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Bipolar disorder

Bipolar disorder is a long-term mental health condition. People with bipolar disorder have periods where they have extremes of moods: 'lows' (depression) and 'highs' (called hypomania or mania). Bipolar disorder can make people extremely unwell, but treatment can help many people to live a normal life.

What is bipolar disorder?

Bipolar disorder is also called bipolar affective disorder. It used to be called manic depression. People with bipolar disorder experience periods of:

- Very low mood - depression.
- Abnormally elated mood - hypomania, or, in a more severe form, mania.

Depression, hypomania, and mania all have other symptoms, aside from mood changes. See "Bipolar symptoms" below for more.

The length of time spent in depression and hypomania/mania can vary. It is usually for several weeks at a time or longer. Bipolar disorder is very different from simple 'mood swings' that many people experience. Mood swings last minutes to hours, whereas episodes of bipolar disorder last much longer.

People with bipolar disorder can have any number of depressive and manic/hypomanic episodes throughout their life. In between the episodes, there may be weeks, months, or years where their mood is normal.

Some people experience very quick swings from highs to lows, and from lows to highs, without long periods of normal mood in between. This is called rapid cycling bipolar disorder.

Some people experience features of mania and depression at the same time, or in very quick succession. These are called mixed features.

Bipolar disorder can make people extremely unwell. It can have major effects on people's lives. As a result, it's considered one of the 'serious mental illnesses'. However, treatment can be very effective.

Bipolar symptoms

People with bipolar disorder get episodes of low mood (depression) and episodes of abnormally high mood (hypomania or mania).

Depression symptoms

The symptoms of depression in bipolar disorder are similar to those of depression generally. (The more common form of depression, which occurs without episodes of abnormally high mood, is sometimes called unipolar depression to distinguish it from bipolar disorder).

The main symptoms are:

- Feeling very low, sad, or tearful.
- Having no interest in, or getting no pleasure from, activities that are normally enjoyable.

Other symptoms can include:

- Under-eating, or over-eating.
- Feeling tired and lacking in energy.
- Sleeping problems: difficulty getting to sleep, problems with waking up too early, or over-sleeping.
- Feeling worthless or guilty.
- Behaving in an agitated way, or moving and talking more slowly than normal.
- Thinking about death and dying.
- Thoughts of suicide.

In severe cases (psychotic depression), people may also have:

- Abnormal, and false, beliefs (delusions): for example, believing that their actions are controlled by someone else.
- Seeing, hearing, tasting, or smelling things that are not really there (hallucinations): for example, hearing voices criticising them.

Hypomanic symptoms

Hypomania is a state of abnormally high mood. It usually lasts anywhere from a few days to a few weeks. Hypomania is less severe than mania, but can still cause significant problems.

Symptoms of hypomania include:

- Feeling very happy, joyful, or elated.
- Feeling irritable or agitated.
- Feeling full of energy, and needing less sleep.
- Feeling full of ideas.
- Having higher self-esteem and self-confidence.
- Losing social inhibitions; for example, being overly-friendly with people.
- Talking rapidly.
- Having racing thoughts, where thoughts move from topic to topic rapidly
- Behaving in risky or harmful ways; for example, spending lots of money, or having unsafe or inappropriate sexual relationships.

People with hypomania are usually still able to function in their day-to-day lives. For some people, hypomania is a pleasant feeling. For others, it feels scary and unpleasant. People with hypomania may do things that they later regret when they are well again, such as doing things that damage their relationship with loved ones.

Manic symptoms

Mania is more severe than hypomania. Mania lasts at least one week, but often lasts much longer than this.

The key feature of mania, which isn't present in hypomania, is psychosis, a state where people start to lose touch with reality. Psychosis in mania can cause symptoms of:

- Abnormal, false beliefs (delusions). For example, someone with mania might believe that they have special supernatural powers.
- Seeing, hearing, tasting or smelling things that are not really there (hallucinations). For example, hearing people talking to them.

People with mania also have similar symptoms to those listed above in hypomania, but typically they will be more severe.

For example, someone with mania may talk very rapidly and be difficult to interrupt. Their speech may jump around from topic-to-topic and be very difficult to follow. People with mania may feel that they need little or no sleep.

People with mania are often seriously unwell. Mania usually stops people from being able to do their normal activities. They may behave in bizarre and unusual ways.

