What is bipolar disorder?

Bipolar disorder, also known as manic-depressive illness, is a brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out daily tasks. Symptoms of bipolar disorder can be severe. They are different from the normal ups and downs that everyone goes through from time to time. Bipolar disorder symptoms can result in damaged relationships, poor job or school performance, and even suicide. But bipolar disorder can be treated, and people with this illness can lead full and productive lives.

Bipolar disorder often appears in the late teens or early adult years. At least half of all cases start before age 25.[1] Some people have their first symptoms during childhood, while others may develop symptoms late in life.

Bipolar disorder is not easy to spot when it starts. Some people suffer for years before they are properly diagnosed and treated. Like diabetes or heart disease, bipolar disorder is a long-term illness that must be carefully managed throughout your life.

What are the signs and symptoms of bipolar disorder?

People with bipolar disorder experience unusually intense emotional states that occur in distinct periods called "mood episodes." **Each mood episode represents a drastic change from a person's usual mood and behavior**.

An overly joyful or overexcited state is called a manic episode, and an extremely sad or hopeless state is called a depressive episode. Sometimes, a mood episode includes symptoms of both mania and depression. This is called a mixed state. People with bipolar disorder also may be explosive and irritable during a mood episode. Extreme changes in energy, activity, sleep, and behavior go along with these changes in mood.

Symptoms of bipolar disorder are described below.

Symptoms of mania or a manic episode include:	Symptoms of depression or a depressive episode include:
Mood Changes	**Mood Changes**
▶ An overly long period of feeling "high," or an overly happy or outgoing mood ▶ Extreme irritability.	▶ An overly long period of feeling sad or hopeless ▶ Loss of interest in activities once enjoyed, including sex.
Behavioral Changes	**Behavioral Changes**
▶ Talking very fast, jumping from one idea to another, having racing thoughts ▶ Being unusually distracted ▶ Increasing activities, such as taking on multiple new projects ▶ Being overly restless ▶ Sleeping little or not being tired ▶ Having an unrealistic belief in your abilities ▶ Behaving impulsively and engaging in pleasurable, high-risk behaviors.	▶ Feeling overly tired or "slowed down" ▶ Having problems concentrating, remembering, and making decisions ▶ Being restless or irritable ▶ Changing eating, sleeping, or other habits ▶ Thinking of death or suicide, or attempting suicide.

Bipolar disorder can be present even when mood swings are less extreme. For example, some people with bipolar disorder experience hypomania, a less severe form of mania. During a hypomanic episode, you may feel very good, be highly productive, and function well. You may not feel that anything is wrong, but family and friends may recognize the mood swings as possible bipolar disorder. Without proper treatment, people with hypomania may develop severe mania or depression.

Bipolar disorder may also be present in a mixed state, in which you might experience both mania and depression at the same time. During a mixed state, you might feel very agitated, have trouble sleeping, experience major changes in appetite, and have suicidal thoughts. People in a mixed state may feel very sad or hopeless while at the same time feel extremely energized.

Sometimes, a person with severe episodes of mania or depression has psychotic symptoms too, such as hallucinations or delusions. The psychotic symptoms tend to reflect the person's extreme mood. For example, if you are having psychotic symptoms during a manic episode, you may believe you are a famous person, have a lot of money, or have special powers. If you are having psychotic symptoms during a depressive episode, you may believe you are ruined and penniless, or you have committed a crime. As a result, people with bipolar disorder who have psychotic symptoms are sometimes misdiagnosed with schizophrenia.

People with bipolar disorder may also abuse alcohol or substances, have relationship problems, or perform poorly in school or at work. It may be difficult to recognize these problems as signs of a major mental illness.

How is bipolar disorder diagnosed?

Bipolar disorder usually lasts a lifetime. Episodes of mania and depression typically come back over time. Between episodes, many people with bipolar disorder are free of symptoms, but some people may have lingering symptoms.

Doctors diagnose bipolar disorder using guidelines from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). **To be diagnosed with bipolar disorder, the symptoms must be a major change from your normal mood or behavior**. There are four basic types of bipolar disorder:

- 1. **Bipolar I Disorder—**defined by manic or mixed episodes that last at least seven days, or by manic symptoms that are so severe that the person needs immediate hospital care. Usually, depressive episodes occur as well, typically lasting at least 2 weeks.
- 2. **Bipolar II Disorder—**defined by a pattern of depressive episodes and hypomanic episodes, but no full-blown manic or mixed episodes.
- 3. **Bipolar Disorder Not Otherwise Specified (BP-NOS)—**diagnosed when symptoms of the illness exist but do not meet diagnostic criteria for either bipolar I or II. However, the symptoms are clearly out of the person's normal range of behavior.
- 4. **Cyclothymic Disorder, or Cyclothymia—**a mild form of bipolar disorder. People with cyclothymia have episodes of hypomania as well as mild depression for at least 2 years. However, the symptoms do not meet the diagnostic requirements for any other type of bipolar disorder.

A severe form of the disorder is called **Rapid-cycling Bipolar Disorder**. Rapid cycling occurs when a person has four or more episodes of major depression, mania, hypomania, or mixed states, all within a year.[2] Rapid cycling seems to be more common in people who have their first bipolar episode at a younger age. One study found that people with rapid cycling had their first episode about 4 years earlier—during the mid to late teen years—than people without rapid cycling bipolar disorder.[3] Rapid cycling affects more women than men.[4] Rapid cycling can come and go.

