

**M.I.N.D**

Bipolar Disorder



Introduction

Bipolar disorder was formerly known as manic depressive disorder. The words "depression" and "mania" have their origins in Ancient Greek. Hippocrates (460-337 B.C.) was the first to systematically describe mania and depression. In prehippocratic Greece the theory of the four bodily fluids essentially considered many disorders were due to an imbalance of four bodily fluids: black bile, yellow bile, phlegm and blood. Melancholia which referred to depression means literally : black bile and mania was due to excess yellow bile (or thought by some to be a mixture of both). In 1st century A.D., Aretaeus of Cappadocia, a Greek historian was the first to explicitly describe the strong link between depression and mania. The famous Persian scientist Avicenna ,in 1025 ,distinguished the illness that comprises mania and depression from other mental disorders. In 1851 a French doctor Jean-Pierre Falret described how mania and depression cycled in people accompanied with intervals that were symptom-free,Baillarger described this disorder shortly after and coined it : "folie circulaire" (circular insanity) and in 1893, Emil Kraepelin, a German psychiatrist was the first to coin the term "manic depressive". Bipolar disorder (appellation first used in 1980 by the American Psychiatric Association) is a disorder involving significant changes in mood and energy that affect negatively (but in some instances positively) the ability to carry out day to day tasks. A person with bipolar disorder has moods that usually alternate between mania or hypomania .These consist of periods of changes in mood : elevated (very happy, euphoric) and or increased irritability (mild , moderate or extreme).These changes in mood are both accompanied with increased levels of energy : all of these changes are above his/her usual moods and energy; the same person experiences at other times the other side of bipolarity, that is he/she experiences episodes of depressions which are characterized by low moods or loss of interest. Such mood swings and energy shifts are different from the usual "ups" or "downs" a person usually feels. In bipolar disorder, the changes in mood or "mood swing" can last for hours, days, weeks, or even months. It can come over for as little as few hours in very "soft" cases or several weeks for others; the mood changes can range from mild to severe. Sometimes, a mood episode includes symptoms of both mania and depression at the same time: this is called a mixed state. It is to be remembered that in manic / hypomanic episodes the mood can be that of irritability and not necessarily that of euphoria. Bipolar I refers to experiencing episodes of mania and Depression, and Bipolar II to hypomania (much milder than mania) and depression.

As stated above, during a manic /hypomania episode, there is significant change in one's mood where one becomes irritable or euphoric. During this mood change there can be important changes in the nature and content of one's thoughts, emotions and behaviors. For example, when someone is experiencing an elevation in his mood, his perceptions could become distorted enabling him to believe that he has above average and exceptional capabilities "I'm invincible, I can do anything". Such distorted thoughts may lead the person to engage in impulsive behaviors that have negative consequences. Frequently what follows (or precedes) a manic/hypomanic episode is usually a depressive episode where sad mood predominates with low self esteem etc... Such disruptive episodes (whether one is in a manic/hypomanic or a depressed phase) may result in problems in relations, work or school. If untreated, a person may put himself at high risk where his safety could be jeopardized and in turn interfere with his adaptive functioning and well-being. Proper treatment is very important since not only does it treat the episode but also because it limits the recurrence of the mood episodes throughout the person's life. With treatment, an individual can very frequently lead a full and productive life. It is important to keep in mind that as in diabetes or heart disease, bipolar disorder is a long term illness that needs to be carefully managed throughout a person's life.

Overview and Facts

Bipolar disorder often develops in a person's late teens or early adult years. At least half of all cases start before age 21. Some have their first symptoms during childhood, while others may develop symptoms late in life or as late as a person's 60s or 70s.

An equal number of men and women develop this illness, and it affects people of all races, ethnic groups and social classes.

A study was conducted by [IDRAAC](#) (Institute for Development, Research, Advocacy and Applied Care) to assess the lifetime prevalence of mental disorders in Lebanon (meeting criteria for a mental disorder at some point in his life). Results showed that the lifetime prevalence of someone having any type of bipolar disorder was 2.4% (Bipolar I 0.4%, Bipolar II 0.5% and Subthreshold Bipolar 1.5%). When assessing the 12-month prevalence of mental disorders in Lebanon (meeting criteria for a mental disorder in the past 12 months), results showed that prevalence rate for individuals meeting criteria for any type of bipolar disorder was 1.9% (Bipolar I 0.4%, Bipolar II 0.5% and Subthreshold Bipolar 1.1%). In comparison, the lifetime prevalence and 12-month prevalence of any bipolar disorder worldwide is 2.4% and 1.5% respectively and in the United States is 4.4% and 2.8% respectively. Hence, the prevalence rates in Lebanon are similar to the average prevalence rate worldwide if not higher (1.9% compared to 1.5%) (Merikangas et al., 2011). However, we suspect that the rates are much higher and Bipolar Disorder affects closer to 6 or 7% of the population as evidenced in another study by IDRAAC involving about 50 000 subjects from all over the world (Karam et al., 2014).