Untreated mania can cause significant problems in people's lives, even after they have recovered. Someone with mania might, whilst they are unwell, do things that permanently damage their relationships, their career, or their finances.

Types of bipolar disorder

Bipolar disorder is often divided into two types:

- Bipolar type 1 or bipolar I. This is diagnosed if someone has one or more episodes of mania.
    - People with bipolar type 1 usually get depressive episodes as well, but these aren't needed to make the diagnosis.

- Bipolar type 2 or bipolar II. This is diagnosed if someone has one or more episodes of hypomania, and one or more episodes of depression.
    - People with bipolar type 2 get hypomania, but not mania.
    - Unlike bipolar type 1, episodes of both hypomania and depression are needed to make the diagnosis of bipolar type 2.

There are a few other forms of bipolar, such as:

- Bipolar with mixed features. This is when someone has symptoms of both depression and mania/hypomania at the same time, or very soon after each other.
- Bipolar with seasonal features. This is when the seasons of the year have a clear effect on someone's mood.
- Rapid cycling bipolar. This is when someone gets 4 or more episodes of depression, hypomania, or mania a year.
- Cyclothymia. This is when someone has episodes of hypomania and episodes of low mood, but not low enough to be called major depression. They also don't get episodes of mania.
    - Cyclothymia is often diagnosed if someone has bipolar-like symptoms, but they're not severe enough to be classified as bipolar disorder. However, it can still have big impacts on people's lives.
- Unspecified bipolar disorder. This is when someone has symptoms of bipolar disorder, but can't be classified into any of the other types.

How common is bipolar disorder?

About 2 in 100 people have bipolar disorder. It can occur at any age but most commonly first develops between the ages of 15 and 24. It's equally common in men and women.

Bipolar disorder is much less common than 'unipolar' depression, which is when people get episodes of depression, but without hypomania or mania. Roughly 1 in 7 people get at least one episode of unipolar depression in their lifetime.

What causes bipolar disorder?

We don't know the exact causes of bipolar disorder. Possibilities include:

- Genetics. People with a family history of bipolar disorder are more likely to get bipolar disorder themselves. It's very unlikely that one single gene causes bipolar, at least for most people. Instead, there are many different gene variants which, when passed on together, increase the risk of developing bipolar disorder.
- Childhood trauma. People with bipolar disorder are more likely to have had difficult experiences in childhood, although this doesn't apply to everyone with bipolar. Trauma in childhood might affect the way in which the brain processes and controls emotions.
- Changes in brain chemicals (neurotransmitters). Many drug treatments for bipolar disorder work by affecting these chemicals. However, the brain is extremely complex, and we don't really know exactly how these relate to bipolar disorder.
- Stressful life events. It's possible that these can trigger episodes of mania/hypomania or depression in people who are already prone to bipolar disorder.

Assessing for bipolar disorder

Bipolar disorder is diagnosed based on having the signs and symptoms of mania or hypomania. People with hypomania or mania may not realise that they are unwell. Often, it's friends or family who spot that something is wrong, and encourage them to see a doctor.

There are no blood tests or scans that can diagnose bipolar disorder, although they may sometimes be done if doctors think another condition could be causing similar symptoms.

It's quite common for bipolar disorder to initially be misdiagnosed as depression. Depression is more common. Some people seeing a doctor for an episode of depression may have had mania or hypomania in the past, which went unrecognised. Alternatively, mania or hypomania may not yet have happened, but might do so in the future - changing the diagnosis from depression to bipolar disorder.

Doctors sometimes ask questions to look for unrecognised episodes of mania or hypomania in the past. These questions might include:

- Are there any times in the past when you have felt that you have increased energy?
- Are there any times in the past when you have felt more self-confident than usual?
- Are there any times in the past when you have felt that your thoughts were racing?

Doctors may also ask if there is a history of bipolar disorder in the family, as this can make it more likely.

Sometimes people who are treated with antidepressants for an episode of depression can develop symptoms of mania or hypomania or may fail to respond to the antidepressants. This can also be a sign that someone actually has bipolar disorder and not depression.

Bipolar disorder is usually diagnosed by psychiatrists (mental health specialists).