When getting a diagnosis, a doctor or health care provider should conduct a physical examination, an interview, and lab tests. Currently, bipolar disorder cannot be identified through a blood test or a brain scan, but these tests can help rule out other factors that may contribute to mood problems, such as a stroke, brain tumor, or thyroid condition. If the problems are not caused by other illnesses, your health care provider may conduct a mental health evaluation or provide a referral to a trained mental health professional, such as a psychiatrist, who is experienced in diagnosing and treating bipolar disorder.

The doctor or mental health professional should discuss with you any family history of bipolar disorder or other mental illnesses and get a complete history of symptoms. The doctor or mental health professional should also talk to your close relatives or spouse about your symptoms and family medical history.

People with bipolar disorder are more likely to seek help when they are depressed than when experiencing mania or hypomania.5 Therefore, a careful medical history is needed to assure that bipolar disorder is not mistakenly diagnosed as major depression. Unlike people with bipolar disorder, people who have depression only (also called unipolar depression) do not experience mania.

Bipolar disorder can worsen if left undiagnosed and untreated. Episodes may become more frequent or more severe over time without treatment.6 Also, delays in getting the correct diagnosis and treatment can contribute to personal, social, and work-related problems.7 Proper diagnosis and treatment help people with bipolar disorder lead healthy and productive lives. In most cases, treatment can help reduce the frequency and severity of episodes.

What illnesses often co-exist with bipolar disorder?

Substance abuse is very common among people with bipolar disorder, but the reasons for this link are unclear.[8] Some people with bipolar disorder may try to treat their symptoms with alcohol or drugs. Substance abuse can also trigger or prolong bipolar symptoms, and the behavioral problems associated with mania can lead to drinking too much.

Anxiety disorders, such as post-traumatic stress disorder (PTSD) and social phobia, also can co-occur with bipolar disorder.[9,10,11] Bipolar disorder can co-occur with attention deficit hyperactivity disorder (ADHD) as well, which has some symptoms that overlap with bipolar disorder, such as restlessness and being easily distracted. However, the symptoms of ADHD are persistent, whereas those of bipolar disorder are episodic.

In addition, people with bipolar disorder are at higher risk for thyroid disease, migraine headaches, heart disease, diabetes, obesity, and other physical illnesses.[12,13] These illnesses may cause symptoms of mania or depression, or they may be caused by some medications used to treat bipolar disorder.

What are the risk factors for bipolar disorder?

Scientists are studying the possible causes of bipolar disorder. Most agree that there is no single cause. Rather, many factors likely act together to produce the illness or increase risk for developing it.

Genetics

Bipolar disorder tends to run in families. Some research has suggested that people with certain genes are more likely to develop bipolar disorder than others.[14] Children with a parent or sibling who has bipolar disorder are much more likely to develop the illness, compared with children who do not have a family history of bipolar disorder.[15] However, most children with a family history of bipolar disorder will not develop the illness.

Technological advances are improving genetic research on bipolar disorder. One example is the launch of the Bipolar Disorder Phenome Database, funded in part by NIMH. Using the database, scientists will be able to link visible signs of the disorder with the genes that may influence them.[16]

Scientists are also studying illnesses with similar symptoms such as depression and schizophrenia to identify genetic differences that may increase a person's risk for developing bipolar disorder.[17,18,19] Finding these genetic "hotspots" may also help explain how environmental factors can increase a person's risk.

But genes are not the only risk factor for bipolar disorder. Studies of identical twins have shown that the twin of a person with bipolar illness does not always develop the disorder, despite the fact that identical twins share all of the same genes. Research suggests that factors besides genes are also at work. It is likely that many different genes and environmental factors are involved. However, scientists do not yet fully understand how these factors interact to cause bipolar disorder.

Brain structure and functioning

Brain-imaging tools, such as functional magnetic resonance imaging (fMRI) and positron emission tomography

(PET), allow researchers to take pictures of the living brain at work. These tools help scientists study the brain's structure and activity.

Some imaging studies show how the brains of people with bipolar disorder may differ from the brains of healthy people or people with other mental disorders. For example, one study using MRI found that the pattern of brain development in children with bipolar disorder was similar to that in children with "multi-dimensional impairment," a disorder that causes symptoms that overlap somewhat with bipolar disorder and schizophrenia.[20] This suggests that the pattern of brain development in the two conditions may be associated with the risk for unstable moods.

Another MRI study found that the brain's prefrontal cortex in adults with bipolar disorder tends to be smaller and function less well compared to adults who don't have bipolar disorder.[21,22] The prefrontal cortex is a brain structure involved in "executive" functions such as solving problems and making decisions. This structure and its connections to other parts of the brain mature during adolescence, suggesting that abnormal development of this brain circuit may account for why the disorder tends to emerge during a person's teen years.[23] Pinpointing brain changes in youth may help us detect illness early or offer targets for early intervention.

The connections between brain regions are important for shaping and coordinating functions such as forming memories, learning, and emotions, but scientists know little about how different parts of the human brain connect. Learning more about these connections, along with information gained from genetic studies, helps scientists better understand bipolar disorder. Scientists are working towards being able to predict which types of treatment will work most effectively.

How is bipolar disorder treated?

Bipolar disorder cannot be cured, but it can be treated effectively over the long-term. Proper treatment helps many people with bipolar disorder—even those with the most severe forms of the illness—gain better control of their mood swings and related symptoms.[24,25,26] But because it is a lifelong illness, long-term, continuous treatment is needed to control symptoms.[27]

However, even with proper treatment, mood changes can occur. In the NIMH-funded Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD) study—the largest treatment study ever conducted for bipolar disorder—almost half of those who recovered still had lingering symptoms. Having another mental disorder in addition to bipolar disorder increased one's chances for a relapse.[28] See STEP-BD for more information.

