DR. JONES MENTAL FITNESS UPDATE©

BIPOLAR DISORDER

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A board certified Psychiatrist with 30+ years of clinical, research, and teaching experience. He is among the first Psychiatrists to be certified as a Psychopharmacologist. His specialties include anxiety and mood disorders, stress management, ADHD, and innovative medication management.

The spectrum of bipolar disorders is characterized by mood instability and impulsivity. About 1% (2 million) of the population is bipolar I. Bipolar has multiple forms. It ranges in severity from mildly disruptive to life destroying. As in other medical conditions such as diabetes and hypertension, the vulnerability to bipolar disorder is inherited. Once you have it, you have it for life. Fortunately, like hypertension, it can be medically controlled.

Mood swings usually start in the 20's, but can start in childhood or during the teens. If depression is present in these early years, there is an increased risk of bipolar. Sometimes, the first major mood swing doesn't occur until the 30's or occasionally, later.

If mood is compared to room temperature, (too cold equals depression and too hot equals mania), bipolar disorder is like having a defective thermostat. The thermostat gets stuck at one extreme (mania or depression) and the temperature (mood) goes out of control.

Mood swings can occur abruptly. They may be induced by seasonal changes, hormonal changes, certain medications (such as steroids, decongestants, antidepressants, stimulants, recreational drugs), or too much or too little sleep.

One of the biggest problems facing those with bipolar disorder is what is described as the "kindling effect". This means that every episode of abnormal mood (low or high), increases the sensitivity of the brain's mood regulators. This makes it easier to have mood swings in the future.

Many of my patients are unquestionably bipolar and many show no signs of the disorder. But, patients that fall in a "gray" area with some symptoms present, make pinpointing the diagnosis very difficult. These individuals often appear to be primarily oppositional, substance abusers, or have personality disorders. This group is the greatest challenge to psychiatry and requires the closest scrutiny. Because of its complexity, bipolar disorder usually needs to be treated by a Psychiatrist.

MEDICAL MANAGEMENT OF BIPOLAR DISORDER

Mood stabilizing medications treat depression and mania:

√Anticonvulsants
- Depakote*
- Lamictal**
- Tegretol*

√Atypical Antipsychotics
- Zyprexa* **** *****
- Risperdal* ****
- Seroquel* ** *** ****
- Geodon* ** ****
- Clozaril
- Abilify* ** *****
- Saphris* ****

√Other Options:
Lithium* **
Thyroid
Symbyax***

FDA approval for:
*Mania
**Maintenance (Stabilization)
***Bipolar depression
****Mixed episodes
*****Agitation

SPECTRUM OF BIPOLAR

Bipolar I: Severe mania, with depression
- Distinct periods of elevated, expansive or irritable mood
- Inflated self esteem/ grandiosity
- Decreased need for sleep
- More talkative than usual
- Racing thoughts/ideas
- Distractibility by the irrelevant
- Increased goal directed activity, psychomotor agitation
- Excessive/impulsive behavior in pleasurable activities

Bipolar II: Major depression, hypomania (milder mania)
- Mood elevated or irritable
- More energy than usual
- Talkative
- Decreased sleep
- Inflated self-esteem
- Hypersexuality
- Excessive involvement in pleasurable acitivities

Major depression:
- No interest or pleasure (Most common symptom)
- Depressed mood
- Weight loss/gain
- Insomnia/hypersomnia
- Psychomotor retardation
- Fatigue or loss of energy
- Feelings of worthlessness/ guilt
- Decreased concentration
- Recurrent thoughts of death

Cyclothymia:
For at least 2 years, periods of hypomania and depression symptoms that do not meet major depression criteria

Bipolar NOS:
Official diagnosis for significant bipolar symptoms, but not enough to qualify for BPI, II, CT

ABOUT OUR STAFF

Paige Embrey, M.B.S., L.P.C. Clinical assistant to Dr. Jones, she is certified as a licensed professional therapist. She is available for personal counseling, including children, teens, social anxiety, and ADHD coaching.

Penny Chaney, B.B.A., -does writing/editing, and research. She develops patient education materials, management of presentations, and web site production.

Melissa King, B.F.A. –Coordinator of our program for total fitness. She will serve as "coach" for patients that wish to initiate positive lifestyle changes.

Davin Williams-A seasoned member of our administrative staff. She has advanced training in stress disorders.

Kelli Miles-Newest addition to our administrative staff. She brings knowledge and experience to complete our team.

