a safe, supportive environment. Group members usually develop a strong bond among themselves. People who have recently been diagnosed with bipolar disorder can benefit from the experiences of others. These groups are usually organized through the local chapters of the Mood Disorders Association (see page 66 for more information). Although these groups are often called *self-help*, peer support actually offers a type of help called *mutual aid*.

Hospitalization

During severe episodes of depression or mania, some people with bipolar disorder may need to be hospitalized. Hospitalization is needed if the illness is out of control and is putting a person at risk

of serious consequences—for example, through aggressive behaviour, risk-taking, failing to look after his or her own basic needs, or suicidal tendencies.

VOLUNTARY VERSUS INVOLUNTARY ADMISSIONS

Patients are usually admitted to hospital *voluntarily*. This means that they:

- agreed to enter the hospital
- are free to leave hospital at any time.

However, in most places, the law also allows any doctor to admit a person to hospital *involuntarily*. This means the person may not agree that he or she needs help, and does not want to be in the hospital. This can happen if the doctor believes there is a serious risk that:

- the person will physically harm himself or herself
- the person will physically harm someone else.

If no doctor has seen the person, families also have the option of asking a justice of the peace to order a psychiatric assessment, and must provide convincing evidence that the person's illness represents a danger to himself or herself, or to others.

Laws protect the rights of people who are admitted involuntarily. For instance, a rights advisor will visit. The rights advisor will ensure that the person has the chance to appeal the involuntary status before an independent board of lawyers, doctors and laypeople.

The police are sometimes needed to help to get a person to hospital. Family members may agonize over whether to involve the

police. They often feel very guilty about calling the police, even if the police are needed to protect the person's life. Remember, when people threaten suicide, they are usually pleading for help. They are taken seriously. Suicidal thinking is often a temporary feeling. When a person feels suicidal, he or she needs to be kept safe.

INPATIENT TREATMENT

A typical hospital stay may be anywhere between a few days and several weeks. Usually patients are expected (or required, if they are involuntary) to remain on the psychiatric unit for the first few days of their stay. As they recover they may be granted increasing privileges to visit other parts of the hospital or to walk outside. Later they will be given passes to go home overnight or for the weekend.

Patients participate in a variety of group educational and therapeutic programs, as well as individual sessions with medical, nursing and other professional staff. Medications may be changed or doses adjusted, and families may be interviewed by medical or social work or other staff.

Discharge planning begins immediately following admission to hospital. Patients should expect to leave hospital as soon as reasonable follow-up arrangements are in place and their symptoms have improved enough to ensure they are able to function safely and care for themselves at home. Staying in hospital after symptoms have improved may not benefit the person. It may in fact cause difficulties by reducing the person's connection to family and social supports, and possibly undermining his or her independent living skills.

6 Recovery and relapse prevention

The goal in treating bipolar disorder is to help people get well again. This includes:

- treating symptoms until they no longer cause distress or problems
- improving work and social functioning
- reducing the risk of relapse.

The process of recovery

Some people may recover quickly from a manic, hypomanic, mixed or depressive episode. For many others, recovery is more gradual. Often, it takes a few months for a person's functioning to return to familiar levels, even if symptoms of the most recent episode have ended completely.

The time needed to recover often frustrates people with bipolar disorder. This is especially true for people who expect a lot of themselves, who may feel demoralized by the delay. As a result, people sometimes rush back into a full or even increased range of activities. They may be trying to convince themselves and others that they are fully recovered. But this "flight into health" often overwhelms and

exhausts them. Just as you would increase activities gradually if you were recovering from a broken leg, a gradual increase in activities after a bipolar episode allows you to slowly take on responsibilities and build self-confidence.

Remember that recovery is a process, not a single event. After a bipolar episode, people often feel fragile, vulnerable and at risk of more episodes. *These feelings are a normal part of the recovery phase.* It takes some time before a person's confidence and performance return to normal. At first, you should ease yourself into familiar activities and have modest expectations. Predict that when you return to activities such as socializing and going to school or work, you will probably feel anxious. Allow yourself to make mistakes. A social worker, occupational therapist or nurse can help plan a strategy for recovery that might include volunteer activities, leisure interests, school courses, and part-time or eventually full-time work.

Preventing relapse and promoting wellness

At this time there is no cure for bipolar disorder, and people with the disorder are at risk of further episodes. *It is important to use periods of wellness as an opportunity to actively prevent relapse.* Bipolar disorder, like illnesses such as diabetes, requires you to pay attention to how you are feeling, so you can catch early warnings of a possible relapse and possibly prevent a full episode.

Many people with bipolar disorder can benefit from counselling, psychotherapy or meeting with an occupational therapist, social worker or nurse. Using such resources can help you find coping strategies to reduce symptoms, cope effectively with day-to-day stress and lower

the risk of recurrence. Health care providers should recommend treatment tailored to your particular situation.

The following tips may help you prevent relapse and have a healthy lifestyle.

1. **Become an expert on your illness.** Read as much as you can about bipolar disorder and its treatment; if there is something you do not understand, ask your mental health care providers.

2. **Live healthily.** Do not use alcohol or other drugs, because they increase your risk of relapse. Eat a healthy diet, and exercise regularly (it can have a positive effect on mood).

