



HOPE

Celebrating 50 issues!

FOR PEOPLE WITH BIPOLAR

Unexpected
signs of
BIPOLAR
DEPRESSION

My **PARTNER** in
RECOVERY

bpKIDS
ADHD or BIPOLAR?
Know the symptoms

BACK CHAT

No more family secrets

MUSIC, MAESTRO, PLEASE!

RONALD BRAUNSTEIN
& the story behind the
ME2/ORCHESTRA

Routine
matters

Schedule for
STABILITY

Getting a
grip on
MANIA

Triggers, symptoms &
effective treatments



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IF YOU'RE STRUGGLING WITH BIPOLAR DEPRESSION, LATUDA MAY HELP.

"Bipolar depression is tough. It made it hard to be there for the people I love. My doctor told me there are many types of depression and that I have bipolar depression." LATUDA is FDA-approved to treat bipolar depression. In clinical studies, once-a-day LATUDA has been shown to be effective in treating many people struggling with bipolar depression. "With LATUDA, I'm grateful to be less depressed and being there for the people I love means so much to me."



ASK YOUR DOCTOR IF LATUDA IS RIGHT FOR YOU. VISIT WWW.LATUDA.COM/INFO

LATUDA is a prescription medicine used to treat adults with depressive episodes associated with bipolar I disorder (bipolar depression), alone or with lithium or valproate.

IMPORTANT SAFETY INFORMATION FOR LATUDA

Elderly patients with dementia-related psychosis (having lost touch with reality due to confusion and memory loss) treated with this type of medicine are at an increased risk of death, compared to patients receiving placebo (sugar pill). LATUDA is not approved to treat elderly patients with dementia-related psychosis.

Antidepressants have increased the risk of suicidal thoughts and actions in some children, teenagers, and young adults. Patients of all ages starting treatment should be watched closely for worsening of depression, suicidal thoughts or actions, unusual changes in behavior, agitation, and irritability. Patients, families, and caregivers should pay close attention to any changes, especially sudden changes in mood, behaviors, thoughts, or feelings. This is very important when an antidepressant medicine is started or when the dose is changed. Report any change in these symptoms immediately to the doctor. LATUDA is not approved for patients under the age of 18 years.

Call your doctor right away if you have high fever; stiff muscles; confusion; changes in pulse, heart rate or blood pressure; sweating; or muscle pain and weakness as they may be signs of a rare but potentially fatal side effect called neuroleptic malignant syndrome (NMS). LATUDA should be stopped if you have NMS.

Tell your doctor about any movements you cannot control in your face, tongue, or other body parts, as they may be signs of tardive dyskinesia (TD), a serious and sometimes

permanent side effect. TD may not go away, even if you stop taking LATUDA. TD may also start after you stop taking LATUDA.

If you have diabetes or risk factors for diabetes, your blood sugar should be tested at the beginning of and throughout treatment with LATUDA. Complications of diabetes can be serious and even life threatening. Call your healthcare provider if you have any of these symptoms of high blood sugar while taking LATUDA: feeling very thirsty; need to urinate more than usual; feeling very hungry, weak or tired; sick to your stomach; confused; or your breath smells fruity.

Increases in triglycerides and in LDL (bad) cholesterol and decreases in HDL (good) cholesterol have been reported with LATUDA. You may not have any symptoms, so your healthcare provider may decide to check your cholesterol and triglycerides during your treatment with LATUDA.

Some patients may gain weight when taking LATUDA. Your doctor should check your weight regularly.

Other risks may include dizziness or lightheadedness upon standing, decreases in white blood cells (which can be fatal), trouble swallowing, or increases in prolactin. Tell your doctor if you experience these. Tell your doctor if you have had seizures or experience prolonged, abnormal muscle spasms or contractions. LATUDA may affect your judgment or motor skills. Until you know how LATUDA affects you, do not drive or operate machinery. LATUDA may make you sensitive to heat. Tell your doctor about all the medicines you are taking, since there are

some risks for drug interactions. You should avoid grapefruit and grapefruit juice while taking LATUDA, as these can interfere with the medication. You should avoid alcohol while taking LATUDA. Tell your doctor if you are pregnant or planning to get pregnant.

Most common side effects in clinical studies in adults include sleepiness, an inner sense of restlessness or need to move (akathisia); difficulty moving, slow movements, muscle stiffness, or tremor.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch or call 1-800-FDA-1088.



FOR SAVINGS ON YOUR PRESCRIPTION SEE WWW.LATUDA.COM/INFO

* Must meet eligibility requirements. For details on rules and regulations, please visit www.latuda.com/info or call 1-855-5LATUDA.

Please see additional Important Information about LATUDA on the next page.

Latuda®
(lurasidone HCl) tablets
20mg | 40mg | 60mg | 80mg | 120mg

LATUDA® (luh-TOO-duh) (lurasidone hydrochloride)

This summary of the Medication Guide contains risk and safety information for patients about LATUDA. This summary does not include all information about LATUDA and is not meant to take the place of discussions with your healthcare provider about your treatment. Please read this important information carefully before you start taking LATUDA and discuss any questions about LATUDA with your healthcare provider.

What is the most important information I should know about LATUDA?

Serious side effects may happen when you take LATUDA, including:

- **Increased risk of death in elderly people who are confused, have memory loss and have lost touch with reality (dementia-related psychosis):**
- Medicines like LATUDA can increase the risk of death in elderly people who are confused, have memory loss and have lost touch with reality (dementia-related psychosis). LATUDA should not be used to treat people with dementia-related psychosis.
- **Increased risk of suicidal thoughts or actions (antidepressant medicines, depression and other serious mental illnesses, and suicidal thoughts or actions):**

Antidepressant medicines may increase suicidal thoughts or actions in some children, teenagers, and young adults within the first few months of treatment. Depression and other serious mental illnesses are the most important causes of suicidal thoughts and actions. Some people may have a particularly high risk of having suicidal thoughts or actions. These include people who have (or have a family history of) depression, bipolar illness (also called manic-depressive illness), or suicidal thoughts or actions.

How can I watch for and try to prevent suicidal thoughts and actions in myself or a family member?

- Pay close attention to any changes, especially sudden changes, in mood, behaviors, thoughts, or feelings. This is very important when an antidepressant medicine is started or when the dose is changed.
- Call the healthcare provider right away to report new or sudden changes in mood, behavior, thoughts, or feelings.
- Keep all follow-up visits with the healthcare provider as scheduled. Call the healthcare provider between visits as needed, especially if you have concerns about symptoms.

Call a healthcare provider right away if you or your family member has any of the following symptoms, especially if they are new, worse, or worry you:

- thoughts about suicide or dying; attempts to commit suicide; new or worse depression; new or worse anxiety; feeling very agitated or restless; panic attacks; trouble sleeping (insomnia); new or worse irritability; acting aggressive; being angry or violent; acting on dangerous impulses; an extreme increase in activity and talking (mania); or other unusual changes in behavior or mood

What else do I need to know about antidepressant medicines?

- Never stop an antidepressant medicine without first talking to your healthcare provider. Stopping an antidepressant medicine suddenly can cause other symptoms.
- **Antidepressants are medicines used to treat depression and other illnesses.** It is important to discuss all the risks of treating depression and also the risks of not treating it. Patients and their families or other caregivers should discuss all treatment choices with the healthcare provider, not just the use of antidepressants.
- **Antidepressant medicines have other side effects.** Talk to the healthcare provider about the side effects of the medicine prescribed for you or your family member.
- **Antidepressant medicines can interact with other medicines.** Know all of the medicines that you or your family member takes. Keep a list of all medicines to show the healthcare provider. Do not start new medicines without first checking with your healthcare provider.
- Not all antidepressant medicines prescribed for children are FDA approved for use in children. Talk to your child's healthcare provider for more information.

What is LATUDA?

LATUDA is a prescription medicine used to treat adults with:

- schizophrenia
- depressive episodes associated with bipolar disorder, alone or with lithium or valproate

R ONLY

It is not known if LATUDA is safe and effective in children.

Who should not take LATUDA?

Do not take LATUDA if you:

- are allergic to lurasidone hydrochloride or any of the ingredients in LATUDA.
- are taking certain other medicines called CYP3A4 inhibitors or inducers including ketoconazole, clarithromycin, ritonavir, voriconazole, mibepradil, rifampin, avasimibe, St. John's wort, phenytoin, or carbamazepine. Ask your healthcare provider if you are not sure if you are taking any of these medicines.

What should I tell my healthcare provider before taking LATUDA?

Before you take LATUDA, tell your healthcare provider if you:

- have or have had diabetes or high blood sugar in you or your family. Your healthcare provider should check your blood sugar before you start LATUDA and also during therapy
- have or have had high levels of total cholesterol, triglycerides or LDL-cholesterol or low levels of HDL-cholesterol
- have or have had low or high blood pressure
- have or have had low white blood cell count
- have or have had seizures
- have or have had abnormal thyroid tests
- have or have had high prolactin levels
- have or have had heart problems
- have or have had liver problems
- have or have had any other medical condition
- are pregnant or plan to become pregnant. It is not known if LATUDA will harm your unborn baby.
- are breastfeeding or plan to breastfeed. It is not known if LATUDA passes into your breast milk. You and your healthcare provider should decide if you will take LATUDA or breastfeed. You should not do both.

Tell the healthcare provider about all the medicines that you take or recently have taken including prescription medicines, over-the-counter medicines, herbal supplements and vitamins.

LATUDA and other medicines may affect each other, causing serious side effects. LATUDA may affect the way other medicines work, and other medicines may affect how LATUDA works.

Especially tell your healthcare provider if you take or plan to take medicines for: depression, high blood pressure, Parkinson's disease, trouble sleeping, abnormal heart beats or rhythm, epilepsy, inflammation, or psychosis.

Know the medicines you take. Keep a list of your medicines to show your healthcare provider and pharmacist when you get a new medicine.

How should I take LATUDA?

- Take LATUDA exactly as your healthcare provider tells you to take it. Do not change the dose yourself.
- Take LATUDA by mouth, with food (at least 350 calories).
- If you take too much LATUDA, call your healthcare provider or poison control center at 1-800-222-1222 right away, or go to the nearest hospital emergency room.

What should I avoid while taking LATUDA?

- Avoid eating grapefruit or drinking grapefruit juice while you take LATUDA, since these can affect the amount of LATUDA in the blood.
- Do not drive, operate machinery, or do other dangerous activities until you know how LATUDA affects you. LATUDA may make you drowsy.
- Avoid getting overheated or dehydrated: do not over-exercise; in hot weather, stay inside in a cool place if possible; stay out of the sun; do not wear too much or heavy clothing; drink plenty of water.
- Do not drink alcohol while taking LATUDA. It may make some side effects of LATUDA worse.

What are possible side effects of LATUDA?

LATUDA can cause serious side effects, including:
See "What is the most important information I should know about LATUDA?"

1. **Stroke that can lead to death can happen in elderly people with dementia who take medicines like LATUDA**
2. **Neuroleptic malignant syndrome (NMS).** NMS is a rare but very serious condition that can happen in people who take antipsychotic medicines, including LATUDA. NMS can cause death and must be treated in a hospital. Call your healthcare provider right away if you become severely ill and have some or all of these symptoms: high fever; excessive sweating; rigid muscles; confusion; changes in your breathing, heartbeat, and blood pressure
3. **Movements you cannot control in your face, tongue, or other body parts (tardive dyskinesia).**

These may be signs of a serious condition. Tardive dyskinesia may not go away, even if you stop taking LATUDA. Tardive dyskinesia may also start after you stop taking LATUDA.

4. **High blood sugar (hyperglycemia).** High blood sugar can happen if you have diabetes already or if you have never had diabetes. High blood sugar could lead to:
 - buildup of acid in your blood due to ketones (ketacidosis)
 - coma
 - death

Increases in blood sugar can happen in some people who take LATUDA. If you have diabetes or risk factors for diabetes (such as being overweight or a family history of diabetes) your healthcare provider should check your blood sugar before you start LATUDA and during therapy.

Call your healthcare provider if you have any of these symptoms of high blood sugar (hyperglycemia) while taking LATUDA:

- feel very thirsty, need to urinate more than usual,
- feel very hungry, feel weak or tired, feel sick to your stomach, feel confused, or your breath smells fruity.

5. **High fat levels in your blood (increased cholesterol and triglycerides).** High fat levels may happen in people treated with LATUDA. You may not have any symptoms, so your healthcare provider may decide to check your cholesterol and triglycerides during your treatment with LATUDA.

6. **Increase in weight (weight gain).** Weight gain has been reported in patients taking medicines like LATUDA. You and your healthcare provider should check your weight regularly. Talk to your healthcare provider about ways to control weight gain, such as eating a healthy, balanced diet, and exercising.

7. **Increases in prolactin levels.** Your healthcare provider may do blood tests to check your prolactin levels.

8. **Low white blood cell count.**
9. **Decreased blood pressure (orthostatic hypotension),** including lightheadedness, or fainting caused by a sudden change in heart rate and blood pressure when rising too quickly from a sitting or lying position.

10. **Seizures.**

11. **Difficulty swallowing.**

The most common side effects of LATUDA include: sleepiness or drowsiness; restlessness and feeling like you need to move around (akathisia); difficulty moving, slow movements, muscle stiffness, or tremor; and nausea.

These are not all the possible side effects of LATUDA. For more information, ask your healthcare provider or pharmacist. Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.

How should I store LATUDA?

- Store LATUDA tablets at room temperature between 68°F to 77°F (20°C to 25°C).
- Keep LATUDA and all medicines out of the reach of children.

General information about the safe and effective use of LATUDA.

- Medicines are sometimes prescribed for purposes other than those listed in a Medication Guide. Do not use LATUDA for a condition for which it was not prescribed. Do not give LATUDA to other people, even if they have the same symptoms you have. It may harm them.
- This summary contains the most important information about LATUDA. If you would like more information, talk with your healthcare provider. You can ask your pharmacist or healthcare provider for information about LATUDA that is written for health professionals. For more information, go to www.LATUDA.com, or call 1-888-394-7377.



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For Customer Service, call 1-888-394-7377.
For Medical Information, call 1-800-739-0565.
To report suspected adverse reactions,
call 1-877-737-7226.

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Looking back. Moving forward.

If you've never heard of the Me2/Orchestra, prepare to be wowed by "The Maestro & Me2/," our cover story on Ronald Braunstein. This brilliant man started his international conducting career at age 23 by winning a hugely prestigious competition, topping nearly 600 entrants from around the world. Later, he inspired young musicians at New York City's top conservatories.

But to my mind, those aren't his most impressive accomplishments. When a professional door slammed shut in his face because of his bipolar disorder, Braunstein opened a window. He created the Me2/Orchestra as a sanctuary not only for himself, but for other musicians who live with brain-based disorders.

Braunstein's life story actually makes a good bookend to our feature article "Getting a Grip on Mania." Yes, manic energy and grandiose self-confidence propelled the conductor through some of his amazing achievements. At a certain point, though, his racing mind and days without sleep undermined his work. It's no secret that mania often leaves a trail of destruction in its wake, from strained relationships to staggering debt.

That's not to say mania is a monolithic mood state. There's a reason mania is diagnosed based on choices from a list of seven symptoms: Different people have different symptom clusters. And some common symptoms aren't even mentioned in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*.

Getting to know your personal triggers and danger signs plays an important part in taming the tiger. For example, Keely Petri knows mania is looming when she starts swearing in everyday conversation. That's not something you're going to find in the *DSM*! We hope our story gives you more insight into how you experience elevated mood—and helps others in your life better understand your actions during a manic episode.

We are thrilled to reach our "golden anniversary" milestone with our Winter 2017 edition! It's been a hard-fought journey of staying alive and thriving—while striving to empower our bipolar community with understanding, support, information and hope!

Perhaps it's fitting that this 50th issue looks even further back—in our Back Chat with Mimi Baird. I had the honor of hearing Ms. Baird give the annual University of Michigan Prechter Bipolar Research Fund lecture. She spoke movingly about the barbaric "treatments" for manic-depression that her father endured during the 1940s and about the toll that era's stigma and secrecy took on her life.

Here's to more progress on both fronts, and to 50 more issues—and counting!



Joanne M. Doan, Publisher



*At the 2016 Heinz C. Prechter Bipolar Research Fund lecture at the University of Michigan in Ann Arbor, bp Magazine publisher Joanne Doan (far left) wears a scarf patterned on images of neural stem cells generated by Prechter-funded research. Next to her, principal investigator and scientific director Melvin G. McInnis, MD, wears a tie from the series by designer Dominic Pangborn, which raises funds for and awareness of bipolar research. At center right stands Mimi Baird, who gave the Prechter lecture in October. She spoke about her father, whose 1944 manuscript is the basis of her book *He Wanted the Moon: The Madness and Medical Genius of Dr. Perry Baird, and His Daughter's Quest to Know Him*. At far right is Waltraud (Wally) Prechter, who founded the Prechter fund in honor of her husband. Photo: Courtesy of HEINZ C. PRECHTER BIPOLAR RESEARCH FUND*

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Our mission is to empower people with hope, helpful tools and ongoing support—so they will feel informed, equipped and motivated to meet their challenges of bipolar disorder and live productive, fulfilling lives.

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PARTNERS:



What is bipolar?

Bipolar disorder is a treatable illness marked by extreme changes in mood, thought, energy, and behavior. Bipolar disorder is also known as manic depression because a person's mood can alternate between the "poles"—mania (highs) and depression (lows). The change in mood can last for hours, days, weeks, or months.

What bipolar is not

Bipolar disorder is not a character flaw or sign of personal weakness.

Whom bipolar disorder affects

Bipolar disorder affects more than 5.7 million adult Americans and 440,000 adult Canadians. It usually begins in late adolescence, often appearing as depression during teen years, although it can start in early childhood or later in life.

An equal number of men and women develop this illness. Men tend to begin with a manic episode, women with a depressive episode. Bipolar disorder is found among all ages, races, ethnic groups, and social classes. The illness tends to run in families and appears to have a genetic link.

Like depression and other serious illnesses, bipolar disorder can also negatively affect spouses, partners, family members, friends, and co-workers.

Types of bipolar disorder

Different types of bipolar disorder are determined by patterns and severity of symptoms of highs and lows.

BIPOLAR I DISORDER is characterized by one or more manic episodes that last at least a week or require hospitalization.

Episodes of depression and hypomania may also occur. Some mood episodes may have mixed features (symptoms of both depression and mania/hypomania).

Behavior during mania and disability during bipolar depression can lead to severe financial, family and social disruption.

BIPOLAR II DISORDER is characterized by one or more depressive episodes accompanied by at least one hypomanic episode. Hypomanic episodes have symptoms similar to manic episodes but are less extreme and don't last as long. However, the person's behavior is clearly different from the norm to observers.