DRUG ABUSE RATES HIGH IN BIPOLAR

Alcohol Abuse/Dependence Lifetime:

- **13% in general population**
- **21% in depressed population**
- **46% in bipolar population**

Drug Abuse Lifetime:

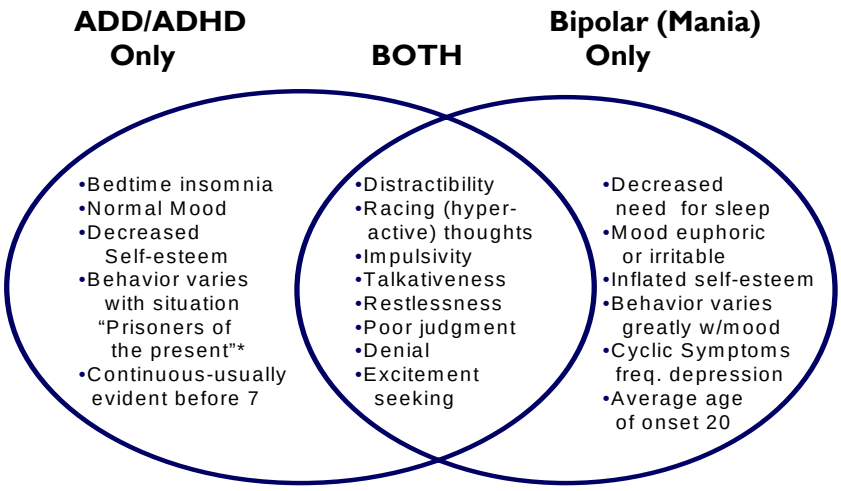
- **6% in general population**
- **18% in depressed population**

MULTIPLE MEDICATIONS OFTEN NEEDED TO CONTROL SYMPTOMS

One study found patients to be on the following to control symptoms:

One medication	**19%**
2 medications	**28%**
3 medications	**28%**
4 or more	**25%**

IS IT ADD/ADHD, BIPOLAR, OR BOTH?



Many times ADD/ADHD and bipolar are hard to distinguish from each other. ADD behavior is consistent and is driven more by interest than by importance. Bipolar is cyclic and behavior is driven by mood. Many people have both disorders. 60% of those with ADD will also be bipolar.

SUBTYPES OF BIPOLAR DISORDER

DYSPHORIC MANIA AND MIXED STATES It is possible to have the symptoms of major depression and mania at the same time. This is called a mixed, or dysphoric state. It is estimated that 31% of patients presenting with mania have a mixed state. It is characterized by distinct periods of abnormally and persistently elevated, expansive, and/or irritable mood with depression (neither is due to just drug abuse.)

While the absolute changes in the brain chemistry are not fully known, mixed mania may be associated with brain transmitters that are too high (dopamine and norepinephrine), and/or too low, (serotonin). Mixed states sometimes occur during transitions from one phase of mood to the other.

In mixed mood states it is essential to treat the mania before treating the depression. Starting treatment with an antidepressant is like throwing kerosene on a fire because it can trigger a manic state.

RAPID CYCLING Persons with rapid cycling have at least 4 episodes per year of mania/hypomania, and/or major depression. It is estimated that 13-20% of bipolar patients are rapid cyclers. It is more common in women, probably because women have more hypothyroidism.

Rapid cycling is frequently caused by low thyroid. Some experts recommend keeping thyroid levels within the top 25% of normal range of free T4. This can be measured by a standard blood test. Note: Many doctors only test the TSH for thyroid disorders. Testing only TSH is *not* adequate for secondary thyroid disorders.

Rapid cycling is difficult to treat and may respond better to a mood stabilizer than Lithium.

"Mania is a sickness for one's friends, depression for one's self!"
-Robert Lowell

HEALTHY LIFESTYLE AND BEHAVIORAL MANAGEMENT

Bipolar is a lifelong disorder. At this time, there is no known medication that can cure or eliminate it. Medication only manages and controls the symptoms. Bipolar disorder must be constantly attended to just as the person with diabetes must do the things necessary to keep it under control.

Along with carefully managed medication, it is essential that a healthy lifestyle be maintained. When both of these are achieved, mood can be stabilized and a normal, stable, high functioning life is possible.

- **Life charting**-Construction of a graphic representation of major symptoms, major life events and treatment over the person's lifetime. This aids in establishing the course of the disorder and the life events that contributed to mood swings.
- **Mood graph**-This helps to optimize medication management. A daily chart monitoring sleep, symptoms, side effects, mood changes, medications, etc. provides a valuable tool for maintaining a good treatment plan.
- **Good health habits**-Developing and maintaining regular patterns of daily activities helps reduce stressors that cause mood swings. It is especially important to develop regular patterns of sleep. Sleep deprivation triggers mania. However, too much sleep causes decreased mental energy and motivation.
- **Involvement of a significant other**-Spouses/friends can play an important role in detecting a mood swing when the impaired person may not know they have a problem (especially when manic). They can also provide encouragement for taking medication even when the bipolar person is feeling well and doesn't think they need medication.

DID YOU KNOW?.....