   If you are struggling with falling asleep or staying asleep, it is important for you to develop good sleep routines. Repeating these routines each night can help restore better sleep patterns. Try to go to bed at the same time each night. Avoid stimulating activities close to bedtime; plan on paying bills, completing work or having important discussions earlier in the day. Many people find that relaxation exercises, easy reading or a warm, non-caffeinated beverage just before retiring are ways to promote a relaxed state of mind. Expect that it will take you some time to fall asleep, and try not to anticipate sleep problems, as this will add to your anxiety. For some people, a sleep medication provides relief and allows them the much-needed rest they have been deprived of.

3. **Continue to take medication until your doctor advises you otherwise.** Often, people begin to feel better and stop taking their medication. Relapse is more likely if medication is discontinued too soon. Recommendations for maintenance, or longer-term, treatment depend on the type of illness. For some people, who have a mild single episode that is not very impairing, staying on medications for one or two years may work. For most other

people, longer-term treatment is recommended. In many cases, treatment may be indefinite.

4. **You can't avoid stress, so find strategies to better cope with stress.** Many people with bipolar disorder tend to use only one coping strategy. For example, they hide their worries and avoid dealing with problems. This may work in some cases, but not in others. Where possible, try different strategies. Deal with some problems as they happen. Avoiding them allows stress to build up. Be realistic about your stress-breaking point. Work toward recognizing what aspects of relationships in your life might be unhealthy and, if possible, try to avoid situations that may trigger relapse.

5. **Avoid isolating yourself and maintain social support.** Some people with bipolar disorder tend to spend too much time alone. This can add to their feeling depressed, demoralized and sad. Strong social networks and social support can serve as a buffer against these feelings. Try to avoid spending too much time alone, and work toward maintaining contact with your social network.

   Whom you tell about your illness is a very personal choice. While the stigma of mental illness is much less than it once was, it remains a concern for many people. As a buffer against relapse, however, it is important to have at least one person you can rely on and you can confide in. Along with family and professional support, many people with bipolar disorder find that peer support groups are a valuable part of their social network.

6. **Try to develop a balanced life.** It might seem easy at first to escape from your depression by focusing entirely on one area, such as work or a hobby. Eventually, however, this coping strategy may not work, and you will need to develop other aspects of your life. It is important to keep in contact with all the facets of your life,

such as school, work or volunteer activities, family and friends, and hobbies. As you recover, investing energy in several areas will help you develop a more balanced and satisfying life, which will help you to avoid relapse.

7. **Monitor your symptoms closely.** Many people with bipolar disorder have a consistent pattern of symptoms across episodes. For example, some people learn to recognize the early phase of an impending relapse through signs such as needing less sleep, becoming irritable, or feeling that they no longer need medication. Monitoring such signs closely and seeking medical attention can stop a full-blown episode developing. Often, a mood diary or mood charting app can help. Most healthy people experience a variety of feelings that change from day to day—not all shifts in your mood are due to bipolar disorder. (See also "Recognizing and responding to early warning signs and triggers," on p. 39.)

8. **Identify family and friends as support.** Insight is commonly lost early in an impending episode. It can be helpful if friends or family can recognize typical bipolar symptoms; they can help you in seeking treatment if necessary.

Practical aspects of recovery

An episode of either depression or mania usually disrupts daily routines as well as work, school and home life. People may feel that life will never be the same. They may also feel unable to assume their previous responsibilities and involvements. These feelings are natural and understandable. Yet, once they are properly stabilized on medication, most people with bipolar disorder can return to their previous responsibilities and activities.

Planning appropriate goals and setting priorities are essential to making this transition successful. Each plan and set of priorities is individual. However, it is important to discuss your ideas and concerns with your psychiatrist. Taking on too many or too few responsibilities can have an impact on recovery. Sometimes, people are advised to discuss their plans with other care providers, such as an occupational therapist, social worker or psychologist. Family members may also need to know about your plans and concerns. Family can give important support and feedback as you resume responsibilities. The aim is to get the "just right" type of challenge. This is true whether people are returning to school or work, or taking on roles within their family and community.

SCHOOL

If you are planning to return to school, you should discuss this with your psychiatrist and/or other mental health care provider. Some people they need to resume studies on a part-time basis. Many people experience problems with concentration and memory. Look for ways to improve or adjust your study habits. Study for shorter periods. Avoid noisy or high-traffic areas, as people often find it hard to block out the surrounding sights and sounds.

Letting your teachers know about some of your difficulties may be helpful. Many schools and most colleges and universities have a "special needs" office that may also be helpful. A counsellor at this office will ask about the reason for your absence. This information will help the counsellors work with your teachers and instructors. A counsellor can suggest the best change to a course load and responsibilities. Sometimes it may be helpful to give permission to these counsellors to speak with your health care providers.

WORK

Returning to work may involve similar challenges and careful planning. It is important to discuss your plans for work with your psychiatrist. You may also need to discuss your concerns and plans with an occupational therapist, who can give you additional advice and support.

It is best to resume your responsibilities gradually, by starting either part-time or with a smaller workload. Your health care provider may recommend specific job accommodations to your work responsibilities and schedule that may also be helpful in this transition. Typical job accommodations include more frequent breaks, time off to attend medical appointments, and a change in non-essential job duties.

Educating your employer and co-workers about some of the typical signs of mood changes may be helpful in some cases. However, some people prefer not to discuss their illness with their employer. This choice will not allow you to ask for accommodations, but it does not mean that you will be unsuccessful in your transition back to work. In this situation it is especially important to have support outside of work to discuss your problems and concerns.