CYCLOTHYMIC DISORDER is characterized by chronic mood fluctuations that do not reach the level of a full manic or depressive episode. However, symptoms cause significant distress in personal relationships, work or school, and other areas of life when they occur. Although symptoms are relatively mild compared to Bipolar I or Bipolar II, they recur within two months each time. People with cyclothymia may go on to develop a more extreme form of bipolar illness.

Symptoms of bipolar disorder

Most people who have bipolar disorder talk about experiencing "highs" and "lows." These swings can be severe, ranging from extreme energy to deep despair. The severity of the mood swings and the way they disrupt normal life activities distinguish bipolar mood episodes from ordinary mood changes.

SYMPTOMS OF MANIA:

- Increased physical and mental activity and energy
- Heightened mood, exaggerated optimism and self-confidence
- Excessive irritability, aggressive behavior
- Decreased need for sleep without experiencing fatigue
- Racing speech, thoughts, and flight of ideas
- Increased sexual drive
- Reckless behavior

SYMPTOMS OF DEPRESSION:

- Prolonged sadness or unexplained crying spells, profound hopelessness

- Significant changes in appetite and sleep patterns
- Irritability, anger, worry, agitation, anxiety
- Pessimism, loss of energy, persistent lethargy
- Feelings of guilt and worthlessness
- Inability to concentrate, indecisiveness
- Recurring thoughts of death and suicide

How common is bipolar disorder in children?

Because bipolar disorder tends to run in families, having a parent with bipolar increases the likelihood that a child also will develop bipolar. When one parent has bipolar disorder, the risk to each child is estimated to be 15–30 percent. When both parents have the disorder, the risk increases to 50–75 percent.

Symptoms of mood disorders may be difficult to recognize in children and adolescents because they can be mistaken for age-appropriate emotions and behaviors, or overlap with symptoms of other conditions such as attention-deficit/hyperactivity disorder (ADHD). However, depression and anxiety in children may be precursors to bipolar and should be carefully evaluated and monitored.

Treatment for bipolar disorder

Several therapies exist for bipolar disorder and promising new treatments are currently under investigation. Because bipolar disorder can be difficult to treat, it is highly recommended that you consult a psychiatrist or a general practitioner with experience in treating this illness. Treatments may include medication, talk therapy, and support groups. ☀

Read more at
bphope.com



We hear you!

ALL JOKING ASIDE

LOVE, LOVE, LOVE Maria Bamford! Her comedy has helped me live my bipolar II life better. Just knowing I'm in such good company is very special!

Jake via bphope.com

MARIA, NICE WAY to focus your energy into a positive project. Congratulations!

R.S. via [f](#)

MARIA, YOU ROCK! Funny women are in such short supply around my very challenging world. You are loved, in the nicest possible way. Rock on from a crazy biker/show-biz guy in the Windy City.

Roadie Ric via bphope.com

I LOVE YOU, MARIA! You are an inspiration and a role model. Your life shows that things can and do get better. Your brutally honest jokes about suicide and psych wards

did more to make me feel normal than two years of therapy. I've watched your psych ward video on YouTube about a hundred times now. Please keep doing what you're doing. (Naps included, of course.) Thank

I love you, Maria! ... Your life shows that things can and do get better.

you for being you. And remember—you're on the cover of a magazine! Frame it! Give them as Christmas gifts! Sell signed copies at concerts!

Mike via bphope.com

FIRST OF ALL, words cannot express how valuable *bp Magazine* and *esperanza* [Editor: Our sister publication for anxiety and depression] are to me. After many years of

suffering in silence with no one who understands but people in the mental health profession, I was fortunate enough to come across both magazines the first year they were published. However, if one of the purposes of the magazines is to help us feel less isolated, featuring celebrities is not the way to go. Their lives are very unlike the lives of most people (with or without mental illness). They have resources that most people do not have. I find information about the coping skills of people like me much more valuable than information about celebrities.

Name Withheld
ATLANTA, GA

ABSOLUTELY POSITIVE

I READ SASHA KILDARE's terrific article "Attitude Adjustment" (Fall 2016) on the StairMaster yesterday and it's already transformative. I never realized that affirmations might be more potent if I used my own name. I had a very critical parent, so negative self-statements were repeating in

my head no matter how hard I tried. I felt foolish doing affirmations. They didn't work! This morning, when I woke up with the usual trepidation, I told myself, "Allison, you are gonna rock today." I said it three times and my mindset right now is this: "No matter how much or how little I accomplish, I rock!" Thank you for this addition to my toolkit.

Allison Strong
HOLLYWOOD, FL

REALLY ENJOYED THE ARTICLE "Attitude Adjustment." I am always struggling with negative thoughts and in not being able to stop until I hit bottom. Friends tell me to think positive, but it never helped. This gives me a new approach that I hope will help.

B.H.
PIKETON, OH

THANKS FOR SHARING THIS. I'm definitely going to try these.

F.S. via 

WHAT AN INSPIRING ARTICLE! Bipolar depression and negative thinking occur daily with me. I have read many articles that, to me, state the obvious. I tend to skip through them thinking, "OK, blah blah blah, tell me something I don't know." Your article, however, flicked a switch in my brain. I'm going to try your methods starting today. Thank you so much for writing this!

K.R.
BARTLESVILLE, OK

THIS IS A VERY helpful article. I will try these methods when I get the negative thinking.

Rosie via 

WHAT HAS HELPED ME so much is positive thoughts that focus on being realistic and accurate in a way that depression tends to push against. None of these are La La Land thoughts. They're more positive than how depression sees things.

R.F.A. via 

BEDTIME STORY

I REALLY LIKED THE ARTICLE "A Field Guide to 40 Winks" (Fall 2016) because even though it repeated some of the same



I am always struggling with negative thoughts.... This **gives me a new approach** that I hope will help.

information I already knew, it was validating to my own circadian rhythms and insomnia. I've actually gone so far as to have my doctor request special accommodations so that I don't work the night shift. I still struggle, but this article mentioned some new techniques that I plan on utilizing (like sunglasses for my computer).

E.H. via 

EXCELLENT ARTICLE! Extremely affirming. I only have two episodes a year, spring and fall. And now I know why vacations trigger me.

Vinediva via 

THIS ARTICLE WAS INTERESTING. I especially liked the tips for better bedtimes. My phone doesn't have the night light feature the new phones do and I never thought to just put on sunglasses in bed. I wish there had been something on dramatic sleep pattern changes. I used to be a lark

but now I'm a hummingbird moving toward night owl. It doesn't seem to relate to my moods either—more a gradual change. I'd like to know why it is happening—maybe I could reverse it!

Laurene Fontain
NEW HARTFORD, CT

FUNNY THAT THIS article doesn't address people who work graveyard shifts.

D.L.S. via 

I FOUND THIS ARTICLE very validating. It also gave me a chance to review the path that I have been on for the past six years. I have had very good results in using a plan: consistent schedule for bedtime; no cell phone or TV in my bedroom; use of a BiPAP machine for sleep apnea; and sleep medications. I have weekly sessions with a therapist. I have a psychiatrist, a medical doctor, and a sleep doctor. I also have a psychiatric service dog trained for PTSD who



I really liked the article 'A Field Guide to 40 Winks' ... it was validating to my own circadian rhythms and insomnia.

sleeps with me every night. Now I sleep 9 to 10 hours a night consistently. I go to sleep with ease and wake up rested. The plan has been in place now for more than two years with consistent success at allowing balance day in and day out.

D.J. via bphope.com

FAVORITE COLUMNS

THANK YOU FOR the reminder that self-care is so important during the holiday season ("Ask the Doctor: Holiday Strategies," Fall 2016). It's easy to accept too many invitations, stress about getting the perfect presents, worry about having the house look just right, etc., etc. If I don't address my own care, I will be of no use to my kids or anyone else. (Writing this on day 6 of hypomania hangover—I do not want to be in this situation again any time soon!)

Denise via bphope.com

HAVING ANY OF THE bipolar disorders and functioning in school properly is very

CIRCADIAN RHYTHMS & SLEEP

A field guide to
40 WINKS

Whether you're a **night owl** or a **lark**,
you can get your **sleep schedule** in sync

By Donna Jackel

Gin Moxon has always been in love with sleep. "I can easily nod off after 11 p.m. or around midnight," she says. "I'm from Falls Church, Virginia. I've always really had a nap." Unfortunately, waking up in the school bus at 6:30 a.m. was a challenge. "I would wake up at 5:30 a.m. and then go back to sleep until the sun. A powerfully bright sun. Moxon is now a college student and loves her morning. When left to her own devices, she tends to fall asleep around 4 p.m. and wake up around 10 p.m. "I'm not sure if it's because of the real world? With difficulty?" "I have held several jobs and I would be exhausted by the time I got home," she says. "Moxon, whose bipolar I was diagnosed at age 18, has found a way to manage her symptoms. She has a plan to adapt to basic sleep needs. Step 1: Getting to bed one hour earlier, although there are fluctuations in age. According to chronobiologist Michael Grandjean, "The average person's biological clock is 8 hours (though, around 30 percent of people can be classified as early birds, while 20 percent are night owls)." Step 2: Adjusting to the body's clock. "I wake up at 6 a.m. and go to bed at 10 p.m. I still feel good in the morning." Step 3: Getting up earlier and missing morning. "Moxon says, "I definitely need a cup of coffee, but I've never overdone it." Step 4: Eat all the best, getting enough exercise. "I eat all the best, getting enough exercise. These chemicals [from the Circadian clock] tell us times to be generally

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trying and very hard. This article ("bpKids: An Education in School Issues," Fall 2016) can give some insight into yours or your child's academic skills.

Name Withheld

CYBERSPACE SUPPORT

YOUR MAGAZINE IS truly a lifesaver. I just stumbled upon it in my doctor's office

and asked if she minded if I took it. That started my calm period. Being able to read the articles and participate in the online forum and discussions is better than therapy. Talking through the magazine with others who live your life and share your joy and pain is so helpful. Knowing that something you said may have helped to change their life or given them the courage to see their doctor is well worth it. It's truly a sounding board. For us "oldies" that have been [diagnosed with] bipolar for many, many years to offer some insight to someone scared at just being diagnosed is truly a blessing. Thank you for being there for this group of "special" people.

Name Withheld

I HAVE BEEN ON BPJOPE.COM for over a year and read everything online. Never have I had a better support group. Keep up the good work. I was diagnosed 40 years ago and have been relatively stable for 30 years.

Name Withheld
ROSWELL, GA

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RICHARD

NICKNAME: Papi.

FAVORITE MOVIE: *The Perks of Being a Wallflower.*

It includes the three things I am most passionate about: mental illness, being yourself, and faith.

FAVORITE FOOD: Sancocho, a popular Dominican soup. It reminds me of my grandmother.

ON TOP OF MY PLAYLIST: Kid Cudi. He's my favorite artist and my biggest inspiration. He's also a mental health advocate like myself.

TO DESTRESS I: Go for a walk, listen to music, journal, play video games, hang out with friends, and read the Bible.

TOP HOBBIES: Writing, reading, and playing basketball.

MOST TREASURED ITEM: A drawing of a car given to me by my friend Samantha during my first hospitalization in 2004.

I WISH I WERE BETTER AT: Letting go.

BIGGEST GUILTY PLEASURE: Online shopping.

BIGGEST ADVENTURE SO FAR: Moving to L.A. five years ago to follow my dreams.

TOP OF MY BUCKET LIST: Get a book deal for my memoir *Out of the Darkness*.

MY MOST VALUABLE COPING STRATEGY: My faith.

GREATEST LESSON I'VE LEARNED:
Loving myself.

CURRENT STATE OF MIND: Grateful.



Diagnosis: Bipolar disorder, Anxiety • **Year Diagnosed:** 2004
Age: 29 • **Location:** Los Angeles • **Occupation:** Writer



newsline

quickpicks

England adding perinatal centers

November 26, 2016, LONDON, England—The National Health Service is expanding services for women who experience mental health problems during pregnancy and after childbirth, the *Guardian* reports. Twenty new community health units will open across England with specialists and staff familiar with perinatal issues, plus a “buddying service” to enable peer support.

PTSD high among Syrian refugees

November 22, 2016, STOCKHOLM, Sweden—One in three Syrians seeking refuge in Sweden has symptoms of depression, anxiety, and post-traumatic stress disorder (PTSD), a Swedish Red Cross study has found. In addition to trauma, refugees often face financial problems, loss of independence and self-worth, and discrimination.

South African facilities swamped

October 19, 2016, CAPE TOWN, South Africa—Western Cape Province’s four psychiatric hospitals and two mental health clinics are facing increasing caseloads, provincial health minister Nomafrench Mbombo, MD, told News24. She stressed the need to strengthen community-based mental health services and reduce stigma.

Pacific nations falling short

October 14, 2016, KOLKATA, India—A new index of mental health policies in 15 Asian Pacific countries found that in India, China and Indonesia, only 10 percent of those diagnosed with a brain-based disorder receive evidence-based care. Even in top-ranked countries like Australia and Singapore, fewer than half get the care they need.

Nebraska task force calls for reforms

December 2, 2016, LINCOLN, NE—A task force report in Nebraska calls attention to the state’s shortage of mental health workers, particularly in rural areas, and the need for continuing services for people released from jails and prisons.

The report from the Behavioral and Mental Health Task Force included 18 recommendations.

Among them: publicly funded post-graduate fellowships in psychiatry for physician assistants and psychiatric nurses and staff retention bonuses at Lincoln Regional Center psychiatric hospital.

The report also pushes for rules to ensure that inmates leaving prison have enough medications to last until they can make an appointment in their communities.



Courtesy of the Be Vocal: Speak Up for Mental Health initiative

Demi Lovato publicizes campaign for more authentic media representations

November 30, 2016, MARLBOROUGH, MA—An ambitious project will offer the media less stigmatizing alternatives to illustrate stories about brain-based disorders, HealthDay news service reports.

The photo project is part of the Be Vocal: Speak Up for Mental Health campaign. It’s supported by entertainment star Demi Lovato, Sunovion Pharmaceuticals Inc., and five mental health advocacy organizations in partnership with Getty Images.

“Too often the imagery we see in media or online sensationalizes or romanticizes mental illness,” said

Lovato, who has bipolar. “We are proud to show what mental health in America can look like when people get the support they need.”

To create the Be Vocal Collection, award-winning Israeli photographer Shaul Schwarz (pictured with Lovato) documented 10 people from across the United States who live with bipolar and other brain-based disorders.

The images are available from Getty for free use in news articles, social media and blog posts, and other editorial communications related to mental health.

U.S. Surgeon General spotlights addiction

November 17, 2016, WASHINGTON, DC—Calling it one of the most pressing public health crises of our time, U.S. Surgeon General Vivek Murthy, MD, issued a landmark report on tackling substance abuse disorders as a nation that he hopes will be a “cultural call to action,” the Huffington Post reports.

More than 400 pages long, “Facing Addiction in America” calls for evidence-based early interventions for young people, investing in substance abuse prevention and research on treatment, and expanding treatment programs

with a proven track record.

Murthy said the view that substance abuse is a “moral failing” creates shame and stigma that makes people less apt to seek help and increases the challenge of marshalling the necessary investments in prevention and treatment.

“We must help everyone see that addiction is not a character flaw—it is a chronic illness that we must approach with the same skill and compassion with which we approach heart disease, diabetes, and cancer,” he said.

Youth suicide rates rising in Ontario

November 13, 2016, TORONTO, ON—The latest data from the Ontario provincial coroner’s office shows a substantial spike in suicides among youth ages 10 to 19, according to a Global News investigation. Deaths by suicide in that age group rose from 54 in 2013 to 81 in 2014.

Over the same period, nearly 2,400 young people ages 10 to 17 were hospitalized after intentional self-harm. That compares to slightly more than 1,500 such hospitalizations from 2010 to 2011, according to statistics from the Canadian

Institute for Health Information.

Suicide is the second-leading cause of death among 15-to 24-year-olds in Canada. In addition, the attempted suicide rate for youth last year was dramatically higher than for any other age group.

“We need to think in terms of prevention. We need to think in terms of early identification and really having the supports that young people find helpful,” Dr. Joanna Henderson, a psychologist at the Centre for Addiction and Mental Health (CAMH) in Toronto, told Global News.

NAMI cites ‘unfulfilled promise’ of parity

November 15, 2016, WASHINGTON, DC—Years after U.S. federal legislation mandated equal insurance coverage for medical and mental health treatments, discrimination persists in the form of difficulty finding “in-network” behavioral care providers, the National Alliance on Mental Illness (NAMI) said.

The advocacy agency released a new report, “Out-of-Network, Out-of-Pocket, Out-of-Options: The Unfulfilled Promise of Mental Health Parity,” highlighting the continuing challenges of using health insurance to pay for behavioral health care.

NAMI said people with mental

health conditions rely on out-of-network care at higher rates than people with other health conditions because they can’t find a practitioner who participates in their insurance plan. That often results in higher out-of-pocket costs as compared to in-network care and, in some cases, prompts people to stop mental health treatment entirely, NAMI said.

The report recommends that health plans maintain up-to-date provider directories, promote integration of mental health and primary care, expand mental health provider networks, and cover out-of-network care to fill provider gaps.

Alabama prisons must defend lack of services

November 26, 2016, MONTGOMERY, AL—A U.S. District Judge in Alabama has ruled that a lawsuit on behalf of prisoners denied mental health care can head to trial as a class action suit.

The opinion by Judge Myron Thompson noted that administrators within the prison system acknowledged a lack of adequate staff and funding to provide appropriate care for prisoners with mental health conditions. Failure to allocate the necessary resources created “a substantial risk of serious harm,” the judge wrote.

“This ruling is very important for all of the people languishing within Alabama’s prisons without the mental health care they need,” said Maria Morris, senior supervising attorney with the Southern Poverty Law Center, which is part of a coalition that filed the suit in 2014.

CAMH urges fixes to mental health system

October 27, 2016, OTTAWA, ON—As Canada’s federal government negotiates a new health accord with provinces and territories, a leading expert called for an agreement to dedicate more funds to research into the biological origins of mood disorders and other psychiatric conditions.

Catherine Zahn, MD, president of the Toronto-based Centre for Addiction and Mental Health (CAMH), also wants the publicly funded health care system to establish national standards for wait times for mental health care, to reduce those wait times over the next decade, and to include “structured psychotherapy” among medically necessary services.

Zahn told the *Toronto Star* that mental illness affects about 6.7 million Canadians, or roughly 20 percent of the population, and costs the economy about \$51 billion a year—more than cancer or infectious diseases. Yet only about 7 percent of the billions of dollars spent on health care goes to mental health interventions, she said.

Checking levels of Vitamin D recommended

December 1, 2016, ALKMAAR, The Netherlands—People with bipolar disorder appear to be at higher risk of having insufficient levels of vitamin D, a new study has found.

Dutch researchers compared a group of outpatients with bipolar disorder to groups with schizophrenia and schizoaffective disorder, noting that an association between schizophrenia and vitamin D deficiency has been previously observed.

