

Chapter

Reflections and insights from the 'lived' experience

Victoria Maxwell

Introduction: practical for both clinician and consumer

Bipolar disorder (BD) destabilises more than just a person's mood, thinking and physiology. It subverts one's identity, life and dreams. It is a disease that ferociously and expertly destroys lives and the sense of meaning, not just of the individual who has the illness but those loved ones around that person. I know. After what was thought to be a brief reactive psychosis (by the way: nothing is really brief when it comes to psychosis), I was eventually diagnosed with rapid-cycling, mixed state BD with psychotic features, mild temporal lobe epilepsy and generalised anxiety disorder. The regrettable (and sadly common) fact is that it took many more psychotic, manic and depressive episodes over a four-year period before I would accept I had BD. And it took an additional five years to regain some semblance of self-esteem and confidence and return to the workforce and independent living.

Prior to and during those first four years, my career careened out of control, my significant other left, my money evaporated, my friends were scared off, my car and home were no longer affordable and my idea of myself permanently changed. The assistance I received from the health professionals who worked with me (more accurately who *tried* to work with me – I wasn't exactly a willing participant for those first few years) included potentially helpful treatment plans and medication regimes. However, I didn't care about these plans – I cared about gathering what was left of my life (and my dignity) and envisioning something beyond attending self-help meetings and cognitive behavioural therapy sessions and cashing welfare cheques and living with my parents.

Understandably, wellness is defined in various ways by different groups. Decreasing the occurrence of disabling symptoms is not to be dismissed. Those living with BD know the importance of being able to get out of bed and to be free of the relentless fatigue that dogs us during

depression. But to have a reason and a life to get out of bed *for* is at the heart of wellbeing. It is something that must be taken into consideration when creating treatment plans – it encompasses wholly different elements but is as essential as reducing episodes of psychosis, mania and depression. To be truly practical, the management of BD must go beyond the reduction of symptoms. It is about understanding what we, as your patients, want in specifics. Does your patient want to work full time, have children, go back to school, afford a car, learn to cook, have a circle of friends, quit smoking, live downtown but not on the Eastside? To be valuable to us, your help must be relevant to our daily lives. That is why including the consumer in the planning of treatment and in the process of delivery of those treatments is essential. Shared decision-making is pivotal. It is also why I am grateful and honoured to be contributing to this guide as one voice of the consumer. In order for this guide to be practical, the information and tactics lying within these pages must in the end benefit not only you, but the patients you serve.

In this chapter I discuss, from the perspective of someone who lives with BD, what makes a guide like this practical to those of us with the illness, and what recovery means and how it relates to the chapters that follow; I also introduce the concept of 'personal medicine' and the critical connection treatment must make with it.

Recovery, personal medicine and treatment: the critical connection

Instead of focusing primarily on symptom relief, as the medical model dictates, recovery casts a much wider spotlight on restoration of self-esteem and identity and on attaining meaningful roles in society. (US Department of Health & Human Services, 1999)

As mentioned previously, symptom abatement alone is not synonymous with recovery. A life defined by decreased hospital days or better medication adherence is only part of the formula indicating recovery and one that is unsatisfactory at best. Dr Patricia Deegan, a

Chapter 1: The 'lived' experience

clinical psychologist and pioneer in the mental illness recovery movement and the study of resilience (who also happens to live with schizophrenia), eloquently states: 'recovery is about changing our lives, not just our biochemistry' (Deegan, 2005). Indeed, having a sense of purpose, feeling like a valued part of the community despite experiencing symptoms of BD, is at the core of what it means to be in recovery. Whether we experience intense symptoms or few at all, we as consumers – like all of us really – need to feel our lives have significance, that our lives have meaning, or that at the very least we are creating meaning.

All of us, regardless of our state of health, utilise what Dr Deegan terms 'personal medicine' (PM), which she defines as the things that give life meaning and 'make life worth living' (Deegan, 2004; Deegan, 2005). This idea of personal medicine is integral to recovery and must be taken into account when creating and executing recovery plans for an individual.