Bipolar treatment

Treatments include:

- Medicines that aim to **prevent** episodes of mania, hypomania and depression. These are called mood stabilisers.
    - Deciding whether or not to take mood stabilisers should be done with input from a psychiatrist. If there has been only one episode of mania, it's difficult to predict how likely another one is; so, some people may choose not to start a mood stabiliser at that point (although others do). If there has been more than one episode of mania, further episodes are very likely, and so a mood stabiliser will be strongly recommended.
    - Treatment with a mood stabiliser is usually continued for at least 2 years, and sometimes longer. Speak to a psychiatrist before stopping medication.

- Treating episodes of mania, hypomania and depression when they occur.

Mood stabilisers

Commonly-used mood stabilising drugs include:

- Lithium. Lithium has been used as a mood stabiliser for many years. There is very good evidence for it in bipolar disorder; it is effective at reducing the risk of suicide and self-harm in people with bipolar disorder, although we don't really know how it works. It can be difficult to get the dose right (meaning that regular blood tests are needed), and lithium also has several side-effects that can be troubling.
- Anticonvulsant, or anti-epileptic, medicines. Although these were originally used to treat epilepsy, they also work for bipolar disorder - though we don't really know how. These can be used on their own, or sometimes in combination with lithium. Commonly-used anticonvulsants include:
    - Sodium valproate.
        - This can harm unborn babies if taken during pregnancy. It should not be used in anyone who could become pregnant; all women and girls of childbearing age must use effective contraception if they are taking valproate.
    - Carbamazepine.
    - Lamotrigine.
- Antipsychotic medications, such as:
    - Haloperidol.
    - Olanzapine.
    - Aripiprazole.
    - Quetiapine.
    - Risperidone.
    - Lurasidone.

Treatments for episodes of mania and hypomania

Episodes of mania or hypomania should be treated by a specialist mental health team.

- People with an episode of mania or hypomania are usually offered antipsychotic medication, such as haloperidol, olanzapine, quetiapine, or risperidone. If these don't work, lithium can be added.
- Antidepressants are usually stopped by psychiatrists during an episode of mania, as they can make mania worse.
- For very severe, life-threatening, cases of mania, where medicines have not worked, electroconvulsive therapy (ECT) might occasionally be used.

People with hypomania or mania might be treated at home or in hospital, depending on how severe the symptoms are. Some people with hypomania and mania do not realise how unwell they are. If someone is seriously unwell, and thought to be a risk to themselves or other people, they might need involuntary admission to hospital ('sectioning') to allow treatment to get them well again.

Treating episodes of depression

The treatment of depression in people with bipolar disorder is mostly similar to that for people who develop depression without episodes of mania, but mood stabiliser drugs are usually given too.

- Antidepressant medicines are commonly prescribed, in combination with antipsychotic drugs:
  - Antidepressants work well to relieve symptoms for about 7 out of 10 people.
  - A common combination is fluoxetine and olanzapine.
  - Antidepressants and antipsychotic drugs are given together, because taking antidepressants on their own increases the risk of developing mania.
- Quetiapine on its own is another option.
- For people already taking lithium or sodium valproate, quetiapine might be added.

- Cognitive behavioural therapy is another option which can work well to treat depression. It is a talking treatment.
- Other forms of talking treatment include interpersonal and social rhythm therapy, and behavioural couples therapy.
- Regular exercise.
- For very severe, life-threatening, cases of depression, where medication hasn't worked, ECT is occasionally offered as a treatment.

Most people with depression can be treated at home, but they might need hospital treatment if they are very unwell.

New developments

Research continues to try to find better mood stabiliser medicines. New non-drug treatments such as vagal nerve stimulation, sleep deprivation, light therapy, transcranial magnetic stimulation and deep brain stimulation are being studied.

Self-help for bipolar disorder

- Try to avoid stressful situations which may trigger an episode of mania or depression. This is often easier said than done. But, a change in lifestyle may be appropriate for some people. See the separate leaflet called Stress Management.
- Try to establish a daily routine and schedule daily activities so that you have things to occupy your time. Make sure that you are eating regularly and healthily and getting plenty of sleep. Regularly working excessively long hours and shift work may not be helpful if you have bipolar disorder.
- Try to do some regular relaxing activities (for example, resting in a quiet place). Also, try to become more aware of how you are thinking, feeling and behaving. You may want to keep a diary of your moods, thoughts and reactions to help this.
- Try not to drink much alcohol or take recreational drugs. These may trigger an episode of mania.