Symptoms

The symptoms of bipolar disorder are divided into manic, hypomanic and depressive episodes.

A) Symptoms of a manic episode

The following are the official DSM V (American Psychiatric Association) criteria:

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood, and abnormally and persistently increased activity or energy lasting at least 1 week and present most of the day, nearly every day. (or any duration if hospitalization is necessary).

B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:

- Inflated self-esteem or grandiosity
- Decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
- More talkative than usual or pressure to keep talking
- Flight of ideas or subjective experience that thoughts are racing
- Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)

- Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
 - Excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)
- C. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).
Note: Manic-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of Bipolar I Disorder unless the syndrome persists beyond the physiologic effects .

B) Symptoms of a Hypomanic episode:

The following is the official DSM V criteria:

Hypomanic Episode

- A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least 4 consecutive days and present most of the day, nearly every day.
- B. During the period of mood disturbance and increased energy and activity, three (or more) of the following symptoms (four if the mood is only irritable) have persisted, represent a noticeable change from usual behavior, and have been present to a significant degree:
1. Inflated self-esteem or grandiosity.
 2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep).
 3. More talkative than usual or pressure to keep talking.
 4. Flight of ideas or subjective experience that thoughts are racing.
 5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.
 6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation.
 7. Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).
- C. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the individual when not symptomatic.
- D. The disturbance in mood and the change in functioning are observable by others.
- E. The episode is not severe enough to cause marked impairment in social or occupational functioning or to necessitate hospitalization. If there are psychotic features, the episode is, by definition, manic.

F. The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment) unless the syndrome persists beyond the physiologic effects.

C) Symptoms of a Depressive episode

The following is the official DSM V criteria:

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, or hopeless) or observation made by others (e.g., appears tearful).
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day (observable by others; not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The episode is not attributable to the physiological effects of a substance or another medical condition.

D) Symptoms of a mixed state:

The following is the official DSM V criteria:

With mixed features: The mixed features specifier can apply to the current manic, hypomanic, or depressive episode in bipolar I or bipolar II disorder:

Manic or hypomanic episode, with mixed features:

A. Full criteria are met for a manic episode or hypomanic episode, and at least three of the following symptoms are present during the majority of days of the current or most recent episode of mania or hypomania:

1. Prominent dysphoria or depressed mood as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful).
2. Diminished interest or pleasure in all, or almost all, activities (as indicated by either subjective account or observation made by others).
3. Psychomotor retardation nearly every day (observable by others; not merely subjective feelings of being slowed down).
4. Fatigue or loss of energy.
5. Feelings of worthlessness or excessive or inappropriate guilt (not merely self-reproach or guilt about being sick).
6. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. Mixed symptoms are observable by others and represent a change from the person's usual behavior.

C. For individuals whose symptoms meet full episode criteria for both mania and depression simultaneously, the diagnosis should be manic episode, with mixed features, due to the marked impairment and clinical severity of full mania.

D. The mixed symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication other treatment).

Depressive episode, with mixed features:

A. Full criteria are met for a major depressive episode, and at least three of the following manic/hypomanic symptoms are present during the majority of days of the current or most recent episode of depression:

1. Elevated, expansive mood.
2. Inflated self-esteem or grandiosity.
3. More talkative than usual or pressure to keep talking.
4. Flight of ideas or subjective experience that thoughts are racing.
5. Increase in energy or goal-directed activity (either socially, at work or school, or sexually).
6. Increased or excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).
7. Decreased need for sleep (feeling rested despite sleeping less than usual; to be contrasted with insomnia).

B. Mixed symptoms are observable by others and represent a change from the person's usual behavior.

C. For individuals whose symptoms meet full episode criteria for both mania and depression simultaneously, the diagnosis should be manic episode, with mixed features.

