Beliefs about Drinking, Drug Abuse, and Bipolar Disorder

People often have mistaken beliefs about alcohol, drug substances, and bipolar disorder. Some of these are listed in the sidebar on this page.

I've heard people with bipolar disorder claim that marijuana or cocaine is just as effective as a mood stabilizer such as Depakote in controlling their mood states. They argue that alcohol calms them down, or reduces their anxiety, or improves their depression; they argue that marijuana boosts their mood when they are depressed. One patient said, "For me, alcohol is like the ropes that keep the hot air balloon from going up . . . and on the other side is like a disguise covering over the depression."

Some people do drink or use drugs to make themselves feel better, but whether these substances are really doing the trick—as opposed to making their moods worse—is another question. We know that alcohol worsens depression (as in the examples given above). People who have both bipolar disorder and alcohol problems also have more rapid cycling, mixed symptoms, and anxiety or panic than those who do not drink. Alcohol can also interfere with sleep, which can worsen mania.

People often assume, as Ruth did, that their depression came first and that they use alcohol or drugs for the purpose of self-medicating this depression. For many people with bipolar disorder, however, the alcohol abuse precedes the depression rather than the reverse (Strakowski et al., 2000). For some, a vicious cycle takes over: They drink heavily and get depressed and anxious, then stop drinking and experience a recurrence of depression or panic symptoms that is attributable to the alcohol withdrawal. Then they try to self-medicate these mood symptoms with more alcohol. This pattern makes the course of both disorders much worse.

Marijuana, although perhaps not as toxic for bipolar persons as alcohol, can also be detrimental to your mood stability. In Strakowski and colleagues'

Mistaken Beliefs about Bipolar Disorder and Alcohol or Drug Abuse

- Alcohol or drugs can be used as mood stabilizers
- Hard drugs like amphetamine, LSD, or cocaine can be used as antidepressants
- Substances cannot worsen your disorder if your mood has been stable

study (2000), marijuana use was associated with manic symptoms, whereas alcohol use was associated with depressive symptoms. One patient put it this way: "Marijuana makes me think and think and think, and then it keeps me from sleeping. It's like a catalyst for something in me." Marijuana can also interfere with your attention and concentration as well as your ability to remember to take your medication. Some people find it makes them lethargic and unmotivated.

Rationalizing their heavy drug use, some people claim that LSD ("acid"), amphetamines (speed), cocaine (or "crack"), and "Ecstasy" are really antidepressants. They argue that these drugs can help their depression more than a standard antidepressant such as Prozac. Some even know about studies showing that LSD stimulates the action of certain serotonin receptors or that amphetamine stimulates and prolongs dopamine activity, as some antidepressants do. But they are misinterpreting the clinical implications of these studies. Even though many street drugs do affect the same neurotransmitter systems as antidepressants, street drugs do not produce true mood stability. Instead, they tend to produce short-term bursts of neuronal activity accompanied by elation or irritability (much like mania or hypomania), rather than truly alleviating depression.

Some people with bipolar disorder use substances to intensify the elated and grandiose aspects of their hypomanic or manic states. They feel driven toward further stimulation and novelty. Cocaine and amphetamine are especially likely to be used in this way. The result is often a severe increase in manic or mixed symptoms, or the initiation of rapid cycling states leading to hospitalization.

You may believe that taking alcohol or drugs is fine as long as you have been feeling well for a period of time. This was Ruth's logic, and she tested it frequently by going "off the wagon" whenever she had a period of mood stability. For her, ordinary life seemed very drab. The up and down periods that alcohol brought were somehow preferable to feeling that life had become ordinary and boring. Many people whose bipolar disorder is stable report that alcohol and drugs provide a relief from their feelings of emptiness. But it is only a temporary relief, as these substances trigger negative mood states that are far more unpleasant than boredom.

The exercise on page 178 may help you identify what makes you want to drink or use drugs (after McCrady, 2001). Its purpose is to help you identify

- Triggers for use (for example, being with people whom you want to impress)
- The feelings you want to alleviate (for many people with bipolar disorder, depression or anxiety)

A MAINTAINING WELLNESS EXERCISE: IDENTIFYING TRIGGERS FOR ALCOHOL AND DRUG ABUSE, YOUR RESPONSES TO THOSE TRIGGERS, AND THE CONSEQUENCES

List the type of alcohol or the drug you use most frequently (*examples:* beer, wine, marijuana, cocaine).

List the *situations* in which you are most likely to get drunk or high (*examples:* being alone; being out with friends; parties; Friday afternoon after work; with specific people).

