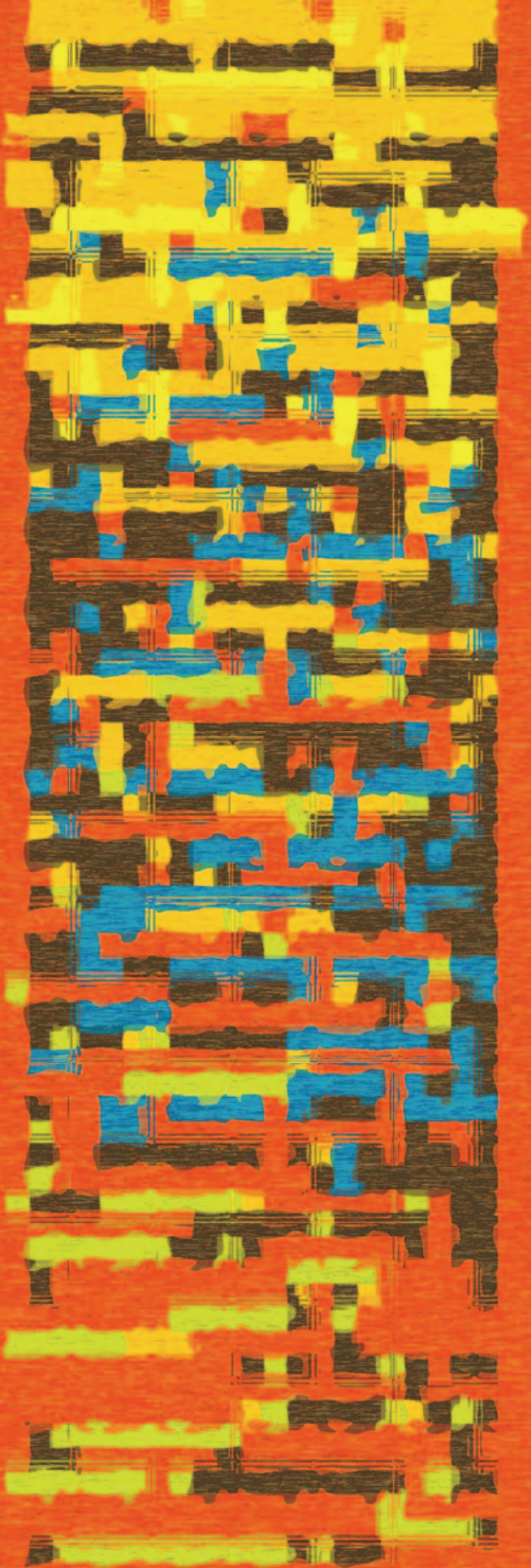
National Institute
of Mental Health

depression



Contents

What is depression?

Everyone occasionally feels blue or sad. But these feelings are usually short-lived and pass within a couple of days. When you have depression, it interferes with daily life and causes pain for both you and those who care about you. Depression is a common but serious illness.

Many people with a depressive illness never seek treatment. But the majority, even those with the most severe depression, can get better with treatment. Medications, psychotherapies, and other methods can effectively treat people with depression.

What are the different forms of depression?

There are several forms of depressive disorders.

Major depressive disorder, or major depression, is characterized by a combination of symptoms that interfere with a person's ability to work, sleep, study, eat, and enjoy once-pleasurable activities. Major depression is disabling and prevents a person from functioning normally. Some people may experience only a single episode within their lifetime, but more often a person may have multiple episodes.

Depression is a common but serious illness.

Most who experience depression need treatment to get better.

Dysthymic disorder, or dysthymia, is characterized by long-term (2 years or longer) symptoms that may not be severe enough to disable a person but can prevent normal functioning or feeling well. People with dysthymia may also experience one or more episodes of major depression during their lifetimes.

Minor depression is characterized by having symptoms for 2 weeks or longer that do not meet full criteria for major depression. Without treatment, people with minor depression are at high risk for developing major depressive disorder.

Some forms of depression are slightly different, or they may develop under unique circumstances. However, not everyone agrees on how to characterize and define these forms of depression. They include:

- **Psychotic depression,** which occurs when a person has severe depression plus some form of psychosis, such as having disturbing false beliefs or a break with reality (delusions), or hearing or seeing upsetting things that others cannot hear or see (hallucinations).
- **Postpartum depression,** which is much more serious than the "baby blues" that many women experience after giving birth, when hormonal and physical changes and the new responsibility of caring for a newborn can be overwhelming. It is estimated that 10 to 15 percent of women experience postpartum depression after giving birth.[1]
- **Seasonal affective disorder (SAD),** which is characterized by the onset of depression during the winter months, when there is less natural sunlight. The depression generally lifts during spring and summer. SAD may be effectively treated with light therapy, but nearly half of those with SAD do not get better with light therapy alone. Antidepressant medication and psychotherapy can reduce SAD symptoms, either alone or in combination with light therapy.[2]

Bipolar disorder, also called manic-depressive illness, is not as common as major depression or dysthymia. Bipolar disorder is characterized by cycling mood changes—from extreme highs (e.g., mania) to extreme lows (e.g., depression). More information about bipolar disorder is available at http://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml.

What are the signs and symptoms of depression?

People with depressive illnesses do not all experience the same symptoms. The severity, frequency, and duration of symptoms vary depending on the individual and his or her particular illness.

I started missing days from work, and a friend noticed that something wasn't right. She talked to me about the time she had been really depressed and had gotten help from her doctor.

SIGNS AND SYMPTOMS INCLUDE:

Persistent sad, anxious, or "empty" feelings

Feelings of hopelessness or pessimism

Feelings of guilt, worthlessness, or helplessness

Irritability, restlessness

Loss of interest in activities or hobbies once pleasurable, including sex

Fatigue and decreased energy

Difficulty concentrating, remembering details, and making decisions

Insomnia, early-morning wakefulness, or excessive sleeping

Overeating, or appetite loss

Thoughts of suicide, suicide attempts

Aches or pains, headaches, cramps, or digestive problems that do not ease even with treatment.

What illnesses often co-exist with depression?

Other illnesses may come on before depression, cause it, or be a consequence of it. But depression and other illnesses interact differently in different people. In any case, co-occurring illnesses need to be diagnosed and treated.

Anxiety disorders, such as post-traumatic stress disorder (PTSD), obsessive-compulsive disorder, panic disorder, social phobia, and generalized anxiety disorder, often accompany depression.[3,4] PTSD can occur after a person experiences a terrifying event or ordeal, such as a violent assault, a natural disaster, an accident, terrorism or military combat. People experiencing PTSD are especially prone to having co-existing depression.

