

Bipolar Clarity

Bipolar Stability Program

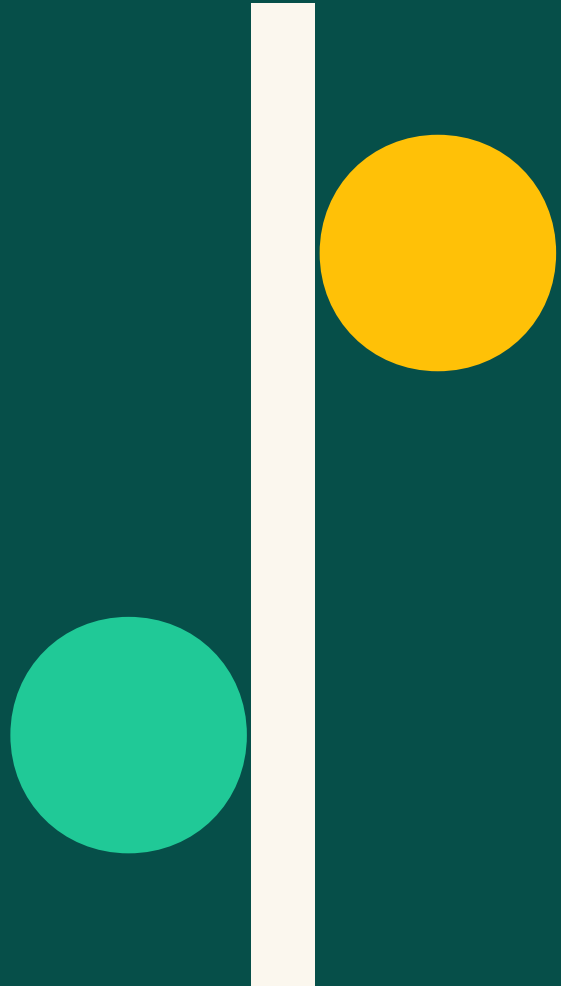
The complete twenty-four-lesson
workbook

24

LESSONS • SIX MONTHS

Print it. Write on it. Keep it.

bipolarclarity.com



Start Here

Three ways in. Any of them counts.

Start at the beginning. Chapter 1 is a safety page and takes a few minutes. The order after it is deliberate: the early chapters ask very little and give you something to hold.

Start where it hurts. If something is happening right now, open the chapter that matches it. The map on the next pages tells you which one. If a page you are asked for is missing, use the minimum information box and carry on.

Start again. If you began this once and stopped, nothing here expired. There is a page near the back that takes you back in without rereading anything.

Every chapter has a shorter route. It is finished, not lesser, and on a hard week it is the one to use. Blank is allowed, and there are five answers you can always use when a question does not fit.

Your answers stay on your paper. Nothing here is submitted, uploaded, collected or monitored.

Some of the pages are written to be filled in by the person with the diagnosis. Those are theirs to fill or leave blank, and reading them over someone's shoulder is not the same as being told.

The next two pages say why this exists and who it is for. What the research does and does not say is at the back, with the sources.

If you need help right now, don't read on. The crisis lines for your country are on page **287**. In the US, call or text 988. Elsewhere: findahelpline.com

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Why this exists

I was diagnosed with bipolar disorder in 2018. The first episode was in 1993. That is twenty-five years of living with something that had a name I hadn't been given.

What happened next was luck, and it took me a while to see it as luck. There was a hospital near where I live that ran a psychoeducation group: a psychiatrist and a psychologist, about ten of us around a table, once a week, for fourteen months. Nobody there told me what to do. They taught me what the thing was — how it moves, what it looks like early, what the medication is trying to do, what to say at an appointment and what to write down before I got there.

The part that stayed with me wasn't any single fact. It was that somebody had put the facts in an order. For twenty-five years I had collected pieces; in that room, for the first time, they were a sequence.

Almost nobody gets that room. Not because it doesn't work — of everything you can add to medication, this is one of the best-studied — but because mine needed two clinicians, a group, a waiting list, and all of it near enough to my home to attend every week for a year. It also cost me thousands of dollars.

I happened to live near one and to be able to pay for it. Most people with this diagnosis have neither, and there is nothing about them that makes them deserve it less.

So I built this. The same idea, rebuilt as something you can start tonight, wherever you are, and published in fifteen languages — because neither where you live nor what you earn should decide whether you ever get taught your own illness.

The Bipolar Stability Program is free. All twenty-four lessons, this workbook, every chapter of it on its own, every language — free now and free later. Not a trial, not a sample, nothing held back for a paid version and nothing behind an email address. I paid for mine so that you don't have to pay for this.

The topics here, and the order they come in, are mine. What I took from that room is that there should be an order at all.

— René, Bipolar Clarity

Who this is for

If you were diagnosed recently, this was built for you first. The order is deliberate: the early lessons ask very little and give you something to hold.

If you were diagnosed years ago and nobody ever sat you down and explained it, this is also for you, and you are not late. Most people never get that conversation. Several of these chapters exist because I didn't get it either until I had lived with the diagnosis for a long time.

If someone you love has bipolar disorder, you can use this to understand what they are managing. Some of the pages are written to be filled in by the person with the diagnosis; those are theirs to fill or leave blank, and reading them over their shoulder is not the same as being told.

And some honest limits.

This is not for a crisis that is happening now. If that is where you are, the crisis lines are on page **287** and they matter more than anything else in this book.

This does not replace your treatment or your clinician. It is built to make the conversations with them better, not to stand in for them. Nothing here tells you to start, stop, taper, restart, select or change a medication — that decision belongs with the person who knows your history.

And this is not a test. Nobody grades it, nobody sees it, and there is no version of it you can fail.

What you are building

Twenty-four chapters, one plan. Each chapter produces one page, and every page has a place waiting for it.

The plan has seven sections. They are not in lesson order: they are in the order you would need them if you were looking something up in a hurry. That is the whole idea. When you need your warning ladder, you are not going to remember that it was lesson 19.

SECTION OF YOUR PLAN	WHAT LIVES THERE	BUILT IN
0 • Cover and permissions	Whose plan this is, what you wanted from it, which version, who may read it, when it was last reviewed	1 • 24
1 • If this is an emergency	The pages somebody could use on your worst day: your routes, your crisis-response draft, your first-72-hours plan	1 • 20 • 21
2 • My signals	What change looks like in you, from the first two signs to the full ladder	4 • 8 • 9 • 19
3 • My baseline	What is usual for you: sleep and rhythm, pressures and protections, routine anchors	3 • 11 • 12 • 22
4 • My diagnosis, in my words	The language in your records, what it means and what it does not decide, and your history	2 • 6 • 7 • 10
5 • My treatment	What your treatment is for, what to report, what to ask, and how to prepare for the appointment	5 • 13 • 14 • 15 • 16 • 17 • 18
6 • My life	Functioning, identity, loss, and the life you are rebuilding around all of it	23 • 24

How to read this map

Some parts fill up fast and some wait. Part 1 has a page in it after the very first chapter, because the routes come before everything. Part 6 stays empty for months, and that is the design, not a delay.

A chapter can feed more than one part. Chapter 24 assembles the whole plan, so it writes the cover and the last part at the same time.

Later pages replace earlier ones. The ladder you build in chapter 19 takes over from the sign records of chapters 4, 8 and 9. When that happens the chapter tells you, and the older page gets dated and archived rather than thrown away. You will be able to see how your own account of yourself changed, which is not a small thing to own.

The default route is chapter 1 to chapter 24, because later pages build on earlier ones. You can still open the chapter that matches what is happening right now: find the part of

the plan it belongs to and go there. If a page you are asked for is missing, use the minimum information box and carry on. You do not have to start over.

How to use this workbook

The program has two halves, and they are made to be used together. Each of the twenty-four lessons is a video; each chapter in here is the paper that goes with it. The video explains the thing. The chapter is where it becomes yours — a question page, a baseline, a warning-sign ladder, a draft to review with your care team, in your own handwriting.

So the order is: watch the lesson, then open the chapter. The chapters do stand on their own if the video isn't an option today, but the questions are easier to answer after somebody has walked you through them.

Everything is at bipolarclarity.com — the twenty-four videos, this workbook, each chapter as its own booklet, fifteen languages, free and with no email address asked for. The code on this page opens the program. Each chapter also ends with three codes: that lesson's video, the next lesson, and the program. Wherever you are in the pile, the video is one scan away.

You can print the whole thing, or print one chapter the week you need it.

Your answers stay on your paper. Nothing here is submitted, uploaded, collected or monitored by Bipolar Clarity. Keep your copy wherever you keep private things — a folder, a drawer, a locked file — and decide for yourself what to write, what to leave blank and what to show anyone.

Go at the pace you actually have. Every chapter has a core route and a shorter low-energy route, and the short route still produces something you can use. The shorter route, finished on a hard week, counts. What it produces is not a lesser answer; it is a smaller one.

Blank is allowed. “Not sure yet” is an answer. “Doesn't apply to me” is an answer. “I'd rather not write that down” is an answer — as long as it's the honest one. A page with three lines on it that are true is worth more than a page filled in to look complete.

Stop if it's making things worse. If reading this is increasing your distress, or if your state is changing quickly, put it down and contact someone who can help. This will still be here.

The country-by-country crisis annex is at the back, on page **287**. Look at it once now, while you're steady, so you know where it is.

If a word gets in your way — in here or in an appointment — the glossary is on page **277**.

Forty-nine entries: first the words this workbook uses in its own way, then the clinical ones, each list in alphabetical order, written for the first year after a diagnosis. Reading it before you start is a reasonable way to use this book.

Watch this lesson
bipolarclarity.com/program/I01



BIPOLAR STABILITY PROGRAM

01

Newly Diagnosed With Bipolar? Write This Page First

Two connected pages. First the routes you would actually use if you needed help; then a realistic way to use this Program.

Two routes: the full one, and a short one

PRINT • WRITE BY HAND • KEEP

Purpose

Two connected pages. First the routes you would actually use if you needed help; then a realistic way to use this Program.

You leave with your own three routes — help early, urgent professional help and immediate danger — copied from the annex onto one page, one optional personal contact, and a small plan for how and when you will use the Program.

The Safety Plan is educational preparation. It does not assess risk, monitor you, or replace a safety or crisis plan written with a clinician.

What this chapter is about

This chapter goes with video lesson 1. It is the working half. The video does the teaching; these pages are where you do the work. What is printed here is what you want in front of you while you write, and what you will want to find again months later without watching anything.

Start with the page you would actually reach for. Not the most important page in the Program — the most *findable* one. Three routes: where you get help early, where you get urgent professional help, and what you do if there may be immediate danger. Copied out in your own handwriting, kept somewhere your hand already knows.

A route you wrote yourself is the one you find under pressure. The annex at the back of this book has the lines country by country, and that is where you copy them from. But a number sitting in a book you have to go and find is not the same as a number on the page you keep. That difference is the whole point of starting here rather than somewhere more interesting.

Who this is for, and when it works. This Program is built for the stretches when you are reasonably well. Not perfectly well — well enough to read, to write a few lines, and to picture a version of yourself who is not feeling like this. That is not a bar you have to clear to deserve a place here. It is simply where the work is possible: you are preparing calmly for a moment when preparing calmly will not be on the menu.

Which also means an episode does not remove you from this Program. It interrupts it. There are twenty-four chapters, they are numbered, and they will sit here through a bad couple of weeks, a hospital stay, or a year in which none of this was possible. When you come back, you do not start again as some kind of penance — you open the page you were on, or go straight to the chapter that matches whatever just happened. Everything you already wrote is still yours. If you are holding the complete workbook, there is a page near the front written for exactly that moment; if you are

holding this chapter on its own, the same page is in the full workbook at bipolarclarity.com/workbook.

And one boundary that outranks everything else here. If you are becoming rapidly more activated, losing touch with reality, unable to care for basic needs, or at risk of harming yourself or somebody else, professional or urgent help comes first and this chapter waits. Nothing in this book is worth finishing at that cost.

Key ideas

1. **Urgent or emergency help takes priority over coursework.** Always, and without finishing the page first.
2. **A findable route beats a remembered one.** Under pressure you will not recall a number you never wrote down.
3. **The Program helps you learn, organize and prepare.** Individualized care stays where it already is.
4. **A shorter route still produces something useful.** Filling in less is not failing.

Watch the video first

Two things live only in the video, and one of them is the reason this Program exists.

- **Where this Program came from.** René spent about fourteen months inside a psychoeducation program at a specialist hospital after his diagnosis, and this course exists because of what that did and what it left out. He tells it himself.
- **Jordan's page, built in front of you.** Watching somebody fill in three routes badly and then fix them is worth more than reading the instruction.

Watch it before you write. The video lesson is *Newly Diagnosed With Bipolar? Write This Page First* — lesson 1 of the Bipolar Stability Program.

Before you begin

This Program provides education and practical preparation. Individual diagnosis, psychotherapy, treatment, clinical monitoring, crisis care, and medical advice remain with the appropriate professionals and services involved in your care.

Your workbook answers are not submitted, uploaded, collected, or monitored by Bipolar Clarity.

Choose today's route:

- **Core:** Safety Plan, then Starting Point.
- **Low energy:** copy your country's emergency number from the annex, and save bipolarclarity.com/gethelp. Add one known service only if useful.
- **Pause:** if education is increasing distress or your condition is changing quickly, stop and contact an appropriate professional.

Answers you can always use:

- **Not known yet**
- **Prefer not to answer**
- **Nothing to record here**
- **Private — not recorded here**
- **I prefer to bring this to a professional conversation**

Where this chapter's claims come from. This chapter makes no clinical claims. What it sets out are the Program's own limits, and those are editorial decisions rather than findings. The rest of the Program is sourced, and the sources are public: bipolarclarity.com/program/sources. A source shows what published guidance says. It does not show what applies to you, and it never overrules the clinician who knows your case.

Core route

Part A — My Safety Plan

Where the numbers are. This workbook is written in one language and read in many countries, so it does not print a national number here — a language does not tell anybody where you live. **The crisis annex at the back of this workbook has the lines country by country**, plus a section for when it is not an emergency but you are struggling, and one for when home is not safe. Find yours there once, now, and copy it onto the line below. A number you have written yourself is the one you will find under pressure.

HELP EARLY

The annex section **“If it’s not an emergency, but you’re struggling”** is where this route starts. Add the clinic, prescriber, primary-care service or other professional route already involved in your care, if you have one.

MY ROUTE FOR HELP EARLY

URGENT PROFESSIONAL HELP

The annex section “**Crisis lines by country**” covers this level. This workbook does not decide whether your situation is urgent — it only makes the route easy to reach.

MY ROUTE FOR URGENT HELP**IMMEDIATE DANGER**

If you may be in immediate danger, contact your local emergency services now. For crisis resources in your country, visit bipolarclarity.com/gethelp, or see the country-by-country crisis annex at the back of this workbook.

MY EMERGENCY NUMBER, COPIED FROM THE ANNEX**ONE PERSONAL CONTACT – OPTIONAL**

Record one clinician, service or trusted person only if it would make the page more useful. Writing a contact does not notify them or make them responsible for treatment or safety.

NAME OR SERVICE**CONTACT ROUTE****WHAT I MAY ASK FOR****FINDABILITY CHECK**

Close the page and find it again. Mark one:

- I can find it quickly.
- I want to move or save it somewhere easier.
- Not known yet.
- Prefer not to answer.

☐

quickly

☐

move it

☐

not known yet

☐

prefer not to answer

Part B — My Starting Point

MY REASON OR GOAL

Write one thing you want to understand, organize or communicate better. Avoid writing a guaranteed outcome such as “never have another episode.”

HOW I MAY USE THE PROGRAM

Choose one starting preference. You can change it later.

☐ video first
 ☐ audio or screen off
 ☐ workbook summary first
 ☐ short sections

☐ not known yet

MY REALISTIC CUE

Choose a time or recurring context that genuinely exists. The length of a chapter is not a clinical dose or a test of commitment.

MY LOW-ENERGY BACKUP

Choose the smallest useful version: one question, five minutes of audio, key ideas only, or your own equivalent.

MY CONFIDENCE SNAPSHOT

- Not confident yet.
- A little confident.
- Fairly confident.
- Very confident.
- Prefer not to answer.

☐ not confident yet
 ☐ a little
 ☐ fairly
 ☐ very

☐ prefer not to answer

Low-energy route

1. Find your country in the crisis annex at the back and copy the emergency number onto the line in §3.
2. Save bipolarclarity.com/gethelp, which holds the same list and stays current.
3. Add one known service or contact only if it helps.
4. Stop. You do not need to complete anything else today.

Worked fictional example

Jordan has already copied the national lines from the annex onto the page. Jordan adds a clinic portal under help early and a friend under personal contact, with one specific request: “Help me find this page and sit with me while I make a call.” The findability check is “I can find it quickly.”

Jordan's Starting Point says: “I want to describe changes clearly at appointments.” The preferred use is video first, the cue is Sunday after lunch, the low-energy backup is one question in two minutes, and confidence is “a little confident.”

This is fictional and demonstrates the fields; it is not a recommended answer.

How this page stands

Choose exactly one: **Ready to use**, **Waiting for information**, or **Keeping this private**.

Mark **Ready to use** only when **at least one route you can actually reach is saved and you have answered the findability check** — neither depends on anybody else. Your Safety Plan is never held up by a missing detail: the general routes above are enough to start. A Safety Plan waiting for one clinic number is a page in use, not an unfinished one.

☐ Ready to use ☐ Waiting for information ☐ Keeping this private

Before you close this page

Optional and private. Never submitted, uploaded, collected or monitored.

ONE THING THAT BECAME CLEARER

ONE QUESTION I MAY WANT TO KEEP

ROUTE USED

☐

core

☐

low energy

☐

pause

☐

prefer not to answer

Where this page goes

Keep the Safety Plan at the front of the Plan while it remains the current version. The crisis-response module creates a fuller Crisis-Response Draft (lesson 20, page **223**). It replaces this provisional page only after the relevant professional and local fields are reviewed.

Keep the Starting Point goal, use preference, cue and low-energy backup. The identity-and-recovery modules revisit the goal in the context of functioning, identity and recovery.

Privacy and safety

- Your workbook answers are not submitted, uploaded, collected, or monitored by Bipolar Clarity.
- A support person receives only what you choose to share and does not become responsible for treatment or safety.
- The Program will never tell you to start, stop, taper, restart, select, or change a medication.
- Do not include method details for self-harm or suicide.
- Do not use this page to assess danger. Urgent or immediate help supersedes completion.

Help where you live

Crisis numbers for your country are at the back of this workbook, on page **287**.

Watch this lesson
bipolarclarity.com/program/102



BIPOLAR STABILITY PROGRAM

02

What Is Bipolar Disorder? (And What It Isn't)

Build accurate, non-stigmatizing language for bipolar disorder without using a worksheet as a diagnostic test.

Two routes: the full one, and a short one

PRINT • WRITE BY HAND • KEEP

Purpose

Build accurate, non-stigmatizing language for bipolar disorder without using a worksheet as a diagnostic test.

You leave with one Meaning / Not-meaning + Diagnostic Wording Card, and one uncertainty to take to a qualified professional.

What this chapter is about

This chapter goes with video lesson 2. It is the working half. The video does the teaching; this page is where you do the work. Printed here is the language you will reach for again — in an appointment, in a difficult conversation, or on a day when somebody says something careless.

The work of this chapter is words, not tests. Nothing you write here diagnoses anything. What it does is give you language accurate enough to use with a professional and steady enough to use with your family, which turns out to be two different problems.

Episodic and longitudinal. Two words worth owning early. *Episodic* means the changes come in recognizable periods rather than running flat forever. *Longitudinal* means the picture only makes sense across time — which is why a single appointment, a single questionnaire or a single bad fortnight cannot settle it.

An episode is a cluster, not a feeling. Mood, energy, activity, thinking, sleep, behavior and how life is actually going — several of those moving together, for a stretch, differently from your own usual. One low afternoon is a low afternoon.

What set something off is not the same as what caused it. The exact cause of bipolar disorder is not known, and several kinds of factor may contribute to how it begins and how it goes — biological ones, including genetic, and psychological, social and structural ones too. A *trigger* is different: it is something that can set an episode moving. Knowing what triggers an episode for you is useful, and it is not a verdict about you. Neither word means you brought this on yourself, and keeping them apart is what stops a useful observation turning into blame.

Baseline is personal. It is your usual pattern — not a flat, emotionless state, and not somebody else's average. Almost everything later in this book compares against it, which is why the word gets defined here rather than assumed.

And the diagnosis is not the person. It can organize care without describing character, capability or worth. That sentence is easy to nod at and hard to hold on a bad day, which is why it is printed rather than left to memory.

Key ideas

1. **Bipolar disorder is episodic and longitudinal.** Recognizable periods of change are understood across time.
2. **An episode involves a cluster, not one feeling.** Mood, energy, activity, thinking, sleep, behavior and functioning may change together.
3. **Baseline is personal.** It is a usual pattern, not a perfectly flat or emotion-free state.
4. **Professional assessment adds context.** One symptom, short period, questionnaire, app or outside opinion cannot establish the diagnosis alone.
5. **The diagnosis is not the person.** It can guide care without defining character, abilities, relationships or the entire future.

Watch the video first

Two things are only in the video.

- **Sam's card, worked through.** The difference between a phrase that survives an appointment and one that collapses is easier to see happening than to describe.
- **Why “the diagnosis is not you” is more than reassurance.** Clara takes it apart properly, and it lands differently spoken than printed.