HOME AND COMMUNITY RESPONSIBILITIES

You may also need to resume home and community duties gradually, in order to find the "just right" challenge of responsibilities and involvements. Reviewing priorities and developing a plan to resume activities may also be necessary. Look at what you can do and have been doing, and plan accordingly.

What you are currently able to do may not match what you were able to do in the past. Although this may be frustrating, set daily goals and monitor your accomplishments. Reflecting on and modi-

fying your expectations is often an important part of this process. In the early stages you may need to rely on family members to absorb some of the daily household and other responsibilities. As recovery continues, you can gradually resume your responsibilities.

Recognizing and responding to early warning signs and triggers

When you return to school, work, or home and community involvement, it is important to learn to recognize and respond to any subtle changes in your mood. Focusing on ways to concentrate better and to work more efficiently may also help. You may also benefit from decreasing some of the external stresses in your environment.

DEPRESSION

Typical signs of starting to feel depressed are:

- trouble concentrating and focusing or completing tasks
- lower energy level and confidence
- sensitivity about the comments of others
- increased worry
- doubting the worth of daily involvement in activities
- trouble making fairly simple decisions
- changes in sleep and appetite.

It is also important to learn to identify your personal triggers, and make plans to cope effectively when they arise. Triggers are external events or circumstances that can precede mood changes. Some examples are:

- anniversary dates
- financial problems
- conflict with an important person
- being in an abusive situation
- physical illness, such as flu.

When you are depressed or are experiencing triggers, you may find it helps to:

- recognize some of the symptoms, and speak to your doctor to see if your medications need to be adjusted or if other treatments may be needed
- seek out family members, friends or co-workers to support you and realistically assess your impressions
- focus on completing simpler, concrete tasks, and delay the harder and more challenging tasks if possible
- delay making any important decisions
- limit time in more public and/or socially demanding activities
- structure your day to include more activities that you find rewarding
- set goals to address these mood changes; for example, make sure you are involved in enjoyable activities with people who support you.

HYPOMANIA

Typical signs of starting to feel hypomanic are:

- decreased need for sleep
- higher energy level and confidence (often includes taking on many tasks)

- trouble settling down to work
- strong feelings or disagreements (more than usual)
- making decisions impulsively (more than usual).

When hypomanic, you may find it helps to:

- recognize some of the symptoms, and speak to your doctor to decide if your medications need to be adjusted or if other treatments may be necessary
- look for ways to make your physical environment less stimulating
- consciously try to get enough sleep and to relax enough
- look for ways to protect yourself against yourself, such as putting away credit cards and avoiding certain social circles
- consider putting off major decisions and cancelling any critical meetings
- plan your day and keep to a limited schedule
- set goals to address these mood changes outside work; for example, find how to work off your extra energy safely with hobbies, exercise, etc.

CONCENTRATION

Whether you are feeling depressed or hypomanic, you may have trouble concentrating. At these times, you should:

- discuss your problems with your doctor
- recognize that this will not last
- try harder to write out goals and make plans for yourself
- set goals that have flexible time limits
- make your environment less stimulating
- try to become aware of what times you perform best during the day.

7 Help for partners and families

What happens when someone you love has bipolar disorder?

When a family member has a chronic illness, it affects your entire family. This is true of a physical illness, such as diabetes, or a mental illness, such as bipolar disorder. When your relative or partner has a mental illness, you must cope with extra stressors, such as stigma. Fearing prejudice, your family may try to deal with mental illness alone. Furthermore, bipolar disorder will affect your relative's mood and behaviour. At times, your family member's mood disorder can make him or her less able to manage the illness, and the person may become less able to work with you to solve problems. This may include changes in how the person can attend to their usual roles and responsibilities.

As a family member, you will likely find both the manic and depressed phases of the illness very distressing. If your family member has only mild mood swings, you may be able to get through them without too much trouble. But if your relative's mood swings are severe, you will likely find them hard to handle.

Depression

Seeing a loved one struggle with depression can make people feel sad, concerned, frightened, helpless and anxious. You may experience guilt, anger and frustration. All depressive episodes are upsetting, but the first episode will probably be especially confusing. You may not understand what is happening and why the person is not getting better on his or her own. Without information about depression, you might assume that your relative is lazy, or give well-meaning advice and become frustrated and annoyed when he or she does not act on it. If your relative talks about suicide, you will understandably live with a great deal of worry.

HOW TO RELATE TO A PERSON WHO IS DEPRESSED

Family members often do not know how to talk to a person who is depressed. They may be afraid to ask too many questions and inadvertently upset their loved one. At the same time, they do not want the ill person to feel that they are not interested or are avoiding him or her.

Try to be as supportive, understanding and patient as possible. Just recognizing that depression is an illness can help your relative to feel less guilty about his or her impaired functioning.

TIPS FOR COMMUNICATING WITH A PERSON WHO IS DEPRESSED

1. Speak in a **calm quiet voice.**

2. **Focus on one subject at a time.** Your relative or friend may have trouble concentrating.

3. If the person is quiet and withdrawn, break the ice with **neutral, non-threatening statements**, such as "It seems a bit warm in here."

4. **Be patient and wait.** It may take a while for your loved to respond.