In a National Institute of Mental Health (NIMH)-funded study, researchers found that more than 40 percent of people with PTSD also had depression 4 months after the traumatic event.[5]

Alcohol and other substance abuse or dependence may also co-exist with depression. Research shows that mood disorders and substance abuse commonly occur together.[6]

Depression also may occur with other serious medical illnesses such as heart disease, stroke, cancer, HIV/AIDS, diabetes, and Parkinson's disease. People who have depression along with another medical illness tend to have more severe symptoms of both depression and the medical illness, more difficulty adapting to their medical condition, and more medical costs than those who do not have co-existing depression.[7] Treating the depression can also help improve the outcome of treating the co-occurring illness.[8]

Personal Story

It was really hard to get out of bed in the morning. I just wanted to hide under the covers and not talk to anyone. I didn't feel much like eating and I lost a lot of weight.

Nothing seemed fun anymore. I was tired all the time, and I wasn't sleeping well at night. But I knew I had to keep going because I've got kids and a job. It just felt so impossible, like nothing was going to change or get better.

What causes depression?

Most likely, depression is caused by a combination of genetic, biological, environmental, and psychological factors.

Depressive illnesses are disorders of the brain. Longstanding theories about depression suggest that important neurotransmitters—chemicals that brain cells use to communicate—are out of balance in depression. But it has been difficult to prove this.

Brain-imaging technologies, such as magnetic resonance imaging (MRI), have shown that the brains of people who have depression look different than those of people without depression. The parts of the brain involved in mood, thinking, sleep, appetite, and behavior appear different. But these images do not reveal why the depression has occurred. They also cannot be used to diagnose depression.

Some types of depression tend to run in families. However, depression can occur in people without family histories of depression too.[9] Scientists are studying certain genes that may make some people more prone to depression. Some genetics research indicates that risk for depression results from the influence of several genes acting together with environmental or other factors.[10] In addition, trauma, loss of a loved one, a difficult relationship, or any stressful situation may trigger a depressive episode. Other depressive episodes may occur with or without an obvious trigger.

Research indicates that depressive illnesses are disorders of the brain.

How do women experience depression?

Depression is more common among women than among men. Biological, life cycle, hormonal, and psychosocial factors that women experience may be linked to women's higher depression rate. Researchers have shown that hormones directly affect the brain chemistry that controls emotions and mood. For example, women are especially vulnerable to developing postpartum depression after giving birth, when hormonal and physical changes and the new responsibility of caring for a newborn can be overwhelming.

Some women may also have a severe form of premenstrual syndrome (PMS) called premenstrual dysphoric disorder (PMDD). PMDD is associated with the hormonal changes that typically occur around ovulation and before menstruation begins.

During the transition into menopause, some women experience an increased risk for depression. In addition, osteoporosis—bone thinning or loss—may be associated with depression.[11] Scientists are exploring all of these potential connections and how the cyclical rise and fall of estrogen and other hormones may affect a woman's brain chemistry.[12]

Finally, many women face the additional stresses of work and home responsibilities, caring for children and aging parents, abuse, poverty, and relationship strains. It is still unclear, though, why some women faced with enormous challenges develop depression, while others with similar challenges do not.

How do men experience depression?

Men often experience depression differently than women. While women with depression are more likely to have feelings of sadness, worthlessness, and excessive guilt, men are more likely to be very tired, irritable, lose interest in once-pleasurable activities, and have difficulty sleeping.[13,14]

Men may be more likely than women to turn to alcohol or drugs when they are depressed. They also may become frustrated, discouraged, irritable, angry, and sometimes abusive. Some men throw themselves into their work to avoid talking about their depression with family or friends, or behave recklessly. And although more women attempt suicide, many more men die by suicide in the United States.[15]

How do older adults experience depression?

Depression is not a normal part of aging. Studies show that most seniors feel satisfied with their lives, despite having more illnesses or physical problems. However, when older adults do have depression, it may be overlooked because seniors may show different, less obvious symptoms. They may be less likely to experience or admit to feelings of sadness or grief.[16]

Sometimes it can be difficult to distinguish grief from major depression. Grief after loss of a loved one is a normal reaction to the loss and generally does not require professional mental health treatment. However, grief that is complicated and lasts for a very long time following a loss may require treatment. Researchers continue to study the relationship between complicated grief and major depression.[17]

Older adults also may have more medical conditions such as heart disease, stroke, or cancer, which may cause depressive symptoms. Or they may be taking medications with side effects that contribute to depression. Some older adults may experience what doctors call vascular depression, also called arteriosclerotic depression or subcortical ischemic depression. Vascular depression may result when blood vessels become less flexible and harden over time, becoming constricted. Such hardening of vessels prevents normal blood flow to the body's organs, including the brain. Those with vascular depression may have, or be at risk for, co-existing heart disease or stroke.[18]

Although many people assume that the highest rates of suicide are among young people, older white males age 85 and older actually have the highest suicide rate in the United States. Many have a depressive illness that their doctors are not aware of, even though many of these suicide victims visit their doctors within 1 month of their deaths.[19]

Most older adults with depression improve when they receive treatment with an antidepressant, psychotherapy, or a combination of both.[20] Research has shown that medication alone and combination treatment are both effective in reducing depression in older adults.[21] Psychotherapy alone also can be effective in helping older adults stay free of depression, especially among those with minor depression. Psychotherapy is particularly useful for those who are unable or unwilling to take antidepressant medication.[22, 23]

How do children and teens experience depression?

Children who develop depression often continue to have episodes as they enter adulthood. Children who have depression also are more likely to have other more severe illnesses in adulthood.[24]

A child with depression may pretend to be sick, refuse to go to school, cling to a parent, or worry that a parent may die. Older children may sulk, get into trouble at school, be negative and irritable, and feel misunderstood. Because these signs may be viewed as normal mood swings typical of children as they move through developmental stages, it may be difficult to accurately diagnose a young person with depression.

Before puberty, boys and girls are equally likely to develop depression. By age 15, however, girls are twice as likely as boys to have had a major depressive episode.[25]

Depression during the teen years comes at a time of great personal change—when boys and girls are forming an identity apart from their parents, grappling with gender issues and emerging sexuality, and making independent decisions for the first time in their lives. Depression in adolescence frequently co-occurs with other disorders such as anxiety, eating disorders, or substance abuse. It can also lead to increased risk for suicide.[24,26]

An NIMH-funded clinical trial of 439 adolescents with major depression found that a combination of medication and psychotherapy was the most effective treatment option.[27] Other NIMH-funded researchers are developing and testing ways to prevent suicide in children and adolescents.