Treatment is more effective if you work closely with a doctor and talk openly about your concerns and choices. An effective maintenance treatment plan usually includes a combination of medication and psychotherapy.

Medications

Different types of medications can help control symptoms of bipolar disorder. Not everyone responds to medications in the same way. You may need to try several different medications before finding ones that work best for you.

Keeping a daily life chart that makes note of your daily mood symptoms, treatments, sleep patterns, and life events can help you and your doctor track and treat your illness most effectively. If your symptoms change or if side effects become intolerable, your doctor may switch or add medications.

The types of medications generally used to treat bipolar disorder include mood stabilizers, atypical antipsychotics, and antidepressants. For the most up-to-date information on medication use and their side effects, contact the U.S. Food and Drug Administration (FDA).

Mood stabilizers are usually the first choice to treat bipolar disorder. In general, people with bipolar disorder continue treatment with mood stabilizers for years. Lithium (also known as Eskalith or Lithobid) is an effective mood stabilizer. It was the first mood stabilizer approved by the FDA in the 1970's for treating both manic and depressive episodes.

Anticonvulsants are also used as mood stabilizers. They were originally developed to treat seizures, but they also help control moods. Anticonvulsants used as mood stabilizers include:

- Valproic acid or divalproex sodium (Depakote), approved by the FDA in 1995 for treating mania. It is a popular alternative to lithium. However, young women taking valproic acid face special precautions. See the sidebar, "Should young women take valproic acid?"
- Lamotrigine (Lamictal), FDA-approved for maintenance treatment of bipolar disorder. It is often effective in treating depressive symptoms.
- Other anticonvulsant medications, including gabapentin (Neurontin), topiramate (Topamax), and oxcarbazepine (Trileptal).

Valproic acid, lamotrigine, and other anticonvulsant medications have an FDA warning. The warning states that their use may increase the risk of suicidal thoughts and behaviors. People taking anticonvulsant medications for bipolar or other illnesses should be monitored closely for new or worsening symptoms of depression, suicidal thoughts or behavior, or any unusual changes in mood or behavior. If you take any of these medications, do not make any changes to your dosage without talking to your doctor.

What are the side effects of mood stabilizers?

Lithium can cause side effects such as:

- Restlessness
- Dry mouth
- Bloating or indigestion
- Acne
- Unusual discomfort to cold temperatures
- Joint or muscle pain
- Brittle nails or hair.

When taking lithium, your doctor should check the levels of lithium in your blood regularly, and will monitor your kidney and thyroid function as well. Lithium treatment may cause low thyroid levels in some people.29 Low thyroid function, called hypothyroidism, has been associated with rapid cycling in some people with bipolar disorder, especially women.

Because too much or too little thyroid hormone can lead to mood and energy changes, it is important that your doctor check your thyroid levels carefully. You may need to take thyroid medication, in addition to medications for bipolar disorder, to keep thyroid levels balanced.

Common side effects of other mood stabilizing medications include:

- Drowsiness
- Dizziness
- Headache
- Diarrhea
- Constipation
- Heartburn
- Mood swings
- Stuffed or runny nose, or other cold-like symptoms.

These medications may also be linked with rare but serious side effects. Talk with your doctor or a pharmacist to make sure you understand signs of serious side effects for the medications you're taking. If extremely bothersome or unusual side effects occur, tell your doctor as soon as possible.

Should young women take valproic acid?

Valproic acid may increase levels of testosterone (a male hormone) in teenage girls. It could lead to a condition called polycystic ovary syndrome (PCOS) in women who begin taking the medication before age 20.[30,31] PCOS can cause obesity, excess body hair, an irregular menstrual cycle, and other serious symptoms. Most of these symptoms will improve after stopping treatment with valproic acid.[32] Young girls and women taking valproic acid should be monitored carefully by a doctor.

Atypical antipsychotics are sometimes used to treat symptoms of bipolar disorder. Often, these medications are taken with other medications, such as antidepressants. Atypical antipsychotics include:

- Olanzapine (Zyprexa), which when given with an antidepressant medication, may help relieve symptoms of severe mania or psychosis.[33] Olanzapine can be taken as a pill or a shot. The shot is often used for urgent treatment of agitation associated with a manic or mixed episode. Olanzapine can be used as maintenance treatment as well, even when psychotic symptoms are not currently present.
- Aripiprazole (Abilify), which is used to treat manic or mixed episodes. Aripiprazole is also used for maintenance treatment. Like olanzapine, aripiprazole can be taken as a pill or a shot. The shot is often used for urgent treatment of severe symptoms.
- Quetiapine (Seroquel), risperidone (Risperdal) and ziprasidone (Geodon) also are prescribed to relieve the symptoms of manic episodes.

What are the side effects of atypical antipsychotics?

If you are taking antipsychotics, you should not drive until you have adjusted to your medication. Side effects of many antipsychotics include:

- Drowsiness
- Dizziness when changing positions
- Blurred vision
- Rapid heartbeat
- Sensitivity to the sun

- Skin rashes
- Menstrual problems for women.

Atypical antipsychotic medications can cause major weight gain and changes in your metabolism. This may increase your risk of getting diabetes and high cholesterol.[34] Your doctor should monitor your weight, glucose levels, and lipid levels regularly while you are taking these medications.

In rare cases, long-term use of atypical antipsychotic drugs may lead to a condition called tardive dyskinesia (TD). The condition causes uncontrollable muscle movements, frequently around the mouth. TD can range from mild to severe. Some people with TD recover partially or fully after they stop taking the drug, but others do not.