Personal medicine defined

The term coined by Deegan refers to activities or wellness strategies we do, rather than things we ingest. They are not goals we set or feelings we have. They are not over-the-counter mixtures of our own making. They are behaviours that enhance our sense of purpose, raise our self-esteem, engage our deepest values and beliefs and improve our wellbeing. At first glance, PM may seem overly simplistic and self-evident, but these behaviours and the ability to engage and align treatment with them have profound impact on patients' recovery and their adherence to treatment plans. Crucial to note is the delicate and often underestimated interplay between PM and treatment. In studies carried out by Deegan, discovering, understanding and aligning medical treatment with a patient's PM can increase medication adherence. She states that 'medication adherence may be improved when clinicians inquire about patients' personal medicine and use pharmaceuticals to support, rather than interfere with, these self-assessed health resources' (Deegan, 2005).

As we explore PM further it will also become apparent that this element in a person's life may be one of the most cost-effective and efficient means of engaging that individual in treatment, as long as this one guideline is followed: medical treatment must align with and complement PM, not the other way around. That is, in order for adherence to improve, treatment and medication must support, not interfere with, PM. Therefore the continued maintenance of PM in a patient's life must

be the priority. Treatment and medications are to be adjusted to the PM in order to interfere as little as possible with the ability to engage in the individual's PM. I know this to be true from my own experience. I have seen and continue to see this phenomenon in action.

Categories, subtypes and unique features of PM

Personal medicine is not instead of, but in addition to, medication and other forms of treatment. It expands and challenges our idea of traditional medicine, entailing a broader definition of how an illness can be treated.

All of us have examples of PM in our lives. For me, these include: window shopping for shoes (note the operative word, 'window' – remember I have bipolar disorder); listening to almost any song of Joni Mitchell or Emmylou Harris; running in trails near my home; watching reruns of 'Friends'; being able to work and perform full time; soaking in our hot tub; spending time with my husband; reading fiction by my favourite authors; and prayer. Personal medicine works simultaneously, on multiple levels, is interdependent and rests on a spectrum. Deegan cites two categories of PM: self-care strategies and activities that give meaning and purpose (Deegan, 2005). Within each of those two classes of PM, I distinguish two further types (Figure 1.1): (1) self-care strategies that soothe the self and decrease the intensity of and occurrence of symptoms; and (2) activities that engage and enhance core ethics and identity.

Dual functionality of a PM measure

Within these two groups, the actions can either contain or activate energy (Erin Michalak, personal communication, 2009). Paradoxically, the same behaviour can accomplish both activation and containment. For example, running in trails for me: when hypomanic, running serves to contain and channel my extraneous energy; when experiencing depression, running and the outdoor environment stimulate dormant energy and counteract inertia. Another example that echoes this dual function is spending one-on-one time with my husband: when I am cycling through mild mania, my time with him acts as a grounding agent, calming and directing my frenetic energy; when I am depressed, his presence soothes and stimulates my enervated sense of aliveness.

Interplay between PM and treatment adherence

How does this alignment of PM and treatment and medication work to increase treatment adherence?

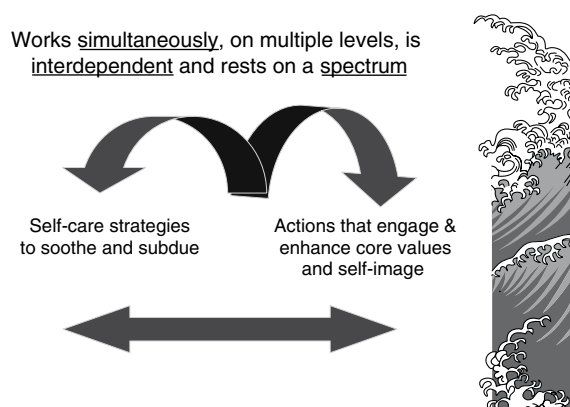


Figure 1.1 Types of personal medicine.

Most PM is present before the onset of the illness and certainly precedes the diagnosis (Deegan, 2005). In addition, PM is actively pursued despite, or perhaps because of, the illness, in order to create some familiarity. Just as personality traits and interests generally remain constant throughout an individual's life (Costa & McCrae, 1997; Soldz & Vaillant, 1999), so too those activities considered to be PM remain stable and persistent (Low & Rounds, 2007). We are intrinsically motivated to continue doing these actions because they are highly valued and connected to our core principles. Because there is a pre-existing commitment to engage in the PM, the actions are most often self-initiated.

