NAMI, the National Alliance on Mental Illness, is the nation’s largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. NAMI advocates for access to services, treatment, supports and research and is steadfast in its commitment to raising awareness and building a community of hope for all of those in need.

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Bipolar Disorder Defined

Bipolar disorder is a chronic illness with recurring episodes of mania and depression that can last from one day to months. This mental illness causes unusual and dramatic shifts in mood, energy and the ability to think clearly. Cycles of high (manic) and low (depressive) moods may follow an irregular pattern that differs from the typical ups and downs experienced by most people. The symptoms of bipolar disorder can have a negative impact on a person’s life. Damaged relationships or a decline in job or school performance are potential effects, but positive outcomes are possible.

Two main features characterize people who live with bipolar disorder: intensity and oscillation (ups and downs). People living with bipolar disorder often experience two intense emotional states. These two states are known as mania and depression. A manic state can be identified by feelings of extreme irritability and/or euphoria, along with several other symptoms during the same week such as agitation, surges of energy, reduced need for sleep, talkativeness, pleasure-seeking and increased risk-taking behavior. On the other side, when an individual experiences symptoms of depression they feel extremely sad, hopeless and loss of energy. Not everyone’s symptoms are the same and the severity of mania and depression can vary.

More than 10 million Americans have bipolar disorder. Because of its irregular patterns, bipolar disorder is often hard to diagnose. Although the illness can occur at any point in life, more than one-half of all cases begin between ages 15-25. Bipolar disorder affects men and women equally.

Abnormal mood states can distort a patient’s perception, and other people who are observing symptoms may attribute unusual behaviors to stress or other circumstances in the person’s life. As a consequence, some individuals living with bipolar disorder go years before they receive proper treatment. The delay between the first signs and symptoms of the disorder and proper diagnosis and treatment can often be as long as 10 years.
Symptoms
The occurrence of at least one episode of abnormal mood elevation such as mania or hypomania is the key feature that distinguishes bipolar disorder from other disorders such as depression. People living with bipolar disorder typically find more difficulty during depressive episodes, which tend to be more frequent and last longer than manic or hypomaniac episodes.

With bipolar disorder there is a spectrum of symptoms, including:

- elevated mood, depressed mood (mania and depression);
- anxiety;
- irritability;
- intense imagination;
- silliness;
- oppositional behavior;
- high activity;
- hypersensitivity; and
- difficulties with sleep.

The states of mania and depression can occur in distinct episodes or can switch rapidly, even multiple times in one week. A person who is experiencing a severe bipolar episode of mania or depression may also have psychotic symptoms such as hallucinations or delusions. In individuals living with bipolar disorder, psychotic symptoms tend to be consistent with the direction of the person’s extreme mood. For example, a person in a manic state might believe he or she is famous or has special powers. An individual in a depressed state, however, might believe he or she is extremely poor or unable to perform normal tasks.

The occurrence of psychotic symptoms may lead to individuals with bipolar disorder being wrongly diagnosed as having schizophrenia, another severe mental illness that is often accompanied by hallucinations and delusions. Fortunately, these symptoms can be managed with the right treatment and support.

Mania Explained
Abnormal mood elevation such as mania or hypomania constitutes the essential feature required for diagnosis of bipolar disorder. The appearance and severity of mood elevation varies among individuals living with bipolar disorder. While some individuals will experience episodes of mania or hypomania many times, others may experience it only rarely. It
is not the number of occurrences of mania that define which type of bipolar disorder is present, but the degree of impairment associated with the most severe episode of elevated mood during a person’s lifetime that determines what subtype of bipolar disorder a person might have.

When a period of lower-intensity mania without significant impairment in social or occupational ability occurs, it is called hypomania. A diagnosable manic episode has to include noticeable impairment. Although the experience of elevated mood may be very appealing, especially if it occurs after depression, the “high” often does not stop at a comfortable or controllable level. A person’s mood state may rapidly become more irritable, his or her behavior more unpredictable and his or her judgment more impaired. During periods of mania, people frequently behave impulsively, make reckless decisions and take unusual risks. More often than not, during an episode the person discounts or is unaware of any negative consequences of their actions.