Watch it before you write. The video lesson is *What Is Bipolar Disorder? (And What It Isn't)* — lesson 2 of the Bipolar Stability Program.

Before you begin

Scope and safety. This chapter is educational. It does not confirm, reject, or change a diagnosis. It is not a diagnostic quiz, professional assessment, treatment plan, monitoring service, or individualized medical advice. If your condition is changing quickly or you may be at risk, use an appropriate professional or urgent route rather than trying to settle the diagnosis here.

Your workbook answers are not submitted, uploaded, collected, or monitored by Bipolar Clarity.

How to use this chapter:

- Record what is known, what is not known, and what you want to ask.
- Do not score the observation prompts or use them to label an episode.

- Not knowing yet is an answer, and so is deciding not to record something. None of them leaves you behind.
- Choose today's route: **core** (the five-input card) or **low energy** (two lines).

Answers you can always use:

- **Not known yet**
- **Prefer not to answer**
- **Nothing to record here**
- **Private — not recorded here**
- **I prefer to bring this to a professional conversation**

Where this chapter's claims come from. The clinical statements in this lesson are sourced, and the sources are public: bipolarclarity.com/program/sources, under lesson 2. A source shows what published guidance says. It does not show what applies to you, and it never overrules the clinician who knows your case.

Core route

Episode and baseline — a visual explanation

This is a learning model, not a diagnostic graph and not a formal criterion set.

Across time:

usual variation near baseline → cluster of meaningful changes → period of greatest impact → movement toward baseline → recovery or continuing difficulties

Under each part of the line, a person might observe several domains:

- mood or emotional tone;
- energy;
- activity or pace;
- thinking or concentration;
- sleep;
- behavior, judgment or communication;
- functioning in self-care, relationships, work, study or daily tasks.

The line does not need to be smooth. Some people have symptoms between clearer episodes. Some return close to their earlier baseline. A person's baseline can also change with health, age, environment, treatment and life circumstances.

Do not use this line to decide whether a period was mania, hypomania, depression or mixed. Use it to prepare questions about sequence, change and impact.

The rule: breadth, time and impact

Three questions read a pattern instead of a moment. They are the rule the lesson rests on, and they are worth knowing by heart, because they are what turns “*I had a terrible night*” into something a professional can work with.

- **Breadth** — how many areas moved together? A change in sleep reads differently when energy, speech, plans, spending and concentration all move with it.
- **Time** — was the change brief, sustained, recurring, or part of a longer sequence? Your memory of it will be patchy. That is normal, and it is exactly where records and other people fill in the gaps.
- **Impact** — what changed in daily life? Self-care, relationships, work or study, safety. Did people around you see a clear difference, the kind they mentioned out loud at the time?

Run it once, on one ordinary night of your own. Pick a night you already have in mind — a bad one, or one you have wondered about. Answer the three questions and stop there.

HOW MANY AREAS MOVED

HOW LONG THEY STAYED MOVED

WHAT THE CHANGE REACHED

Breadth, time and impact organize a description. They stop short of a diagnosis, and a professional reads your description against your wider history. **Not known yet** is a complete answer to any of the three, and one night is not a pattern — that is the point of the exercise, not a failure of it.

Required core artifact — Meaning / Not-meaning + Diagnostic Wording Card

Purpose: record what is already known, prevent the label from carrying meanings it does not justify, and keep one useful uncertainty visible.

Destination: Bipolar Stability Plan, **Section 4 — My diagnosis, in my words.**

How this page stands

Choose exactly one: **Ready to use**, **Waiting for information**, or **Keeping this private**.

Mark **Ready to use** only when **at least one line is written in your own words about what your diagnosis does not mean about you** — that line depends on nobody else. A card waiting for the exact wording of your record is a valid state, not an unfinished card.

☐ Ready to use ☐ Waiting for information ☐ Keeping this private

Complete five inputs. Do not use the card to select a subtype, choose a diagnostic framework, or label past experiences as episodes.

CORE 1 OF 5 – DIAGNOSIS WORDING ALREADY USED IN MY CARE, IF KNOWN

Wording from a current record or professional conversation. Options: exact wording not known yet / prefer not to answer.

Optional metadata, not part of the five core inputs — framework or terminology noted in my record, if known. Options: **Private** — not recorded here / **Not known yet**.

FRAMEWORK OR TERMINOLOGY NOTED IN MY RECORD

CORE 2 OF 5 – ONE THING THE DIAGNOSIS MAY HELP EXPLAIN OR ORGANIZE IN CARE

Option: not known yet.

CORE 3 OF 5 – ONE CONCLUSION THE DIAGNOSIS DOES NOT JUSTIFY

Example: “It does not mean every strong emotion is a symptom.”

CORE 4 OF 5 – MY PREFERRED IDENTITY-LANGUAGE CHOICE OR BOUNDARY

Choose one way to record your preference. Either select a preferred term — a person with bipolar disorder, a person living with bipolar disorder, bipolar person, the specific diagnosis only when relevant, another preference, not known yet, prefer not to answer — or complete the identity-

boundary sentence: “This diagnosis describes a health condition and an episode pattern relevant to my care. It does not define my **[write here]**.”

Complete only the route you selected. The unselected route is optional.

- | | |
|---|--|
| ☐ a person with bipolar disorder | ☐ a person living with bipolar disorder |
| ☐ bipolar person | ☐ diagnosis only when relevant |
| ☐ another preference | ☐ identity-boundary sentence instead |
| ☐ not known yet | ☐ prefer not to answer |

CORE 5 OF 5 – ONE UNCERTAINTY OR QUESTION FOR A QUALIFIED PROFESSIONAL

Options: nothing to record here / prefer not to answer.

ONE UNCERTAINTY I WANT TO KEEP VISIBLE

ONE QUESTION FOR A QUALIFIED PROFESSIONAL

Do not change the diagnosis wording through self-assessment. Update the card when a current record or a qualified professional clarifies it.

OPTIONAL — reflection

When I first heard or read the diagnosis, I thought it meant — options: not known yet / prefer not to answer

One belief about the diagnosis that I want to check is — options: not known yet / prefer not to answer

One part of my identity or life that I do not want reduced to a diagnosis is — options: nothing to record here / prefer not to answer

OPTIONAL — three-prompt changes-over-time micro-preview

This is a micro-prompt, not a checklist, diagnostic test, timeline or life chart. Use only a period already discussed with a professional. The full personal timeline and life-chart exercise is built in the life-chart module.

ONE PREVIOUSLY DISCUSSED PERIOD OR CONTEXT

CHANGE ONE THAT SEEMED TO OCCUR TOGETHER WITH IT

CHANGE TWO THAT SEEMED TO OCCUR TOGETHER WITH IT

One impact or question that remains — options: not ready / not known yet / prefer not to answer

OPTIONAL — question bank for a clinician or treating professional

The core card requires only one question. Choose additional questions only if useful.

- What diagnosis is currently recorded, and what terminology does that record use?
- Which parts of my history were most important to the assessment?
- What symptoms or difficulties between clearer episodes are relevant to my care?
- Which alternative explanations, coexisting conditions, physical-health factors, substances or medication effects were considered?
- What uncertainty remains, and how might it be reviewed over time?

ADDITIONAL QUESTION, IF ANY

Low-energy route

Complete these two lines and stop. They are a usable minimum version of the core card, and you can return later.

1. “This diagnosis may help describe or organize a pattern in care; it does not...”

2. “One uncertainty or question I want to keep is...”

Worked fictional example

Sam's record says “bipolar disorder,” but Sam does not know which subtype is documented. Sam does not select a subtype from an online description. Sam writes:

- Diagnosis wording already used in my care, if known: “Bipolar disorder appears in my current record.”
- One thing the diagnosis may help explain or organize in care: “The diagnosis is used to make sense of periods involving changes in mood, sleep, pace and functioning.”
- One conclusion the diagnosis does not justify: “It doesn't mean my enthusiasm, grief, anger or ambition is automatically a symptom.”
- One uncertainty I want to keep visible: “Subtype not clear to me — ask which diagnosis and framework are in my current record.”
- My preferred identity-language choice or boundary: “Person with bipolar disorder.”
- One question for a qualified professional: “Which parts of my history mattered most to this diagnosis?”

This is a fictional example, not a recommended answer and not a patient history.

Before you close this page

Optional and private. Never submitted, uploaded, collected or monitored.

THE CLUSTER-OVER-TIME IDEA IS

☐ clear ☐ partly clear ☐ unclear ☐ not known yet

THE MEANING/NOT-MEANING EXERCISE WAS

☐ useful ☐ somewhat useful ☐ not useful yet ☐ not completed

ONE USEFUL DISTINCTION

ONE QUESTION THAT REMAINS

Where this page goes

Your completed card moves into **Section 4 – My diagnosis, in my words**: the diagnosis wording, your selected identity-language preference or boundary, and the field for what is still uncertain.

One action this week: complete the integrated Meaning / Not-meaning + Diagnostic Wording Card.

One observation: notice one place where “pattern over time” changes how you understand a single symptom.

Low-energy backup: complete the not-meaning line and one uncertainty or question.

The diagnostic-language module replaces this high-level subtype preview with the full distinctions. The life-chart module replaces the three-prompt micro-preview with the full longitudinal timeline. Keep this card until then; it is not superseded by either.

Privacy and safety

- Your workbook answers are not submitted, uploaded, collected, or monitored by Bipolar Clarity.
- This chapter does not assess your level of risk.
- Do not use the worksheet to reclassify your diagnosis or label past experiences as episodes.
- Contact a treating professional when diagnostic uncertainty is causing significant distress, when you are considering a major treatment decision because of it, or when you need clarification about current records.
- Seek a sooner or urgent professional assessment if mood, energy, activity, sleep, thinking, judgment, self-care or functioning is changing rapidly or severely.

If you may be in immediate danger, contact your local emergency services now. For crisis resources in your country, visit bipolarclarity.com/gethelp, or see the country-by-country crisis annex at the back of this workbook.

Help where you live

02

Crisis numbers for your country are at the back of this workbook, on page **287**.

Watch this lesson
bipolarclarity.com/program/103



BIPOLAR STABILITY PROGRAM

03 • LESSON

03

Bipolar Sleep: 3 Short Nights That Mean Different Things

A private seven-day observation of your sleep and one daily anchor. Not a test, not a score, and not a diagnosis.

Two routes: the full one, and a short one

PRINT • WRITE BY HAND • KEEP

Purpose

A private seven-day observation of your sleep and one daily anchor. Not a test, not a score, and not a diagnosis.

You leave with a short description of what is usual for you, one flexible anchor, and one message you could actually use if a change deserves professional attention.

What this chapter is about

This chapter goes with video lesson 3. It is the working half. The video does the teaching; this grid is where you do the work.

Seven days of watching, and nothing else. No score, no test, no verdict. You write down when you slept, how much you wanted to, whether you had the chance, and one daily anchor. That is the entire exercise, and it is deliberately small because it has to survive an ordinary week.

The number on its own is not the pattern. Five hours can be three completely different things. It can be insomnia — you wanted to sleep and could not. It can be insufficient opportunity — a baby, a shift, a deadline, a flight. Or it can be a decreased need for sleep, where you slept less and did not feel tired, which is the one worth noticing early. The hours look identical on paper. What separates them is desire, opportunity and what your energy did afterwards, which is why this grid asks for all of it and not just the number.

One anchor, not a schedule. Pick a single thing that happens at roughly the same time each day and that you can mostly control — a first meal, going outside, the same alarm. Not a timetable, not a regime. Something observable and gentle enough that a bad Tuesday does not break it.

Baseline is yours. Usual means usual *for you*. There is no target here set from outside, and this page is not asking you to sleep more, sleep better, or hit a recommended figure.

And a blank is legitimate. A missed day is data about the week, not a failure of the exercise. Write what you have.

Key ideas

Four things worth knowing before you write anything.

1. **The number alone is not the pattern.** Compare desire for sleep, opportunity, fatigue, energy, behavior and context.

2. **Three short nights can be three different things:** insomnia, too little opportunity, or a decreased need for sleep.
3. **Baseline is personal.** Usual is your own reference, not a target set from outside.
4. **One anchor, not a schedule.** Something observable, partly in your control, and gentle enough for an ordinary difficult day.

Watch the video first

This page is the second half of the lesson. The video does the teaching; the page is where you do the work. If you have not watched lesson 3 yet, watch it before you start writing. The video lesson is *Bipolar Sleep: 3 Short Nights That Mean Different Things* — lesson 3 of the Bipolar Stability Program.

It explains **why** the same five hours can mean three different things, **when** a short night is worth telling somebody about before the week is over, and **how much you can leave out** on a bad day. Without that, the grid below is a form to fill in. With it, the grid becomes a description you can hand to somebody.

The lesson is *Bipolar Sleep: 3 Short Nights That Mean Different Things* — lesson 3 of the Bipolar Stability Program.

Before you begin

Scope and safety. This workbook does not diagnose an episode, prescribe sleep hours, or tell you to change treatment. **Do not wait seven days** if less need for sleep arrives with rising activation, serious impairment, psychosis or danger.

Your workbook answers are private. Bipolar Clarity does not receive them and nobody here monitors them.

Three words this chapter uses.

- **Sleep window** — the stretch between getting into bed meaning to sleep and getting up for the day. Not the time you fell asleep: the time you were trying to. If you lay awake for an hour, that hour is inside the window, and that gap is itself worth noticing.
- **Anchor** — one small thing you do at roughly the same time most days, that you can see yourself doing. Opening the curtains. Eating breakfast sitting down. Taking the bin out. One, not a routine. It is a marker you can read, not a target to hit.

- **Activation** — going faster than your usual: talking more, moving more, starting things, ideas arriving quicker, needing less sleep without feeling tired for it. It is not the same as being in a good mood, and it can arrive with irritability rather than with cheerfulness.

Your route today. The core route is one short entry a day for a week. The low-energy route is three fields a day. Missing a day is not a failure — leave the gap and pick up the next one.

Answers you can always use:

- **Not known yet**
- **Prefer not to answer**
- **Nothing to record here**
- **Private — not recorded here**
- **I prefer to bring this to a professional conversation**

Where this chapter's claims come from. The clinical statements in this lesson are sourced, and the sources are public: bipolarclarity.com/program/sources, under lesson 3. A source shows what published guidance says. It does not show what applies to you, and it never overrules the clinician who knows your case.

Core route

Three short-sleep patterns

Use these as descriptions for communication — not as diagnostic criteria.

- **Insomnia.** “I had an opportunity and wanted or needed sleep, but sleep was difficult.” Often tired or distressed; cause remains open.
- **Too little opportunity.** “Work, care, travel, environment or another demand left too little protected time.” Tired, but the available window was compressed.
- **Decreased need.** “I slept clearly less than usual and did not feel tired in the expected way.” More concerning with rising energy, speed, irritability, confidence, impulsivity or visible behavior change.

The number alone is not the pattern. “Uncertain” is a valid description.

A recent night, if useful

CLOSEST DESCRIPTION

- | | |
|---|---|
| ☐ resembled insomnia | ☐ resembled too little opportunity |
| ☐ resembled decreased need for sleep | ☐ uncertain or not completing this now |

WHAT MAKES THAT DESCRIPTION FIT

Prepare the baseline — what is usual, and one workable anchor

Usual is a personal reference, not a target imposed from outside. Write this **before Day One**.

When reasonably stable, my sleep window is usually around

MY SLEEP NEED USUALLY FEELS LIKE

MY ENERGY IS USUALLY

☐

low

☐

usual

☐

high

☐

uncertain

My one anchor — observable, partly in my control, gentle on a difficult day

My earlier-contact route, written now, for if sleep need drops while energy or activation rises

Seven-day observation

Approximate entries are enough. Observe before trying to optimize.

No opportunity is a real entry for your anchor, and it is not the same as **did not happen**. Use it on a day that gave the anchor no chance — you were travelling, in hospital, away from home, or the day simply had no version of it. **Did not happen** means the chance was there and it did not happen, which is different information and worth keeping separate.

	SLEEP WINDOW BEGAN	GOT UP FOR THE DAY	SLEEP NEED	ENERGY	ANCHOR	CONTEXT, OPTIONAL
			usual	low	happened	
			higher	usual	did not happen	
			lower	high	no opportunity	
			uncertain	uncertain		
Day 1						
DATE						
Day 2						
DATE						
Day 3						
DATE						
Day 4						
DATE						
Day 5						
DATE						
Day 6						
DATE						
Day 7						
DATE						

Burden limit — was this week workable to track?

Simplify or stop if tracking becomes harmful or compulsive. More data is not automatically better data.

WAS THIS WEEK WORKABLE

- | | |
|--|---|
| ☐ yes at about the right level | ☐ only with the low-energy route |
| ☐ no, tracking increased anxiety, shame, checking, conflict or activation | ☐ uncertain |

WHAT WOULD MAKE OBSERVATION SAFER OR LIGHTER

Review without scoring — describe the week, do not diagnose it

Look for change from your own baseline and keep context visible.

WHAT LOOKED CLOSE TO USUAL

WHAT CLEARLY DIFFERED

If sleep was shorter, did I feel tired — or did sleep need feel lower while energy rose

WHAT CONTEXT MAY HELP EXPLAIN THE WEEK

HOW REPRESENTATIVE THIS WEEK WAS☐

reasonably representative

☐

disrupted by unusual circumstances

☐

uncertain

Care-message builder

“Over the last [write here] days, my sleep window changed from [write here] to [write here]. My need for sleep felt [write here]. My energy or behavior changed in these ways: [write here]. Relevant context was [write here]. I would like advice about what to do next.”

MY MESSAGE**Low-energy route**

Three fields, and that is a complete entry. One day is still information. Stop here if this is enough today.

TIME I GOT UP**ENERGY**☐

low

☐

usual

☐

high

☐

uncertain

One context word — shift, pain, travel, baby, illness, Not known yet

Worked fictional example

Maya is a fictional composite. She records three nights from one week and reads them side by side.

- **Monday.** Late shift, then an early hospital appointment with her mother. Sleep window about five hours; she felt exhausted and wanted more sleep. Closest description: too little opportunity.
- **Wednesday.** The night was available and she wanted to sleep, and she spent much of it awake and worried. Tired the next day. Closest description: insomnia.

- **Saturday.** About five hours again, no fatigue, reorganizing the apartment before sunrise, a stream of ambitious messages, faster speech, unusually irritable when her sister questioned the plans. Closest description: decreased need for sleep, with rising activation.

Her usual pattern, written before Day One: a sleep window of roughly seven to eight hours, sleep need “usual for me,” energy “usual.” Her one anchor: opening the curtains after getting up. Her earlier-contact route: the clinic number already in her phone.

Her message: “Over the last seven days my sleep window changed from about seven to eight hours to about five. My need for sleep felt lower on Saturday, my energy and speech changed, and my sister noticed the difference. Relevant context was a late shift and a family appointment. I would like advice about what to do next.”

Maya is fictional. The example demonstrates the fields; it is not a diagnosis, a recommended answer or a target to match. Five hours diagnosed nothing — the third night was worth communicating because of the combination.

How this page stands

Choose exactly one: **Ready to use**, **Waiting for information**, or **Keeping this private**.

Mark **Ready to use** only when **at least one day is recorded in your own words** — one row is enough. A week you did not finish observing is a valid state, not a failed one.

☐ Ready to use ☐ Waiting for information ☐ Keeping this private

Before you close this page

Private; never submitted, uploaded, collected or monitored.

HOW CLEAR THE THREE SLEEP PATTERNS ARE

☐ clear ☐ partly clear ☐ unclear ☐ not known yet

HOW CLEAR MY OBSERVATION PLAN IS

☐ clear ☐ partly clear ☐ unclear ☐ not known yet

Where this page goes

Transfer concise meaning — not the full private diary. Five items travel, and five only.

MY USUAL SLEEP-AND-ENERGY PATTERN

A PERSONALLY MEANINGFUL CHANGE I WANT TO NOTICE

EARLIER-CONTACT ROUTE

URGENT-ASSESSMENT ROUTE

EMERGENCY ROUTE

Leave behind a guessed diagnosis, a promise that one anchor prevents episodes, and any rigid sleep target this workbook seems to imply.

Privacy and safety

If you are pregnant or have recently given birth, raise meaningful sleep disruption with your care team early. Bipolar disorder is associated with increased risk of becoming unwell after birth — association, not prediction — and guidelines ask services to stay alert through those first weeks even when you are well; a tracker is preparation, not a substitute for care. Context to raise early

☐ yes

☐ no

☐ not known yet

☐ prefer not to answer

If you may be in immediate danger, contact your local emergency services now. For crisis resources in your country, visit bipolarclarity.com/gethelp, or see the country-by-country crisis annex at the back of this workbook.

Help where you live

Crisis numbers for your country are at the back of this workbook, on page **287**.

Watch this lesson
bipolarclarity.com/program/104



BIPOLAR STABILITY PROGRAM

04 • LESSON

04

Bipolar Early Warning Signs: Pick 4 That Are Yours

A small, provisional card: up to two changes you have noticed going up, up to two going down, what else was happening, and one move you can make now. It supports describing and contacting earlier. It does not diagnose an episode, predict relapse or prescribe treatment.

Two routes: the full one, and a short one

PRINT • WRITE BY HAND • KEEP

Purpose

A small, provisional card: up to two changes you have noticed going up, up to two going down, what else was happening, and one move you can make now. It supports describing and contacting earlier. It does not diagnose an episode, predict relapse or prescribe treatment.

