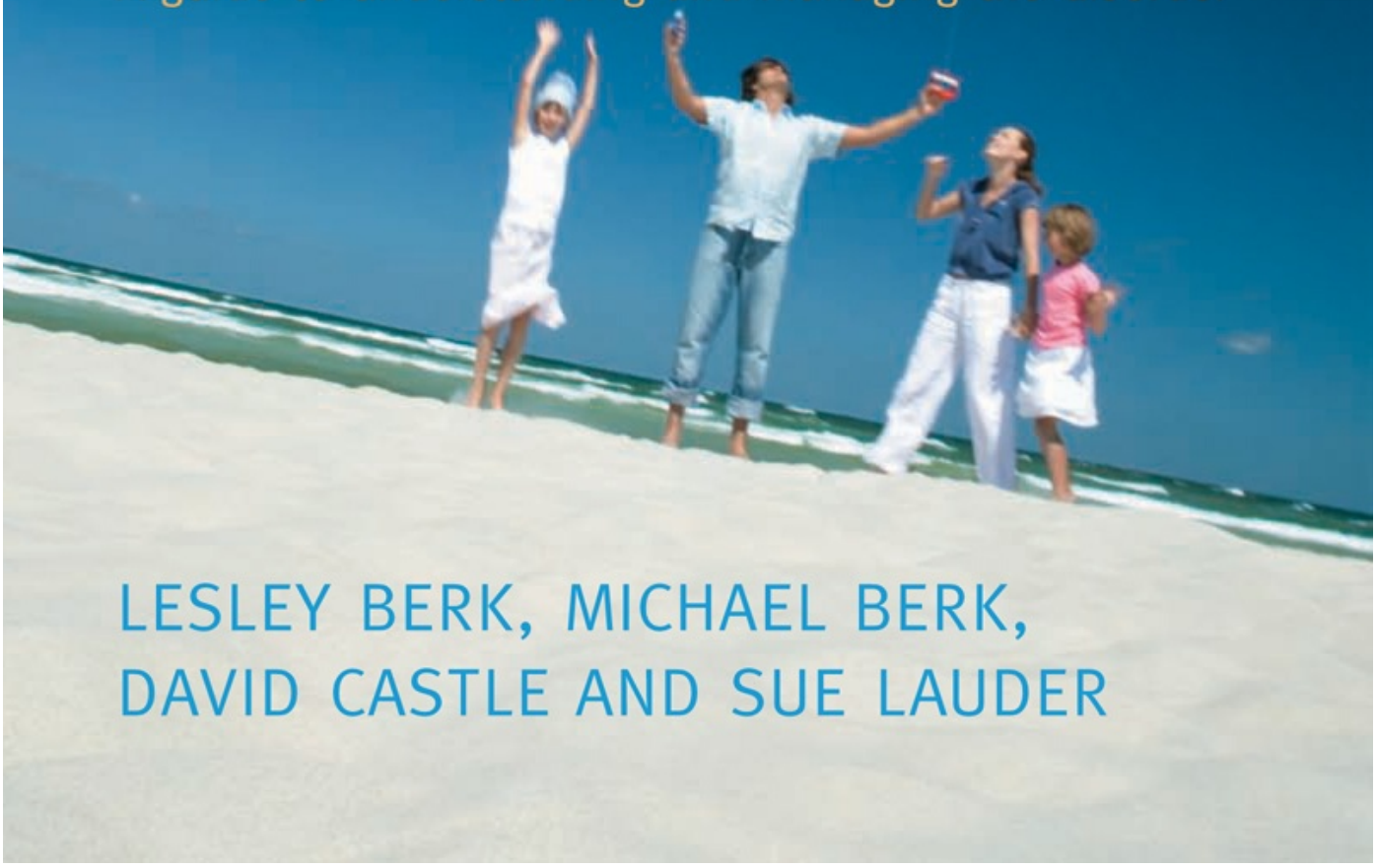
Living with Bipolar

A guide to understanding and managing the disorder



LESLEY BERK, MICHAEL BERK,
DAVID CASTLE AND SUE LAUDER

Lesley Berk MA (Clin Psych) is a psychologist with extensive experience in the clinical management of bipolar and other mood disorders. She has also been involved in psychosocial research in bipolar disorder and has contributed to scientific journals and presented at conferences in this area.

Michael Berk MBBCh, MMed (Psych), FF(Psych), FRANZCP, PhD is Professor of Psychiatry at Barwon Health and The Geelong Clinic at The University of Melbourne, and heads the Bipolar program at Orygen Research Centre. He is president of the International Society of Bipolar Disorders

David Castle MB ChB, MSc., MD, DLSHTM, MRCPsych, FRANZCP is Professor of Psychiatry, St Vincent's Health and The University of Melbourne. He has published widely in scientific journals an co-authored 13 books.

Sue Lauder MA (Clin) is a psychologist and has worked in private practice and in a variety of clinic research settings as well as teaching in undergraduate psychology programs. Sue also has a nursing background working in community settings on a range of health and welfare initiatives.

Please visit
www.allenandunwin.com/livingwithbipolar
to access downloadable forms and other support materials from the *Living with Bipolar* website.