Symptoms of mania can include:

• feeling overly happy for an extended period of time;
• an abnormally increased level of irritability;
• overconfidence or an extremely inflated self-esteem
• increased taliativeness;
• decreased amount of sleep;
• engaging in lots of risky behavior, such as spending sprees and impulsive sex;
• racing of thoughts, jumping quickly from one idea to another;
• easily distractible; and
• feeling agitated or “jumpy.”

**About Depression**

Depression is more than just a sad mood that a person may experience after a bad day. Major depression is a medical illness that produces a combination of physical and emotional symptoms that inhibit one’s ability to function nearly every day for a period of at least two weeks.

Symptoms of depression can include:

• diminished capacity for pleasure or loss of interest in activities once enjoyed;
• a long period of feeling hopeless, helpless or low self-esteem;
• decreased amount of energy; feeling constantly tired;
• inability to concentrate and make simple decisions;
• change in eating, sleeping or other daily habits;
• being agitated or slowed down in movement, speech or thought; and
• thoughts of death or suicide attempts.

Not everyone will experience all of these symptoms. For example, someone may have problems sleeping and feel low in energy but find that their appetite is unaffected. The level of depression can range from severe to moderate to mild low mood. Mild low mood is called dysthymia when it is chronic or long term.

The lows of depression are often so debilitating that people in this phase of the illness may even be unable to get out of bed. Typically, depressed individuals have difficulty falling asleep and awaken throughout the night. However, about 20 percent of depressed individuals sleep more than usual.

When experiencing depression, even minor decisions such as what to have for dinner can be overwhelming; self-esteem plummets and the mind often becomes obsessed with losses and personal failures, and feelings of guilt and helplessness abound.

Negative thinking can lead to thoughts of suicide and actual ideation of suicide. In bipolar disorder, suicide is an ever-present danger on both sides of mood swings, as some individuals can become suicidal in manic or mixed (high and low) states.

Risk Factors
Although some ground has been made in discovering the factors associated with the risk of developing bipolar disorder, scientists have not discovered a single precise cause. Based on the best available data, many scientists suggest that bipolar disorder can be caused by more than one factor (e.g., genes, environmental stress, nutrition, inflammatory factors or other stress in the brain).

Genetics
Bipolar disorder often runs in families and studies suggest a genetic component to the illness. Genes help control how the body works and grows. The chances of manifesting bipolar disorder are increased if a child’s parents or siblings have the disorder. However, this does not necessarily mean that a child from a family with a history of bipolar disorder will develop the disorder.
Furthermore, studies of identical twins have found that even if one twin develops bipolar disorder it does not mean the second twin will develop it as well. This is worth noting because identical twins share all the same genes. Because one twin may develop bipolar disorder and the other may not means that there are other factors in play.

**Environment**

Often a stressful event such as an unexpected loss, general medical illness, difficult relationship or financial problems—or any major change in life—can trigger the first bipolar episode. Therefore, an individual’s coping skills or style of handling stress may also play a role in the development of the illness. In some cases, drug abuse can trigger the disorder. For some people triggers are not identifiable or become harder to identify as an individual experiences more episodes.

**Brain Structure**

Brain scans cannot diagnose bipolar disorder in an individual. However, researchers using techniques such as functional magnetic resonance imaging (FMRI) and positron emission tomography (PET) have shown subtle differences in the average size or pattern activation of some brain structures in the people with bipolar disorder compared to the brains of people without a mental illness as well as people with other mental disorders. While brain structure alone may not cause bipolar disorder, some conditions which damage brain tissue can predispose a person to the mental illness.
Co-occurring Disorders
A person living with bipolar disorder often meets the criteria for one or more additional disorders. Anxiety disorders, including posttraumatic stress disorder (PTSD) and attention-deficit hyperactivity disorder (ADHD) routinely co-occur with bipolar disorder.