Antidepressants are sometimes used to treat symptoms of depression in bipolar disorder. Fluoxetine (Prozac), paroxetine (Paxil), sertraline (Zoloft), and bupropion (Wellbutrin) are examples of antidepressants that may be prescribed to treat symptoms of bipolar depression.

However, taking only an antidepressant can increase your risk of switching to mania or hypomania, or of developing rapid-cycling symptoms.35 To prevent this switch, doctors usually require you to take a mood-stabilizing medication at the same time as an antidepressant.

What are the side effects of antidepressants?

Antidepressants can cause:

- Headache
- Nausea (feeling sick to your stomach)
- Agitation (feeling jittery)
- Sexual problems, which can affect both men and women. These include reduced sex drive and problems having and enjoying sex.

Report any concerns about side effects to your doctor right away. You may need a change in the dose or a different medication. You should not stop taking a medication without talking to your doctor first. Suddenly stopping a medication may lead to "rebound" or worsening of bipolar disorder symptoms. Other uncomfortable or potentially dangerous withdrawal effects are also possible.

Some antidepressants are more likely to cause certain side effects than other types. Your doctor or pharmacist can answer questions about these medications. Any unusual reactions or side effects should be reported to a doctor immediately.

FDA Warning on Antidepressants

Antidepressants are safe and popular, but some studies have suggested that they may have unintentional effects on some people, especially in adolescents and young adults. The FDA warning says that patients of all ages taking antidepressants should be watched closely, especially during the first few weeks of treatment. Possible side effects to look for are depression that gets worse, suicidal thinking or behavior, or any unusual

changes in behavior such as trouble sleeping, agitation, or withdrawal from normal social situations. For the latest information, see the FDA website .

Should women who are pregnant or may become pregnant take medication for bipolar disorder?

Women with bipolar disorder who are pregnant or may become pregnant face special challenges. Mood stabilizing medications can harm a developing fetus or nursing infant.[36] But stopping medications, either suddenly or gradually, greatly increases the risk that bipolar symptoms will recur during pregnancy.[37]

Lithium is generally the preferred mood-stabilizing medication for pregnant women with bipolar disorder.[38,39] However, lithium can lead to heart problems in the fetus. In addition, women need to know that most bipolar medications are passed on through breast milk.[40] The FDA has also issued warnings about the potential risks associated with the use of antipsychotic medications during pregnancy. If you are pregnant or nursing, talk to your doctor about the benefits and risks of all available treatments.

Psychotherapy

When done in combination with medication, psychotherapy can be an effective treatment for bipolar disorder. It can provide support, education, and guidance to people with bipolar disorder and their families. Some psychotherapy treatments used to treat bipolar disorder include:

- **Cognitive behavioral therapy (CBT)**, which helps people with bipolar disorder learn to change harmful or negative thought patterns and behaviors.
- **Family-focused therapy**, which involves family members. It helps enhance family coping strategies, such as recognizing new episodes early and helping their loved one. This therapy also improves communication among family members, as well as problem-solving.
- **Interpersonal and social rhythm therapy**, which helps people with bipolar disorder improve their relationships with others and manage their daily routines. Regular daily routines and sleep schedules may help protect against manic episodes.
- **Psychoeducation**, which teaches people with bipolar disorder about the illness and its treatment. Psychoeducation can help you recognize signs of an impending mood swing so you can seek treatment early, before a full-blown episode occurs. Usually done in a group, psychoeducation may also be helpful for family members and caregivers.

In a STEP-BD study on psychotherapies, researchers compared people in two groups. The first group was treated with collaborative care (three sessions of psychoeducation over 6 weeks). The second group was treated with medication and intensive psychotherapy (30 sessions over 9 months of CBT, interpersonal and social rhythm therapy, or family-focused therapy). Researchers found that the second group had fewer relapses, lower hospitalization rates, and were better able to stick with their treatment plans.[41] They were also more likely to get well faster and stay well longer. Overall, more than half of the study participants recovered over the course of 1 year.

A licensed psychologist, social worker, or counselor typically provides psychotherapy. He or she should work with

your psychiatrist to track your progress. The number, frequency, and type of sessions should be based on your individual treatment needs. As with medication, following the doctor's instructions for any psychotherapy will provide the greatest benefit.

Visit the NIMH website for more information on psychotherapy.

Other treatments

Electroconvulsive Therapy (ECT)—For cases in which medication and psychotherapy do not work, electroconvulsive therapy (ECT) may be useful. ECT, formerly known as "shock therapy," once had a bad reputation. But in recent years, it has greatly improved and can provide relief for people with severe bipolar disorder who have not been able to recover with other treatments.

Before ECT is administered, a patient takes a muscle relaxant and is put under brief anesthesia. He or she does not consciously feel the electrical impulse administered in ECT. On average, ECT treatments last from 30–90 seconds. People who have ECT usually recover after 5–15 minutes and are able to go home the same day.[42]

Sometimes ECT is used for bipolar symptoms when other medical conditions, including pregnancy, make the use of medications too risky. ECT is a highly effective treatment for severely depressive, manic, or mixed episodes. But it is generally not used as a first-line treatment.

ECT may cause some short-term side effects, including confusion, disorientation, and memory loss. People with bipolar disorder should discuss possible benefits and risks of ECT with an experienced doctor.[43]

Sleep Medications—People with bipolar disorder who have trouble sleeping usually sleep better after getting treatment for bipolar disorder.[44] However, if sleeplessness does not improve, your doctor may suggest a change in medications. If the problems still continue, your doctor may prescribe sedatives or other sleep medications.