D. The mixed symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication or other treatment).

With rapid cycling (can be applied to bipolar I or bipolar II disorder):

Presence of at least four mood episodes in the previous 12 months that meet the criteria for manic, hypomanic, or major depressive episode.

With melancholic features:

A. One of the following is present during the most severe period of the current episode:

1. Loss of pleasure in all, or almost all, activities.
2. Lack of reactivity to usually pleasurable stimuli (does not feel much better, even temporarily, when something good happens).

D. The mixed symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication or other treatment).

With rapid cycling (can be applied to bipolar I or bipolar II disorder):

Presence of at least four mood episodes in the previous 12 months that meet the criteria for manic, hypomanic, or major depressive episode.

With melancholic features:

A. One of the following is present during the most severe period of the current episode:

1. Loss of pleasure in all, or almost all, activities.
2. Lack of reactivity to usually pleasurable stimuli (does not feel much better, even temporarily, when something good happens).

1. Significant weight gain or increase in appetite.

2. Hypersomnia.

3. Lead paralysis (i.e., heavy, leaden feelings in arms or legs).

4. A long-standing pattern of interpersonal rejection sensitivity (not limited to episodes of mood disturbance) that results in significant social or occupational impairment.

C. Criteria are not met for "with melancholic features" or "with catatonia" during the same episode.

With psychotic features: Delusions or hallucinations are present at any time in the episode. If psychotic features are present, specify if mood-congruent or mood-incongruent:

With mood-congruent psychotic features: During manic episodes, the content of all delusions and hallucinations is consistent with the typical manic themes of grandiosity, invulnerability, etc., but may also include themes of suspiciousness or paranoia, especially with respect to others' doubts about the individual's capacities, accomplishments, and so forth.

With mood-incongruent psychotic features: The content of delusions and hallucinations is inconsistent with the episode polarity themes as described above, or the content is a mixture of mood-incongruent and mood congruent themes.

With catatonia: This specifier can apply to an episode of mania or depression if catatonic features are present during most of the episode.

With peripartum onset: This specifier can be applied to the current or, if the full criteria are not currently met for a mood episode, most recent episode of mania, hypomania, or major depression in bipolar I or bipolar II disorder if onset of mood symptoms occurs during pregnancy or in the 4 weeks following delivery.

With seasonal pattern: This specifier applies to the lifetime pattern of mood episodes. The essential feature is a regular seasonal pattern of at least one type of episode (i.e., mania, hypomania, or depression). The other types of episodes may not follow this pattern. For example, an individual may have seasonal manias, but his or her depressions do not regularly occur at a specific time of year.

A. There has been a regular temporal relationship between the onset of manic, hypomanic, or major depressive episodes and a particular time of the year (e.g., in the fall or winter) in bipolar I or bipolar II disorder.

B. Full remissions (or a change from major depression to mania or hypomania or vice versa) also occur at a characteristic time of the year (e.g., depression disappears in the spring).

C. In the last 2 years, the individual's manic, hypomanic, or major depressive episodes have demonstrated a temporal seasonal relationship, as defined above, and no non-seasonal episodes of that polarity have occurred during that 2-year period.

D. Seasonal manias, hypomanias, or depressions (as described above) substantially outnumber any non-seasonal manias, hypomanias, or depressions that may have occurred over the individual's lifetime.

Causes and Risk Factors

Bipolar disorder is one of the most highly heritable disorders in medicine. A large number of studies have shown that bipolar disorder runs in families. Twin studies have clearly shown that bipolar disorder is inherited because of genetic influences. It is well established that the degree of similarity (concordance rate) in monozygotic twins (who are genetically identical) is significantly greater than dizygotic twins (who genetically share half the genes), 38.5%-43% compared to 4.5%-5.6%. In addition, heritability of bipolar disorder was estimated at 79%-93%, much higher than many medical disorders such as breast cancer. Finally, the risk for 1st degree relative is 9% (Barnett & Smoller, 2009).

