Bipolar Disorder

Treatment & Referral Guide

- How to recognise Bipolar
- Who to approach for treatment
- Treatment Options
- Self Help

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NEUROSCIENCE
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THE SOUTH AFRICAN DEPRESSION AND ANXIETY GROUP

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Quotes from patients

"The highest, biggest quickest, can't keep up with it all, from can't possibly fail, to irritation to rage, and finally to the lowest, murky chamber of hell where the darkest of moods slowly strangles every hope... and, maybe, in-between all is all right."

Depression: "I doubt completely my ability to do anything well. It seems as though my mind has slowed down and burned out to the point of being virtually useless... [I am] haunt[ed]... with the total, the desperate hopelessness of it all... Others say, "It's only temporary, it will pass, you'll get over it, but they don't know how I feel, even it they think they do. If I can't feel, move, think or not care, then what on earth is the point?"

Mania: "The fast ideas become too fast and there are far too many... overwhelming confusion replaces clarity... you stop keeping up with it - memory goes. Infectious humor ceases to amuse. Your friends become frightened... everything is now against the grain... you are irritable, angry, frightened, uncontrollable, and trapped."

Hypomania: "At first when I'm high, it's tremendous... ideas are fast... like shooting stars you follow until brighter ones appear... all shyness disappears, the right words and gestures are suddenly there... uninteresting people and things, becoming intensely interesting. Sensuality is pervasive, the desire to seduce and be seduced is irresistible. Your marrow is infused with unbelievable feelings of ease, power, well-being, omnipotence, euphoria... you can do anything... but, somewhere, this changes."

Descriptions offered by patients themselves offer valuable insights into the various mood states associated with bipolar disorder.

• Abraham Lincoln, • Virginia Woolf, • Lionel Aldridge, • Beethoven, • Gaetuno Donizelti, • Robert Schuman, • Leo Tolstoy, • Vaslav Njinshy, • John Keats, • Tennesse Williams, • Vincent Van Gogh, • Isaac Newton, • Ernest Hemingway, • Sylvia Plath, • Michaelangelo, • Winston Churchill, • Vivien Leigh, • Emporor Norton, • Jimmy Piersall, • Patty Duke, • Charles Dickens

PEOPLE WITH MENTAL ILLNESSES ENRICH OUR LIVES

These people have experienced one of the following mental illnesses: Schizophrenia, Bipolar, Depression or Anxiety

Introduction

Bipolar disorder is more than just a simple mood swing. You experience a sudden dramatic shift in the extremes of emotions. These shifts seem to have little to do with external situations. In the manic or "high" phase of the illness you aren't just happy, you are ecstatic. A great burst of energy can be followed by a severe depression, which is the "low" phase of the disease. Periods of fairly normal moods can be experienced between cycles. These cycles are different for different people. They can last for days, weeks, or even months.

Although bipolar disorder can be disabling, it also responds well to treatment. Since many other diseases can masquerade as manic depression, it is important you and your loved ones receive a competent medical evaluation as soon as possible.

Now let's talk about how we can help

This booklet was created to help you understand how treatment may make living with bipolar disorder easier. As you read, you'll discover what you may expect from therapy and medication, how they work alone and with other treatments, and when to call your physician and/or mental health professional. You'll learn about the different types of bipolar disorder and respective symptoms. You will also learn about the way to help yourself. At the back of this booklet you will find a list of resources to help you learn more about bipolar disorder.

What is Bipolar Disorder?

Bipolar disorder is a physical illness marked by extreme changes in mood, energy and behavior. That's why doctors classify it as a mood disorder.

Bipolar disorder - which use to be known as manic depressive illness - is a mental illness involving episodes of serious mania and depression. The person's mood usually swings from overly "high" and irritable to sad and hopeless, and then back again, with periods of normal mood in between.

Essentially bipolar disorder consists of four states:

- Highs
- Lows
- Mixed states
- Rapid cycling

Bipolar disorder typically begins in adolescence or early adulthood and continues throughout life, but it can start at any age. It can start with depression, even recurrent depressions. The individual may only experience a high or a mixed state after many years. It is often not recognized as an illness, and people who have it may suffer needlessly for

years or even decades. Effective treatments are available that greatly alleviate the suffering caused by bipolar disorder.

What causes Bipolar Disorder?

The exact cause of bipolar disorder is not known, but it is believed to be a combination of biochemical, genetic and psychological factors.

Biochemistry

Research has shown that this disorder is associated with a chemical imbalance in the brain, that can be corrected with appropriate medication.

Genetics / Heredity

Bipolar disorder tends to run in families. Researchers have identified a number of genes that may be linked to the disorder suggesting that several different biochemical problems may occur in bipolar disorder (just as there are different kinds of arthritis). However, if you have bipolar disorder and your spouse does not, there is only one in seven chance that your child will develop it. The chance may be greater if you have a number of relatives with bipolar disorder or depression.

Biological Clocks

Mania and depression are often cyclical, occurring at particular times of the year. Changes in biological rhythms, including sleep and hormone changes, characterize the illness. Changes in the seasons are often associated triggers.

Psychological Stress

People who are genetically susceptible may have a faulty "switch - off" point - emotional excitement may keep escalating into mania setbacks may worsen into profound depression.

Sometimes a stressful life event such as a loss of a job, marital difficulties, or a death in the family may trigger an episode of mania or depression. Very often, episodes occur for no apparent reason. The earlier treatment is started, the more effective it may be in preventing future episodes.

Who gets Bipolar Disorder?