5. **Your ability to listen is a valuable resource to your relative**. Depression causes people to talk a lot about how bad they feel, yet they may not be ready to discuss solutions to their problems. Listening and letting the person know, in a neutral manner, that you have heard what he or she has said is valuable and supportive. You do not have to offer immediate solutions.

6. **If the person is irritable, you probably need to slow down, adjust your expectations and use a very neutral approach.** Neutral comments about the weather, what you are making for dinner or other routine subjects are the safest way to develop a dialogue. Listen for opportunities to acknowledge or add to your relative's responses. At these times, conversations about important decisions or issues are unlikely to be productive. You may need to plan to discuss important issues at a later date.

7. **Avoid quizzing people about what made them feel depressed. Do not blame them for the way they feel, or tell them to snap out of it.** People who are moderately depressed may be able to hear your helpful suggestions, but be unable to act on your advice. Quizzing or blaming them will only reinforce their guilt, loneliness and isolation. Often, people with depression cannot identify what made them depressed or what will be helpful.

8. **Pace yourself.** If your relative is severely or more chronically depressed, it is normal for you to find his or her company very draining. Brief, frequent contacts are often the best way to relate to someone with severe depression. If your relative is hospitalized, family members might take turns in visiting.

Mania

How a person behaves during a manic episode stirs up intense feelings, especially family members. You may feel frustrated, annoyed, angry or even hatred. The strength of your feelings will depend on how severe the episode is. It is particularly frightening if, in a manic episode, the family member you know seems to be replaced by a stranger. For example, a reserved, responsible person can become loud and sexually free; a kind, gentle person can become bossy and cruel.

As well, people experiencing mania usually think that they are right and everyone else is wrong. This aspect of mania is challenging for relatives and others around the person. Your family member may take no responsibility for what he or she says or does. As a result, there may be times when you have to bail the person out. Moreover, your relative may be acutely sensitive to weaknesses in others and can behave in ways that embarrass them. A person with severe mania can easily "blow up," and being with someone in this state has been compared to walking in a minefield—you never know when there will be an explosion. Hardest of all, when someone is experiencing mania, he or she may have no insight into the manic behaviour.

If your partner has a manic episode, you may find it particularly hard because you, more than anyone, may be the target of his or her anger. You may also become a "buffer" between the person and the community, as others demand that he or she be controlled. If your partner runs up large bills, you may be hounded by creditors. Some people experiencing severe mania have extramarital affairs, which they may flaunt. If this happens, you may feel humiliated and betrayed.

Withdrawing from your partner and considering divorce may seem the only way out of an intolerable situation. But you should not make big decisions, such as whether or not to divorce, when the person is severely ill. The situation will probably change when he or she has recovered.

HOW TO RESPOND TO A PERSON EXPERIENCING MANIA

Early in a manic episode, a person may be overly happy, energetic and outgoing. Those around the person can easily be caught up in the high spirits. **Stay realistic and do not get carried away by this high mood**. A person experiencing mania feeds on attention and conflict. Try to discourage the person from becoming involved in stimulating situations, such as long talks and parties.

Only a small percentage of people with bipolar disorder experience severe mania. A person with severe mania may become hostile and suspicious, or may explode verbally and physically. Avoid arguing with someone in this state. The person will only become angrier and may even assault you.

Typically, in a manic episode, people may behave without being aware of or considering the dangers to themselves and others. They may take on risky business ventures, overspend, drive recklessly, etc. You may need to step in. The best way of preventing this kind of behaviour is to plan for it when your relative is well. During stable periods, discuss and set rules that may involve safeguards. For example, consider withholding credit cards, banking privileges and car keys. Hospitalization can save the life of a person experiencing mania.

TIPS FOR COMMUNICATING WITH A PERSON EXPERIENCING MANIA

1. **Reduce stimulation.** People with mania are easily overstimulated. You may need to have fewer people visit at the same time. Or you may need to reduce noise and activity in the house.

2. **Keep conversations brief.**

3. **Deal only with immediate issues.** Do not try to reason or argue.

4. **Discourage discussing feelings.**

5. **Try not to be authoritative, but be firm, practical and realistic.**

6. **Do not jump to the person's demands.**

7. **Do not get caught up with the person's euphoria or unrealistic expectations.**

8. **Do not try to convince the person that his or her plans are unrealistic.** At the same time, take steps to ensure his or her safety (e.g., by removing car keys or credit cards).

Getting treatment for your family member

FOLLOWING THROUGH WITH TREATMENT

Some people are very relieved when they are finally diagnosed and receive treatment that stabilizes their moods. For others, however, it is a long and bumpy road to accepting that they have a disorder that

must be managed over their lifespan. Some people must endure several manic or depressive episodes before they consistently accept help from doctors and therapists. Mild mania can be seductive because it often includes feeling happy, more confident, more energetic and more creative. The lure of these feelings may keep some people from taking their medication.

As a family member, it can be very difficult to watch this process without trying repeatedly to convince your relative to "take your medication" or "go and talk to your doctor." Repeated attempts to convince and coax can lead to heated arguments and power struggles. If you are very close to the person with bipolar disorder, and yet you feel that he or she may not be open to your observation that something is wrong, it may be more effective to have another trusted person approach your relative.