Substance abuse is also common among people with bipolar disorder. Many people use alcohol or drugs to try to control their mood states or help treat symptoms. However, using drugs will ultimately result in a worsening of the illness not an improvement. The use of drugs can lead to more frequent relapse and an increase in suicide attempts.

Successful treatment of bipolar disorder almost always improves these other conditions. Similarly, successful treatment of these conditions usually improves the symptoms of bipolar disorder. These other illnesses, however, can make it hard to diagnose and treat bipolar disorder. Some medicines used to treat obsessive-compulsive disorder (antidepressants) and ADHD (stimulants) may worsen symptoms of bipolar disorder and may even trigger a manic episode, so care should be taken when beginning medication.

Diagnosing Bipolar Disorder
As with all types of illness, a doctor must be seen to provide a proper diagnosis. The doctor may perform a physical examination, an interview and lab tests. Unfortunately, bipolar disorder cannot be identified through a simple blood test or body scan. But these tests can help rule out other potential causes such as a hyperthyroidism. If it is determined that the symptoms are not caused by any other illness, the doctor may recommend the individual sees a mental health professional such as a psychiatrist. A careful medical history must be conducted to assure bipolar disorder is not mistakenly diagnosed as major depressive disorder.

African Americans and Latinos are more prone to misdiagnosis, likely due to differing cultural or religious beliefs or language barriers. For anyone who has received a diagnosis of bipolar disorder, it is important to look for a health care professional who understands a person’s cultural background and shares the same expectations for treatment.

Doctors usually diagnose bipolar disorder by using the Diagnostic and Statistical Manual of Mental Disorders, or DSM.
It is currently in its fourth edition, with a new revision slated to come out in 2013. The DSM-IV defines four basic subtypes of bipolar disorder:

**Bipolar I Disorder** is defined as an illness in which people have experienced one or more episodes of mania. Though an episode of depression is not necessary for a diagnosis, most people will have episodes of both mania and depression. In order to be diagnosed, manic or mixed episodes must last at least seven days, or be so severe that they require hospitalization.

**Bipolar II Disorder** is a subset of bipolar disorder in which people largely experience depressive episodes shifting back and forth with hypomanic episodes, but never a full manic episode.

**Cyclothymic Disorder, or Cyclothymia,** refers to a more chronic unstable mood state. This diagnosis is given when an individual experiences hypomania and mild depression for at least two years. A person with cyclothymia may have periods of normal mood, but these periods are brief and last less than eight weeks.

**Bipolar Disorder Not Otherwise Specified (BP-NOS)** is diagnosed when a person does not meet the criteria for bipolar I, II or cyclothymia but has had periods of clinically significant abnormal mood elevation. The symptoms may either not last long enough or did not meet the full criteria for episodes required to diagnose bipolar I or II. For instance, a person with one or more episodes of hypomania but never depression or mania would be diagnosed BP-NOS, as would a person with periods of fluctuating mood as described above for cyclothymia but lasting less than one year.

**Treatment**
Because bipolar disorder is a chronic illness, continuous maintenance to help prevent the reemergence of symptoms is recommended. Providing proper treatment helps most individuals living with bipolar disorder control their mood swings and other symptoms. The management of the illness should include attention to lifestyle, stress management, supports and also medication options. There is no one approach. It is essential to put together a care plan with elements specific to your needs. If bipolar disorder is left
untreated, it tends to get worse and the symptoms can become more pronounced. Recognition and diagnosis of the disorder in its earliest stages is important so that one can receive effective treatment. Effective treatment plans usually include medication, psychotherapy, education, self-management strategies and external supports such as family, friends and formal support groups. Combining these elements and revising the treatment plan based on assessment of an individual’s response is the best means of preventing relapse and reducing the severity of symptoms.

**Medications**

Not everyone responds to medications in the same way. Often, multiple types of medication must be assessed in order to find the one, or ones, that are the most effective for an individual. Some of the types of medication used to treat bipolar disorder are listed below. Information on medications can change. For the most up to date information on use and side effects contact the U.S. Food and Drug Administration (FDA) at www.fda.gov.