Bipolar disorder is common - affecting about 1% of the population. Men and women are equally effected. While the disorder has been seen in children, the usual age of onset is late adolescence and early adulthood. Mania occasionally appears for the first time in the elderly and when it does, it is often related to another medical disorder. Bipolar disorder is not restricted to any social or educational class, race, or nationality. Although an equal number of men and women develop the illness, men tend to have more manic episodes while women experience more depressive episodes.

What are the different types and patterns of Bipolar Disorder?

People vary in the types of episodes they usually have and how often they become ill. Some people have equal numbers of manic and depressive episodes; others have mostly one type or the other. The average with bipolar disorder has four episodes during the first 10 years of illness. Men are more likely to start with a manic episode, women with a depressive episode. While a number of years can elapse between the first two or three episodes of mania or depression, without treatment most people eventually have mor frequent episodes.

Episodes can last days, months or sometimes even years. On average without treatment, manic or hypomanic episodes last a few months while depression often last well over six months. Some individuals recover completely between episodes and may go many years without any symptoms, while others continue to have low-grade but troubling depression or mild swings up and down.

Special terms are used to describe common patterns:

- ***In Bipolar I Disorder,*** a person has manic or mixed episodes (an episode when symptoms of mania and depression occur together) and almost always has depression as well. If you have just become ill for the first time ad it was with a manic episode, you are still considered to have bipolar 1 disorder. It is likely that you will go on in the future to have episodes of depression, as well as mania-unless you get effective treatment.
- ***In Bipolar II Disorder,*** a person has only hypomanic (a mild form of mania) and depressive episodes, not full manic or mixed episodes. Bipolar II is *frequently misdiagnosed*. This type is often hard to recognize because hypomania may seem "supernormal", especially if the person feels happy, has lots of energy, and avoids getting into serious trouble. If you have bipolar II disorder, you may overlook hypomania and seek treatment only for your depression. Unfortunately, if the only medication you receive is an antidepressant, there is a risk that the medication may trigger a "high" or set off frequent cycles.
- ***In Rapid Cycling Bipolar Disorder,*** a person has at least four episodes per year, in any combination of manic, hypomania, mixed or depressive episodes. This course pattern is seen in approximately 5%-15% of patients with bipolar disorder. It sometimes results from "chasing" depressions too hard with antidepressants, which may trigger a high followed by a crash (i.e. you keep going up and down as if on a roller coaster).
- ***Schizoaffective Disorder:*** This term is used to describe a condition that in some ways overlaps with bipolar disorder. In addition to mania and depression, there are persistent psychotic symptoms (hallucinations or delusions) during times when mood symptoms are

under control. In contrast, in bipolar disorder, any psychotic symptoms that occur during severe episodes of mania or depression end as the mood returns to normal.

- ***Cyclothymia*** can be diagnosed if a person has a low grade, chronic and fluctuating disturbance. In cyclothymia there are mild highs and lows, which are not severe enough to be diagnosed as a full manic or depressive disorder.

What causes the symptoms of Bipolar Disorder?

In the course of bipolar disorder, four different kinds of mood episodes can occur:

1. Mania (manic episode)

During a manic episode the mood can be abnormally elevated, euphoric, or irritable. Thoughts race and speech is rapid, sometimes non-stop, often jumping from topic to topic in ways that are difficult for others to follow. Energy level is high, self-esteem inflated, sociability increased, and enthusiasm abounds. There may be very little need for sleep ("a waste time") with limitless activity extending around the clock. During a manic episode, a person may feel "on top of the world" and have little or no awareness that feelings and behaviors are not normal.

Mania comes in degrees of severity and, while a very little amount may be pleasant and productive, even the less severe form known as hypomania can be problematic and cause social and occupational difficulties. A manic episode is more severe than a hypomania episode with a magnification of symptoms to the extent that there is marked impairment in interpersonal and social interactions and occupational functioning. Hospitalization is often necessary. Severe mania can be psychotic - the person loses contact with reality and may experience delusions (false beliefs), especially of a grandiose ("I am the President"), religious ("I am God") or sexual nature, and hallucinations (hearing voices or seeing visions). Psychotic mania my be difficult to distinguish from schizophrenia and, indeed, mistaking the former for the latter in not uncommon.

During a manic episode, judgement is often greatly impaired as evidenced by excessive spending, reckless behaviors involving driving, abuse of drugs and alcohol and sexual indiscretion, and impulsive, sometimes catastrophic business decisions. You may feel unusually "high", euphoric, or irritable (or appearing this way to those who know you well).

Plus at least four (and most often all) of the following:

- Needing little sleep yet having great amounts of energy.
- Talking so fast that others can't follow your thinking,
- Having racing thoughts.

- Being so easily distracted that your attention shifts between many topics in just a few minutes.
- Having an inflated feeling of power, greatness, or importance.
- Doing reckless things without concern about possible bad consequences- such as spending too much money, inappropriate sexual activity, making foolish business investments.
- Extreme irritability and distractibility.
- Abuse of alcohol or drugs.

In very severe cases, there may be psychotic symptoms such as hallucinations (hearing or seeing things that aren't there) or delusions (firmly believing things that aren't true).

2. Mixed Episode

Perhaps the most disabling episodes are those that involve symptoms of both mania and depression occurring at the same time or alternatively frequently during the day. You are excitable, or agitated as in mania but also feel irritable and depressed, instead of feeling on top of the world.