These behaviours that help create meaning in a patient's life, that help restore esteem, are also at times compromised and limited by treatment and the side effects of medication. And frequently, a patient is encouraged to tolerate these impositions rather than being given the opportunity, no less the power, to explore options to better integrate the suggested recovery plans into existing and personally important PM.

Discussing PM with patients to avoid non-adherence

Why must health providers make discussing and identifying current and potential PM with their patients a priority? Part of treatment needs to be working with the patient to identify current PM and discover new or latent PM. As Rapp describes in his strengths approach (Rapp, 1998), it is imperative and more effective to concentrate on what is already working in an individual's life or what has worked in the past. The congruency between treatment and PM will provide a vehicle to engage the patient proactively and to benchmark

Box 1.1. Personal medicine (PM) primer

significant barriers to taking medication or accepting certain treatment plans. The most effective management of BD ensures that prescribed treatment and medication supports rather than encumbers individualised life goals, current 'meaning-making' activities and already existing valued aspects and coping tools within your patient's life. This may seem like common sense, but unfortunately, common sense is not always common practice. More accurately even, practitioners often believe they understand this interplay and already align PM with medication and treatment. But I would dare to differ. The subtlety of PM is underestimated, as is the hesitation – and quite frankly fear – that we as patients have in challenging our health-care provider's mandates.

Non-adherence to medication and other treatment elements is a common issue in BD (Lingam & Scott, 2002). Studies indicate that over 60% of patients with BD have some adherence difficulties with medication (Gaudiano *et al.*, 2008). But the real reasons for the resistance are often misunderstood. Exploring a patient's PM and how that patient personally defines quality of life are keys to removing barriers to treatment cooperation (Box 1.1).

PM and removing barriers to treatment and medication adherence: real-life examples

As Deegan asserts, 'non-adherence with prescribed psychiatric medications was found to occur when pharmaceuticals interfered with personal medicine resulting in a diminished quality of life' (Deegan,

Cambridge University Press

978-0-521-73489-9 - Practical Management of Bipolar Disorder

Edited by Allan H. Young, I. Nicol Ferrier and Erin E. Michalak

Excerpt

[More information](#)**Chapter 1: The 'lived' experience**

2005). I have acutely experienced how the failure to enquire about my PM resulted in my refusal to take medication, even to accept the diagnosis of BD, and resulted in much more time being sick. When I had my first psychotic experience, I was in a meditation group and involved in an intense spiritual practice. My manic psychosis was, in fact, very important to me. Although obviously many aspects were delusional, some also held valuable and cherished spiritual insights for me. But when I landed in the hospital, what I underwent was pathologised, and medication was prescribed so that it never happened again. One well-meaning, but misdirected doctor emphasising the benefits of pharmacology, explained to me: 'We don't want you to go down that path again...' What he failed to realise is that the 'path' that he saw only from a medical model, I held in a much wider framework. Like many in Deegan's study, I didn't discuss my interest in pursuing meditation and my practice further, as I feared, understandably, that it would not meet with the approval of my doctors (Deegan, 2005). In my mind I was being prescribed mood stabilisers, antipsychotics and antidepressants to eradicate the very thing that gave meaning to my life. So I refused to take them. Rather than a discussion taking place about my PM and how the medication and diagnosis undermined it, a power struggle between me, my family and my psychiatrist began. When faced with the choice of either taking pharmaceuticals and denying my spiritual life or refusing medication but embracing my relationship with my spirituality regardless of the symptoms I might have to endure – it was obvious to me which I was going to choose. It wasn't until further manias, several additional psychoses and more trips to the hospital, where I met a different psychiatrist, that a breakthrough occurred. In my initial meeting with this doctor he asked me to explain what led to my first psychosis, and what the meditation I was engaged in meant to me. In essence, he was exploring my PM in order to understand the vital role it played in my life.

This astute doctor worked with me and discussed how to incorporate my desire, and in fact my need, to follow my spiritual path with the goals of medication and his treatment plans. Our time together became a process of shared decision-making (Deegan & Drake, 2006). We agreed that temporarily I would put meditation on the 'back burner', and instead I would find a spiritual counsellor to help make sense of what happened to me and put it in a context that would be meaningful. This wise doctor told me that having a spiritual experience (which is how I defined what I went through, at least in part) and a mental illness are not mutually

exclusive. It is not an 'either/or' scenario. Most importantly we discussed the fact that if I accepted I had the mental disorders I had been diagnosed with and took the medication prescribed, this in no way had to minimise the impact of what I went through or render it meaningless and merely a result of the illnesses. I see in hindsight that without either of us knowing it, he was ensuring that the treatment and medication goals were in harmony and alignment with one of my most important self-assessed health resources, or my PM.