**Mood-stabilizing medications** are often the first choice of medication when treating bipolar disorder. They are referred to as “mood stabilizers” because of their ability to return an individual to usual level of psychosocial functioning. Except for lithium, all of the below “mood stabilizer” medications are known as anticonvulsants.

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Brand Name</th>
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<tbody>
<tr>
<td>Lithium</td>
<td>Eskalith or Lithobid</td>
</tr>
<tr>
<td>Valproic Acid (or Divalproex Sodium)</td>
<td>Depakote</td>
</tr>
<tr>
<td>Lamotrigine</td>
<td>Lamictal</td>
</tr>
<tr>
<td>Carbamazepine</td>
<td>Tegretol</td>
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</tbody>
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Lithium has been used for more than 50 years for the stabilization and treatment of bipolar disorder. It is typically more effective when administered earlier in the course of the illness. Research has also shown that it is most effective in those individuals with a family history of the illness and in those experiencing the bipolar I swings between mania and depression with a return to normal function between episodes. The use of lithium has proved effective in helping prevent relapse as well as beneficial in the continued treatment of bipolar depression. There is evidence that lithium can lower the risk of suicide but the FDA has not granted approval specifically for this purpose.
Like all medications, lithium treatment produces side effects. The most common unwanted effects vary in intensity with the dose and can be effectively managed. However, for about 30 percent of people who try lithium, it is not tolerable. Lithium side effects may include frequent urination, excessive thirst, weight gain, memory problems, hand tremors, gastrointestinal problems, hair loss, acne and water retention. There are two main side effects of lithium that require monitoring by a simple blood test: 1) hypothyroidism, which can mimic depression, and 2) impaired kidney function, which is less common, but still needs to be monitored.

The FDA has approved valproic acid and carbamazepine for treating mania. These drugs, also approved to treat epilepsy, were found to be as effective as lithium for treating acute mania and may be better than lithium in treating the more complex bipolar subtypes of rapid cycling and dysphoric mania as well as co-morbid substance abuse. As with lithium, valproic acid and carbamazepine may also produce sedation and gastrointestinal distress, but these side effects are generally resolved within the first six months of treatment or with dose adjustment. It is important to monitor liver function on these medications.

Unlike valproate and carbamazepine, Lamotrigine has not shown benefits for treatment of mania but it has approval from the FDA for delaying occurrences of bipolar I disorder. For most people, it produces very few side effects. Lamotrigine does not have FDA approval for treatment of the acute episodes of depression or mania. Studies of lamotrigine for treatment of acute bipolar depression have produced inconsistent results. Lamotrigine can trigger Stevens-Johnson syndrome in some people—eight in 1,000 children and three in 1,000 adults. Stevens-Johnson syndrome is a toxic skin condition that can result in death. Carefully monitor your skin when taking Lamotrigine.

All anticonvulsant medications carry an FDA warning stating that their use may increase the risk of suicidal thoughts or behaviors. Individuals beginning a regimen of anticonvulsant medications for bipolar disorder or other illness should be closely monitored for new or worsening symptoms.

Second-generation antipsychotics (SGAs) are also commonly used to treat the symptoms of bipolar disorder and are often paired with other medications, including mood stabilizers. They are generally used for treating manic or mixed episodes.
These medications are often prescribed to help control acute episodes of mania or depression. At present only quetiapine and the combination of olanzapine and fluoxetine have FDA approval for treatment of bipolar depression. Finding the right preventive/maintenance medicine is not an exact science and is specific to each individual.

Weight gain is a serious clinical concern related to the use of all atypical antipsychotics. Not only can weight gain lead to adult-onset diabetes and cardiovascular diseases, but being overweight is also the leading cause of discontinuing the use of medication. For weight and other health management strategies, visit NAMI’s Hearts & Minds program at www.nami.org/heartsandminds. Atypical antipsychotics can also cause drowsiness, dizziness when changing positions, blurred vision, rapid heartbeat and skin rashes. All antipsychotic medication carry some risk for causing abnormal involuntary movement disorders and require careful monitoring.