List the *feelings* you ordinarily have right before you drink/get high (*examples:* depressed, anxious, irritable, excited).

Describe your *expectations* about what this drink/drug will do for you (*examples:* it will make me relax and ease up with people; help me deal with difficult situations; decrease my depression; help me sleep; make me think more clearly).

Describe the *actual consequences* of your drinking/drug use the last few times. Try to distinguish (1) what happens immediately after you drink/get high (*examples:* relaxed me, got me into an argument, alleviated my depression, made me feel more social) versus (2) the delayed effects (made me feel more depressed the next day, had hangover, got to work late).

Immediate effects:

Delayed effects:

- Your expectations
- The immediate consequences of using the drug/alcohol (for example, feeling relaxed, feeling more confident, forgetting your medications)
- The extended or delayed consequences of use (for example, sleep disturbance, missing work the next day, feeling irritable, drowsy, or anxious several days later)

In other words, think of drinking or drug use as one event in a sequence of events rather than a singular, isolated act. Then you'll be in a position to think about changing this sequence. For example, Amy learned to avoid certain situations and people who, she believed, made her drink more. Earl, who smoked marijuana heavily, learned to plan things for times of the day when he was most likely to get high (typically late afternoons after he finished his classes). Bethany learned to challenge her belief that alcohol alleviated her depressions. When she systematically evaluated the results of her drinking, she concluded that she felt better at first but more irritable and depressed later. She began to think of alcohol as a cause rather than an effect of her mood problems.

Maintaining Wellness Tip No. 4: Relying on Social Supports

Candace, a 49-year-old woman with bipolar II disorder, suffered from an ongoing depression that was not alleviated by antidepressants or mood stabilizers. After becoming frustrated with the myriad of medications she had tried, she consulted a psychotherapist, who observed that she was quite socially isolated: She had broken up with her boyfriend two months earlier, she had few new friends or even acquaintances, and she had become disconnected from her parents and her two sisters. Her therapist encouraged her to try some new social activities, which she strongly resisted doing. Her weekends were largely spent alone in her apartment, where "my thoughts eat me alive."

Candace had few hobbies in her current life but had played soccer in college. With some reluctance, she joined a group who played soccer on weekends. She felt awkward at first. "They're not my kind of people," she observed. At the beginning she had to force herself to go. Little by little, however, she found that her weekends became more structured because of the soccer practices. Although she never admitted to enjoying the members of the team, she did notice that her mood brightened when she participated in an activity with them. At first she thought this was due to physical exercise, but she found that her mood also brightened when she went to pot-luck dinners or movies at the team members' houses. She eventually disclosed her illness to a few of her teammates, who "weren't

gether, perhaps one that emphasizes the patient's personality or that views the deviant behavior in historical perspective (for example, "She's always been moody"). Although often quite different, there is a degree of validity to all three points of view.

In this chapter you'll gain a sense of the different perspectives people take in understanding bipolar mood swings and how these different perspectives can lead to very different feelings about which treatments should be undertaken. These perspectives include the personal standpoint, as described by patients who have the disorder; the observers' viewpoint, which usually means parents, spouses, or close friends; and the doctor's viewpoint. Questions to pose to yourself when reading this chapter are:

- How do I experience swings in my mood?
- Are they similar to the ways others with bipolar disorder experience them?
- How do I understand my own behavior?
- How is my understanding different from the way others perceive me?
- How do I see myself differently from the way my doctor sees me?
- What kinds of problems arise from these differences in perceptions?

Understanding these varying perspectives will be of use to you, whether you are on your first episode or have had many episodes, in that you will gain some clarity on how your own experiences may differ from those of people without bipolar disorder. You may also come to see why others in your family or work/social environment think you need treatment, even if you don't agree with them.

Nuts and Bolts: What Is Bipolar Disorder?

Let's begin by defining the syndrome of bipolar disorder. Its key characteristic is extreme mood swings, from manic highs to severe depressions. It is called a mood disorder because it profoundly affects a person's experiences of emotion and "affect" (the way he or she conveys emotions to others). It is called *bipolar* because the mood swings occur between two poles—high and low—as opposed to unipolar disorder, where mood swings occur along only one pole—the lows.

In the manic "high" state, people experience different combinations of the following: elated or euphoric mood (excessive happiness or expansiveness), irritable mood (excessive anger and touchiness), a decreased need for sleep, grandiosity or an inflated sense of themselves and their abilities, increased

talkativeness, racing thoughts or jumping from one idea to another, an increase in activity and energy levels, changes in thinking, attention, and perception, and impulsive, reckless behavior. These episodes alternate with intervals in which a person becomes depressed, sad, blue, or "down in the dumps," loses interest in things he or she ordinarily enjoys, loses weight and appetite, feels fatigued, has difficulty sleeping, feels guilty and bad about him- or herself, has trouble concentrating or making decisions, and often feels like committing suicide.