Herbal Supplements—In general, not much research has been conducted on herbal or natural supplements and how they may affect bipolar disorder. An herb called St. John's wort (Hypericum perforatum), often marketed as a natural antidepressant, may cause a switch to mania in some people with bipolar disorder.[45] St. John's wort can also make other medications less effective, including some antidepressant and anticonvulsant medications.[46] Scientists are also researching omega-3 fatty acids (most commonly found in fish oil) to measure their usefulness for long-term treatment of bipolar disorder.[47] Study results have been mixed.[48]

> Be sure to tell your doctor about all prescription drugs, over-the-counter medications, or supplements you are taking. Certain medications and supplements taken together may cause unwanted or dangerous effects.

What research is NIMH doing to improve treatments for bipolar disorder?

Scientists are working to identify new targets for improving current medications or developing new treatments for bipolar disorder.[49,50] In addition, NIMH researchers have made promising advances toward finding fast-acting

medication treatment. In a small study of people with bipolar disorder whose symptoms had not responded to prior treatments, a single dose of ketamine—an anesthetic medication—significantly reduced symptoms of depression in as little as 40 minutes.[51] These effects lasted about a week on average.

Ketamine itself is unlikely to become widely available as a treatment because it can cause serious side effects at high doses, such as hallucinations. However, scientists are working to understand how the drug works on the brain in an effort to develop treatments with fewer side effects and that act similarly to ketamine. Such medications could also be used for longer term management of symptoms.

In addition, NIMH is working to better understand bipolar disorder and other mental disorders by spearheading the Research Domain Criteria (RDoC) Project, which is an ongoing effort to map our current understanding of the brain circuitry that is involved in behavioral and cognitive functioning. By essentially breaking down mental disorders into their component pieces—RDoC aims to add to the knowledge we have gained from more traditional research approaches that focus solely on understanding mental disorders based on symptoms. The hope is that by changing the way we approach mental disorders, RDoC will help us open the door to new targets of preventive and treatment interventions.

How can I help a friend or relative who has bipolar disorder?

If you know someone who has bipolar disorder, it affects you too. The first and most important thing you can do is help him or her get the right diagnosis and treatment. You may need to make the appointment and go with him or her to see the doctor. Encourage your loved one to stay in treatment.

To help a friend or relative, you can:

- Offer emotional support, understanding, patience, and encouragement
- Learn about bipolar disorder so you can understand what your friend or relative is experiencing
- Talk to your friend or relative and listen carefully
- Listen to feelings your friend or relative expresses and be understanding about situations that may trigger bipolar symptoms
- Invite your friend or relative out for positive distractions, such as walks, outings, and other activities
- Remind your friend or relative that, with time and treatment, he or she can get better.

Never ignore comments from your friend or relative about harming himself or herself. Always report such comments to his or her therapist or doctor.

How can caregivers find support?

Like other serious illnesses, bipolar disorder can be difficult for spouses, family members, friends, and other caregivers. Relatives and friends often have to cope with the person's serious behavioral problems, such as wild spending sprees during mania, extreme withdrawal during depression, or poor work or school performance. These behaviors can have lasting consequences.

Caregivers usually take care of the medical needs of their loved ones. But caregivers have to deal with how this affects their own health as well. Caregivers' stress may lead to missed work or lost free time, strained relationships with people who may not understand the situation, and physical and mental exhaustion.

It can be very hard to cope with a loved one's bipolar symptoms. One study shows that if a caregiver is under a lot of stress, his or her loved one has more trouble following the treatment plan, which increases the chance for a major bipolar episode.[52] If you are a caregiver of someone with bipolar disorder, it is important that you also make time to take care of yourself.

How can I help myself if I have bipolar disorder?

It may be very hard to take that first step to help yourself. It may take time, but you can get better with treatment.

To help yourself:

- Talk to your doctor about treatment options and progress.
- Keep a regular routine, such as going to sleep at the same time every night and eating meals at the same time every day.
- Try hard to get enough sleep.
- Stay on your medication.
- Learn about warning signs signaling a shift into depression or mania.
- Expect your symptoms to improve gradually, not immediately.

Where can I go for help?

If you are unsure where to go for help, ask your family doctor. Others who can help are listed below.

- Mental health specialists, such as psychiatrists, psychologists, social workers, or mental health counselors
- Health maintenance organizations
- Community mental health centers
- Hospital psychiatry departments and outpatient clinics
- Mental health programs at universities or medical schools
- State hospital outpatient clinics
- Family services, social agencies, or clergy
- Peer support groups
- Private clinics and facilities
- Employee assistance programs
- Local medical and/or psychiatric societies.

You can also check the phone book under "mental health," "health," "social services," "hotlines," or "physicians" for phone numbers and addresses. An emergency room doctor can also provide temporary help and can tell you where and how to get further help.

What if I or someone I know is in crisis?

If you are thinking about harming yourself, or know someone who is, tell someone who can help immediately.

-

- Call your doctor.
- Call 911 or go to a hospital emergency room to get immediate help or ask a friend or family member to help you do these things.
- Call the toll-free, 24-hour National Suicide Prevention Lifeline at 1-800-273-TALK (1-800-273-8255); TTY: 1-800-799-4TTY (4889) to talk to a trained counselor.

Make sure you or the suicidal person is not left alone.

Citations

1. Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Arch Gen Psychiatry*. 2005 Jun;62(6):593–602.