Other examples can be less complex but no less pivotal. As one woman diagnosed with anxiety and BD explained to me:

When I am as anxious and depressed as I am, it's important to be able to enjoy the small things. So when I get drowsy too early to watch my favorite TV show or not be able to get up in the morning and be able to be clear headed to write my to do list... I don't want to take my medication... it's not the kind of life I want (Velma, personal communication, 2008)

The ability to watch a much-loved television programme can be an important ingredient in a patient's recovery plan – and if it is one of the few activities a person is willing or able to partake in, it is essential that medication and treatment support these endeavours. Although hesitant to 'complain' about side effects and ask for the pills to be adjusted, Velma eventually did speak with her doctor to find a better match of medication to her PM.

Although I am speaking from my 'lived' experience and with anecdotal evidence, I posit that the more that prescribed pharmaceuticals and treatments plans align with an individual's already established and strongly embraced PM, the more a person will comply. And the more likely a person's quality of life will improve, even if symptom abatement does not occur fully. And if this discussion happens early on, during the initial stages of intervention with the health-care provider and patient, the better the rapport and the less likely non-adherence will take place.

PM as priority**Self-perpetuating reinforcement phenomenon of alignment**

When clinicians I work with make my PM the benchmark from which to develop my treatment and set the goals of my medication, an interesting process begins to occur. I have also witnessed this sequence of events in others as they work with doctors who make PM the starting point. Deegan & Drake describe it as the

Chapter 1: The 'lived' experience

- The more my doctor helps me to align my treatment with my existing PM...
- The more valued and respected I feel...
- The better the rapport I have with my doctor; the more I trust him/her...
- The more willingly I embrace treatment plans...
- The more my wellness improves...
- The more my self-esteem improves...
- The more I practise my PM...
- The more I adhere to treatment...
- The more my wellness improves...
- The more I adhere to treatment and practise my PM...



Figure 1.2 Self-perpetuating reinforcement phenomenon of alignment, or Deegan's 'cascading effect of personal medicine and psychiatric medication'.

'cascading effect of personal medicine and psychiatric medication' (Deegan & Drake, 2006). I see it in a more comprehensive light, enlarging the focus to highlight the potent effect the congruency of treatment with PM has on the recovery process. I call it the 'self-perpetuating reinforcement phenomenon of alignment'.

Figure 1.2 outlines what occurred and continues to occur when my psychiatrist takes into account my PM first rather than focusing solely on symptom abatement. This is not to say that the reduction of symptoms is not important, but if it comes at the cost of cherished wellness activities and beliefs, then any decrease in symptoms may not be seen as important from a patient's perspective.

I experience this process to this day, and I see others experience it on their journey to recovery. As with any other course of action, there may be setbacks, but the overall effect is one of growth and improvement.

The interrelatedness of respect, rapport and recovery

A myriad studies reveal the same conclusion: rapport of the clinician with the patient is one of the most powerful agents of change when it comes to positive outcomes and recovery (Luborsky *et al.*, 1985; Truax & Carkhuff, 1967). And this is even more salient when it comes to blending treatment with PM. Within this sequence of events, rapport and trust with the clinician prove to be essential components. Without strong therapeutic alliance and attunement, this 'self-perpetuating reinforcement phenomenon of alignment' will not easily occur. When we are treated as partners in the process of our recovery, where opportunities are set up for shared decision-making and to discuss our PM, this is when true healing can occur. Even in the acute stages of our illness – mania, depression and psychosis – in which our

ability to contribute and make sound decisions is limited, if we are treated with respect and given an opportunity to contribute in any way, no matter how small, this is never forgotten. This is healing in and of itself.