Episodes of either mania or depression can last anywhere from days to months. Some people (about 40% by some estimates; Calabrese et al., 1996) don't experience depressions and manias in alternating fashion. Instead, they experience them simultaneously, in what we call "mixed episodes," which I'll talk about in the next chapter.

Episodes of bipolar disorder do not develop overnight, and how severe the manias or depressions get varies greatly from person to person. Many people accelerate into mania in stages. Drs. Gabrielle Carlson and Frederick Goodwin (1973) observed that in the early stages of mania, people feel "wired" or charged up and their thoughts race with numerous ideas. They start needing less and less sleep and feel giddy or mildly irritable ("hypomania"). Later they accelerate into a full-blown mania, marked by euphoria, impulsive behaviors such as spending sprees, and intense, frenetic periods of activity. In the most advanced stages, the person can develop mental confusion, delusions (beliefs that are irrational), hallucinations (hearing voices or seeing things), and severe anxiety. Not everyone experiences these stages, and many people receive treatment before they get to the most advanced stage.

People also spiral into depression gradually, although its stages are less clear-cut. For some, severe depressions arise when they were otherwise feeling well. In others, major depression develops on top of ongoing, milder depressions called "dysthymias" (see Chapter 10).

The periods in between manic and depressive episodes are symptom-free in some people. For others, there are symptoms left over from the episodes, such as sleep disturbance, ongoing irritability, or dysthymic or hypomanic disorders. Most people experience problems in their social and work life because of the illness (Coryell et al., 1993; Goldberg et al., 1995).

Between 0.8% and 1.6% of the general population has "bipolar I" disorder, marked by swings from extreme depression to extreme mania. About 0.5% (1 in 200) has "bipolar II" disorder, in which people vary from severely depressed to hypomanic, a milder form of mania (Kessler et al., 1994; Regier et al., 1990). New cases of bipolar disorder have been recognized in young children and in the elderly, but the typical age at first onset is between 15 and 19 (Goodwin & Jamison, 1990). It is generally treated with a range of drugs in combination with psychotherapy:

- Mood stabilizers (for example, lithium carbonate, Depakote, or Tegretol)
- Antidepressants (for example, Paxil or Wellbutrin)
- Antipsychotics (for example, Zyprexa or Seroquel), and/or
- Antianxiety agents (for example, Klonopin or Ativan).

Different Perspectives on Mania and Depression

As noted, the symptoms associated with bipolar mood disorder can be experienced quite differently by the person with the disorder, by an observer, and by a physician. The disorder primarily affects *mood* and *behavior*. Your moods cannot always be observed by others, although you will usually be aware of them. Likewise, you may not always be aware of your behavior or its impact on others, while others (family, friends, or doctors) are acutely aware of it. When people look at and evaluate the same set of behaviors or experiences through different lenses, you can imagine how much room there is for interpretation and misinterpretation.

You may be quite articulate in describing what you are feeling and thinking. When in a manic phase, your thoughts flow rapidly and life feels exotic and wonderful. You may speak more than usual and more freely reveal your inner thoughts. An observer, such as a family member, usually focuses on your behavior, which he or she may describe as too outspoken, boisterous, verbally hostile, dangerous to yourself or others, or impulsive in ways that negatively affect others (for example, spending or investing your money suddenly). Your doctor is usually attuned to whether your mood and behavior are significant departures from your normal states, taking into account such things as whether the symptoms have lasted for a period of time, how intense they are, and whether they cause impairment in your functioning.

In the following sections, I will describe mania and depression from these three perspectives. I will focus on the personal experiences that really define episodes of bipolar disorder, which are summarized in the sidebar on page 18.

Roller Coaster Mood States

"How can I ever make plans or count on anything or anybody? I never know how I'm going to feel. I can be up and happy and full of ideas, but then the littlest things set me off. I'll drink a cup of tea and it doesn't match my expectation of how hot it should be, and I'll just react—I'll cuss, scream—I'm bitterly volatile . . . I'm afraid of my own moods."