2. Akiskal HS. "Mood Disorders: Clinical Features." in Sadock BJ, Sadock VA (ed). (2005). *Kaplan & Sadock's Comprehensive Textbook of Psychiatry*. Lippincott Williams & Wilkins:Philadelphia.

3. Schneck CD, Miklowitz DJ, Miyahara S, Araga M, Wisniewski S, Gyulai L, Allen MH, Thase ME, Sachs GS. The prospective course of rapid-cycling bipolar disorder: findings from the STEP-BD. *Am J Psychiatry*. 2008 Mar;165(3):370–7; quiz 410.

4. Schneck CD, Miklowitz DJ, Calabrese JR, Allen MH, Thomas MR, Wisniewski SR, Miyahara S, Shelton MD, Ketter TA, Goldberg JF, Bowden CL, Sachs GS. Phenomenology of rapid-cycling bipolar disorder: data from the first 500 participants in the Systematic Treatment Enhancement Program. *Am J Psychiatry*. 2004 Oct;161(10):1902–1908.

5. Hirschfeld RM. Psychiatric Management, from "Guideline Watch: Practice Guideline for the Treatment of Patients With Bipolar Disorder, 2nd Edition". http://www.psychiatryonline.com/content.aspx?aID=148440 . Accessed on February 11, 2008.

6. Goodwin FK, Jamison KR. (2007) *Manic-Depressive Illness: Bipolar Disorders and Recurrent Depression, Second Edition*. Oxford University Press: New York.

7. *Constituency Survey: Living With Bipolar Disorder: How Far Have We Really Come?* National Depressive and Manic-Depressive Association. 2001.

8. Bizzarri JV, Sbrana A, Rucci P, Ravani L, Massei GJ, Gonnelli C, Spagnolli S, Doria MR, Raimondi F, Endicott J, Dell'Osso L, Cassano GB. The spectrum of substance abuse in bipolar disorder: reasons for use, sensation seeking and substance sensitivity. *Bipolar Disord*. 2007 May;9(3):213–220.

9. Mueser KT, Goodman LB, Trumbetta SL, Rosenberg SD, Osher C, Vidaver R, Auciello P, Foy DW. Trauma and posttraumatic stress disorder in severe mental illness. *J Consult Clin Psychol*. 1998 Jun;66(3):493–499.

10. Strakowski SM, Sax KW, McElroy SL, Keck PE, Jr., Hawkins JM, West SA. Course of psychiatric and substance abuse syndromes co-occurring with bipolar disorder after a first psychiatric hospitalization. *J Consult Clin Psychol*. 1998 Sep;59(9):465–471.

11. Krishnan KR. Psychiatric and medical comorbidities of bipolar disorder. *Psychosom Med*. 2005 Jan–

Feb;67(1):1–8.

12. Krishnan KR. Psychiatric and medical comorbidities of bipolar disorder. *Psychosom Med*. 2005 Jan–Feb;67(1):1–8.

13. Kupfer DJ. The increasing medical burden in bipolar disorder. *JAMA*. 2005 May 25;293(20):2528–2530.

14. Sklar P et al. Large-scale genome-wide association analysis of bipolar disorder identifies a new susceptibility locus near ODZ4. *Nat Genet*. 2011 Sep 18;43(10):977–983.

15. Nurnberger JI, Jr., Foroud T. Genetics of bipolar affective disorder. *Curr Psychiatry Rep*. 2000 Apr;2(2):147–157.

16. Potash JB, Toolan J, Steele J, Miller EB, Pearl J, Zandi PP, Schulze TG, Kassem L, Simpson SG, Lopez V, MacKinnon DF, McMahon FJ. The bipolar disorder phenome database: a resource for genetic studies. *Am J Psychiatry*. 2007 Aug;164(8):1229–1237.

17. Bipolar Disorder Genome Study (BiGS) Consortium, McMahon FJ, Akula N, Schulze TG, Muglia P, Tozzi F, Detera-Wadleigh SD, Steele CJ, Breuer R, Strohmaier J, Wendland JR, Mattheisen M, Mühleisen TW, Maier W, Nöthen MM, Cichon S, Farmer A, Vincent JB, Holsboer F, Preisig M, Rietschel M. Meta-analysis of genome-wide association data identifies a risk locus for major mood disorders on 3p21.1. *Nat Genet*. 2010 Feb;42(2):128–131.

18. Purcell SM, et al. Common polygenic variation contributes to risk of schizophrenia that overlaps with bipolar disorder. July 1, 2009, *Nature*.

19. Kumar RA, McGhee KA, Leach S, Bonaguro R, Maclean A, Aguirre-Hernandez R, Abrahams BS, Coccaro EF, Hodgins S, Turecki G, Condon A, Muir WJ, Brooks-Wilson AR, Blackwood DH, Simpson EM. Initial association of NR2E1 with bipolar disorder and identification of candidate mutations in bipolar disorder, schizophrenia, and aggression through resequencing. *Am J Med Genet B Neuropsychiatr Genet*. 2008 Sept 5;147B(6):880–889.

20. Gogtay N, Ordonez A, Herman DH, Hayashi KM, Greenstein D, Vaituzis C, Lenane M, Clasen L, Sharp W, Giedd JN, Jung D, Nugent Iii TF, Toga AW, Leibenluft E, Thompson PM, Rapoport JL. Dynamic mapping of cortical development before and after the onset of pediatric bipolar illness. *J Child Psychol Psychiatry*. 2007 Sep;48(9):852–862.

21. Blumberg HP. The next wave in neuroimaging research in pediatric bipolar disorder. *J Am Acad Child Adolesc Psychiatry*. 2008 May;47(5):483–5.