The researchers hypothesized that vitamin D deficiency wouldn't be as high in the group with bipolar as in the comparison groups. Instead, they found people in all three groups were 4.7 times more likely to have vitamin D deficiency than the general public. Almost a third of those with the psychiatric conditions tested below optimum levels of vitamin D.

Because the vitamin is important to maintain bone health and muscle strength and to prevent osteoporosis, the study authors said people with bipolar should have their vitamin D levels measured annually.

The study, which appeared in the *Journal of Clinical Psychopharmacology*, was entitled "Prevalence of vitamin D deficiency in adult outpatients with bipolar disorder or schizophrenia."

Online searches may yield questionable results

December 1, 2016, DRESDEN, Germany—A new study indicates that clinicians should be more proactive about discussing reliable online information about bipolar disorder with their patients.

An international team of researchers surveyed 1,222 people with bipolar in 17 countries about their online search habits regarding medical information. They found 77 percent had searched for information about bipolar. The three main reasons were looking up medication side effects, learning anonymously, and getting coping tips. Only 20 percent reported reading or participating in online support groups.

About two-thirds of patients didn't discuss their Internet findings with their doctors. The researchers said more patient education is needed because of concerns about the quality of online information, especially related to prescription drugs, and because individuals may not fully understand the limitations of online privacy. They added that clinicians should be able to recommend a few high-quality websites.

The study, which appeared in the *International Journal of Bipolar Disorders*, was entitled "Online information seeking by patients with bipolar disorder: Results from an international multisite survey."

Benefits of early bipolar treatment confirmed

December 1, 2016, COVENTRY, UK—A new analysis emphasizes the importance of getting people who have bipolar disorder into treatment as soon as possible.

British researchers reviewed various studies involving nearly 9,000 patients in total to gauge the impact of early treatment versus later treatment in the course of the illness.

They discovered a "consistent finding" that treatment in earlier illness stages resulted

in better outcomes in terms of response, time to recurrence, remission, relapse rate, symptom recovery, employment and psychosocial functioning. Those improvements applied for both medication treatment and psychological treatments.

The study, which appeared in the *International Journal of Bipolar Disorders*, was entitled "Is treatment for bipolar disorder more effective earlier in illness course? A comprehensive literature review."

Better outcomes with integrated pharmacies

November 1, 2016, MORRISVILLE, NC—Having pharmacies integrated with community health centers where mental health services are delivered may reduce the need for expensive hospital-based services, a new study suggests.

American researchers found that patients with bipolar and other mood and mental disorders who used integrated pharmacies had

higher medication adherence rates, lower rates of hospitalizations, and lower emergency room usage than peers filling their prescriptions at community pharmacies.

The study, which appeared in the *Journal of Managed Care & Specialty Pharmacy*, was entitled "Integrated pharmacies at community mental health centers: Medication adherence and outcomes."



'Eveningness' linked to poor functioning

December 1, 2016, HONG KONG, China—Night owls who have remitted bipolar disorder appear to fare worse at daily functioning than their peers who are morning people, according to a new study.

Hong Kong researchers looked at the impact of eveningness—the tendency to be more alert and energetic later in the day and to stay up later at night—on people with bipolar I, II, or otherwise not specified whose illness was well controlled.

Eveningness was associated with

greater sleep-wake disturbances, more unhealthy eating habits, worse quality of life, more impaired interpersonal relationships, and more dysfunctional sleep-related cognitions and behaviors.

Targeted intervention on dysfunctional sleep behavior could help to reverse eveningness and improve function in bipolar disorder, the authors said.

The study, which appeared in the journal *Behavioral Sleep Medicine*, was entitled “Eveningness and its associated impairments in remitted bipolar disorder.”

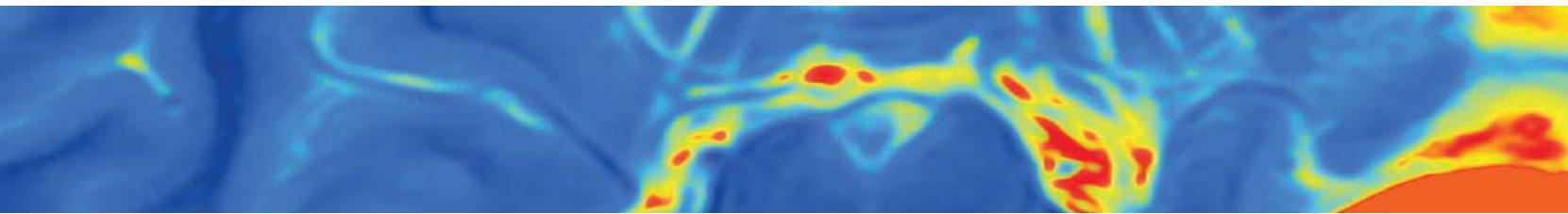
Cognitive impairment common in stable mood

November 15, 2016, GLASGOW, Scotland—Cognitive impairment is widespread among people with bipolar disorder who are currently in a stable mood state, a new study suggests.

Scottish researchers analyzed results of 15 previous studies that included statistics on the prevalence of cognitive impairment. They found up to 57.7 percent of study participants showed noticeable deficits in executive function (the ability to plan and organize) and attention/working memory. Up to 44.2 percent had deficits in reaction time, verbal memory, and visual memory.

Greater cognitive impairment was associated with a more severe or long-standing illness, and antipsychotic medication.

The study, which appeared in the *Journal of Affective Disorders*, was entitled “Prevalence and correlates of cognitive impairment in euthymic adults with bipolar disorder: A systematic review.”



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Mobile devices may aid psychotherapy

November 1, 2016, PROVIDENCE, RI—Delivering interventions via mobile devices as an adjunct to psychotherapy sessions appears beneficial for improving treatment adherence in bipolar disorder, a new study suggests.

Study participants completed four weekly in-person sessions of individual therapy, then received twice-daily alerts of coping tools, behavioral recommendations or helpful reminders—formally known as ecological momentary interventions (EMI)—for two more months. They returned for in-person therapy visits at 30 days and 60 days.

EMI therapy has been used to promote behavioral changes such as smoking cessation, weight loss, and alcohol use, and in the management of anxiety, diabetes, and eating disorders.

The American authors of the new study said their findings add to the small but growing body of literature suggesting that EMI is feasible and acceptable for use in people with bipolar disorder.

The study, which appeared in the *Journal of Psychiatric Practice*, was entitled “An open trial of a smartphone-assisted, adjunctive intervention to improve treatment adherence in bipolar disorder.”

Group psychoeducation early in the course of bipolar has strong impact on recurrence

November 1, 2016, NOTTINGHAM, UK

—Structured group psychoeducation may be especially influential early in the course of bipolar disorder, a new study suggests.

British researchers looked at 304 people who had not experienced a bipolar mood episode in the previous four weeks. Participants were assigned to either structured group treatment or unstructured peer support and asked to complete 21 two-hour sessions.

After nearly two years, attendance at psychoeducation groups was higher than at peer-support groups. Overall, 58 percent of those in the psychoeducation group had another mood episode, com-

pared to 65 percent in the peer-support group.

When participants were sorted by number of lifetime mood episodes, however, those with fewer than seven previous episodes showed the most benefit from structured psychoeducation in terms of recurrence and time to next episode.

The study, which appeared in the journal *Lancet Psychiatry*, was entitled “Clinical effectiveness and acceptability of structured group psychoeducation versus optimised unstructured peer support for patients with remitted bipolar disorder (PARADES): A pragmatic, multi-centre, observer-blind, randomised controlled superiority trial.”

Two-question assessment can identify those more likely to develop metabolic syndrome

October 5, 2016, LEUVEN, Belgium—

Asking routinely about physical activity during clinical visits can identify whether someone with bipolar disorder is at risk for medical conditions such as diabetes and heart disease, a new study concludes.

Researchers from Belgium, Australia and England tested what's known as the Physical Activity Vital Sign assessment, a two-question tool that clarifies whether someone meets the recommended 150 minutes of physical activity a week. They also had study participants undergo

metabolic screening and perform a six-minute walk test.

Those who did not meet the physical activity recommendations tended to have a higher body mass index, performed worse on the walk test, and were at significantly higher risk for cardio-metabolic diseases.

The study, which appeared in the journal *Psychiatry Research* online ahead of print, was entitled “Physical activity as a vital sign in patients with bipolar disorder.”

Improved parent coping an influential factor in pediatric bipolar

October 1, 2016, CHICAGO, IL—

Improving parent coping skills and family functioning through a specific form of cognitive behavioral therapy appears to influence outcomes in pediatric bipolar disorder, a new study suggests.

American researchers looked at 69 children ages 7 to 13 who had been diagnosed with bipolar disorder. As add-on

treatment to medication, the youth were randomly assigned to treatment as usual or participated with their parents in child- and family-focused cognitive behavioral therapy (CFF-CBT).

Children in the CFF group exhibited greater improvement in mania, depression, and global functioning. Parenting skills, parent coping, and family flexibility

also improved significantly, and the study authors said those factors were associated with the child's improvement in mood and functioning.

The study, which appeared in the journal *Behaviour Research and Therapy*, was entitled “Mediators in the randomized trial of child- and family-focused cognitive-behavioral therapy for pediatric bipolar disorder.”

Head vs. hand

Recently, due to an injury, my right hand was immobilized for six weeks. But for years I've felt that my head has been similarly immobilized (at least at times) because of bipolar.

Having my hand in a splint afforded me a chance to see how different a "broken" brain can be from a hurt hand. The distance from my head to my outstretched hand is about 3 feet; however, in countless ways, the two are worlds apart.

First, I can't tell you how many people offered a helping hand while mine was out of commission. From opening doors to offering to cut my steak, the outpouring of care was amazing. In addition, numerous people voiced their concern. People could identify with the difficulty associated with having a disabled hand, even if they had never experienced that misfortune.

Unfortunately, that's often not the case with a mood disorder. People are not always quick to rally around you and offer support. Brain illnesses simply do not elicit the same level of empathy from the public, sometimes not even from those who know what you're facing. And let's not forget what people say, sometimes under their breath.

Now, don't get me wrong. The help I've personally received from family, friends, and professionals has been invaluable. I wouldn't be here without it. And, obviously, it's not always easy to "see" that someone has bipolar disorder. Nevertheless, in a contest between head and hand, there's a notable disparity in the level of awareness people have and the amount of assistance they offer.

Another significant difference concerns healing time. For my hand, recovery took about six weeks, though it seemed like forever. Despite the downtime affecting

my dominant hand, I adapted—in large part because others didn't hesitate to help. Until there's a cure, living with bipolar is a lifetime undertaking, and the challenges far outweigh being unable to write (at least neatly) for a while.

Then there's the matter of insurance. Though there's been some progress, true parity is hardly a reality. Insurance companies almost cut us off at the neck, addressing a physical illness quite differently from a "mental" one. Look at just about any



Stephen Propst

Finally, there's the matter of access to care. I had countless orthopedists from which to choose. The doctor I saw was one of 15 hand specialists in a firm with around 90 physicians. Even the therapist I saw focused on hands. Let me ask a question: *Have you tried to find a psychiatrist who is accepting new patients and your insurance, much less one who focuses on bipolar?*

It's becoming increasingly difficult, sometimes impossible, to find a competent, capable psychiatrist who is ready and willing to see you, especially one with whom you'll feel comfortable.

Admittedly, there are many concerns throughout the US health-care system, particularly when it comes to mental health.

In a contest between head and hand, there's a notable disparity in the level of awareness people have and the amount of assistance they offer.

policy, and you'll see that the head and hand are worlds apart.

And let's not forget the "s" word. Not one person looked at me funny because of my hand. No one discriminated against me or questioned the legitimacy of my condition. But when it comes to bipolar, the false perceptions and mistaken beliefs persist. The **stigma** is still there. No wonder it takes so long for people to get properly diagnosed and even longer to achieve recovery. Had I faced similar issues with my hand, it would still be in a splint!

People battling conditions like bipolar face a handful of unique burdens—a lack of understanding, inadequate parity, rampant stigma, and a shortage of providers. Let's put our heads together and our hands to work improving the health and the lives of people living with mood disorders. It's time to narrow the gap between head and hand. ☀

Stephen Propst is an advocate, writer, public speaker, and coach/consultant focusing on living successfully with conditions like bipolar. He can be reached at info@atlantamoodsupport.com.

THE MAESTRO & ME2/

Ronald Braunstein's setback led to a stigma-free orchestra for musicians with mental health challenges

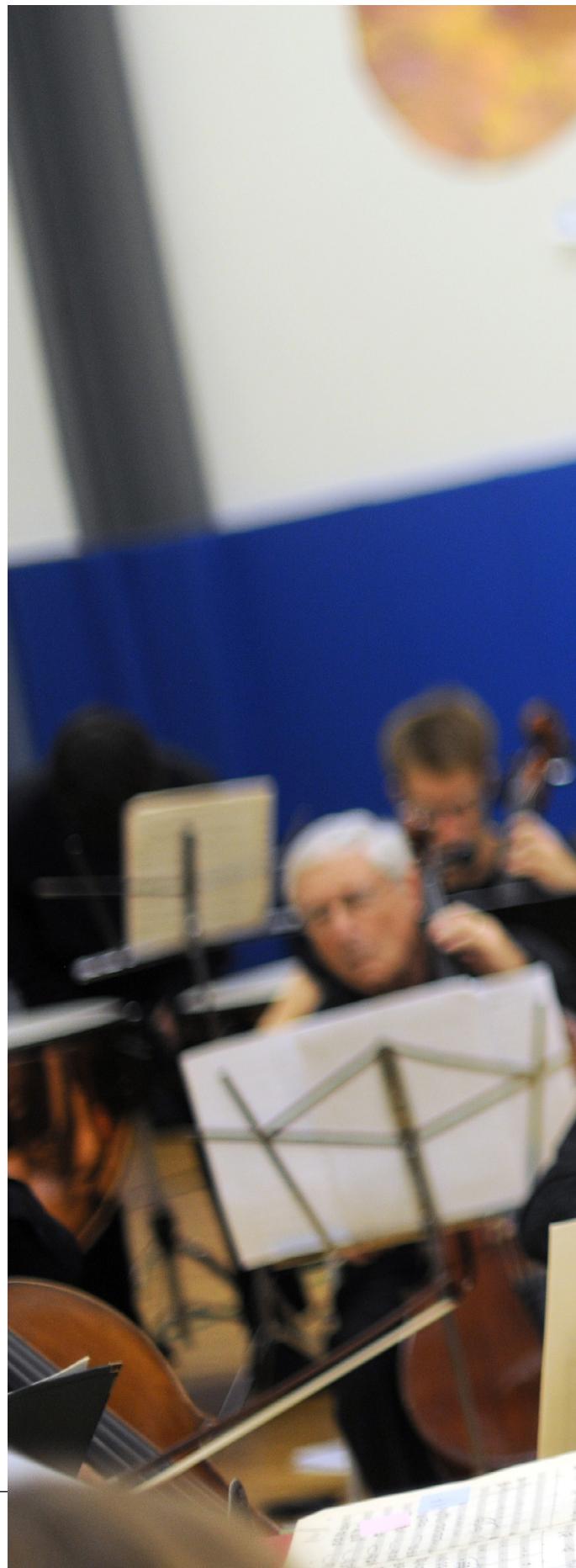
By Robin L. Flanigan

Maestro Ronald Braunstein's amazing splash on the international music stage at a mere 23 years old was a sign of things to come—in more ways than one.

After graduating from the prestigious Juilliard School in New York City, Braunstein had entered a summer program at the Salzburg Mozarteum in Austria. He describes washing his clothes in a laundromat at the end of that summer, wondering what to do next.

What came to mind was the Herbert von Karajan International Conducting Competition in Berlin, taking place a mere 10 days away. In order to enter the acclaimed event, he would have to pull together a repertoire of some 15 pieces—a seemingly impossible feat.

A JOYFUL NOISE Ronald Braunstein leads the Me2/Orchestra in a program of Dvořák, Brahms, Rossini and Bizet at the Baird School in Burlington, Vermont, in October 2016. The concert celebrated the ensemble's fifth anniversary. Photo: DAVID SEAVER PHOTOGRAPHY







PRODIGY As a boy, Braunstein studied with Eugene Phillips of the Pittsburgh Symphony Orchestra. In the photo at right, Braunstein leaves for high school at the University of North Carolina School of the Arts, where he studied music composition.

continues. He pauses again to sing a few measures.

"Yeah," he says. "It's the greatest exaltation about God. It's the highest, most spiritual moment in the whole symphony, then there's a short note played by the lowest two instruments in the whole orchestra, the contrabassoon and a big drum."

"I cried. I cried because I knew it was a turning point in my life."

That wasn't his first strong emotional reaction to music, though. He started playing the violin in third grade after being "overwhelmed" by a professional string quartet at his public school.

Passion and discipline led him to Juilliard, regarded as one of the world's best conservatories for the performing arts, and to his conducting debut at Lincoln

"But I was on a roll," Braunstein recalls, referring to the grandiose conviction of his manic state. "So I took all my wet clothes out of the dryer, put them in a big, black plastic bag, and was gone."

"I left all my belongings in my room. I only had a dripping suitcase and [musical] scores in my briefcase."

Thus in September 1979, Braunstein became the first American to win the Karajan competition, beating out roughly 600 applicants from around the world.

"It's like the Olympics of conducting, and I won the gold prize," he explains.

That launched a career that brought him work with orchestras in Europe, Israel, Australia, Taiwan, Tokyo, and elsewhere abroad and in America.

The manic behaviors and depressive sloughs of bipolar disorder traveled along, too, making it more and more difficult to continue on that path. Yet after a difficult and painful period, he's found a musical niche that's left him better than before.

Braunstein now serves as music director and conductor for Me2/Orchestra, an organization he created with his wife, Caroline Whiddon. Based in Burlington, Vermont, where the couple live, Me2/ is the world's only classical music organization for individuals living with mental illnesses and the people who support them.

The flagship ensemble in Burlington launched in 2011. A second ensemble started in Boston in 2014. Braunstein and

Whiddon, who is executive director of Me2/, travel there for two-hour rehearsals every Monday night.

MUSIC & MANIA

Braunstein's musical calling and psychiatric symptoms both manifested in his early teens in Pittsburgh. He remembers his dad taking him to a psychiatrist who "said I just have 'bad nerves' and gave me some pills. I didn't take them for long."

I thought I could draw more color out of the music by using a colored pencil [to conduct]. I was positive that I could do that.

—RONALD BRAUNSTEIN

Around the same time, Braunstein realized what he wanted to do with his life. He remembers the ecstatic moment in explicit detail: He was 14, sitting with his father in the nosebleed seats at the Pittsburgh Symphony Orchestra.

"I was sitting way, way up, and I can tell you the exact chord ..."

Braunstein pauses to reach for a piece of music on a bookshelf, flipping to the right spot in Beethoven's *Symphony No. 9*.

"Bar 330 in the fourth movement," he

Center at age 20.

