CONDITION

Bipolar disorder

Learn how bipolar disorder affects mood, energy, sleep, and behavior, and how it is diagnosed, treated, and monitored over time.

WHAT IT IS
Long-term mental health condition causing distinct mood episodes

BODY SYSTEM
Mental health

MAIN SYMPTOMS
Elevated or irritable mood, depression, reduced need for sleep, risky behavior

WHAT CAUSES IT
Unknown, with inherited risk

HOW IT IS DIAGNOSED
Detailed clinical history and assessment

MAIN TREATMENT
Mood-stabilizing medicines and psychotherapy

CAN IT BE CURED?
No, requires long-term treatment and follow-up

IS IT AN EMERGENCY?
Sometimes, with immediate suicide or self-harm risk

LONG-TERM OUTLOOK
Effective treatment can support a stable, meaningful life

Overview

Bipolar disorder is a long-term mental health condition that causes distinct episodes of unusually elevated or irritable mood and episodes of depression. These changes also affect energy, sleep, thinking, judgment, and activity. They are more intense and persistent than ordinary mood changes.

A manic episode involves a major change in mood and behavior that causes serious difficulty with daily life. It may lead to unsafe decisions, psychosis, or a need for hospital care. Psychosis means losing contact with reality, such as hearing voices or having firmly held beliefs that are not based in reality.

A hypomanic episode has similar symptoms but is less severe. The change is noticeable, but it does not cause the major impairment associated with mania. Hypomania can still disrupt

relationships, finances, work, or health.

Bipolar I disorder is diagnosed after at least one manic episode. Depression and hypomania are common in bipolar I, but a depressive episode is not required for the diagnosis. Bipolar II disorder involves both hypomanic episodes and major depressive episodes, without a history of mania. Bipolar II is not simply a milder form because its depressive episodes can be severe and disabling.

Cyclothymic disorder is a related condition involving repeated periods of hypomanic and depressive symptoms that do not meet full episode criteria. Bipolar conditions can begin at different ages and affect people of any background.

Bipolar disorder matters because untreated episodes may affect safety, physical health, relationships, education, employment, and finances. Effective treatment can reduce symptoms, lower the chance of future episodes, and support a stable and meaningful life.

Symptoms

Symptoms occur in episodes that represent a clear change from a person's usual behavior. Episodes may last days, weeks, or longer. Some people return to their usual level of functioning between episodes, while others continue to have symptoms.

Symptoms of mania or hypomania can include:

Mania causes marked impairment, may include psychosis, or may require hospital care. Hypomania does not cause that degree of impairment or psychosis. A hypomanic period may initially feel productive or enjoyable, which can make it harder to recognize as part of an illness.

A depressive episode may involve:

Some episodes have mixed features , meaning symptoms of depression and elevated mood occur together. For example, a person may feel hopeless while also having racing thoughts, agitation, or very little need for sleep. Mixed symptoms can be especially distressing and require prompt clinical attention.

Children and teenagers may also develop bipolar disorder, but irritability or rapidly changing moods alone do not establish the diagnosis. Clinicians look for distinct episodes and changes in sleep, energy, thinking, and behavior that differ from the young person's usual pattern.

- Feeling unusually cheerful, powerful, energetic, or irritable
- Needing much less sleep without feeling tired
- Talking more or faster than usual

- Having racing thoughts or being easily distracted
- Starting many activities or becoming unusually driven toward goals
- Showing increased confidence or an unrealistic sense of ability
- Spending excessively, driving dangerously, or taking sexual, financial, or business risks
- Persistent sadness, emptiness, or irritability
- Loss of interest or pleasure
- Low energy or slowed movement
- Sleeping too little or too much
- Changes in appetite or weight
- Difficulty concentrating or making decisions
- Feelings of guilt, worthlessness, or hopelessness
- Thoughts about death or suicide

Causes and risk factors

Bipolar disorder does not have one known cause. Research suggests that inherited traits, brain biology, and life experiences interact. It is not caused by a lack of willpower or a character flaw.

Having a close biological relative with bipolar disorder raises the likelihood of developing it, but family history does not make the condition inevitable. Many people with an affected relative never develop bipolar disorder, and some people diagnosed with it have no known family history.

Factors that may trigger an episode in someone who is vulnerable include major stress, disrupted sleep, childbirth, and substance use. Seasonal changes or travel across time zones can also disturb sleep and daily rhythms.

Some medicines can produce mood symptoms or contribute to an episode. Examples include corticosteroids like prednisone or hydrocortisone and, in certain people, antidepressants like sertraline or fluoxetine . Recreational stimulants can resemble or worsen mania. These effects do not always mean a person has bipolar disorder, so a careful assessment is important.

Other mental health conditions, including anxiety disorders, attention-deficit/hyperactivity disorder, post-traumatic stress disorder, and substance use disorders, may occur alongside bipolar disorder. Their symptoms can overlap and may complicate diagnosis and treatment.

Diagnosis

There is no blood test or brain scan that confirms bipolar disorder. Diagnosis is based on a detailed history of mood episodes, sleep, energy, behavior, functioning, substance use, medicines, and family health.

A clinician may ask when symptoms began, how long they lasted, and whether they caused problems at home, work, school, or in relationships. Information from a trusted relative or partner can be useful because a person experiencing mania may not recognize how much their behavior has changed.

The assessment distinguishes bipolar disorder from unipolar depression, which involves depressive episodes without mania or hypomania. This distinction matters because treatment approaches differ. Clinicians also consider anxiety, trauma-related conditions, attention disorders, personality disorders, and psychotic disorders.