Mixed episodes sometimes known dysphoric mania occur in up to 40% of individuals with bipolar disorder and can be particularly troublesome because they may be more difficult to treat.

3. Depression (Major Depressive Episode)

In a full-blown major depressive episode, the following symptoms are present for at least 2 weeks and make it difficult for you to function:

- Feeling sad, blue, or down in the dumps.
- Losing interest in things you normally enjoy.

Plus at least four of the following:

- Trouble sleeping or sleeping too much.
- Loss of appetite or eating too much.
- Problems concentrating, remembering or making decisions.
- Feeling slowed down or feeling too agitated to sit still.
- Feeling worthless or guilty or having very low self-esteem.
- Loss of energy or feeling tired all of the time.
- Prolonged sadness or crying spells.
- Pessimism, indifference.
- Recurring thoughts of suicide or death.

During a depressive episode, mood is sad, unhappy or irritable. Self-esteem is low, thoughts are negative, and there is loss of interest in usual activities and inability to experience pleasure. Concentrating is difficult and decision-making impaired. Feelings of hopelessness and helplessness are common with both the present and future looking bleak. Guilt, crying and social withdrawal are additional features. Suicidal thoughts, plans and attempts are common and, in fact, suicide is a cause of death in many

people with depression. Physiological findings associated with depression include sleep disturbance (either insomnia or oversleeping) change in appetite, fatigue, loss of interest in sex, and bodily pains.

Untreated manic depression can be devastating with great personal suffering, disruptive relationships, derailing careers, increased risk of death from suicide and accident, and enormous financial cost to the individual and society. Proper treatment, however, can be effective in returning people to more healthy and productive lives.

Is Bipolar Disorder treatable?

Fortunately, the answer to this question is "yes". Treatment is the form of medication and counselling can be effective for most people with manic depression.

Bipolar disorder is similar to other lifelong illnesses - such as high blood pressure and diabetes - in that it cannot be "cured". It can, however, be managed successfully through proper treatment, which allows most patients to return to productive lives.

On the other hand, if not diagnosed and not treated, the impact of the illness can be devastating to the individual, significant others, and society in general.

Around 85% of people who have a first episode of bipolar disorder will have another. Because of this maintenance treatment is essential in this illness. Good quality of life is usually possible with effective treatment.

How do I get help?

If you suspect that you, a family member, or a friend has bipolar disorder, you should consult a mental health professional. This can be done through your family doctor, psychiatrist or your community mental health centre, the self-help and support groups listed on the back page can also be very helpful.

If you are not happy with your doctor or therapist, don't be afraid to speak up or seek a second opinion. Many people go through more than one mental health professional before developing a comfortable partnership most of us are probably more aggressive about our choice of hairdresser or car mechanic. What could be more important than your health?

Psychiatrists are medical doctors who specialise in the diagnosis of mental illness. In addition to providing counselling, they are the only mental health professional who can prescribe medication. Clinical psychologists, clinical workers and nurse specialists can also diagnose and provide counselling and psychotherapy.

The outlook for people with bipolar disorder today is optimistic. Many new and promising treatments are being developed and with the right treatment most should be able to lead full and productive lives.

How is Bipolar Disorder diagnosed?

Obtaining a thorough present and past history is key to the diagnosis of bipolar disorder. While the patient is usually the main source of information, contributions from family members and other involved persons can be helpful. The diagnosis may be missed if the patient presents for treatment during a depressive episode unless care is taken to uncover a history of prior manic or hypomanic episodes, Since some of the symptoms of severe mania and schizophrenia may be similar, distinguishing the two may be difficult unless a detailed history is obtained of the entire clinical course of the illness. While there are not laboratory tests that diagnose bipolar disorders, certain tests may be helpful in excluding medical disorders that can mimic mania or depression.

How often should I talk with my doctor?

During acute mania or depression, most people talk with their doctor at least once a week, or even daily, to monitor symptoms, medication doses an side effects. As you recover, contact becomes less frequent. Once you are well, you might see your doctor for a quick review every few months.

Regardless of scheduled appointments or blood tests, call your doctor if you have:

- Suicidal or violent feelings.
- Changes in mood, sleep, or energy.
- Changes in medication side effects.
- A need to use over-the-counter medications such as cold medicine or pain medicine.
- Acute general medical illness or a need for surgery, extensive dental care, or changes in other medicines you take.

What type of medication is used for bipolar disorder?

The symptoms of bipolar disorder vary over time, from mania to depression, with many people experiencing complex mood states at various times.

The most important medicines used to manage bipolar disorder are mood stabiliser. To treat depression, antidepressants may be added to the mood stabilisers. To treat mania, antipsychotic medicines and other sedative medicines may be used. To maintain normal mood, mood stabilisers need to be used in an ongoing way.

Over the life time of a person living with bipolar disorder many symptoms and symptom complexes may appear necessitating the use of a range of interventions. Your doctor will discuss the need for additional medication should their use be considered necessary.

What are mood stabilisers?

Mood stabilisers are medications used to stabilise the mood, i.e. to prevent mania or depression. Mood stabilisers are the mainstay of management of bipolar disorder. There is general agreement that mood stabilisers should be used in all phases of the condition, for acute states of mania, hypomania, depression, mixed states, and complex presentations such as psychosis, agitation, anxiety, as well as for wellness maintenance and prevention of further episodes.

The evidence supporting the use of the various mood stabilisers changes over time. Based on current research the following statements can be supported.

Initial treatment should be a first or second line mood stabiliser.