SUICIDAL THOUGHTS

A person with moderate depression will probably agree to medical treatment without needing too much encouragement. However, a person who is severely depressed and suicidal may refuse treatment because he or she feels so hopeless and worthless. In this case, you or another trusted person should insist that the person see his or her doctor or go to the emergency department of a local hospital.

Many people will agree to go to the hospital. If the person refuses, there are a number of options the family can take. For example, you can go to a justice of the peace to get an order allowing police to take the person to hospital for an assessment. If there is an immediate risk of suicide, you should call 911.

Involving the police is a painful and difficult decision, although it is sometimes necessary in order to get an ill person to hospital. Family

members often feel overwhelmingly guilty about this decision. It is important to remember that when people threaten suicide, they are usually making a plea for help, which should be taken seriously. Suicidal thinking is usually a temporary emotional state during which a person needs to be in a place of safety.

MANIC EPISODES

You may see that your family member is developing hypomania (e.g., being more energetic than usual, sleeping less, talking a lot). If so, encourage the person to see a doctor at once to get medication that will help calm down and stabilize his or her mood. For some people, hypomania leads to mania. If they are treated when they are hypomanic, they may avoid a full-blown manic episode. Once your family member develops full mania, the person may be unable to see that he or she is ill, and so may refuse to see a doctor. Manic episodes can make a person behave dangerously, with potentially serious consequences. People experiencing mania are therefore best treated in hospital.

YOUR FAMILY MEMBER IN HOSPITAL

Once in hospital, if your relative is quite ill and impaired, it is sometimes better for both the patient and the family if visits are frequent but short. People who are acutely ill do not benefit from long conversations in which they can become overwhelmed as they ruminate, or repeatedly focus on their feelings of hopelessness and negativity. Frequent, brief contacts allow you to stay in touch with your relative, and reassure him or her that you remain supportive.

For some people, being in hospital is very challenging because their movements may be restricted to ensure safety. They may wish to leave the hospital before the professional staff feel their mood and

behaviour are stabilized. For family members, this is particularly difficult as they can foresee the problems at home if the person becomes acutely ill again and requires hospitalization. Some patients will respond to the concerns of friends and family and agree to stay longer in hospital. This is more easily accomplished if there are clear goals to be achieved during the admission. For example, it might be helpful to concretely state that the person must be stabilized on medication and connected with a day program or community therapist before discharge.

Most jurisdictions in North America have mental health legislation that permits involuntary hospitalization of people only if they threaten to harm themselves or other people, or cannot care for themselves. Many ill people who would benefit from hospitalization do not meet these criteria and therefore may refuse to enter the hospital, or leave the hospital against medical advice. Families usually have a very hard time living with a person with mania who refuses treatment and who cannot be legally hospitalized or kept in hospital.

In these situations, try to negotiate with your relative when it might be best to leave the hospital. What must be accomplished during the admission for you to feel it is safe for the person to return home? Could these issues be discussed in a **discharge planning meeting** with your relative, the doctor and any other care providers who work with him or her?

Sometimes, you can slow your relative down by saying that you need this meeting to take place before consenting to his or her returning home. Families often feel guilty at insisting on these conditions, because they worry that their loved one will feel rejected. However, the result of premature discharge and poor discharge planning is frequently a relapse in the illness and a more complicated situation.

Care for partners and families

When someone has a serious illness, it is natural for family members to feel worried and stressed. In an effort to spend time comforting or helping their loved one, family members may give up their own activities. Unsure of how others may respond to their ill partner or relative, they may also avoid having friends visit their home. Over time, they may become isolated from their own network of friends, or find that most of their own routines and activities have been replaced by the demands of caring for their loved one. Often, they are well into this situation before they realize how emotionally and physically drained they have become. This stress can lead to sleep disturbances, exhaustion or chronic irritability.

It is important to recognize these signs of stress in yourself and look after your own physical and mental health. Recognizing your own limitations and making time for yourself are key elements in "self-care." Ensure that you have a good support system of reliable friends and relatives. Think about whom you want to share the details of the situation with. Mental illness is a difficult thing for some people to make sense of, so it is understandable if you want to be selective and choose only people who you know will be supportive.

Families and partners need to get as much information as possible about bipolar disorder. Knowledge and understanding will improve your ability to help and support your loved one, deal with your own feelings, and explain the situation to extended family, friends and colleagues. Information is available from the treating doctor, social worker or other mental health care providers. In addition to this publication, there are numerous books written for people with bipolar disorder and their families. They are usually available through public libraries.

Consider getting professional support for yourself, and joining a peer-support group or family support program, which may be offered at a local hospital or community mental health clinic. Keep up your interests outside the family and apart from your ill relative. Acknowledge and accept that sometimes you will have negative feelings about the situation. These feelings are normal and should not be a source of guilt.

Being ready for a relapse or crisis

Families often avoid talking to their relative about relapses or crises. They fear that talking about a crisis will bring one on, or they simply do not want to upset their relative. However, the best way to handle a crisis is to know what to do before it happens. It is important to focus on maintaining wellness, but some planning for a possible crisis can create a sense of security for the ill person and the family.

When your family member is well, discuss what you will do if he or she should become ill again. Is it possible to visit your relative's doctor together to discuss his or her condition and the possibility of a crisis? If your relative became ill, would you have permission to contact his or her doctor? Would you have consent to take the person to the hospital, and which hospital is preferred? If your loved one were acutely ill, would you be allowed to make decisions? Could you put the conditions of an agreement in writing to ensure that these instructions were followed? A prearranged plan and a good working relationship with your relative's doctor can help to contain an emergency situation.