That momentous occasion mixed music and mania: Braunstein conducted Beethoven's *Symphony No. 1* not with a traditional conductor's baton, but with a blue pencil.

"I thought I could draw more color out of the music by using a colored pencil," he says. "I was positive that I could do that. I thought [the concert] was a roaring success, but everyone else felt there was something very, very wrong happening."

"It didn't matter what they thought, really," he adds. "But for the first time, I noticed I am different."

Braunstein wouldn't be diagnosed with bipolar I until 1985, nearly a decade later. Even then, he kept it to himself.

"I always hid it," he says. "And I hid it very well, even to my physician."

DISCLOSURE & DISGRACE

For many years, Braunstein's career flourished despite mood episodes and occasional extreme behavior—like the time he climbed onto a tin roof after a performance and told the musicians he was with that he could fly. (They persuaded him not to try.)

In addition to guest-conducting gigs, Braunstein served as music director of the Texas Chamber Orchestra in the early 1980s and later for student orchestras at Juilliard and the Mannes College of

Performing Arts—highly sought-after positions in a highly competitive field. He also joined the conducting staff at the American Opera Center.

A conductor normally spends several months mastering a score; in the throes of mania, Braunstein would spend one or two days learning the symphonies he needed to conduct. His rehearsals got shorter and shorter. He rarely slept or ate. When he did sleep, it was usually on other people's floors.

What goes up must come down—and in May 2003, Braunstein fell hard. He pinpoints a moment, just after conducting Dvořák's *New World Symphony* with the Mannes Preparatory Division Orchestra: "It ended at such a high point of energy and passion that I knew absolutely I had to crash down then. It was all over and I had to spend a year in bed."

Braunstein had studied graphic design at the Pratt Institute in Brooklyn in the late 1990s. Once he resurfaced from his

"The stigma and discrimination I observed during this time period truly rocked my entire world."

—CAROLINE WHIDDON

GOLD MEDALIST Braunstein signs autographs after winning the prestigious Herbert von Karajan International Conducting Competition in 1979. He then apprenticed with von Karajan and the Berlin Philharmonic.





IN HARMONY Braunstein and Caroline Whiddon met at the Vermont Youth Orchestra Association, launched the Me2/Orchestra together (he is music director, she is executive director), and married in April 2013. Photos: (left and opposite page) SHAUL SCHWARZ/GETTY IMAGES

“All my orchestra members support me every day. . . as soon as I get there, I feel so great.”

—RONALD BRAUNSTEIN

depressive episode, he spent the next few years focusing more on design work and not doing much conducting.

Eventually he began sending out job applications to dozens of orchestras, though it “took a lot of energy just to get the right cover letter into the right envelope.” When he was hired as music director of the Vermont Youth Orchestra Association in 2010, he was elated.

He was still struggling to manage episodes of depression and mania, however, and working with a new psychiatrist to adjust his medication. He thrived on the podium, but in other ways his eccentric behavior—in reality, manic symptoms—began to worry others. After only a few months on the job, Braunstein disclosed his diagnosis to the association’s board. Shortly afterward, he was fired.

Braunstein sued for libel, slander and

discrimination. The lawsuit settled out of court in 2011. Media coverage put every point in that arc before the public eye.

“It was the most painful thing of my life,” he says. “I wanted to change my name.”

ME2/ & MENTAL HEALTH

As awful as it was, that experience wound up propelling him in new directions that have been healing for him and a positive force on countless other lives.

For one thing, he met his future wife. Whiddon was executive director of the Vermont Youth Orchestra Association when Braunstein was hired. She recalls watching videos of him conducting before she picked him up at the airport for his job interview. In the videos he appeared “expressive, confident and powerful,” but in

person he was “timid, nervous and soft-spoken,” she recollects.

“I knew something was going on within five minutes of meeting him,” she recalls. “As we got to know each other, I told him, ‘If we’re going to work together, you might as well tell me what’s going on with you. I can help.’ But he was very guarded. He did not want me to know about his diagnosis.”

When he finally did tell Whiddon, she says her reaction was, “now it’s time to learn about bipolar disorder.”

The pair didn’t date as colleagues, but Whiddon reached out to be supportive and help Braunstein be successful. She would send him texts such as, “Have you eaten?”

“I suppose it was naive of me to think that everyone else would have the same reaction,” she says. “[But] there were people around me who reacted with fear and disdain.

“They painted a picture of Ronald that mirrored the type of mentally unstable people they had heard about in the media.... It makes my stomach churn just thinking about it today. The stigma and discrimination I observed during this time period truly rocked my entire world.”

Burned out after 13 years with the association, Whiddon coincidentally gave her notice around that time. She figured she’d start looking for another job. Braunstein talked her out of it.

“He said, ‘Nope. I have this great idea,’” Whiddon recounts.

That idea turned into Me2/Orchestra. Whiddon became a member as well as the chief administrator.

Whiddon had studied French horn at the renowned Eastman School of Music in Rochester, New York. She left performing behind after graduation because of anxiety and depression. Although her depression

has been well-managed for years, she had long since sold her French horn. So she found “an old clunker of a French horn” online and started making music again.

The couple, who married in April 2013, are a team at work and in recovery.

She makes sure his pill box is full for the month, encourages him to get plenty of sleep, and cooks healthy meals. He models a carefree, confident attitude when she starts to worry about what other people are thinking or when she feels a lack of control.

For his part, Braunstein surrounds himself with good friends and talented, caring physicians.

“I don’t have symptoms right now, and haven’t for five years,” he says.

That’s the length of time the orchestra has been in existence. Coincidence?

“All my orchestra members support me every day. Sometimes I don’t feel like going to work, but as soon as I get there, I feel so great,” he reflects.

Of course, it also helps that Braunstein

is more consistent about taking his meds. He’s been in talk therapy steadily for the past six years, another important change. And he feels liberated by not having to hide his bipolar disorder anymore.

“I’ve come out and I don’t have to worry about it anymore,” he says. “My best 25 years are coming.... I’m just getting warmed up.” ☀

Robin L. Flanigan is an award-winning journalist whose work has appeared in People magazine, US Airways Magazine and other national and regional publications. She lives in Rochester, New York.

MAKING MUSIC, FIGHTING STIGMA



IT ALL STARTED with a press release in some local newspapers and neighborhood bulletins. Now the Me2/Orchestra is the world’s only classical music organization for individuals living with brain-based mental disorders and the people who support them.

Me2—which is actually two ensembles, one in Burlington, Vermont, and an offshoot in Boston—has been featured in numerous media outlets, including the Associated Press and BBC News. There’s also a documentary in the works: Filming for *Orchestrating Change* is expected to wrap up in mid-2017.

The orchestras play in concert halls, psychiatric hospitals, youth centers and correctional facilities. They bring the arts to underserved audiences while providing a creative outlet and emotional haven for the performers.

Co-founders Ronald Braunstein and Caroline Whiddon aim for a “stigma-free zone,” a community whose foundation is compassion and empathy. Their goal is to establish 20 affiliate ensembles by 2020.

Marek Lorenc of Burlington, a clarinet player, joined Me2/ “when I wasn’t doing so well” due to bipolar symptoms. With his health and outlook much improved, he

continues to play with—and take pride in—the orchestra.

“You wouldn’t be able to guess that any of the players are ‘disadvantaged’ in any way just by listening—the mission doesn’t take away from the music,” he says.

Still, Braunstein does not demand the kind of technical excellence he would expect from a professional orchestra when he conducts. There is no audition to join—and a psychiatric diagnosis is not required, either.

Marissa Dennis, a psychology major at the University of Vermont, was drawn to Me2/ as a form of social action.

“I saw that people with mental illness are treated as these enigmas just because of a diagnosis, and that this was a group of people who were taking a stand against the stigma,” says Dennis, who plays the flute.

For many of the musicians, the orchestra becomes an important support network. When Burlington violinist Jessica Stuart took a five-month break because she was “struggling pretty severely,” orchestra members checked in to see how she was doing.

“I felt like I had let them down,” says Stuart, who has a dual bipolar and substance use diagnosis. “But Caroline was very reassuring. Her stance was, ‘Just take care of what you have to do, and if you need help, let me know.’

“To find a place like this,” she adds, “it’s given me hope that I can be accepted for who I am.”

GETTING A Grip On Main



a

The ELECTRIFYING PULSE of elevated mood plays out in different ways—and often leads to scorching consequences

By Donna Jackel

W

hen Keely Petri describes her first manic episode, she lists what might be considered “classic” symptoms.

“I had lots of energy, a case of the giggles, and racing thoughts,” says Petri, 43. “I couldn’t sit still. I’d go to my office and sit down and then I’d have to get up and pace the floors.

“I felt like Wonder Woman,” adds Petri, who lives outside of Boston. “No one could knock me down.”

For Julianna Shapiro of Orange County, California, the trademark manic exhilaration quickly breaks down into agitation, irritability, and physical discomfort.

“I get like 24 hours of euphoria and then a feeling like ants in my pants—like I’m crawling out of my skin,” the 46-year-old reports. “I get very agitated and I pick on people.”

In this mindset, Shapiro can’t stand to see things out of place. She’ll yell at her husband for leaving his shoes in the family room or dramatically sweep messy papers to the floor.

“I scratch my neck until it’s red,” she adds. “I feel so yecch.”

Psychiatry has established a central set of criteria to diagnose mania. But the list of symptoms in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* doesn’t fully reflect how mania can vary from individual to individual.

Just as episodes play out differently for different people, so does the course of episodes over time. Some people respond quickly to standard medications after a first manic episode and don’t relapse for years, if ever.

“There is a subgroup who, once they get on the right treatment, remain largely controlled—they might almost seem cured, but it’s because the treatment is working,” says psychiatrist Murray Enns, MD, a researcher and professor of psychiatry at the University of Manitoba in Winnipeg, Canada. “But not everyone latches on to the right treatment.”

MANIA

by the book

The *Diagnostic and Statistical Manual of Mental Disorders*, the standard psychiatric reference in North America, tells practitioners what to look for in order to diagnose a manic episode:

- A distinct period of unusual and persistent elevated, expansive or irritable mood that lasts at least one week, requires hospitalization, or results in psychosis
- A sustained increase in goal-directed activity or energy levels
- Noticeable difficulty at work, at school, or in social activities or relationships due to the mood disturbance.
- Three or more of the following symptoms (or four if the abnormal mood is irritable):
 - ▶ Inflated self-esteem or grandiosity
 - ▶ Decreased need for sleep (for example, you feel rested after only three hours of sleep)
 - ▶ Unusual talkativeness and rapid speech
 - ▶ Racing thoughts
 - ▶ Distractibility
 - ▶ Increased goal-directed activity (such as taking on new projects) or agitation
 - ▶ Doing things that have a high potential for painful consequences, such as buying sprees, sexual indiscretions, or risky business investments.

Hypomania means “below mania” in Greek. In a hypomanic episode, the mood changes and symptoms last four to six days and do not cause significant disruptions in usual pursuits.

Colors may seem brighter, images more vibrant, sound more pronounced.

For others, mania revisits despite the best interventions. It has taken Shapiro years to find medication that keeps her relatively stable, but she still has manic episodes every couple of months.

Of course, that presupposes clinicians know what they’re treating in the first place. Clayton Buck consulted psychiatrists and counselors over the years as abrupt, disruptive mood shifts cost the chartered accountant two marriages and numerous jobs. It wasn’t until 2006, while living in a homeless shelter, that he was accurately diagnosed and prescribed effective medication. Now 66, he’s a peer specialist in Calgary.

WHAT'S IN A NAME

The DSM lays out a list of core symptoms, starting with changes in mood and energy levels. Other diagnostic indicators include unrealistic self-confidence, a hyped-up buzz of ideas, talking more than usual, sleeping less than usual, and taking on lots of activities—including ones that are likely to have negative consequences.

Other fairly common symptoms aren’t noted. For instance, heightened senses.

“Colors may seem brighter, images more vibrant, sound more pronounced,” says Shefali Miller, MD, a clinical assistant professor of psychiatry and behavioral sciences at Stanford University.

That increased sensitivity can result in irritable reactions to noise. Cognitive changes—trouble with memory, obsessive thoughts—may also occur. Eating habits may veer toward voracious appetite or zero interest in food.

Some symptoms not mentioned in the core criteria are recognized in the *DSM* as “specifiers.” Thus an episode can be diagnosed as mania with anxious distress, say, or mania with psychotic features.

The longer mania goes untreated, the greater the risk of psychosis. In a psychotic episode, you have difficulty distinguishing what is rational and real from what is not. That may take the form of delusions—believing you have a special relationship with God, say—or hallucinations, either auditory or visual.

Buck recalls “visions of becoming the Prime Minister of Canada” during one euphoric state. During Petri’s first manic episode a decade ago, she had a recurring hallucination, “clear as day,” of a female stick figure seated on a horse and holding a spear.

“It would just show up, but oddly, it didn’t scare me,” she says.

One-third of people with bipolar I experience elevated mood episodes with mixed features—symptoms of mania and depression at the same time. Research shows that suicide risk is higher during such episodes.

ON IMPULSE

Impaired judgment and impulsive behavior are hallmarks of mania, often leading to life-shattering consequences like losing jobs and deep-sixing relationships—sometimes due to the fallout from manic

actions, sometimes simply by deciding to up and leave.

In one hot-headed moment, Shapiro walked out on her marriage. The couple has since reconciled, but fractures remain. Shapiro’s daughter, upset over how her mother treated her stepfather, has not spoken to her for a year.

“It was a rash decision,” Shapiro admits. “Instead of going into [marriage counseling] I left my husband.”

A variety of studies suggest that lower impulse control and greater responsiveness to rewards may be characteristic of people with bipolar. For example, a 2014 paper in the journal *Comprehensive Psychiatry* found youth with bipolar scored higher on an impulsivity scale than those with major depressive disorder and those without any mood disorder.

Sheri Johnson, PhD, a professor at the University of California–Berkeley, leads research on the intersection between reward-driven activities and mania. Her Cal Mania (CALM) Program has found that goal-related pursuits and achievements can be a trigger for mania. Furthermore, the degree of sensitivity to rewards can predict increases in mania over time.

In turn, escalating mood intensifies the drive for pleasure and excitement. Deeply engrained moral codes may get swept away in the rush, and people may act completely out of character: gambling, cheating on a partner, even stealing for the thrill of it.

The combination of impulsivity and grandiosity—feeling you’re invincible—can prove disastrous to one’s bank account. Individuals who are normally responsible with money can find themselves

leaping into dubious investment schemes, launching business projects, or spending beyond their means.

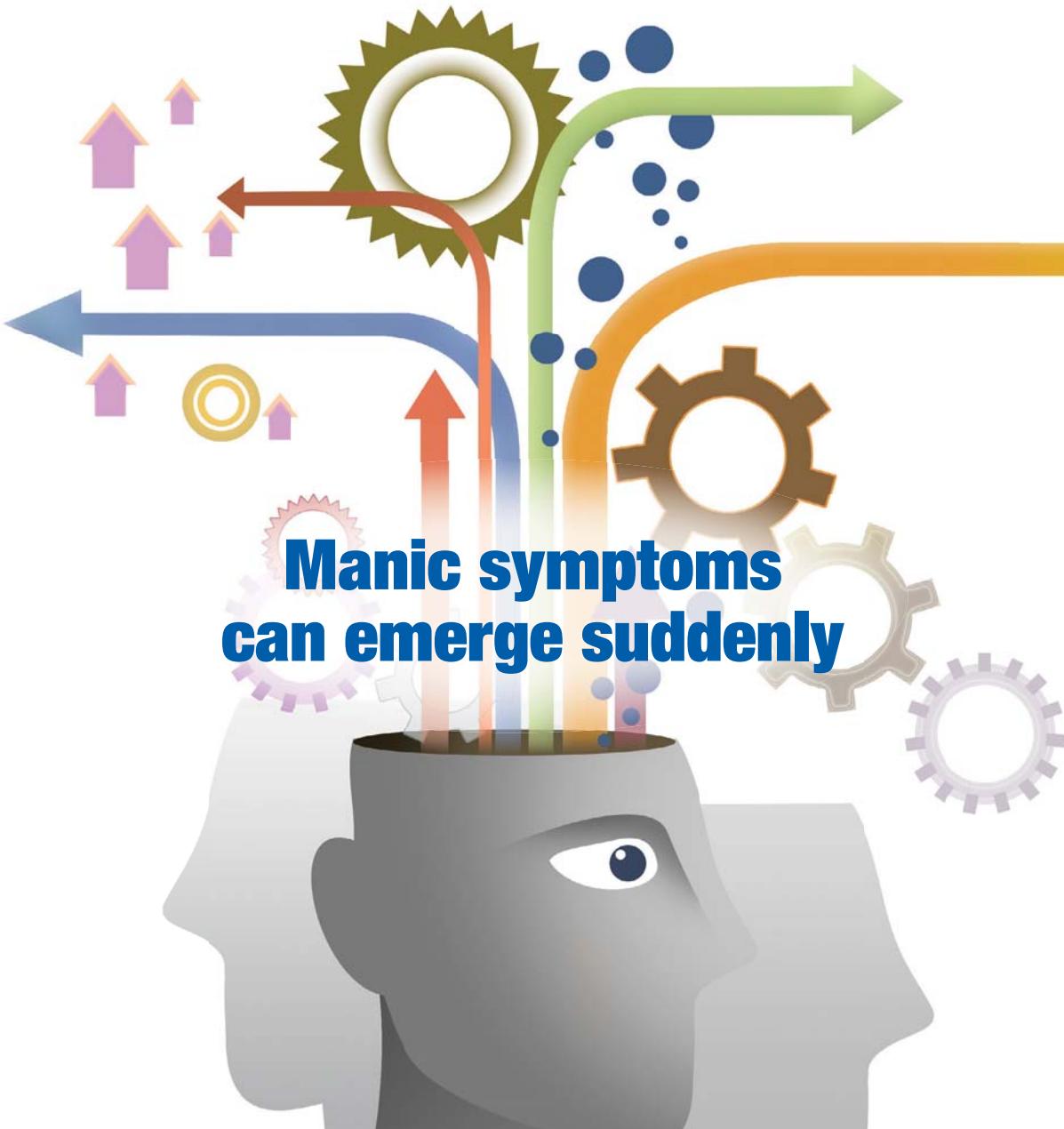
Petri currently lives on disability insurance, so she can ill afford her mania-fueled shopping splurges.

“I recently spent money on pocketbooks—I have a collection in my closet,” she says. “I get to a point where I have to borrow money from my dad because I have no money left.”

TREAT IT RIGHT

It can be difficult for people on the upswing to detect changes in their own behavior—or to feel like their greater productivity and upbeat mood are signs of illness. In psychiatric terms, this is known as lack of insight.

I get like
24 hours of
euphoria
and then a
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I'm crawling
out of my
skin.



IMPORTANT RISK INFORMATION

What is the most important information I should know about SAPHRIS?