You leave with one Starter Early-Change Card you can hand to a professional, and one first move you can make before you are certain of anything.

What this chapter is about

This chapter goes with video lesson 4. It is the working half. The video does the teaching; this card is where you do the work. What is printed here is what you want in front of you the day something feels slightly off.

The useful moment is earlier than the obvious one. Most plans start once everything is already clear, which is exactly when they are hardest to use. This card starts earlier, and it is useful *because* it is small: up to two changes going up, up to two going down, what else was going on, and one first move you can make before you are certain of anything.

A signal is personal, not universal. The test is not whether something appears on a list. It is whether it is meaningfully different from what is usual for you. Six hours of sleep is an ordinary Tuesday for your neighbor and a sharp departure for you.

Candidate means candidate. The card uses that word on purpose: worth watching, worth describing, and a long way short of proven. A confidence label — known, possible, uncertain — describes your observation, never a diagnosis.

Write what somebody could have watched you do. This is the part that decides whether the card is any use. *I sent messages after midnight on three nights* is something you and another person can both point at. *I was becoming manic* is a conclusion, and conclusions are the one thing this card makes badly.

Context does not cancel the change. A stressful week, an infection, a flight, a new medicine — all of that belongs on the page beside the observation. It stops the card pretending one explanation covers everything, and it stops you deleting a real change because you found a reason for it.

And a false alarm is information. It costs you a note and teaches you something about your own pattern. A missed change teaches you something too. Neither is a reason to stop keeping the card.

Key ideas

1. **A signal is personal, not universal.** The test is whether it is meaningfully different from what is usual *for you*.
2. **Candidate means worth watching — it stops a long way short of proven.**
3. **A confidence label describes your observation, never a diagnosis.**
4. **Context does not cancel the change;** it stops the card pretending one explanation covers everything.

Watch the video first

Three things happen in the video that a page cannot do.

- **The word that ruins most cards.** Clara takes the most commonly written warning sign apart and shows what to write instead — the difference between a description and a verdict, on a real example.
- **A fictional first move, chosen out loud,** including why the small ones work best when you are least certain.
- **What to do when the first move is urgent help,** said plainly and without drama.

Watch it before you name yours. The video lesson is *Bipolar Early Warning Signs: Pick 4 That Are Yours* — lesson 4 of the Bipolar Stability Program.

Before you begin

Scope and safety. If reviewing changes increases distress or the situation needs help now, stop. Use the help routes you wrote in chapter 1 and any plan already agreed with a professional.

Your workbook answers are not submitted, uploaded, collected, or monitored by Bipolar Clarity. They are a personal draft.

Choose today's route: **core** (the full card) or **low energy** (one change, one label, one move).

Answers you can always use:

- **Not known yet**
- **Prefer not to answer**
- **Nothing to record here**

- **Private — not recorded here**
- **I prefer to bring this to a professional conversation**

Where this chapter's claims come from. The clinical statements in this lesson are sourced, and the sources are public: bipolarclarity.com/program/sources, under lesson 4. A source shows what published guidance says. It does not show what applies to you, and it never overrules the clinician who knows your case.

04

Core route

Before you fill in A and B

These are examples, not criteria. Nobody has all of them, having several proves nothing, and the one that matters for you may not be on either list. The test is only whether it is meaningfully different **for you** — six hours of sleep is an ordinary Tuesday for your neighbor and a sharp departure for you.

And one on its own is usually just one on its own. One late night after a flight is one thing; several nights of lower sleep need, arriving alongside faster speech, unusual certainty and a pile of new plans, is something else. One withdrawn afternoon is one thing; a continuing cluster of low interest, slowed functioning and difficulty with basic care is, again, something else.

Waiting for a textbook pattern will cost you weeks. Calling every fluctuation a relapse will cost you your peace of mind. This card sits between the two: it compares, describes and prompts contact. It scores nothing.

A. Candidate upward changes — maximum two

Use observations rather than labels. Example: “I sent messages after midnight on three nights,” rather than “I was becoming manic.”

One word to watch out for. *Irritable* is probably the change most often written on a page like this, and it is the one that works least well: it names how something felt from the inside, so nobody else can see it, and saying it out loud tends to start the argument you were hoping to head off. Write what somebody could have watched you do instead — *I was short with two people at dinner*. Same afternoon, same change, and this version is one you and the person beside you can both point at.

Things people have written here: less sleep without the expected tiredness · faster thinking or speech · more plans than usual · unusual certainty · more social, talking over people, short with them · faster spending, or a decision that looked fine at the time.

CANDIDATE CHANGE ONE

CONFIDENCE IN CHANGE ONE☐ known☐ possible☐ uncertain**CANDIDATE CHANGE TWO****CONFIDENCE IN CHANGE TWO**☐ known☐ possible☐ uncertain**B. Candidate downward changes — maximum two**

Use observations rather than labels. Example: “I stopped answering messages and missed two meals,” rather than “A depressive episode had started.”

Things people have written here: lost interest • moving or thinking more slowly • waking very early, or sleeping much longer • withdrawing from messages • ordinary tasks becoming unusually effortful • a fall in work, study, self-care or connection.

CANDIDATE CHANGE ONE**CONFIDENCE IN CHANGE ONE**☐ known☐ possible☐ uncertain**CANDIDATE CHANGE TWO****CONFIDENCE IN CHANGE TWO**☐ known☐ possible☐ uncertain**C. Context**

What else was happening? Record timing without deciding cause.

CONTEXT LINE

CLUSTER CHECK☐

one change

☐

several changes

☐

uncertain

CONTINUING☐

yes

☐

no

☐

uncertain

04**Visible effect on functioning, judgment, distress or safety****D. My first move**

Choose one small, reversible move that is safe before certainty and fits your existing care: observe once more at a set time; use your earlier-contact route; ask one trusted person for one concrete observation, with your permission; or postpone one non-urgent, high-stakes commitment while you gather information.

MY CHOSEN FIRST MOVE

Do not use this field for starting, stopping, restarting, tapering, selecting or changing medication. Medication decisions belong with your prescriber or clinician.

E. One person or service

Writing this information does not notify anyone or make them responsible for treatment or safety.

NAME OR SERVICE – OPTIONAL**VERIFIED ROUTE ALREADY USED IN MY CARE – OPTIONAL****WHEN I MAY USE IT – OPTIONAL**

Low-energy route

Complete only these three, and that is a complete card.

1. One candidate change

2. One confidence label – known / possible / uncertain

☐ known

☐ possible

☐ uncertain

3. One first move

Worked fictional example

Elena — fictional composite.

- Possible upward change one: less sleep without expected tiredness — possible.
- Possible upward change two: increasingly urgent late-night project messages — known, from timestamps.
- Possible downward change one: stopped morning walks — possible.
- Possible downward change two: basic meals became unusually difficult — possible.
- One context line: work deadline and recent travel; meaning uncertain.
- One useful first move: check sleep and message timing tomorrow morning; if both continue, use the clinic's earlier-contact route.

This example demonstrates form, not a recommended answer.

How this page stands

Choose exactly one: **Ready to use**, **Waiting for information**, or **Keeping this private**.

Mark **Ready to use** only when **at least one candidate change is written in your own words, together with your first move** — neither depends on anybody else. A card waiting for a conversation is a valid state.

☐ Ready to use

☐ Waiting for information

☐ Keeping this private

Before you close this page

Private; never submitted, uploaded, collected or monitored.

WHAT BECAME CLEARER

WHAT REMAINS UNCERTAIN

WHAT I MIGHT DISCUSS WITH A PROFESSIONAL

Where this page goes

Keep this Starter Card provisionally. The elevated-state and low-and-mixed-state modules replace the short candidate lists with fuller inventories. The warning-sign-ladder module replaces the entire Starter Card with the full Early-Warning Ladder. Do not stack contradictory versions — one current version takes the active place.

Privacy and safety

- The Program will never tell you to start, stop, taper, restart, select, or change a medication.
- Your workbook answers are not submitted, uploaded, collected, or monitored by Bipolar Clarity. They are a personal draft.
- This card does not assess your level of risk, and no score in it is required before you make contact.
- **Seek urgent professional assessment** for rapid escalation, psychosis, severe agitation, seriously impaired judgment, dangerous or highly uncharacteristic behavior, an inability to care for basic needs, or a serious loss of functioning — any one of those, on its own.
- **If hopelessness, suicidal thoughts, self-harm urges, or activation with severe distress appear,** use an appropriate urgent route.

- If low mood and agitation or restlessness are happening at the same time, that combination is worth raising with a professional sooner rather than later. Judging what it means is far outside what a worksheet does.

Your country's lines are in the crisis annex at the back of this workbook: emergency and crisis lines country by country, a section for when it is not an emergency but you are struggling, and one for when home is not safe. bipolarclarity.com/gethelp holds the same list and stays current.

If you may be in immediate danger, contact your local emergency services now. For crisis resources in your country, visit bipolarclarity.com/gethelp, or see the country-by-country crisis annex at the back of this workbook.

Help where you live

Crisis numbers for your country are at the back of this workbook, on page **287**.

Watch this lesson
bipolarclarity.com/program/105



BIPOLAR STABILITY PROGRAM

05 • LESSON

05

What Is My Bipolar Medication Actually For?

One page that does the remembering for you: what you take, what it is meant to do, what seems to help, what concerns you, and what still needs clarification or monitoring.

Two routes: the full one, and a short one

PRINT • WRITE BY HAND • KEEP

Purpose

One page that does the remembering for you: what you take, what it is meant to do, what seems to help, what concerns you, and what still needs clarification or monitoring.

You leave with a page you can put on the table at your next appointment, and up to three questions worth asking.

Boundary. This Program does not recommend a medicine, compare doses, select a treatment, or tell you to start, stop, restart, taper, change or combine anything. This page is not an emergency medication list, and it does not replace the current record your care team holds.

If a medication change is being considered, contact the appropriate prescriber or clinician before acting. Use an urgent route when the situation is urgent.

What this chapter is about

This chapter goes with video lesson 5. It is the working half. The video does the teaching; this page is where you do the work — and it is the page you actually put on the table at the appointment.

The problem is a memory test under time pressure. What was the name? What changed? Was the benefit worth the cost? Which blood test was due? Which question vanished the moment the appointment started? Nobody told you it was an open-book exam. This page is the open book.

A category name is a map, not an instruction. You will hear broad terms — mood stabilizer, antipsychotic, anticonvulsant, antidepressant, medicine for sleep or anxiety — and most of them are historical accidents. *Mood stabilizer* is an umbrella word rather than a precise category. *Antipsychotic* is named after what that family was first developed for, and in bipolar disorder these are frequently prescribed for a mood episode: seeing that word on your label is not a hint that somebody thinks you have psychosis. *Anticonvulsant* arrives from epilepsy. The *antidepressant* is handled with more care here than elsewhere, and guidance generally has it accompanied rather than working alone.

Knowing the family is worth having, and it still is not the job. Two people can be given the same family for opposite reasons. What matters for your page is the job your prescriber intends for *your* medicine, now and over the years — so the page asks what you were told, and where you were told it.

Copy exact information; never reconstruct it. Take the name from your current label, list or record. If two sources disagree, write *sources differ* and take both to a pharmacist. **Needs verification** is a better entry than a confident guess, and it is not an admission of anything.

Benefit is an observation. *My sleep became more regular. Agitation reduced. I could make a decision.* Timing on its own promises nothing about cause, and your concerns and quality of life are legitimate inputs to a treatment decision rather than complaints.

Monitoring is individual. Some medicines involve physical checks, blood tests or level monitoring; what applies depends on the medicine and on you. This page never invents a schedule. It turns monitoring into four questions instead: what applies, when it is due, who orders it, and where the result gets reviewed.

Key ideas

1. **Your medication has a specific intended job.** Asking what that job is now, and over the years, is fair game.
2. **Copy exact current information.** Never reconstruct it from memory — **needs verification** beats a guess, every time.
3. **A benefit is an observation, not a conclusion.** Timing on its own promises nothing about cause.
4. **Concerns and quality of life are legitimate inputs** to a treatment decision.
5. **Monitoring is individual.** There is no universal schedule, and this page never invents one.
6. **The page carries the question.** It never carries the decision.

Watch the video first

The video carries two things this page deliberately leaves out.

- **Daniel has eleven days until his appointment and a plan he has not told anybody about.** What he does with this page is the point of the whole lesson, and none of it becomes treatment advice.
- **Why each medicine family carries the name it does,** and what that name is and is not evidence of. The glossary here defines the words; the video explains why they mislead.

Watch it before you fill this in. The video lesson is *What Is My Bipolar Medication Actually For?* — lesson 5 of the Bipolar Stability Program.

Before you begin

- Have a reliable current source in front of you: the label, the pharmacy list or the care record.

- You do not need to prove causation before recording a concern.
- Nothing here asks you to place a medicine in a category or to infer why it was prescribed.
- If the situation is urgent, stop and use an urgent route. See **Privacy and safety**.

Answers you can always use:

- **Not known yet**
- **Prefer not to answer**
- **Nothing to record here**
- **Private — not recorded here**
- **I prefer to bring this to a professional conversation**

Where this chapter's claims come from. The clinical statements in this lesson are sourced, and the sources are public: bipolarclarity.com/program/sources, under lesson 5. A source shows what published guidance says. It does not show what applies to you, and it never overrules the clinician who knows your case.

Low-energy route

Two lines. That is the whole route.

1. The exact current medicine name, copied from a reliable label, list or record — or needs verification

2. The one question you want answered

These two lines are a complete low-energy version. You can stop here.

Core route

The page has five parts, and they are the same five you heard in the lesson: **exact current information • intended job • possible benefit • concern • questions and monitoring**.

Exact current information

Copy, do not reconstruct from memory.

Exact medicine name and exact current instructions, as written:

SOURCE CHECKED:☐

label

☐

pharmacy list

☐

care record

☐

other

☐

needs verification

DATE SOURCE CHECKED:

05

Intended job — as I understand it

Current purpose, in ordinary language — or purpose unclear / needs confirmation

Possible benefit

What I observed, roughly when, and what else was going on at the time:

CONFIDENCE ABOUT THE TIMING:☐

known

☐

possible

☐

uncertain

An observation is “my sleep became more regular during the month after the change.” A conclusion is “this medication fixed my sleep.” This page holds the first.

Concern or possible side effect

What I observed, when it began or changed, whether it is continuing, and how much it matters to me:

CONFIDENCE ABOUT THE TIMING:☐

known

☐

possible

☐

uncertain

You do not have to prove causation before recording a concern.

Questions and monitoring

What monitoring applies in my situation, when is it due, who orders it, and where is the result reviewed?

Next date confirmed by the care or pharmacy service — leave blank until somebody confirms it, or mark unclear / needs verification

Never prefill a universal test or schedule. Your edition may explain how to contact a pharmacist or prescriber; the professional or local source confirms the individual requirement.

My questions — maximum three. Prompts, if a blank page is hard:

- What is this intended to help with now and over the years?
- What are the main benefits and risks in my situation?
- How will we know whether it is helping?
- What monitoring applies, when is it due, and who reviews it?
- What options could we discuss for this concern?
- What should I do if this happens again?
- What should I verify with a pharmacist?

MY QUESTIONS FOR THE APPROPRIATE PROFESSIONAL

How this page stands

Choose exactly one: **Ready to use**, **Waiting for information**, or **Keeping this private**.

Mark **Ready to use** only when at least one core field that does not depend on an external source — the intended job as you understand it, a concern, or your question — is written in your own words. A page waiting for a pharmacy list or a confirmed monitoring date is a valid state, not an unfinished page.

☐ Ready to use

☐ Waiting for information

☐ Keeping this private

Worked fictional example

Daniel – fictional composite

- Exact current information, copied from a reliable source: copied from the current pharmacy label.
- Source checked: label. Date checked: this week.
- Intended job, as I understand it: “I think this is for preventing high states; needs confirmation.”
- Possible benefit I observed: “Fewer nights of escalating activity since the last review; several other things changed too.” Confidence: possible.
- Concern or possible side effect: “Morning slowing affects the first part of work; began after the dose change; still present.” Confidence about timing: known.
- Monitoring question: “Blood test mentioned; date and owner unclear.”
- My questions for the appropriate professional: “What is the intended job of this medicine now, what monitoring is due, and what options could we discuss for the morning slowing?”

Daniel is fictional. This demonstrates the page, not a recommended medicine or decision. No medicine name, dose, test or schedule is supplied in the example.

Before you close this page

Optional and private. Never submitted, uploaded, collected or monitored.

WHAT THIS MEDICINE IS FOR

☐ clear ☐ partly clear ☐ unclear ☐ not known yet

WHAT I WOULD REPORT NEXT TIME

☐ clear ☐ partly clear ☐ unclear ☐ not known yet

ONE THING I WANT TO ASK ABOUT:

.....

.....

Where this page goes

Transfer only:

- the verified current-information source and date;

- one benefit/concern summary;
- the monitoring uncertainty;
- up to three questions.

Do not transfer a self-directed treatment decision. Replace the summary when verified information changes.

Privacy and safety

Your workbook answers are not submitted, uploaded, collected, or monitored by Bipolar Clarity.

- This page is a personal draft. It is not a prescription, not an emergency medication list, and it does not replace the current record your care team holds.
- The Program will never tell you to start, stop, taper, restart, select, or change a medication.
- Do not let this page delay help. That is the one way it can hurt you.

When to get help sooner

Seek urgent professional advice for a severe or rapidly worsening reaction, a major change in mental state, psychosis, severe agitation, serious loss of judgment or functioning, inability to care for basic needs, or concern about harm.

For a question about a medicine rather than an emergency — “is this normal”, “can I take this with that”, “I have missed a dose” — a pharmacist is usually the fastest qualified person to reach, and in most countries you do not need an appointment. Write yours here once, with the opening hours if they matter.

MY PHARMACY OR MEDICINES-ADVICE ROUTE

Your country's lines are in the crisis annex at the back of this workbook: emergency and crisis lines country by country, a section for when it is not an emergency but you are struggling, and one for when home is not safe. bipolarclarity.com/gethelp holds the same list and stays current.

If you may be in immediate danger, contact your local emergency services now. For crisis resources in your country, visit bipolarclarity.com/gethelp, or see the country-by-country crisis annex at the back of this workbook.

Help where you live

Crisis numbers for your country are at the back of this workbook, on page **287**.

Watch this lesson
bipolarclarity.com/program/106



BIPOLAR STABILITY PROGRAM

06 • LESSON

06

Bipolar Life Chart: How to Map Your Mood History

Three broad periods of your life on one page, so the next clinical conversation starts from an organized history instead of a rushed reconstruction.

Two routes: the full one, and a short one

PRINT • WRITE BY HAND • KEEP

Purpose

Three broad periods of your life on one page, so the next clinical conversation starts from an organized history instead of a rushed reconstruction.

You leave with a cautious first-pass chart, one short course summary and the main gap in what you know.

What this chapter is about

This chapter goes with video lesson 6. It is the working half. The video does the teaching; this chart is where you do the work.

One appointment is a pin. A life chart is the route. A clinician meeting you today sees one point. What changes a conversation is the shape across years — when things shifted, roughly how long they lasted, what was going on around them, and what helped. Most people arrive at that conversation reconstructing it under pressure, badly, from memory.

Three broad periods, not a courtroom case. You are not proving anything. You are organizing what you already know into something legible: three stretches of your life, described well enough that somebody qualified can ask better questions.

Approximate is enough, and always was. *Around the time I changed jobs. The winter after the move. Somewhere in my twenties.* Perfect dates were never the point, and waiting until you can produce them is how this page never gets written.

Six lenses for each period. Mood and energy, sleep, functioning, treatment, life circumstances, and what other people noticed. Not every lens will have something in it. The empty ones are informative too.

Sequence is not proof of cause. Two things happening in order is the most seductive pattern there is, and the chart deliberately does not let you promote it into an explanation. You record what happened and when. Somebody qualified handles why.

And uncertain is a real answer — often the most useful line on the page, because it tells a clinician exactly where to start asking.

Key ideas

1. Your diagnosis lives in the route across years, not in one appointment.

2. **A life chart organizes information.** Proving an episode, settling a diagnosis or establishing a cause is beyond it.
3. **Approximate periods are enough.** Perfect dates were never the point.
4. **known / possible / uncertain qualify the information,** never a diagnosis.
5. **Sequence is not proof of cause.**
6. **Uncertain is a real answer,** and it is often the most useful line on the page.

Watch the video first

06

Watch it for two things that are hard to put on paper.

- **A fictional chart built from nothing,** which is the fastest way to see that approximate dates really are enough.
- **Why sequence keeps looking like cause,** and what a clinician does with a chart that resists the temptation.

Watch it before you start. The video lesson is *Bipolar Life Chart: How to Map Your Mood History* — lesson 6 of the Bipolar Stability Program.

Before you begin

- Choose only the anchors you are comfortable recording. Trauma and private context are always optional.
- No investigation is required. Use records you already have lawful and comfortable access to.
- Another person's account is one perspective, not a verdict, and it is asked for with permission.
- If reviewing the past leaves you significantly more distressed, activated, confused or unsafe, stop early. See **Privacy and safety**.