**Standard antidepressant medications** are sometimes administered to address symptoms of depression in bipolar disorder. However, a recent study funded by the National Institute of Mental Health (NIMH) showed that taking an antidepressant in addition to a mood stabilizer is no more effective that using a mood stabilizer alone for bipolar I.

These are only some of the many antidepressants that may be prescribed for helping control the depressive symptoms of bipolar disorder, but none has FDA approval specifically for treatment of bipolar depression.
As with anticonvulsants, antidepressant medications also carry an FDA warning. The FDA warning says that patients of all ages taking antidepressants should be watched closely, especially during the first few weeks of treatment. Possible side effects to look for are depression that gets worse, suicidal thinking or behavior, or any unusual changes in behavior such as trouble sleeping, agitation or withdrawal from normal social situations.

**Psychotherapy and Other Interventions**

While medication is one key element in successful treatment of bipolar disorder, psychotherapy, support groups and knowledge about the illness are also essential components of the treatment process. The most useful psychotherapies generally focus on understanding the illness (psychoeducation), learning how to cope and changing ineffective patterns of thinking. One popular type of psychotherapy used for changing these ineffective patterns is Cognitive Behavioral Therapy, or CBT.

Each of these components serves a critical role in helping people recognize the specific factors that can trigger their episodes. It is also important for individuals living with bipolar disorder, and their families, to play active roles in learning about the illness, and in developing and carrying out a treatment plan of the person’s choosing. This is known as family-focused therapy.

Recently, the NIMH funded a clinical trial called the Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD). It showed that several psychotherapy interventions were more advantageous in treating bipolar depression than a three-session intervention teaching collaborative care strategies and directing individuals to self-manage their plans. The three types of psychotherapy examined focused on cognitive strategies, family involvement and schedule and stress regulation.

**Electroconvulsive Therapy (ECT)**

For severe cases where medication and psychotherapy do not work, ECT may be worth considering. ECT involves the use of short electrical impulses transmitted into the brain. Although ECT is a highly effective treatment for severe depression, manic, or mixed episodes, it is not the first choice in providing treatment. Although ECT still produces some side effects, including some memory loss, modern techniques carried out under general anesthesia are much safer than previously used methods. As with other interventions, the risks and benefits of ECT should be carefully reviewed.
Complementary and Alternative Medicine (CAM)
CAM refers to alternative forms of medicine that are not considered part of conventional (Western) medicine. In recent years, CAM has become increasingly popular, but no CAM strategy has won FDA approval. While there is still limited data showing support for many CAM practices and some inconsistency in results, there are studies which support the usefulness of CAM strategies that are considered to have minimal if any adverse effects. One practice that has shown some promise for the treatment and management of bipolar disorder, as well as other mental illnesses, are omega-3 fatty acids, which are commonly found in fish oil. Some researchers hypothesize that omega-3 may be beneficial in treating mental illness because of its ability to protect or support the replenishing of neurons and connections in areas of the brain that are affected by these illnesses.

Treatment for Women
Administering medication and treatment for women living with bipolar disorder can sometimes be difficult. For women who begin taking valproic acid before age 20, there may be an increase in levels of testosterone (a male hormone). This can lead to polycystic ovary syndrome (PCOS). PCOS is a syndrome that causes an imbalance in a woman’s female sex hormones. This can result in changes in a woman’s menstrual cycle, skin changes, small cysts in the ovaries and other problems. Most of these symptoms will improve after stopping treatment with valproic acid.

Pregnant women and nursing mothers living with bipolar disorder should talk to their doctors about the benefits and risks of all available treatments. The mood stabilizing medications used today can hurt a developing fetus or nursing infant. However, stopping medications, suddenly or gradually, greatly increases the risk that bipolar symptoms will recur during pregnancy, which compounds risk for mother and baby alike.

Treatment for Children
The childhood diagnosis of bipolar disorder has received a great deal of attention and has also generated controversy. Getting a comprehensive evaluation of a child’s health and mental health is important before making any psychiatric diagnosis.