—A 30-year-old woman with bipolar I disorder

Experiences of Manic and Depressive Episodes

- Roller-coaster mood states (euphoria, irritability, depression)
- Changes in energy or activity levels
- Changes in thinking and perception
- Suicidal thoughts
- Sleep problems
- Impulsive or self-destructive behavior

Most people with bipolar disorder describe their moods as volatile, unpredictable, "all over the map," or "like a seesaw." Mood states accompanying bipolar disorder can be irritable (during either depression or mania), euphoric, elevated or excessively giddy (during mania), or extremely sad (during depression).

You may agree that you have variable mood states, but your explanation for these mood states may be quite different than those of your doctor, family members, or friends. People with bipolar disorder often get angry when their doctors bring out a list of symptoms and ask them how many they have had and for how long. They find themselves reluctantly agreeing that they suffer from irritable moods but also know the triggers for these moods that other people may not see.

"When I'm mad, nobody better get in my face. I feel like crushing everything and everybody. Every little thing will provoke me. I hate everybody, I hate my life and want to kill myself in some really dramatic way. It's like a sharp-edged, pointed anger, like a burning feeling."

—A 23-year-old woman with bipolar II disorder

Family members, when describing the emotional volatility of their bipolar sibling, child, or parent, tend to emphasize the intimidation they feel in the face of sudden outbursts that they don't feel they've provoked. Consider this interchange between Kirsten, age 21, and her mother, after Kirsten had railed at her mother just minutes earlier.

KIRSTEN: I wanna come back and live with you. I can handle it.

MOTHER: But you're not in a good place right now. Look how angry you just got.

KIRSTEN: But you told me I wasn't ready to take care of myself! Of course I exploded!

MOTHER: And you're not. I can tell because you're overreacting to me, and that tells me you're probably not better yet.

It's hard to think of your mood swings as evidence of an illness, especially when every emotional reaction you have seems perfectly justifiable, given what's just happened to you. To Kirsten, her angry outburst seemed perfectly justified, because her mother had questioned her competency. Her mother knows what her daughter is like when she's well and sees her irritability as a departure from this norm.

In contrast, the elated, euphoric periods of the manic experience feel exceptionally good to the person with the disorder. Kay Jamison has written extensively about the wondrous feelings that can accompany manic episodes and how the desire to sustain these feelings can lead a person to resist taking medication (Jamison et al., 1979; Jamison, 1995). Not all people with bipolar disorder experience their high moods as euphoria, however. For example, Beth, age 42, described her mood during manic episodes as "the sudden awareness that I'm not depressed anymore."

To others, your euphoria or high mood may seem strange or clownish, and they may not share it with you, but they are unlikely to be as disturbed by it as they are by your irritability. To your relatives, especially those who have gone through one or more previous episodes with you, euphoric mood is worrisome to the extent that it heralds the development of a full-blown manic episode.

Now consider how you experience depression. Would you describe it as an intense sadness . . . a numbing feeling . . . a feeling of being removed from others . . . a lack of interest in things you ordinarily enjoy? One man put it bluntly: "My depressions eat me alive. I feel like I'm in a tank that separates me from other people. It's all just hopelessness, and I don't see any future for myself."

In contrast, a family member, friend, or lover might see your depression as self-inflicted. People who are close to you might feel sympathetic at first but then get irritated and annoyed. They may think you're not trying hard enough or could "make this all go away if you had the right mental attitude."

What does the doctor look for? To determine whether the diagnosis is correct (if you are being diagnosed for the first time), or whether you are experiencing a recurrence of the disorder (if you've been diagnosed before), your doctor will evaluate whether your mood states are different, in terms of degree or intensity, from those of "normal" people. Do your moods—

euphoric, irritable, or depressed—get out of hand and stay out of hand for days at a time? Do your mood swings cause problems in your social, work, and/or family life? The questions listed in the sidebar on this page will figure prominently in your doctor's evaluation of whether your mood states are problematic from a clinical perspective.

Changes in Energy and Activity Levels

If someone asked you to describe your symptoms, you might not focus on your mood fluctuations. In fact, many people who are asked about their mood states answer with descriptions of their energy and activity levels instead. They're more conscious of what they do or don't do than of how they feel. They focus on the great increases in energy that they experience during the manic or mixed phases or the decreases in energy they experience during the depressive phases.

One way to understand these fluctuations is to think of bipolar disorder as a dysregulation of drive states as well as of mood. Changes in normal motivational drives, such as eating, sleeping, sex, interacting with others, and achievement are part and parcel of the bipolar pendulum. The normal drives

Questions a Doctor Might Ask to Distinguish Bipolar Mood Swings from Normal Mood Variability

- Do your mood swings cause problems in your social or family life?
- Do your mood swings lead to decreases in your work productivity that last more than a few days?
- Do your mood states last for days at a time with little relief, or do they change when something good happens?
- Do other people notice and comment when your mood shifts?
- Do your mood changes go along with noticeable changes in thinking, perceiving, sleeping, and/or energy or activity levels?
- Do your mood swings ever get so out of hand that the police have to be called or a hospitalization becomes necessary?