Answers you can always use:

- **Not known yet**
- **Prefer not to answer**
- **Nothing to record here**
- **Private — not recorded here**
- **I prefer to bring this to a professional conversation**

Where this chapter's claims come from. The clinical statements in this lesson are sourced, and the sources are public: bipolarclarity.com/program/sources, under lesson 6. A source shows what published guidance says. It does not show what applies to you, and it never overrules the clinician who knows your case.

Low-energy route

Two lines. That is the whole route.

1. One broad period, and what changed in it

2. One question you want to ask about it

Mark the information **known**, **possible** or **uncertain** if that is easy today. If it is not, leave it.

These two lines are a complete low-energy version. You can stop here.

Core route

Choose up to three periods

Broad anchors are enough: a school stage, job, relationship period, move, year, before/around/after diagnosis, or another personally useful period. More than three is worse, not better. Do not record private context you do not want on the page.

PERIODS I HAVE CHOSEN

One period at a time

The ten lines below describe **one period**. You fill them again for each period you chose, up to three. Nothing here is a separate page. Leave any line empty whenever it deserves to be empty.

PERIOD NAME:

PERIOD NAME – PERIOD 2

PERIOD NAME – PERIOD 3

APPROXIMATE START/END OR ANCHOR:

.....

APPROXIMATE START, END OR ANCHOR – PERIOD 2

.....

APPROXIMATE START, END OR ANCHOR – PERIOD 3

.....

What changed? (observable changes from your usual pattern in mood, energy, activity, thinking, speech, confidence or irritability)

.....

WHAT CHANGED – PERIOD 2

.....

WHAT CHANGED – PERIOD 3

.....

What happened to sleep and rhythm? (sleep timing, sleep need, daily routine, night activity)

.....

SLEEP AND RHYTHM – PERIOD 2

.....

SLEEP AND RHYTHM – PERIOD 3

.....

What happened to your functioning, visibly? (work, study, relationships, self-care, money, commitments, driving, safety)

FUNCTIONING, VISIBLY – PERIOD 2

FUNCTIONING, VISIBLY – PERIOD 3

What care and treatment were around? (help, medication, therapy, hospital care, self-management – and what seemed helpful, unhelpful or unclear at the time)

CARE AND TREATMENT AROUND THE PERIOD – PERIOD 2

CARE AND TREATMENT AROUND THE PERIOD – PERIOD 3

What about health and substances? (timing only, no assumed cause)

HEALTH AND SUBSTANCES – PERIOD 2

HEALTH AND SUBSTANCES – PERIOD 3

And what was going on in your life? Optional – private – not recorded here is a complete entry

06

LIFE CONTEXT – PERIOD 2

LIFE CONTEXT – PERIOD 3

CONFIDENCE IN THE EVENTS:

☐ known	☐ possible	☐ uncertain
--------------------------------	-----------------------------------	------------------------------------

CONFIDENCE IN THE EVENTS – PERIOD 2

☐ known	☐ possible	☐ uncertain
--------------------------------	-----------------------------------	------------------------------------

CONFIDENCE IN THE EVENTS – PERIOD 3

☐ known	☐ possible	☐ uncertain
--------------------------------	-----------------------------------	------------------------------------

MEANING REMAINS:

☐ known	☐ possible
☐ uncertain	☐ I prefer to bring this to a professional conversation

MEANING REMAINS – PERIOD 2

☐ known	☐ possible
☐ uncertain	☐ I prefer to bring this to a professional conversation

MEANING REMAINS – PERIOD 3☐

known

☐

possible

☐

uncertain

☐

I prefer to bring this to a professional conversation

Compare without diagnosing

Now read across your periods, with three questions in mind: what seems to repeat, what was present only once, and what stayed there in between. There is nothing to fill in here. You are noticing, not concluding – and what you notice will come out later, in the summary and in the question you take to an appointment.

Sequence is not proof of cause. If one thing arrived after another, that is worth mentioning and it is not an explanation.

WHERE YOUR ACCOUNT AND SOMEBODY ELSE'S DIFFER

If a period looks different to somebody who was there, write it as it stands – “My memory differs from my partner's” – and take both accounts to the appointment. Neither one has to win first. A disagreement recorded plainly is more useful to a professional than a single version that has been smoothed over.

Sources I may choose to consult — optional

- Current care records already available to me.
- Calendar/messages/work records I can access lawfully and comfortably.
- One trusted person's observable account, with permission.

No investigation is required. Another person's account is one perspective, not a verdict.

Course summary**MY SHORT DESCRIPTION OF THE PATTERN ACROSS TIME:**

MAIN INFORMATION GAP:

One question: "Across these periods, I noticed [write here]. I am uncertain about [write here] – what else should we consider – and what information would help?"

06**How this page stands**

Choose exactly one: **Ready to use**, **Waiting for information**, or **Keeping this private**.

Mark **Ready to use** only when **at least one core entry that does not depend on an external source – the period name, what changed, or your one question – is written in your own words**. A page waiting for a record that is not available to you yet is a valid state, not an unfinished page.

☐ Ready to use ☐ Waiting for information ☐ Keeping this private

Worked fictional example

Noah records university years, first full-time job and year of diagnosis. Some events are known from records; other meanings remain uncertain. Noah writes sequences without labeling episodes and asks which observations matter most to the current formulation.

Noah is fictional. The example demonstrates the fields; it is not a diagnosis or a recommended answer.

Before you close this page

Optional and private. Never submitted, uploaded, collected or monitored.

MAPPING THREE PERIODS

☐ clear ☐ partly clear ☐ unclear ☐ not known yet

THE KNOWN / POSSIBLE / UNCERTAIN LABELS

☐ clear ☐ partly clear ☐ unclear ☐ not known yet

ONE THING THAT BECAME EASIER TO SEE:

Where this page goes

Keep only the short course summary, the main information gap and the question. The triggers-and-protections lesson and the warning-sign ladder lesson may later update the meaning; replace outdated summaries rather than stacking contradictions.

Do not transfer: a self-assigned episode label, a diagnosis you concluded from this chart, or another person's account presented as a verdict.

Privacy and safety

Your workbook answers are not submitted, uploaded, collected, or monitored by Bipolar Clarity.

- Your chart is private, and nobody sees it unless you choose to share it.
- Pause if review becomes significantly distressing, activating, confusing or unsafe. Pause early rather than after an evening that cost you something.
- Keep your chart away from three things: confronting somebody, proving blame, and pressuring anyone to confirm your version of a memory.
- The Program will never tell you to start, stop, taper, restart, select, or change a medication.

Help threshold

Current severe activation, psychosis, inability to care for basic needs, thoughts of harm or immediate danger require an appropriate urgent route, not retrospective analysis.

Your country's lines are in the crisis annex at the back of this workbook: emergency and crisis lines country by country, a section for when it is not an emergency but you are struggling, and one for when home is not safe. bipolarclarity.com/gethelp holds the same list and stays current.

If you may be in immediate danger, contact your local emergency services now. For crisis resources in your country, visit bipolarclarity.com/gethelp, or see the country-by-country crisis annex at the back of this workbook.

Help where you live

Crisis numbers for your country are at the back of this workbook, on page 287.

Watch this lesson
bipolarclarity.com/program/107



BIPOLAR STABILITY PROGRAM

07 • LESSON

07

Bipolar 1 vs Bipolar 2: What the Number Really Means

Record the diagnostic language already in your care, exactly as written, and separate what it means from what it does not decide.

Two routes: the full one, and a short one

PRINT • WRITE BY HAND • KEEP

Purpose

Record the diagnostic language already in your care, exactly as written, and separate what it means from what it does not decide.

You leave with your own terms preserved word for word, and one question for the professional who wrote them.

What this chapter is about

This chapter goes with video lesson 7. It is the working half. The video does the teaching; this page is where you do the work — and what it asks you to do is unusually simple: copy, exactly, and then ask.

Bipolar I and bipolar II are different episode histories, not two rungs on a severity ladder. That sentence is the whole chapter. The type describes which episodes appear in the assessed history — nothing else. It does not rank how hard your life has been, how much you have lost, or how much help you need.

Mania is the distinction that decides bipolar I. Not intensity of feeling; mania, as assessed. Bipolar II involves hypomania and major depression, without mania.

Hypomania is less severe than mania — and bipolar II is not therefore a milder illness. Both things are true at once, and the second one gets forgotten. The depression in bipolar II can be long and disabling, and the type says nothing about it.

Mixed features and rapid cycling answer different questions. Mixed features concern overlap: high and low arriving together. Rapid cycling concerns frequency: how many episodes in a period. They get confused constantly, and they lead to different conversations.

Copy the exact words in your record, and copy them wrong on purpose if that is what they say. Different frameworks use different wording, and a term rewritten into what you assume it means loses the thing that made it useful. If your record says something you do not understand, that is not a problem with you — it is the question to bring.

And a label decides less than it looks. It can organize care and open doors. It does not settle what your life is like, what treatment suits you, or what happens next.

Key ideas

1. **Bipolar I and bipolar II describe different episode histories** — not levels on a severity scale.

2. **Mania is the central distinction for bipolar I.**
3. **Bipolar II involves hypomania and major depression**, without mania.
4. **Hypomania is less severe than mania. Bipolar II is not therefore a milder illness** — the type describes which kind of high you have had, not how much of your life this takes up.
5. **Mixed features concern overlap**; rapid cycling concerns episode frequency.
6. **Frameworks may use different wording.** Preserve the exact term and ask what it means in your care.

Watch the video first

07

The video does two things this page cannot.

- **A fictional record read out loud**, layer by layer, so you can see where a term came from and what it is actually claiming.
- **Why the two types get ranked**, and what that ranking costs the people on the wrong end of it.

Watch it before you copy anything. The video lesson is *Bipolar 1 vs Bipolar 2: What the Number Really Means* — lesson 7 of the Bipolar Stability Program.

Before you begin

Scope and safety

This workbook is educational. It does not confirm, reject, or change a diagnosis; identify an episode; compare treatments; or assess risk. If changes are severe, escalating, or unsafe, use an appropriate professional or urgent route rather than completing this exercise.

Two words the table rests on.

The whole map turns on mania and hypomania, so here is what they mean before you read it.

Mania is a period of unusually high or irritable mood with unusually high energy, going on day after day, and severe enough to break things: work, money, relationships, safety, judgement. It can involve losing contact with shared reality, and it can end in hospital.

Hypomania is the same kind of shift, smaller. Others can usually see it — often before you can. It does not involve losing contact with reality, and it does not reach the point of needing hospital care. From the inside it can feel good, or productive, or simply like a version of yourself you prefer.

The line between them is drawn on severity, on how much is broken, and on whether reality holds.

Where exactly that line falls in your case is an assessment, not a self-check.

And now the sentence that matters most on this page, because it is the one most often got wrong.

Hypomania is less severe than mania. **Bipolar II is not therefore a milder illness**, and here is the reason, which is worth having in your own words the next time somebody hands you the word “mild”.

The type does not describe how much of your life the condition takes up. It describes which kind of high you have had. And what fills the years, in bipolar II, is not the high at all: it is the low. In the longest study to follow people with bipolar II week by week — 86 people, over an average of thirteen years — they had symptoms in about **half of all the weeks**, and **almost all of that was depression: about 39 weeks of depressive symptoms for every one week of hypomania**.

So “less severe episode” and “less severe illness” are two different statements, and only the first one is true. The functional impact, and the risk that comes with it, are not the poor relation of anything.

(Source: Judd LL et al., “A prospective investigation of the natural history of the long-term weekly symptomatic status of bipolar II disorder”, *Archives of General Psychiatry* 2003 – PMID 12622659. *Mania and hypomania described following NIMH, Bipolar Disorder. Listed at bipolarclarity.com/program/sources under lesson 7.*)

The map in plain English. Read for orientation. Do not use these descriptions as criteria.

TERM	WHAT IT COMMUNICATES AT A HIGH LEVEL
Bipolar I disorder	The assessed history includes mania. Depression is common but is not what defines bipolar I.
Bipolar II disorder	The assessed history includes hypomania and major depression, without mania. This does not mean the overall condition is mild.
Mixed features / mixed presentation	Activated and depressive features occur together or overlap within an episode or period. Exact wording varies by framework.
Rapid cycling	In common DSM-oriented information, four or more distinct mood episodes occur within twelve months. A professional determines what counts as an episode.
Cyclothymia / cyclothymic disorder	A longer-term pattern of recurring hypomanic and depressive symptoms that does not form the same episode history as bipolar I or II.

Answers you can always use:

- Not known yet
- Prefer not to answer
- Nothing to record here
- Private — not recorded here
- I prefer to bring this to a professional conversation

Where this chapter's claims come from. The clinical statements in this lesson are sourced, and the sources are public: bipolarclarity.com/program/sources, under lesson 7. A source shows what published guidance says. It does not show what applies to you, and it never overrules the clinician who knows your case.

Low-energy route

Two lines. That is the whole route.

1. The exact diagnosis wording already used in my current care, copied if I have access to it

2. One term or question I want clarified

These two lines are a complete low-energy version. You can stop here.

Core route

Six inputs, in the same order the lesson teaches them.

1 of 6 • Exact wording already used in my care

Copy it as it stands. Options: copied from a current record • recalled from a professional conversation • **the record is not in front of me right now** • exact wording not known yet • prefer not to answer.

Most people do not have their report at home, and that is not a failure of preparation. Tick that option, carry on with the rest of the page, and ask for a copy at your next appointment — it is yours and you are entitled to it.

2 of 6 • Source and approximate date, if known

Source or professional role, and the approximate date. This is what stops an old note, your current diagnosis and something half-remembered from a corridor blending into one. Option: not known yet.

3 of 6 • Episode-history distinction I understand

- | | |
|---|---|
| ☐ history includes mania | ☐ hypomania and major depression without mania |
| ☐ different, incomplete or unclear | ☐ leave for a professional conversation |

Complete one route only. This records your understanding of existing wording; it does not select a diagnosis. Options: the wording refers to a history that includes mania • the wording refers to hypomania and major depression without mania • the wording is different, incomplete or not known yet • I prefer to leave this for a professional conversation.

4 of 6 • One thing the label does not tell me

Write it in your own words. Examples: "It doesn't rank how difficult my life is." "It does not predict my whole future."

5 of 6 • One unfamiliar or framework-sensitive term

Copy the term exactly, and where you saw or heard it. Options: no unfamiliar term in the wording I have • not known yet.

6 of 6 • One question for a qualified professional

Write it in your own words. Options: nothing to record here • prefer not to answer.

How this page stands

Choose exactly one: **Ready to use**, **Waiting for information**, or **Keeping this private**.

Mark **Ready to use** only when **at least one core input that does not depend on an external source — number 4, what the label does not decide, or number 6, your question — is written in your own words**. Everything else on the page can legitimately be waiting on a record you have not been able to reach.

- | | | |
|---------------------------------------|--|---|
| ☐ Ready to use | ☐ Waiting for information | ☐ Keeping this private |
|---------------------------------------|--|---|

Ready to use — *when the minimum above is met.*

You have finished the required artifact. The remaining **fields on this page** are optional.

Waiting for information — *shown in every other case.*

This is a valid state, not an unfinished page. The wording, the source and the date live in a record that is not available to you yet; the map is ready for them.

07

Worked fictional example

What a completed map can look like. Alex records existing wording rather than trying to improve or reinterpret it.

- **Exact wording already used in my care:** “Bipolar II disorder, current episode depressed, with mixed features.”
- **Source and approximate date, if known:** current clinic summary; this year.
- **Episode-history distinction I understand:** “My record refers to hypomania and major depression, without mania.”
- **One thing the label does not tell me:** “It doesn't mean my depression is mild.”
- **One unfamiliar or framework-sensitive term:** “with mixed features.”
- **One question for a qualified professional:** “When you use ‘mixed features’ in my record, which period are you describing, and what should I notice or report?”

What Alex does not do

Alex does not add criteria, count symptoms, classify an episode, or change the diagnosis. The map makes the next conversation clearer.

Alex is fictional. This example is not a diagnostic template or recommended answer.

OPTIONAL — Question bank

Choose only what helps. These questions are not prompts to prove a subtype.

- What diagnosis and exact terminology are currently recorded?
- Which part of my assessed history supports that wording?
- When this record says ‘mixed features,’ ‘mixed state,’ or another term, what does it mean here?

- Is 'rapid cycling' current, historical, or not part of my record?
- Has the wording changed across records or frameworks? If so, what should I understand from the change?
- What uncertainty remains, and what information would help clarify it over time?

A note about frameworks. DSM and ICD are classification systems used in different settings. Records, guidelines, and clinicians may also use shorthand. A terminology difference is a reason to ask for clarification; it does not by itself prove that a diagnosis or treatment is wrong.

OPTIONAL — Misunderstanding check

07

Mark anything you want to discuss. This section is not scored.

- I have heard bipolar II described as mild.
- I have assumed that rapid cycling means several mood changes in one day.
- I have assumed that mixed features means alternating cleanly between high and low.
- I am unsure whether wording in an older record is still current.

Before you close this page

Optional and private. Never submitted, uploaded, collected or monitored.

BIPOLAR I AND BIPOLAR II

☐ clear ☐ partly clear ☐ unclear ☐ not known yet

MIXED FEATURES AND RAPID CYCLING

☐ clear ☐ partly clear ☐ unclear ☐ not known yet

ONE USEFUL DISTINCTION, AND ONE QUESTION THAT REMAINS:

Where this page goes

- Exact confirmed diagnosis wording.
- Source and date, if known.
- Any uncertainty marker.
- One framework-sensitive term.

- One question for clarification.

Do not transfer

A self-selected subtype, guessed episode label, symptom score, or conclusion based only on this workbook.

Week-in-practice card

- **ONE ACTION:** complete My Diagnostic Language Map.
- **ONE OBSERVATION:** notice where a label gives useful information and where it leaves an individual question open.
- **LOW-ENERGY BACKUP:** copy the current wording and write one question.

07

Privacy and safety

Your workbook answers are not submitted, uploaded, collected, or monitored by Bipolar Clarity.

- This chapter does not assess risk and is not monitored.
- The Program will never tell you to start, stop, taper, restart, select, or change a medication.
- This lesson explains diagnostic language. It cannot confirm your subtype or classify a past experience as an episode.

When to get help sooner

- Contact a treating professional when terminology is unclear, when you are considering a treatment change because of something you read, or when current symptoms may need assessment.
- Seek prompt professional help if severe distress or hopelessness appears with intense activation, agitation, impaired judgment, psychosis, or thoughts of harm.

If you may be in immediate danger, contact your local emergency services now. For crisis resources in your country, visit bipolarclarity.com/gethelp, or see the country-by-country crisis annex at the back of this workbook.

Evidence checked • Cutoff August 13, 2026. Sources: NIMH; NICE CG185; VA/DoD Bipolar Disorder CPG v2.0; APA DSM and bipolar-disorder educational resources; WHO ICD-11; CANMAT/ISBD guidance (Keramatian, Chithra & Yatham, *Focus*, 2023) and the bipolar II state-of-the-art review (Berk et al., *World Psychiatry*, 2025).

Help where you live

Crisis numbers for your country are at the back of this workbook, on page **287**.

Watch this lesson
bipolarclarity.com/program/108



BIPOLAR STABILITY PROGRAM

08 • LESSON

08

Hypomania Signs Others Often Notice Before You Do

Collect candidate changes from a high or irritable period, from more than one viewpoint, in language a professional can work with.

Two routes: the full one, and a short one

PRINT • WRITE BY HAND • KEEP

Purpose

Collect candidate changes from a high or irritable period, from more than one viewpoint, in language a professional can work with.

You leave with your Elevated-State Inventory — one somebody can review, one question to ask, and your three help routes written down.

What this chapter is about

This chapter goes with video lesson 8. It is the working half. The video does the teaching; this inventory is where you do the work.

08

The hard part of this chapter is that the state it describes can feel like an improvement. More energy, more ideas, less need for sleep, more certainty. From the inside it can read as finally being well — which is exactly why it gets described late, and usually by somebody else first.

Energy alone does not separate mania from hypomania. What separates them is severity, impact on your life, whether psychosis appears, and whether care was needed. A cheerful high and a difficult one can carry the same amount of energy.

A high state is not always cheerful. It can be elevated, irritable or mixed — and the mixed and irritable versions are the ones people leave off the page, because they do not match the picture.

Three positions, all useful. *I notice this. Others notice this. Unsure.* Disagreement between you and somebody who knows you is not a problem to resolve before writing: it is information, and it goes on the page as a disagreement.

Write behavior, not verdicts. *Eleven project messages sent overnight. Two commitments made without checking the diary.* Those travel into an appointment. *I was manic* does not, because it is the conclusion the page is supposed to help somebody else reach.

And rising activation protects you from nothing. Severe distress and suicide risk can appear inside a high state, not only inside a low one. That is here rather than assumed, because it is the assumption that causes harm.

Key ideas

1. **Mania and hypomania are not separated by energy alone:** severity, impact, psychosis and need for care are what matter.
2. **A high state can be elevated, irritable or mixed,** and it often feels useful from the inside.

3. “I notice,” “others notice” and “unsure” are all useful positions. Disagreement is recorded, not resolved.
4. Rising activation does not protect you from severe distress or suicide risk.

Watch the video first

Three things belong to the video.

- **Why somebody else usually notices first**, explained without making that humiliating.
- **The outbox test**, and the other small checks that work when your own judgement is the thing that changed.
- **Leah's period, described twice** — once as she saw it, once as her colleague did.