A physical examination and laboratory tests may be used to look for other explanations, such as thyroid disease, medication effects, substance use, sleep disorders, or certain neurological conditions. Tests may also provide a baseline before treatment.

Diagnosis sometimes takes time. Many people first seek care during depression and may not remember a previous hypomanic period as unusual. A mood and sleep record can help identify patterns, but an app or screening questionnaire cannot make the diagnosis by itself.

Treatment and management

Treatment depends on the type and severity of the current episode, past treatment response, other health conditions, pregnancy considerations, and the person's goals. Care may involve a primary care clinician, psychiatrist, therapist, pharmacist, and supportive family members or friends.

Medicines used for bipolar disorder include mood stabilizers and certain antipsychotic medicines. The term mood stabilizer generally refers to a medicine that treats or helps prevent major mood episodes. Lithium, valproate, carbamazepine, and lamotrigine are examples, but they have different roles. Some are more useful for mania, while others are used more often for bipolar depression or prevention.

Several newer antipsychotic medicines can treat mania, bipolar depression, or both. The specific choice depends on the clinical situation. Short-term medicines may sometimes be used for severe agitation or insomnia while the main treatment begins working.

Antidepressants require special care in bipolar disorder because they may trigger mania,

hypomania, or unstable mood in some people. They are generally not used alone for bipolar I depression. A clinician can discuss whether an antidepressant has an appropriate role alongside a medicine that protects against elevated mood.

Medication monitoring is important. Depending on the medicine, this may include blood levels, blood counts, liver or kidney tests, thyroid tests, weight, blood pressure, blood sugar, and cholesterol. Side effects should be discussed rather than managed by suddenly stopping treatment. Abrupt discontinuation can increase the risk of relapse.

Pregnancy planning deserves early discussion. Some bipolar medicines can harm a developing fetus, while untreated severe episodes also carry risks. Valproate presents important fetal and developmental risks. People who are pregnant, could become pregnant, or are breastfeeding should review treatment with qualified clinicians and should not stop medicine abruptly without medical guidance.

Psychotherapy can improve understanding of the condition and strengthen relapse-prevention skills. Helpful approaches may include cognitive behavioral therapy, family-focused therapy, structured education about bipolar disorder, and interpersonal and social rhythm therapy. Social rhythm therapy focuses on keeping sleep, meals, activity, and social routines regular.

Day-to-day management often includes protecting sleep, limiting alcohol and recreational drugs, exercising as health allows, and maintaining predictable routines. A written plan can list early warning signs, preferred treatments, emergency contacts, and ways that trusted people can help.

Electroconvulsive therapy, or ECT, uses controlled electrical stimulation under anesthesia. It may be considered for severe depression, mania, catatonia, psychosis, or symptoms that have not improved with other treatments. It can also be used when a rapid response is medically important.

Hospital care may be needed when symptoms create immediate safety concerns, when a person cannot meet basic needs, or when treatment cannot be provided safely in an outpatient setting.

Medicines commonly used for this include quetiapine and ziprasidone . Which one suits you, if any, is a decision for you and your doctor.

Complications

Bipolar episodes can interfere with judgment and daily functioning. Possible consequences include relationship conflict, job or school loss, debt, legal problems, injuries, and sexually

transmitted infections related to impulsive behavior.

Depression and mixed episodes can involve self-harm or suicide risk. Substance use may worsen symptoms, interfere with treatment, and make episodes harder to recognize. Poor sleep can both signal and intensify a mood episode.

People with bipolar disorder may also have a higher burden of physical health problems, including metabolic and cardiovascular conditions. The illness, smoking, reduced activity, access to care, and side effects from some medicines may all contribute. Routine physical health care is therefore an important part of treatment.

Follow up

Bipolar disorder usually requires long-term follow-up, including during periods of stable mood. Routine visits may review symptoms, sleep, functioning, side effects, substance use, physical health, and whether treatment still fits the person's goals. Recommended laboratory monitoring depends on the medicine being used.

Contact the treating clinician promptly if early warning signs appear. These may include sleeping less, becoming unusually energetic or irritable, spending more, talking rapidly, withdrawing from others, or developing persistent depressive symptoms. Early treatment may prevent symptoms from becoming more severe.

Seek urgent professional help if there is rapidly worsening mania, psychosis, severe agitation, several nights with little or no sleep, dangerous impulsive behavior, or an inability to eat, drink, take medicine, or manage basic needs.

Call emergency services or go to an emergency department if there is an immediate risk of suicide, self-harm, or harm to someone else. Emergency help is also appropriate when severe confusion, violence, or loss of contact with reality makes the situation unsafe. Stay with the person if it is safe to do so, and reduce access to weapons or other lethal means while help is arranged.

Sources

- American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders . 5th ed., text revision. American Psychiatric Association Publishing; 2022.
- Department of Veterans Affairs and Department of Defense. VA/DoD Clinical Practice Guideline for Management of Bipolar Disorder . Version 1.0; 2023.

- National Institute for Health and Care Excellence. Bipolar Disorder: Assessment and Management . NICE guideline CG185. Published 2014; updated 2023.
- National Institute of Mental Health. Bipolar Disorder . U.S. Department of Health and Human Services; accessed March 2025.
- Yatham LN, Kennedy SH, Parikh SV, et al. Canadian Network for Mood and Anxiety Treatments and International Society for Bipolar Disorders 2018 guidelines for the management of patients with bipolar disorder. Bipolar Disorders . 2018;20(2):97-170.
- American College of Obstetricians and Gynecologists. Treatment and management of mental health conditions during pregnancy and postpartum. ACOG Clinical Practice Guideline No. 5. Obstetrics & Gynecology . 2023;141(6):1262-1288.