When the opposite occurs, when I am almost literally locked out of discussing my own recovery process, not only does healing not occur, but in fact damage is also done. It is close to impossible to tell how aware a person is when they are actively manic or psychotic and just what will be remembered. But I'd advise you to err on the side of caution. Awareness is a powerful and mysterious element that should not be underestimated. Each time I entered into psychosis and mania, I was acutely conscious of how I was being treated, even if it was impossible for me to express that. I clearly recall – although floridly psychotic and struggling to free myself from the straps that held my wrists in place – the words that spouted from an emergency room worker as I made a run for a nearby washroom: 'Hey...stop the crazy woman!'. I can laugh at it now, but days later in the hospital and months later in my life, those words scalded me to the core when I thought of them. However, I also recollect just the opposite experience when the female police officer and two ambulance attendants caught up with me after I had decided (in another manic psychosis) to take an ecstatic skip through my neighbourhood 'sans clothes'. I recall the kind way the officer reassured me and offered me a blanket, how the EMS workers gently guided me into the ambulance and sat me down. It was the look in their eyes, the language of their body and face – you can't fake compassion. I never met the officer or those attendants again; I wish I had (under different circumstances, mind you). I would thank them for giving me hope and respect. Their behaviour registered within me (perhaps my unconsciousness, initially). But that experience stays with me. And for years it was a beacon of encouragement and flame of promise

Chapter 1: The 'lived' experience

that I might indeed recover. That brief encounter with them gave me a palpable and lasting sense that I was something, someone other than my illness; the way they treated me indicated they saw who I was – not what I had become. It is not just what my health-care providers say, or even whether what my clinicians suggest as a treatment works (although this is important); more vital is how they make me feel when I leave their offices.

It is exciting to see the emphasis on making the data in each of the following chapters relevant to the lives of individuals like myself who live with the illness – the consumers. Your rapport with your patients is one of those invisible factors that will determine the level of wellness they will reach, and whether or not adherence continues to be an obstacle. I invite you to listen, not just to what your patients are telling you, but also to what they aren't telling you – and in fact why they don't.

Summary

When clinicians inquire about a patient's PM, and align treatment and pharmaceutical goals with it, non-adherence is likely to be diminished. This is because important activities and core values of the patient are not disrupted, and the patient's quality of life remains a priority, not just the reduction of symptoms.

Accurate reflection of bipolar disorder in the chapters that follow

It is both eerily and excitingly surreal to see my life distilled into precise clinical depictions. Seeing the words 'anxiety' and 'lethality' bookending the illness I live with is at once both frightening and encouraging. Encouraging? Yes, because I have been fortunate to receive and eventually actively participate in treatment for BD that has allowed me to regain a meaningful life. I missed falling into the crevasse of completed suicide, active addiction and chronic anxiety. This is because, like the researchers and practitioners who are the authors of the words that follow, those of you reading these pages are clinicians who care deeply about helping the people you work with.

As I review the various chapters, I can't help but be stunned at how my personal experience is reflected, and faithfully so, in the wide array of scientific research. Far from feeling like a number in a study, I feel somehow validated and comforted. My 'lived' experience is 'normal' (for a person with bipolar disorder, that is). It's good to be normal sometimes. I am not alone in

what I have undergone – repeated hospitalisations, denial of the diagnosis, resistance to take prescribed medication or in the length of time or the challenges I faced – it took over four years for me to accept the illness and another five to live independently and regain employment.

Apparently I am a textbook case of BD (much to the chagrin of my ego). In Chapter 8, Drs E. Jane Garland and Anne Duffy cite among other conclusions that 'at least one-quarter of patients with bipolar disorder experience the onset of their first major mood episode during adolescence...which is usually depressive and (have) a positive family history of bipolar disorder.' With hindsight I recognise that my first major depressive episode, which went undetected and was chalked up to adolescent angst, was around the age of 17. Anxiety, an aspect that Garland explores, was present as early as 8 years old but again went undetected, manifesting itself in a refusal to go to school, social awkwardness and home sickness (which lasted until I was almost 13). The generalised anxiety, however, persisted throughout and into my adult years, co-occurring with my mood disorder.

My mother was hospitalised several times before being diagnosed with BD when I was 8 and relapsed into depression several times over the course of my childhood. I had what I kindly call a 'double-barrelled' genetic vulnerability: my mother has BD and anxiety; my father was never diagnosed with but dealt with anxiety and depression; and many of my relatives on my father's side make up a motley crew of individuals with different psychiatric disorders. So goes the luck of the draw. I doubt I will ever wear a pink ribbon and run for breast cancer – my genetics are not stacked in that direction – but I am already hoping I can wear a coloured ribbon and do a 10 k for my wonky brain in the not-so-distant future.