Childhood depression often persists, recurs, and continues into adulthood, especially if left untreated.

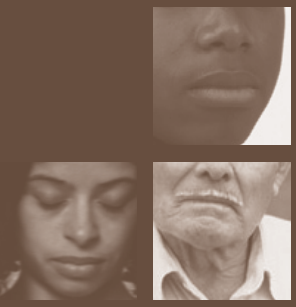
How is depression diagnosed and treated?

Depression, even the most severe cases, can be effectively treated. The earlier that treatment can begin, the more effective it is.

The first step to getting appropriate treatment is to visit a doctor or mental health specialist. Certain medications, and some medical conditions such as viruses or a thyroid disorder, can cause the same symptoms as depression. A doctor can rule out these possibilities by doing a physical exam, interview, and lab tests. If the doctor can find no medical condition that may be causing the depression, the next step is a psychological evaluation.

The doctor may refer you to a mental health professional, who should discuss with you any family history of depression or other mental disorder, and get a complete history of your symptoms. You should discuss when your symptoms started, how long they have lasted, how severe they are, and whether they have occurred before and if so, how they were treated. The mental health professional may also ask if you are using alcohol or drugs, and if you are thinking about death or suicide.

Once diagnosed, a person with depression can be treated in several ways. The most common treatments are medication and psychotherapy.



I called my doctor and talked about how I was feeling. She had me come in for a checkup and gave me the name of a specialist, who is an expert in treating depression.

Medication

Antidepressants primarily work on brain chemicals called neurotransmitters, especially serotonin and norepinephrine. Other antidepressants work on the neurotransmitter dopamine. Scientists have found that these particular chemicals are involved in regulating mood, but they are unsure of the exact ways that they work. The latest information on medications for treating depression is available on the U.S. Food and Drug Administration (FDA) website at http://www.fda.gov.

Popular newer antidepressants

Some of the newest and most popular antidepressants are called selective serotonin reuptake inhibitors (SSRIs). Fluoxetine (Prozac), sertraline (Zoloft), escitalopram (Lexapro), paroxetine (Paxil), and citalopram (Celexa) are some of the most commonly prescribed SSRIs for depression. Most are available in generic versions. Serotonin and norepinephrine reuptake inhibitors (SNRIs) are similar to SSRIs and include venlafaxine (Effexor) and duloxetine (Cymbalta).

SSRIs and SNRIs tend to have fewer side effects than older antidepressants, but they sometimes produce headaches, nausea, jitters, or insomnia when people first start to take them. These symptoms tend to fade with time. Some people also experience sexual problems with SSRIs or SNRIs, which may be helped by adjusting the dosage or switching to another medication.

One popular antidepressant that works on dopamine is bupropion (Wellbutrin). Bupropion tends to have similar side effects as SSRIs and SNRIs, but it is less likely to cause sexual side effects. However, it can increase a person's risk for seizures.

Tricyclics

Tricyclics are older antidepressants. Tricyclics are powerful, but they are not used as much today because their potential side effects are more serious. They may affect the heart in people with heart conditions. They sometimes cause dizziness, especially in older adults. They also may cause drowsiness, dry mouth, and weight gain. These side effects can usually be corrected by changing the dosage or switching to another medication. However, tricyclics may be especially dangerous if taken in overdose. Tricyclics include imipramine and nortriptyline.

MAOIs

Monoamine oxidase inhibitors (MAOIs) are the oldest class of antidepressant medications. They can be especially effective in cases of "atypical" depression, such as when a person experiences increased appetite and the need for more sleep rather than decreased appetite and sleep. They also may help with anxious feelings or panic and other specific symptoms.

However, people who take MAOIs must avoid certain foods and beverages (including cheese and red wine) that contain a substance called tyramine. Certain medications, including some types of birth control pills, prescription pain relievers, cold and allergy medications, and herbal supplements, also should be avoided while taking an MAOI. These substances can interact with MAOIs to cause dangerous increases in blood pressure. The development of a new MAOI skin patch may help reduce these risks. If you are taking an MAOI, your doctor should give you a complete list of foods, medicines, and substances to avoid.

MAOIs can also react with SSRIs to produce a serious condition called "serotonin syndrome," which can cause confusion, hallucinations, increased sweating, muscle stiffness, seizures, changes in blood pressure or heart rhythm, and other potentially life-threatening conditions. MAOIs should not be taken with SSRIs.

How should I take medication?

All antidepressants must be taken for at least 4 to 6 weeks before they have a full effect. You should continue to take the medication, even if you are feeling better, to prevent the depression from returning.

Medication should be stopped only under a doctor's supervision. Some medications need to be gradually stopped to give the body time to adjust. Although antidepressants are not habit-forming or addictive, suddenly ending an antidepressant can cause withdrawal symptoms or lead to a relapse of the depression. Some individuals, such as those with chronic or recurrent depression, may need to stay on the medication indefinitely.

In addition, if one medication does not work, you should consider trying another. NIMH-funded research has shown that people who did not get well after taking a first medication increased their chances of beating the depression after they switched to a different medication or added another medication to their existing one.[28,29]

Sometimes stimulants, anti-anxiety medications, or other medications are used together with an antidepressant, especially if a person has a co-existing illness. However, neither anti-anxiety medications nor stimulants are effective against depression when taken alone, and both should be taken only under a doctor's close supervision.

More information about mental health medications is available on the NIMH website at http://www.nimh.nih.gov/health/publications/mental-health-medications/index.shtml.

Report any unusual side effects to a doctor immediately.

FDA warning on antidepressants

Despite the relative safety and popularity of SSRIs and other antidepressants, studies have suggested that they may have unintentional effects on some people, especially adolescents and young adults. In 2004, the Food and Drug Administration (FDA) conducted a thorough review of published and unpublished controlled clinical trials of antidepressants that involved nearly 4,400 children and adolescents. The review revealed that 4 percent of those taking antidepressants thought about or attempted suicide (although no suicides occurred), compared to 2 percent of those receiving placebos.

This information prompted the FDA, in 2005, to adopt a "black box" warning label on all antidepressant medications to alert the public about the potential increased risk of suicidal thinking or attempts in children and adolescents taking antidepressants. In 2007, the FDA proposed that makers of all antidepressant medications extend the warning to include young adults up through age 24. A "black box" warning is the most serious type of warning on prescription drug labeling.