First line mood stabilisers:

- Lithium better at preventing mania and hypomania, more useful for "above the line" mood disorders. Long term use is supported.
- Lamotrigine better at preventing depressive relapses, may have some use for "below the line" mood disorders. Long term use is supported.

Second line mood stabilisers:

- Valproate- recent evidence possibly downgrades valproate as a first line agent, although still widely used and may have particular effectiveness in mixed states. Long term use is supported in management of other disorders. Alternative agent where lithium is not suitable.
- Carbamazepine - there is little recent data, but carbamazepine may be useful where other agents have failed. Long term use is supported in management of other disorders.

Evidence still accumalating:

- Oxcarbazepine - break down product of carbamazepine. Short and long term information still needed.

Evidence supported:

- Topiramate - evidence does not support of topiramate as a mood stabiliser on its own. Occassionally effective.
- Gabapentin - evidence does not support use of gabapentin as a mood stabiliser on its own. Occasionally effective. May have use as anxiety relieving agent in management of mood disorders.

The above agents are all anti-convulsants (anti-epilepsy medicines), with the exception of lithium. This does not imply that bipolar disorder is a form of epilepsy. Many medicines used to treat epilepsy are not useful for the management of bipolar disorder. Each of these differs from the others quite significantly.

Other agents that may act as mood stabilisers

Recently there has been some evidence to support the use of so-called atypical antipsychotics as an alternative class of drugs that may be useful for the management of bipolar disorders. Use of these medicines in bipolar disorder is not necessarily related to their anti-psychotic activity. They may emerge as alternative mood stabilising medicines in their own right. Long term data supporting their use in bipolar disorder are lacking, especially with respect to possible so-called metabolic side effects, especially weight gain, increased risk of diabetes and raised levels of cholesterol and triglycerides. This means there is a need for caution at this stage before these agents can be confidently recommended for long term use in bipolar disorder.

- Olanzapine - good evidence to support the use of olanzapine in the management of acute mania, and in the prevention of relapse into mania and to some extent into depression up to one year. Use up to one year as first line agent alternative to lithium and limotrigine is supported. Caution still required with respect to long term use.
- Quetiapine - some data emerging that Quetiapine may have similar efficacy to olanzapine, possible with more effecacy for "below the line" moods. Long term data still lacking.
- Risperidone, Ziprasidone, Aripiprazole - data shows efficacy in management of acute mania. Long term data lacking. Long term use of risperidone supported in other psychiatric conditions.

(New avenues of research continue and medicines with novel actions are likely to be introduced over the next few years. Studies of currently used medicines also continue to be published, updating the knowledge base).
Your doctor should suggest the use of one or more of these medicines and be able to review the advantages/disadvantages of each agent in your particular agent in your particular situation.

Current evidence shows that use of a single mood stabiliser is not usually effective in the long run, with the possible exception of lithium, and then in selected individuals.

Although these medicines all belong to two large classes of medicines, anticonvulsants (anti-epilepsy agents) and atypical antipsychotics, each one has a specific action on the brain and in the body. Thus, if one drug is not effective,

or causes you to experience intolerable side effects, your doctor can suggest another drug, or may combine two medications at doses you can manage. Each of these medicines must be monitored, and for many of them blood tests and other examinations are regularly needed to ensure optimal use and to detect the emergence of side effects.

Medication selection for managing an acute episode

Acute manic episodes remain poorly understood and relatively poorly studied. Except in mild cases, initial treatment usually occurs in a hospital setting. Many people suffering from acute mania fail to recognize their condition and dramatic changes in mood and behavior may impact on family members and loved ones.

Although mild euphoric (overly happy) manic episodes may be managed with lithium, and dysphoric irritable manic episodes and mixed manic (irritable excitable states interspersed with depressive symptoms) states may be managed with valproate or lithium, in all but mild presentations, additional medicine will probably be required in the initial stages.

Valproate may begin working effectively within a week and lithium within one to two weeks. Given the often rapidly changing and somewhat unpredictable nature of mania, additional medicines that work more rapidly may be necessary.

In acute phases, and in more severe forms of mania, most doctors will select one of the antipsychotic medicines to help achieve remission more rapidly. Medicines used in this manner include haloperidol, olanzapine risperidone quetiapine ziprasidone or clozapine.

Selecting additional medications for management of a manic episode.

Two types of medicines are used for insomnia, anxiety and agitation during a manic episode:

- Anti-anxiety medicines, especially lorazepam and clonazepam.
- Anti-psychotic medicines such as haloperidol, olanzapine risperidone, Quetiapine, amisulpride, ziprasidone and clozapine.

During acute treatment of mania you may need to be on one of these agents to help you sleep or to reduce physical or mental agitation. Anti-psychotic medication is useful if you have delusions, hallucinations, severe agitation or extreme irritability and aggression.

Anti-anxiety and anti psychotic medicines work rapidly and can be given by mouth or by injection. If you are severely manic, you may not recognise that you are ill and may refuse medication. Injections may save your life,

preventing you from acting in irrational, dangerous, or impulsive ways.

Anti-anxiety and anti psychotic medicines may cause drowsiness as a side effect. Antipsychotic medicines may cause muscle stiffness, motor restlessness (typically you feel unable to sit still) and other side effects. If you experience problems with side effects, be sure to tell your doctor who can adjust the dose or add other medicine to help.

As you recover from the manic episode these additional medicines are tapered, over a period of weeks or months.