22. Chepenik LG, Raffo M, Hampson M, Lacadie C, Wang F, Jones MM, Pittman B, Skudlarski P, Blumberg HP. Functional connectivity between ventral prefrontal cortex and amygdala at low frequency in the resting state in bipolar disorder. *Psychiatry Res*. 2010 Jun 30;182(3):207–10.

23. Blumberg HP. The next wave in neuroimaging research in pediatric bipolar disorder. *J Am Acad Child Adolesc Psychiatry*. 2008 May;47(5):483–5.

24. Sachs GS, Printz DJ, Kahn DA, Carpenter D, Docherty JP. The Expert Consensus Guideline Series: Medication Treatment of Bipolar Disorder 2000. *Postgrad Med*. 2000 Apr;Spec No.:1–104.

25. Sachs GS, Thase ME. Bipolar disorder therapeutics: maintenance treatment. *Biol Psychiatry*. 2000 Sep 15;48(6):573–581.

26. Huxley NA, Parikh SV, Baldessarini RJ. Effectiveness of psychosocial treatments in bipolar disorder: state of the evidence. *Harv Rev Psychiatry*. 2000 Sep;8(3):126–140.

27. Miklowitz DJ. A review of evidence-based psychosocial interventions for bipolar disorder. *J Consult Clin Psychol*. 2006 67(Suppl 11):28–33.

28. Perlis RH, Ostacher MJ, Patel JK, Marangell LB, Zhang H, Wisniewski SR, Ketter TA, Miklowitz DJ, Otto MW, Gyulai L, Reilly-Harrington NA, Nierenberg AA, Sachs GS, Thase ME. Predictors of recurrence in bipolar disorder: primary outcomes from the Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD). *Am J Psychiatry*. 2006 Feb;163(2):217–224.

29. Kupka RW, Nolen WA, Post RM, McElroy SL, Altshuler LL, Denicoff KD, Frye MA, Keck PE, Jr., Leverich GS, Rush AJ, Suppes T, Pollio C, Drexhage HA. High rate of autoimmune thyroiditis in bipolar disorder: lack of association with lithium exposure. *Biol Psychiatry*. 2002 Feb 15;51(4):305–311.

30. Vainionpaa LK, Rattya J, Knip M, Tapanainen JS, Pakarinen AJ, Lanning P, Tekay A, Myllyla VV, Isojarvi JI. Valproate-induced hyperandrogenism during pubertal maturation in girls with epilepsy. *Ann Neurol*. 1999 Apr;45(4):444–450.

31. Joffe H, Cohen LS, Suppes T, McLaughlin WL, Lavori P, Adams JM, Hwang CH, Hall JE, Sachs GS. Valproate is associated with new-onset oligoamenorrhea with hyperandrogenism in women with bipolar disorder. *Biol Psychiatry*. 2006 Jun 1;59(11):1078–1086.

32. Joffe H, Cohen LS, Suppes T, Hwang CH, Molay F, Adams JM, Sachs GS, Hall JE. Longitudinal follow-up of reproductive and metabolic features of valproate-associated polycystic ovarian syndrome features: A preliminary report. *Biol Psychiatry*. 2006 Dec 15;60(12):1378–1381.

33. Tohen M, Sanger TM, McElroy SL, Tollefson GD, Chengappa KN, Daniel DG, Petty F, Centorrino F, Wang R, Grundy SL, Greaney MG, Jacobs TG, David SR, Toma V. Olanzapine versus placebo in the treatment of acute mania. Olanzapine HGEH Study Group. *Am J Psychiatry*. 1999 May;156(5):702–709.

34. Lieberman JA, Stroup TS, McEvoy JP, Swartz MS, Rosenheck RA, Perkins DO, Keefe RS, Davis SM, Davis CE, Lebowitz BD, Severe J, Hsiao JK. Effectiveness of antipsychotic drugs in patients with chronic schizophrenia. *N Engl J Med*. 2005 Sep 22;353(12):1209–1223.

35. Thase ME, Sachs GS. Bipolar depression: pharmacotherapy and related therapeutic strategies. *Biol Psychiatry*. 2000 Sep 15;48(6):558–572.

36. Llewellyn A, Stowe ZN, Strader JR, Jr. The use of lithium and management of women with bipolar disorder during pregnancy and lactation. *J Consult Clin Psychol*. 1998 59(Suppl 6):57–64.

37. Viguera AC, Whitfield T, Baldessarini RJ, Newport J, Stowe Z, Reminick A, Zurick A, Cohen LS. Risk of recurrence in women with bipolar disorder during pregnancy: prospective study of mood stabilizer discontinuation. *Am J Psychiatry*. 2007 Dec;164(12):1817–1824.

38. Viguera AC, Whitfield T, Baldessarini RJ, Newport J, Stowe Z, Reminick A, Zurick A, Cohen LS. Risk of recurrence in women with bipolar disorder during pregnancy: prospective study of mood stabilizer discontinuation. *Am J Psychiatry*. 2007 Dec;164(12):1817–1824.

39. Yonkers KA, Wisner KL, Stowe Z, Leibenluft E, Cohen L, Miller L, Manber R, Viguera A, Suppes T, Altshuler L. Management of bipolar disorder during pregnancy and the postpartum period. *Am J Psychiatry*. 2004 Apr;161(4):608–620.

40. Yonkers KA, Wisner KL, Stowe Z, Leibenluft E, Cohen L, Miller L, Manber R, Viguera A, Suppes T, Altshuler L. Management of bipolar disorder during pregnancy and the postpartum period. *Am J Psychiatry*. 2004 Apr;161(4):608–620.