Elderly people with dementia-related psychosis (having lost touch with reality due to confusion and memory loss) taking antipsychotic drugs are at an increased risk for death. SAPHRIS is not approved for treating people with dementia-related psychosis.

SAPHRIS may cause serious side effects, including:

- **Stroke (which can be fatal) in elderly people with dementia**
- **Neuroleptic malignant syndrome (NMS):** Call your healthcare provider right away if you have high fever; stiff muscles; confusion; changes in pulse, heart rate, or blood pressure; or sweating. These can be symptoms of a rare but potentially fatal side effect called NMS. SAPHRIS should be stopped if you have NMS
- **Tardive dyskinesia (TD):** Tell your healthcare provider if you cannot control the movements of your face, tongue, or other body parts. These could be signs of a serious and sometimes permanent side effect called TD. Risk of developing TD and the chance that it will become permanent are thought to increase the longer a person takes the medicine and the more medicine a person takes over time. TD can develop even after a person has been taking the medicine for a short time at low doses. TD may not go away, even if you stop taking SAPHRIS. TD may also start after you stop taking SAPHRIS

For the acute treatment of manic or mixed episodes associated
with bipolar I disorder in adults

SAPHRIS can help you handle them

- **SAPHRIS** helps manage the symptoms of mania in manic or mixed episodes of bipolar I disorder in adults

- A manic episode includes symptoms of mania, while a mixed episode includes symptoms of mania and depression

- **SAPHRIS** is an FDA-approved prescription medicine that can be:

- Taken alone, **OR**
 - Taken with the mood stabilizers lithium or valproate



*Restrictions apply. For details, please visit www.SAPHRISsavings.com.

Ask your doctor about SAPHRIS today

- Problems with your metabolism, which may increase your risk for heart disease or stroke, such as:

- **High blood sugar and diabetes:** If you have diabetes or risk factors for diabetes (eg, being overweight or family history of diabetes), your blood sugar should be tested before you start SAPHRIS and regularly during treatment. Complications of diabetes can be serious and even life threatening. Tell your healthcare provider if you have symptoms such as feeling very thirsty or very hungry, urinating more than usual, or feeling weak
 - **Increased blood cholesterol or triglycerides:** Your healthcare provider may decide to check your cholesterol and triglyceride levels during treatment
 - **Weight gain:** Weight gain has been reported with SAPHRIS. Your healthcare provider should check your weight regularly
- **Decreased blood pressure:** You may feel lightheaded or faint when you rise too quickly from a sitting or lying position. Ask your healthcare provider about ways to reduce feeling dizzy or lightheaded upon standing, such as sitting on the edge of the bed for several minutes before getting up in the morning or slowly rising after sitting

Please see additional Important Risk Information and Brief Summary of full Product Information, including Boxed Warning, on the following pages.

Saphris® (asenapine)
sublingual tablets 5 and 10 mg

THE ONE UNDER THE TONGUE™

IMPORTANT RISK INFORMATION (CONTINUED)

What is the most important information I should know about SAPHRIS? (continued)

- **Low white blood cell count:** Low white blood cell counts have been reported with antipsychotic drugs, including SAPHRIS. This may increase your risk of infection. Very low white blood cell counts, which can be fatal, have been reported with other antipsychotics
- **Increases in prolactin levels:** Tell your healthcare provider if you experience a lack of menstrual periods, leaking or enlarged breasts, or impotence, because SAPHRIS may raise the levels of prolactin. The levels may continue to be high when SAPHRIS is used over time
- **Seizures**
- **Impaired judgment, thinking, and motor skills:** Do NOT drive or use dangerous machinery until you know how SAPHRIS affects you. SAPHRIS may make you drowsy
- **Increased body temperature:** SAPHRIS may make you more sensitive to heat. You may have trouble cooling off. Be careful when exercising or when doing things likely to cause dehydration or make you warm
- **Suicide:** Tell your healthcare provider right away or go to an emergency room if you have thoughts of suicide or of hurting yourself or others. People with schizophrenia and bipolar disorder may have these thoughts
- **Difficulty swallowing:** SAPHRIS and medicines like it have been associated with difficulty swallowing

Who should not take SAPHRIS?

Do not take SAPHRIS if you have certain liver problems, or if you are allergic to any of its ingredients. Get emergency medical help if you are having an allergic reaction (eg, difficulty breathing; itching; swelling of the face, tongue, or throat; or light-headedness).

What should I tell my healthcare provider before taking SAPHRIS?

Tell your healthcare provider about any medical conditions and if you have or have had:

- Diabetes or high blood sugar in you or your family
- High levels of total cholesterol, triglycerides, or LDL-cholesterol; or low levels of HDL-cholesterol

Please see additional Important Risk Information on the previous pages, and Brief Summary of full Product Information, including Boxed Warning, on the following page.

To learn more about SAPHRIS, visit www.SAPHRIS.com

- Seizures or conditions that increase your risk for seizures
- Low or high blood pressure
- Low white blood cell count
- Certain heart problems such as irregular heartbeats or are at risk for these problems, or if you take medicines that can cause irregular heartbeats, because SAPHRIS should be avoided in these circumstances

Tell your healthcare provider if you are pregnant, or if you plan to become pregnant. SAPHRIS may cause harm to your unborn baby. A special program (National Pregnancy Registry for Atypical Antipsychotics) collects information on the safety of antipsychotic drugs, including SAPHRIS, during pregnancy. For information, contact the program at 1-866-961-2388 or <http://www.womensmentalhealth.org/clinical-and-research-programs/pregnancyregistry/>.

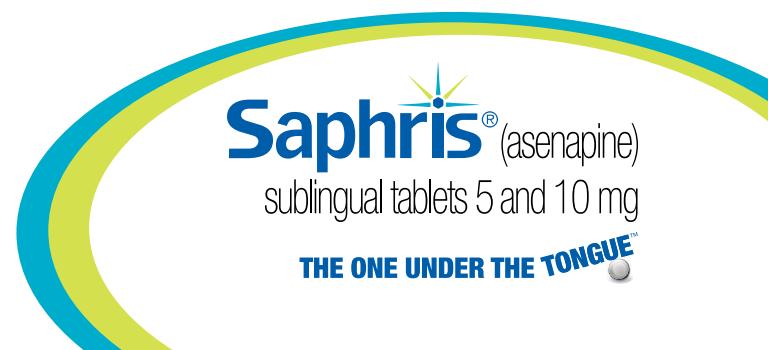
Tell your healthcare provider about all medicines that you take or have recently taken, including prescriptions, over-the-counter medicines, and supplements. SAPHRIS may affect the way other medicines work, and other medicines may affect how SAPHRIS works.

What are possible side effects of SAPHRIS?

- The most common side effects in adults were sleepiness, dizziness, uncontrolled movements of the body and face, muscle stiffness, weight gain, numbing of the mouth, and restlessness
- Since FDA approval, patients taking SAPHRIS have reported reactions under the tongue (where you place SAPHRIS), such as sores, oral blisters, peeling/sloughing, or inflammation. Choking has also been reported

Tell your healthcare provider if you have any side effect that bothers you or that does not go away. These are not all possible side effects of SAPHRIS.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.FDA.gov/medwatch, or call 1-800-FDA-1088.



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**Brief Summary of
Important Risk
Information**
SAPHRIS® [SAF-ris]
(asenapine) sublingual tablets

Saphris® (asenapine)
sublingual tablets 2.5 mg • 5 mg • 10 mg

This information does not take the place of talking to your healthcare provider about your medical condition or your treatment.

What is SAPHRIS?

SAPHRIS is a prescription medicine used for:

- Acute treatment of manic or mixed episodes of bipolar I disorder when used alone in adults or in children (ages 10-17)
- Acute treatment of manic or mixed episodes of bipolar I disorder when used with a mood stabilizer (lithium or valproate) in adults
- Treatment of schizophrenia in adults

What is the most important information I should know about SAPHRIS?

Serious side effects can happen with SAPHRIS, including:

- **Increased risk of death in elderly patients with dementia-related psychosis:** Medicines like SAPHRIS can increase the risk of death in elderly people who have lost touch with reality due to confusion and memory loss (dementia-related psychosis). **SAPHRIS is not approved for treating people with dementia-related psychosis**

Who should not take SAPHRIS?

People with certain liver problems should not take SAPHRIS. Talk with your healthcare provider before taking SAPHRIS if you have any liver problems. Also, do not take SAPHRIS if you are allergic to asenapine or any of the ingredients in SAPHRIS. **Also see "What are the ingredients in SAPHRIS?"**

What should I tell my healthcare provider before taking SAPHRIS?

Tell your healthcare provider if you have or have had:

- Diabetes or high blood sugar in you or your family. Your healthcare provider should check your blood sugar before you start SAPHRIS and during therapy
- High levels of total cholesterol, triglycerides or LDL-cholesterol or low levels of HDL-cholesterol
- Seizures or conditions that increase your risk for seizures
- Low or high blood pressure
- Low white blood cell count
- Certain heart problems such as irregular heartbeats, or if you take medicines that can cause irregular heartbeats, because SAPHRIS should be avoided
- Pregnancy or plans to become pregnant. SAPHRIS may cause harm to your unborn baby. A special program (National Pregnancy Registry for Atypical Antipsychotics) collects information on the safety of antipsychotic drugs, including SAPHRIS, during pregnancy. For information, contact the program at 1-866-961-2388 or visit <http://www.womensmentalhealth.org/clinical-and-research-programs/pregnancyregistry/>.
- Any other medical condition

Tell your healthcare provider about all the medicines that you take or recently have taken, including prescription medicines, non-prescription medicines, herbal supplements, and vitamins. SAPHRIS and other medicines may affect each other, causing serious side effects. SAPHRIS may affect the way other medicines work, and other medicines may affect how SAPHRIS works.

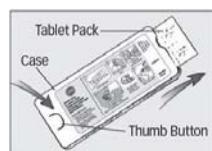
How should I take SAPHRIS?

Take SAPHRIS exactly as prescribed by your healthcare provider.

IMPORTANT:

- For sublingual (under your tongue) use only
- Do not remove tablet until ready to administer
- Use dry hands when handling tablet

Your SAPHRIS tablets



STEP 1. Firmly press and hold thumb button, then pull out the tablet pack.

Do not push tablet through the tablet pack. Do not cut or tear tablet pack.



STEP 2. Peel back the colored tab.



STEP 3. Gently remove the tablet.



Do not split, cut, or crush the tablet.



STEP 4. Place the **whole** tablet under tongue and allow it to dissolve completely.



Do not chew or swallow the tablet.

Do not eat or drink for 10 minutes.

STEP 5. Slide the tablet pack back into case until it clicks.



What should I avoid while taking SAPHRIS?

- Do NOT drive, operate machinery, or do other dangerous activities until you know how SAPHRIS affects you. SAPHRIS may make you drowsy
- Avoid getting over-heated or dehydrated: Do not over-exercise; in hot weather, stay inside in a cool place if possible; stay out of the sun; do not wear too much or heavy clothing; drink plenty of water

What are possible side effects of SAPHRIS?

SAPHRIS can cause serious side effects, including:

- See "What is the most important information I should know about SAPHRIS?"
- **Stroke (which can be fatal) in elderly people with dementia**
- **Neuroleptic malignant syndrome (NMS):** Call your healthcare provider right away if you have high fever, stiff muscles; confusion; changes in pulse, heart rate, or blood pressure; or sweating. These can be symptoms of a rare but potentially fatal side effect called NMS. SAPHRIS should be stopped if you have NMS
- **Tardive dyskinesia (TD):** Tell your healthcare provider if you cannot control the movements of your face, tongue, or other body parts. These could be signs of a serious and sometimes permanent side effect called TD. Risk of developing TD and the chance that it will become permanent are thought to increase the longer a person takes the medicine and the more medicine a person takes over time. TD can develop even after a person has been taking the medicine for a short time at low doses. TD may not go away, even if you stop taking SAPHRIS. TD may also start after you stop taking SAPHRIS
- **Problems with your metabolism, which may increase your risk for heart disease or stroke, such as:**

- **High blood sugar (hyperglycemia) and diabetes:** Extremely high blood sugar can lead to coma or death. If you have diabetes or risk factors for diabetes (eg, being overweight or a family history of diabetes), your blood sugar should be tested before you start SAPHRIS and regularly during treatment. **Call your healthcare provider if you have symptoms of high blood sugar while taking SAPHRIS**, such as feeling very thirsty or very hungry, urinating more than usual, or feeling weak
- **Increased blood cholesterol or triglycerides:** Your healthcare provider may decide to check your cholesterol and triglyceride levels during your treatment with SAPHRIS
- **Weight gain:** Weight gain has been reported with SAPHRIS. You and your healthcare provider should check your weight regularly

- **Serious allergic reaction:** Do not take SAPHRIS if you are allergic to any of its ingredients. Get emergency medical help if you think you are having an allergic reaction. Symptoms may include difficulty breathing; itching, swelling of the face, tongue, or throat; or light-headedness

- **Decreased blood pressure (orthostatic hypotension),** including light-headedness or fainting caused by a sudden change in heart rate and blood pressure when rising too quickly from a sitting or lying position. Ask your healthcare provider about ways to reduce feeling dizzy or lightheaded upon standing, such as sitting on the edge of the bed for several minutes before getting up in the morning or slowly rising after sitting

- **Low white blood cell (WBC) count:** Low WBC counts have been reported with antipsychotic drugs, including SAPHRIS. This may increase your risk of infection. Very low WBC counts, which can be fatal, have been reported with other antipsychotics

- **Increases in prolactin levels:** You may experience a lack of menstrual periods, leaking or enlarged breasts, or impotence, because medicines like SAPHRIS may raise prolactin levels. The levels may continue to be high when SAPHRIS is used over time. Your healthcare provider may do blood tests to check your prolactin levels

Seizures

- **Impaired judgment, thinking, and motor skills:** Do NOT drive or use dangerous machinery until you know how SAPHRIS affects you

- **Increased body temperature:** SAPHRIS may make you more sensitive to heat. You may have trouble cooling off

- **Suicide:** Tell your healthcare provider right away or go to an emergency room if you have thoughts of suicide or of hurting yourself or others. People with schizophrenia or bipolar disorder may have these thoughts

- **Difficulty swallowing:** SAPHRIS and medicines like it have been associated with difficulty swallowing

Common side effects with SAPHRIS include the following:

- **In adults:** sleepiness, dizziness, uncontrolled movements of the body and face, muscle stiffness, weight gain, numbing of the mouth, and restlessness

- **In children (ages 10-17):** sleepiness, dizziness, strange sense of taste, numbing of the mouth, nausea, increased appetite, feeling tired, and weight gain

In addition, patients taking SAPHRIS have reported reactions under the tongue (where you place SAPHRIS), such as sores, blisters, peeling/sloughing or inflammation. Choking has also been reported.

These are not all the possible side effects of SAPHRIS. Tell your healthcare provider about any side effect that bothers you or does not go away.

Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.

Keep SAPHRIS and all medicines out of the reach of children.

What are the ingredients in SAPHRIS?

Active Ingredient: asenapine maleate

Inactive Ingredients: gelatin, mannitol, sucralose, and black cherry flavor

Need more information?

- This page summarizes the most important information about SAPHRIS. Talk to your healthcare provider for more information
- To learn more, go to www.saphris.com or call 1-800-678-1605. Please also see full Prescribing Information at www.saphris.com

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Based on PI SPH28143-F-03/2015
SPH41005 12/15



With current treatments

you can reduce the frequency, severity and duration of episodes.

Friends, family or co-workers are better equipped to notice changes like increased activity, greater inclination to socialize, less need for sleep, heightened irritability, and a general speeding up in speech and movement.

"If you're euphoric, you feel very good but you could be making people around you very miserable by talking incessantly, moving constantly, leaping out of a moving car, or walking into traffic," says Miller. "The family is stressed out while you're on top of the world."

Petri was working as a case manager in a psychiatric hospital when her manic symptoms emerged. Co-workers quickly diagnosed the episode based on her ramped-up restlessness and unusual liveliness.

"All the clinicians were concerned about how I was doing," she says.

It's essential to get psychiatric care as soon as possible, preferably before hypomania escalates to mania. For safety, a full-blown manic episode may require hospitalization because thinking becomes so distorted.

It's also essential to maintain treatment after a first manic episode because it's likely there will be future episodes, says Enns.

"With current treatments you can reduce the frequency, severity and duration of episodes," he explains.

Enns recommends formulating a plan of action with your treating practitioner that goes into effect when symptoms first surface. You can work together on adjusting medications to address mood issues, sleep problems, and anxiety.

By carefully tracking your moods over time, you can learn to identify triggers for and warning flags of a mood episode. For those who experience abrupt onset, Enns notes, preventive interventions can be challenging.

When Petri begins swearing in everyday conversation, she knows mania is looming—even if she takes evasive action in the form of an extra dose of her antipsychotic.

"It seems as though I don't have time to slow down or prevent a full-blown episode. It just happens so fast," she says.

MORE THAN MEDS

Meds are just one thread in managing manic episodes. Buck faithfully takes his medications, but still experiences mild mood shifts. Through counseling and peer support, he's learned strategies like scaling back his social life when he's experiencing hypomania.

Any skills that contribute to staying in balance will reduce the risk of mania. Psychotherapy can provide tools to better cope with life events and aspects of the illness. Self-care, including decent sleep and regular

exercise, plays a huge role in stability.

"Even one night without sleep can lead to mania," warns Miller.

Ryan Griffith adheres to his medication regimen, makes sure to go to bed early, and swims every morning at 5 a.m. Those changes keep his moods in check while he handles a demanding job as exhibit coordinator of the first children's museum in Saudi Arabia and the equally demanding role of dad to a baby daughter.

Another essential change: Sobriety. Although alcohol often acts as a depressant, for Griffith it's tied closely to mania.

Griffith dates the onset of his manic episodes to 2005, when he was a Peace Corps volunteer in northern Thailand. Far from home and quartered in a rural village, he began drinking to excess.

"The isolation of the assignment exacerbated the loneliness, and the primary outlet was alcohol," he recalls. "I engaged in a lot of risky behavior that could have really ruined my life."

The whole cycle "started really spinning out of control" after Griffith and his wife settled in Saudi Arabia, affecting his reputation in their small community and straining his marriage.

Griffith, 35, marvels that his wife "stuck by me" despite behaviors like getting unreasonably angry, inappropriate contact with other women, and crashing his car after a night of drinking.

Those who have family support are fortunate. Petri lived with her father for two years after her initial manic episode. She was touched that he accompanied her to doctor's appointments to learn as much

MANIA in context

Although bipolar disorder was once known as manic-depression, the current designation “bipolar I” is given when someone has a manic episode—no matter what has occurred on the depressive side.

A bipolar II diagnosis means someone has experienced at least one episode of depression and an episode of hypomania. A subgroup of people with bipolar II—about 5 percent over a five-year period—

may go on to have a manic episode, according to psychiatrist Murray Enns, MD. This would change their diagnosis to bipolar I.