Watch it before you start listing. The video lesson is *Hypomania Signs Others Often Notice Before You Do* — lesson 8 of the Bipolar Stability Program.

08

Before you begin

Recognize a pattern — not a score. Three questions organize everything here.

1. **CLUSTER.** Several changes move together. One short night, energetic day, confident decision, or irritable moment is not enough.
2. **CHANGE.** The pattern is meaningfully different from what is usual for you. Context and alternative explanations stay visible.
3. **COURSE.** Duration, functioning, judgment, psychosis, need for care, and the broader history help a professional interpret the period.

Scope and safety

This workbook cannot diagnose mania or hypomania and does not tell you to change treatment. Do not complete it before seeking help when there is rapid escalation, psychosis, dangerous behavior, serious loss of judgment, or immediate danger.

Mania and hypomania

Both involve a clear change in mood, energy, and activity. Mania crosses a more serious boundary of marked impairment, seriously compromised judgment, possible hospital care, or psychosis. Hypomania is less severe, but not imaginary or automatically harmless.

Do not classify yourself here

Record candidate observations. A qualified professional considers severity, duration, context, course, health conditions, substances, medicine effects, and other explanations.

REFERENCE • Six domains to review. Look for observable departures from your baseline within a larger cluster.

DOMAIN	WHAT A CANDIDATE CHANGE CAN LOOK LIKE
SLEEP + ENERGY	Lower need for sleep; rising energy or activity; wired, driven, restless, or unusually irritable.
SPEED + ATTENTION	Faster thoughts or speech; rapid topic shifts; many simultaneous tasks; harder to pause or follow a shared plan.
PLANS + CONFIDENCE	Rapid multiplication of projects or commitments; less feasibility checking; unusually fixed certainty.
COMMUNICATION	Major change in calls, posts, disclosure, social contact, argument, flirtation, or overnight messaging.
RISK + JUDGMENT	A change in evaluation of cost, consent, safety, evidence, or consequence — not another person's moral approval.
IMPACT + CARE	Effects on work, study, relationships, self-care, money, housing, safety, urgent assessment, hospital care, or psychosis.

Neutral language

Write what changed and who observed it. Creativity, confidence, sexuality, irritability, or spending alone is not a diagnosis.

Answers you can always use:

- Not known yet
- Prefer not to answer
- Nothing to record here
- Private — not recorded here
- I prefer to bring this to a professional conversation

Where this chapter's claims come from. The clinical statements in this lesson are sourced, and the sources are public: bipolarclarity.com/program/sources, under lesson 8. A source shows what published guidance says. It does not show what applies to you, and it never overrules the clinician who knows your case.

Low-energy route

Two lines. That is the whole route.

1. One possible change, and who noticed it: me / someone else / unsure

2. One effect, or one question

These two lines are a complete low-energy version. You can stop here.

08

Core route

Optional reference period already discussed professionally — or write 'no confirmed period' or 'not known yet'.

One observation at a time

Use no more than six in total. That is the ceiling, not a target; leave any card blank.

The four lines below describe **one observation**. You fill them again for each one, up to six.

POSITION:

☐ I notice	☐ others notice	☐ unsure
-----------------------------------	--	---------------------------------

WHO NOTICED IT – CARD 2

☐ I notice	☐ others notice	☐ unsure
-----------------------------------	--	---------------------------------

WHO NOTICED IT – CARD 3

☐ I notice	☐ others notice	☐ unsure
-----------------------------------	--	---------------------------------

WHO NOTICED IT – CARD 4

☐ I notice	☐ others notice	☐ unsure
-----------------------------------	--	---------------------------------

WHO NOTICED IT – CARD 5

☐ I notice	☐ others notice	☐ unsure
-----------------------------------	--	---------------------------------

WHO NOTICED IT – CARD 6

☐ I notice ☐ others notice ☐ unsure

DOMAIN:

☐ sleep/energy ☐ speed/attention ☐ plans/confidence ☐ communication
☐ risk/judgment ☐ impact/care

DOMAIN – CARD 2

☐ sleep/energy ☐ speed/attention ☐ plans/confidence ☐ communication
☐ risk/judgment ☐ impact/care

DOMAIN – CARD 3

☐ sleep/energy ☐ speed/attention ☐ plans/confidence ☐ communication
☐ risk/judgment ☐ impact/care

DOMAIN – CARD 4

☐ sleep/energy ☐ speed/attention ☐ plans/confidence ☐ communication
☐ risk/judgment ☐ impact/care

DOMAIN – CARD 5

☐ sleep/energy ☐ speed/attention ☐ plans/confidence ☐ communication
☐ risk/judgment ☐ impact/care

DOMAIN – CARD 6

☐ sleep/energy ☐ speed/attention ☐ plans/confidence ☐ communication
☐ risk/judgment ☐ impact/care

OBSERVABLE CHANGE, IN YOUR OWN WORDS:

OBSERVABLE CHANGE – CARD 2

OBSERVABLE CHANGE – CARD 3

.....

.....

OBSERVABLE CHANGE – CARD 4

.....

.....

OBSERVABLE CHANGE – CARD 5

.....

.....

OBSERVABLE CHANGE – CARD 6

.....

.....

CONTEXT OR SOURCE (OPTIONAL):

.....

.....

CONTEXT OR SOURCE – CARD 2

.....

.....

CONTEXT OR SOURCE – CARD 3

.....

.....

CONTEXT OR SOURCE – CARD 4

.....

.....

CONTEXT OR SOURCE – CARD 5

.....

.....

CONTEXT OR SOURCE – CARD 6

.....

.....

POSITION, NOT VERDICT

'I notice,' 'others notice,' and 'unsure' are all useful. Record disagreement rather than forcing consensus.

Impact, uncertainty, and one question

These positions support communication; they are not diagnostic thresholds. A noticeable change means a change in functioning or in relationships. Serious impairment or urgent care covers urgent assessment, hospital care, or psychosis.

IMPACT POSITION:

- | | |
|--|--|
| ☐ no clear impact recorded | ☐ noticeable change |
| ☐ serious impairment or urgent care | ☐ unsure |

WHAT HAPPENED – OR WHAT REMAINS UNCERTAIN?

.....

.....

ONE QUESTION FOR A QUALIFIED PROFESSIONAL:

.....

.....

Care-message builder — optional

During [write here], I noticed [write here]. Someone else noticed [write here]. The changes appeared together with [write here]. The effect on functioning or safety was [write here]. I am unsure about [write here]. I would like help understanding what this pattern may mean and what to do if it returns.

MY MESSAGE:

How this page stands

Choose exactly one: **Ready to use**, **Waiting for information**, or **Keeping this private**.

Mark **Ready to use** only when **at least one candidate observation is written in your own words, together with your one question** — neither of those depends on anybody else. A page waiting for an appointment that has not happened yet is a valid state, not an unfinished page.

☐ Ready to use ☐ Waiting for information ☐ Keeping this private

Worked fictional example

Leah is a fictional composite reviewing a period she has already discussed with her clinician.

- **Optional reference period already discussed professionally:** a period already discussed professionally.
- **I notice:** “Four hours of sleep felt like plenty.” Domain: sleep + energy. “Ideas came quickly.” Domain: speed + attention.
- **Others notice:** “A friend saw long messages sent through the night.” Domain: communication. “I became sharply irritable when asked to wait.” Domain: **sleep + energy** — irritability sits in the sleep-and-energy domain in the reference above, not in communication.
- **Unsure:** “My confidence shifted.” Leah cannot judge that one clearly from the inside, so it stays under unsure rather than being promoted.
- **Impact position:** noticeable change in functioning or relationships — commitments made without checking the schedule, work later cancelled, several relationships to repair.
- **One question for a qualified professional:** “When I describe this period, which parts would you want more detail about, and what should I report if it starts again?”

Notice what Leah leaves out: “My friend knew the truth.” An outside account is recorded beside her own, each one marked with who noticed it, and neither one is crowned as the truth.

Leah is fictional. The example demonstrates the fields; it is not a diagnosis or a recommended answer.

A second one, because most weeks are not episodes

Priya is a fictional composite, working through a good stretch she was not sure about. This is the case the Program has been quiet about, and it is the more common one.

- **Optional reference period already discussed professionally:** three weeks in May when she felt better than she had in a year.
- **I notice:** “I was getting things done and enjoying it.” Domain: speed/attention. “I felt like myself again, and I stopped putting off the things I had been putting off.” Domain: plans/confidence.
- **Others notice:** nothing. “I asked my sister and my partner separately. Neither had noticed anything they would have mentioned.”
- **Sleep:** “Seven hours, same as always. I was not sleeping less — I just minded the mornings less.”
- **Impact position:** no clear impact recorded. Nothing was cancelled, nothing was overcommitted, nothing needed repairing afterwards.
- **One question for a qualified professional:** “I had three good weeks in May. Nothing else moved — same sleep, nobody noticed anything, nothing to clean up afterwards. Is there any reason to treat that as anything other than three good weeks?”

Priya writes nothing on her ladder from that period. **A good stretch that stays a good stretch is not a missed sign, and being well is not a symptom that has escaped detection.** The inventory did its job by coming back empty — that is a result, not a blank page.

Two things separated Priya's May from Leah's period, and neither of them is how good it felt from the inside: **whether anybody else saw it, and whether anything needed repairing afterwards.**

Before you close this page

Optional and private. Never submitted, uploaded, collected or monitored.

THE MANIA-HYPOMANIA BOUNDARY

☐ clear ☐ partly clear ☐ unclear ☐ not known yet

MY INVENTORY

☐ useful ☐ needs discussion ☐ not using now ☐ prefer not to answer

ONE THING I WOULD DESCRIBE DIFFERENTLY NEXT TIME:

Where this page goes

Transfer concise meaning — not the full private inventory.

CANDIDATE SIGN 1:

CANDIDATE SIGN 2:

CANDIDATE SIGN 3:

ONE IMPACT PHRASE:

The warning-sign ladder lesson will build the full subtle / clear / urgent activation ladder. Do not build it here.

Privacy and safety

Your workbook answers are not submitted, uploaded, collected, or monitored by Bipolar Clarity.

- This workbook is private and not monitored.
- The Program will never tell you to start, stop, taper, restart, select, or change a medication.
- An outside observation is information, never a license to control. Consent applies at every step.
- Rising activation does not protect you from severe distress or suicide risk.

My three help routes

Write these down before you need them. They are part of the artifact, not an appendix.

Earlier-contact route — who I contact when something is changing but is not an emergency

Urgent-assessment route — who I contact for an urgent assessment

EMERGENCY ROUTE — WHAT I DO IN IMMEDIATE DANGER

Seek urgent assessment

Rapid escalation, psychosis, severe agitation, dangerous or highly uncharacteristic behavior, seriously impaired judgment, inability to care for basic needs, or serious loss of functioning.

IMMEDIATE DANGER

If you may be in immediate danger, contact your local emergency services now. For crisis resources in your country, visit bipolarclarity.com/gethelp, or see the country-by-country crisis annex at the back of this workbook.

Help where you live

Crisis numbers for your country are at the back of this workbook, on page **287**.

Watch this lesson
bipolarclarity.com/program/109



BIPOLAR STABILITY PROGRAM

09 • LESSON

09

Manic and Depressed at the Same Time? Mixed Features

Describe candidate low and low-plus-activated changes in language that can travel into a professional conversation. Choose a help route before certainty about a diagnostic label.

Two routes: the full one, and a short one

PRINT • WRITE BY HAND • KEEP

Purpose

Describe candidate low and low-plus-activated changes in language that can travel into a professional conversation. Choose a help route before certainty about a diagnostic label.

You leave with your Low & Mixed-State Inventory: up to six described observations, one main impact, and the help route you would use if the pattern returned.

This inventory cannot diagnose bipolar depression or mixed features. It does not assess suicide risk, monitor safety or recommend treatment.

What this chapter is about

This chapter goes with video lesson 9. It is the working half. The video does the teaching; this inventory is where you do the work.

Bipolar depression is not only about mood, and describing it as sadness is what makes it hard to report. It can show up in interest, in movement, in how fast thinking happens, in sleep, in what you can still do, and in whether you answer anybody. Somebody can be severely unwell and still describe their mood as *fine, just tired*.

Low and activated can arrive together. Restlessness inside exhaustion. Racing thoughts inside hopelessness. Irritation with no energy behind it. This is the combination that gets missed most often, because each half explains the other away.

And it is the combination that changes the help question. Depressive distress with activation in it may carry higher risk, which is why this chapter asks you to choose a help route *before* you are certain what any of it is called. You do not need a label, a score or confidence to ask for help — and waiting for one is how people arrive late.

Four positions, none of them a diagnosis. *Low. Activated. Both together. Unsure.* They describe where an observation sits, and **unsure** is a real entry rather than a gap.

The cluster matters more than any single sign. Change from your own baseline, how long it has run, what else is going on, and what it has cost you — those four together mean something. One of them alone rarely does.

Key ideas

1. **Bipolar depression is not only about mood.** It can affect interest, movement, thinking, sleep, functioning and safety.

2. **Low and activated changes can appear together.**
3. **“Low,” “activated,” “both together” and “unsure” describe a position, not a diagnosis.**
4. **The cluster matters more than any single sign:** change from your baseline, course, context and impact.
5. **Depressive distress combined with activation deserves attention.** It may carry higher risk — which is not the same as saying every mixed symptom is an emergency.
6. **You do not need a label, a score or certainty before asking for help.**

Watch the video first

The video carries three things worth having before you write.

- **Owen's pattern**, which is what low-plus-activated looks like when it is happening rather than when it is defined.
- **Why the combination changes the help question**, taken slowly and without alarm.
- **Depression described through body, thinking and function**, not through sadness — which is what makes it recognizable.

Watch it before you fill this in. The video lesson is *Manic and Depressed at the Same Time? Mixed Features* — lesson 9 of the Bipolar Stability Program.

Before you begin

Stop-before-writing safety block

Do not use this lesson or workbook to assess suicide risk or decide whether you are safe.

If you are having thoughts of suicide or self-harm, feel unable to keep yourself or someone else safe, or notice rapidly worsening agitation or activation, contact an appropriate professional or urgent service now rather than completing this inventory.

Psychosis, inability to care for basic needs, or serious loss of functioning requires urgent professional assessment.

If you may be in immediate danger, contact your local emergency services now. For crisis resources in your country, visit bipolarclarity.com/gethelp, or see the country-by-country crisis annex at the back of this workbook.

Do not record suicide or self-harm method details in this workbook. Use the appropriate help route instead.

Privacy and treatment boundary

Your workbook answers are not submitted, uploaded, collected, or monitored by Bipolar Clarity.

The Program will never tell you to start, stop, taper, restart, select, or change a medication.

09

Choose one route for today:

- **Core:** one complete observation is required; three are recommended; six is the maximum. Then add impact, help route and care message.
- **Low energy:** one change, its position and one help route.
- **Pause:** use professional, urgent or emergency help instead of completing the page.

Answers you can always use:

- **Not known yet**
- **Prefer not to answer**
- **Nothing to record here**
- **Private — not recorded here**
- **I prefer to bring this to a professional conversation**

Where this chapter's claims come from. The clinical statements in this lesson are sourced, and the sources are public: bipolarclarity.com/program/sources, under lesson 9. A source shows what published guidance says. It does not show what applies to you, and it never overrules the clinician who knows your case.

Safe reference

Recognition frame

- **Cluster:** several changes travel together.
- **Change:** the pattern differs from what is usual for you.
- **Course:** timing, persistence, context and impact belong in the wider clinical picture.
- **Combination:** low and activated changes may occur together.
- **Help:** certainty about the label is not required before contact.

Four positions

- **Low:** mainly slowed, depleted, disconnected or depressed changes.
- **Activated:** mainly speed, pressure, agitation, irritability or drive.
- **Both together:** low/depressive distress and activated changes overlap.
- **Unsure:** the position is unclear, mixed in another way or hard to remember.

These are descriptive options, not diagnostic categories.

Six domains

1. **Mood + interest** — low, empty, numb, anxious, hopeless, disconnected, loss of interest or pleasure.
2. **Body + movement** — heavy, slowed, exhausted, restless, agitated, pacing, unable to settle.
3. **Thinking + decisions** — foggy, slowed, repetitive, crowded or racing thoughts; concentration, memory, indecision or unusually fixed conclusions.
4. **Sleep + daily rhythms** — insomnia, early waking, fragmented sleep, sleeping much more, timing/ appetite change, reduced sleep with rising activation.
5. **Function + connection** — self-care, basic needs, work/study, household tasks, appointments, messages, withdrawal, conflict or unusual urgent communication.
6. **Activation inside distress** — unusual speed, pressure, irritability, agitation, impulsive action, increased talk or drive alongside low/depressive changes.

Core route

Optional reference period

Choose a period already discussed professionally, if one exists. Otherwise select an uncertainty option. Do not reinterpret your history to fill the page.

- A period already discussed professionally.
- No confirmed period.
- Not known yet.
- Prefer not to answer.

☐ discussed
professionally

☐ no confirmed period

☐ not known yet

☐ prefer not to record

09

REFERENCE-PERIOD NOTE

Candidate observations

Start with one complete observation. Three usually make the pattern easier to describe; six is the maximum. Every row after the first is optional.

Observation 1 — the only required one

Domain — mood + interest / body + movement / thinking + decisions / sleep + daily rhythms / function + connection / activation inside distress

WHAT I OBSERVED, IN MY OWN WORDS

POSITION

☐ low

☐ activated

☐ both together

☐ unsure

CONFIDENCE

☐ known

☐ possible

☐ uncertain

CONTEXT OR SOURCE – OPTIONAL

Observation 2 – optional

Domain – mood + interest / body + movement / thinking + decisions / sleep + daily rhythms / function + connection / activation inside distress

WHAT I OBSERVED, IN MY OWN WORDS

POSITION

☐

low

☐

activated

☐

both together

☐

unsure

CONFIDENCE

☐

known

☐

possible

☐

uncertain

CONTEXT OR SOURCE – OPTIONAL

Observation 3 – optional

Domain – mood + interest / body + movement / thinking + decisions / sleep + daily rhythms / function + connection / activation inside distress

WHAT I OBSERVED, IN MY OWN WORDS

POSITION

☐

low

☐

activated

☐

both together

☐

unsure

CONFIDENCE

☐

known

☐

possible

☐

uncertain

CONTEXT OR SOURCE – OPTIONAL

Observation 4 – optional

Domain – mood + interest / body + movement / thinking + decisions / sleep + daily rhythms / function + connection / activation inside distress

WHAT I OBSERVED, IN MY OWN WORDS

POSITION

☐

low

☐

activated

☐

both together

☐

unsure

CONFIDENCE

☐

known

☐

possible

☐

uncertain

CONTEXT OR SOURCE – OPTIONAL

Observation 5 – optional

Domain – mood + interest / body + movement / thinking + decisions / sleep + daily rhythms / function + connection / activation inside distress

WHAT I OBSERVED, IN MY OWN WORDS

POSITION

☐

low

☐

activated

☐

both together

☐

unsure

CONFIDENCE

☐

known

☐

possible

☐

uncertain

CONTEXT OR SOURCE – OPTIONAL

Observation 6 – optional

Domain – mood + interest / body + movement / thinking + decisions / sleep + daily rhythms / function + connection / activation inside distress

WHAT I OBSERVED, IN MY OWN WORDS

POSITION

☐ low☐ activated☐ both together☐ unsure

CONFIDENCE

☐ known☐ possible☐ uncertain

CONTEXT OR SOURCE – OPTIONAL

Main impact

Choose the position that best supports communication. This does not calculate diagnosis or risk.

Describe one effect or uncertainty in a short phrase.

MAIN IMPACT POSITION

☐ no clear impact☐ noticeable change☐ serious loss of functioning or urgent care☐ unsure☐ prefer not to answer

MAIN IMPACT NOTE

Help route

Choose the route you would use if the concerning pattern returned. This records access; it does not assess your current safety.

- ☐ earlier professional contact
 ☐ urgent professional help
- ☐ route for immediate danger shown in this edition
 ☐ route agreed with my care team
- ☐ help choosing a route

HELP-ROUTE NOTE

Your country's lines are in the crisis annex at the back of this workbook: emergency and crisis lines country by country, a section for when it is not an emergency but you are struggling, and one for when home is not safe. bipolarclarity.com/gethelp holds the same list and stays current.

09

Care-message builder

Use any parts that help:

During [write here], I noticed [write here]. The low changes were [write here]. The activated changes were [write here]. They appeared together in [write here]. The main impact was [write here]. I remain uncertain about [write here]. I want help understanding [write here]. If this returns, I plan to contact [write here].

CARE MESSAGE

Low-energy route

Complete these three items and stop:

1. One possible change

2. Its position: low / activated / both / unsure

- ☐ low
 ☐ activated
 ☐ both
 ☐ unsure

3. One help route to keep

The low-energy route is complete: one candidate change, its position, and one help route.

Worked fictional example

Owen reviews a period already discussed with a clinician. He is reviewing it this week because he caught himself drafting the same two-in-the-morning resignation email a second time.

- **Optional reference period:** timing marked **possible**, not confirmed.
- **Mood + interest:** “Music and food brought little pleasure.” Position: low. Confidence: known.
- **Function + connection:** “Getting dressed took longer and messages went unanswered.” Position: low. Confidence: known.
- **Sleep + rhythms:** “Sleep became fragmented.” Position: unsure. Confidence: known.
- **Body + movement:** “Paced between rooms at night while exhausted.” Position: both together. Confidence: known.
- **Activation inside distress:** “Thoughts crowded and urgent messages increased.” Position: both together. Confidence: possible.
- **Urge to resign:** confidence **uncertain**.
- **Main impact note:** missed work, reduced self-care and relationship strain.
- **Help route:** earlier professional contact, with urgent route already saved if agitation or safety worsens.

