A GUIDE FOR FAMILY & LOVED ONES

Bipolar Disorder (Manic Depression)

Understanding mood episodes, recognising changes, supporting treatment and recovery, and protecting the wellbeing of everyone in the relationship.

Why this guide matters

Bipolar disorder involves significant changes in mood, energy, activity and functioning that go beyond ordinary emotional ups and downs. Family members may witness periods when the person seems unusually energised, driven or irritable and other periods of profound depression. This guide is designed to help loved ones understand patterns, respond safely and support recovery without becoming responsible for managing another adult's entire life.

Understanding bipolar disorder

Bipolar disorder is a mental-health condition characterised by episodes of elevated or irritable mood and increased energy - mania or hypomania - and, for many people, episodes of depression. The older term 'manic depression' is still recognised by some families, but bipolar disorder is the term generally used in current clinical practice.

Bipolar I disorder involves at least one manic episode. Depressive episodes are common but are not required for the diagnosis. Bipolar II disorder involves hypomanic episodes alongside major depressive episodes and no history of full mania. Other bipolar-spectrum presentations exist and require professional assessment. The distinction matters because severity, risk and treatment needs can differ.

What mania can look and feel like

Mania is not simply being happy or productive. Mood may be euphoric, intensely confident, irritable or rapidly changing. Energy can increase dramatically. The person may sleep very little without initially feeling tired, talk faster, move rapidly between ideas, take on multiple projects, become unusually sociable, sexual or driven, spend large amounts of money, make unrealistic plans or feel exceptionally powerful or important.

Judgement can become impaired. A person may drive dangerously, resign from work, make major purchases, gamble, give money away, enter risky relationships, travel unexpectedly or make business decisions they would not usually make. Some people develop psychotic symptoms during severe mania, including delusions or hallucinations.

From the inside, mania can initially feel wonderful. The person may feel clearer, more creative, more alive and more capable than ever. This is one reason concern from relatives can feel insulting or controlling. As mania escalates, however, thoughts may become too fast to organise, irritability can increase, conflict grows, and the person's ability to assess risk may reduce.

Hypomania: less severe does not mean insignificant

Hypomania involves similar changes in mood and energy but is less severe than mania and does not cause the same degree of marked impairment. The person may feel unusually productive, confident and sociable. Families may even prefer the person this way after a long depression. Yet hypomania can still disrupt sleep, relationships, spending and decision-making, and it can precede a more severe episode in some people.

The comparison should be with the person's usual baseline, not with somebody else's personality. A naturally energetic person is not hypomanic simply because they talk quickly or have many ideas.

Bipolar depression

Depressive episodes can involve persistent low mood, loss of pleasure, exhaustion, slowed thinking, sleep and appetite changes, guilt, hopelessness, poor concentration, withdrawal and thoughts of death or suicide. After mania, depression can be complicated by shame about things said, money spent, relationships damaged or opportunities lost during the elevated episode.

Families sometimes struggle to understand how somebody who recently had enormous energy can now be unable to get out of bed. This is not evidence that the depression is laziness. At the same time, support should aim to preserve achievable autonomy rather than automatically taking over every task.

Mixed features and rapidly changing states

Some episodes include features of both elevation and depression - for example high energy alongside despair, agitation, racing thoughts or suicidal thinking. These states can be extremely distressing and may carry significant risk. 'Mixed' does not simply mean being happy in the morning and sad at night; it is a clinical description that needs professional assessment.

Look for change from baseline

Instead of asking only **'Is this behaviour unusual?'**, ask: **'Is this a clear change for this person in sleep, energy, speech, confidence, activity, spending, irritability or judgement - and is the change becoming sustained or impairing?'**

Early warning signs and relapse signatures

Relapse signs are individual. Common changes before mania or hypomania can include needing less sleep, becoming unusually goal-focused, starting many projects, increased messaging or social media use, heightened confidence, rapid speech, increased spending, irritability or becoming convinced that others are slowing them down. Before depression, signs may include withdrawal, sleeping more or less, reduced self-care, cancelling plans, loss of interest and increasing hopelessness.

Families often notice change before the person does. This can create conflict. A pre-agreed plan is far easier to use than inventing rules during an episode. When well, discuss which signs the person wants relatives to mention, what wording feels respectful, who should contact the clinical team and what changes require urgent help.