Again my profile is unmistakably reflected in other chapters, such as Chapter 6 with a review and comparisons of various psychosocial interventions by Drs Parikh and Velyvis. They describe the study of Lam and colleagues (Lam *et al.*, 2004) in which traits of 'perfectionism and excessive striving for achievement may confer increased vulnerability to experience mood relapse'. All through high school, in university and as I pursued my acting career, I set high – and frequently unrealistic – goals, fuelling a sense of failure when these targets weren't met. And perfectionism was learned early from my mother – again feeding

a sense of anxiety, insecurity and helplessness as I unsuccessfully met my self-imposed goals. All of this contributed to feelings of low mood and anxiousness – emotions that eventually developed into painful clinical depression and a nerve-racking anxiety disorder. Although my pursuit of achievement is still strong, it is manageably so. The perfectionism I wrestled with for years thankfully left after a good amount of time in psychotherapy – in large part due to the cognitive therapy. Paradoxically, as my perfectionism faded into the background, my ability to reach my goals successfully increased.

In addition, Parikh and Velyvis explain that psychoeducation is loosely based on the age-old adage that 'knowledge is power'. And as such, patients make better decisions about their illness based on accurate information offered in such interventions. This is evident in my own journey to wellness – once the myths of mental illness and psychiatric medications I held were exposed, the easier it was to accept treatment as it was prescribed. As I gained correct information about how and why doctors believed pharmaceuticals would work – and that indeed BD is as biological as it is environmental and how those elements interact – the less problematic it was for me to admit I had a mental illness (several actually) and that the antidepressant and mood stabiliser I was prescribed were necessary. I recognised that my personal determination to get well would not be enough. In doing so, my adherence to medication and treatment improved.

In Chapter 16, Drs Erin Michalak and Greg Murray beautifully articulate what I feel must be foremost in the minds of practitioners when treating BD: that functioning and quality of life are as significant, if not more so, than improvements in symptoms. In addition, I echo the sentiment that there has been a misplaced assumption that symptoms and functioning are highly related.

Conclusion

This guide offers concrete tools and data that can result in better and more positive outcomes for those of us living with BD – not necessarily quickly or easily, but over time and with effort and patience. And when we work as partners, this knowledge can be harnessed into power. The alignment of treatment with a patient's PM also plays an integral role in the effectiveness of the treatment you offer. Ours is a symbiotic relationship. I rely on your expertise, and you rely on my feedback to inform the application of your expertise.

I still face bouts of depression (milder ones mind you, but disruptive all the same) and mini hypomanias, yet I live with a strong sense of recovery and self – a purposeful existence that incorporates meaningful relationships, a rewarding career, a robust identity and goals I actively pursue. This is a result of the tools I use to stay mentally well and manage my illnesses. Key reasons I am willing to be proactive and take charge of my mental health are the relationships my health professionals have established with me and the respect they have of my personal medicine. They work with me as partners, reminding me my insight into my illnesses is more crucial than their and is equally as important and is equally as important as their clinical expertise. This dynamic is what keeps me well. And this I am grateful for – just as I am grateful to contribute a voice to this text.

References

- Costa, P.T. & McCrae, R.R. (1997). Stability and change in personality assessment: the revised NEO Personality Inventory in the year 2000. *Journal of Personality Assessment*, **68**, 86–94.
- Deegan, P.E. (2004). *Recovery journal: the importance of personal medicine*. www.patdeegan.com/blog/archives/000013.php [accessed 1 March 2009].
- Deegan, P.E. (2005). The importance of personal medicine: a qualitative study of resilience in people with psychiatric disabilities. *Scandinavian Journal of Public Health Supplement*, **66**, 29–35.
- Deegan, P.E. & Drake, R.E. (2006). Shared decision making and medication management in the recovery process. *Psychiatric Services (Washington, D.C.)*, **57**, 1636–9.
- Gaudiano, B.A., Weinstock, L.M., Miller, I.W. (2008). Improving treatment adherence in bipolar disorder: a review of current psychosocial treatment efficacy and recommendations for future treatment development. *Behavior Modification*, **32**, 267–301.
- Lam, D.H., Wright, K., Smith, N. (2004). Dysfunctional assumptions in bipolar disorder. *Journal of Affective Disorders*, **79**, 193–9.
- Lingam R. & Scott, J. (2002). Treatment non-adherence in affective disorders. *Acta Psychiatrica Scandinavica*, **105**, 164–72.
- Low, K.S. & Rounds, J. (2007). Interest change and continuity from early adolescence to middle adulthood. *International Journal of Educational and Vocational Guidance*, **7**, 23–36.
- Luborsky L., McLellan A.T., Woody G.E., O'Brien C.P., Auerbach A. (1985). Therapist success and its determinants. *Archives of General Psychiatry*, **42**, 602–11.