Owen's care message:

“I felt empty and lost interest — while sleep broke up, thoughts crowded and urgent messages increased. I want help understanding the combination and what route to use if it returns.”

Owen is fictional. The example demonstrates the fields; it is not a diagnostic model or recommended answer.

How this page stands

Choose exactly one: **Ready to use**, **Waiting for information**, or **Keeping this private**.

Mark **Ready to use** only when **at least one candidate change is written in your own words, together with your help route** — neither depends on anybody else. A page waiting for a professional conversation is a valid state, not an unfinished page.

☐ Ready to use ☐ Waiting for information ☐ Keeping this private

Before you close this page

Optional and private:

ONE DISTINCTION THAT BECAME CLEARER

ONE UNCERTAINTY TO KEEP VISIBLE

ONE QUESTION FOR A QUALIFIED PROFESSIONAL

ROUTE USED

☐ core ☐ low energy ☐ pause ☐ prefer not

Where this page goes

Transfer concise meaning rather than the entire private inventory.

1. Up to three candidate low or low-plus-activated signs.
2. One impact phrase.
3. Earlier-contact route.
4. Urgent-help route.

TRANSFER — CANDIDATE SIGN ONE

TRANSFER — CANDIDATE SIGN TWO

TRANSFER – CANDIDATE SIGN THREE

TRANSFER – IMPACT PHRASE

TRANSFER – EARLIER-CONTACT ROUTE

TRANSFER – URGENT-HELP ROUTE

Replacement rule

- These candidate signs replace the two provisional downward changes recorded in the early-change module – the two you wrote there are now covered by this page.
- Keep the Elevated-State Inventory (lesson 8, page 77) from the elevated-state module; this page does not replace it.
- The warning-sign ladder module later replaces the provisional sign lists with the full early-warning ladder.
- The crisis-response and first-72-hours modules remain separate artifacts.

Privacy and safety

- Your workbook answers are not submitted, uploaded, collected, or monitored by Bipolar Clarity.
- Your answers remain in your own copy.
- A blank field, **unsure**, **uncertain** or **prefer not to answer** is valid.
- Do not record suicide or self-harm method details.
- Workbook completion never takes priority over professional, urgent or emergency help.
- The inventory does not classify a mood episode, assess suicide risk, monitor safety or recommend treatment.

Help where you live

Crisis numbers for your country are at the back of this workbook, on page 287.

Watch this lesson
bipolarclarity.com/program/l10



BIPOLAR STABILITY PROGRAM

10

10 • LESSON

Bipolar Disorder or Something Else? Thyroid, Trauma, ADHD

Turn one area of diagnostic or clinical uncertainty into a clear professional question. Record what you observed, which kinds of information may help, what remains unknown and what you want to ask.

Two routes: the full one, and a short one

PRINT • WRITE BY HAND • KEEP

Purpose

Turn one area of diagnostic or clinical uncertainty into a clear professional question. Record what you observed, which kinds of information may help, what remains unknown and what you want to ask.

You leave with one observed pattern written neutrally, the information lanes that matter to it, the gap you would name, and one question for a qualified professional.

What this chapter is about

This chapter goes with video lesson 10. It is the working half. The video does the teaching; this map is where you do the work.

This chapter answers a question most people ask silently: why are they asking me about that? Sleep. Attention as a child. Alcohol. Your family. A head injury. It can feel like the diagnosis is being doubted, or like the assessment has wandered off. Usually it is neither.

Two different questions, and they are not in competition. *Another explanation?* asks whether something else could account for part of the pattern better. *Also present?* asks whether something else could be there **as well** — because coexisting conditions are common, and finding one does not remove the other. Hearing those as one question is what turns an assessment into a threat.

Every lane gives information; none of them gives a diagnosis. Course over time. Development and childhood. How things look in different settings. Relationships. Physical health, sleep and medicines. Substances. Each one narrows a question. None of them settles it, and the map deliberately does not let a single lane win.

Timing supports a question; it does not establish cause. *It started after I began X* is worth recording and is not evidence of anything on its own. The page keeps the sequence and leaves the cause open.

Trauma and private developmental context are optional here. You can mark that a lane is relevant without writing a word about what happened. No detail is required, and nothing on this page is owed to anybody.

Key ideas

1. **Another explanation?** asks whether something else could account for part of a pattern better.
2. **Also present?** asks whether another condition or factor could coexist with bipolar disorder — and both questions can stay open at once.

3. **Every lane gives information; none gives a diagnosis** — course, development, settings, relationship to mood, health, sleep, treatment, substances and context.
4. **Timing can support a professional question**, but it doesn't establish cause.
5. **Trauma and private developmental context are optional here**. No details are required.

Watch the video first

Two things happen only in the video.

- **Nadia's open map**, built while the questions are still unanswered, which is the state this page is designed for.
- **Why a question about attention, or a drink, or your childhood is not a doubt about your diagnosis**. That reframe is the point of the lesson and it works better spoken.

Watch it before you map anything. The video lesson is *Bipolar Disorder or Something Else? Thyroid, Trauma, ADHD* — lesson 10 of the Bipolar Stability Program.

10

Before you begin

Scope and safety

This map cannot confirm, reject, or replace a diagnosis.

An alternative explanation and a coexisting condition are different questions; both can remain open.

Developmental or persistent versus episodic course is information, not a diagnostic rule.

The Program will never tell you to start, stop, taper, restart, select, or change a medication.

Current psychosis, severe activation, inability to meet basic needs, serious loss of judgment or functioning, thoughts of harm, or immediate danger interrupts this exercise and requires an appropriate urgent route.

Your country's lines are in the crisis annex at the back of this workbook: emergency and crisis lines country by country, a section for when it is not an emergency but you are struggling, and one for when home is not safe. bipolarclarity.com/gethelp holds the same list and stays current.

If you may be in immediate danger, contact your local emergency services now. For crisis resources in your country, visit bipolarclarity.com/gethelp, or see the country-by-country crisis annex at the back of this workbook.

Privacy and sensitive information

Your workbook answers are not submitted, uploaded, collected, or monitored by Bipolar Clarity.

Do not record trauma narratives, self-harm method details or identifying information about another person. **Private context — not recorded here** is a complete response.

10

Choose one route:

- **Core:** one map row, relevant information lanes, one gap and one professional question.
- **Low energy:** one observed pattern, one question lane and one professional question.
- **Pause:** use an appropriate professional, urgent or emergency route instead of completing the page.

Answers you can always use:

- **Not known yet**
- **Prefer not to answer**
- **Nothing to record here**
- **Private — not recorded here**
- **I prefer to bring this to a professional conversation**

Where this chapter's claims come from. The clinical statements in this lesson are sourced, and the sources are public: bipolarclarity.com/program/sources, under lesson 10. A source shows what published guidance says. It does not show what applies to you, and it never overrules the clinician who knows your case.

Safe reference

Two open questions

- **Another explanation:** Could something else account for part of this pattern better?
- **May coexist:** Could another condition or factor be present alongside bipolar disorder?
- **Both questions open:** Either or both may still need assessment.
- **Unsure:** You do not yet know how the question has been framed.
- **Not discussed in my care:** The topic has never been raised with an appropriate professional.
That is a fact about your care so far, not a gap in your preparation.

These positions record a question, not a conclusion.

Six information lanes

1. **Course** — what changed, when, how it unfolded and what was present between clearer periods.
2. **Development + settings** — earlier-life pattern and presence across home, school, work, relationships or other settings.
3. **Mood relationship** — only during, mainly around or also outside clearer mood episodes.
4. **Physical health + sleep** — relevant bodily, hormonal, neurological, sleep or other health changes.
5. **Treatment + substances** — medicine, supplement, alcohol, cannabis, stimulant or other substance timing; sequence is not causation.
6. **Context + sources** — stress, optional private/developmental context, records and consent-based observations from somebody else.

Question areas

Do not use the list to select a diagnosis.

Core route

Choose one question area

Start with a topic already raised in your care or an observed pattern you want to ask about.

Selecting an area does not mean that condition is present.

QUESTION AREA

- | | |
|---|---|
| ☐ repeated depression and activated history | ☐ attention / ADHD question |
| ☐ trauma or private context | ☐ long-standing emotion, relationship or identity patterns |
| ☐ psychosis or unusual perceptions and their mood relationship | ☐ physical health or sleep |
| ☐ medicine, supplement or treatment timing | ☐ alcohol, cannabis, stimulants or another substance |
| ☐ another question already raised in my care | ☐ prefer not to categorize |

10

Record the observed pattern

Use neutral, experience-near wording. Describe what happened without assigning cause.

Examples:

- “Attention problems continue between clearer mood episodes; childhood pattern uncertain.”
- “Unusual perceptions appeared during one severe mood episode; outside-episode history not discussed.”
- “Sleep and activation changed after a treatment change; relationship uncertain.”
- “A private history topic may be relevant; details not recorded here.”

OBSERVED PATTERN

Mark the question status

QUESTION STATUS

- | | |
|---|--|
| ☐ another explanation | ☐ may coexist |
| ☐ both questions open | ☐ unsure |
| ☐ not discussed in my care | ☐ I prefer to bring this to a professional conversation |
| ☐ prefer not to answer | |

Select relevant information lanes

INFORMATION LANES

- | | | | |
|---|---|--|--|
| ☐ course | ☐ development + settings | ☐ mood relationship | ☐ physical health + sleep |
| ☐ treatment + substances | ☐ context + sources | ☐ not known yet | ☐ prefer not to answer |

10

Record information and confidence

Write one or two concise pieces of information. Then mark the overall confidence:

INFORMATION

CONFIDENCE

- | | |
|--|---|
| ☐ known | ☐ possible |
| ☐ uncertain | ☐ not discussed in my care |
| ☐ I prefer to bring this to a professional conversation | ☐ prefer not to answer |

Do not investigate private records or another person's history for this worksheet. Use only information already available and observations shared with appropriate consent.

Name the information gap

What would you like a professional to help clarify? **Uncertain** is valid.

INFORMATION GAP

Prepare one professional question

Use or adapt:

Could this pattern be relevant as another explanation, something coexisting, or both? What information would help us assess it?

ONE PROFESSIONAL QUESTION

10

Optional additional rows

Use up to three additional rows only when they improve a real care conversation. More rows are not a better score.

Additional row 1 — optional

QUESTION AREA

- ☐ repeated depression and activated history
- ☐ attention / ADHD question
- ☐ trauma or private context
- ☐ long-standing emotion, relationship or identity patterns
- ☐ psychosis or unusual perceptions and their mood relationship
- ☐ physical health or sleep
- ☐ medicine, supplement or treatment timing
- ☐ alcohol, cannabis, stimulants or another substance
- ☐ another question already raised in my care
- ☐ prefer not to categorize

OBSERVED PATTERN, IN NEUTRAL WORDING

QUESTION STATUS

- | | |
|---|--|
| ☐ another explanation | ☐ may coexist |
| ☐ both questions open | ☐ unsure |
| ☐ not discussed in my care | ☐ I prefer to bring this to a professional conversation |
| ☐ prefer not to answer | |

INFORMATION LANES

- | | | | |
|---|---|--|--|
| ☐ course | ☐ development + settings | ☐ mood relationship | ☐ physical health + sleep |
| ☐ treatment + substances | ☐ context + sources | ☐ not known yet | ☐ prefer not to answer |

10

INFORMATION, IN ONE OR TWO CONCISE PIECES

CONFIDENCE

- | | |
|--|---|
| ☐ known | ☐ possible |
| ☐ uncertain | ☐ not discussed in my care |
| ☐ I prefer to bring this to a professional conversation | ☐ prefer not to answer |

THE INFORMATION GAP I WOULD NAME

ONE QUESTION FOR A QUALIFIED PROFESSIONAL

Additional row 2 – optional

QUESTION AREA

- | | |
|---|---|
| ☐ repeated depression and activated history | ☐ attention / ADHD question |
| ☐ trauma or private context | ☐ long-standing emotion, relationship or identity patterns |
| ☐ psychosis or unusual perceptions and their mood relationship | ☐ physical health or sleep |
| ☐ medicine, supplement or treatment timing | ☐ alcohol, cannabis, stimulants or another substance |
| ☐ another question already raised in my care | ☐ prefer not to categorize |

10

OBSERVED PATTERN, IN NEUTRAL WORDING

QUESTION STATUS

- | | |
|---|--|
| ☐ another explanation | ☐ may coexist |
| ☐ both questions open | ☐ unsure |
| ☐ not discussed in my care | ☐ I prefer to bring this to a professional conversation |
| ☐ prefer not to answer | |

INFORMATION LANES

- | | | | |
|---|---|--|--|
| ☐ course | ☐ development + settings | ☐ mood relationship | ☐ physical health + sleep |
| ☐ treatment + substances | ☐ context + sources | ☐ not known yet | ☐ prefer not to answer |

INFORMATION, IN ONE OR TWO CONCISE PIECES

CONFIDENCE

☐ known

☐ possible

☐ uncertain

☐ not discussed in my care

☐ I prefer to bring this to a professional conversation

☐ prefer not to answer

THE INFORMATION GAP I WOULD NAME

10

ONE QUESTION FOR A QUALIFIED PROFESSIONAL

Additional row 3 — optional

QUESTION AREA

☐ repeated depression and activated history

☐ attention / ADHD question

☐ trauma or private context

☐ long-standing emotion, relationship or identity patterns

☐ psychosis or unusual perceptions and their mood relationship

☐ physical health or sleep

☐ medicine, supplement or treatment timing

☐ alcohol, cannabis, stimulants or another substance

☐ another question already raised in my care

☐ prefer not to categorize

OBSERVED PATTERN, IN NEUTRAL WORDING

QUESTION STATUS

- ☐ another explanation
 ☐ may coexist
- ☐ both questions open
 ☐ unsure
- ☐ not discussed in my care
 ☐ I prefer to bring this to a professional conversation
- ☐ prefer not to answer

INFORMATION LANES

- ☐ course
 ☐ development + settings
 ☐ mood relationship
 ☐ physical health + sleep
- ☐ treatment + substances
 ☐ context + sources
 ☐ not known yet
 ☐ prefer not to answer

10**INFORMATION, IN ONE OR TWO CONCISE PIECES****CONFIDENCE**

- ☐ known
 ☐ possible
- ☐ uncertain
 ☐ not discussed in my care
- ☐ I prefer to bring this to a professional conversation
 ☐ prefer not to answer

THE INFORMATION GAP I WOULD NAME**ONE QUESTION FOR A QUALIFIED PROFESSIONAL**

Condition-specific guardrails

Attention / ADHD

Developmental and cross-setting persistence may help professional assessment; episodic departure from baseline may help too. This contrast is not a diagnostic rule, and both conditions can coexist.

Do not write **persistent = ADHD** or **episodic = bipolar**.

Trauma and private context

Trauma or private developmental context is optional. No narrative, event description or identifying detail is required. Use:

Private context may be relevant — not recorded here.

10

Long-standing personality patterns

Conflict, strong emotion, impulsivity, self-harm or relationship distress alone does not assign a personality diagnosis. Record the course question, not a label.

Psychosis or unusual perceptions

Timing in relation to mood can inform assessment but does not decide a diagnosis. Current psychosis or serious loss of judgment requires prompt assessment rather than workbook analysis.

Physical health, medicines and substances

Record sequence accurately. Timing does not establish cause. A qualified professional decides whether a physical review, medication review, test or other assessment is appropriate.

The substance-and-mood module provides the separate nonjudgmental Substance-and-Mood Honest Note (lesson 11, page **118**).

Low-energy route

Complete these two items and stop:

1. One observed pattern

2. One question lane

A professional question is optional; if one would help, write it here

The low-energy route is complete: one observed pattern and one question lane.

Worked fictional example

Nadia is a fictional composite: thirty-four, four years since diagnosis, recently passed over for a role she had prepared six months for, because she keeps losing the thread of long pieces of work.

- **Question area:** attention / ADHD question.
- **Observed pattern:** “I lose track of tasks between mood episodes as well as during depression. During activated periods, my thinking becomes much faster and I start several projects.”
- **Question status:** both questions open.
- **Information lanes:** development + settings; mood relationship; context + sources.
- **Information** — confidence **known**: teachers described unfinished work when she was fifteen; a partner notices task-switching between episodes, with Nadia's permission to include that observation.
- **Information** — confidence **uncertain**: earlier childhood pattern and the level of impairment outside episodes.
- **Information gap:** “What was present before adolescence, and how much of this happens outside mood episodes?”
- **One professional question:** “Could we assess whether my persistent attention difficulties need their own explanation or coexist with bipolar disorder, and what information would help?”

The map does not give Nadia another diagnosis. It prepares a bounded question.

How this page stands

Choose exactly one: **Ready to use**, **Waiting for information**, or **Keeping this private**.

Mark **Ready to use** only when **at least one observed pattern is written in your own words, together with your one question** — neither depends on anybody else. A map waiting for information only a clinician holds is a valid state.

☐ Ready to use

☐ Waiting for information

☐ Keeping this private

Before you close this page

Optional and private:

The difference between an alternative and a coexisting condition is

☐ clear

☐ partly clear

☐ unclear

☐ prefer not to answer

ONE UNCERTAINTY I CAN LEAVE OPEN

ONE PHRASE THAT HELPS ME ASK WITHOUT DECIDING

ROUTE USED TODAY

☐ core

☐ low energy

☐ pause

☐ prefer not

10

Where this page goes

Transfer concise meaning, not sensitive background:

1. Question area.
2. Main information gap.
3. Professional question.

TRANSFER – QUESTION AREA

TRANSFER – MAIN INFORMATION GAP

TRANSFER – PROFESSIONAL QUESTION

Preservation rule

- This lesson adds a retained context-and-questions page; it supersedes nothing.
- Keep the Diagnostic Language Map (lesson 7, page **67**) from the record-language module.
- Keep the Elevated-State Inventory (lesson 8, page **77**) from the elevated-state module.
- Keep the Low & Mixed-State Inventory (lesson 9, page **89**) from the low-and-mixed module.

- The substance-and-mood module may add substance timing and the stop-decision module may add a treatment question; neither automatically resolves or replaces this map.
- Update the map after an appropriate professional discussion when new information changes the question.

Privacy and safety

- Your workbook answers are not submitted, uploaded, collected, or monitored by Bipolar Clarity.
- Your answers remain in your own copy.
- Blank, **uncertain, I prefer to bring this to a professional conversation, private context – not recorded** and **prefer not to answer** are valid.
- Do not record trauma narratives, self-harm method details or identifying information about another person.
- Another person's observation is included only when relevant and shared with appropriate consent.
- Do not use the map to diagnose, reject a diagnosis, order tests, attribute causation or change treatment.
- Workbook completion never takes priority over prompt, urgent or emergency help.

10

Help where you live

Crisis numbers for your country are at the back of this workbook, on page **287**.

Watch this lesson
bipolarclarity.com/program/l11



BIPOLAR STABILITY PROGRAM

11

11 • LESSON

Alcohol, Cannabis, and Bipolar Disorder: What to Notice

Use one private page to describe one occasion or recurring pattern involving alcohol, cannabis or a stimulant. Record the sequence accurately, keep unknown information unknown and prepare one professional question.

Two routes: the full one, and a short one

PRINT • WRITE BY HAND • KEEP

Purpose

Use one private page to describe one occasion or recurring pattern involving alcohol, cannabis or a stimulant. Record the sequence accurately, keep unknown information unknown and prepare one professional question.

You leave with one accurate sequence — before, during, later — the part that stays unknown, and one question for a professional.

This page can also record **no current use to map** and a prevention question.

What this chapter is about

This chapter goes with video lesson 11. It is the working half. The video does the teaching; this page is where you do the work — privately, and with no verdict attached.

Honest information here is clinical context, not a confession. This page has no opinion about whether you should drink, and it is not a step toward stopping anything. It exists because a clinician trying to read a mood pattern needs to know what else was in the week, and because most people leave that out.

Start before the substance. What was already happening — sleep, mood, stress, whatever was going on that day — is the part people skip, and it is usually the part that explains the sequence. A page that begins at the drink has already lost the information.

Keep during and soon after separate from later and next day. They are different effects with different timings and they get merged into one memory. Alcohol is the clearest example: what it does at the time and what it does to sleep six hours later are not the same event.

Categories stay distinct. Prescribed, prescribed-but-altered, and non-prescribed stimulants are three different things clinically, and collapsing them into *stimulants* destroys the useful part.

Unknown stays unknown. Amount, strength, what was actually in it — if you do not know, write that you do not know. An estimate invented to fill a gap looks like data and is worse than a blank.

And no current use to map is a complete answer, with a prevention question if you want one.

Key ideas

1. **Honest information is clinical context, not a confession.**
2. **Record what was already happening before use.** That is the part people skip, and it is the part that carries the meaning.

3. Keep “during / soon after” separate from “later / next day.”
4. Prescribed, altered-prescribed and non-prescribed stimulants stay distinct categories.
5. Unknown amount, strength or contents stay unknown. Do not estimate to fill the gap.

Watch the video first

Two things stay in the video.