If your answer to most of these questions is yes, then it is likely that your mood swings go beyond the normal range.

BIPOLAR SYMPTOMS: A SELF-ADMINISTERED CHECKLIST

DEPRESSION[1]

Has there ever been a period of time lasting two weeks or more when you were not your usual self and you experienced five or more of the following:

	Yes	No
Felt sad, blue, or down in the dumps?	____	____
Were uninterested in things?	____	____
Lost or gained more than 5% of your body weight?	____	____
Slept too little or too much?	____	____
Were slowed down or sped up in your movements?	____	____
Felt fatigued or low in energy?	____	____
Felt worthless or very guilty about things?	____	____
Were unable to concentrate or make decisions?	____	____
Thought about killing yourself or making plans to do so?	____	____

MANIA OR HYPOMANIA[2]

Has there been a period of time when you were not your usual self and you:

	Yes	No
Felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	____	____
Were so irritable that you shouted at people or started fights or arguments?	____	____
Felt much more self-confident than usual?	____	____
Got much less sleep than usual and found you didn't really miss it?	____	____
Were much more talkative or spoke much faster than usual?	____	____
Had thoughts racing through your head or couldn't slow down your mind?	____	____
Were so easily distracted by things around you that you had trouble concentrating or staying on track?	____	____
Had much more energy than usual?	____	____
Were much more active or did many more things than usual?	____	____
Were much more social or outgoing than usual; for example, telephoning friends in the middle of the night?	____	____

over page

	Yes	No
Were much more interested in sex than usual?	_____	_____
Did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	_____	_____
Spent excessive money that got you or your family into trouble?	_____	_____
If you checked yes to more than one of the above, have several of these ever happened during the same period of time?	_____	_____

How much of a problem did any of these cause you—like being unable to work; having family, money, or legal troubles; getting into arguments or fight? Please check one response only.

No problem _____ Minor problem _____ Moderate problem _____
Serious problem _____

[1]Adapted by permission from the criteria for major depressive and manic episodes of the *DSM-IV-Text Revision* (American Psychiatric Association, 2000). Copyright 2000 by the American Psychiatric Association.
[2]Adapted by permission from Hirschfeld et al. (2000). Copyright 2000 by the American Psychiatric Association.

Step 1: The Diagnostic Referral

The first step in getting a proper diagnosis is to find the right doctor. If you have private insurance, you may be able to see someone who specializes in mood disorders. If it is unclear whether a doctor is a specialist, you should feel free to ask. You can also obtain information about who in your area treats persons with mood disorders from the American Psychiatric Association's referral line (202-682-6800) or from the books in the "How to Find the Best Doctors" series (for example, Connolly, 2000).

If you have a managed care plan or no insurance, you may not have a lot of choice about whom you see. Hopefully, your plan will direct you to a mental health professional who has at least some experience in mood disorders. But this may require some detective work on your part. Nancy, for example, thought she might have bipolar disorder and wanted to see a psychiatrist but was confused by the number of doctors listed in the Yellow Pages who purportedly treated mood problems. She called several but could reach only their receptionists, who gave her information like "Dr. _____ sees mainly adults" or "she has a general psychiatry practice." She finally discussed the matter with her general practitioner, who referred her to a psychiatrist in town who was covered by her insurance plan and was known to have expertise in the treatment of mood disorders.

The strategies you'll learn will be of most help when you are feeling well or experiencing only mild mood swings. They can also help protect you from more severe bipolar episodes. Throughout the chapter, I show you how other people with bipolar disorder have used these strategies in their daily lives and how they have avoided some of the pitfalls associated with implementing them. Chapters 9, 10, and 11 give you tools to use when you want to stop a developing manic, depressive, or suicidal episode from spiraling beyond your control.

Maintaining Wellness Tip No. 1: Keeping a Mood Chart

If you've been seeing a psychiatrist for a long time, you're probably familiar with some form of mood chart. If this is your first episode, your psychiatrist or therapist may not have introduced this assignment yet. A mood chart is simply a daily diary of your mood states, with dates indicating when these moods start and stop. The chart can also incorporate information about your sleep, medication, and life stressors.