Cambridge University Press
978-0-521-73489-9 - Practical Management of Bipolar Disorder
Edited by Allan H. Young, I. Nicol Ferrier and Erin E. Michalak
Excerpt
[More information](#)

Chapter 1: The ‘lived’ experience

Rapp C.A. (1998). *The Strengths Model*. New York: Oxford University Press.

Soldz, S. & Vaillant, G. (1999). The big five personality traits and the life course: a 45-year longitudinal study. *Journal of Research in Personality*, 33, 208–32.

Truax C.B. & Carkhuff R.R. (1967). *Toward Effective Counseling and Psychotherapy*. Chicago: Aldine Publishing.

US Department of Health & Human Services (1999). *Mental Health: a Report of the Surgeon General*, Chapter 2, Section 10. www.surgeongeneral.gov/library/mentalhealth/chapter2/sec10.html [accessed 1 March 2009].

Chapter

2

Overview of bipolar disorder

Allan H. Young, I. Nicol Ferrier and Erin E. Michalak

Bipolar disorder (BD) is a complex mood disorder that is typically characterised by recurring episodes of depression and mania (a distinct period of abnormally elevated, expansive or irritable mood) called BD type I, or depression and hypomania (a less severe form of mania) called BD type II.

The past two decades have witnessed a burgeoning of interest in BD. This has been fuelled in part by a wealth of new research evidence but also by an increasing understanding of the significant impact that this severe illness has, not only for sufferers and their loved ones, but also society more broadly. Bipolar disorder is surprisingly common; BD type I and type II subtypes have a lifetime prevalence of between 1 and 2%, and the bipolar spectrum, a category about which much remains unknown, is found in up to an additional 5% (Angst, 2007). The World Health Organization (WHO) has estimated that BD is the sixth leading cause of disability worldwide among young adults (Murray & Lopez, 1997), underlining the idea that BD is a serious public health concern. Advances are being made in the understanding of the aetiopathogenesis of BD, with certain genes being strongly implicated for the first time and other modalities, such as neuroimaging, identifying fruitful leads. Research interest is also being focused upon issues such as physical morbidity and neurocognition. An avalanche of publications has reported new data on treatment modalities, including psychosocial, somatic and pharmacological interventions. The impact of BD on outcomes such as psychosocial functioning and quality of life is being explored. It is within the context of this sometimes overwhelming and confusing proliferation of new knowledge that we frame this book.

Our objective is to provide a practical and pragmatic guide to the management of BD for the busy clinician. To this end we have sought contributions from acknowledged experts in BD that provide contemporary evidence-based reviews and insights into areas of prime clinical relevance. We have chosen to begin the book from the perspective of an individual who is

living with BD (Maxwell), underscoring our belief in the importance of maintaining a patient-centred stance for the successful management of this complex condition. Subsequent chapters deal with the pharmacological treatment of mania (Grunze) and depression (Young and Nemeroff). A summary of treatment guidelines is provided by Yatham and a guide to somatic treatments (electroconvulsive therapy, transcranial stimulation, etc.) by Le Masurier, Herrmann, Coulson and Ebmeier. Psychosocial treatments are ably detailed by Parikh and Velyvis. A number of chapters deal with management in special populations: the elderly (Thomas); women and reproductive issues (Macritchie and Henshaw); and those with physical morbidity (Joseph and Mok). The treatment of BD in the early stages of the illness is reviewed by Garland and Duffy. Anxiety disorders are now recognised as an important feature of BDs, and Chokka and Yeragani expertly review this complex subject. Similarly, substance abuse is reviewed by Goikolea and Vieta. Further chapters cover service delivery (Morriss), psychosocial functioning and quality of life (Michalak and Murray), brain imaging (Ferrier and Lloyd), the practical management of cyclothymia (Perugi and Popovic) and, crucial to the optimal management of this condition, circadian and sleep/wake issues (Murray). There is a review of training issues by Parikh and Michalak, and the book ends with a chapter by Kuan, Curtis and Young, who attempt to integrate the path from neuroscience to clinical practice. We are grateful to all the contributors and thank them all for sharing their expertise with us. This is therefore first and foremost a 'practical guide' to the management of BD; we trust that you will find it a useful aid for this fascinating, complex and ever-challenging illness.