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David Castle and Sue Lauder

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Allen & Unwin
83 Alexander Street
Crows Nest NSW 2065
Australia
Phone: (61 2) 8425 0100
Fax:
(61 2) 9906 2218
Email: info@allenandunwin.com
Web: www.allenandunwin.com

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This book is dedicated to those people with bipolar disorder who have touched us with their suffering, taught us with their experiences, inspired us with their resilience, and motivated us to try to make a difference.

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Author's note:

Names of people with bipolar disorder and their families have been changed to protect their identity.

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Introduction

This book aims to provide practical information about managing bipolar disorder for people with bipolar disorder and those close to them—their partners, close relatives and friends. The idea of writing a book came from people with bipolar disorder in our treatment programs, who requested more information about their illness and its treatment. They wanted information that combined the latest research with practical, hands-on suggestions relevant to their daily lives. This information wa requested not only for themselves, but also for the people important to them, to help them understanc and find ways of dealing with bipolar disorder. The information we present here comes from current research findings, our clinical experience and from those people with bipolar disorder who have taug us so much about helpful strategies for living with their illness.

Bipolar disorder, previously referred to as manic depression, is about mood swings, but they are n ordinary mood swings. If you have bipolar disorder, you will know that rather than simpl experiencing the usual ups and downs of everyday life, you can experience extreme highs and lov that seem to take on a life of their own independent of events around you. You may experienc different degrees of these mood states, ranging from hardly noticeable to very severe at differe times. You may also have some aspects of high mood combined with low mood at the same time.

These mood swings are *not* character flaws. They result from biological changes in areas of th brain that control mood. These biological changes respond to medication, and bipolar disorder considered to be an illness. The illness does not end when your extreme mood subsides—rather, it is recurrent illness that may be compared to asthma. People with asthma experience recurrent attack and different degrees of wellness between attacks. The thing about the 'attacks' in bipolar disorder that they are so personal. They bring about changes in how you feel, both physically and emotionall in what you think and what you do. Some of these changes can have serious consequences for yo safety, and affect your finances, your career and relationships. Fortunately, there *are* effectiv treatments and personal strategies for managing episodes and preventing relapse.

We include information about bipolar disorder, its causes and triggers, treatment options and way of preventing relapse, minimising possible negative consequences and dealing with the impact of th illness on your life. Everyone finds some way of coping with their illness, but not all strategies a constructive. This book points out some of the common pitfalls that can be unhelpful or make yo illness worse, as well as strategies that help. In addition, we try to address some of the questions w have encountered from patients and their families over the years. We examine ways of keeping an ey on your bipolar disorder, implementing healthy lifestyle choices and drawing up your own relaps prevention plans. You can combine this information with your personal experience and discover ne ideas for managing your illness, or confirm your own successful strategies.

The strategies for managing bipolar disorder mentioned here are not intended to replace yo medical or psychological treatment. They aim to assist you to be informed, get the best from yo treatment and augment it with your own personal strategies.

Finding personal strategies for managing your illness has been termed 'self-management' (Russel 2005). Sarah Russell, an author and researcher who also has bipolar disorder, explains how misleadin this term can be, as it can seem to indicate that people do it all on their own. What self-manageme of bipolar disorder really means is using the resources available to you for managing your illne

wisely. Your bipolar disorder often affects those close to you, some of whom might have litt
understanding of the illness, or of how they could help. Here we provide information to assist tho
who care about you in dealing with bipolar disorder. We discuss ways of involving trusted others i
the management of your illness, and of enhancing your relationship with your clinician. Bipol
disorder is potentially a very isolating and challenging illness, and having allies in your battle
manage it is a distinct advantage. Enjoying good relationships is part of the richness of life, and w
emphasise the importance of finding people you can relate to and of maintaining good relationships.

Living with bipolar disorder also involves adapting to the changes the illness brings to your life. W
have found that people who live well with their bipolar disorder combine living a healthy lifesty
with constructive plans for managing the different phases of their illness.

Bipolar disorder is an illness that can affect your life and who you are to the point that the bounda
between you and the illness blurs. There may be times when you are so ill that all your energy
devoted to battling your illness and simply surviving. When you are well you may still need to tal
prescribed medications and keep an eye on your disorder, or attend to a few mild persistent symptom
but it is easier to devote more attention to the things in life that matter to you, your own goals an
interests. Many people report that the illness never leaves them, but it can become a smaller an
smaller part of whom they are. Being well provides the opportunity to rebuild your life and yoursel
We examine ways of keeping well and enriching life.

The suffering and negative consequences experienced at times as a result of the illness must not b
underplayed. At the same time, having bipolar disorder has been connected with creativit
achievement and fame. People like the artist Vincent Van Gogh, composer Robert Schumann an
author Virginia Woolf all had bipolar disorder. Bipolar disorder is quite common and affects the live
of many ordinary people. Over one in every hundred people has the diagnosis of bipolar disorder an
you can add another two to four people in a hundred if you consider its milder forms as well. Th
disorder affects women and men equally, as it does people in different countries and from differe
socioeconomic levels. Despite its prevalence, however, bipolar disorder is not yet complete
understood. An added burden for people with bipolar disorder is that unlike illnesses such as asthm
bipolar disorder carries the stigma of ‘mental illness’, which makes it harder for many people
accept. We discuss ways of coming to terms with your illness and living beyond the confines o
stigma.