41. Miklowitz DJ, Otto MW, Frank E, Reilly-Harrington NA, Wisniewski SR, Kogan JN, Nierenberg AA, Calabrese JR, Marangell LB, Gyulai L, Araga M, Gonzalez JM, Shirley ER, Thase ME, Sachs GS. Psychosocial treatments for bipolar depression: a 1-year randomized trial from the Systematic Treatment Enhancement Program (STEP). *Arch Gen Psychiatry*. 2007 Apr;64(4):419–426.

42. Pandya M, Pozuelo L, Malone D. Electroconvulsive therapy: what the internist needs to know. *Cleve Clin J Med*. 2007 Sep;74(9):679–685.

43. *Mental Health: A Report of the Surgeon General*. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health. 1999.

44. Plante DT, Winkelman JW. Sleep disturbance in bipolar disorder: therapeutic implications. *Am J Psychiatry*. 2008 Jul;165(7):830–43.

45. Nierenberg AA, Burt T, Matthews J, Weiss AP. Mania associated with St. John's wort. *Biol Psychiatry*. 1999 Dec 15;46(12):1707–1708.

46. Henney JE. From the Food and Drug Administration: Risk of Drug Interactions With St John's Wort. *JAMA*. 2000 Apr 5;283(13):1679.

47. Stoll AL, Severus WE, Freeman MP, Rueter S, Zboyan HA, Diamond E, Cress KK, Marangell LB. Omega 3 fatty acids in bipolar disorder: a preliminary double-blind, placebo-controlled trial. *Arch Gen Psychiatry*. 1999 May;56(5):407–412.

48. Freeman MP, Hibbeln JR, Wisner KL, Davis JM, Mischoulon D, Peet M, Keck PE, Jr., Marangell LB, Richardson AJ, Lake J, Stoll AL. Omega-3 fatty acids: evidence basis for treatment and future research in psychiatry. *J Consult Clin Psychol*. 2006 Dec;67(12):1954–1967.

49. Du J, Creson TK, Wu L-J, Ren M, Gray NA, Falke C, Wei Y, Wang Y, Blumenthal R, Machado-Vieira R, Yuan P, Chen G, Zhuo M, Manji HK. The Role of Hippocampal GluR1 and GluR2 Receptors in Manic-like Behavior. *The Journal of Neuroscience*, 2008; 28: 68–79.

50. Maeng S, Hunsberger J, Pearson B, Yuan P, Wang Y, Wei Y, McCammon J, Schloesser RJ, Zhou R, Du J, Chen G, McEwen B, Reed JC, Manji HK. BAG1 plays a critical role in regulating recover from both manic-like and depression-like behavioral impairments. *Proc Natl Acad Sci USA*. 2008 Jun 24;105(25):8766–8771.

51. Diazgranados, N., Ibrahim, L., Brutsche, N.E., Newberg, A., Kronstein, P., Khalife, S., Kammerer, W. A., Quezado, Z., Luckenbaugh, D.A., Salvadore, G., Machado-Vieira, R., Manji, H.K., and Zarate, C. A randomized add-on trial of an N-methyl-D-aspartate antagonist in treatment-resistant bipolar depression. *Archives of General Psychiatry* 2010;67(8):793–802.

52. Perlick DA, Rosenheck RA, Clarkin JF, Maciejewski PK, Sirey J, Struening E, Link BG. Impact of family burden and affective response on clinical outcome among patients with bipolar disorder. *Psychiatr Serv*. 2004 Sep;55(9):1029–1035.

For more information on bipolar disorder

Visit the National Library of Medicine's MedlinePlus

En Español

For information on clinical trials

National Library of Medicine clinical trials database

Information from NIMH is available in multiple formats. You can browse online, download documents in PDF, and order materials through the mail. Check the NIMH website for the latest information on this topic and to order publications. If you do not have Internet access, please contact the NIMH Information Resource Center at the numbers listed below.

National Institute of Mental Health
Office of Science Policy, Planning and Communications
Science Writing, Press and Dissemination Branch
6001 Executive Boulevard
Room 6200, MSC 9663
Bethesda, MD 20892-9663
Phone: 301-443-4513 or 1-866-615-NIMH (6464) toll-free
TTY: 301-443-8431 or 1-866-415-8051 toll-free
FAX: 301-443-4279
E-mail: nimhinfo@nih.gov
Website: http://www.nimh.nih.gov

Reprints

restricted.

If you have questions regarding these guidelines and use of NIMH publications, please contact the NIMH Information Resource Center at 1-866-615-6464 or e-mail at nimhinfo@nih.gov.

U.S. Department of Health and Human Services
National Institutes of Health
NIH Publication No. 12-3679
Revised 2012

Find Publications About:

- Bipolar Disorder

Related Information

- Browse Mental Health Topics
- About NIMH Publications

En Español

Esta página está disponible en español.

More from NIMH

- Image Library
- NIMH Multimedia
- Director's Blog
- Science News
- NIMH Copyright Information

Educational Resources

- The Science of Mental Illness: Grades 6-8

- The Brain's Inner Workings: Activities for Grades 9 through 12
- Brain Basics Module
- Neuroscience and Psychiatry Modules

Materials from Other Organizations

Other organizations offer various publications on mental health. Links on our website to other organizations do not constitute an endorsement of their policies or products.

- Substance Abuse and Mental Health Services Administration (SAMHSA)
- ClinicalTrials.gov
- MedlinePlus