Medication selection for depressive episodes

Treatment of depressive symptoms in bipolar illness is more problematic. One reason is that the diagnosis of bipolar disorder may not have been made and treatment for unipolar depression is initiated and maintained. Other reasons include the possibility of antidepressive medicine causing a switch into mania, or, if not causing a full manic episode, causing a mild manic episode, or a so-called mixed state with both depressive and manic symptoms. Although not well studied, there does seem to be, in many people, a loss of effectiveness of antidepressants in the treatment of bipolar depression throughout the life of the individual. For these reasons, there remains some debate about the role of antidepressive medication in the management of bipolar disorder.

Although mood stabilisers, especially lamotrigine and lithium to some extent, may pull you out of the depression, you may also need to take antidepressant medication to treat a depressive episode. In bipolar disorder, antidepressant medication should always be used together with a mood stabiliser to try to prevent the overshoot into mania.

Antidepressants usually take several weeks to start working; don't be discouraged by lack of early improvement. Although the first drug tried will usually work, it is common to try two or three antidepressant trials before discovering the one that is effective for you, with tolerable side effects.

While waiting for the antidepressant to work your doctor may prescribe a sedating medicine to assist your sleep. or to quell anxiety or agitation. Once you have recovered from your depression for a sufficient time your doctor will help you decide whether to taper the antidepressant.

Many different types of antidepressant medication are available. The medicines may differ in their chemical action, so changing from one to another may be necessary if you do not react sufficiently to a given antidepressant.

All antidepressant medicines may be effective, but there is some consensus among experts that the medicines should be applied in the following class order, unless there is information to suggest one or other agent should be tried first, or avoided:

- Selective serotonin re-uptake inhibitors: Citalopra, escitalopram, fluvoxamine, fluoxetine, sertraline, paroxetine. There is no evidence to favour any one of these agents above the others.

If one of these agents is not effective, other agents can be tried:

- Bupropion.

If these medicines do not work, there are many other choices:

- Venlafixine. There is some indication that venlafaxine may be more likely to induce mania or mixed states, that is, the depression, instead of lifting to the position of normal mood, keeps lifting beyond normal into a manic episode. This concern is based upon the effect of this agent on noradrenaline in the brain.
- If activity on noradrenaline in the brain carries increased risk for a medicine to induce mania, other medicines that could carry higher risk for including mania include:
  - Tricyclic antidepressants: amitriptyline, dothiepin, imipramin, clomipramine.

  Clearly these medicines must always be combined with effective mood stabilisation and their use should be supervised by clinicians with experience in this area.

Other antidepressants that may be considered, although there is little data to assist with their choice for bipolar, include:

- Mirtazapine
- Moclobemide
- Trazodone
- Mianserin

If an anitdepressant is used in your case, and proves effective, there is still uncertainty as to how long the antidepressant should be continued. Long term use of antidepressants may increase the risk of cycling, or other forms of mood destabilisation occurring, but some people relapse into depression when the antidepressant is tapered. Decisions of this nature should always be made in conjunction with your doctor, and in complex cases it is advisable to obtain a second opinion.

There is emerging evidence that so-called atypical antipsychotic agents, especially in their lower dose range may be useful in the management of bipolar depression, especially where other agents are not completely effective. Although the word "anti-psychotic" sounds alarming,

especially if you have never been psychotic, antiphychotic medicines have been used, for many years, to help control symptoms of agitation and anxiety in people who suffered from severe depressive and anxiety disorders but who were not psychotic. Once again, the optimal duration to remain on these medicines is uncertain.

Novel antidepressant medicines, that is medicines with new mechanisms of action, are likely to be introduced at regular intervals in the future.

- Agomelatine

Manage your medication by taking the following steps:

- Take responsibility for your medicines. Learn about your medicines, how they work, what to expect, possible side effects as well as dietary and lifestyle restrictions. It is important to gain some understanding of the concept of side effects. You should understand the common side effects of the medicine and that common side effects tend to be mild and pass off with time. Knowledge of the serious side effects of your medicine is important, along with the realisation that serious side effects of your medicine is important, along with the realisation that serious side effects tend to be uncommon, but that some serious side effects may be delayed in onset, and may only appear after prolonged use of the medicine. Serious side effects that occur early on in the use of a particular medicine usually necessitate stopping the medicine. These issues and your concern should be discussed with your doctor. There is a lot of information about psychotropic medication in the lay press, but much of the reporting is inaccurate or sensational. If you have doubts about your medication consult your doctor.
- Take medicines only as prescribed. Inform all doctors who prescribe medicine for you of all the medicines you are taking.
- Use a daily reminder/medication saver system to ensure regular use. If possible use the medicine at the same time of day each day. Include the medicines on your mood chart, and document benefits and side effects of future reference.
- Discard medications no longer in use.
- Don't expect medicines to fix a bad diet, lack of exercise or an abusive or chaotic life style. Establish a regular daily schedule and stick to it. Optimise your diet. Remove mood destabilising chemicals from your life, including alcohol (as completely as possible) and recreational drugs. Avoid stimulants.
- Many medicines used to treat "physical" illnesses can cause mood changes. or can interfere with your psychotropic medicines. Discuss all medicine changes with all relevant prescribing doctors.

- Stopping and starting medicines can seriously negatively influence the outcome of your condition. Stopping medication because you are "well" has been shown to increase your chance of relapse. Bipolar disorder is a recurring condition. Most people require long term prophylactic medication. Most people who stop medication do so because they are relapsing into another episode.

What about hospitalisation?