Tips for helping your family member and supporting recovery

1. **Learn as much as you can about bipolar disorder.** Learning about the causes, signs and symptoms, and treatment of bipolar disorder will help you to understand and support your family member in his or her recovery.

2. **Acknowledge and accept your own feelings.** Having conflicting emotions is normal when a loved one is diagnosed with bipolar disorder. Knowing this can help you control these emotions when you want to support your relative in making steps toward recovery. For example, you may feel sad that your family member has a mental illness, and angry at what has happened and its effect on you. You may fear what the future holds and worry about how you will cope. If you are a parent, you may feel that somehow you caused the bipolar disorder, even though doctors have told you otherwise. It is also normal to feel a deep sense of loss when your relative is behaving in troubling, unfamiliar ways. And you may feel burdened by the extra tasks you have to take on.

3. **Encourage your family member to follow the prescribed treatment.** If your relative is not showing improvement or is having uncomfortable side-effects, encourage him or her to speak to the doctor about the medication, or to get a second opinion. It is helpful if you can go with your relative to the doctor and share what you have observed.

4. **Learn the warning signs of suicide.** These signs include your relative showing increasing despair, winding up his or her affairs and talking about "When I'm gone . . . ." Take any threats very seriously and get help immediately. Call 911 if the situation gets desperate. Recognize, and help your family member to see, that

suicidal thinking is a symptom of the illness. Always stress how much you value the person's life.

5. **When your family member is well, plan how to try to avoid crises.** Plan together how you will respond to periods of acute illness, including dealing with suicidal behaviour and preventing harmful results of manic behaviour, such as overspending or reckless driving.

6. **Remember your own needs.** Try to:

   - take care of yourself
   - keep up your own support network
   - avoid isolating yourself
   - acknowledge, within your family, the stresses of coping with bipolar disorder
   - share the responsibility with others
   - stop bipolar disorder from taking over family life.

7. **Recognize that recovery from a manic or depressive episode is slow and gradual.** Know that your family member needs to recover at his or her own pace. Try not to expect too much but avoid being overprotective. Remember that stabilizing mood is the first step towards a return to normal functioning. Try to do things *with* your relative rather than *for* him or her. That way, your relative will gradually regain self-confidence.

8. **View bipolar disorder as an illness, not a character flaw.** Treat your relative normally once he or she has recovered. At the same time, watch for possible signs of recurrence. In a caring way, point out any early symptoms and suggest a talk with the person's doctor.

9. **Learn, with your family member, to distinguish a good day from hypomania and a bad day from depression.** Like everybody else, people with bipolar disorder have good and bad days that are not part of their illness.

8 Explaining bipolar disorder to children

Explaining bipolar disorder or other mental illness to children can be awkward and difficult. To protect their children, the parent with bipolar disorder and the well parent (if present) may choose to say nothing and try to continue with family routines as if nothing were wrong. While this may provide a short-term solution, over the long term it can leave children confused and worried about the changes in behaviour that they have inevitably noticed.

Children are sensitive and intuitive, and quickly notice when someone in the family has changed. If the atmosphere in the family suggests that the subject should not be discussed, children will draw their own, often incorrect, conclusions. Young children, especially those of pre-school or elementary school age, often see the world as revolving around themselves. If something negative or unpleasant happens, they assume they did something to cause it. For example, if a child disobeys a parent and gets into trouble, and the next morning the parent is depressed, the child may assume that he or she caused the parent's depression.

To explain mental illness and bipolar disorder to children, you provide them with them as much information as they are mature enough to understand. Toddlers and pre-school children are able

to understand simple, short sentences, without much technical information. School-age children can process more information, but may be overwhelmed by details about medications and therapies. Teenagers are generally able to manage most information, and often need to talk about their impressions and feelings. They may have questions about how open they should be about the situation, and concerns about the stigma of mental illness. Sharing information with them provides an opening for further discussion.

It is helpful to cover three main areas:

1. **The parent or other family member behaves this way because he or she is sick.** It is important to tell children that the family member is ill with a sickness called bipolar disorder. Bipolar disorder makes people feel one of two ways. They might be very depressed, or sad, sometimes for no reason. They might cry a lot, sleep all day and have trouble eating or talking to people. At other times, they might become very loud and happy, although small things might irritate them and make them angry.

2. **Reassure the child that he or she did not cause the family member's illness.** Children need to be reassured that they did not cause their loved one's changes in mood through something they did or did not do. This is a frequent assumption that children will feel guilty about. Bipolar disorder needs to be explained as an illness, just like having chicken pox or a bad cold.

3. **Reassure the child that the adults in the family and other people, such as doctors, are trying to help the person who has bipolar disorder. Looking after the person is an adult responsibility, and not something the child should worry about.** Children need the well parent, or other trusted adults, to serve as a buffer against the effects of a parent's symptoms of depression and mania. They may find it very helpful to talk about their feelings with someone who

empathizes with how hard it is to see their mother, father or other relative suffering. Many children are frightened by the changes in their parent. They miss the time previously spent with this parent. Participation in activities outside the home is helpful because it exposes children to other healthy relationships. As the ill parent recovers, gradually resuming family activities can help restore the relationship between the children and the ill parent.