Why should you keep a mood chart? First, becoming aware of even subtle changes in your mood and activity levels will help you recognize if you are having a mood disorder relapse and determine whether you should contact your doctor to see if a change in medication would be helpful. Many bipolar people have been able to "head off at the pass" their episodes by observing the minor fluctuations on their mood charts, which often herald the onset of major manic, mixed, or depressive episodes. A picture is worth a thousand words!

Second, your doctor will find the chart useful, in that he or she will be able to see how well your medication is working or, alternatively, when it is making you feel worse (such as when antidepressants bring about rapid cycling). He or she may also want to monitor symptoms other than mania or depression, such as your anxiety, sleep disturbance, or irritability.

Third, you can use your mood chart information to identify environmental triggers of your mood cycling, which can then lead to stress-management strategies to lessen the impact of these triggers. With time and practice, many of my clients have become effective at identifying stress triggers, such as the onset of their menstrual cycle, arguments with particular family members, or work stress. Amy, for example, came to recognize through mood charting that conflicts with her boyfriend were a trigger for her mood cycling. She also found that her usual strategy for coping with distress—going out drinking—was contributing to her irritable mood states for several days later. This realization did not stop her from drinking altogether, but it did make her weigh the pros and cons of alcohol as a means of self-medicating her emotions.

The chart on page 156 is used in the NIMH Systematic Treatment Enhancement Program for Bipolar Disorder (Sachs, 1993, 1998). There is a blank version of this chart at the end of the book that you can copy for your own use, or you can download it from www.manicdepressive.org. The website also contains instructions for filling out the chart, which are also detailed below. Each chart allows you to track your moods for up to one month. So, if you have started the chart in the middle of the month, continue to use the same sheet until the middle of the next month, and then begin a new sheet. In other words, "day 1" need not be the first of the month. It could be the 10th, and day 10 could be the 20th.

People with bipolar disorder find this to be a "user-friendly" method of recording the cycling of their moods over time, even though it looks intimidating at first. Once you get used to it, you can usually fill it out in a few minutes each day. I usually suggest that people keep the chart on an indefinite basis, but if this seems daunting then try it for a month or two to see if it proves useful. After that, you may decide to chart your moods in a different way (or your doctor may have another chart for you to use).

For now, let's consider Amy's mood chart, which she completed during a month in which she experienced significant mood fluctuations. Her "X" marks indicate her mood states on any given day. Notice that on some days she has made two ratings, one for mania and one for depression (her mixed mood states).

Amy identified some of the factors that contributed to her mood swings, including life events such as the illness of her dog. Her mood had been relatively stable (note the absence of "peaks" between the argument with her dad and the rejecting event with her boyfriend), but then she stayed out late at a concert and experienced a hypomanic period. By day 16 of the month, she'd had seven consecutive nights of poor sleep and began to experience mixed mood symptoms. Her medication was not changed during this interval, but she had been inconsistent with her regimen during days 10 and 11. So she identified four things that may have correlated with her mood shifts during this particular month: events involving her pet, problems with her boyfriend, sleep deprivation, and medication inconsistencies.

We don't know for sure whether these variables would have affected Amy's moods during a different month. This is one of the reasons it is important to keep the chart on an ongoing basis—to determine whether you have a predictable set of "mood triggers" (for example, arguments with family members, final exams, changing time zones, a specific pattern of sleep deprivation). Identifying mood triggers is an important step in gaining control over your moods, as you'll learn more about in this and subsequent chapters.

stressful and forced her to stay up later at night. Darryl, age 24, became manic shortly after his graduate school finals, during which he had stayed up later and later. Losing even a single night's sleep can precipitate a manic episode in people with bipolar disorder who have otherwise been stable (Malkoff-Schwartz et al., 1998). In parallel, sleep deprivation can improve the mood of a person with depression, although only briefly (Barbini et al., 1998; Liebenluft & Wehr, 1992).

Limits to model of change

What Affects Our Sleep–Wake Regularity?: Social Zeitgebers and Zeitstorers

Unless you speak German, you've probably never heard these terms before—nor had I until I started reading about the *social rhythm stability hypothesis* of Cindy Ehlers and her associates at the University of Pittsburgh Medical Center (Ehlers et al., 1988; Ehlers et al., 1993). This model helps us understand why life events might affect bipolar people's mood cycles.

Ehlers' theory states that the core problem in bipolar disorder is one of instability. Usually, people maintain regular patterns of daily activity and social stimulation, such as when they go to bed, when they get up and go to work, how many people they ordinarily socialize with, or where they go after work. These "social rhythms" are important in maintaining our "circadian rhythms," which are the more biologically driven cycles such as when you actually fall asleep, the production of hormones like melatonin (which is produced when you are approaching sleep), or your pattern of rapid eye movement activity during sleep.