Treatment in hospital is sometimes necessary, but is usually brief - a few weeks. Hospitalisation can be essential to prevent self-destructive behaviour, as well as aggressive and impulsive behaviours, that may have serious consequences that the person will regret. Manic patients often require hospitilisation as they do not recognise they are ill.

Research shows that, after their recovery, most manic patients are grateful for the help they received, even if it was against their will at the time.

Depression is sometimes treated in hospital, when there is a threat to the person's life, from self neglect or suicide, or when there are medical complications that make the medicating of the depression too complicated to proceed at home. Some people require hospitalisation to help them stop using drugs or alcohol.

Early recognition and management of mania and depression helps prevent the need for hospitalisation.

What side effects are most common?

It is important to recognise that common side effects tend to be mild, and that serious side effects are usually rare. Side effects are dose related and reducing the dose will usually lessen a side effect. Side effects that occur early in management may resolve with time. Side effects are only important inasmuch as they affect you. Many people take medicines without developing any side effects.

Side effects of mood stabilisers, atypical antipsychotic and SSRI antidepressant.

	Common early side effects you may experience early in treatment, depending on dose.	Long-term problems to watch for-there are usually workarounds for most of these problems
Lithium	Nausea, upset stomach, diarrhoea. Thirst, drinking fluids and increased urination. Tremor Concentration problems Muscle weakness.	Weight gain Thyroid problems Skin problems, especially acne. Kidney problems. Regular blood Level monitoring is required. Drug interactions.
Lamotrigine	Nausea, vomiting upset stomach. Headaches.	Potentially dangerous skin rashes. Weight neutral. levels affected by valproate and carbomazepine
Valproate	Nausea, vomiting, upset stomach Dizziness, drowsiness. Tremor.	Weight gain. Hair thinning. Potential-ovarian cysts. Altered liver function. Drug interactions.
Carbamazepine	Nausea, vomiting, upset stomach. Drowziness, dizziness. Headache. Visual disturbance	Mild changes in liver enzymes. Weight neutral. Lowered white cell count. Drug interactions.
Olanzapine	Drowsiness. Stomach upset. Increased appetite. Tremor. Dizziness	Weight gain. Increased risk of diabetes. Increased cholesterol. Risk for tardive dyskinesia (movement disorder) uncertain.
SRRI's	Nausea, vomiting, Stomach upset. Headaches. Agitation, insomnia, Tremor Sweating	Lowered libido Discontinuation problems. Weight changes.

What about ECT?

ECT or electronconvulsive therapy has acquired a controversial public image. So much so that people who might benefit form a course of treatment with ECT are often reluctant to have the treatment. Modern ECT is performed under general anaesthesia according to strictly defined criteria. As such it remains a useful treatment for the most serious forms of depression, especially where there is threat to life, and where other antidepressants have failed to relieve the depression. There may be an effect of ECT on memory, but the effect usually passes with time. Studies comparing ECT with antidepressant have tended to show the ECT is more effective at relieving depression than antidepressants in the short term.

What to do medication side effects

Tell your doctor right away about any side effects you have. Some people have different side effects than others and one person's side effect (e.g., unpleasant sleepiness) may actually help another person (e.g., someone who suffers from insomnia).

- At least half of those who take mood stabilisers have side effects (see table). These are especially common in high doses and a combination of medicines are needed during the acute phase of treatment. Lowering doses and decreasing the number of medicines usually helps, but some people may have enough side effects to require a change of medicines. Side effects tend to be worse early in the treatment, but some people have taken lithium for 20 years or longer with good results develop problems with side effects or toxicity as they become older. Fortunately, Valproate or carbamazepine are often excellent alternatives as long as the switch is made gradually. Valproate appears to case the fewest side effect during long-term treatment. If side effects are a problem for you, there are a number of approaches your doctor may suggest:
- Reducing the amount of medicines you take.
- Trying a different medicine to see if there are fewer or less bothersome side effects.
- Taking your medicine at night.

Remember: Changing medicine is a complicated decision. It is very dangerous to make changes in your medicine on your on your own!

How quickly does the medication work?

Some patients symptoms may begin to improve within several days. Others may take up to several weeks to see maximum effects from the medication. Some physicians will prescribe an additional medication temporarily.

How well does prevention medication work?

Mood stabilisers (lithium, valproate, carbamazepine) are the core of prevention. About one in three people with

bipolar disorder will be completely free of symptoms by taking mood stabilising medication for life. Most people experience a great reduction in how often they become ill or in the severity of each episode. Don't be discouraged if you occasionally feel that you might be going into a manic or depressive episode. Always report changes to your doctor immediately, because adjustments in your medicine at the first warning signs can usually restore a normal mood. Sometimes it just takes a slight increase in the blood level of your mood stabiliser, or other medicines may need to be added. Medication adjustments are usually a routine part of treatment (just as insulin doses are changed from time to time in diabetes). Never be afraid to report changes in symptoms - they usually don't require any very dramatic change in treatment and your doctor will be eager to help.

Take your medicine as directed even if you have felt better for a long time.

Sometimes people who have felt well for a number of years hope that the bipolar disorder has gone away and that they don't need medicine anymore. Unfortunately, the medication do not 'cure' bipolar disorder. Stopping them, even after many years of good health, can lead to disastrous relapse, sometimes within a few months. Generally, the only times you should seriously think of stopping preventive medication are if you want to become pregnant or have a serious medical problem that would make the medicine unsafe. Even these may not be absolute reason to stop. Always talk these situations over carefully with the doctor. If you are going to stop. it is important to taper the medicines very slowly (over weeks or months).