- **Mateo's honest note**, which shows what an accurate sequence looks like when it is uncomfortable.
- **Why this page is not about stopping anything**, said clearly enough that you can believe it before you write.

Watch it before you use this page. The video lesson is *Alcohol, Cannabis, and Bipolar Disorder: What to Notice* — lesson 11 of the Bipolar Stability Program.

Before you begin

Choose the safest way to use this page

- Complete it only when you are able to reflect safely.
- Choose one recent occasion, one important occasion or one recurring pattern.
- You may choose **no current use to map**.
- You may use **uncertain, not known yet, I prefer to bring this to a professional conversation or prefer not to answer**.
- You may keep this page private or discuss the topic verbally instead.

Scope

This note cannot diagnose a substance-use disorder or determine whether a substance caused a mood episode.

Timing can support a professional question, but it does not establish cause.

This is not a safe-use guide, interaction checker, detox plan or medication instruction.

Immediate safety interruption

Current severe confusion, psychosis, chest pain, seizure, difficulty breathing, collapse, serious loss of judgment, thoughts of harm or immediate danger interrupt the exercise and require appropriate urgent local help.

Do not drive, operate machinery or take another dose to “correct” the situation when currently impaired; use appropriate local help and a sober trusted person where available.

Stop here.

If you may be in immediate danger, contact your local emergency services now. For crisis resources in your country, visit bipolarclarity.com/gethelp, or see the country-by-country crisis annex at the back of this workbook.

When an unknown or dangerous substance may be involved, use your local emergency number. Most countries also run a poison-information line, and it is usually faster than an emergency department for “what is this and what does it do” — but this workbook does not list one, because they are national and it does not know where you are. bipolarclarity.com/gethelp links the finder that does: search for poison information plus your country. Look it up now, not on the night you need it.

Alcohol-withdrawal interruption

If prolonged heavy drinking may apply, do not suddenly stop on the basis of this lesson; alcohol withdrawal can be life-threatening, so seek medical help to plan safely.

This page does not assess withdrawal risk. If unsure, prepare this question: **Could stopping suddenly be risky in my situation, and what is the appropriate medical route?**

Medication boundary

The Program will never tell you to start, stop, taper, restart, select, or change a medication.

That covers skipping a dose and increasing one.

Ask the relevant prescriber or pharmacist about your exact products, timing and health context.

Privacy

Your workbook answers are not submitted, uploaded, collected, or monitored by Bipolar Clarity.

Do not include names or identifying details about another person, illegal-source details, self-harm method details or anything that would make the page unsafe to keep.

You may use **prefer not to answer**, keep the page private or discuss the topic verbally instead.

Answers you can always use:

- Not known yet
- Prefer not to answer
- Nothing to record here
- Private — not recorded here
- I prefer to bring this to a professional conversation

Where this chapter's claims come from. The clinical statements in this lesson are sourced, and the sources are public: bipolarclarity.com/program/sources, under lesson 11. A source shows what published guidance says. It does not show what applies to you, and it never overrules the clinician who knows your case.

Safe reference — the Honest Sequence

WINDOW	RECORD	DO NOT CONCLUDE
WHAT + WHEN	product/category, prescribed status, amount/strength if known, timing, purpose/context, nearby substances/medicines	whether it was safe or caused an episode
BEFORE	sleep, mood, energy, activation, anxiety, perception, judgment and functioning already present	that the substance began the whole pattern
DURING / SOON AFTER	observed changes while effects may have been present	that every change came from the substance
LATER / NEXT DAY	sleep, mood, energy, anxiety, craving, decisions and functioning afterward	that sequence proves cause
OPEN QUESTION	recurrence, missing information and a professional question	a diagnosis or treatment decision

Observation lanes

- sleep timing, sleep need and sleep quality;

- mood direction or emotional intensity;
- energy, speed or activation;
- anxiety, agitation or physical arousal;
- perception or thought clarity;
- inhibition, judgment or decisions;
- functioning or consequences;
- no change noticed;
- **Not known yet.**

No change noticed means only that you did not notice a change. It is not proof of no effect.

Core route

Choose one note type

NOTE TYPE

- | | |
|--|---|
| ☐ one recent occasion | ☐ one important past occasion |
| ☐ one recurring pattern | ☐ no current use to map — prevention question only |
| ☐ not known yet | ☐ prefer not to answer |

- one recent occasion;
- one important past occasion;
- one recurring pattern;
- no current use to map — prevention question only;
- **Not known yet;**
- **Prefer not to answer.**

Record what and when

SUBSTANCE OR PRODUCT

- | | |
|---|--|
| ☐ alcohol | ☐ cannabis |
| ☐ prescribed stimulant | ☐ high-caffeine product |
| ☐ cocaine | ☐ methamphetamine |
| ☐ another stimulant or product | ☐ not known yet |
| ☐ prefer not to answer | |

STIMULANT STATUS

A prescribed stimulant used as directed, a prescribed stimulant used differently and a non-prescribed stimulant are recorded separately; none receives an automatic conclusion here.

- | | |
|--|--|
| ☐ prescribed to me and used as directed | ☐ prescribed to me and used differently from directions |
| ☐ prescribed to someone else / non-prescribed | ☐ high-caffeine product |
| ☐ illicit or unregulated stimulant | ☐ uncertain |
| ☐ no stimulant use | ☐ prefer not to answer |

AMOUNT, STRENGTH AND ROUTE

Record only what you already know. Examples:

- two cans; size known;
- three home-poured glasses; exact amount uncertain;
- edible; labelled THC known;
- inhaled cannabis; THC/CBD uncertain;
- prescribed tablet; timing known;
- powder sold under an uncertain name.

Unknown amount, strength or contents must remain unknown; do not recreate the exposure to find out.

Do not use this field to calculate a safe amount or compare methods of use.

TIMING, PURPOSE/CONTEXT AND NEARBY EXPOSURES

When, purpose/context and nearby substances or medicines

Record:

- date or general period;
- start time and last-use time, if remembered;
- reason/context in neutral words;
- other substances or prescribed/non-prescribed products used nearby;
- medicine timing, without changing it.

PURPOSE OR CONTEXT

- | | | | |
|---------------------------------------|-------------------------------------|---|---|
| ☐ social | ☐ sleep | ☐ anxiety/relief | ☐ energy/focus |
| ☐ low mood | ☐ recreation | ☐ pain | ☐ habit/routine |
| ☐ craving/urge | ☐ uncertain | ☐ another reason | ☐ prefer not to answer |

BEFORE snapshot

Choose relevant lanes and write one concise snapshot of what was already happening.

Prompts:

- How much had you slept during the previous two or three nights?
- Was mood lower, higher, more irritable, more anxious or close to baseline?
- Was energy or speed already changing?
- Had judgment, spending, conflict or functioning already shifted?

Use **uncertain** or **not known yet** when accurate.

DURING / SOON AFTER snapshot

Choose relevant lanes and write only observed changes.

Examples: **sleepy, calmer, more talkative, more anxious, faster, memory gap, unusual perception, more impulsive, no change noticed, uncertain.**

Avoid **this caused mania, this cured anxiety** or other causal conclusions.

LATER / NEXT DAY snapshot

Record sleep timing/quality and any later change in mood, energy, anxiety, perception, judgment, craving or functioning.

Examples:

- **fell asleep quickly; woke four times; irritable next morning;**
- **low energy and poor concentration for two days;**
- **energy stayed high despite little sleep;**
- **no change noticed;**
- **not known yet.**

11

Mark recurrence and confidence

RECURRENCE

- ☐ noticed more than once
 ☐ possible recurrence
 ☐ one occasion only
 ☐ no pattern noticed
- ☐ uncertain
 ☐ prefer not to answer

CONFIDENCE IN THE SEQUENCE

- ☐ known
 ☐ partly remembered
- ☐ uncertain
 ☐ I prefer to bring this to a professional conversation
- ☐ prefer not to answer

Name the important gap or safety concern

IMPORTANT GAP OR SAFETY CONCERN

Examples:

- amount or strength uncertain;
- change started before use;
- medicine interaction not reviewed;
- possible alcohol-withdrawal risk needs medical assessment;
- unusual perception or impaired judgment occurred;
- repeated pattern uncertain;
- another gap;
- prefer not to answer.

Prepare one professional question

ONE QUESTION FOR A QUALIFIED PROFESSIONAL

Choose or adapt:

- How should we interpret what began before use, what changed afterward and what remains uncertain?
- Could you review this exact pattern for interactions with my medicines?
- Could stopping alcohol suddenly be risky in my situation, and what medical route should I use?
- How can we distinguish a substance effect, an after-effect and a mood-state change in this pattern?
- What information would help us assess whether this pattern repeats?

Optional additional note rows

Up to two additional Honest Sequence rows may be added. They are optional. Do not complete them merely to make the workbook look finished.

Condition-specific guardrails

Alcohol

- Record actual containers/pours and amounts as known.
- Standard-drink and unit definitions vary by location; use only a verified localized reference.
- This workbook does not set a universal safe limit.
- Alcohol may interact with medicines; use a prescriber or pharmacist for your exact combination.
- Possible prolonged heavy use activates the withdrawal boundary above.

Cannabis

- Product form and labelled THC/CBD are useful only if already known.
- Unknown or unregulated contents remain uncertain.
- Record mood, thought, perception, anxiety, judgment and sleep observations.
- Do not interpret one response as proof for or against a diagnosis.

Stimulants

- Name the exact product and prescribed status.
- Do not treat prescribed medication, caffeine, cocaine and methamphetamine as equivalent.
- Record sleep, wakefulness, energy, anxiety, heart symptoms, perception, judgment and later low mood as observed.
- Do not change a prescription from this page.

Combinations

- Record what appeared nearby in time.
- Do not use the page to rank, test or recreate combinations.
- Unknown contents and unexpected effects may require appropriate urgent or poison-information help.

Low-energy route

Complete these two items and stop:

1. **What and when:** one substance/product and approximate timing.
2. **One before/after observation:** **Before** [write here]; **afterward** [write here].

A professional question is optional here.

The low-energy route is complete: what and when, plus one before/after observation.

Do not return later merely to satisfy the full route. Add detail only if it will help you.

Worked fictional example

Mateo — recurring Saturday pattern

- Substance or product: several alcoholic drinks at a social event; a cannabis vape later.
- Amount, strength and route: amount varied; THC strength unknown.
- When, purpose/context and nearby substances or medicines: a Saturday social event; prescribed evening medicine usually after returning home.
- BEFORE snapshot: two short-sleep nights; energy already higher than usual.
- DURING / SOON AFTER snapshot: more talkative and impulsive; spending increased; final-hour memory incomplete.
- LATER / NEXT DAY snapshot: fell asleep quickly, woke repeatedly, felt anxious and irritable; energy rose again Sunday evening.
- Recurrence: possible.
- Important gap or safety concern: amounts, medicine interaction and whether activation was already developing independently.
- One question for a qualified professional: **How should we interpret the short sleep and higher energy that began before use, the alcohol-cannabis pattern, and the medicine timing? What should I discuss with my prescriber?**

Mateo receives no diagnosis or causal conclusion from the page.

How this page stands

Choose exactly one: **Ready to use**, **Waiting for information**, or **Keeping this private**.

Mark **Ready to use** only when **at least one row is written in your own words** — the conclusion is meant to stay open. A note you deliberately keep partial is a valid state.

☐ Ready to use ☐ Waiting for information ☐ Keeping this private

Before you close this page

Optional and private.

I CAN SEPARATE SEQUENCE FROM CAUSE

☐ clear ☐ partly clear ☐ unclear ☐ prefer not to answer

THE MOST USEFUL WINDOW WAS

☐ what and when ☐ before ☐ during ☐ later

☐ open question ☐ prefer not to answer

ROUTE USED

☐ core ☐ low energy ☐ prevention question ☐ paused for safety

☐ prefer not to answer

ONE PHRASE I WANT FOR CARE – OPTIONAL

Where this page goes

Transfer only:

1. **Pattern noticed** — one concise sequence.
2. **Important uncertainty or safety concern** — one line.
3. **Professional question** — one line.

Keep detailed quantities, sensitive context and the full sequence on this private lesson page. If it is unsafe to store, transfer only the question or choose verbal discussion.

Preservation rule

- This page adds a retained Substance-and-Mood Honest Note; it supersedes nothing.

- Keep the 7-Day Sleep & Rhythm Baseline (lesson 3, page **30**). Do **not** carry the candidate changes from the Starter Early-Change Card (lesson 4, page **40**) forward: the elevated-state and low-and-mixed inventories have already replaced them.
- Keep the Elevated-State Inventory (lesson 8, page **77**) and the Low & Mixed-State Inventory (lesson 9, page **89**).
- Keep Alternatives & Coexisting Map (lesson 10, page **102**) open until appropriate professional review.
- The Vulnerability & Protection Map (lesson 12, page **132**) may add context; the Stop-Decision Worksheet (lesson 16, page **184**) and the First-72-Hours Action Draft (lesson 21, page **234**) may use a reviewed summary. None automatically changes the causal status of this note.

Privacy and safety

- Your workbook answers are not submitted, uploaded, collected, or monitored by Bipolar Clarity.
- Your answers remain in your own copy.
- Do not enter another person's identifying details.
- Do not record illegal-source details or self-harm method details.
- Do not complete the page while currently impaired or unsafe.
- Use **prefer not to answer**, a verbal question or a separate secure note when appropriate.
- Dispose of printed drafts securely if they contain sensitive personal information.
- This page is a **private** document, not a **protected** one. It has no legal privilege, and a saved or printed file can be read by somebody else.
- ⚠ **The legal status of the substances named here varies by country.** In some editions personal use is a criminal offence. Think about that before you write anything here that could be used against you.

Help where you live

Crisis numbers for your country are at the back of this workbook, on page **287**.

Watch this lesson
bipolarclarity.com/program/112



BIPOLAR STABILITY PROGRAM

12

12 • LESSON

Bipolar Triggers: What Adds Pressure—and What Protects You

Build one personal map row linking a candidate pressure, its earliest observable effect, your real influence, one protection, that protection's function and availability, and one small strengthening step.

Two routes: the full one, and a short one

PRINT • WRITE BY HAND • KEEP

Purpose

Build one personal map row linking a candidate pressure, its earliest observable effect, your real influence, one protection, that protection's function and availability, and one small strengthening step.

You leave with one complete row — a candidate pressure, its earliest observable effect, one protection and one small step to strengthen it.

This is a planning map. It is not a prediction, causal verdict or relapse score.

What this chapter is about

This chapter goes with video lesson 12. It is the working half. The video does the teaching; this map is where you do the work.

A trigger is a candidate pressure, not a switch. Nothing on this page flips anything. What the map does is link a pressure you can name to its earliest observable effect, to how much influence you actually have over it, and to one protection that helps — so that the plan exists before the pressure arrives.

Welcome events count. A new job, a wedding, a birth, a move you chose and wanted. They change load and rhythm exactly like difficult ones do, and they are the ones nobody plans for, because planning for them feels ungrateful.

Structural pressure belongs on the map. Housing, money, insecure work, discrimination, caring responsibilities. These are not personal failures and they are not off-topic — they change sleep, rhythm and load as reliably as anything else, and leaving them off makes the map lie.

A protection helps by function, and guarantees nothing. What matters is what it *does*: protects sleep, adds a person, reduces a demand, buys time. Naming the function is what lets you swap one protection for another when the first stops being available.

Availability is its own question. A protection you have thought of is not the same as one that exists. If it needs setting up, that is the small step this page asks for — one, not five.

And one honest row is a complete route. The map is not scored on how full it is.

Key ideas

1. **A trigger is a candidate pressure, not a switch.**
2. **Welcome events change load and rhythm too, not only difficult ones.**

3. **Structural pressure belongs on the map.** Housing, money and discrimination are not personal failure.
4. **A protection helps by function; it never guarantees prevention.**
5. **Availability matters.** A protection you have planned may still need setting up before it exists.
6. **One honest row is a complete route.**

Watch the video first

The video adds two things the map cannot hold.

- **Amina's row, built out loud**, including the moment she picks the wrong protection and changes it.
- **Why pressure is not blame** — the distinction the whole map depends on, and the easiest one to lose on a bad day.

Watch it before you build yours. The video lesson is *Bipolar Triggers: What Adds Pressure—and What Protects You* — lesson 12 of the Bipolar Stability Program.

Before you begin

12

Scope

This map cannot predict an episode, prove what caused one or guarantee prevention.

A pressure is not blame, and a protection is not a guarantee.

Use **known**, **possible** or **uncertain**; an episode without a remembered pressure remains valid.

Do not use this page to test a suspected pressure, diagnose yourself, score relapse risk or make a major treatment or life decision.

Safety interruption

Current severe activation, psychosis, inability to meet basic needs, thoughts of harm or immediate danger interrupt the exercise and require appropriate urgent local help.

Stop the workbook.

If you may be in immediate danger, contact your local emergency services now. For crisis resources in your country, visit bipolarclarity.com/gethelp, or see the country-by-country crisis annex at the back of this workbook.

You do not need a completed map or a proven explanation before seeking help.

Medication and major-change boundary

The Program will never tell you to start, stop, taper, restart, select, or change a medication.

And it does not authorize a major life change either.

The map can prepare a conversation with an appropriate professional. It cannot authorize a treatment change, leaving a job, ending a relationship, cancelling care or recreating a suspected pressure.

Privacy and consent

Your workbook answers are not submitted, uploaded, collected, or monitored by Bipolar Clarity.

Trauma, conflict and private events are optional; no detail is required.

Do not include third-party identifying details, a trauma narrative, self-harm method details or anything unsafe to keep.

Use **private relationship pressure**, **private event** or **prefer not to answer** when that is enough.

Involving another person requires consent and an agreed role; support is not surveillance.

Answers you can always use:

- **Not known yet**
- **Prefer not to answer**
- **Nothing to record here**
- **Private — not recorded here**

- I prefer to bring this to a professional conversation

Where this chapter's claims come from. The clinical statements in this lesson are sourced, and the sources are public: bipolarclarity.com/program/sources, under lesson 12. A source shows what published guidance says. It does not show what applies to you, and it never overrules the clinician who knows your case.

Safe reference — the five-part map

PART	QUESTION	EXAMPLE	BOUNDARY
PRESSURE	What condition, event or change may matter?	three late deadlines in one week	narrow candidate, not a cause
EARLIEST EFFECT	What could I observe first?	working after midnight	observation, not diagnosis
INFLUENCE ZONE	What kind of influence is realistic?	I can prepare for some of it	no blame for limited control
PROTECTION	What function supports stability here?	protected decompression period	support, not guarantee
AVAILABILITY + STEP	Does it exist today, and what strengthens it?	partly available; ask to trade one task	gap is information, not failure

Candidate pressure families

- sleep or rhythm disruption;
- demands, deadlines or too many simultaneous goals;
- transitions, travel or schedule changes;
- welcome events, celebration or goal acceleration;
- conflict, isolation, caregiving or social overload;
- pain, illness, recovery or another body change;
- treatment confusion, appointment, pharmacy, cost or transport barrier;
- substance-related context already observed in the Substance-and-Mood Honest Note (lesson 11, page **118**);
- housing, finances, work conditions, discrimination or basic-needs pressure;
- another narrow pressure;
- no pressure identified;
- prefer not to answer.

Earliest-effect lanes

- sleep timing or sleep need;
- daily rhythm or meals;

- energy, speed or number of goals;
- mood, irritability or emotional intensity;
- thinking, attention or decisions;
- connection, conflict or isolation;
- body or physical functioning;
- work, study, care tasks or daily functioning;
- uncertain or not noticed.

Protection functions

Core route — one map row

Complete one row. Optional rows appear later.

Candidate pressure

Choose one narrow condition, event or change. Describe the load or disruption rather than labeling an entire person, job, relationship or life period.

Examples:

- **wake time shifts after travel;**
- **several exciting projects begin together;**
- **private conflict continues late at night;**
- **pharmacy access becomes uncertain;**
- **caregiving removes my recovery period.**

You may write **no pressure identified** or **prefer not to answer**.

Confidence status

Choose one:

- **known** — repeatedly observed or carefully reviewed;
- **possible** — worth watching or discussing;
- **uncertain** — connection remains open;
- **no pressure identified;**
- **prefer not to answer.**

Do not promote a pressure to **known** only because it occurred before one episode.

Earliest observable effect

Write the first specific change you might realistically notice. Include the lane and observation, not an interpretation.

Examples:

- **Sleep:** I begin preparing for work after midnight.
- **Goals:** I add commitments before finishing existing ones.
- **Connection:** I stop replying for several days.
- **Functioning:** one ordinary admin task fills most of the day.
- **Uncertain** — I have not identified an early effect.

This field can later inform the Full Early-Warning Ladder (lesson 19, page **214**). It does not diagnose a state here.

Influence zone

Choose the best current fit:

- I can change some of it;
- I can prepare for it;
- it needs support or system change;
- it is outside my control;
- prefer not to answer.

Structural pressures and conditions outside your control are not personal failures.

If more than one fits, select the one that shapes your next step today.

Protection

Name one condition, resource, relationship, routine or access route that may help with this pressure or its earliest effect.

Examples:

- **weekday wake anchor;**
- **one protected recovery period;**
- **brief private sleep-and-energy note;**
- **saved care contact and transport route;**

- one consent-based check-in;
- benefits, housing or workplace advocate.

You may record **no usable protection identified yet**.

Protection function

Choose the function that matters most in this row, even when the protection does more than one thing.