Social rhythms stay stable, in part, because of *social Zeitgebers*, which are persons or events that function as an external time clock to regulate your habits. Your dog can be a social Zeitgeber if she or he needs to be walked at a certain time of the morning. If you have a spouse, he or she almost certainly plays a role in organizing your eating and sleeping schedules and probably affects how much stimulation you have from other people during the day. If you were to split up with your spouse, or even if he or she were to go away for a period of time, your daily and nightly routines would be disrupted. Your job also keeps you on a regular routine.

In contrast, a *social Zeitstorer* (time disturber) is a person or a social demand that throws everything off balance. When you start a new relationship, your patterns of sleeping, waking, and socializing change. The same thing will happen if you have a baby. In these cases, the new romantic partner or your baby is a Zeitstorer. If you take on employment that has constantly shifting work hours or requires that you travel across different time zones, your social and circadian rhythms will be disrupted considerably.

What does all of this mean for a person with bipolar disorder? Events that

bring about changes in social rhythms, either by introducing Zeitstorers or removing Zeitgebers, alter circadian rhythms. You are particularly vulnerable to a manic episode after you have experienced a social rhythm-disrupting life event (for example, Malkoff-Schwartz et al., 1998).

Let me give you an example. Debra, a 36-year-old woman with bipolar II disorder, lived with her husband, Barry. During a therapy session with the couple, Debra complained that Barry had changed the schedule for feeding their two cats. He had begun feeding them both in the morning instead of the evening, and as a result one or both of the cats were coming into the couple's room in the middle of the night, crying for food. Debra wanted to feed the cats before she and Barry went to bed, but he refused, saying it would make the cats overweight. After three consecutive nights of poor sleep, she became irritable, experienced mental confusion at work, and developed racing thoughts. Finally, Barry agreed to the new evening feeding schedule, which alleviated the problem with the cats. As Debra got back on a regular sleep–wake cycle and experienced several nights of restorative sleep, her hypomania started to settle down. In Debra's case, a major episode was averted by reestablishing routines that had been disrupted by a relatively minor event.

Miriam, a 47-year-old woman with bipolar I disorder, reported that she developed manic or mixed symptoms the morning or afternoon after drinking alcohol, even if only in small quantities. It wasn't entirely clear to me why a small amount of alcohol would make her manic until I considered her sleep cycle: alcohol was acting as a disruptive Zeitstorer. She had much more difficulty falling asleep after drinking. Once she stopped drinking (or limited herself to one beer, usually consumed early in an evening), she had less trouble sleeping and fewer shifts in her mood states.

In Chapter 8, "Practical Ways to Maintain Wellness," I'll tell you about a method for keeping your social routines regulated even when events conspire to change them (the social rhythm stability method; Frank et al., 2000). This self-monitoring technique can help you keep your mood and sleep–wake cycles stable.

Conflicts with Significant Others

So far, we've talked about single life events and changes in your routine. The other major type of stress has to do with your ongoing relationships. Chapter 12 is devoted to dealing with family members, so I'll give it only brief mention here. There is no evidence that disturbances in family relationships (for example, poor parenting when you were a child) cause bipolar disorder in the first place. But high-conflict family or marital situations can increase your likelihood of having a recurrence of bipolar disorder once you have it.

It is not only people with mood disorders who have to stay on regular, regimented schedules. Parents usually need to follow very predictable routines to manage the daily activities of their children. Athletes need to stick to well-regulated training schedules. People who become expert performers, such as accomplished professional musicians, have often developed highly regimented routines to help them accomplish their craft (for example, Krampe & Ericsson, 1996).

Nonetheless, if you're finding a regimented routine too stifling, discuss this with your doctors. There may be compromises that can be made. Perhaps you can identify the point at which fluctuating routines negatively affect your mood. For example, a 30-minute departure from your bedtime may make no difference, but 90 minutes might make a big difference. Try to see if you can identify the range of fluctuation in routines within which you can function and still feel stable.

"OK, Now That I'm Going to Bed on Time, How Do I Fall Asleep?"

"I toss and turn, look at the clock, sneer and snort through my nose, walk around the house . . . do my yoga, do my meditation, turn on *American Gladiators* . . ., but I still can't sleep. It irks me to no end that my wife can just lie down and she's out. I almost want to wake her up to make her suffer like I am, but I don't. . . . It goes like this every night, and then, of course, I'm a wreck at work the next day."