Both the ill and the well parent should talk with the children about explaining the illness to people outside the family. Support from friends is important for everyone; however, bipolar disorder can be difficult to explain, and some families are concerned about the stigma attached to mental illness. The level of openness you and your children are comfortable with is a very individual choice.

Some parents with bipolar disorder may not be able to tolerate the boisterous activities and noise that are part of children's everyday play and routines. It may be necessary to take special measures to protect against events that could trigger irritability in the ill parent and cause him or her to be abrupt with the children. You may need to plan time for the children to play outside the home, or arrange for the ill parent to rest for part of the day in a quiet area of the house.

Once recovered, it is helpful for the parent who was ill to explain his or her behaviour to the children. The recovered parent may need to plan some special times with the children, to re-establish the relationship and to reassure the children that he or she is again available and interested in them.

More information on talking to children about depression is available in the pamphlet *When a Parent Has Bipolar Disorder . . . What Kids Want to Know*, available from the Centre for Addiction and Mental Health. An online version is available at www.camh.ca.

The CAMH children's book *Can I Catch It Like a Cold? Coping with a Parent's Depression* may also be helpful resource.

Glossary

Adjunct medication: Medicine that complements a main medication.

Agitation: A severe inner restlessness that is often accompanied by anxiety. Patients typically cannot sit still; they may pace and wring their hands.

Antidepressants: Medicines used to treat the symptoms of depression. Antidepressants may also be used to treat other mental health problems, such as panic disorder and obsessive-compulsive disorder.

Antipsychotics: Medications that quickly control mania and treat psychotic symptoms. Antipsychotics can also prevent new attacks of mania.

Anxiety: An emotional state characterized by excessive worry, apprehension or fear of impending actual or imagined danger, vulnerability or uncertainty. In a more acute form it can include intense fear and discomfort, with symptoms such as a pounding heart, sweating, shortness of breath, nausea, dizziness and fear of losing control. Anxiety is common in bipolar disorder.

Anxiolytics: Anti-anxiety medicines, such as benzodiazepines.

Benzodiazepines: A group of anti-anxiety medications that share a similar chemical structure. Some common benzodiazepines are diazepam (Valium) and lorazepam (Ativan).

Bipolar disorder: Formerly known as manic-depressive illness; a disorder characterized by mood swings, which includes the occurrence of one or more manic or hypomanic episodes and usually one or more major depressive episodes.

Bipolar-I disorder: A type of bipolar disorder in which people experience full manic or mixed episodes.

Bipolar-II disorder: A type of bipolar disorder in which people experience only hypomania and depression.

Catatonic symptoms: People who become catatonic have trouble with movement: they may experience extreme physical agitation or slowness and odd movements or postures.

Cognitive-behavioural therapy (CBT): A time-limited psychotherapy that focuses on how thoughts influence mood and how some thought patterns contribute to depression. CBT is beginning to be tested in the treatment of bipolar disorder, with promising early results.

Comorbid disorder: A medical condition that often accompanies, or co-occurs with, another disorder; for example, alcohol or other drug abuse, panic disorder, obsessive-compulsive disorder or binge eating disorder can co-occur with bipolar disorder.

Complimentary medicines: For bipolar disorder, these include "natural remedies," such as fish oil and inosital (a kind of sugar). Little research has been done on these products.

Cycle: The time from the start of one episode until the start of the next.

Delusion: A false, fixed belief not shared by your culture, such as believing that your thoughts are being controlled by forces outside you. There are various types of delusions, such as paranoid (with feelings of suspicion) and grandiose (with feelings of excessive self-importance).

Depression: An episode characterized by a loss of energy, feelings of worthlessness and loss of interest in things that usually bring pleasure (food, sex, work, friends and entertainment). People may think often about death or suicide. Depression is diagnosed when at least five of a group of symptoms have lasted for at least two weeks.

Electroconvulsive therapy (ECT): A treatment procedure for severe depression and severe mania. ECT involves passing a controlled electric current between two metal discs applied on the surface of the scalp.

Episode: A period of illness. This can include depression, hypomania, mania or a mixed state.

Group therapy: Therapy for a number of patients together. Group therapy has been used successfully to give patients support and psychoeducation.

Hallucination: a false sensory experience, such as seeing, hearing, tasting, smelling or feeling something that does not really exist.

Hypersomnia: The condition of sleeping too much, especially during the day. Hypersomnia can be a symptom of bipolar disorder.

Hypomania: A state characterized by a high mood and overactivity, but not as extreme as mania.

Insomnia: The condition of not being able to fall asleep, or of waking too soon or repeatedly. Insomnia can be a symptom of bipolar disorder.

Light therapy: Light therapy is a form of treatment involving exposure to a specific type of light for 30 minutes to one hour daily,

for several weeks. This light is usually provided by a special light box, and is useful for the treatment of seasonal depressions and occasionally for other types of depression.

Maintenance treatment: Treatment intended to prevent a new episode (including depression, mania, hypomania).

Mania: A state characterized by an unusually high mood, irritability, overactivity, excessive talking, racing thoughts, inflated ideas of self, lack of insight, poor judgment, impulsiveness and financial extravagance.

Manic-depressive illness: See Bipolar disorder above.

Mixed episode: An episode in which people experience both manic and depressive symptoms. The symptoms either occur at the same time or alternate quickly.