- If you are prescribed a mood stabiliser medicine, take it regularly. Sometimes, suddenly stopping a mood stabiliser can trigger an episode of mania. So, if you get any side-effects, tell a doctor. The dose or type of medication can often be changed but do this with the advice of a doctor.
- Consider being quite open to family and friends about your condition. If they understand the condition, they may be able to tell if you are becoming ill, even if you do not realise it yourself - particularly, if you are developing an episode of mania. Rather than thinking of you as bizarre they may think of you as ill and may encourage you to get help.
- Learn about your condition. It has been shown that if you are taught to recognise the early stages of mania, you are more likely to seek help and treatment which may prevent a major episode developing. Your doctor or psychiatrist may help to teach you about recognising when to seek help.
- Consider joining a self-help or patient group. They are a great source of advice, information, support and help.
- When you are well, consider putting some safeguards on your money so that you cannot overspend if you become unwell. Consider granting lasting power of attorney to someone you trust; they can make financial decisions on your behalf if you become too unwell to do so.
- If you are the main or only carer of children (for example, if you are a single parent), it is important that someone else who knows you well should be aware that you may become ill quite quickly and not be able to care for your children properly, so that they can arrange to look after them at short notice.

What is the usual pattern and outcome of bipolar disorder?

Bipolar disorder is a lifelong condition. Some general points include the following:

Without treatment

- The average length for an episode of mania is four months. But for some people it can last much longer.
- In some people, their mood recovers completely between episodes of mania or depression. In others, their mood does not completely recover.
- The average length for an episode of depression is six months but, again, it can be longer.
- We can't reliably predict how often episodes of mania and depression will occur.
    - After recovering from a mood episode, a further episode of mania or depression occurs within one year in about half of cases. Within four years, three out of four people will have had another episode.
    - Some people only ever have one episode of mania for a few weeks or months.
    - The average number of episodes in a lifetime (of either depression or hypomania/mania) is ten.
- As time goes on, the time period of normal mood between episodes of mania or depression tends to get shorter. Also, episodes of depression tend to become more frequent and last for longer.

Some people have more frequent and severe episodes than others. Because of the nature of the condition, people with bipolar disorder have a lower chance of holding down a job than average. Relationships can be strained. There is also an increased risk of suicide if depression becomes severe and an increased risk of death from risky adventures during an episode of mania. The outlook is worse for people who use recreational drugs, including excessive alcohol.

With treatment

Treatment for bipolar disorder can help to control the symptoms, and reduce how often episodes of depression or mania/hypomania occur. However, there is no once and for all cure. Treatment usually means that episodes of mania or depression are shorter and/or may be prevented.

Bipolar disorder and driving

Symptoms of bipolar disorder can sometimes affect people's ability to drive safely. Drugs used to treat bipolar disorder may also affect driving ability.

You must tell the Driver and Vehicle Licensing Agency (DVLA) if you have a diagnosis of bipolar disorder.

See Further Reading, below, for more.

Pregnancy and bipolar disorder

Like many mental health conditions, bipolar disorder can get worse during pregnancy. Supporting the mother's mental health is extremely important for both mother and baby.

If you are planning to become pregnant, or if you find out that you are pregnant, contact your doctor or specialist mental health team as soon as possible.

Pregnant women with bipolar disorder should be under the care of a specialist mental health team, and ideally a perinatal psychiatrist - a psychiatrist who specialises in the care of women during and after pregnancy.

Regular medication for bipolar disorder may need to be changed before or during pregnancy. This is because some bipolar disorder medicines have risks for the unborn baby, and may need to be changed to safer ones.

Don't stop or change any medication without seeing a doctor, though. Stopping medication can cause people to relapse, which may be more dangerous. Decisions about stopping or changing medication should be made alongside a psychiatrist with expertise in treating mental health problems in pregnancy.

Further reading

- Bipolar disorder - the assessment and management of bipolar disorder in adults children and young people in primary and secondary care; NICE Clinical Guideline (Sept 2014 - last updated December 2023)
- Bipolar disorder; NICE CKS, October 2022 (UK access only)
- Bipolar disorder (manic depression) and driving. DVLA, 2023.

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