It can take time to develop a fulfilling lifestyle that helps you keep well. There may still be tim
when your symptoms break through and you need to use your personal strategies for preventing
minimising relapse. It helps to be prepared. This book aims to demystify the illness, enhan
understanding and acceptance and provide practical options for your own strategies. We see managin
your bipolar disorder as part of the larger journey of living your life, and hope that this book provid
you with ideas and inspiration along the way.

1

WHAT IS BIPOLAR DISORDER?

> Being diagnosed with bipolar disorder meant that finally not only did my moods have a name but there was also something I could do to get them more under control. This name did not capture all my experience and the impact that bipolar disorder had on my life but it provided an explanation and a way forward. **Phillip**

Bipolar disorder involves biological changes in mood that are more noticeable, severe, longer lasting and often more disruptive than everyday ups and downs. Recognition of the difficulties and the burdens experienced by people with these extreme mood swings intensified the search for a common language to help describe and treat bipolar disorder. The typical mood changes that occur in the disorder have been organised into specific categories to make them easier to understand, diagnose an treat. In this chapter we discuss the current classification of bipolar disorder. People with bipolar disorder experience the illness differently depending on their symptoms, how often they occur and how their lives are affected. Knowing the current classifications and how they apply to your own experience may assist you in managing your illness.

It is also helpful to be aware of and to recognise symptoms from other disorders, such as drug ar alcohol abuse and anxiety, that may be causing additional distress. As we find out more about bipol disorder, the current diagnostic system may be refined to include milder manifestations of the illne and take into account areas of overlap with other mood disorders.

A BIT OF HISTORY

Bipolar disorder is not a new illness. In ancient Greece, people were aware of melancholia (depression) and mania. In 1851, the French psychiatrist Jean-Pierre Falret described bipolar disorde as *la folie circulaire*, involving changes from mania to melancholia, and in 1854 neurologist Jules Baillarger described these changes as two different stages of the same illness (*folie à double forme*). Towards the end of that century, the German psychiatrist Emil Kraepelin distinguished schizophrenia which involves psychotic symptoms such as delusions and hallucinations without the extreme mood symptoms, from manic depression. Much later, in 1979, Karl Leonhard separated bipolar disorder from unipolar depression, which is the experience of depression with no mania or hypomania, and so the idea of ‘bipolar disorder’ was conceptualised (Goodwin & Redfield Jamison, 2007).

THE DIAGNOSIS OF BIPOLAR DISORDER

Unlike physical illnesses such as diabetes and stroke, bipolar disorder cannot be diagnosed by a medical test such as a blood test or brain scan. Instead, diagnosis relies on identifying your current and past symptoms. The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) (America Psychiatric Association, 2000) and the *International Classification of Diseases* (ICD-10) (World Health Organisation, 2006) stipulate certain criteria as a guide for diagnosis.

This illness usually starts in adolescence or the early twenties, but can occur later or in earli childhood where it can present a little differently (see the website attached to this book for resourc on bipolar in childhood). Many people report that it took a long time for their bipolar disorder to b correctly diagnosed and treated.

Episodes of illness

Bipolar disorder involves 'episodes' of illness. For a diagnosis of bipolar disorder to be made, you will have experienced an episode of mania or hypomania, or a mixed episode, at some stage in your life. Most people experience depressive episodes and milder forms of depression. Episodes differ in severity, occur when you are acutely ill, and exhibit a number of symptoms over a specific period. Once you have experienced an episode of bipolar disorder, the chances of having another episode are high, but ongoing treatment can help to prevent relapse.

An episode of major depression

A depressive episode occurs when you experience depressive symptoms for at least two weeks that cause you distress and affect your relationships, work or daily activities. According to DSM-IV classification, an episode of depression is diagnosed when you have *five or more* of the symptoms listed below. At least one of these symptoms is:

- depressed mood, which may include intense sadness, emptiness, tearfulness or irritability, or
- a loss of interest or pleasure in things, which lasts nearly all day, nearly every day.

The other possible symptoms include:

- lack of energy, and constant tiredness
- restlessness or alternatively a marked lack of activity, known as *lethargy*, which is noticeable by others
- noticeable changes in appetite and weight, either up or down
- sleep problems, which might involve difficulty in falling asleep, waking up a lot during the night, or waking up early in the morning and being unable to return to sleep; or equally, sleeping too much
- feelings of worthlessness and excessive guilt
- difficulty in concentration and/or poor memory or difficulties in making decisions
- persistent thoughts about death and suicide or hopelessness.

Some people have *psychotic symptoms* as part of their depression. This can include delusions (strong beliefs that have no connection with reality) and/or hallucinations (seeing, hearing or smelling things that are not actually there).

An episode of mania

According to the DSM-IV classification, an episode of mania is diagnosed when your mood is excessively happy, elevated, or irritable for at least a week *or* has led to your being admitted to hospital. *At least three* of the following symptoms (*four* if the mood is irritable) must be present:

- needing less sleep than usual
- thoughts racing so quickly that you may get confused and find it difficult to articulate what you want to say
- talking much more than usual or feeling a pressure to keep talking
- being easily distracted from tasks to attend to irrelevant or unimportant things

- feeling a marked increase in self-esteem or thinking you have unique gifts or talents that you do not have
- increasing activity directed to achieving goals (at work, school or sexually) or increasing restlessness and agitation
- participating excessively in pleasurable activities with no regard for the consequences, for example, massive buying sprees, gambling, irresponsible investments, high sex drive and sexual indiscretions.