The warning emphasizes that patients of all ages taking antidepressants should be closely monitored, especially during the initial weeks of treatment. Possible side effects to look for are worsening depression, suicidal thinking or behavior, or any unusual changes in behavior such as sleeplessness, agitation, or withdrawal from normal social situations. The warning adds that families and caregivers should also be told of the need for close monitoring and report any changes to the doctor. The latest information from the FDA can be found on their website at http://www.fda.gov.

Results of a comprehensive review of pediatric trials conducted between 1988 and 2006 suggested that the benefits

Children, adolescents, and young adults taking antidepressants should be closely monitored.

of antidepressant medications likely outweigh their risks to children and adolescents with major depression and anxiety disorders.[30] The study was funded in part by NIMH.

Also, the FDA issued a warning that combining an SSRI or SNRI antidepressant with one of the commonly-used "triptan" medications for migraine headache could cause a life-threatening "serotonin syndrome," marked by agitation, hallucinations, elevated body temperature, and rapid changes in blood pressure. Although most dramatic in the case of the MAOIs, newer antidepressants may also be associated with potentially dangerous interactions with other medications.

WHAT ABOUT ST. JOHN'S WORT?

The extract from the herb St. John's wort (Hypericum perforatum) has been used for centuries in many folk and herbal remedies. Today in Europe, it is used extensively to treat mild to moderate depression. In the United States, it is one of the top-selling botanical products.

In an 8-week trial involving 340 patients diagnosed with major depression, St. John's wort was compared to a common SSRI and a placebo (sugar pill). The trial found that St. John's wort was no more effective than the placebo in treating major depression.[31] However, use of St. John's wort for minor or moderate depression may be more effective. Its use in the treatment of depression remains under study.

St. John's wort can interact with other medications, including those used to control HIV infection. In 2000, the FDA issued a Public Health Advisory letter stating that the herb may interfere with certain medications used to treat heart disease, depression, seizures, certain cancers, and those used to prevent organ transplant rejection. The herb also may interfere with the effectiveness of oral contraceptives. Consult with your doctor before taking any herbal supplement.

Psychotherapy

Several types of psychotherapy—or "talk therapy"—can help people with depression.

Two main types of psychotherapies—cognitive-behavioral therapy (CBT) and interpersonal therapy (IPT)—are effective in treating depression. CBT helps people with depression restructure negative thought patterns. Doing so helps people interpret their environment and interactions with others in a positive and realistic way. It may also help you recognize things that may be contributing to the depression and help you change behaviors that may be making the depression worse. IPT helps people understand and work through troubled relationships that may cause their depression or make it worse.

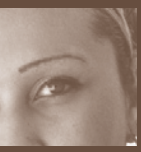
For mild to moderate depression, psychotherapy may be the best option. However, for severe depression or for certain people, psychotherapy may not be enough. For teens, a combination of medication and psychotherapy may be the most effective approach to treating major depression and reducing the chances of it coming back.[27] Another study looking at depression treatment among older adults found that people who responded to initial treatment of medication and IPT were less likely to have recurring depression if they continued their combination treatment for at least 2 years.[23]

More information on psychotherapy is available on the NIMH website at http://www.nimh.nih.gov/health/topics/psychotherapies/index.shtml.

Electroconvulsive therapy and other brain stimulation therapies

For cases in which medication and/or psychotherapy does not help relieve a person's treatment-resistant depression, 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 depression who have not been able to feel better with other treatments.

Before ECT begins, a patient is put under brief anesthesia and given a muscle relaxant. He or she sleeps through the treatment and does not consciously feel the electrical impulses. Within 1 hour after the treatment session, which takes only a few minutes, the patient is awake and alert.



Now I'm seeing the specialist on a regular basis for "talk therapy," which helps me learn ways to deal with this illness in my everyday life, and I'm taking medicine for depression.

A person typically will undergo ECT several times a week, and often will need to take an antidepressant or other medication along with the ECT treatments. Although some people will need only a few courses of ECT, others may need maintenance ECT—usually once a week at first, then gradually decreasing to monthly treatments. Ongoing NIMH-supported ECT research is aimed at developing personalized maintenance ECT schedules.

ECT may cause some side effects, including confusion, disorientation, and memory loss. Usually these side effects are short-term, but sometimes they can linger. Newer methods of administering the treatment have reduced the memory loss and other cognitive difficulties associated with ECT. Research has found that after 1 year of ECT treatments, most patients showed no adverse cognitive effects.[32]

Nevertheless, patients always provide informed consent before receiving ECT, ensuring that they understand the potential benefits and risks of the treatment.

Other more recently introduced types of brain stimulation therapies used to treat severe depression include vagus nerve stimulation (VNS), and repetitive transcranial magnetic stimulation (rTMS). These methods are not yet commonly used, but research has suggested that they show promise.

More information on ECT, VNS, rTMS and other brain stimulation therapies is available on the NIMH website at http://www.nimh.nih.gov/health/topics/brain-stimulation-therapies/brain-stimulation-therapies.shtml.

The National Institute of Mental Health funds cutting-edge research into this debilitating disorder.

How can I help a loved one who is depressed?

If you know someone who is depressed, it affects you too. The most important thing you can do is help your friend or relative get a diagnosis and treatment. You may need to make an appointment and go with him or her to see the doctor. Encourage your loved one to stay in treatment, or to seek different treatment if no improvement occurs after 6 to 8 weeks.

TO HELP YOUR FRIEND OR RELATIVE

Offer emotional support, understanding, patience, and encouragement.

Talk to him or her, and listen carefully.

Never dismiss feelings, but point out realities and offer hope.

Never ignore comments about suicide, and report them to your loved one's therapist or doctor.

Invite your loved one out for walks, outings and other activities. Keep trying if he or she declines, but don't push him or her to take on too much too soon.

Provide assistance in getting to the doctor's appointments.

Remind your loved one that with time and treatment, the depression will lift.

How can I help myself if I am depressed?

If you have depression, you may feel exhausted, helpless, and hopeless. It may be extremely difficult to take any action to help yourself. But as you begin to recognize your depression and begin treatment, you will start to feel better.

TO HELP YOURSELF

Do not wait too long to get evaluated or treated. There is research showing the longer one waits, the greater the impairment can be down the road. Try to see a professional as soon as possible.

Try to be active and exercise. Go to a movie, a ballgame, or another event or activity that you once enjoyed.

Set realistic goals for yourself.

Break up large tasks into small ones, set some priorities and do what you can as you can.