What should you do when you feel like quitting your treatment?

It is normal to have occasional doubts and discomfort with treatment. Be sure to discuss all your concerns and any discomforts with the doctor, therapist and family. If you feel a treatment is not working or is causing unpleasant side effects, tell your doctor - don't stop or adjust your medication on your own. Symptoms that come back after stopping medication are sometimes much harder to treat. You and your doctor can work together to find the best and most comfortable medicine or you. Also, don't be shy about asking or a second opinion from another clinician. Consultants can be a great help.

Will I have to take medication for my whole life?

Successful management of bipolar disorder requires a great deal from patients and families. There will almost certainly be many times when you will be sorely tempted to stop your medication because 1) you feel fine, 2) you miss the highs or 3) you are bothered by side effects. If you stop your medication, you probably won't have an acute episode immediately in the next days or weeks, but

eventually you will probably have a relapse. There is a well studied model of bipolar disorder that suggests that each episode worsens your chances of having a smooth long-term course.

Is counselling / therapy useful for treating Bipolar Disorder?

Counselling plays an important adjunctive role in the treatment of bipolar disorder. Therapy issues include dealing with the psychosocial stressors that may precipitate or worsen manic and depressive episodes and dealing with the individual, interpersonal, social and occupational consequences of the disorder itself. Counselling can also help ensure better compliance with medication.

Types of psychotherapy

Three types of psychotherapy appear to be particularly useful:

Behavioural therapy focuses on behaviours that can increase or decrease stress and on ways to increase pleasurable experiences that may help improve depressive symptoms.

Cognitive therapy focuses on identifying and changing the pessimistic thoughts and beliefs that can lead to depression.

Interpersonal therapy focuses on reducing the strain that a mood disorder may place on relationships.

Psychotherapy can be individual (only you and a therapist), group (with other people with similar problems), or family. The person who provides therapy may be your doctor or another clinician (e.g. a social worker, psychologist, nurse or counsellor) who works in partnership with your doctor.

How to get the most out of psychotherapy:

- Keep your appointments.
- Be honest and open.
- Do the homework assigned to you as part of your therapy.
- Give the therapist feedback on how the treatment is working.

During treatment psychotherapy usually works more gradually than medication and may take two more to show its full effects. However, the benefits may be long lasting. Remember that people can react differently to psychotherapy, just as they do the medicine. Marital therapy and counselling for children in affected families may also be of value.

Once the acute episode is over, long-term psychotherapy can help maintain stability and prevent further episodes, but cannot replace ling-term preventive treatment with medication.

What can you do to help yourself?

▸ First, become an expert on your illness. Since bipolar disorder is a lifetime condition (like many other medical disorders such as diabetes), it is essential the you and your family or others close you learn all about it and its treatment. Read books, attend lectures, talk to your doctor or therapist.

Learn as much as you can about bipolar disorder. The more you know, the more control you have over your life. Be your doctor's partner. Take your medication as prescribed. Inform your doctor of all the medication you are taking. Call and check before the list.

- Maintain a stable sleep pattern. Go to bed around the same time each night and get up about the same time each morning. Disrupted sleep patterns appear to cause chemical changes in your body that can trigger mood episodes. If you have to take a trip where you ill change time zones and might have jet lag, get advice from your doctor.
- Maintain a regular pattern of activity, Don't be frenetic or drive yourself impossibly hard.
- Do not use alcohol or illicit drugs, These chemicals cause an imbalance in how the brain works. This can, and often does, trigger mood episodes and interferes with your medications. You may sometimes find it tempting to use alcohol or illicit drugs to "treat" your own mood or sleep problems- but this almost always makes matters worse. If your gave a problem with substances, as your doctor for help can consider self help groups such as Alcohol Anonymous.
- Be very careful about "everyday" use of small amounts of alcohol, caffeine and some over-the -counter medications for colds, allergies, or pain. Even small amounts of these substances can interfere with sleep, mood or your medicine. It may not seem fair that you have to deprive yourself of a cocktail before dinner or morning cup of coffee, but for many people this can be the "straw that breaks the camel's back".
- Support from family and friends can help a lot. However, you should also realise that it is not always easy to live with someone who has mood swings. If all of you learn as much as possible about bipolar disorder, you will be better able to help reduce the inevitable stress and mutual criticisms that the disorder can cause. Even the "calmest" family will sometimes need outside help in dealing with the stress of a loved one who has continuous symptoms. Ask your doctor or therapist to help educate both of you and your family about bipolar disorder. Family therapy or joining a support group can be very helpful.
- Try to reduce stress at work. Of course you want to do your very best at work, but always remember that avoiding relapses is of primary importance and in the long run will increase your overall productivity. Try to keep predictable hours that allow you to get to sleep at a reasonable time. If mood symptoms interfere with your

ability to work, discuss with your doctor whether to "tough it out" or take time off. How much to discuss openly with employers and co-workers is ultimately up to you. If you are unable to work, you might have a family member tell your employer that you are not feeling well and that you under a doctor's care and will return to work as soon as possible.

Key recovery concepts

Five key recovery concepts provide the foundation for effective recovery. They are:

- ***Hope:*** With good symptoms management, it is possible to experience long periods of wellness.
- ***Personal responsibility:*** It's up to you , with the assistance of others, to take action to keep your moods stabilised.
- ***Self advocacy.*** Become an effective advocate for yourself so you can access the services and treatment you need, and make the life you want for yourself.
- ***Education:*** Learn all you can about depression and bipolar disorder. This allows you to make good decisions about all aspects of your treatment and life.
- ***Support:*** While working toward your wellness is up to you, the support of others is essential to maintaining your stability and enhancing the quality of your life.