In young children, bipolar is most commonly diagnosed at the age of 12. Children who live with bipolar disorder may also
have other co-occurring conditions. These can include attention-deficit hyperactivity disorder, posttraumatic stress disorder, learning disabilities and even substance abuse problems. Each of these co-occurring conditions requires a thoughtful and individualized treatment plan. Appropriate treatment for children should include psychotherapy and psychosocial interventions as the first line of treatment before medications are introduced.

**Treatment and Culture**

African Americans and Latinos are more prone to misdiagnosis, likely due to differing cultural or religious beliefs or language barriers. For anyone who has received a diagnosis of bipolar disorder, it is important to look for a health care professional who understands a person’s cultural background and shares the same expectations for treatment.

**What Does Recovery Look Like?**

As people become familiar with their illness, they recognize their own unique patterns of behavior. If individuals recognize these signs and seek effective and timely care, they can often prevent relapses. But because bipolar disorder has no cure, treatment must be continuous.

Individuals who live with bipolar disorder also benefit tremendously from taking responsibility for their own recovery. Once the illness is adequately managed, one must monitor potential side effects.

The notion of recovery involves a variety of perspectives. Recovery is a holistic process that includes traditional elements of physical health and aspects that extend beyond medication. Recovery from serious mental illness also includes attaining, and maintaining, physical health as another cornerstone of wellness.

The recovery journey is unique for each individual. There are several definitions of recovery; some grounded in medical and clinical values, some grounded in context of community and successful living. One of the most important principles of recovery is this: *recovery is a process, not an event*. The uniqueness and individual nature of recovery must be honored. While serious mental illness impacts individuals in many challenging ways, the concept that all individuals can move towards wellness is paramount.
Bipolar disorder presents a special challenge because its manic, or hypomania, stages can be seductive. People with bipolar disorder may be afraid to seek treatment because they are afraid that they will feel flat, less capable or less creative. These fears must be weighed against the benefits of getting and staying well. A person may feel good while manic but may make choices that could seriously damage relationships, finances, health, home life or job prospects.

It is very common for people living with bipolar disorder to want to discontinue their medication because of side effects or because it has been a long time since the last episode of illness. However, it should be remembered that the progress one has attained is reliant upon continuing to take medication.

**Coping Strategies**

Leading a balanced lifestyle can help make living with bipolar disorder more manageable. The strategies below are suggestions from real people who have had success in managing the illness.

**Become an expert**

There are many excellent sources of information on bipolar disorder. Learn all you can about medications, keep up with current research and treatment options, attend local conferences and network with other people at meetings and support groups. Build a personal library of useful websites and helpful books.

**Recognize early symptoms**

Learning your pattern of symptom development is key. Identifying certain stressors, times of year or other factors that trigger symptoms may help identify an emerging episode. This can prompt more aggressive intervention to prevent the worsening of symptoms. Don’t be afraid to ask the people around you for help—they can help monitor behavior.

**Engage in your treatment**

The relationship with your health care provider is fundamental to the successful management of bipolar disorder. To be partners, you both must develop a trust and a strong line of communication. Provide the information your health care provider needs to help you recover, including complete and honest reports about reactions to medications, improving or worsening symptoms and anything that could trigger stress.
**Develop a plan**
To reduce uncertainty and stress, know what to do in a crisis. Although it might be challenging to discuss your illness, get your loved ones, friends and health care providers to help. Most communities have a crisis hotline or emergency walk-in centers, so know where they are and keep them handy.

**Find support**
Emotional support from others living with this disorder is an important part of recovery. It is helpful to share thoughts, fears and questions with others who have the same illness. For more on NAMI support and education programs, see the resources section. Online message boards and groups found through social sites are good resources for connecting with others, too.

**Avoid alcohol and substances**
Drugs and alcohol disturb an already delicate emotional balance, and can also interact dangerously with medications. Both depression and mania make these drugs appear to be attractive options to “slow down” or “perk up,” but the potential damage will block your road to recovery.

