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Learn About These Medications for Bipolar Disorder

Understanding Your Bipolar Medication Options

Every day we take medications several times a day as directed by our doctor, hoping for the best result. In a perfect world the expected results would quickly manifest, alleviating us from our symptoms and allowing us to go on with our lives. But the real world is not perfect, and doctors can spend months, even years, finding the right combination of drugs for each patient.

The process can be long and drawn out in some part because the process is not an exact science. Simply put, even the best doctor cannot predict how a patient will react to a medication.

As more drugs are added to the cocktail, the process gets more complicated and even less predictable. So most of us will experience ongoing changes in our medications.

If you have bipolar, your cocktail generally consists of three types of drugs: mood stabilizers, anti-depressants and anti-psychotics. Let's take a look at the options for each.

Mood Stabilizers

Mood stabilizers are drugs that help keep you steady, avoiding both the highs and lows of the illness. The primary mood stabilizers are:

- **Lithium** – [Lithium](#) was discovered in the 1940s, but did not achieve widespread use in the United



States until the 1960s. Unlike many other psychotropic drugs, lithium is found in nature and was not created in a laboratory.

- **Depakote (valporic acid)** – Valporic acid was originally patented as an anti-convulsant. It has been widely used since the early 1980s and surpassed lithium as the most used anti-psychotic in the 1990s.
- **Lamictal (lamotrigine)** – Like valporic acid, lamotrigine is also used as an anti-convulsant for seizures. It was introduced for use in bipolar patients around 2003.
- **Equetro, Tegretol (carbamazepine)** – Carbamazepine also originated as an anti-convulsant, but was approved for use in bipolar patients in 2005.

Anti-Depressants

Anti-depressants are one of the most prescribed drug classes in all of medicine, so there are many choices. However, researchers have noted differences in the treatment of bipolar depression versus unipolar depression.

Generally speaking, some medications are not as effective in bipolar patients, giving them fewer choices. Many anti-depressants are indicated for OCD (obsessive compulsive disorder), eating disorders and other conditions. The following is a review of the different sub-classes of anti-depressants:

Tricyclic Anti-Depressants

TCAs were developed and marketed in the 1950s. The goal of the TCA is to increase the amount of neurotransmitters like serotonin and noradrenaline.

However, TCAs work differently than SSRIs and SSNIs. These drugs prevent the neurotransmitters from binding with specific receptors on the nerves where they build up in between the nerve cells. This allows the neurotransmitter levels to increase.

Common TCAs include:

- Amitriptyline
- Amoxapine
- Desipramine (Norpramin)
- Doxepin

- Imipramine (Tofranil)
- Nortriptyline (Pamelor)
- Protriptyline (Vivactil)
- Trimipramine (Surmontil)

Monoamine Oxidase Inhibitors

MAOIs were introduced in the late 1950s and used up into the 1970s. These drugs inhibit the activity of the monoamine oxidase enzyme family. Because of potentially lethal dietary and drug interactions, MAOIs are now reserved as a last line of treatment, used only when other classes of antidepressant drugs have failed.

MAOIs include:

- Isocarboxazid (Marplan)
- Phenelzine (Nardil)
- Tranylcypromine (Parnate)

Tetracyclic Anti-Depressants

TeCAs came on the market in the 1970s. They are similar to TCAs in that they increase the neurotransmitter levels; however, unlike TCAs, which have three rings on the atomic level, tetracyclic anti-depressants have four rings.

- Amoxapine (Asendin)
- Maprotiline (Ludiomil)
- Mianserin (Bolvidon, Norval, Tolvon)
- Mirtazapine (Remeron)
- Setiptiline (Tecipul)

Selective Serotonin Reuptake Inhibitors

SSRIs are designed to increase the level of the neurotransmitter serotonin. This is done by limiting its reabsorption into a specific type of cell, which then increases the level of serotonin in other cells so it can bind to the desired receptors.

SSRIs became available in the 1980s and are the most widely used antidepressants, although some bipolar patients do not respond well to these drugs.

- Citalopram (Celexa)
- Escitalopram (Lexapro, Cipralex)
- Paroxetine (Paxil, Seroxat)
- Fluoxetine (Prozac)
- Fluvoxamine (Luvox)
- Sertraline (Zoloft, Lustral)

Next page: more anti-depressants and other bipolar medication options.

Anti-Depressants

Serotonin and Noradrenaline Reuptake Inhibitors

SNRIs are similar to SSRIs, but also limit the reabsorption of noradrenaline in addition to that of serotonin. SNRIs became available in the 1990s, and are not as widely used as SSRIs. Common SNRIs include:

- Desvenlafaxine (Pristiq)
- Duloxetine (Cymbalta)
- Levomilnacipran (Fetzima)
- Milnacipran (Ixel, Savella)
- Tofenacin (Elamol, Tofacine)
- Venlafaxine (Effexor)

Noradrenaline Reuptake Inhibitors

NRIs work by blocking the action of the norepinephrine transporter (NET). Norepinephrine is also a neurotransmitter, like serotonin. This blockage allows for increased concentrations of norepinephrine outside of the cells.

- Reboxetine (Edronax)
- Viloxazine (Vivalan)

Melatonergic Antidepressants

These are a new class of antidepressants that came in the last 10 years. The drugs are the result of an accidental discovery of a synthetic melatonin and its effect on serotonergic receptors. This led to a more thorough investigation where the serotonin benefits were documented. Options include:

- Agomelatine (Valdoxan, Melitor, Thymanax)

Atypical Anti-Psychotics

These are a separate sub-class of bipolar drugs used to control mania. However, a few of these drugs are used as anti-depressants too:

- Amisulpride (Solian)
- Lurasidone (Latuda)
- Quetiapine (Seroquel)

Anti-Psychotic Drugs

Anti-psychotics are used to inhibit bipolar mania. Many of these drugs are also used by those diagnosed with schizophrenia.

In the past 30 years a new class of anti-psychotic medications was developed; because they were different from the original drugs they became known as atypical anti-psychotics.

Atypical antipsychotics are so named because they treat the symptoms in a manner that is not like its predecessors. The chemistry of these drugs involves neurotransmitters, but is more complex as the drug attacks specific sites of the cell, relying upon specific receptors.

Just like anti-depressants, anti-psychotics work on the brain chemistry. In addition affecting the serotonin and noradrenaline, these drugs also affect the dopamine levels. If your doctor has prescribed an antipsychotic it is likely one of these drugs:

- Aripiprazole (Abilify)
- Asenapine (Saphris)
- Clozapine (Clozaril)
- Olanzapine (Zyprexa)

- Quetiapine (Seroquel)
- Lurasidone (Latuda)
- Risperidone (Risperdal)
- Ziprasidon (Geodon)

Commonly prescribed *typical* antipsychotics are listed below:

- Chlorpromazine (Thorazine)
- Haloperidol (Haldol)

Thorazine was introduced in the 1950s and Halodol came in the 1970s. While it is possible for your doctor to temporarily prescribe one of these medications, it is unlikely you will be on any of these drugs for the long term.

The newer atypical antipsychotic drugs represent significant advancement, leaving little need for the original antipsychotics.



Sharon Davis

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