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What is the Treatment for Bipolar Disorder?

By Michael G. Rayel, MD

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How do we treat bipolar disorder? Specifically, how do we treat mania or depression associated with bipolar disorder? The treatment of these two clinical states is not the same.

The treatment of mania is dependent upon its severity and acuity. For mild to moderate mania, mood stabilizers such as lithium and valproic acid (Valproate) are still the standard of treatment and may be sufficient to contain the symptoms. Lithium starts to work after 10 to 14 days while valproic acid, about 7 to 10 days.

Also, recent studies have shown the effectiveness of atypical antipsychotics such as risperidone, olanzapine, and quetiapine even when used alone to treat the acute phase of bipolar disorder.

These drugs are relatively safe but they don't come without side effects. Nausea, vomiting, tremors, and dizziness during the initial phase of treatment are commonly experienced. The more serious side effects such as renal and thyroid problem from lithium, liver dysfunction and pancreatitis from valproic acid, and increased risk of diabetes and high cholesterol from atypical antipsychotics are uncommon. However, regular blood tests are required to monitor any abnormalities.

For moderate to severe cases, atypical antipsychotics such as risperidone and quetiapine should be added to the mood stabilizers during the acute phase. Once the illness has stabilized and the symptoms have subsided, then the atypical neuroleptics can be gradually tapered off. But the mood stabilizers should continue. Regardless of severity, patients usually do well on a combination of mood stabilizer and atypical antipsychotic during the acute phase.

What is the treatment for bipolar depression? In general, the mood stabilizers' dosage should be optimized or if the patient is not on any medication yet, a mood stabilizer such as lithium should be started. Physicians should make sure that the medication maintains a "therapeutic level." If not, the dosage should be adjusted. Moreover, possible precipitants such as stresses at home should be

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addressed.

If these measures don't help and the depression is so severe, an antidepressant with the least risk to induce mania such as bupropion should be added to the mood stabilizer. When the depression is resolved, then the antidepressant can be gradually tapered off because its prolonged use even in the presence of mood stabilizer can still induce mania.

When should the medication be discontinued? Bipolar patients have to continue taking the medication for several months even after they become normal. High relapse rate is common if medications are prematurely stopped. Also, for patients with multiple or difficult-to-treat episodes, they may need to take the medication for years or even for life to prevent recurrence.

Patients and their physicians should thoroughly discuss the risk and benefits of any treatment intervention. Knowledge about the drug's indication, side effects, and prognosis with or without

treatment is a must.

Furthermore, it is crucial that bipolar patients should also receive individual psychotherapy to help them deal with the many personal and psychosocial issues they face on a daily basis. As you know, medication alone won't suffice to address financial problems, marital conflict, work issues, and prior abuse.

In summary, the combination of medication and psychotherapy is the best treatment for bipolar disorder.

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My Experience With Bipolar

By Triston Huntsmin

As a counseling psychologist, I enjoy a variety of clients each day with a variety of needs. I see couples who are on the edge of divorce yet still want to save their marriage and I see young children who are struggling after the loss of a parent or sibling. Some of my most interesting clients are those that deal with bipolar. I was never trained to specifically deal with bipolar, so I had to dive in with my first bipolar client and learn as I went.

I'll never forget meeting with my first (of many) client who was struggling with bipolar. I was a little bit afraid because I only had a basic knowledge of the problem and even less understanding of effective treatment plans for the disorder. The first three sessions I had with this bipolar client I simply let her

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talk. I asked questions as a method of gaining information, but I barely gave any tidbit of counsel or direction. Why? Because I didn't know what to say. I had never experienced someone in my years of preparation and internship for counseling who was so clearly up and down and almost living two different lives.

Each day after I met with my first bipolar client I shut myself in my office and spent the day pouring over books and other credible resources that would help me learn about the disorder. I called up a few friends that were specialists on the topic and I did ever possible proactive thing to be more prepared for my client by the next week.

The things I have learned in the fifteen years since that first close encounter with someone struggling with bipolar are things I never expected to learn. I have become so intrigued with the subject that I have conducted a series of clinical research studies aimed at bringing further understanding of bipolar into the medical and psychological communities. Studying and aiding people with bipolar truly has become my life's work and passion. In the strangest way it snuck up on me and became all I could focus on. It has been my privilege to receive certification as a "bipolar needs specialist" and to begin teaching other counselors how to aptly deal with the problems of bipolar.

If you or someone you know struggles with bipolar disorder, then my advice is simple: learn more. Educating yourself on this important topic is the most important thing you can do. There is much to be learned and much victory to be gained in this area as more people learn the truth.

Triston Huntsmin is a counseling psychologist who now specializes in the diagnosis and treatment of bipolar patients. See

for more information on the disorder.

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