**Get healthy, get rest**
Maintain a well-balanced diet and engage in regular exercise. Be sure to work to keep a regular schedule with adequate sleep. These strategies help to produce positive mental and physical health benefits. Try to incorporate low-key activities like meditation, yoga or Tai Chi into your life to help alleviate stress and achieve balance.

**Get involved**
If paid employment is not an option now, volunteer work can enrich your life, teach you useful skills and help create a sense of purpose and structure. Learning a new skill or immersing yourself in a hobby, particularly a creative one, can offer constructive alone time to help balance out a busy life. Engaging in your community—from coaching youth sports to helping your parks and neighborhoods stay clean and green—are all ways you can get involved with the world around you.
I was going through a crisis. The dramatic onset of severe mental illness sent me spiraling out of control. I was barely hanging on to the threads of sanity. In the beginning, I did not accept that I had a mental illness. I refuted my diagnosis of bipolar disorder. I just needed to harness the dizzying pace of my thinking and get some sleep. What would people think? How could they understand when I didn’t even understand myself?

I thought it was work stress that was causing my mind to overload. I couldn’t stop thinking. My thoughts raced. Sleep was impossible. I began self-medicating with alcohol. At first, it soothed my nerves and settled my manic episodes. Later, its medicinal properties were ineffectual. I existed in a turbulent world of extremes. Nothing helped.

For the first time in my life, I sought outside help. My psychiatrist gave me my unwanted diagnosis: Bipolar disorder, mixed state. My mind reeled as childhood memories of growing up in a family ravaged by mental illness surged forth. I refused all medication except something to help me sleep. The diagnosis had to be incorrect. I was not functioning well at work. I needed to tell my boss. My desk was strewn with unfinished projects. I canceled meeting after meeting.

I was overcome with emotions as I tried to explain my diagnosis. My boss reacted with concern and compassion, and assured me that he would make whatever accommodations were necessary to get me through my crisis. I finally accepted intensive treatment and was spared hospitalization. A combination of medication and psychotherapy saved me from losing who I was.

Recovery didn’t happen all at once. Psychotherapeutic drugs restored functioning, but I was not the person I once knew. My sanity was kept intact with psychotherapy and higher and higher doses of my anti-convulsant medication, but sedation was a side effect. I desired my whirlwind life back. Finally, my psychiatrist said, “It’s too dangerous to increase your dosage...
again...I want to try an antipsychotic.” That decision paved the way for real recovery.

Nearly two years after my diagnosis, I attended a legislative breakfast co-hosted by the California Psychiatric Association and NAMI California on behalf of my boss. I told the president of NAMI California that I lived with bipolar disorder, and that he could mention it if he wanted. That announcement was my final piece of acceptance. I accepted the whole of me and believed others would, too. Afterward, many people thanked me for coming forth. One mother said, “You are like a beacon of light, a beacon of hope.” I was deeply touched.

Three months later, a newspaper columnist asked me if I’d do an interview for National Mental Health Month. Impulsively, I said, “Yes.” I passionately told my story and seized the opportunity to combat stigma. The response to my interview was great. The reporter told me she was flooded with calls wishing to thank me for speaking out about mental illness. My story is a success story. Others are not so fortunate. Society needs to be enlightened about mental illness. Stories need to be told—I will tell mine.

–Sheila LaPolla
Friends and Family

There are many actions a caregiver can take to provide help to a loved one living with bipolar disorder. Offering emotional support, talking and listening carefully to what a loved one is experiencing and learning about the illness so you can understand what your friend or relative is experiencing are all great ways to be supportive.

Caregivers also need support and the opportunity to talk to people who understand and can help. It is common for both the person living with the illness and family members to experience grief because of the drastic changes in their lives and the trauma that previous episodes may have caused.

Individuals living with bipolar disorder, and their families, must work together and discuss past episodes so that they can clearly recognize the early signs of a developing episode. Whatever the indicator of possible relapse is, everyone should agree on what the objective signs of a possible episode are.