Mania is diagnosed if these symptoms are severe enough to cause serious disruption to your work or social activities. As with depression, mania may include the presence of psychotic symptoms, including hallucinations and delusions, related to your mood. Extremely disordered or confused thinking is another psychotic symptom that can occur in mania.

Hypomania

The diagnosis of hypomania is based on similar symptom criteria as mania, except that hypomania is milder or briefer. Although you have symptoms, they are not necessarily disruptive and you may be able to carry out your normal day-to-day activities. Still, the changes in your behaviour are obvious enough to be noticed by others. To be classified as a hypomanic episode, the symptoms must last for at least four days. Hypomania does not involve psychotic symptoms.

Mixed episode

You may have thought that having bipolar disorder means that you experience either the lows or the highs, but many people experience a simultaneous mix of these two opposite poles. At first glance th makes no sense, like being hot and cold or black and white at the same time. However, it is possible t have some symptoms of mania and some of depression at the same time. Recognising this combination is vital, as it has specific implications for your treatment. This is explained in more detail in chapter 7 on medications.

According to the DSM-IV classification, a mixed episode occurs when you have a manic and depressive episode at the same time for *at least a week* and the symptoms cause significant disruptio to your daily life, sometimes necessitating hospitalisation. For example, you experience rapid moo swings (happy, sad, irritable), you need less sleep, your appetite is affected, and you are restless an uptight, undertake risky activities, and may have delusions of excessive unrealistic guilt and suicid thinking.

Other classifications of mixed states do not require that you have full manic and depressiv episodes at the same time (Benazzi, 2007; Cassidy et al., 2007). It is common for people who a depressed to have a few manic symptoms, such as racing thoughts, restlessness or a decreased need f sleep, and for people who are manic to experience isolated symptoms of depression, irritability suicidal thoughts. Mixed states may be divided into depressive and manic mixed states, depending o which type of symptoms predominate. Marcel, a patient of ours, describes his experience of mixe states:

> During these patches, I am miserable and agitated. I feel impatient, and am so irritable and angry I am scared of what I could do. The way I feel switches from moment to moment. My thoughts are churning like a washing machine. I am very negative, and thoughts of suicide keep intruding. I have harmed myself before when I feel like this. I am restless, feel as though I have to do stuff and keep moving, although I get very disorganised. I can’t sleep.

Although some people are just prone to mixed states, in other people illicit drug use may have a role in developing mixed states. For some people, certain antidepressants may exacerbate mixed states.

People with mixed states are more vulnerable to developing symptoms of psychosis, such hearing voices or having paranoid ideas. As in depressive episodes, there is an increased risk suicidal ideas and attempts in mixed episodes. Ways of managing this risk are discussed in chapter 1

TYPES OF BIPOLAR DISORDER

People experience different patterns of episodes which characterise their specific type of bipolar disorder. The dominant patterns outlined in DSM-IV are bipolar I and bipolar II disorder; other categories are cyclothymic disorder, and bipolar disorder not otherwise specified (NOS). These patterns may occur with or without other features, such as rapid cycling or psychotic symptoms. The severity of symptoms varies widely between individuals and in the same person over time.

Bipolar I disorder

This type of bipolar disorder is diagnosed if you have had one or more full manic or mixed episode(s although you may have had depressive episodes as well, as shown in figure 1.1. Although less common, some people experience episodes of mania without ever experiencing a depressive episode.

Mary, who has bipolar I disorder, describes her experience:

> I was hospitalised five years ago after a manic episode. It was a scary experience for all of us. I did not think there was anything wrong with me but I was behaving so strangely, speaking very fast and increasingly incoherently, spending money we did not have, staying up all night and going to parties on my own and inviting people to join my 'grand' schemes, that my husband took me to the doctor. I had married the man of my dreams and we had just had a beautiful baby daughter. The diagnosis of bipolar I disorder sounded cold and clinical and definitely had nothing to do with me. In the next few years I was again hospitalised a few times for mania and once because I was feeling very depressed and suicidal. I have been quite well now for two years and what has helped has been getting to know this illness rather than running away from it. As with any other illness, medication helps, and I have found other strategies that work for me.

Figure 1.1 Bipolar I disorder

Bipolar II disorder

This type involves one or more episodes of hypomania and one or more episodes of depression, but n mania, as illustrated in figure 1.2. If you have bipolar II disorder, you may find that you experience depression more often than hypomania.

Figure 1.2 Bipolar II disorder

Grant discovered he had bipolar II disorder about ten years after his first episode of depression. H explains:

> When I think back, I realise that for years I have had distinct patches lasting a few weeks when I feel much more confident than usual, think and do things more quickly, and have new ideas and goals. I don't need much sleep and instead I get so much done. At this time, my social life peaks

and my family remark about my ‘unusual energy’. Everything is in technicolour. Then there are months when things are more grey and sombre and I feel empty and exhausted. Nothing is enjoyable and eventually it becomes a struggle even to get out of bed. For a long time these dark depressions dominated my life. My previous doctor never enquired about my technicolour patches, and they were not disturbing, so I never mentioned them. Recently [my current] doctor asked me about hypomania and we discussed changing my treatment.