- 70% of persons with two bipolar parents will be bipolar
- Untreated bipolar disorder will worsen over time becoming more frequent and severe
- Bipolar often begins with depression
- Antidepressants can induce a manic response in a person that is bipolar
- Bipolar is a serious disorder with a 15% rate of suicide
- 5-8% of the population have a bipolar spectrum disorder
- The average age of onset is 15-19
- treatment of bipolar
- Bipolar disorder is not diagnosed on average for 9-10 years
- 20% of those with bipolar disorder have panic disorder
- 25% of those depressed are bipolar
- 48% of those with bipolar disorder consult 3 or more professionals before receiving correct diagnosis
- Bipolar disorder can be caused by head injury, substance abuse or genetics
- Substance abuse or dependence is more likely during mania
- 70% of bipolars that stay up all night become manic the next day

IS IT DEPRESSION OR BIPOLAR DISORDER?

Fred Goodwin, M.D., an expert on bipolar disorder, cautions that antidepressants can trigger symptoms of bipolar disorder in a person that has never had symptoms in the past.

What does this mean? When an individual goes to the doctor suffering from symptoms of depression the genes could be present for bipolar depression, not just depression. If the bipolar genes are present, initial treatment with antidepressants alone can cause symptoms of bipolar even if the patient had no symptoms in the past.

It is extremely important to give the physician a thorough family history when seeking treatment of depression for the first time. If any known relative, (parent, sibling, child, Grandparent), has had any symptoms of bipolar, it is usually safer to treat with a mood stabilizer first, not an antidepressant. Clues to look for in family history:

- √ Any extremes in mood/behavior
- √ Periods of high productivity
- √ Period of low or no productivity
- √ Episodic alcohol/substance abuse
- √ Relatives that had "nervous breakdowns" causing lost jobs, relationship problems, or hospitalization
- √ Dramatic changes in sleep habits (going without sleep for days or staying in bed for days at a time)
- √ Persons that seem normal most of the time, then suddenly become withdrawn, irritable, argumentative, or extremely talkative or aggressive

RESOURCE CORNER

- √ *The Unquiet Mind*, by Kay Jamison, Ph.D
- √ *Brilliant Madness*, by Patti Duke
- √ *Manic Depression*, by Fred Goodwin, M.D.
- √ *Sad to Glad*, by Nathan Kline, M.D.
- √ *Mood Swings*, by Ron Fieve, M.D.

National Depressive & Manic-Dep. Assoc.
730 North Franklin St., Suite .501
Chicago, IL 60610
Phone: 1-800-826-3632

www.dbsalliance.org (depression & bipolar support alliance)

Mental Fitness Update
375 Municipal Suite 224
Richardson, TX 75080
972-234-0489 FAX 972-235-1558
www.AskDrJones.com
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Question: What was the ONLY mental disorder Nazi Germany chose to spare in the so-called quest to "cleanse" the human race?
Answer: The bipolar population.

Although Hitler's decision was purely self-serving, he made a very astute observation. The manic people got things done. They were energetic, required little sleep, (so they worked harder and longer), and they were passionate, creative people.

Indeed, the world would probably be a gray, boring place without these people. In her book, *Touched With Fire*, Kay Jamison explores the lives of many of the artists that have given us great works. They all share a common struggle with bipolar disorder. This does not mean that all creative people are bipolar. But a much larger percentage of creative people have bipolar tendencies than the general population. Some studies suggest bipolar is as high as 50% in creative people.

Many poets, painters, composers, and writers were inspired to create great works of genius when in the exhilarating highs of mania. These same people often wrote of the unbearable pain they experienced when the highs plunged into deep and often suicidal depression. Great poets and writers have penned beautiful, moving narratives of the agony and ecstasy of being bipolar. William Wordsworth explains it this way:
"By our own spirits are we deified.
We poets in our youth begin in gladness,
But thereof come in the end desponding and madness."

Other studies of bipolar and creativity found the following:

- Four American poets have won the Pulitzer prize. All four have committed suicide.
- While only 1% of the general population is bipolar I , 25% of award winning writers, artists, and musicians in England were found to be bipolar I.

Just a few of the notable people that have blessed us with "mad genius" include:

- Lord Byron
- Emily Dickinson
- T.S. Eliot
- John Keats
- Ernest Hemingway
- F. Scott Fitzgerald
- Michelangelo
- Georgia O'Keefe
- Vincent van Gogh
- Edgar Allan Poe
- Ralph Waldo Emerson
- Robert L. Stevenson
- Charles Dickens
- Samuel Clemens
- Cole Porter
- Irving Berlin
- Peter Tchaikovsky
- George Handel

This passage by the poet Lord Byron beautifully reflects the struggle of bipolar:

"Yet must I think less wildly-I have thought
too long and darkly, til my brain became,
In its own eddy boiling and o'erwrought,
A whirling gulf of phantasy and flame:
And thus, untaught in my youth my heart to tame,
My springs of life were poison'd" -Lord Byron

Our main goal in writing this newsletter is to provide education that helps people have better quality lives and relationships! We would like to remind you however, our intention is not to personally advise anyone on treatment or medications. Please consult your physician before making any decisions concerning your own diagnosis and treatment plan. We would be delighted to get comments/suggestions from you! Fax or E-Mail anyone on our staff at the numbers listed above. . .

I HOPE SOMETHING IS OF VALUE TO YOU!