Sleep deserves particular attention

Sleep disruption can be both a warning sign and a factor that worsens mood instability. Several nights of sharply reduced sleep combined with rising energy, activity or irritability should be taken seriously in someone with a history of mania. Families can encourage regular routines and prompt contact with clinicians without turning bedtime into a battle.

Shift work, travel across time zones, all-night socialising and prolonged stress can disturb routines. A personalised relapse plan can identify which disruptions have mattered previously and how to respond early.

How to raise concerns without starting a war

Use observations rather than labels. 'You've slept about three hours for the last three nights and you've made several large purchases' is more useful than 'You're manic again.' Speak when the environment is calm, keep the message short and avoid recruiting a room full of relatives to confront the person.

Try: 'I may be wrong, but I'm noticing some of the changes we put on your early-warning list. Can we look at the plan together?' If the person disagrees, you can remain respectful while still acting on serious safety concerns.

During mania: reduce escalation

Keep communication simple. Long arguments, criticism and attempts to match the person's speed can increase conflict. Reduce unnecessary stimulation where possible. Avoid encouraging grand plans, lending large amounts of money or joining risky schemes simply to preserve the relationship. If judgement is significantly impaired, seek professional advice early.

Do not humiliate the person by filming, posting about or mocking behaviour. Mania can lead to actions the person later deeply regrets. Protecting dignity during an episode can make recovery and relationship repair easier afterwards.

Money, spending and financial risk

Financial consequences can be substantial. When the person is well, discuss safeguards they voluntarily want in place: spending alerts, agreed limits, delaying major purchases, a trusted person to contact, or professional financial advice. Any formal control of another adult's finances or decisions must follow appropriate legal processes; family concern alone does not give automatic authority.

Supporters should protect their own accounts, credit and savings. Do not take on unaffordable debt to repair repeated spending or allow yourself to be pressured into financing risky decisions.

Sex, relationships and impulsivity

Elevated mood can increase sexual drive, confidence and impulsivity for some people. This can lead to relationship rupture, unsafe sex or behaviour that feels completely out of character. A diagnosis can help explain changes in judgement but does not erase the impact on partners or remove the need for consent, sexual-health care, accountability and later relationship repair.

Partners may experience betrayal, anger and grief even when behaviour occurred during illness. They are allowed support for their own experience rather than being told simply to forgive because the person was unwell.

Alcohol, drugs and stimulation

Alcohol and recreational drugs can complicate mood symptoms, sleep, medication and risk. Stimulants can be particularly concerning in someone vulnerable to mania. Caffeine and other stimulants may also affect sleep. Conversations are more useful when factual and non-shaming, and significant substance use may need specialist support alongside bipolar treatment.

Create the plan while well

Include **baseline sleep**, early signs, spending changes, medication concerns, substance use, preferred language, trusted contacts, clinician/team details, what family should do if the person refuses help, financial safeguards the person has chosen, and clear crisis thresholds.

Professional assessment and treatment

Assessment considers the pattern and duration of mood episodes, functioning, sleep, psychotic symptoms, depression, suicide risk, medication, substances, physical health and family history. Clinicians may need to distinguish bipolar disorder from unipolar depression, ADHD, personality-related emotional instability, substance effects, thyroid or other medical problems and different causes of psychosis.

Medication

Medication is a central part of treatment for many people with bipolar disorder. Depending on the presentation, clinicians may use mood-stabilising medicines, antipsychotics and other treatments. Lithium is one established treatment and requires blood monitoring because safe and effective levels matter. Other medicines have their own monitoring and side-effect considerations.

Antidepressants require careful clinical consideration in bipolar disorder and are not simply managed in the same way as unipolar depression. Families should never start, stop, hide or alter medication doses themselves. If side effects, pregnancy planning, physical illness or adherence problems arise, encourage prompt discussion with the prescriber.

Psychological treatment and psychoeducation

Psychological interventions can help people understand mood patterns, recognise early warning signs, strengthen routines, improve coping and address the impact of episodes on relationships. Family intervention or structured family work can support communication and relapse planning. Therapy is not a substitute for appropriate medical treatment during severe mania.

Recovery and living well between episodes

Recovery is more than preventing crisis. It can involve rebuilding confidence, returning to work or education, repairing relationships, developing a sustainable sleep routine, understanding personal triggers, managing medication collaboratively, protecting finances and reconnecting with identity beyond diagnosis.