Cyclothymic disorder

Cyclothymia refers to a pattern involving hypomanic and mild depressive symptoms that have been experienced for two or more years. Although milder than bipolar I or II, the symptoms of cyclothymi disorder are still severe enough to cause difficulties at work, in education, employment and relationships. Bipolar disorder and cyclothymia exist on a continuum.

Figure 1.3 Cyclothymic disorder

Bipolar disorder not otherwise specified

Bipolar disorder NOS is used to diagnose illness episodes that do not last long enough to be describe as manic, hypomanic, mixed or major depressive episodes, or which do not have the required numbe of symptoms.

There is some debate about whether to categorise particular temperaments as bipolar disorder NO or to subdivide bipolar disorder further on a continuum from its more severe to its mild presentations. Some people may have temperaments that look like very mild bipolar symptoms a which sometimes later develop into more established forms of bipolar disorder (Akiskal et al., 1998)

- *hyperthymic*: very cheerful, optimistic, extroverted, confident, always busy
- *cyclothymic*: fluctuating mild mood changes, changing levels of self-esteem
- *dysthymic*: usually joyless, lacking energy but not as severe as depression
- *depressive mixed*: mild symptoms of anxiety, irritability, restlessness, sadness.

The bipolar spectrum

For people who have never experienced mania or hypomania, a diagnosis of unipolar illness may be clear. Many people view bipolar disorder as distinct from unipolar disorder. In reality, the difference is less clear-cut. For example, you may have predominant symptoms of depression as well as minor experiences of mood elevation that are too mild or brief to be diagnosed as having bipolar disorder. These symptoms fall into the bipolar spectrum, however, and you may find that you benefit from treatments that are usually used for bipolar disorder. Similarly, some people diagnosed with unipola depression develop hypomania when taking antidepressant treatment. The boundaries of the spectrum are controversial, but it is likely that almost half of all people who experience diagnosed depression have some form of bipolar disorder. People whose illness falls into the bipolar spectrum are more likely to have depression associated with increased sleep and marked fatigue, and to experience feelings of flatness, rather than sadness.

RAPID CYCLING

Cycling occurs when you swing from one episode of illness, such as depression, into another, such as mania or a mixed state. According to DSM-IV, rapid cycling occurs when you have at least four episodes of illness, either mania or depression, in a calendar year—but rapid cycling can be far more frequent than that, with some people cycling within weeks or even days. Rapid cycling is not rare, occurring in somewhere between 15 and 25 per cent of people who suffer from bipolar disorder. The treatment for people who have a pattern of rapid cycling differs significantly from the treatment for people who don't, so it is important to recognise if this is your pattern.

People who suffer from rapid cycling are more likely to be female and younger, or to have becom ill later in life, and may have more episodes and hospitalisations. Thyroid problems ar antidepressants may contribute to rapid cycling. For some people, although they cycle fro depression to mania, the dominant experience is depression.

SEASONAL PATTERN

Some people find that they usually have episodes at a particular time of year. You may find that you tend to develop a major depressive episode in winter or autumn and/or a hypomanic or manic episod in spring or summer. Knowing these patterns can be useful as you can find ways of preventing or reducing the severity of the episode.

WHAT BIPOLAR DISORDER IS NOT

Bipolar disorder may need to be distinguished from signs and symptoms that resemble it in order for people to get the right treatment. Not all mood swings are bipolar. Most people will experience bette or worse days. At times, these can happen in response to the ups and downs of life, but sometimes yo can just 'get out of bed on the wrong side'. Mood swings that are within the realm of everyone's experience, such as understandable reactions to an unfortunate event or that are not particularly intense, distressing, disruptive or noticeable, are unlikely to be part of bipolar disorder.

Hypomanic, manic or mixed episodes distinguish bipolar disorder from unipolar depressio Bipolar disorder can also be confused with illnesses that involve psychosis, such as schizophreni Schizophrenia involves periods of prominent psychotic symptoms, including delusions, hallucinatio and disordered thinking but, rather than experiencing intense moods, schizophrenia is associated wi blunted moods. While people with schizophrenia may become depressed, their psychotic symptoms d not occur only in the presence of a manic, hypomanic or depressed episode, as they do in bipol disorder.

Bipolar disorder has also been confused with schizoaffective disorder, another illness that includ both psychotic and mood symptoms. The essential difference here is that in bipolar disorder psychot symptoms occur only in the presence of mood symptoms, whereas in schizoaffective disord psychotic symptoms occur both in the presence of mood symptoms and when mood symptoms hav been absent for at least two weeks.

Mood swings are common in borderline personality disorder, but these do not usually last as lon and are not as marked as the moods in bipolar disorder. In borderline personality, mood swings occu as a reaction to events and are linked to particular personality characteristics.

Some altered states brought on temporarily by taking certain illicit drugs may mimic episodes bipolar disorder, but the effects of intoxication wear off rapidly and do not constitute bipolar disorde The symptoms of certain medical conditions such as hypothyroidism or multiple sclerosis can als mimic bipolar disorder. Accurate diagnosis of bipolar disorder is essential for appropriate treatment.