Try to spend time with other people and confide in a trusted friend or relative. Try not to isolate yourself, and let others help you.

Expect your mood to improve gradually, not immediately. Do not expect to suddenly "snap out of" your depression. Often during treatment for depression, sleep and appetite will begin to improve before your depressed mood lifts.

Postpone important decisions, such as getting married or divorced or changing jobs, until you feel better. Discuss decisions with others who know you well and have a more objective view of your situation.

Remember that positive thinking will replace negative thoughts as your depression responds to treatment.

Continue to educate yourself about depression.

Everything didn't get better overnight, but I find myself more able to enjoy life and my children.

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 RESOURCES

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 also can 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.

- Do not leave your friend or relative alone, and do not isolate yourself.
- 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 hotline of the 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.

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Bipolar Disorder

National Institute of Mental Health

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES • National Institutes of Health

Contents

This booklet discusses bipolar disorder in adults. For information on bipolar disorder in children and adolescents, see the NIMH booklet, “Bipolar Disorder in Children and Teens: A Parent’s Guide.”

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 day-to-day tasks. Symptoms of bipolar disorder are 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 develops in a person's 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. The symptoms may seem like separate problems, not recognized as parts of a larger problem. 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 a person's life.

What are the symptoms of bipolar disorder?

People with bipolar disorder experience unusually intense emotional states that occur in distinct periods called "mood episodes." 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. It is possible for someone with bipolar disorder to experience a long-lasting period of unstable moods rather than discrete episodes of depression or mania.

A person may be having an episode of bipolar disorder if he or she has a number of manic or depressive symptoms for most of the day, nearly every day, for at least one or two weeks. Sometimes symptoms are so severe that the person cannot function normally at work, school, or home.

Symptoms of bipolar disorder are described below.

Symptoms of mania or a manic episode include:

Mood Changes

- A long period of feeling "high," or an overly happy or outgoing mood
- Extremely irritable mood, agitation, feeling "jumpy" or "wired."

Behavioral Changes

- Talking very fast, jumping from one idea to another, having racing thoughts
- Being easily distracted
- Increasing goal-directed activities, such as taking on new projects
- Being restless
- Sleeping little
- Having an unrealistic belief in one's abilities
- Behaving impulsively and taking part in a lot of pleasurable, high-risk behaviors, such as spending sprees, impulsive sex, and impulsive business investments.

Symptoms of depression or a depressive episode include:

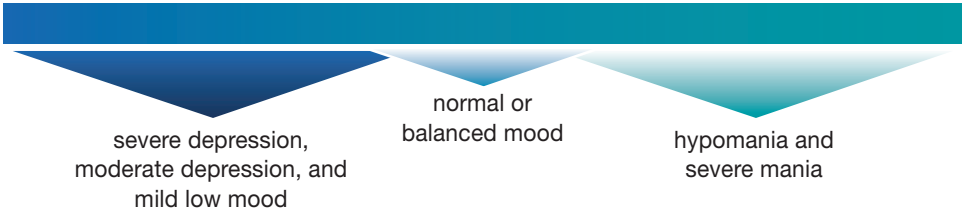
Mood Changes

- A long period of feeling worried or empty
- Loss of interest in activities once enjoyed, including sex.

Behavioral Changes

- Feeling 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.

In addition to mania and depression, bipolar disorder can cause a range of moods, as shown on the scale.



One side of the scale includes severe depression, moderate depression, and mild low mood. Moderate depression may cause less extreme symptoms, and mild low mood is called dysthymia when it is chronic or long-term. In the middle of the scale is normal or balanced mood.

At the other end of the scale are hypomania and severe mania. Some people with bipolar disorder experience hypomania. During hypomanic episodes, a person may have increased energy and activity levels that are not as severe as typical mania, or he or she may have episodes that last less than a week and do not require emergency care. A person having a hypomanic episode may feel very good, be highly productive, and function well. This person may not feel that anything is wrong even as family and friends recognize the mood swings as possible bipolar disorder. Without proper treatment, however, people with hypomania may develop severe mania or depression.

During a mixed state, symptoms often include agitation, trouble sleeping, major changes in appetite, and suicidal thinking. People in a mixed state may feel very sad or hopeless while feeling 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, psychotic symptoms for a person having a manic episode may include believing he or she is famous, has a lot of money, or has special powers. In the same way, a person having a depressive episode may believe he or she is ruined and penniless, or has committed a crime. As a result, people with bipolar disorder who have psychotic symptoms are sometimes wrongly diagnosed as having schizophrenia, another severe mental illness that is linked with hallucinations and delusions.

People with bipolar disorder may also have behavioral problems. They may abuse alcohol or substances, have relationship problems, or perform poorly in school or at work. At first, it's not easy to recognize these problems as signs of a major mental illness.

How does bipolar disorder affect someone over time?

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 usually diagnose mental disorders using guidelines from the *Diagnostic and Statistical Manual of Mental Disorders*, or DSM. According to the DSM, there are four basic types of bipolar disorder:

1. **Bipolar I Disorder** is mainly 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, the person also has depressive episodes, typically lasting at least two weeks. The symptoms of mania or depression must be a major change from the person's normal behavior.

2. **Bipolar II Disorder** is defined by a pattern of depressive episodes shifting back and forth with hypomanic episodes, but no full-blown manic or mixed episodes.
3. **Bipolar Disorder Not Otherwise Specified (BP-NOS)** is diagnosed when a person has symptoms of the illness that do not meet diagnostic criteria for either bipolar I or II. The symptoms may not last long enough, or the person may have too few symptoms, to be diagnosed with bipolar I or II. However, the symptoms are clearly out of the person's normal range of behavior.
4. **Cyclothymic Disorder, or Cyclothymia**, is a mild form of bipolar disorder. People who have cyclothymia have episodes of hypomania that shift back and forth with mild depression for at least two years. However, the symptoms do not meet the diagnostic requirements for any other type of bipolar disorder.

Some people may be diagnosed with **rapid-cycling bipolar disorder**. This is when a person has four or more episodes of major depression, mania, hypomania, or mixed symptoms within a year.[2] Some people experience more than one episode in a week, or even within one day. Rapid cycling seems to be more common in people who have severe bipolar disorder and may be more common in people who have their first episode at a younger age. One study found that people with rapid cycling had their first episode about four years earlier, during mid to late teen years, than people without rapid cycling bipolar disorder.[3] Rapid cycling affects more women than men.[4]

Bipolar disorder tends to worsen if it is not treated. Over time, a person may suffer more frequent and more severe episodes than when the illness first appeared.[5] Also, delays in getting the correct diagnosis and treatment make a person more likely to experience personal, social, and work-related problems.[6]

Proper diagnosis and treatment helps 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.[7] Some people with bipolar disorder may try to treat their symptoms with alcohol or drugs. However, substance abuse may trigger or prolong bipolar symptoms, and the behavioral control problems associated with mania can result in a person drinking too much.