Some famous people “thought” to have bipolar disorder:

Actors: Jim Carey, Robert Downey Jr., Ben Stiller, Robin Williams, Mel Gibson, Jean-Claude Van Damme, Tim Burton, Drew Carey, Marilyn Monroe

Musicians: Ludwig Von Beethoven, Jimi Hendrix, Axl Rose, Kurt Cobain, Ray Davies, Mozart

General: Vincent Van Gogh, Kay Redfield Jamison (Psychologist at Johns Hopkins), Isaac Newton, Napoleon Bonaparte

Poets: Charles Baudelaire, William Blake, TS Elliott, Victor Hugo

Politicians: Winston Churchill, Theodore Roosevelt, Abraham Lincoln

Writers: Edgar Allen Poe, Mark Twain, Virginia Woolf, Ernest Hemingway, Lord Byron, Ralph Emerson, Hans Christian Anderson, Agatha Christie, Emily Dickinson

Tests and Diagnosis

To be able to diagnose a person with bipolar disorder, the examiner needs to assess the symptoms, their length, frequency and severity in order to be able to formulate a clear diagnosis. The Bipolar Spectrum includes different types of Bipolar Disorders that differ based on the length, frequency and pattern of the manic and depressive episodes. The bipolar spectrum includes Bipolar I, Bipolar II and Cyclothymia and other forms of bipolarity (see below).

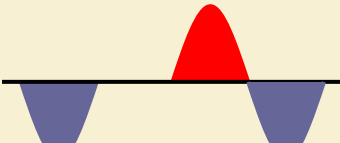
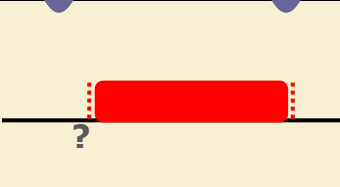
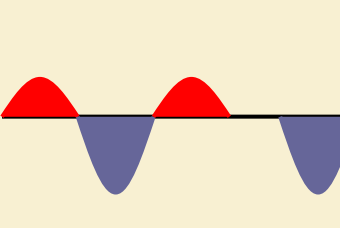
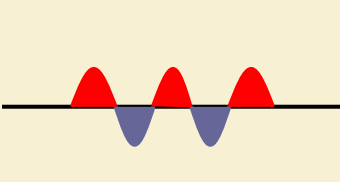
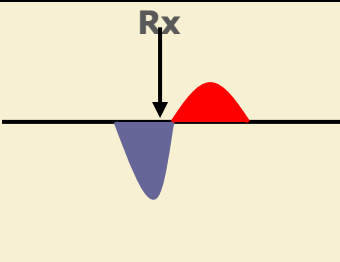
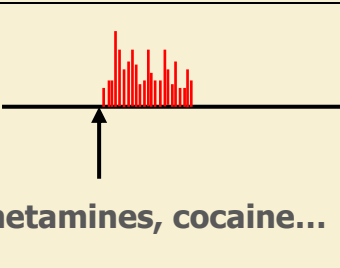
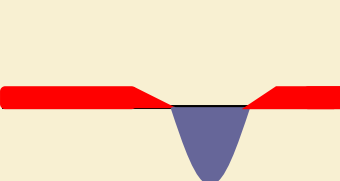
A) **Bipolar I** is characterized by periods of full blown mania and could be accompanied with major depressive episodes and/or psychotic symptoms at times (hallucinations hearing and seeing things that are not real, delusions- strongly held false beliefs that are not explained by reason). It is the most severe form of Bipolar Disorder.

B) **Bipolar II** is characterized by hypomanic symptoms which are less severe than manic symptoms and major depressive episodes.

C) **Cyclothymia** is characterized by at least two years of hypomanic and mild depressive symptoms that do not meet criteria for manic or depressive episodes.

There are other types of bipolar disorders such as Bipolar III and Bipolar IV and three subtypes Bipolar I ½ , Bipolar II ½ , and Bipolar III½. Please refer to the Bipolar Spectrum graph below for a thorough description of the different types and subtypes of Bipolar Disorders. In addition, when 4 or more episodes of depression, mania, hypomania or mixed state occur in a 12 month period, it is referred to as [rapid cycling](#). When the 4 episodes occur in one month it is referred to as ultra rapid cycling and if they occur in a 24 hour period it is called ultra ultra rapid cycling.