A small fraction of those with bipolar I experience only manic episodes when destabilized. Most experience the full trifecta: mania, hypomania, and depression.

The various mood states often abut, so that hypomania may transition

into mania and mania quite typically dive-bombs into depression.

While manic episodes can have severe and dramatic consequences, depressive episodes may prove more debilitating over time.

“In any given year, people with bipolar I and bipolar II spend up to half their time with some degree of depressive symptoms and only 1 percent or 2 percent in mania,” Enns says.

about the illness as he could.

Shapiro enlists her husband to help mitigate the consequences of her manic phases. He has durable power of attorney for her psychiatric care. According to a plan they agreed on together, he makes sure she doesn’t drive and takes away her credit cards.

“The trick is to stick to the agreement,” she admits.

Learning better ways to cope with stress—a notorious trigger for mood shifts—is an important preventive measure. For many, meditation can be a powerful force for maintaining calmness and clarity.

And if you’re feeling too antsy to meditate? That’s when Petri turns to adult coloring books.

Shapiro, a Buddhist, meditates three

times a day. The practice helps her stay motivated to do the hard work of staying well.

“When I [meditate] I am always thinking about others in my life and how they need to be treated,” she explains.

In the past, Shapiro didn’t fully appreciate how her behavior affected others.

“I hurt my husband, my daughter, my in-laws,” she says. “Everything used to be about me..... I’d rather do the work than feel the way I do when I feel manic, and avoid hurting the people I love.” ☀

Donna Jackel, a freelance journalist in upstate New York, has written for BBC Travel, YES! Magazine, the Chicago Tribune, and other outlets.

I engaged in
a lot of risky
behavior
that could
have really
ruined my
life.



Manic episodes are different for everyone. TURN FOR MORE

HIGH TIMES

the question?

Manic episodes are different for everyone. What are your most prominent symptoms during mania? How has your life been affected?

MANIA FOR ME is one extreme to the next. I feel I can accomplish everything. I feel so alive and desirable. I can wake up so high in happiness and energy, but by afternoon my bank account is dwindling and by dinner I'm screaming and angry. I tell people I need time alone, so I don't ruin any more relationships with my angry, manic words and actions. I've lost a lot of my life to mania, more so than from depression. Being consistent with taking meds helps tremendously.

Jami Hollibush
ILLINOIS

MY MOST PROMINENT hypo/manic symptoms are extreme irritability that comes out of nowhere, recklessness, and a pronounced increase in interest in the opposite sex. It is a challenge to temper the irritability during frustrating parenting moments, but I'm getting much better at recognizing it as a symptom, lowering expectations, and taking time out for myself. Being a single parent naturally restricts my ability to date, which keeps my libido from getting me into too much trouble! As for the recklessness, I make sure I put on my seat belt and slow down.

A.C.
CHICAGO, IL

MANIA TO ME is all about loss. I have lost my marriage and livelihood due to extreme manic episodes. I have permanently lost memory from the ECT used to treat it. I have lost time which might have better

been spent enjoying my children. There is an upside to all of this loss, however. I have become very grateful for the times that I am stable. My mania and the agitation that comes with it have motivated me to keep being compliant with my medication regimen. Mania has driven me into treatment that has literally saved my life.

Raymond Jensen
NORFOLK, VA

MY MANIA IS wanting to be left alone. I don't want to be bothered, just be on my own getting over whatever it is that burns my biscuits.

M.R. via 

... I'm getting much better at recognizing [irritability] as a symptom, lowering expectations, and taking time out for myself.

I EXPERIENCE MANIA or hypomania in a variety of ways, but many center around the urge to feel good/self-importance. I become obsessed with things, absurd things, convinced that they will change my life and make it better if only I bought this/did that/cleaned this/ran for this long. I also lose sleep, spend hours cleaning or writing at odd times, speak fast, lose perspective, and go on shopping binges. Again, most of that becomes, "This will make everything okay!" It's frustrating at times because of its unpredictability.

Stacie Hanson
LONDON, ON

AS A CHILD and young adult, I was normally afraid of everything; i.e., swimming, riding a bike, skating, driving a car, etc. When I was in a manic episode, I lost all fear and was able to take walks at night.

Carole Silverman
CULVER CITY, CA

MANIA FOR ME is forgetting what I've said, spending money on things I really don't need, or gambling. It's also the feeling of YOLO [you only live once], and I don't give a damn about the consequences of my actions. I've gotten into a lot of debt and trouble because of this, but more importantly, I've done damage to my relationships with my parents and my loyal-but-frustrated-with-me partner. I also can't hold down a job longer than a month because I keep making mistakes, forgetting things, and fail to get a basic grasp of things because I rapid-cycle so much.

Ashlea Stephens
MELBOURNE, Australia

MY MANIA IS angry and fun and energetic at the same time.

Y.K.F. via 

MANIA THANKFULLY IS an infrequent visitor in my life. I have had only four manic episodes in 15 years. Mania scares me to death. I hate the loss of control. Give me depression any day.

Patti Breon
SUNBURY, PA

I talk so much and tend to attract people from being the funny and interesting guy or from starting arguments.

RECKLESS SPENDING. Two new coats instead of one, three new tops instead of one. Wanting to take on a new hobby or project and do it to the max—staying up through the night to do it—spending money I don't have on that new hobby. Excessive “housework” where normally I wouldn't want to do it. Feeling extremely energized where normally I am lethargic and more “down.” Overly sexualized behavior—unusual for me.

M.A.
UNITED KINGDOM

MANIA FOR ME is months long. Seasonal. I can't tell, and will argue if you bring it up. It can vary from feeling like I can hug the world, to being a cold narcissist, to cheating and lying. I rarely sleep or eat and as a guy will wear makeup and change my look. I talk so much and tend to attract people from being the funny and interesting guy or from starting arguments. In my last few manias I ended up psychotic. I thought I was president/a mafia boss/etc. It's humiliating after. I am educated and employed, and my reputation suffers.

Matt S.
BURLINGTON, VT

I HAD SO MUCH ENERGY. I was jumping out of bed early, grabbing my list, crossing things off, adding more things, getting those done, staying up late and making more lists for the next day. As a new mother with a full-time job it was the absolute best. I convinced myself that I didn't need to sleep on Saturday nights. It was like a present: an entire eight hours of free time! Needless to say, I found out the hard way, that schedule doesn't work for me or my bipolar.

A.W.
LOUISVILLE, KY

MY MANIA HAS two flows. I feel super-powered and energized in the night. I can't rest because of the megalomaniac ideas and racing thoughts. Everything is amplified. In consequence, during the day I feel irritated and hypersensitive to sounds or body contact. It's like having electricity in my veins. In the night it's a good sensation, but in the day it's unpleasant and hard to manage.

F.G. via 

IMPULSIVE, CAN'T STOP cracking jokes, socially inappropriate, taking risks. In the past people just called me brave, funny, or not afraid to stand up for myself. I did at one point think I had a special relationship with God. Sometimes I spend too much on projects I may never do. I have put myself in some very risky situations. One time I was going to marry a man I hardly knew and go off to New Zealand (where he was from) to raise sheep for a living. Now, that I can see is a bit manic.

Patricia Perez
TARPON SPRINGS, FL

WANT TO PARTY, spend money, talk so fast I can't get the words out right, tons of energy.

M.K. via 

Visit bphope.com for the next **SoundOFF!** topic



National Network of Depression Centers

The National Network of Depression Centers (NNDC) is a nonprofit research consortium dedicated to improving the lives of those living with depressions and bipolar illnesses.

The NNDC approach mobilizes large-scale, collaborative efforts to work towards three primary goals:

Advance scientific knowledge

Develop evidence-based care practices

Reduce stigma through education and outreach

NNDC Member Centers



● Center of Excellence
● Associate Member Center

To learn more about our Member Centers or to support the NNDC mission, visit nndc.org or find us on social media.



FINDING BALANCE



ROUTINE MAINTENANCE

Keeping to a **regular schedule for daily activities** lays down a sound foundation for wellness

BY SASHA KILDARE

TOTING MY WORKOUT BAG, I pass a co-worker in the hallway who remarks, “You are so good about exercising.”

I muzzle myself to keep from voicing my instant reaction: “Fear of psychosis is a pretty good motivator!” Instead, I smile and say, “Too much sitting.”

I’m faithful to my exercise routine—30 minutes of intense

activity, six days a week—because it helps me sleep through the night and combats the tentacles of depression. Two other simple routines have kept me from flirting with mania for years: Taking my medication by 10 p.m. and getting to bed by 10:30.

It turns out there’s a lot of science to back up the importance of regular daily habits when you live with bipolar disorder. In fact, some researchers have suggested that bipolar links to an “underlying circadian pathology.” (See box on Page 33.)

A bit of background: Circadian rhythms are biological cycles that occur roughly every 24 hours. They are governed by a countless array of individual “clock genes” throughout the body as well as a “master clock” in the brain called the suprachiasmatic nucleus (SCN).



Greg Murray, PhD, a leading researcher into bipolar and circadian rhythms, describes it this way: "The circadian system is like the drummer in a band. Everyone in the front line can play their solos and melodies, but if the drummer is unreliable, the people in the front line can't engage with the audience and be present."

Murray, who is a professor at Swinburne University in Melbourne, Australia, uses phrases like "arrhythmic" and "prone to dysregulation" to describe the circadian system in people with bipolar.

for his blog, Insights from a Bipolar Bear. On weekdays he walks five miles to the public library—getting in exercise and exposure to natural light, which are both important in regulating mood—and works on his novel from noon to 5 p.m. He also sets aside time to keep up with other writers and current events.

"During the week, I try to read two hours' worth of blogs—one hour before breakfast and one hour after dinner," he says.

Through his participation in Weight Watchers, Shreve learned to plan meals in

That first meal of the day and the last meal of the day are very important. When you exercise, in terms of regularity, is vital.

DAVID J. KUPFER, MD

In another colorful metaphor, he urges the need for scaffolding—in the form of daily routines—to shore up the shaky mechanism and achieve a good quality of life.

"The regularity of activity, separate of the types of activity ... keeps the body clock in tune," he says.

The power of regularity was demonstrated in a recent British study of flight crews who regularly cross multiple time zones. Keeping to a regular schedule of meals on days off was shown to reduce jet lag irrespective of sleep habits. The researchers noted that eating meals at appropriate times in the light-dark cycle helps synchronize the circadian system.

Brad Shreve of Los Angeles, CA, has structured his life around regular meal-times and a strict schedule for his writing activities.

On Sundays, he writes most of the posts

advance. He preps breakfast and lunch the night before, which makes it easier to eat at the same time every day.

HABIT FORMING

The bottom line: Regular habits help regulate the running of your biological clock.

"Everything we do sends messages to the brain. Every activity affects body temperature, cortisol levels, and more," explains David J. Kupfer, MD, a distinguished professor emeritus of psychiatry from the University of Pittsburgh Medical Center.

"That first meal of the day and the last meal of the day are very important. When you exercise, in terms of regularity, is vital. You should take naps at the same time."

In some ways, Kupfer says, "doing everything at the same time every day ... can be just as powerful as taking medication."

But what if sticking to a routine doesn't come naturally? That's when sensible goal-setting comes into play.

Articulate the change you're aiming for—eating a healthy dinner every evening at 6 p.m., for example—then break it down into manageable steps that will move you in that direction.

Setting goals that are too hard to meet is setting yourself up for failure, warns Louisa Sylvia, PhD, an assistant professor of psychology at Massachusetts General Hospital and author of *The Wellness Workbook for Bipolar Disorder*.

"A big chunk of the work we do is understanding what are realistic goals to achieve and how to reward yourself appropriately," says Sylvia, adding: "Learning how to reward yourself takes practice like any other new skill."

Sylvia recommends basing your desired changes on what you are already doing and building up routines slowly, extending bit by bit as each new behavior becomes more established.

"I always want people to realize that they are probably doing more activity than they realize, such as changing their clothing or walking upstairs," she says.

Take Shreve as a case in point. His structured life of today looks far different from the period following his diagnosis more than a decade ago.

"I kept my list really short. Wake up. Go to post box to get outside. Take a shower. Dress.... Doing those four things would be a full day for me at the time."

He adds, "I am lucky in that I married someone that is a huge cheerleader for the whole thing. He helped me establish a good schedule, especially in the beginning, and would double-check to make sure I was doing those things."

It's essential to not get discouraged by slow progress or setbacks.

As Kupfer points out, "Any chronic condition requires you to buy in and take

ownership. You have to be able to control your own changes in establishing routines and learn what goes well and what doesn't go well."

OBSTACLE COURSE

Establishing consistent daily routines is especially challenging when your work schedule doesn't cooperate.

"People with bipolar disorder tend to be creative and not to like routine, so they can be attracted to jobs with tight deadlines like musician, cook, or journalism—jobs that don't have routines built in," Murray says.

When Murray counsels musicians who are having trouble with their moods, he asks them, "What is it about being a musician that you value, and how do you protect that while you make some changes?"

Brainstorm ways to break down the day, such as scheduling music students and personal practice in a regular block every morning and setting a time in the afternoon to answer emails and arrange gigs. Additional planning can address how to handle disruptions like late nights and time on the road.

Mauricio, a tennis teacher and coach in Southern California, has a hectic schedule between his various tennis jobs and attending college part-time. His workout and

The regularity of activity, separate of the types of activity ... keeps the body clock in tune.

GREG MURRAY, PHD

end-of-day routines keep him on track, along with a daily meditation practice.

Mood shifts present another obstacle to sticking with your routines. If motivation lags during depression, Murray recommends a two-prong approach: cognitive and behavioral.

Cognitive strategies involve training yourself to notice critical self-talk and other negative thoughts and countermand those defeatist notions. On the behavioral side, Murray recommends sitting down with someone—a friend, therapist, or partner—to plan in a diary what you will do every hour over the next week.

"The next day, you're by yourself, you

look at your schedule, and the decision has been made. There is nothing to decide. When we're depressed, one of the things that keeps us stuck is indecisiveness," Murray says.

The challenge with mania or hypomania is taking on too many activities. A good question to ask: "How many new plans have you got at the moment?"

Murray recommends giving permission to someone you trust to let you know when your behavior hints at elevated mood.

Mauricio credits the awareness that comes from regular meditation with letting him know when it's time to cut back on commitments so that he doesn't head

CIRCADIAN RHYTHMS

Circadian rhythms are physiological changes that follow a roughly 24-hour cycle. ("Circadian" means "around a day" in Latin.) Research has shown that some of those daily oscillations, including basal body temperature and certain hormone levels, look different in people with bipolar than in the general population.

That's one clue that bipolar disorder may link to irregularities in the circadian system.

Such a link would explain "high day-to-day variability in activity and sleep timing" in people with bipolar, reports Isabella Soreca, MD, of the University of Pittsburgh Medical Center, as well as "persistent disturbances of sleep or wake cycles."

In other words, having bipolar goes along with a tendency toward day-to-day shifts in when you get hungry, when you feel most alert, what time you go to bed, and how long you stay asleep.

Another clue: The body's "master clock," the suprachiasmatic nucleus (SCN), has a direct connection to the eye's retina and responds to light signals. People with bipolar appear especially vulnerable to such cues. For example, seasonal changes in length of day and crossing time zones count among common triggers for mood shifts.

... we talk a lot about the importance of structure and routine. It's foundational.

SARA LAPSLEY, MA

toward mania or depression.

"All it takes is 10 to 15 minutes to be able to sit still in a place where there is not a lot of stimulus, mind my breath, settle into where I am sitting, and let my mind go away from the rush of thoughts and into breathing," he says.

END-OF-DAY ROUTINES

When it comes to regular routines, getting your "sleep-wake cycle" in order plays a huge role in wellness.

Many of the standard recommendations from sleep specialists keep your circadian rhythms in synch, including getting up at the same time even on weekends and going outdoors early to absorb morning light.

Evening rituals for winding down train the brain to prepare for sleep. Popular methods include having a cup of herbal tea (chamomile is documented to have a sedative effect), taking a hot bath (the rise and subsequent drop in your body's baseline temperature appears to promote sleep), and listening to calming music.

Mauricio has a number of strategies to help him relax. He might stretch for 10 minutes using a foam roller or do breathing exercises to release physical tension. He might make a to-do list for the next day on a whiteboard or piece of paper so he won't continue to fret.

"If I lie down with a tense body, if something is bothering me, I will be

restless," he explains.

Mauricio started learning about healthy behaviors and stress reduction while participating in a research program at University of California-Los Angeles. Weekly visits with a psychologist help him to maintain and build on what he learned.

Recruiting support for lifestyle changes can only help. There's actually a specific therapeutic approach called interpersonal and social rhythm therapy that was developed to help people with bipolar cope with circadian disruption. However, the tenets of rhythm therapy have spread into many other settings.

"In group treatment, we talk a lot about the importance of structure and routine. It's foundational," Sara Lapsley, MA, says of her counseling work at a psychiatric hospital in Vancouver.

Before her own bipolar diagnosis in 2001, routine was not in Lapsley's vocabulary. A former punk rocker and veteran of the Vancouver music scene, she was no stranger to chaos. These days, Lapsley finds that rehearsing twice a week with her band, the

PRNs, gives "rhythm to the week."

She shares her personal wellness journey with the people she counsels to emphasize how regular habits help control mood shifts.

"Most people have had devastating episodes.... If stability can offer some protection against reoccurrence of an episode, it's a small price. It's more fun to live an unfettered life, but ultimately structure and routine pay off." ●

Sasha Kildare, a freelance writer and occasional standup comic from California, has completed a novel about addiction and bipolar disorder titled Dream Walking.

SYNCHING YOUR SLEEP

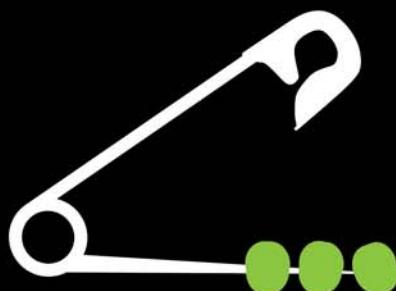
Fluctuating levels of melatonin, a hormone made by the pineal gland, direct the body's sleep-wake cycle—when we feel ready for bed or ready to start the day. The system is governed by light signals. Melatonin levels start to rise as night falls, preparing us for rest. Production shuts down in the morning so that we'll feel more alert.

Exposure to bright light early in the day contributes to better sleep by synching the melatonin "clock." Keeping the house dim as you approach bedtime—and avoiding use of electronic devices with "blue light" screens—allows the melatonin cycle to follow its natural pattern.





When you feel like you have no one to talk to, know *I'm here...*



I'm here...

DBSAAlliance.org/ImHere
#ImHereDBSA

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Spreading Awareness

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Depression and Bipolar
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CHANGE AGENT

Lauren Burke has been honored as a champion for social justice. Her bipolar diagnosis was a heads-up to address her own pain, too.