Some people fear that stability will remove creativity or personality. Treatment should not aim to erase the person. A useful conversation with clinicians is about preserving meaningful energy and identity while reducing the destructive consequences of episodes.

After mania: shame and repair

As insight returns, the person may be horrified by spending, messages, sexual behaviour, arguments or decisions made during the episode. Families can hold two truths: the illness affected judgement, and real consequences may still need repair. Shame alone rarely creates healthy accountability. Focus on practical restitution, apologies where appropriate, rebuilding trust and strengthening the relapse plan.

Avoid repeatedly using the episode as a weapon in future arguments. Equally, supporters should not be pressured to pretend nothing happened. Couples or family therapy may help when trust has been significantly damaged.

Supporting depression without taking over

During depression, break tasks into manageable steps and offer specific support: 'Would you like me to sit with you while you call the GP?' or 'Shall we make something simple to eat?' Encourage routine and connection without treating low energy as a moral failure. If suicidal thinking is present, ask directly and seek appropriate help rather than relying on encouragement alone.

Work, parenting and ordinary life

Bipolar disorder can affect employment through absence, overcommitment during elevation or reduced functioning during depression. Occupational health and reasonable workplace adjustments may help. Parenting can also be affected; children need age-appropriate explanations and dependable adults. They should not become responsible for monitoring a parent's mood, medication or safety.

Keep ordinary family identity alive. Talk about hobbies, holidays, food, television, grandchildren, work and plans. Constantly asking 'How is your mood?' can make the diagnosis dominate every relationship.

Safeguarding yourself as a supporter

Mood episodes can have a major impact on partners and families. You may deal with sleepless nights, angry calls, financial consequences, broken promises, accusations, risky behaviour or long periods of depression. Supporters often become hypervigilant, watching every change in sleep or enthusiasm and wondering whether ordinary happiness is the start of mania.

Your fear is understandable, but constant monitoring can damage both people. Use the agreed relapse indicators rather than treating every energetic day as illness. If you remain traumatised by previous episodes, you may need your own support even when the person is currently well.

Boundaries are not abandonment

Examples include: 'I will talk with you, but I won't stay in a conversation where I am being threatened.' 'I cannot lend more money.' 'I can help contact the team, but I cannot be awake all night.' 'I will not cover up dangerous behaviour.' 'If I believe there is immediate risk, I will seek emergency help.' Boundaries describe your actions and limits; they are not punishments.

Diagnosis does not remove accountability

Illness can profoundly affect judgement, inhibition and behaviour. That context matters. But supporters are still entitled to physical, emotional, sexual and financial safety. A diagnosis does not require somebody to tolerate abuse, coercion, violence or repeated exploitation. Safety planning should focus on actual behaviour rather than stigmatising bipolar disorder as inherently dangerous.

Carer fatigue and burnout

Warning signs include poor sleep, irritability, resentment, anxiety when the person is out, constantly checking bank accounts or messages, neglecting your own health, cancelling plans, reduced work performance, feeling emotionally numb or believing you alone can prevent relapse. These are signs the support arrangement needs strengthening.

Supporter wellbeing check-in

Ask: **Am I safe? Am I sleeping? Are my finances protected? Can I have a good day without feeling guilty? Do I have someone I can tell the whole truth to? Am I carrying responsibilities that belong to the person or their clinical team? Are children being affected? What boundary needs strengthening?**

Support versus rescue

Support encourages the person to use their own skills and treatment network. Rescue repeatedly removes every consequence, makes every call, pays every debt, lies to employers or family, or makes the supporter responsible for mood stability. Rescue often grows from fear, but it can exhaust the family and reduce opportunities for autonomy and accountability.

Getting help for yourself

Family intervention, counselling, peer support, carers' services and trusted relatives can help. A carer's assessment may identify your own support needs. Confidentiality may limit what a clinical team can tell you about another adult, but you can still provide professionals with information about changes or risks you have observed.

Urgent and emergency situations

Seek urgent professional help for rapidly escalating mania, prolonged severe sleep loss with increasing activation, psychosis, dangerous spending or behaviour, inability to meet basic needs, severe agitation, serious self-harm or suicidal intent. Mixed states can also be high risk because despair may coexist with energy and agitation.