What can families and friend do to help?

If you are a family or friend of someone with bipolar disorder, become informed about the patient's illness, its causes, and its treatments. Talk to the patient's doctor if possible. Learn the particular warning signs for how that person acts when he or she is getting manic or depressed. Try to plan, while the person is well, for how you should respond when you see these symptoms. You will be thanked later!

- Encourage the patient to stick with the treatment, see the doctor and avoid alcohol and drugs. If the patient has been on a certain treatment for an extended period of time with little improvement in symptoms or has troubling side effects, encourage the person to ask the doctor about other treatments or getting a second opinion. Offer to come to the doctor with the person to share your observations.
- If your loved one becomes ill with a mood episode and suddenly views your concern as interference, remember that this is not a rejection of you-it is the illness talking.
- Learn the warning signs of suicide. Take any threats the person makes very seriously. If the person is "winding up" his or her affairs, talking abut suicide, frequently discussing methods of following-through, or exhibiting increased feelings of despair, step in and seek help from the patient's doctor or other family members or friends. Confidentiality is important but does not stack up against the risk of suicide. Call an ambulance or a hospital emergency room if the

situation becomes desperate. Encourage the person to realise that suicidal thinking is a symptom of the illness. Always stress that the person's life is important to you and to others and that his or her suicide would be a tremendous burden and not a relief.

- With someone prone to manic episodes, take advantages of periods fo stable mood to arrange "advance directives"- plans and agreements you make with the person when he or she is stable to try to avoid problems during future episodes of illness. You should discuss and set rules that may involve safeguards such as withholding credit cards, banking privileges and car keys. Just like suicidal depression, uncontrollable manic episodes can be dangerous to patient. Hospitalisation can be life saving in both cases.
- If you are helping care for someone at home, try if possible , to take turns "checking in" on a patient's needs so that the patients doesn't overburden one family member or friend.
- When patients are recovering from an episode, let them approach life at their own pace and avoid the extremes of expecting too much or too little. Don't push too hard. Remember that stabilising the mood is the most important first step towards a full return to function. On the other hand, don't be overprotective. Try to do things with them, rather than for them so that they are able to regain their sense of self-confidence.
- Treat people normally once they have recovered, but be alert for telltale symptoms. If there is a recurrence of the illness, you may notice if before the person does. In a caring manner, indicate the early symptoms and suggest a discussion with the doctor.
- Both you and patient need to tell the difference between a good day and hypomania, and between a bad day and depression. Patients taking medication of bipolar disorder, just like everyone else, do have good days and bad days that are not part of their illness.
- Take advantage of the help available support groups.

FOR FURTHER HELP CONTACT

ASTRA ZENECA BIPOLAR HELPLINE 0800 70 80 90

SOUTH AFRICAN DEPRESSION AND ANXIETY GROUP
Tel: 011 262-6396

SCHIZOHRENIA AND BIPOLAR DISORDERS ALIANCE
Tel: (011) 463-9901

MENTAL HEALTH INFORMATION CENTRE
Tel: 021 938 9229

CAPE MENTAL HEALTH
Tel: 021 447 9040

SOUTH AFRICAN FEDERATION FOR MENTAL HEALTH

Tel:	011 781 1852
Johannesburg	011 614 9890
Pretoria	012 332 3927
Vaal	016 931 2910
Western Cape	021 447 9040
Northern Cape	053 841 0537
Eastern Cape	043 722 9680
Freestate	051 444 0212/3
Durban	031 207 2717
North West	018 297 5270
Mpumalanga	017 631 2506

BIPOLAR SUPPORT GROUPS

GAUTENG

Alberton	Driekie	011 908 4417 / 082 379 2689
Bertrams	Charlene	011 614 9890
Edenvale	Winnie	011 972 2879
Faerie Glen (Pretoria)	Francois	082 990 7074
Heidelberg	Avril	082 226 6679 / 016 341 6779
Johannesburg	Linda Trump	011 485 2406
Randburg	Anna	084 471 8004
Randburg	Suzi	082 775 6544
West rand	Sister Mae Barrington	011 6741200 ext 2140

KWAZULU NATAL

Durban	Linda	031 205 8915
Westville	Marry-Rose	031 563 5765
Pietermaritzburg	Claire	033 345 2041/ 0842409610
Kwa Dukuza	Anna Govender	032 947 2381 / 084 455 4433

LIMPOPO

Mrs Sinyosi	Mrs Sinyosi	Mrs Sinyosi

MPUMALANGA

Witbank	Gwen	013 692 5388
Witbank	Irene	073 448 4085
Witbank	Emma	083 599 4603 / 013 699 1974
Ermelo	Judy Grey	076 474 6994/ 017 811 1919

WESTERN CAPE

Kenilworth	Jay	022 485 7200/ 072 424 1812
Malmesburg	Michelle	021 460 3924/ 082 412 4448
Mowbray	Sherill	021 686 6033
Rondebosch	Suzanne	021 794 2738
Worcester	Francis Crous	082 647 8883 / 023 342 1881

Please contact us SADAG on 011 262 6396 for new support groups new groups opening in an area near you.

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Compiled by the Scientific & Advisory Board Members of the South African Depression & Anxiety Group, and reviewed by the MRC Research unit on Anxiety and Stress Disorders.