COMORBIDITY

Bipolar disorder can occur together with many other disorders, so you may find that you have other symptoms besides those of bipolar disorder. This is called ‘comorbidity’. Two problems that commonly occur with bipolar disorder are drug and alcohol problems and anxiety.

Alcohol and drug problems

While some people with bipolar disorder have no alcohol or drug problems, there are many (50 to 70 per cent of people with bipolar disorder) whose lives are complicated by these additional difficulties (Brady & Sonne, 1995). Of the substances that are used, by far the most common is alcohol, although there are also high rates of marijuana, cocaine, amphetamine, benzodiazapine and heroin use among people with bipolar disorder. The risk of relapse, mixed episodes, rapid cycling, suicide and violent behaviour are increased in people with bipolar disorder who have drug or alcohol problems (Balázs et al., 2006), thus people with drug or alcohol problems tend to suffer more as they end up more ill, being hospitalised more often, and suffering greater disruption to their lives than people with bipolar disorder who do not abuse these substances.

Facing up to drug and alcohol problems can make an enormous difference to your bipolar disorder and your life. Some people find it hard to reduce their drug or alcohol use even when they know it is causing major problems and undermining their health. If this is your experience, discussing this problem with your clinician may be a first step towards treatment. Remember you are not alone with this dilemma. We list some resources on the website (www.allenandunwin.com/livingwithbipolar) that you can use to help reduce your drug or alcohol consumption.

Anxiety

Many people with bipolar disorder experience anxiety, which may be most common in people with bipolar II disorder and in females (McIntyre et al., 2006). Anxiety may predate your bipolar disorder, occur when you experience an episode of bipolar disorder, be part of your rapid cycling or be present when you are well. For some people, anxiety increases the risk of recurrence of bipolar episodes. Anxiety symptoms can be distressing and disruptive, and people with bipolar disorder are becoming increasingly aware of the need to identify and treat their anxiety together with their bipolar disorder. A few helpful resources are listed on the website associated with this book. Many people work at reducing their anxiety together with their clinician.

Your experience of anxiety may range from a few mild symptoms to a disabling disorder. Some anxiety symptoms resemble symptoms of physical illness so it is important to differentiate them. Common anxiety symptoms include:

- increased heart rate, pounding or palpitations
- feeling as if you are short of breath or suffering a choking sensation
- sweating
- feeling dizzy or light-headed or cut off or distant from things
- shaking or trembling
- difficulty concentrating
- nausea, vomiting or diarrhoea
- pins and needles or numbness
- feeling very cold or hot flushes
- aches and pains

- indigestion
- excessive worry
- intense fear of losing control or feelings of dread.

Some people experience anxiety disorders such as panic disorder, specific phobia, social phobia, obsessive-compulsive disorder, posttraumatic stress disorder and generalised anxiety disorder, which are outlined below. Discussing your anxiety problems with your clinician may help you to get the bes treatment.

Panic disorder with or without agoraphobia
Panic disorder involves panic attacks, which are short, intense periods of anxiety. Agoraphobia involves anxiety about being in certain situations that feel unsafe and so are avoided, such as being away from home, or in a crowd. For some people, panic attacks are linked to these specific situations

Specific phobia
Specific phobia involves excessive and irrational anxiety and avoidance of specific objects or events such as snakes, spiders or flying.

Social phobia
Social phobia involves excessive anxiety about how you will perform in social situations and how others will judge you. You may find that you avoid certain social situations, and that even anticipatin these situations makes you panic or feel distressed.

Obsessive-compulsive disorder
Obsessions are persistent, intrusive thoughts, impulses or images that cause distress but are hard to stop or ignore. Compulsions are repetitive actions considered to bring relief or prevent disaster relate to your obsessions, such as excessively washing your hands, checking things or counting. These obsessions and compulsions can be very time-consuming and disrupt your daily life.

Post-traumatic stress disorder
Post-traumatic stress disorder sometimes occurs when you have experienced a very threatening or traumatic event which evoked intense fear and helplessness. The event is re-experienced in different ways such as flashbacks, when you encounter things that remind you of the trauma, or in nightmares. As a result you may avoid any associations with or reminders of the event, and generally cut off your feelings. You may feel very distressed, and this can interfere with your daily life.

Generalised anxiety disorder
The predominant symptoms of generalised anxiety disorder are excessive worry and anxiety combine with other symptoms such as difficulty concentrating, sleep disturbances, feeling on edge and unsettled, or fatigued. This anxiety usually persists longer than six months, makes you feel distressed and can interfere with your daily functioning.

KEY POINTS

- All people with bipolar disorder have episodes of hypomania and/or mania at some stage, which

may vary in severity and in terms of the combination of symptoms experienced.

- Becoming familiar with your pattern of hypomania or mania can help you to reduce the impact o bipolar disorder on your life and help your loved ones to understand your illness and be supportive.
- Making short lists of the typical symptoms you experience in a hypomanic or manic episode, an your warning signs, can help you to monitor your illness and take action to prevent or reduce episodes when necessary.
- Disturbing and disruptive behaviour is a symptom of illness and not your fault.
- For some people, the experience of hypomania or mania involves pleasure and productivity, but this is short lived and soon transforms into depression or mixed states.
- Even when mania is a pleasant experience, it can have devastating consequences on relationship occupations and financial security.
- Effective treatment involves medication, psychotherapy and personal strategies, which are explained fully in later chapters.