BIPOLAR SPECTRUM

<p>Bipolar I Full-Blown Mania</p>		<p><i>Explosive Mania</i>, often psychotic. Need for <i>Hospitalization</i> is undeniable.</p>
<p>Bipolar I 1/2 Protracted Hypomania</p>	<p>?</p> 	<p><i>Prolonged Hypomanic</i> episode of <i>2 to 3 months</i>. Some trouble <i>without</i> reaching destructive potential of full-blown mania.</p>
<p>Bipolar II Hypomania (the most common phenotype of Bipolar Disorder)</p>		<p><i>Hypomanic</i> periods of at least <i>4 days</i> <i>without</i> marked impairment, interspersed with impairing major <i>Depressions</i>. Judgment relatively preserved compared with Mania.</p>
<p>Bipolar II 1/2 Cyclothymic Depressions</p>		<p><i>Short Hypomanic</i> periods of <i>1 to 3 days</i> & <i>Minidepressions</i>. Moodiness could be misdiagnosed as a cluster B personality disorder.</p>
<p>Bipolar III Antidepressant-Induced Hypomania</p>	<p>Rx</p> 	<p><i>Hypomania</i> only during Antidepressant <i>Treatment</i>. Often depressive temperament & family history of bipolarity.</p>
<p>Bipolar III 1/2 Bipolarity Masked- and Unmasked-by Stimulant Abuse</p>	<p>?</p>  <p>Amphetamines, cocaine...</p>	<p>Periods of <i>Excitement</i> linked to <i>Substance or Alcohol Use & Abuse</i>.</p>
<p>Bipolar IV Hyperthymic Depression</p>		<p><i>Depression</i> on <i>lifelong hyperthymic temperament</i>. Typically men in their 50s who have a family history of bipolarity.</p>

Reference: Hagop S. Akiskal M.D. Bipolarity Beyond Classic Mania. The Psychiatric Clinics Of North America Volume 22. Number 3, September 1999.

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Treatment

Treatments include specialized evidence-based treatments such as medications, psychological treatments (ex: cognitive behavioral therapy which addresses specifically parameters that link together dysfunctional patterns of thoughts, emotions and behaviors) and overall lifestyle changes.

A) Medications for Bipolar Disorder

There are specific medications for treating bipolar disorder. They include:

- **Mood stabilizers:** These medications help regulate your mood fluctuations. Some examples are Lithium Carbonate (Camcolit, Litocip , Teralithe), Valproic Acid (Depakine, Depakote, Convulex), Lamotrigine (Lamictal, Lepigine,) and Carbamazepine (Tegretol, Neurotop). Following are some common side effects:

- i. Lithium Carbonate (Camcolit, Litocip , Teralithe):

Tremors, increase in frequency of urination as well as increased thirst, nausea (which is why it is best to be taken after meals), and acne vulgaris. If not monitored properly, Lithium may cause toxicity. Hence, to prevent toxicity we monitor Lithium levels in the blood through a blood test which has to be done 10-12 hours after the last dose was taken. Signs of Lithium toxicity are the following: severe vomiting and diarrhea, as well as confusion. Lithium may also affect the kidneys and the thyroid, therefore we ask for a blood test that includes Urea, Creatinine, and TSH levels in order to monitor thyroid and kidney functions.

- ii. Valproic Acid (Depakine, Depakote, Convulex):

Tremors, nausea, vomiting, hair loss, weight gain, Hepatitis, and increases the level of an enzyme called Transaminase. When taking Valproic acid you are asked to have a liver function test (SGOPT, SGPT) as well as a CBC. Valproic acid level is monitored in the blood by a specific blood test that should be done 10-12 hours after taking the last dose.

- iii. Lamotrigine (Lamictal, Lepigine):

Allergic reaction in the form of skin rash, anxiety, insomnia, problems coordinating muscle movements, and Diabetes Insipidus.

- iv. Carbamazepine (Tegretol, Neurotop):

Anemia, Hepatitis, Agranulocytosis (Decrease in white blood cell count), nausea, vomiting, and skin allergy.

- **Antipsychotics:** They are part of another class of medication but are highly used and recommended in treating symptoms of mania. There are two main categories of antipsychotics (old generation and new generation). The most famous example of the old generation is Haloperidol (Haldol). Some examples of the new generation are Quetiapine (Seroquel), Risperidone (Risperdal, Respal, Depia), Olanzapine (Zyprexa, Zyrwan, Olanzamed, Prexal), Ziprasidone (Zeldox, Geodon), Aripiprazole (Abilify, Xalipro) and Paliperidone (Invega). Here are some examples of side effects that can be encountered with old generation and new generation antipsychotics.

i. Old generation Anti-Psychotics:

General side effects include developing extrapyramidal symptoms (such as rigidity, tremors, restlessness, and involuntary movements), increase in a hormone called prolactin, disruption of menstrual cycle, sometimes even lack of menstruation, weight gain, decrease in libido, convulsions, sedation, increased sensitivity to light, insomnia and the risk of developing Neuroleptic Malignant Syndrome (muscle rigidity, elevated temperature, confusion, fluctuations in blood pressure)

ii. New Generation Anti-Psychotics:

General side effects include developing extrapyramidal symptoms (less frequent), sedation, decrease in blood pressure, weight gain, and increase in a hormone called prolactin (less frequent).