By Michelle Roberts

At 33, Lauren Burke has an eye-popping list of achievements. That's due to an almost obsessive drive to help those less fortunate than herself—the product of a deep empathy forged in bipolar depressions, combined with hypomanic energy and self-confidence.

Burke's passion crystallized at Connecticut College when she couldn't stop dwelling on world problems and how she might help solve them. After her graduation from the New York University School of Law in 2009, she used her fluent Mandarin to represent youth trafficked to the U.S. from China. Her work inspired the 2011 documentary *Walking Merchandise*.

In 2012, Burke launched Atlas: DIY

(Developing Immigrant Youth), a Brooklyn-based empowerment center for young people regardless of country of origin or documentation status. The cooperative organization provides free legal resources, career and college prep, and arts enrichment activities.

And those are just a few highlights from her resumé. Her activism and accomplishments earned Burke two prestigious

fellowships—and landed her on *Forbes* magazine's "30 Under 30" list of young movers-and-shakers in January 2013.

That may sound mind-boggling to people whose bipolar disorder is profoundly disabling. One of Burke's coping methods: "complete denial." Yet she wasn't immune to the debilitating effects of her undiagnosed condition.

Three years after being celebrated in *Forbes*, a column titled "This '30 Under 30' Wants the World to Know She's Bipolar" appeared on *Forbes.com*. In this "coming out" letter to the world, Burke writes about keeping her panic attacks and mood symptoms secret because she felt she had to appear strong for her staff, clients and funders.

"The world celebrated my accomplishments by day while I felt like I was drowning at night," she reports.

Behind the closed doors of her New York City apartment, she sought ways to numb her racing brain and bruised heart. Netflix binges were the mildest form of temporary relief from feelings she didn't discuss with others or even acknowledge to herself.

Getting a diagnosis that explained her overwhelming emotions and bouts of low mood—and the promise of more positive ways to manage them—opened the door to a new way of being.

"We treat our emotions as some disease to eradicate," she writes, "when instead they are what make us alive."

EMOTIONAL TOLL

Burke grew up in the college town of Amherst, Massachusetts, the elder of two girls. Her mother is a college professor and her father is a financial planner. She started

studying Chinese at a young age, and lived in China for a year in high school to practice the language.

In retrospect, Burke can identify moments that hint at bipolar. She was dubbed too “hyper” to be invited to some birthday parties and remembers causing “lots of scenes” as a kid.

“I did a ton of activities,” she recalls. “I never sat still. I did all the sports.”

She experienced her first suicidal ide-

During law school, she spent a summer in China researching access to treatment for children living with HIV/AIDS. When swamped by irrational guilt, she would have thoughts such as, “I don’t deserve a nice coffee because there are children who can’t afford their AIDS medication.”

Later, her work on child trafficking issues triggered a more extreme response: worrying at her forearms. “It was a physical reaction to the feelings I was feeling, my

Eventually the lows refused to retreat. In January 2016, Burke’s longtime therapist referred her to a psychiatrist, who diagnosed her with bipolar II.

“It had gotten really bad, and I was in this more stuck, gray place than I’d been in a long time,” she explains. “By mid-January, I thought, ‘I’m not coming out of this funk. It’s affecting my day-to-day life.’”

Soon after the psychiatrist’s verdict, Burke decided that staying silent would only further the stigma around living with brain-based illnesses.

“I’d been trying to keep [my mental health issues] secret for so long, but when there was a diagnosis I wanted to come clean about it,” she says.

Burke says her very public disclosure was also a way to own her vulnerabilities so that others would feel more empowered.

“I am in such a privileged position that it’s important for me to shed light on my own imperfections to make others feel better about theirs,” she says. “I wanted to break stigma. If a *Forbes* ‘30 Under 30’ can come clean about their bipolar disorder, then anyone can.”

It's a diagnosis I'm learning about, and I'm still learning the best ways to cope with it, but it's a part of who I am.

ation when she was 10 years old, during a seemingly idyllic stay at summer camp.

The obsessive thought patterns that can accompany bipolar were also present early on. After watching *Fried Green Tomatoes* as a girl, she fixated on the movie’s depiction of homelessness. She slept outside her house, crying, because she didn’t think she deserved a bed.

At college, she ran the East Asian Studies Student Advisory Board, was captain of the rugby team, directed plays, and was an admissions fellow. But the weight of real-world problems could devastate her.

“I couldn’t stop thinking about wars and famine, and getting really depressed about it,” she says. In her *Forbes* essay, she describes her low points as an “endless parade of hopelessness at its worst ... of wishing the world would end humanity’s suffering.”

For the most part, Burke took those dark feelings and channeled them into action. Yet her good works often took an emotional toll that ended up deepening the shadows.

HAVING A BALL Burke plays host at a benefit gala for Atlas: DIY. Running a nonprofit calls for a different skill set than practicing public interest law and teaching at Brooklyn Law School.

anger at myself,” she says.

Medications helped her control that behavior, but she found another self-destructive outlet in alcohol. She saw so much pain in her job, “but I wouldn’t let myself process or feel sad with it,” she explains. “If I was drunk, it seemed OK to cry.”





'SECOND LIFE'

Burke circulated the column at *Atlas: DIY* before it was published.

"I finally had to recognize with my staff the way [bipolar] impacted my work," she says. "I would snap at my staff and that was in part because of bipolar."

Burke has been graced with other insights as she reassesses herself and her past in light of her diagnosis.

"In retrospect, I can see how this illness has always been at play in my life, particularly in my bouts of depression, but also in having a lot of energy and really being able to get a lot done," she reflects.

"It's a diagnosis I'm learning about, and I'm still learning the best ways to cope with it, but it's a part of who I am."

Some parts of herself have been changing for the better. For one thing, she's more willing to ask for help and not try to go it alone. For another, she experienced a major breakthrough during a yoga retreat—finally accepting that she's a person "worthy of love."

"I used to believe that I had a black heart," she recalls. "The world thought I was shiny, but inside I knew I was black and dark. But then I had a vision of the black heart cracking open, and there was a big diamond inside."

"That was the beginning of my journey to start to love myself, or at least thinking I didn't deserve to treat myself as [badly] as

I had been," she recalls. "We also had to write a letter to someone that we'd wronged in the past. I wrote the letter to myself."

Burke now has a diamond tattooed on her right forearm, where she used to self-harm, as a symbol of her transformative revelation.

Since her diagnosis, Burke has been evaluating how she wants to move forward. She's making plans to move to the Hudson Valley. She describes it as "looking for a smaller life."

Although she loves New York City, she is trying to honor her diagnosis by finding an environment with "fewer stressors and

FINDING BALANCE Burke has a strategy for her daily yoga practice: Do at least five minutes, then see if she feels like continuing. She's pictured in Tree Pose overlooking the Cape of Good Hope in South Africa.

triggers. I don't want to work all day and then get on a subway with people screaming at each other," she says.

That means leaving her brainchild, *Atlas: DIY*, but she's ready to help the world while also tending to her own needs. For starters: write a book about how to create social change. And open a consulting business, *The Possible Lab*, to help organizations and individuals do just that.

She still wants to fight injustice, but, "I also want to get a typewriter and write outside every day."

She's approaching this major shift in her life with characteristic can-do élan:

"When I was younger I thought I'd have everything figured out by now, and I thought you had this one life," she muses. "I had this first life and it was great, tumultuous and hard and beautiful, and now I get to have this second life, and I'm really excited about that." ☀

Michelle Roberts is a freelance writer based in St. Louis. A past recipient of the Rosalynn Carter Fellowship for mental health journalism, she is pursuing a doctorate in counseling and family therapy.

Lauren Burke's coping tips

Here's a short list of what helps Lauren deal with stress and stay in balance:

CHILD'S PLAY: I get such wonderful energy from hanging out with children and playing and bringing back my childhood. Hanging with my friends' kids, face painting, playing tag, just experiencing that childlike wonder is great!

COMIC RELIEF: Reading *Calvin and Hobbes*—always.

PET THERAPY: I have two wonderful cats, Muffin and Pumpkin. Pumpkin sleeps under my arm every night, which grounds me at the end of the day.

STRIVE FOR FIVE: Sometimes doing a whole hour of yoga will frustrate me, so I try to commit to five minutes a day, then do longer if I feel like it. YouTube has tons of great yoga videos for free.

NATURE NURTURE: My mom has an amazing lake house in western Massachusetts where I try to spend a few weekends every year totally alone. Cooking from the local co-op, having coffee and reading on the dock in the morning, and getting comfortable with my own thoughts is really rejuvenating.

Eat better, feel better!

We are what we eat may be a cliché, but it's true! According to the Centers for Disease Control and Prevention, more than 68 percent of all Americans are considered overweight or obese. People with bipolar disorder are not alone in their tendency to reach for fast foods, simple "carbs," and caffeinated energy drinks. Eating better could help you feel better!

How does eating processed foods affect my body?

Several large studies have shown that dietary patterns high in processed foods and simple sugars are associated with increased incidence of depression, whereas diets high in whole foods like vegetables, whole grains, and fatty fish are associated with reduced incidence. Research indicates that the unfavorable nutrient ratio in processed foods contributes to the body perceiving that it is in a chronic state of inflammation; in other words, you feel lousy.

Inflammation is a normal immune response, and it's usually a good thing: acute inflammation after injury or infection is the body's attempt to heal itself. Chronic inflammation, on the other hand, is when your body no longer has the ability to turn off the inflammatory response and it starts damaging healthy tissue in your body and sending signals to your brain that can influence neuronal circuits to depress your mood; some studies have shown that inflammation can actually lead to depression. Chronic inflammation also has been linked to a higher risk for so-called lifestyle diseases like diabetes and heart disease.

Can you explain "good" vs. "bad" fats?

The benefits of omega-3 fatty acids, a polyunsaturated fat found most abundantly in some kinds of seafood, nuts, and seeds,

are well publicized. These "good fats" have been shown to *combat* inflammation. Less talked about is the ratio of omega-3 and omega-6 fatty acids in the modern diet. Although omega-6 is also a polyunsaturated fat, excessive levels may *contribute* to inflammation in the absence of adequate omega-3s. Vegetable oils used to manufacture processed foods, including safflower, corn and, soybean, are a common dietary source of omega-6.

The evidence that diets of individuals with bipolar disorder are of lower quality overall comes from research in which participants were asked to maintain a food diary; subsequently, dietary elements in the blood were measured. Analyses found a lower intake of polyunsaturated fatty acids and a greater amount of saturated fatty acids—the "bad fats" found in whole-fat dairy foods, fatty meats, and palm and coconut oils. Furthermore, omega-3 was disproportionately reduced compared to omega-6. High levels of omega-6 relative to omega-3 are associated with inflammatory states and have been shown to be unfavorable for mood disorders and other health conditions.

How can I improve my diet?

Here are some tips for better eating:

- Avoid mindless snacking. Practice mindful awareness of each bite. Think about *why* you are eating right now as well as *what*. Bored? Restless? Maybe a walk around the block is what you really need.
- Plan ahead. Many people with bipolar are prone to impulse buying, so thinking ahead about meals and making a shopping list can be very helpful. Keep fruit handy on the counter, carrot sticks prepped and ready in the fridge. Carry healthy snacks with you to cut down on fast-food stops.



Simon Evans, PhD, is a research assistant professor in the Department of Psychiatry at the University of Michigan School of Medicine, where his current research focuses on dietary intake and metabolism in bipolar disorder, including effects on the gut microbiome and psychiatric outcomes. He holds a PhD in molecular and cellular biology and a master's degree in nutritional sciences.

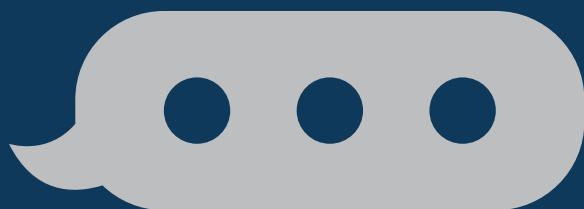
- Shop smart. When shopping for groceries at a large store, shop around the *outer* sections first—that is where the healthier foods are typically found. Be selective on items in the middle of the store, and read labels. Locate a farmers' market and explore it and ask questions.
- Keep a food diary. As an exercise in mindful eating, write down everything you eat or drink for a few days (there are several freely available smart phone apps to make this easier). Often just the simple action of being aware of what you are putting in your mouth is enough to spur you to make wiser choices.

Bon appétit! ☺

ASK THE DOCTOR Is there a question you would like to see addressed in this column? Email your questions to mailbag@bphope.com.



Hey, can I tell you something? I really need to talk to someone right now.



How you respond **MATTERS**

Be informed. Be a friend. Be...

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My partner in recovery

I met my husband in 1997. He was 19, I was 18, and the Internet was barely a thing. Neither of us had a cell phone or an online dating profile. There was no swiping right or left. There was only invested, real-life, emoji-less conversation. We spent three years talking—in person, by phone, via letters with stamps—before we ever began dating, and by the time we finally did become a couple, we were both already in love.

I was never one of those girls who fantasized about her wedding day. Rather, I fantasized about traveling the world, writing books, and prosecuting war criminals. In short, marriage was never a goal of mine. Nonetheless, I'd stumbled upon a man whom I loved more than anyone I'd ever met, and I wanted to spend the rest of my life with him. So I went for it, and in 2002 we got married.

At the time, neither Matthew nor I had any idea that I had bipolar disorder. It wasn't until six years into our marriage, after an acute manic episode and a psychotic break, that I was finally diagnosed with bipolar I.

Looking back, it's clear to both of us that I had been struggling with this illness for more than a decade. But apart from some mildly debilitating bouts of depression, I had also managed to remain relatively high-functioning during those same years: to graduate law school, pass the bar exam, earn a master's in public health, publish my first book, make friends, hold down jobs, and maintain strong and healthy relationships that whole time.

But mania and psychosis hit me hard. I'd never before experienced delusions, but while manic, my mind tricked me into believing that I could fly, that I'd won the lottery, and that I was a prophet. For the first time in my life, I had truly—and, some feared, irretrievably—lost my mind.

But Matthew had faith that I could come back from this. A researcher and

statistician by trade, he is the most intelligent, rational, and curious person I know. So, true to form, he studied up, refusing to reduce me to a pile of symptoms. The more he learned about bipolar disorder, the more he was able to separate me from a diagnosis that, while valid, did not and could not *define* me. Matthew's unshakable faith in my ability to battle adversity helped me travel the road to recovery.



Melody Moezzi

with invaluable hard-won wisdom. Thanks to Matthew's tireless encouragement, I landed in a place where I could learn from others' mistakes and successes in order to avoid and create my own. Suddenly, recovery felt possible.

Matthew and I have now known each other for more than half our lives, recently celebrating our 14th wedding anniversary. While every marriage is different, I have learned a few things over the years about what makes a marriage work, especially in the face of chronic illness.

For us, it's about love, respect, gratitude, friendship, honesty, laughter, and faith. Because we believe in each other—especially when one of us isn't able to believe in her- or himself—we've managed

[My husband's] unshakable faith in my ability to battle adversity helped me travel the road to recovery.

He dragged me to my first Depression and Bipolar Support Alliance (DBSA) group, for example, shortly after I was released from the hospital. When I asked why he wanted to go so badly, he replied, "The data are fantastic!" He showed me journal articles, full of charts and graphs, and I agreed to go—not because of the data, but because of *him*.

Matthew had stood beside me through this horrible ordeal, and I figured that going to a few support groups was the least I could do *for him*. But those meetings did more *for me* than I had ever imagined they could. In fact, they helped save my life, proving to me not only that I wasn't alone, but that I was in good company, brimming

to face life's adventures and challenges, including bipolar disorder, as a unified front. At times, his belief in me has been the one thing to get me believing in myself again—and the same has been true for him. Whether it's a spouse, a sibling, a friend, or a parent, having someone who believes in you can make all the difference when it comes to recovery. It has for me. ☺

*Melody Moezzi is a writer, attorney, activist, speaker, and award-winning author, most recently of *Haldol and Hyacinths: A Bipolar Life*. She lives in North Carolina with her husband, Matthew, and their cats, Keshmesh and Nazanin.*

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Could be habit-forming

For many of us, New Year's resolutions are as easy to break as they are to make. To help your promises become part of the program, clinical psychologist Josh Klapow, PhD, recommends the "SMART" strategy:

SET SPECIFIC GOALS. Rather than committing to get fit, pledge to walk five minutes daily. Increase a minute a week until you're walking 30 minutes a day.

MONITOR YOUR ACTIONS. Tracking workouts on a calendar increases the likelihood that you'll continue.

ARRANGE FOR SUCCESS. If you're an a.m. exerciser, lay out clothes the night before.

RECRUIT SUPPORT. Share your efforts with friends who will cheer your achievements and nudge you past setbacks.

TREAT YOUR ACTIONS. Rewarding yourself for reaching milestones helps you convert resolutions into habits. Movie, anyone?

Free your mind

The key to banishing negative thoughts is challenging them, according to Ora Nadrich, author of *Says Who?* She recommends asking yourself pointed questions such as:

"HAVE I HEARD SOMEONE SAY THIS BEFORE?" If you're echoing something hurtful your boss said, acknowledging the source separates you from the thought.

"DOES THIS THOUGHT WORK FOR ME?" A sure way to unmask counterproductive blanket statements ("I'll never get a job.").

"DO I WANT TO KEEP THIS THOUGHT OR LET IT GO?" Consider whether it's worth latching on to thoughts that serve no purpose.

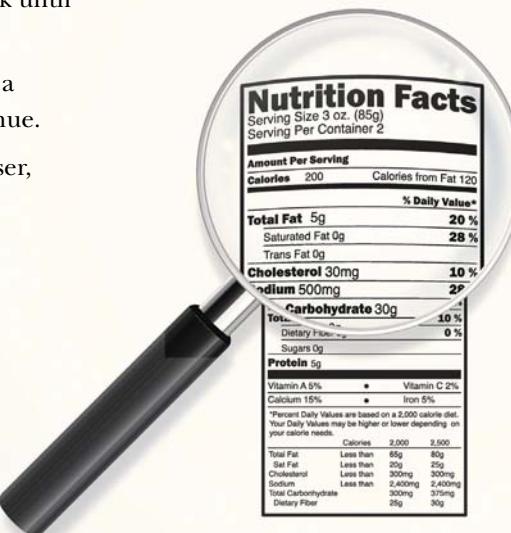
Good-for-you convenience

Packaged meals come through in a pinch, but it takes sleuthing to find healthy options.

Start by reading ingredients, advises registered dietitian Kathy McManus. You should see real food on the list—and the fewer ingredients, the better.

Next, check out the nutrition label. Make a place in your cart only for entrees with:

- 600 or fewer calories per serving
- 5 or more grams of fiber
- 500 or fewer milligrams of sodium
- 5 or fewer grams of saturated fat
- 0 grams of trans fat and sugar



Shut-eye solution

When you have trouble falling asleep, try 4-7-8 breathing.

