SPEAKER NOTES

# Exploring Bi-Polar Disorder

*Summarized by Thomas T. Thomas*

Often known as "manic depression" and sometimes diagnosed as "schizo-affective disorder," bi-polar sets its own parameters on the lives of those who have it. Helpful medications and managing skills are available, as we learned from the video *Exploring Bi-Polar Disorder* shown at our May 24 meeting. This NAMI video was produced and directed by Dan Weisburd, editor of *The Journal*, and features conversations between **Jerome Vaccaro, MD**, and six patients.

One of the patients, a doctor himself, said that he "now lives in the world of mental illness," because he has friends among the mentally ill, works with consumers of mental health services, and has become an advocate for treatment. Society at large does not know how to handle mental illness, he observed. The average person rejects the mentally ill, believing them to be dangerous and violent. "But the patients are only a danger to themselves. People do not understand the biochemical nature of the illness. They have to accept it first as a physical disease."

A woman patient said it took her a year and a half to accept the disease herself. At first, she thought she could control her moods through will power alone. She stopped taking medication three times but could not master her bi-polar disorder. "It is not a matter of psychological weakness or strength," she concluded. After she accepted the diagnosis of bi-polar as real, she had to accept the severity of her illness and the permanence of it before she was able to accept treatment.

"It's like having a wooden leg called bi-polar," another patient said.

While some mental illnesses—particularly schizophrenia—are characterized by disordered thoughts, bi-polar is characterized by disordered moods and emotional states.

Most of the patients seemed to regard the manic phase as more of a pronounced symptom than the depressed state. Mania, they agreed, is not always fun, euphoric, or grandiose, or a time of intense energy and creativity. Some of the patients reported feeling anxiety and stress, a disturbing sense of movement inside their heads, and perhaps an intense reaction to noise or a visual cue. One patient knew she was entering a manic phase when her sleep cycle fell off, from eight hours a night, to six, to four, to two hours. And then she would go for up to two weeks without sleeping, although she desperately wanted to rest.

Sleeplessness adds to the patient's sense of paranoia. And 50 percent of bi-polar patients report paranoia as a symptom of their mania. Other symptoms are obsessions, intense feelings of jealousy, and an anxious "searching for something." One patient said he knew a manic phase was coming when his personal relationships went sour or he could feel the stresses in his life. "I would get in a lot of fights."

But not all manic phases are "dysphoric," as this form of mania is called. One patient said his manic phase was "a high. I feel so happy it hurts." Others described their mania as getting off on engaging in risky activity, like buying drugs

in a bad neighborhood. Another patient said she became careless when she was manic, bumping into things and once nearly being hit by a car, because she was unable to assess the dangers. Several patients said they spend money carelessly while in the manic phase.

On the subject of drugs, many bi-polar patients are admittedly dual-diagnosed and try to medicate themselves with drugs or alcohol. One man said that drinking interfered with his medication compliance, because he would forget to take his pills. A woman said she would drink to try to calm herself when a manic state was coming on, but the effect did not last and the alcohol would interact badly with the medications she was taking. "With the right medication, I don't feel the need," she said, "and I don't feel the inner whirl of mania."

When the mania goes away, there is always depression. "You get so low, the world becomes overwhelming." Many patients become so severely depressed that they think about suicide. One patient said he had mixed feelings about that. "I didn't *want* to do it, but life was not worth living."

Another said, "I can't carry out my tasks, and then I beat myself up over the failure. Finally, there's no way out but suicide. I tried that—a serious attempt, with no note or anything—but I did not understand the drug I was using and didn't take enough of it, so I woke up in the hospital. When I couldn't even kill myself, my sense of incompetence reached a new low."

One in ten bi-polar patients who attempt suicide are successful.

The cycle time between mania and depression is not always consistent with bi-polar disorder. A few patients reported one or two manic periods over several years, with deep depression in the times between them. However, one man reported being admitted to the hospital for mania four times in one month. So some people have a cycle time of weeks and even days. The characteristic element is that, unlike normal feelings of happiness and sadness that are a reaction to everyday life, the disordered moods come seemingly of themselves. One patient reported feeling an "aura" heralding her mood swing, in the same way that migraine and epilepsy are preceded by a distinct sensory signal.

Because bi-polar is a biochemical dysfunction of the brain, medication is key to its management. The traditional treatment is with lithium carbonate, although several of the patients said it did nothing for them. The medications specific to the manic phase are Depakote (generic: divalproex sodium), Depakene (generic: valproic acid), and Tegretol (generic: carbamazepine). Antidepressants may be prescribed for the depressed phase of the illness, although some patients reported a tendency of these medications to kick them into a manic phase.

The one side effect mentioned in the video was a patient's growing sense of confusion when his level of Depakote was too high.

Patients generally agreed that it was best to work in collaboration with the doctor on issues of medication and dosage. "The doctor knows medicine," one said, "and I know me." They also agreed that it was important for the patient to take responsibility for his or her own treatment.

Patients spoke of keeping a "mood chart," to relate their emotions to medication levels. They also said it was important to heed the warning signs of an approaching manic episode, including feeling angry, going off task, or thinking they were feeling good and did not need their medication—which is a form of

denial. They said the sooner they caught the symptoms, the easier it was to stave off a relapse. In these terms, it often helped to be sensitive to the comments and observations of friends and family members as clues to their own behavior.

However, one patient was uncomfortable with revealing his illness to acquaintances. He would only do so if he was feeling good and well managed on medication.

There was general agreement that, because of side effects, taking only the lowest useful dosage of a medication was the best approach. "Stability comes with the right medicine and stress management," was how one woman expressed her treatment.

"The mental health system is not designed for sick people," said the patient who is also a doctor and an advocate. "You need to be in control of yourself and know what you want to get anything out of it. And that's the one thing you can't do when you're sick."

The patient has to ask the physician to help in managing the disease. "Trust whoever it is your working with," one patient summed up, "and have an open and honest relationship." But another added, "Be ready to walk out if you're not getting what you need."