2

BIPOLAR DEPRESSION

My depression was so strange . . . As if the elves had stolen me and had left a block of wood instead.

Marc De Hert et al., *Anything or Nothing*, 2004: 15.

Bipolar depression is not just feeling a bit blue because of the everyday stresses and strains of life. The experience of depression is markedly more distressing and long lasting than that, and can interfere with your daily life and what is important to you. Your mood involves the way you think, feel and behave, as well as the biological changes happening in your brain. In this chapter we look more closely at some of the changes in feelings, thinking and behaviour reported by people with bipolar depression. This depression can be experienced in a variety of ways, depending on the combination of symptoms, their level of severity and how often you experience them. If you recogni your experience in these pages, know that you are not alone. About 90 per cent of people with bipola disorder experience depression at some time. Although depression may seem endless and overwhelming at times, a lot can be done to treat it and we discuss this in more detail in later chapte Depression is *not* something you *are*, it is something you *have*. It is not your fault any more than having an illness like asthma is your fault. Getting to know your experience of depression and recognising symptoms as they occur may give you the chance to implement appropriate treatment an strategies early.

WHAT CHANGES WHEN YOU BECOME DEPRESSED?

Below we list a few changes in feeling, thinking and behaving reported by people who have experienced bipolar depression. You may find that you or those close to you have experienced some these changes.

Changes in feeling

Changes in how you feel include:

No feeling or tears

Many people with bipolar disorder experience an absence of feeling, or feel flat and empty, as part o their depression. For some there is a pervasive feeling of sadness and tearfulness.

Don’t care

You sometimes hear people who are feeling depressed declaring that they no longer care about anything, even those things that used to matter to them.

Nothing’s interesting
You may lose interest and motivation to do things. Sometimes people don’t feel better even temporarily when something good happens.

Can’t enjoy anything
You may find that your capacity to experience pleasure diminishes. Many people find their sex drive decreases. Your senses may even be dulled so that things don’t taste or smell as good as they used to and the world looks grey.

Too tired, no energy
It is common to feel as though you have just run a marathon and have no energy left.

Mornings are worse
You may feel worse at a particular time of day, especially in the morning, although some people feel worse in the evening.

Worthless
An important clue is a fall in self-esteem, which makes people lack confidence and feel useless, and temporarily forget all their strengths and abilities.

Guilt
You may feel excessively guilty for even minor mistakes or indiscretions, and recall with shame simple, very human errors.

Criticism and rejection
Many people become more sensitive to criticism and rejection.

Irritable, impatient, aggressive
Being more aggressive, argumentative, impatient and irritable in general, or with those closest to you is common when experiencing depression, mania or mixed states.

Hopeless, helpless
Another clue to recognising depression is the hopelessness you may feel about the future, and the helplessness about not feeling able to change things. When severe, this hopelessness contributes to feeling suicidal.

Worried, anxious
This worry may be a global anxiety when everything is a worry, or limited to something specific, suc as worrying about physical health.

Physical symptoms of anxiety
Common anxiety symptoms include tremor, sweating, a racing heart, hot or cold flushes, or discomfort in the stomach or chest.

Aches and pains

Some people experience numerous physical aches and pains when depressed. A warning sign of depression might be an increase in physical symptoms and an increase in trips to the doctor by a person who is generally healthy.

Depressed activity

You may notice changes in what you do including:

Hibernation

Depression has been compared to a kind of hibernation from the world. Even the most outgoing of people may find that when they become depressed they start refusing invitations and want to be alone

Lethargy

Lethargy means being very tired, unmotivated and slowed down. Joe explains:

> I told him that doing the dishes when I felt like this was similar to him trying to run a race when his body was rendered weak by a fever. He could not see my illness, but it was sapping my energy and making all those tasks one normally takes for granted into major hurdles.

People with bipolar depression may talk slowly, use shorter sentences and move slowly. Outsiders sometimes comment that people who are depressed have fewer facial expressions and gestures. In its milder form, this drop in activity level can mean that it is harder than usual to keep to arrangements to get going in the morning. Thoughts can become slower and fewer. Lethargy in its more severe form can mean that it is difficult to get even basic things done, or even to get out of bed.

Agitation

Some people experience agitation as part of their depression, so that they find it hard to sit still and are restless. In some cases they may experience fluctuations from being slowed down to being agitated. Agitation can also make it hard to complete tasks.

Procrastination, withdrawal and avoidance

Delaying tasks, withdrawing from commitments or arrangements and avoiding social contacts can all be signs of growing depression.

Sleeping and eating

Depression can affect basic activities such as sleeping and eating. Sleeping much more than usual is typically associated with bipolar depression, although some people with bipolar disorder suffer from insomnia as a sign of depression. Some people with bipolar depression lose their appetite when depressed, resulting in significant weight loss, whereas others crave ‘comfort food’ and eat more.

Depressed thinking

Your thinking may become more one-sided and negative. Concentration and memory difficulties can temporarily detract from your usual sharpness and slow you down.