With eyes closed, inhale through your nose to a mental count of four. Hold your breath for seven counts; exhale through your mouth for eight. Repeat the cycle three more times.

Since deep breathing curtails the production of stress hormones, this technique serves as a natural tranquilizer when you're feeling anxious, too.



Unexpected signs of depression

Depression can make us weepy, sad, and needy—but did you know it can also make us really irritated, unloving, and restless? So many of my relationship problems stemmed from the negative filters of depression. I didn't even know that I was an incredibly positive person until my depression was brought under control.

SIGN #1: IRRITATION

Irritated depression makes me kick and punch things, have terrible road rage, see the dirt of the world instead of the beauty, and experience the most caustic, negative, and judgmental thoughts you can imagine. It's awful. I'm a witch. It's as though I put on negativity glasses and the lenses make it impossible for me to think a nice thought or say a nice word.

SIGN #2: CAN'T FEEL LOVE

Weepy depression takes away my ability to enjoy the people I love. Instead, I worry about their health, whether they love me, or if I am going to lose them. Unloving depression is the opposite. I don't feel the love! I just want them out of my life because they are such a bother. I left my first husband during an unloving depressive episode. I thought I didn't love him. I woke up one day and my love was just gone. This was almost 10 years before I was diagnosed with bipolar disorder. I had no idea it was a symptom, and we were both very, very confused as to how my feelings could change overnight.

SIGN #3: RESTLESSNESS

When restless depression shows up, I sometimes feel like my organs are crawling out of my skin. Nothing feels right. There isn't a table in paradise or a couch in the greatest house in the world that feels good. I can't sit, I can't work, I can't enjoy a movie when this depression is around. I drive around in circles and constantly change

what I'm doing. Everything feels wrong.

How did I change? To answer that, I want to tell you a story. More than 20 years ago, I went to a concert with a friend. I was in fine irritable form. I can see it now: I complained about the parking, the sound, the number of steps up to the venue, the weather, and anything else that was on my mind. I had no filter, and no idea that I was in an episode. My friend turned to me and said, "Your negativity is killing me and I can't take it any more. I



Julie A. Fast

needs to be discussed with your health-care provider.

Here is a script you can use when you recognize that depression's negativity is taking hold:

I'm sorry I was just snappy with you. My bipolar disorder is getting to me today and making me negative and unfeeling. I don't want to be this way. I could use your help. My goal is to stay positive even when my thoughts are negative. I will not take my depression out on you. If you hear me say something nasty, mean,

My negative perspective was an offshoot of depression, and once I learned to manage my depression, I learned to manage its negativity too.

am done." She was. Our relationship ended that night.

My friend unknowingly gave me a nugget of information on my path to wellness. But I still couldn't pinpoint why I acted so up and down. I was not in control of my moods and because of this, I could not control my negativity. I wasn't negative when I was younger; this was rather new behavior. I finally got my answer when I was diagnosed with bipolar disorder. Once I learned to manage my depression, I learned to manage its negativity as well.

Caveat: If you also have signs of mania, such as rapid speech, significantly less sleep without feeling tired, and an increase in dangerous activities along with these three signs of depression, this describes dysphoric mania. This is quite different from what I call "negativity" depression and

or unkind, please remind me that depression is talking and I can focus on ending my depression instead of taking my illness out on the world.

I have a challenge for you: If you think this article makes even a small amount of sense, show it to someone who knows you and ask them to be honest. Ask: "Do I seem more irritable/ unloving/restless to you?" Expect to feel angry when they say yes ... and then do something about it. That's what I did. ☺

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A screening test is one of the quickest and easiest ways to determine whether you are experiencing symptoms of a mental health condition. It only takes a few minutes to take a screen, and you can check for symptoms of Depression, Anxiety, Bipolar Disorder or PTSD. These are serious conditions that can affect not only your quality of life but your physical health as well, and the earlier you catch them, the better.

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ADHD or mania?

Clarifying the diagnosis in children

Pediatric attention-deficit/hyperactivity disorder (ADHD) affects 4–8 percent of preteens and 4 percent of those in adolescence and beyond. In children with ADHD, up to 20 percent have a comorbid mood disorder, the most common being major depression. Bipolar disorder affects about 1 percent of adolescents overall and is less common in prepubertal children.

How are pediatric mania and ADHD alike?

Children with either diagnosis may be restless, impulsive, and inattentive. They frequently have poor peer interactions and poor or deteriorating academic performance, and may also have signs of comorbid conduct disorder or disruptive behavioral symptoms, such as oppositionality. They may exhibit difficulties both at home and at school in following rules—but children with ADHD don't follow the rules because they act without thinking; in contrast, children with mania know their actions are wrong but feel that the rules do not apply to them.

How does ADHD differ from mania?

ADHD has a younger age of onset—as early as preschool—and there is a *chronic course* of impulsive, restless, and inattentive behavior. Family history is positive for ADHD in 10–35 percent of cases, and up to 26 percent of kids with ADHD have a family member with a mood disorder. Mood is variable, and people with ADHD do not experience delusions or hallucinations. Speech may be rapid but is not tangential (that is, they don't wander off-topic and never come back to the original thought). They do not have a decreased need for sleep, though they may have trouble falling asleep at bedtime; they may



Adelaide Sherwood Robb, MD, a board-certified child and adolescent psychiatrist, is division chief of psychology and behavioral health at Children's National Health System in Washington, DC. She also is a professor of psychiatry and pediatrics at The George Washington University.

have some loss of appetite due to the effects of ADHD treatment, such as stimulants; and they have a long-term pattern of high-level purposeless energy or hyperactivity. Seventy-five to 90 percent of those with ADHD show rapid improvement when treated with stimulants. Mood stabilizers are not effective for ADHD.

Bipolar disorder is usually the *acute onset* of impulsivity, motor restlessness, and inattention. Only 0.5 percent of youth are diagnosed with bipolar disorder before puberty. In 22 percent of prepubertal children and 18 percent of adolescents with mania, we find a recent deterioration in schoolwork and social activities and a new onset of disruptive behavior. There is a positive family history of bipolar disorder in up to 10 percent of first-degree relatives (parent, sibling, child). Youth with bipolar disorder may have a euphoric or irritable mood, delusions of grandeur, paranoia, and auditory or visual hallucinations. They frequently have pressured and tangential speech (wandering off-topic on different tangents) and are internally distracted with racing thoughts. They have a decreased need for sleep, a marked increase or decrease in appetite with weight change, and often new-onset boundless energy. Treatment with stimulants may increase or decrease their symptoms. Mood

stabilizers can improve symptoms of mania in three to six weeks, depending on the medication.

What do I do for my child who has both?

For the child with ADHD, the time of risk for the development of bipolar disorder increases after puberty. Parents should be paying attention and consulting their clinician if their child with previously stable ADHD develops new symptoms. Multiple studies have shown that *the mood must be stabilized first*; then ADHD medications can be judiciously added back in to the treatment regimen. For parents of teens with bipolar disorder, they may wish to ask about ADHD if their child's mood is stable on medication but he or she continues to struggle academically with poor focus and attention.

Due to the high level of overlap and comorbidity, several academic bipolar experts have examined the key distinguishing symptoms between childhood ADHD and mania. The *cardinal symptoms* of bipolar disorder include elation or euphoria, grandiosity, racing thoughts, decreased need for sleep, and hypersexuality. Referencing these cardinal symptoms helps to distinguish between mania and ADHD. ☀

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What I wish family and friends knew

I don't know a single person with bipolar disorder who doesn't have that one friend or family member who just doesn't get it. They either have no idea about mental illnesses in general or believe they are something you can "fix."

For me, it's more than frustrating; it's downright cruel. You would think your family and friends would be there to support you. Unfortunately, you get the usual confusion and apathy. Or you get the anger.

Here are three basic premises that I wish they knew:

You can't understand my bipolar and you never will.

I'm sorry this sounds harsh, but it's 100 percent true. Unless you have walked a mile in my shoes, there is no way you will ever be able to understand. My depressions are so dark and morbid that they drain me of all my energy. The thought of taking a shower or even just getting out of bed is overwhelming. Depending on how low I get, I honestly contemplate suicide because I can't bear to go on like this. My manias are so wild and unpredictable that irritability and insomnia cause major health issues. Sure, it's nice to have more energy—but not when I can't control my actions. Overspending and grandiosity can get me into major trouble in my financial and social life.

Bipolar depression and mania are far more extreme levels of emotions than you have ever experienced or can even conceive of. Trust me when I say you don't—you *can't*—understand. So don't even try. Just be there.

When I'm manic or depressed, that's not the real me.

Everything is amplified when I'm in the middle of an episode, so it's much easier

for me to say or do things that I wouldn't if I were well. This doesn't by any means excuse anything—bipolar is an *explanation* but not an *excuse*. A lot of outside stimuli are attacking my senses, and it's hard for me to hold back the things I feel compelled to say and do. The fact is, my bipolar affects my ability to react "normally" to the world around me.

The last thing I need is anger and criticism while I'm trying to deal with my



Jess Melancholia

it. They just won't. So for someone to tell you that you just need to do this one thing (practice the Tree Pose, boost your omega-3s) and you won't be depressed or manic anymore is absurd and irresponsible. It perpetuates the stigma that this is "all in your head" and you should be able to "just get over it."

Here's the bottom line: My brain doesn't function the same as everyone else's, regardless of public opinion. But that doesn't mean I am weak. In fact, it means I am much stronger than you think. It takes monumental courage and strength to live life battling bipolar. Every moment

For someone to tell you that you just need to do this one thing ... and you won't be depressed or manic anymore is absurd and irresponsible.

symptoms the best way I know how. My personal catchphrase is, "Don't be ashamed of your actions; learn from them and grow."

Your coping skills won't "fix" me.

While there are plenty of good tips out there for living a well-balanced life, like doing yoga or eating healthy, they do very little if anything to help when you are deep in the throes of depression or mania. Logic and reason go out the window. I fully believe in cognitive behavioral therapy (CBT) and dialectical behavior therapy (DBT) as useful tools to help manage bipolar disorder, but these will not *cure*

I continue breathing, I am winning this fight.

And I will never stop fighting. Having my friends and family stick by my side gives me hope that I can manage whatever happens. Through their strength, I know I have a reason to keep on going.

If they only knew how much their support means to me. ☺

"Jess Melancholia" is a pseudonym for a molecular biologist, writer, and mental health advocate who lives in San Diego, California, with her husband and cat. She writes for her personal blog at bipolarcompass.com.

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Medication and inspiration

By Francisco X. Stork

It almost never fails to happen. When I talk about my experiences with bipolar disorder at one of my book events, someone, usually the mother of a budding artist, will come up afterward, wait until no one is in sight, and proceed to tell me that her son is refusing to take his medication for fear that it will dull his creativity.

What I would like to say to that mother is that if her son truly has bipolar, then whatever he thinks he is doing while in its grip is not art.

That's what I would like to say. But usually I tell people that since I began treatment for bipolar 10 years ago, I've written and published four well-received novels. There were times when I was stuck, unable to write, and times when what I wrote was worthy only of the trash can—but my medication was not responsible for either my lack of creativity or the bad results of my efforts.

As someone who has experienced full-blown mania, it is impossible for me to conceive of creating anything other than gibberish during this state. Mania is a chaotic torrent of disconnected thoughts accompanied by an inflated arrogance of self. To others, the expression of this inner whirlwind is seen as unrestrained, egocentric babble.

I suppose that a young person with a milder form of mania could confuse its electric, undirected energy with the unself-conscious flow of words, ideas and images that we call inspiration. But even this hypomania, in my experience, will not lead to the kind of artistic work that others will recognize as lasting art.

What I want to tell young artists who have bipolar disorder is that medication does not prevent that wonderful, sometimes rare, absorption that seems to take us out of the grips of time. Medication does not prevent the reception of those gift-like intuitions, images, insights that we all depend upon as artists or creative persons.

were a burden they must bear for the sake of their art. Sometimes it seems we carry our mental illness like a badge of specialness that thankfully separates us from all those ordinary accountants, lawyers, IT people and other common folk too insensitive to be unhappy.

I am grateful for the lessons of self and life that bipolar has brought me. But bipolar disorder is still an illness that hurts me and the people I love. I need to control it so that I can create with intelligence, which includes all my mental faculties, including imagination and intuition.

If you have bipolar and use your creativity, the power to generate something new with your mind in any form, here's what you need to know: Your creativity comes from a place deep in you that *is not* affected by medication but which is affected by the illness. The place it comes from is deep in your soul, the same place where you find meaning and purpose in your life.

You will continue to be special and gifted when your illness is controlled. You will be special and gifted and unique like every other human being.

You won't be better than them, it is true. You will have to settle for being useful to them. ☺

*Francisco X. Stork, an author and retired lawyer, lives outside Boston. His young-adult novels *Marcelo in the Real World* and *The Last Summer of the Death Warriors* won awards from the American Library Association, the National Council of Teachers of English, and Latino Literacy Now. His latest YA novel, *The Memory of Light*, draws on his experiences with bipolar depression.*



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Does medication affect my work? Yes. But not nearly as much as the unfettered symptoms of bipolar disorder. I am fortunate enough to have found the right person to help me find the right dosage—a dosage that is monitored constantly and adjusted periodically so that I can function with a minimum of disruption.

It saddens me to hear young people talk about their bipolar disorder as if it

WHAT'S ON YOUR MIND? Share your thoughts in a personal essay and send your submission to onmymind@bphope.com.

Perry Baird was a Harvard-trained doctor, teacher, and researcher who published the first scientific paper arguing that “manic depression” has a biochemical basis. He was also an articulate chronicler of his own bipolar disorder, which took him away from his family in the 1940s. A manuscript that made its way to his daughter **MIMI BAIRD became the basis for her book *He Wanted the Moon*—which Brad Pitt is turning into a movie.**

Your father vanished from your life when you were 6 years old. How was that explained to you?

Back in those days, you just didn't talk about things that were "unseemly." My mother remarried, we moved to a new house, and just lived life as if it didn't happen. I wasn't allowed to talk about my father.

What about his mania-fueled actions before that?

It was not good in my house, but it wasn't discussed. That's the way we coped with unhappiness in those days. You develop a numbness because you don't know how to process things.

And that's why you're passionate about not keeping family secrets?

I suffered for years making mistakes in my own life because I didn't know my father's story, didn't know about the mental illness that was prevalent in generations of my family. When you've experienced silence, you want to empower others to start becoming more forthcoming.

By creating awareness, you can watch younger members of the family for any signs of mental illness. It makes you more sensitive to patterns. You can look within yourself and say, "That's why...." For example, I have a tendency to buy things in multiples—four pairs of shoes instead of one. Now I understand why.

When you finally “met” your father through his manuscript, what did you think?

I gained great respect for him. I was so moved by his ability to write, and that he

was able to write so vividly and beautifully in the environment he was in.

Why did you decide to publish it?

In his manuscript, my father stated three or four times that he wanted his work to be published. There was a tremendous stigma around mental illness, as there is today. He felt that by publishing his writing, people would understand what it was like and that would help defray the stigma. The least I could do as a daughter was to fulfill his wishes.

Twenty years poring over this difficult material—how did that affect you?

It's not easy reading. But I couldn't react to the material because I needed to put it all together. I wrote the book at arm's length. Now that I am going out and talking about it, I am reacting—at age 77 and 78. Sometimes I choke up.

What touches you the most?

It's the horrible, horrible stuff he endured—treatments that were done in the 1930s and '40s. It's pretty powerful when you read it. That's one of the reasons they want to make a movie about it.

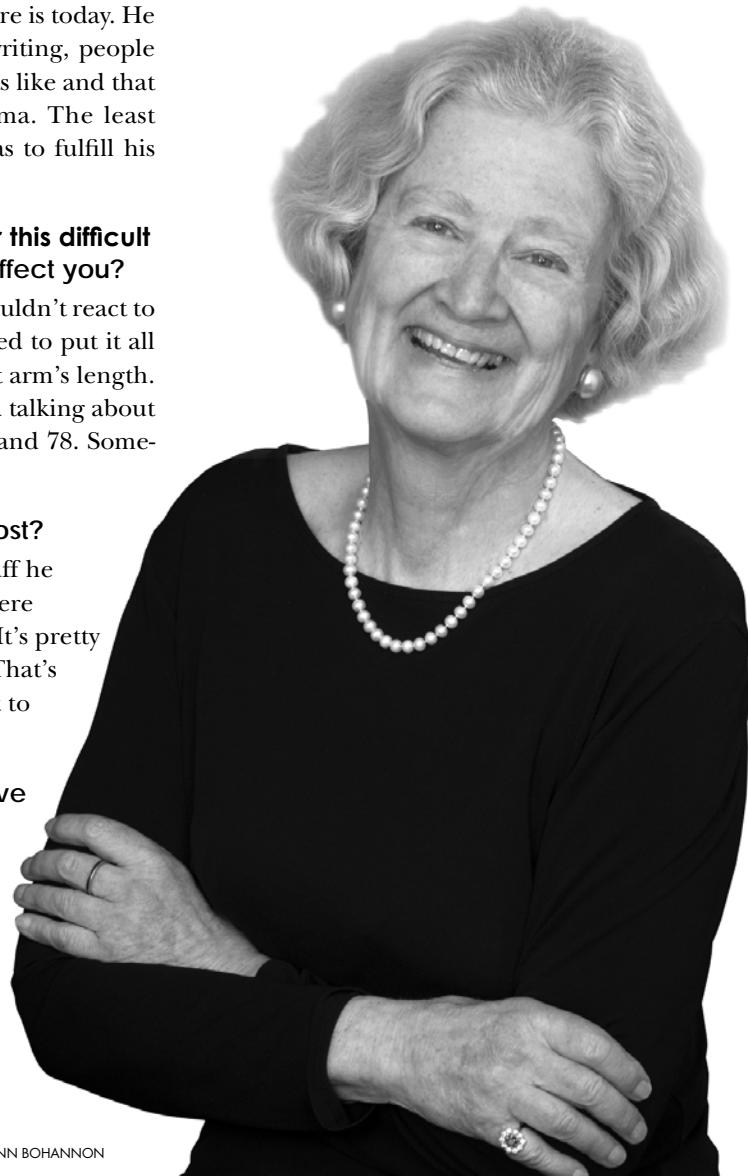
So how does it feel to have Brad Pitt and playwright Tony Kushner on board?

It still doesn't seem real to me, to be honest. Brad Pitt's production company, Plan B, is known for their integrity and honesty and above-board interpretation

of books. *The Big Short*, *12 Years a Slave*, *Selma*—they're all about important issues in our society. This film will bring added awareness of mental illness to the general public.

Were you tempted to censor anything about your father's manic behavior?

I never for a minute thought of not telling the truth. Knowledge is power. That's exactly what my father kept saying. By educating people to the symptoms and behaviors of mental illness, people understand it better and they can help better. One of the main things about mental illness is having the support of your family. If you don't understand what you're dealing with, you're not going to be able to do that. ☺



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