Anxiety disorders, such as post-traumatic stress disorder (PTSD) and social phobia, also co-occur often among people with bipolar disorder.[8-10] Bipolar disorder also co-occurs with attention deficit hyperactivity disorder (ADHD), which has some symptoms that overlap with bipolar disorder, such as restlessness and being easily distracted.

People with bipolar disorder are also at higher risk for thyroid disease, migraine headaches, heart disease, diabetes, obesity, and other physical illnesses.[10, 11] These illnesses may cause symptoms of mania or depression. They may also result from treatment for bipolar disorder (see "Lithium and Thyroid Function" section on page 10).

Other illnesses can make it hard to diagnose and treat bipolar disorder. People with bipolar disorder should monitor their physical and mental health. If a symptom does not get better with treatment, they should tell their doctor.

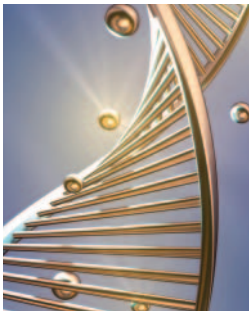
What are the risk factors for bipolar disorder?

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

Genetics

Bipolar disorder tends to run in families, so researchers are looking for genes that may increase a person's chance of developing the illness. Genes are the "building blocks" of heredity. They help control how the body and brain work and grow. Genes are contained inside a person's cells that are passed down from parents to children.

Children with a parent or sibling who has bipolar disorder are four to six times more likely to develop the illness, compared with children who do not have a family history of bipolar disorder.[12] However, most children with a family history of bipolar disorder will not develop the illness.



Genetic research on bipolar disorder is being helped by advances in technology. This type of research is now much quicker and more far-reaching than in the past. 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. So far, researchers using this database found that most people with bipolar disorder had:[13]

- Missed work because of their illness
- Other illnesses at the same time, especially alcohol and/or substance abuse and panic disorders
- Been treated or hospitalized for bipolar disorder.

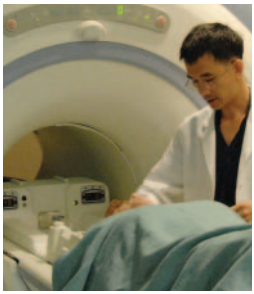
The researchers also identified certain traits that appeared to run in families, including:

- History of psychiatric hospitalization
- Co-occurring obsessive-compulsive disorder (OCD)
- Age at first manic episode
- Number and frequency of manic episodes.

Scientists continue to study these traits, which may help them find the genes that cause bipolar disorder some day.

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. This is important because identical twins share all of the same genes. The study results suggest factors besides genes are also at work. Rather, it is likely that many different genes and a person's environment are involved. However, scientists do not yet fully understand how these factors interact to cause bipolar disorder.

Brain structure and functioning



Brain-imaging studies are helping scientists learn what happens in the brain of a person with bipolar disorder.[14, 15] Newer 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.[16] This suggests that the common pattern of brain development may be linked to general risk for unstable moods.

Learning more about these differences, along with information gained from genetic studies, helps scientists better understand bipolar disorder. Someday scientists may be able to predict which types of treatment will work most effectively. They may even find ways to prevent bipolar disorder.

How is bipolar disorder diagnosed?

The first step in getting a proper diagnosis is to talk to a doctor, who may conduct a physical examination, an interview, and lab tests. Bipolar disorder cannot currently be identified through a blood test or a brain scan, but these tests can help rule out other contributing factors, such as a stroke or brain tumor. If the problems are not caused by other illnesses, the doctor may conduct a mental health evaluation. The doctor may also 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 conduct a complete diagnostic evaluation. He or she should discuss any family history of bipolar disorder or other mental illnesses and get a complete history of symptoms. The doctor or mental health professionals should also talk to the person's close relatives or spouse and note how they describe the person's 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.[17] Therefore, a careful medical history is needed to assure that bipolar disorder is not mistakenly diagnosed as major depressive disorder, which is also called unipolar depression. Unlike people with bipolar disorder, people who have unipolar depression do not experience mania. Whenever possible, previous records and input from family and friends should also be included in the medical history.

How is bipolar disorder treated?

To date, there is no cure for bipolar disorder. But proper treatment helps most people with bipolar disorder gain better control of their mood swings and related symptoms.[18-20] This is also true for people with the most severe forms of the illness.

Because bipolar disorder is a lifelong and recurrent illness, people with the disorder need long-term treatment to maintain control of bipolar symptoms. An effective maintenance treatment plan includes medication and psychotherapy for preventing relapse and reducing symptom severity.[21]

Medications

Bipolar disorder can be diagnosed and medications prescribed by people with an M.D. (doctor of medicine). Usually, bipolar medications are prescribed by a psychiatrist. In some states, clinical psychologists, psychiatric nurse practitioners, and advanced psychiatric nurse specialists can also prescribe medications. Check with your state's licensing agency to find out more.

Not everyone responds to medications in the same way. Several different medications may need to be tried before the best course of treatment is found.

Keeping a chart of daily mood symptoms, treatments, sleep patterns, and life events can help the doctor track and treat the illness most effectively. Sometimes this is called a daily life chart. If a person's symptoms change or if side effects become serious, the doctor may switch or add medications.

Some of the types of medications generally used to treat bipolar disorder are listed on the next page. Information on medications can change. For the most up to date information on use and side effects contact the U.S. Food and Drug Administration (FDA) at http://www.fda.gov.

1. **Mood stabilizing medications** are usually the first choice to treat bipolar disorder. In general, people with bipolar disorder continue treatment with mood stabilizers for years. Except for lithium, many of these medications are anti-convulsants. Anticonvulsant medications are usually used to treat seizures, but they also help control moods. These medications are commonly used as mood stabilizers in bipolar disorder:
   - Lithium (sometimes known as Eskalith or Lithobid) was the first mood-stabilizing medication approved by the U.S. Food and Drug Administration (FDA) in the 1970s for treatment of mania. It is often very effective in controlling symptoms of mania and preventing the recurrence of manic and depressive episodes.
   - Valproic acid or divalproex sodium (Depakote), approved by the FDA in 1995 for treating mania, is a popular alternative to lithium for bipolar disorder. It is generally as effective as lithium for treating bipolar disorder.[23, 24] Also see the section in this booklet, "Should young women take valproic acid?"
   - More recently, the anticonvulsant lamotrigine (Lamictal) received FDA approval for maintenance treatment of bipolar disorder.
   - Other anticonvulsant medications, including gabapentin (Neurontin), topiramate (Topamax), and oxcarbazepine (Trileptal) are sometimes prescribed. No large studies have shown that these medications are more effective than mood stabilizers.