*** What should a person do if he experiences side effects?***

A person does not need to be discouraged by side effects because there are ways to reduce them or get rid of them. However, it is imperative that he/she informs his/her doctor of any side effects he may be experiencing. One should never stop taking his medication or change the dosage without talking first to his/her doctor.

It is important for someone to contact the doctor or a hospital emergency room right away if side effects cause him to become very ill with symptoms such as fever, rash, jaundice (yellow skin or eyes) breathing problems, heart problems, or other severe changes that concern him. This includes any changes in thoughts, such as hearing voices, seeing things or having thoughts of death or suicide.

B) Psychological Treatments

There are many types of therapy that can help someone address issues in his/her life and learn new ways to cope with his illness. An example of an evidence-based approach in treating bipolar disorder is cognitive behavioral therapy (CBT). The focus is on understanding the relationships between thoughts, emotions and behaviors and identifying distorted automatic thoughts, dysfunctional core beliefs and assumptions that are associated with the illness and interfere with the way one views himself, others and his environment. Specialized psychological treatments can help the person achieve the following:

- Understand his illness
- Better cope with stressful situations
- Identify triggers that may worsen his symptoms
- Improve interpersonal relationships with others
- Establish a stable and predictable routine
- Understand why some situations are painful and learn better problem solving skills.
- Help decrease ruminations
- End destructive habits such as drinking, using drugs, overspending or risky sex

Some people are able to stabilize quickly after starting treatment; others take longer and need to try several treatments, medications or medication combinations before they feel better.

A healthy lifestyle is always conducive to better wellbeing. Hence, one can improve his mood by improving his health habits.

- Ensure treatment compliance (medication and/or therapy compliance)
- Maintain a regular sleep schedule.
- Avoid high-stress situations
- Share talking and listening time with a friend often, especially during difficult times.
- Exercise regularly. It helps one relax and reduce stress.
- Take a walk each day.
- Engage attention in pleasant and interesting activities.
- Create a daily planning calendar.
- Limit alcohol and avoid illegal drugs.
- Avoid caffeine and stimulants (ex: energy drinks).
- Try to maintain a calming and safe environment.

When someone has an episode of bipolar disorder, friends and family members might not know how to help. They might be hesitant to talk about the person’s illness, or feel guilty, angry, or helpless. All of these things are normal. Here are some examples of what one can say that helps and what one should avoid saying:

Examples of what may help	Examples of what may NOT help
<ul style="list-style-type: none"> • You are not alone in this. I’m here for you. • I understand you have a special condition and that’s what causes these thoughts and feelings. • You may not believe it now, but the way you’re feeling will change. • I may not be able to understand exactly how you feel but I care about you and want to help. • When you want to give up, tell yourself you will hold of for just one more day. • Tell me what I can do now to help you. • Talk to me, I’m listening. 	<ul style="list-style-type: none"> • It’s all in your head. • You have nothing, stop worrying. • It’s your imagination. • I can’t do anything about your situation. • Just snap out of it. • Stop acting crazy. • What’s wrong with you? • Shouldn’t you be better by now?

Family and friends who are supportive and dependable can make a big difference in a person's ability to cope.

Here are some examples of what family members and friends can do to help:

- Encourage treatment compliance
- Offer emotional support and understanding.
- Help with health care and other responsibilities.
- Help monitoring symptoms, progress, and side effects.
- Focus on their strengths.
- Help the person recognize that his symptoms are time limited.
- Recognize that when someone is experiencing a mood disorder episode, communication may become more difficult during these times.
- Encourage them to maintain a healthy lifestyle

Individuals who experience symptoms of bipolar disorder are encouraged to seek help as soon as possible in order to ensure their health and pre serve their wellbeing.

Sources and Links

Adapted from National Institute of Mental Health (NIMH), Depression and Bipolar Support Alliance (DBSA), Child and Adolescent Bipolar Foundation, Medical Institute of Neuropsychological Disorders (MIND).

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