References

- Angst J. (2007). The bipolar spectrum. *British Journal of Psychiatry*, **190**, 189–91.
- Murray, C.J. & Lopez, A.D. (1997). Global mortality, disability, and the contribution of risk factors: Global Burden of Disease Study. *Lancet*, **349**, 1436–42.

Chapter

3

The treatment of mania

Heinz Grunze

Introduction

Mania is the hallmark of bipolar disorder (BD) and differentiates it from unipolar depression. *The Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV-TR; APA, 2000), characterises bipolar I disorder by the occurrence of at least one manic or mixed episode; Table 3.1 and Table 3.2 summarise diagnostic criteria for mania and mixed episodes according to DSM-IV-TR (APA, 2000). By contrast, the *International Classification of Diseases*, 10th edition (ICD-10; WHO, 2007), differentiates unipolar mania (ICD-10, F30) from bipolar disorder (ICD-10, F31), the latter requiring not only a manic episode, but also at least one episode of major depression. However, as unipolar mania is a rare disorder and is also conceptualised as part of the bipolar spectrum, treatment recommendations given in this chapter imply the assumption of a long-term course with opposing mood deflections.

The true complexity of mania, however, is hardly captured by any current categorical classification. Manic states are not monolithic, nor do they always fit into clear clinical distinctions. A wide range of symptoms may occur in an acute manic episode (Table 3.3), with some symptom clusters being more likely than others. The European mania in bipolar longitudinal evaluation of medication (EMBLEM) study (Goetz *et al.*, 2007) found the presence of three major clinical subtypes of patient with acute mania using latent class analysis to define discrete groups of patients. The authors identified: 'typical mania' (59% of patients); 'psychotic mania' (27%) with more severe mania and presence of psychotic symptoms; and 'dual mania' (13%) with a high proportion of substance abuse. These patient groups differed in age of onset, social functioning, service needs and outcome (van Rossum *et al.*, 2008). However, controlled clinical studies usually exclude at least the group of dual mania, which makes it difficult to give substantiated treatment recommendations for all subgroups.

General principles when treating manic patients

Treatment of mania requires hospitalisation in most cases, often even emergency treatment and involuntary detention. There may be a few exceptions where manic patients still have sufficient insight and behavioural control to allow treatment in the community, but ensuring sufficient guarding of the patient to minimise risk is often the limiting factor. In addition, having to cope with a manic relative at home may easily devastate any relationship. Advantages of inpatient treatment include risk limitation in a secure environment, professional care around the clock and the opportunity to create a non-stimulating environment. It also allows for more aggressive pharmacotherapy as vital parameters can be monitored and side effects more rapidly recognised and counteracted.

Treatment should involve the same humane principles as for any other patient, respecting the patient's dignity and rights, and hostility as part of a manic syndrome should lead to adequate safety measures but never provoke a similar response from professionals. Responsible treatment of a manic patient includes the physician taking full responsibility for diagnosis, physical examination, other investigations and explanation of the medical plan of management to the patient and their relatives. The physician should always communicate clearly, understandably and honestly, but calmly, what he or she thinks. Mania is often accompanied by anxiety, and giving the patient the feeling that they are not threatened or getting tricked, but that they are safe, is essential for cooperation and future compliance.

Ideally, the manic patient will then consent to treatment. If agreement cannot be reached, it is the task of the responsible psychiatrist to estimate the risks of non-treatment. If there are no other means to avert acute risks to the patient or others, and once a decision has been made to initiate treatment against the patient's