   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 closely monitored for new or worsening symptoms of depression, suicidal thoughts or behavior, or any unusual changes in mood or behavior. People taking these medications should not make any changes without talking to their health care professional.

Lithium and Thyroid Function

People with bipolar disorder often have thyroid gland problems. Lithium treatment may also cause low thyroid levels in some people.[22] 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 to have a doctor check thyroid levels carefully. A person with bipolar disorder may need to take thyroid medication, in addition to medications for bipolar disorder, to keep thyroid levels balanced.

Should young women take valproic acid?

Valproic acid may increase levels of testosterone (a male hormone) in teenage girls and lead to polycystic ovary syndrome (PCOS) in women who begin taking the medication before age 20.[25, 26] PCOS causes a woman's eggs to develop into cysts, or fluid filled sacs that collect in the ovaries instead of being released by monthly periods. This condition can cause obesity, excess body hair, disruptions in the menstrual cycle, and other serious symptoms. Most of these symptoms will improve after stopping treatment with valproic acid.[27] Young girls and women taking valproic acid should be monitored carefully by a doctor.

2. **Atypical antipsychotic medications** are sometimes used to treat symptoms of bipolar disorder. Often, these medications are taken with other medications. Atypical antipsychotic medications are called "atypical" to set them apart from earlier medications, which are called "conventional" or "first-generation" antipsychotics.
   - Olanzapine (Zyprexa), when given with an antidepressant medication, may help relieve symptoms of severe mania or psychosis.[28] Olanzapine is also available in an injectable form, which quickly treats agitation associated with a manic or mixed episode. Olanzapine can be used for maintenance treatment of bipolar disorder as well, even when a person does not have psychotic symptoms. However, some studies show that people taking olanzapine may gain weight and have other side effects that can increase their risk for diabetes and heart disease. These side effects are more likely in people taking olanzapine when compared with people prescribed other atypical antipsychotics.
   - Aripiprazole (Abilify), like olanzapine, is approved for treatment of a manic or mixed episode. Aripiprazole is also used for maintenance treatment after a severe or sudden episode. As with olanzapine, aripiprazole also can be injected for urgent treatment of symptoms of manic or mixed episodes of bipolar disorder.
   - Quetiapine (Seroquel) relieves the symptoms of severe and sudden manic episodes. In that way, quetiapine is like almost all antipsychotics. In 2006, it became the first atypical antipsychotic to also receive FDA approval for the treatment of bipolar depressive episodes.
   - Risperidone (Risperdal) and ziprasidone (Geodon) are other atypical antipsychotics that may also be prescribed for controlling manic or mixed episodes.

3. **Antidepressant medications** are sometimes used to treat symptoms of depression in bipolar disorder. People with bipolar disorder who take antidepressants often take a mood stabilizer too. Doctors usually require this because taking only an antidepressant can increase a person's risk of switching to mania or hypomania, or of developing rapid cycling symptoms.[29] To prevent this switch, doctors who prescribe antidepressants for treating bipolar disorder also usually require the person to take a mood-stabilizing medication at the same time.

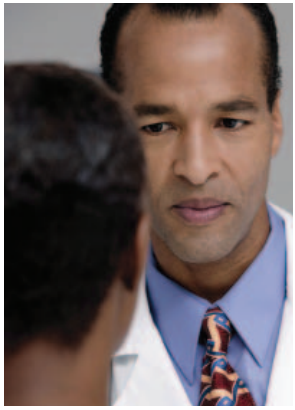
   Recently, a large-scale, NIMH-funded study showed that for many people, adding an antidepressant to a mood stabilizer is no more effective in treating the depression than using only a mood stabilizer.[30]

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

Some medications are better at treating one type of bipolar symptoms than another. For example, lamotrigine (Lamictal) seems to be helpful in controlling depressive symptoms of bipolar disorder.

What are the side effects of these medications?

Before starting a new medication, people with bipolar disorder should talk to their doctor about the possible risks and benefits.



The psychiatrist prescribing the medication or pharmacist can also answer questions about side effects. Over the last decade, treatments have improved, and some medications now have fewer or more tolerable side effects than earlier treatments. However, everyone responds differently to medications. In some cases, side effects may not appear until a person has taken a medication for some time.

If the person with bipolar disorder develops any severe side effects from a medication, he or she should talk to the doctor who prescribed it as soon as possible. The doctor may change the dose or prescribe a different medication. People being treated for bipolar disorder should not stop taking a medication without talking to a 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.

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. Families and caregivers should report any changes to the doctor. The latest information from the FDA can be found at http://www.fda.gov.

The following sections describe some common side effects of the different types of medications used to treat bipolar disorder.

1. Mood Stabilizers

In some cases, 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.[31]

Lithium also causes side effects not listed here. If extremely bothersome or unusual side effects occur, tell your doctor as soon as possible.

If a person with bipolar disorder is being treated with lithium, it is important to make regular visits to the treating doctor. The doctor needs to check the levels of lithium in the person's blood, as well as kidney and thyroid function.

Common side effects of other mood stabilizing medications include:

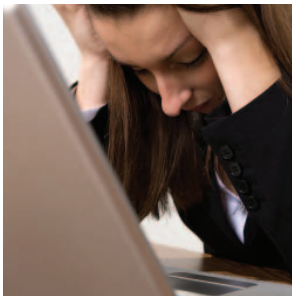
- Drowsiness
- Dizziness
- Headache
- Diarrhea
- Constipation
- Heartburn
- Mood swings
- Stuffed or runny nose, or other cold-like symptoms.[32-37]

These medications may also be linked with rare but serious side effects. Talk with the treating doctor or a pharmacist to make sure you understand signs of serious side effects for the medications you're taking.

2. Atypical Antipsychotics

Some people have side effects when they start taking atypical antipsychotics. Most side effects go away after a few days and often can be managed successfully. People who are taking antipsychotics should not drive until they adjust to their new 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 a person's metabolism. This may increase a person's risk of getting diabetes and high cholesterol.[38] A person's weight, glucose levels, and lipid levels should be monitored regularly by a doctor while 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 muscle movements that commonly occur around the mouth. A person with TD cannot control these moments. TD can range from mild to severe, and it cannot always be cured. Some people with TD recover partially or fully after they stop taking the drug.