Becoming an Advocate

Becoming an advocate means working to change the world, starting with oneself. Advocates change what they can, beginning with small, everyday problems but dreaming big. There are numerous social issues that are related to mental illness and bipolar disorder, in particular:

- funding for treatment, including new treatments and disparities;
- homelessness;
- funding for research;
- supported employment;
- state health care budgets; and
- criminalization of people living with mental illness.

Learn about these issues and how to encourage policy makers to take action on them in NAMI’s Legislative Action Center at www.nami.org/advocacy/policy.

For years in this county, mental health care services have fallen short when it comes to the support and treatment of individuals living with mental illness. It is very important to make sure competent care is available in your state. NAMI’s 2009 Grading The States report reviews the care systems in every state and provides advocacy points as well as outlining...
strengths and urgent needs for each state. The report is available at www.nami.org/grades.

Participation in research studies is another way to take an active part in improving options for people living with bipolar disorder. Scientists need volunteers from all backgrounds to volunteer for studies. ClinicalTrials.gov is one resource for finding these opportunities and www.nami.org/research also lists research studies.
Resources

BP Magazine
www.bphope.com

The Balanced Mind Foundation
www.thebalancedmind.org

Depression and Bipolar Support Alliance
www.dbsalliance.org

National Center for Complementary and Alternative Medicine (NCCAM)
www.nccam.nih.gov

National Institute of Mental Health (NIMH)
www.nimh.nih.gov

First Episode of Psychosis is a web section that helps individuals and families deal with a first-time psychotic episode.
www.nami.org/firstepisode

Bipolar disorder is explained in more detail at www.nami.org/bipolar, where you’ll find fact sheets and even more resources.

www.nami.org features the latest information on mental illnesses, medication and treatment and resources for support and advocacy. Other features include online discussion groups and fact sheets.

StrengthOfUs.org is an online social community for teens and young adults living with mental illness, is a place where they can connect while learning about services, supports and handling the unique challenges and opportunities of transition-age years.

The NAMI HelpLine receives more than 8,000 requests each month from individuals needing support, referral and information. More than 60 fact sheets on a variety of topics are available along with referrals to NAMI State Organizations and NAMI Affiliates in communities across the country.
www.nami.org/helpline • 1 (800) 950-NAMI (6264)

NAMI Hearts & Minds is an online, interactive wellness educational initiative intended to promote quality of life and recovery for individuals who live with mental illness. Focuses include exercise, nutrition and smoking cessation.
www.nami.org/heartsandminds

NAMI Peer-to-Peer is a free, 10-week education course on the topic of recovery for any person living with a serious mental illness. Led by mentors who themselves have achieved recovery, the course provides participants comprehensive information and teaches strategies for personal and interpersonal awareness, coping skills and self-care. www.nami.org/peertopeer
NAMI Family-to-Family is a free, 12-week course for family caregivers of adults living with mental illness. An evidence-based practice taught by trained NAMI family members who have relatives living with mental illness, the course provides caregivers with communication and problem-solving techniques, coping mechanisms and the self-care skills needed to deal with their loved ones and the impact on the family. Also available in Spanish. www.nami.org/familytofamily

NAMI In Our Own Voice is a public education presentation. It enriches the audiences' understanding of how the more than 58 million Americans contending with mental illness cope while also reclaiming rich and meaningful lives. Presented by two trained speakers who themselves live with mental illness, the presentation includes a brief video and personal testimonials, last 60-90 minutes and is offered free of charge. www.nami.org/ioov

NAMI Connection is a recovery support group for adults living with mental illness regardless of their diagnosis. Every group is offered free of charge and meets weekly for 90 minutes. NAMI Connection offers a casual and relaxed approach to sharing the challenges and successes of coping with mental illness. The groups are led by trained individuals who are in recovery—people who understand the challenges others living with mental illness face. www.nami.org/connection

NAMI Basics is a free, educational program for parents and other primary caregivers of children and adolescents living with mental illness. The course is presented in six different classes, provides learning and practical insights for families and is taught by trained parents and caregivers who have lived similar experiences with their own children. www.nami.org/basics