Thinking negatively

> The voice of depression is often a bully and it tends to block out alternatives . . . Depression is very keen to tell us what we can't do, what we shouldn't do and how bad things are . . . there are two basic orientations that we can take that will help control it: insisting on rational questioning and alternatives, and developing basic compassion (Gilbert, 2000:99).

In everyday life, even when in a relatively stable mood, everyone experiences negative thoughts from time to time—but depression involves more than occasional negative thinking. It is as if you put on dark glasses and see yourself, others and the future in only one rigid way, the worst and most critical way. Distrustful thoughts or believing that others are against you is also typical of depression—for example, in a stable loving relationship suddenly deciding that your partner is rejecting you or having an affair.

A one-sided, negative interpretation of events is often unrealistically applied to everything and all time—for example, 'I did not manage to pass this exam so I will never be able to pass an exam do anything else that is important to me ever again.' Such thinking can increase feelings hopelessness, so that it's not surprising that people who experience depression may be plagued wi thoughts about suicide. Suicidal thoughts need to be taken seriously, because there is a high risk suicide. Fortunately, there is a lot that can be done to reduce this risk, as explained in chapter 13.

Your thinking may become dominated by selective negative memories from the past or worri about the present or the future. These thoughts sometimes repeat themselves endlessly, so that it difficult to think of other things. This is called 'rumination'. Cognitive behaviour therapy (CBT) a mindfulness-based psychotherapy both have special strategies that people have found helpful dealing with depressed thinking (see chapters 8 and 12).

Sluggish thoughts and memory

Another big clue about depressed thinking is that you may feel as if your head is full of fog. Difficult remembering even recent things or in concentrating on everyday tasks can get in the way of getting things done. At times like these, it can be hard going to make decisions or to work at your usual pace Temporarily reducing your expectations of yourself and setting smaller achievable goals are among the strategies recommended for dealing with these changes.

DIFFERENT KINDS OF DEPRESSION

Many different clusters or combinations of depression symptoms are possible, including atypical, psychotic and mixed depression.

Atypical depression

The experience of depression may be subtly different for people with bipolar disorder and those who have unipolar depression (where only depression is experienced, not hypomania or mania). A pattern of so-called *atypical depression* may occur more often in people with bipolar disorder. One of the reasons this pattern is called atypical is that instead of having insomnia, loss of appetite, and being very sad and tearful, which are all characteristic of unipolar depression, people need to sleep and eat more, and feel flat and slowed down when depressed. You may feel temporarily better when good things happen, but this does not change your underlying mood. Marked fatigue and sensitivity to rejection are also common in atypical depression (Cuellar et al., 2005).

Psychotic depression

For some people with bipolar disorder, extreme negative thinking can take the form of psychotic delusions, including beliefs about excessive personal guilt, such as believing that you have committe a sin or a terrible crime, or paranoid delusions, such as believing the police are out to get you. Hallucinations are occasionally present. In psychotic depression, however, psychotic symptoms accompany the symptoms of depression. Psychotic depressions typically respond to medical treatment:

> I really believed that I was guilty of ruining my children's lives by being an inadequate parent and of causing the natural disasters that had recently hit the world. The way I was feeling (my depression) was God's way of punishing me for this. **George**

Mixed depression

You may have mixed depression if you have a major depressive episode (see chapter 1) plus some symptoms that are typical of hypomania or mania at the same time. The number of manic symptoms required for a depression to be considered a mixed state is not certain, but recent studies suggest that you need to have at least three hypomanic or manic symptoms (Benazzi, 2007). These often include irritability, racing thoughts, talkativeness, agitation or distractibility. It is important to know whether you have a mixed depression, because for some people, antidepressant medications may aggravate rather than reduce these moods. Tim discovered that he sometimes experienced a mixed depression:

> Everything was dark and I felt oversensitive. The usual friendly faces just irritated and annoyed me. Sleep did not come easily and I could not sit still and my thoughts raced but I felt tired and run down. Nothing gave me enjoyment. I was restless and just felt on edge and thought how worthless I was and how little point there was to anything.

HOW SEVERE IS YOUR DEPRESSION?

The experience of depression in bipolar disorder ranges from having only a few mild symptoms to having frequent or severe episodes. You may find it helpful to work out a list of symptoms that you typically experience in an episode of depression or/and mixed depression. A template for the list is available at www.allenandunwin.com/livingwithbipolar. This can help to identify your typical warning or early symptoms, as explained in chapter 10, which means that you can implement strategies for managing your depression before it gets too severe. Recognising symptoms that may persist between episodes provides the opportunity to address and minimise these too.

A full episode of depression

The diagnosis of a full major depressive episode involves a cluster of five or more persistent symptoms (for at least two weeks), one of which is either depressed mood or loss of pleasure in things. Episodes range from mild to severe depending on how intense the symptoms are and how much they interfere with your daily life, relationships and safety. It is important to note that the symptoms of depression are not always static throughout an episode. For example, some people repo a progression from lethargy and feeling flat, to severe negative thinking and suicidality as they start t gain more energy. The frequency and duration of a person's depressive episodes also vary.

While medical treatment is standard for depressive episodes, research has found that medicatio