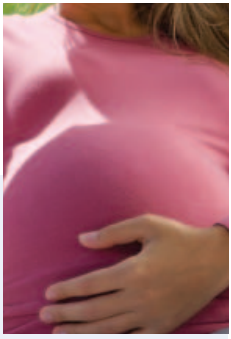
3. Antidepressants

The antidepressants most commonly prescribed for treating symptoms of bipolar disorder can also cause mild side effects that usually do not last long. These can include:

- Headache, which usually goes away within a few days.
- Nausea (feeling sick to your stomach), which usually goes away within a few days.
- Sleep problems, such as sleeplessness or drowsiness. This may happen during the first few weeks but then go away. To help lessen these effects, sometimes the medication dose can be reduced, or the time of day it is taken can be changed.
- Agitation (feeling jittery).
- Sexual problems, which can affect both men and women. These include reduced sex drive and problems having and enjoying sex.

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.

For the most up-to-date information on medications for treating bipolar disorder and their side effects, please see the online NIMH Medications booklet at http://www.nimh.nih.gov/health/publications/medications/complete-publication.shtml.



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. The mood stabilizing medications in use today can harm a developing fetus or nursing infant.[39] But stopping medications, either suddenly or gradually, greatly increases the risk that bipolar symptoms will recur during pregnancy.[40]

Scientists are not sure yet, but lithium is likely the preferred mood-stabilizing medication for pregnant women with bipolar disorder.[40, 41] However, lithium can lead to heart problems in the fetus. Women need to know that most bipolar medications are passed on through breast milk.[41] Pregnant women and nursing mothers should talk to their doctors about the benefits and risks of all available treatments.

Psychotherapy

In addition to medication, psychotherapy, or "talk" therapy, 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:

1. **Cognitive behavioral therapy (CBT)** helps people with bipolar disorder learn to change harmful or negative thought patterns and behaviors.
2. **Family-focused therapy** includes family members. It helps enhance family coping strategies, such as recognizing new episodes early and helping their loved one. This therapy also improves communication and problem-solving.
3. **Interpersonal and social rhythm therapy** 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.
4. **Psychoeducation** teaches people with bipolar disorder about the illness and its treatment. This treatment helps people recognize signs of relapse so they 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.

A licensed psychologist, social worker, or counselor typically provides these therapies. This mental health professional often works with the psychiatrist to track progress. The number, frequency, and type of sessions should be based on the treatment needs of each person. As with medication, following the doctor's instructions for any psychotherapy will provide the greatest benefit.

For more information, see the Substance Abuse and Mental Health Services Administration Web page on choosing a mental health therapist at http://mentalhealth.samhsa.gov/publications/allpubs/KEN98-0055/default.asp.

Recently, NIMH funded a clinical trial called the Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD). This was the largest treatment study ever conducted for bipolar disorder (information at http://www.nimh.nih.gov/health/trials/practical/step-bd/index.shtml). In a study on psychotherapies, STEP-BD researchers compared people in two groups. The first group was treated with collaborative care (three sessions of psychoeducation over six weeks). The second group was treated with medication and intensive psychotherapy (30 sessions over nine 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.[42] They were also more likely to get well faster and stay well longer.

NIMH is supporting more research on which combinations of psychotherapy and medication work best. The goal is to help people with bipolar disorder live symptom-free for longer periods and to recover from episodes more quickly. Researchers also hope to determine whether psychotherapy helps delay the start of bipolar disorder in children at high risk for the illness.

For more information on psychotherapy, visit the NIMH Web site at http://www.nimh.nih.gov/health/topics/treatment/index.shtml.

Other treatments

1. **Electroconvulsive Therapy (ECT**)—For cases in which medication and/or psychotherapy does 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 feel better 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.[43]

   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 is generally not a first-line treatment.

ECT may cause some short-term side effects, including confusion, disorientation, and memory loss. But these side effects typically clear soon after treatment. People with bipolar disorder should discuss possible benefits and risks of ECT with an experienced doctor.[44]

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

People with bipolar disorder should tell their doctor about all prescription drugs, over-the-counter medications, or supplements they are taking. Certain medications and supplements taken together may cause unwanted or dangerous effects.

Herbal Supplements

In general, there is not much research about herbal or natural supplements. Little is known about their effects on 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] It is important to talk with a doctor before taking any herbal or natural supplements because of the serious risk of interactions with other medications.

What can people with bipolar disorder expect from treatment?

Bipolar disorder has no cure, but can be effectively treated over the long-term. It is best controlled when treatment is continuous, rather than on and off. In the STEP-BD study, a little more than half of the people treated for bipolar disorder recovered over one year's time. For this study, recovery meant having two or fewer symptoms of the disorder for at least eight weeks.

However, even with proper treatment, mood changes can occur. In the STEP-BD study, almost half of those who recovered still had lingering symptoms. These people experienced a relapse or recurrence that was usually a return to a depressive state.[49] If a person had a mental illness in addition to bipolar disorder, he or she was more likely to experience a relapse.[49] Scientists are unsure, however, how these other illnesses or lingering symptoms increase the chance of relapse. For some people, combining psychotherapy with medication may help to prevent or delay relapse.[42]

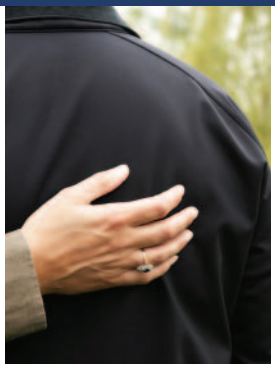
Treatment may be more effective when people work closely with a doctor and talk openly about their concerns and choices. Keeping track of mood changes and symptoms with a daily life chart can help a doctor assess a person's response to treatments. Sometimes the doctor needs to change a treatment plan to make sure symptoms are controlled most effectively. A psychiatrist should guide any changes in type or dose of medication.

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—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 about your friend or relative harming himself or herself. Always report such comments to his or her therapist or doctor.

Support for caregivers

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, poor work or school performance. These behaviors can have lasting consequences.

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

Stress from caregiving can make it 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.[50] It is important that people caring for those with bipolar disorder also take care of themselves.

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 eating meals at the same time every day and going to sleep at the same time every night
- Try 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 hotline of the 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.

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NIMH supported clinical trials
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