In an immediate life-threatening emergency call 999 or attend A&E.; NHS 111 can provide urgent health advice. Follow an existing crisis-team or care plan where available. Samaritans can be contacted on 116 123 in the UK and ROI. Do not place yourself or children in danger while attempting to manage a crisis alone.

Practical family coaching tools

1. Personal baseline. When well, record usual sleep, speech, activity, spending, sociability, work pattern and energy. This makes it easier to distinguish personality from significant change.

2. Traffic-light relapse plan. Green: well and maintaining routines. **Amber:** early changes such as reduced sleep or increased spending - use agreed actions and contact support. **Red:** severe impairment, psychosis, dangerous behaviour or major risk - follow crisis arrangements.

3. Spending plan. What financial safeguards has the person chosen while well? What purchase amount triggers a pause? Who can be consulted? Which accounts belong solely to the supporter and must remain protected?

4. Relationship repair. What happened? What impact did it have? What part was influenced by illness? What still needs accountability or repair? What practical change reduces the chance of repetition? What does the supporter need before trust can rebuild?

5. Boundary plan. I can... / I cannot... / If I feel unsafe I will... / I will not finance... / My protected time is... / The responsibility that belongs to professionals is... / The people I can call are...

6. Supporter recovery plan. What did the last episode cost you emotionally, physically, financially and socially? Which part of your own life needs rebuilding? Who supports you? What signs tell you that you are becoming hypervigilant again?

Common myths

'Bipolar means ordinary mood swings.' No; clinical episodes involve significant changes in mood, energy and functioning. **'Mania is just being very happy.'** Mania can involve severe impairment, irritability, psychosis and risk. **'Bipolar II is a mild version.'** Hypomania is less severe than mania, but bipolar II depression can be profoundly impairing. **'Medication changes personality.'** Treatment aims to reduce harmful episodes, not erase identity. **'Family members must prevent every relapse.'** No supporter can guarantee this.

Recommended reading and UK resources

The Bipolar Disorder Survival Guide - David J. Miklowitz: a detailed, practical guide to understanding episodes, treatment and relapse prevention. **Loving Someone with Bipolar Disorder** - Julie A. Fast and John D. Preston: partner-focused strategies; best used alongside individual clinical advice. **An Unquiet Mind** - Kay Redfield Jamison: a well-known lived-experience memoir by a clinical psychologist with bipolar disorder.

Useful UK sources include NHS information on bipolar disorder, NICE guideline CG185 on bipolar disorder assessment and management, Mind information on bipolar disorder, and Bipolar UK for peer and family support. Local NHS mental-health and crisis services vary by area. Information and service details should be checked periodically.

Clinical note

This guide is educational, not diagnostic, and does not replace individual medical or mental-health advice. Mood elevation can have several psychiatric, substance-related and medical causes. Medication requires qualified prescribing and monitoring. New, severe or rapidly changing symptoms should be professionally assessed.

A message from Maggie

Loving someone with bipolar disorder can sometimes feel as though you are trying to work out which changes are simply part of the person you know and which are signs that something is beginning to shift. After a difficult episode, even ordinary excitement or a late night can make families anxious. That fear can stay with you long after the crisis has passed.

The answer is not to watch the person every minute. It is to build understanding when things are well: know their baseline, agree the early signs, talk honestly about sleep, money, treatment and safety, and decide together what should happen if those signs return. A plan made during stability can protect dignity when judgement becomes harder.

There may also be real hurt to repair. Illness can explain behaviour without making its impact disappear. Partners and family members are allowed to feel angry, frightened, betrayed or exhausted. You can understand what happened and still need boundaries, accountability, financial protection or support for yourself.

Please do not lose your own life while trying to protect somebody else's. You are allowed sleep, work, friendships, laughter and days that are not organised around mood. You are allowed to say no. You are allowed to involve professionals when the situation has moved beyond what a family can safely hold.

The person you love is more than bipolar disorder, and you are more than their supporter. My hope is that knowledge, planning and honest boundaries allow both of you to have more room for the ordinary parts of life - the parts where relationships, identity, purpose and hope can grow.

Maggie Learoyd
Space to Breathe Therapy

Final coaching question

If another episode began, what would you wish your family had already agreed about **sleep, spending, treatment, communication, safety and supporter boundaries**? That is the plan to begin while things are stable.