Mood disorders: Disorders that have a disturbance in mood (typically depression or mania) as the predominant feature. The two main categories are unipolar depression and bipolar disorder.

Mood stabilizers: Medicines, such as lithium, that help reduce swings in abnormal moods. They can also help prevent fresh mood episodes.

Neurotransmitters: Chemicals that carry signals between neurons (nerve cells) in the brain. Neurotransmitters include norepinephrine, serotonin, dopamine and acetylcholine.

Psychoeducation: An educational process that allows people to better understand and manage mental health and/or substance use problems, whether their own or those of a family member or friend.

Psychosis: A term that refers to disturbances that cause the personality to disintegrate and the person to lose contact with reality.

Psychotherapy: A general term used to describe a form of treatment based on talking with a therapist. Psychotherapy aims to relieve distress by allowing a person to discuss and express feelings. The goal is to help the person change attitudes, behaviour and habits, and develop better ways of coping.

Rapid cycling: Bipolar disorder is said to be rapid cycling if a person experiences more than four episodes a year. Only 20 per cent of people with bipolar disorder experience rapid cycling.

Relapse: Return of the symptoms of an illness after a person has seemingly responded to treatment, but before the symptoms have fully gone.

Transcranial magnetic stimulation (TMS): A brain stimulation treatment that involves a series of short magnetic pulses directed to the brain.

Trigger: A situation that can cause either mania or depression in a person who has already had an episode of illness. Stress, sleep loss, steroids and street drugs are some of the triggers for bipolar disorder.

Unipolar depression: Another name for major depressive disorder.

Resources

SUGGESTED READING

Basco, M.R. (2005). *The Bipolar Workbook: Tools for Controlling Your Mood Swings*. New York: Guilford Press.

Burns, D. (1999). *The Feeling Good Handbook* (Rev. ed.). New York: Penguin.

Centre for Addiction and Mental Health. (2003). *When a Parent Has Bipolar Disorder . . . What Kids Want to Know*. Retrieved from knowledgex.camh.net/amhspecialists/resources_families/Documents/when_parent_bipolar.pdf

Copeland, M.E. (2001). *The Depression Workbook: A Guide for Living with Depression and Manic Depression* (2nd ed.). Oakland, CA: New Harbinger.

Fast, J.A. (2006). *Take Charge of Bipolar Disorder: A 4-Step Plan for You and Your Loved Ones to Manage the Illness and Create Lasting Stability*. New York: Warner Books.

Fuller Torrey, E. & Knable, M. (2005). *Surviving Manic Depression: A Manual on Bipolar Disorder for Patients, Families and Providers*. New York: Basic Books.

Greenberger, D. & Padesky, C. (1995). *Mind over Mood*. New York, Guilford Press.

Last, C.G. (2009). *When Someone You Love Is Bipolar: Help and Support for You and Your Partner*. New York: Guilford Press.

Kabat-Zinn, J. (1994). *Wherever You Go, There You Are: Mindfulness Meditation in Everyday Life*. New York: Hyperion Books.

Miklowitz, D.J. (2011). *The Bipolar Survival Guide: What You and Your Family Need to Know* (2nd ed.). New York: Guilford Press.

Redfield Jamison, K. (1995). *An Unquiet Mind*. New York: Random House.

Redfield Jamison, K. (2004). *Exuberance: The Passion for Life*. New York: Knopf.

INTERNET RESOURCES

Bipolar Network News
www.bipolarnews.org

Canadian Mental Health Association (CMHA)
www.cmha.ca

Canadian Network for Mood and Anxiety Treatments (CANMAT)
www.canmat.org

Depression and Bipolar Support Alliance
www.dbsalliance.org

Mood Disorders Association of Canada
www.mooddisorderscanada.ca

Optimism (a mood charting app)
www.findingoptimism.com

Organization for Bipolar Affective Disorder (OBAD)
www.obad.ca

Other guides in this series

Addiction

Anxiety Disorders

Cognitive-Behavioural Therapy

Concurrent Substance Use and Mental Health Disorders

Couple Therapy

Depression

First Episode Psychosis

The Forensic Mental Health System in Ontario

Obsessive-Compulsive Disorder

Schizophrenia

Women, Abuse and Trauma Therapy

Women and Psychosis

To order these and other CAMH publications,
contact Sales and Distribution:
Toll-free: 1 800 661-1111
Toronto: 416 595-6059
E-mail: publications@camh.ca
Online store: http://store.camh.ca

Bipolar disorder is a serious medical condition in which people have extreme mood swings that affect how they think, behave and function. It typically includes a high state (mania) and a low state (depression)—both of which can include many different symptoms—in addition to a well state.

This guide is for people living with bipolar disorder, their families and anyone else who wants to understand this disorder. The guide describes the clinical features and symptoms of bipolar disorder, what is thought to cause it, and how it can be managed and treated. It also includes ways family members can support people with bipolar disorder while also taking care of themselves, and tips on explaining the disorder to children.

This publication may be available in other formats.
For information about alternate formats or other CAMH publications, or to place an order, please contact Sales and Distribution:
Toll-free: 1 800 661-1111
Toronto: 416 595-6059
E-mail: publications@camh.ca
Online store: http://store.camh.ca

Website: www.camh.ca

Disponible en français.

camh
Centre for Addiction and Mental Health

ISBN 978-1-77052-579-5

9 781770 525795

3973f / 01-2014 / PM105