—*A 51-year-old man with rapid cycling bipolar disorder*

For some bipolar people, getting to bed at the right time isn't the main problem. The problem is falling asleep and staying asleep. There is nothing more frustrating than lying awake and trying to fall asleep. Sleep disturbance is a key symptom of bipolar disorder and sometimes can be a side effect of antidepressant medications. It can also be due to substances like caffeine, excessive sugar, tobacco, or alcohol, especially if these are ingested close to your bedtime.

Your doctor may decide to give you medications for sleep, such as Klonopin or zolpidem (Ambien). Although these medications often work well, not everyone likes to take them because you can become addicted or tolerant (that is, you may need a bigger dosage over time to achieve the same effect). But you and your physician may decide that a sleeping medication is the best alternative in order to keep sleep disturbance from contributing to your worsening mood state.

Fortunately, there is a literature on behavioral interventions for sleep

Ways to Combat Sleep Disturbance

- Keep stress out of the bedroom
- Give yourself time to unwind before sleep
- Never "compete" to get to sleep
- Use muscle relaxation techniques
- Adjust your sleep cycle before travel

Source: Otto et al. (1999)

problems. Michael Otto and his colleagues at the Harvard Medical School/Massachusetts General Hospital (1999) have developed recommendations for ways to improve sleep if you're suffering from bipolar disorder (see the sidebar on this page). Some of these sleep techniques would be applicable to people without bipolar disorder as well.

Examples of "stress in the bedroom" include having arguments with your spouse, preparing work assignments for the next day while in bed, examining your next day's work schedule, checking the stock market pages, checking your e-mail one last time, eating in bed, and making last-minute phone calls. These activities should be avoided right before bedtime. More generally, try to keep the last hour just before sleep free of stressful activities so that you can unwind and relax. If possible, try to arrange your bedroom such that noise is blocked out (for example, the telephone is turned off, no radios are playing) or wear earplugs.

Paradoxically, activities that people often take for granted as necessary for falling asleep may actually contribute to sleep disturbance. For example, many people watch the evening news in bed before turning out the lights, but the news overstimulates them and cranks them up. Likewise, many people feel they can't fall asleep without reading a book, yet sometimes reading, even if it's only a novel, can get the brain running in all sorts of different directions. If you've been reading a good murder mystery, it may be hard to put down and stop thinking about! Likewise, most people believe that regular exercise contributes to good sleep because it tires you out and relaxes your muscles. But it can also keep you awake if you exercise right before bedtime—try to give yourself as much as three hours between finishing your exercises and going to bed.

If you want to investigate which activities are contributing to your sleep problems, try nights with and without these activities and record the changes

on your mood chart or SRM (for example, write "no TV" on Thursday night, and "yes TV" on Friday night, and record your sleep for each). Try to see if you can detect whether doing or not doing certain activities affects your sleep and mood.

Some people feel that falling asleep is like an athletic competition, like running a race in a certain time. Being unable to sleep makes them feel inadequate or incompetent, and "performance anxiety" begins to accompany their attempts to sleep. Try not to think of your ongoing sleep disturbance as something you're doing to yourself, but rather as a biological sign of your disorder. Rather than wrestling with yourself about being unable to sleep, instead experience the physical sensations of being in bed, including how your body feels, how you experience the covers over you, or how the pillow feels against your head. If you have access to a relaxation tape or meditation exercises, you may wish to use these to help you experience the physical sensations that lead to sleep (Otto et al., 1999).

Many people have trouble sleeping when they travel. If you fly from the West Coast of the United States to the East Coast, you may arrive when everyone else is going to sleep, but for you it is three hours earlier. Transatlantic travel (for example, flying from Chicago to Paris) is particularly difficult for people with bipolar disorder because there is such a dramatic shift in circadian rhythms. But travel is often unavoidable.

One way to combat this travel disruption is to gradually adjust your internal time clock to the new place you're going, before you actually leave. So, over the course of the week before you travel to a later time zone, go to bed an hour earlier than usual, then an hour and a half, and then two hours earlier, and so forth. By the time you arrive, it may be easier to adjust to the hours of the new time zone. This procedure usually works best if you'll be in the new time zone for more than a few days.

There are other strategies you can use to improve your sleep, some of which go beyond our scope. If you've been having difficulties, consider reading self-help books specifically oriented toward sleep issues, such as William Dement and Christopher Vaughan's (1999) *The Promise of Sleep* or Peter Hauri and colleagues' (1996) *No More Sleepless Nights*.

Maintaining Wellness Tip No. 3: Avoiding Alcohol and Recreational Drugs

Ruth, a 32-year-old woman who had just been diagnosed with bipolar I disorder, had a severe problem with drinking that usually began when she