Availability today

Choose one:

- **READY NOW;**
- **PARTLY AVAILABLE;**
- **NEEDS SETUP;**
- **DEPENDS ON SOMEBODY ELSE OR A SERVICE;**
- **UNAVAILABLE / UNCERTAIN.**

A planned protection is not the same as one available in real life; a gap is information, not failure.

12

If another person appears in the protection, confirm that the role is a request they can accept or decline.

Smallest strengthening step

Write one action that strengthens availability without redesigning your life or changing treatment.

Useful forms:

- **save...**
- **ask whether...**
- **write the first sentence of...**
- **place... where I will see it;**
- **request...**
- **preserve...**
- **name this gap for...**

Examples:

- **Save the clinic number and opening hours.**

- Ask whether we can trade one evening task for two weeks.
- Preserve my ready wake anchor during the first work week.
- Write: “I want help planning around this access barrier.”

Keep the step small, observable and reversible.

Your core row, in one place

CANDIDATE PRESSURE:

CONFIDENCE:

☐ known

☐ possible

☐ uncertain

☐ no pressure identified

☐ prefer not to answer

EARLIEST EFFECT:

INFLUENCE ZONE:

☐ I can change some of it

☐ I can prepare for it

☐ it needs support or system change

☐ it is outside my control

☐ uncertain

☐ prefer not to answer

PROTECTION:

PRIMARY FUNCTION:

☐ stabilizes rhythm

☐ reduces load

☐ helps me notice

☐ helps me act

☐ maintains connection

☐ maintains access to care or basic needs

☐ uncertain

AVAILABILITY:☐

READY NOW

☐

PARTLY AVAILABLE

☐

NEEDS SETUP

☐

DEPENDS ON SOMEBODY ELSE OR A SERVICE

☐

UNAVAILABLE / UNCERTAIN

SMALLEST STRENGTHENING STEP:

Read the row once. Check only:

- Is the pressure narrow enough to observe?
- Is the confidence label honest?
- Is the protection genuinely available at the state you selected?
- Is the next step small and safe?

Low-energy route

Complete only:

1. one possible pressure;
2. one protection that is ready now;
3. one smallest strengthening step.

The low-energy route is complete: one possible pressure, one ready protection and one smallest strengthening step.

If no protection is ready now, write **no ready protection identified** and use **name the gap for support** as your step. That is a valid result.

Optional depth

Optional map row 2

Repeat the eight fields only if a second row adds a meaningfully different pressure or protection.
Do not use it to prove the first row.

CANDIDATE PRESSURE – ROW 2

CONFIDENCE STATUS – ROW 2

- ☐ known
- ☐ possible
- ☐ uncertain
- ☐ no pressure identified
- ☐ prefer not to answer

EARLIEST OBSERVABLE EFFECT – ROW 2

INFLUENCE ZONE – ROW 2

- ☐ I can change some of it
- ☐ I can prepare for it
- ☐ it needs support or system change
- ☐ it is outside my control
- ☐ uncertain
- ☐ prefer not to answer

PROTECTION – ROW 2

PROTECTION FUNCTION – ROW 2

- ☐ stabilizes rhythm
- ☐ reduces load
- ☐ helps me notice
- ☐ helps me act
- ☐ maintains connection
- ☐ maintains access to care or basic needs
- ☐ uncertain

AVAILABILITY TODAY – ROW 2☐

READY NOW

☐

PARTLY AVAILABLE

☐

NEEDS SETUP

☐

DEPENDS ON SOMEBODY ELSE OR A SERVICE

☐

UNAVAILABLE / UNCERTAIN

SMALLEST STRENGTHENING STEP – ROW 2**Optional map row 3**

Use only when it improves planning. An empty row is not missing work.

CANDIDATE PRESSURE – ROW 3**CONFIDENCE STATUS – ROW 3**☐

known

☐

possible

☐

uncertain

☐

no pressure identified

☐

prefer not to answer

EARLIEST OBSERVABLE EFFECT – ROW 3**INFLUENCE ZONE – ROW 3**☐

I can change some of it

☐

I can prepare for it

☐

it needs support or system change

☐

it is outside my control

☐

uncertain

☐

prefer not to answer

PROTECTION – ROW 3

PROTECTION FUNCTION – ROW 3

- | | |
|---|--|
| ☐ stabilizes rhythm | ☐ reduces load |
| ☐ helps me notice | ☐ helps me act |
| ☐ maintains connection | ☐ maintains access to care or basic needs |
| ☐ uncertain | |

AVAILABILITY TODAY – ROW 3

- | | |
|--|--|
| ☐ READY NOW | ☐ PARTLY AVAILABLE |
| ☐ NEEDS SETUP | ☐ DEPENDS ON SOMEBODY ELSE OR A SERVICE |
| ☐ UNAVAILABLE / UNCERTAIN | |

SMALLEST STRENGTHENING STEP – ROW 3

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Optional supporting observation

Write one brief reason for your confidence label:

- noticed more than once;
- one occasion only;
- discussed in care;
- supported by my earlier workbook pages;
- relationship uncertain;
- prefer not to answer.

Optional consent-based support note

Complete only when another person may be involved:

WHAT I MIGHT REQUEST:

WHAT I WILL NOT ASK THEM TO DO:

HOW THEY CAN ACCEPT, CHANGE OR DECLINE THE ROLE:

Do not create monitoring access, password sharing, location tracking or an open-ended duty.

Optional care question

This page does not require a professional question. If one would help, write it here

Could we review whether this is a useful candidate pressure, how to interpret the earliest effect, and which protection is realistic in my care context?

12

Where this page goes

Transfer only three concise lines:

Top candidate pressure

Use neutral wording plus its confidence label.

Example: **possible** — several exciting projects plus repeated late preparation.

Strongest ready protection

Choose a protection marked **READY NOW**. If none is ready, write **No ready protection identified yet**.

Protection gap or next step

Write the availability gap or smallest strengthening step.

Detailed context, names, trauma history and supporting observations stay on this lesson page — or remain unwritten.

Halfway — look at the plan you already have

Lessons 1–12 now form the first working edition of your Bipolar Stability Plan.

Twelve lessons is a working plan, not half a plan. The rest of the Program builds on what you have, and none of it takes any of it back.

First, the part that is yours

Before you check anything, go and look at what you actually wrote. Turn back to four of your own pages and copy one line from each — the line you would want somebody to read if they only had thirty seconds.

From your sleep and rhythm baseline (lesson 3, page 30), one line about what your usual looks like

From your early-change card (lesson 4, page 40) or your inventories (lesson 8, page 77), one change you would want to catch early

From your medication questions page (lesson 5, page 49), the question you still want answered

In your own words, today, one thing you understand now that you did not in lesson 1

Four lines, in your handwriting, on one page. That is the plan. Everything below is just checking you can still find the rest of it.

Then, the housekeeping

This review checks usability; it does not ask you to rewrite prior pages. **It is a find-it check, not a form.** If you can put a hand on your pages, you already know the answer and can leave it blank.

SECTION	WHAT YOU SHOULD BE ABLE TO FIND	STATUS
Safety Plan and Starting Point (lesson 1, page 11)	Safety access and program boundaries	HALFWAY CHECK – L01 SECTION STATUS ☐ READY TO USE ☐ WAITING FOR INFORMATION ☐ KEEPING THIS PRIVATE ☐ REPLACED BY A LATER PAGE ☐ NOT WRITTEN YET
Meaning / Not-meaning Card (lesson 2, page 19)	What bipolar disorder means for your learning	HALFWAY CHECK – L02 SECTION STATUS ☐ READY TO USE ☐ WAITING FOR INFORMATION ☐ KEEPING THIS PRIVATE ☐ REPLACED BY A LATER PAGE ☐ NOT WRITTEN YET
7-Day Sleep & Rhythm Baseline (lesson 3, page 30)	Sleep and rhythm baseline	HALFWAY CHECK – L03 SECTION STATUS ☐ READY TO USE ☐ WAITING FOR INFORMATION ☐ KEEPING THIS PRIVATE ☐ REPLACED BY A LATER PAGE ☐ NOT WRITTEN YET
Starter Early-Change Card (lesson 4, page 40)	Candidate early changes	HALFWAY CHECK – L04 SECTION STATUS ☐ READY TO USE ☐ WAITING FOR INFORMATION ☐ KEEPING THIS PRIVATE ☐ REPLACED BY A LATER PAGE ☐ NOT WRITTEN YET
Medication Questions Page	Medication questions	

SECTION	WHAT YOU SHOULD BE ABLE TO FIND	STATUS
(lesson 5, page 49)		HALFWAY CHECK – L05 SECTION STATUS ☐ READY TO USE ☐ WAITING FOR INFORMATION ☐ KEEPING THIS PRIVATE ☐ REPLACED BY A LATER PAGE ☐ NOT WRITTEN YET
Three-Period Life Chart (lesson 6, page 57)	Life-course context	HALFWAY CHECK – L06 SECTION STATUS ☐ READY TO USE ☐ WAITING FOR INFORMATION ☐ KEEPING THIS PRIVATE ☐ REPLACED BY A LATER PAGE ☐ NOT WRITTEN YET
Diagnostic Language Map (lesson 7, page 67)	Subtype language	HALFWAY CHECK – L07 SECTION STATUS ☐ READY TO USE ☐ WAITING FOR INFORMATION ☐ KEEPING THIS PRIVATE ☐ REPLACED BY A LATER PAGE ☐ NOT WRITTEN YET
Elevated-State Inventory (lesson 8, page 77)	Elevated-state observations	HALFWAY CHECK – L08 SECTION STATUS ☐ READY TO USE ☐ WAITING FOR INFORMATION ☐ KEEPING THIS PRIVATE ☐ REPLACED BY A LATER PAGE ☐ NOT WRITTEN YET
Low & Mixed-State Inventory (lesson 9, page 89)	Low and mixed-state observations	

SECTION	WHAT YOU SHOULD BE ABLE TO FIND	STATUS
HALFWAY CHECK – L09 SECTION STATUS		
☐ READY TO USE ☐ WAITING FOR INFORMATION ☐ KEEPING THIS PRIVATE ☐ REPLACED BY A LATER PAGE ☐ NOT WRITTEN YET		
Alternatives & Coexisting Map (lesson 10, page 102)	Alternative and coexisting questions	HALFWAY CHECK – L10 SECTION STATUS
☐ READY TO USE ☐ WAITING FOR INFORMATION ☐ KEEPING THIS PRIVATE ☐ REPLACED BY A LATER PAGE ☐ NOT WRITTEN YET		
Substance-and-Mood Honest Note (lesson 11, page 118)	Substance-and-mood context, if relevant	HALFWAY CHECK – L11 SECTION STATUS
☐ READY TO USE ☐ WAITING FOR INFORMATION ☐ KEEPING THIS PRIVATE ☐ REPLACED BY A LATER PAGE ☐ NOT WRITTEN YET		
Vulnerability & Protection Map (this chapter)	Pressures, protections and availability	HALFWAY CHECK – L12 SECTION STATUS
☐ READY TO USE ☐ WAITING FOR INFORMATION ☐ KEEPING THIS PRIVATE ☐ REPLACED BY A LATER PAGE ☐ NOT WRITTEN YET		

One small maintenance choice

- ☐ update one outdated line
- ☐ remove one detail that feels too private
- ☐ complete one missing low-energy route
- ☐ mark one section to discuss later
- ☐ make no change today

This is a working plan, not a test or a permanent record.

How this page stands

Choose exactly one: **Ready to use**, **Waiting for information**, or **Keeping this private**.

Mark **Ready to use** only when **at least one pressure and one protection are written in your own words** – neither depends on anybody else. A map waiting for a protection you have not been able to arrange yet is a valid state, not an unfinished page.

☐ Ready to use ☐ Waiting for information ☐ Keeping this private

Before you close this page

Optional and private.

The idea I want to keep – pressure is a candidate, not a cause

☐ clear ☐ partly clear ☐ unclear ☐ prefer not to answer

THE PART I NEARLY SKIPPED

☐ availability ☐ influence zone ☐ earliest effect ☐ none of them
☐ prefer not to answer

ROUTE USED

☐ core ☐ low energy ☐ paused for safety ☐ prefer not to answer

ONE PHRASE I WANT FOR CARE – OPTIONAL

Privacy and safety

- Your workbook answers are not submitted, uploaded, collected, or monitored by Bipolar Clarity.
- Your answers remain in your own copy.
- Blank, **uncertain**, **private relationship pressure**, **private event** and **prefer not to answer** are valid, complete answers.
- Do not record third-party identifying details, a trauma narrative or self-harm method details.
- Do not complete this page during severe activation, psychosis, overwhelming depression or immediate danger. Safety interrupts the workbook; see the safety interruption above.

- A protection that involves another person needs their consent and an agreed role. Support is not surveillance.
- Dispose of printed drafts securely if they contain sensitive personal information.
- Workbook completion never takes priority over professional, urgent or emergency help.

Closing summary

Your map separates:

- candidate pressure from proven cause;
- earliest observation from diagnosis;
- realistic influence from blame;
- protection function from prevention guarantee;
- a written idea from a protection available today.

If you stop here, you stop at a real point — and your how this page stands says whether the page is finished or still waiting on something outside you.

If you continue, bring only the parts you choose into the treatment-conversation module. You never need to share the complete private workbook.

12

Worked fictional example

Amina is a fictional composite, and she is in the middle of it: day nine of a job she wanted for two years, with earlier mornings, a long commute and a steep learning curve. It is going well, which is part of the problem.

- **Candidate pressure:** “New-job weeks with early starts, evening preparation and several exciting new ideas.”
- **Confidence status:** **possible** — she has seen parts of the pattern before, though the job itself is new.
- **Earliest observable effect:** “I prepare after midnight, wake early without feeling tired and add new commitments.”
- **Influence zone:** **I can change some of it** for the evening preparation; the commute and the start time need planning rather than control.
- **Protection:** a weekday wake anchor plus one thirty-minute decompression period after the commute.
- **Protection function:** stabilizes rhythm — with reducing load as the second effect she chose not to record as primary.

- **Availability today:** the wake anchor is **READY NOW**; decompression is **PARTLY AVAILABLE**, because family responsibilities begin as soon as she gets home.
- **Smallest strengthening step:** “Ask my partner whether trading one task on Monday through Thursday for the first two weeks works, then review.” A request, not an assumption.

Amina transfers three lines to her Bipolar Stability Plan: the possible pressure, the strongest ready protection, and the protection gap she wants to address.

Amina is fictional. The example demonstrates the fields; it is not a prediction, a causal verdict or a recommended answer.

Help where you live

Crisis numbers for your country are at the back of this workbook, on page **287**.

Halfway

Twelve chapters behind you. This page is not a test, and there is nothing to add up.

Three things worth checking

Can you find your Safety Plan and Starting Point? Not from memory. Go and put a hand on it. If it takes more than a minute, that is the thing to fix today, and it is the only thing.

Do you know which page you would take to a conversation? One page, not the pile. The medication questions before an appointment, the ladder after a scare, the crisis draft when somebody asks how they can help.

Do you know where you are going next? Chapter 13 if you are moving in order. Otherwise, the chapter that matches what is happening.

A page that is waiting for a phone number is not an unfinished page; it is a page doing its job while somebody else does theirs.

If you stopped for a while

Most people do. Nothing here expired, and you do not start again from chapter one. Check three things and carry on: your emergency route is still the one you would use, anything you left as Waiting for information is still waiting on the same thing, and your baseline still sounds like your ordinary week. There is a longer version of this on page **275**.

The second half

The chapters ahead are about appointments, medication questions, warning signs and what to do in the first days of a change. They lean on what you already wrote. If a page they ask for is missing, use the minimum information box and keep going.

You do not have to do the second twelve in twelve weeks either.

Watch this lesson
bipolarclarity.com/program/113



BIPOLAR STABILITY PROGRAM

13

Bipolar Psychiatry Appointment: Make the Short Visit Count

Prepare one appointment with three ranked priorities, the smallest useful information set, one professional question and a brief record of what was decided or remains open.

Two routes: the full one, and a short one

PRINT • WRITE BY HAND • KEEP

Purpose

Prepare one appointment with three ranked priorities, the smallest useful information set, one professional question and a brief record of what was decided or remains open.

You leave with three ranked priorities, the smallest useful set of things to bring, one question you will definitely ask, and a place to write down what you were told.

This is an agenda, not a treatment recommendation, diagnostic tool or substitute for assessment.

What this chapter is about

This chapter goes with video lesson 13. It is the working half. The video does the teaching; this card is where you do the work — and then it comes with you through the door.

Fifteen minutes and a whole life do not fit. That is the entire problem this chapter solves. Most appointments end with the important thing unsaid, not because anybody handled it badly, but because a person who is unwell, nervous and under time pressure cannot rank their own concerns in real time.

So rank them beforehand: three, in order. Three is not a limit imposed for tidiness. It is roughly what survives an appointment, and choosing which three is work you can only do calmly — which means now, not in the waiting room.

Bring observations and an accurate list; leave the interpretation to the conversation. Dates, changes, what you actually take. Not a theory. The theory is what the two of you build together, and arriving with one already assembled tends to narrow the conversation rather than open it.

A shared decision has two halves. One is professional evidence and judgement. The other is your goals, your values, your circumstances and what you are willing to live with. Both halves are required, and the second one does not turn up unless you bring it.

A visit can end three ways, and all three are legitimate: a decision, a request for more information, or a plan to review. An appointment that ends without a decision has not failed.

Write down what was decided, in your own words, before you leave the building. What was agreed, what stayed uncertain, and who to contact if something changes. Memory after a difficult appointment is unreliable in a specific way: it keeps the emotional tone and loses the instructions.

And access needs are part of preparing, not an extra. Someone with you, a written summary, more time, a quieter room — asking is preparation, not a favor.

Key ideas

1. **Three ranked priorities are more usable than an unranked life history.**
2. **Bring observations and an accurate list.** Leave the interpretation to the conversation.
3. **A shared decision has two halves:** professional evidence and judgment, and your goals, values, circumstances and preferences.
4. **A visit may end in a decision, a request for more information, or a review plan.** All three are outcomes.
5. **Write down what was decided, in your own words,** along with what stayed uncertain and who to contact next.
6. **Access needs and consented support are part of preparing,** not an extra.
7. **The two-line route is complete** when energy is limited.

Watch the video first

Three things stay in the video.

- **The moment outside the door,** which is where this card is actually used and where most preparation falls apart.
- **Marco's card,** and what changes when the three priorities get ranked rather than listed.
- **The four questions to ask around any choice,** taken slowly enough to remember one of them.

Watch it before your next appointment, not after. The video lesson is *Bipolar Psychiatry Appointment: Make the Short Visit Count* — lesson 13 of the Bipolar Stability Program.

Before you begin

Scope

This agenda organizes a professional conversation. It does not choose treatment or replace assessment.

The Program will never tell you to start, stop, taper, restart, select, or change a medication.

Use the page to record what you observe and what you want to ask. Do not use it to carry out a medication or treatment change by yourself.

Safety interruption

Current immediate danger, thoughts of harm, severe activation, psychosis, serious loss of judgment or inability to meet basic needs interrupts routine appointment preparation. Stop the workbook and use any route you have already agreed, the care contact you have already named, or your local emergency services.

If you may be in immediate danger, contact your local emergency services now. For crisis resources in your country, visit bipolarclarity.com/gethelp, or see the country-by-country crisis annex at the back of this workbook.

You do not need a completed agenda before asking for help.

Privacy, consent and storage

Your workbook answers are not submitted, uploaded, collected, or monitored by Bipolar Clarity.

Do not store prescription images, account numbers, passwords, access codes, self-harm method details, unnecessary third-party identifiers or anything unsafe to keep.

Use **Private – not recorded here** when a topic is better discussed verbally.

A support person participates only with your consent and an agreed role. Support is not surveillance.

Valid responses

Answers you can always use:

- **Not known yet**
- **Prefer not to answer**
- **Nothing to record here**
- **Private – not recorded here**
- **I prefer to bring this to a professional conversation**

These are valid responses. They are not errors or missing effort.

Where this chapter's claims come from. The clinical statements in this lesson are sourced, and the sources are public: bipolarclarity.com/program/sources, under lesson 13. A source shows what

published guidance says. It does not show what applies to you, and it never overrules the clinician who knows your case.

Core route

Complete the card before the appointment. Fill the **LEAVE WITH** line during the final part of the visit or immediately afterwards.

Zone 1 — THREE PRIORITIES

APPOINTMENT PURPOSE

What do you think this appointment is for?

Examples: **review recent changes, discuss an unwanted effect, understand the next assessment, Not known yet.**

PRIORITY 1 — MUST COVER

Write one observable concern, question or impact that must be part of this appointment.

Useful form: **What changed + when + what it affected + what I want to ask.**

PRIORITY 2 — COVER IF TIME

Write one second item, or choose **Nothing to record here.**

PRIORITY 3 — CAN WAIT

Give one item a safe place to wait, or choose **Nothing to record here.**

If several items affect immediate safety or basic functioning, tell the service at the start rather than forcing them into this ranking.

Zone 2 — WHAT I BRING

ONE USEFUL OBSERVATION

Bring the smallest observation that helps this conversation. It may come from a prior lesson page.

Examples:

- For twelve days, I have been waking three hours earlier and beginning more tasks.
- Lower mood is now interfering with meals and work.
- Trembling began four days after the treatment change; relationship not known yet.

CURRENT MEDICATION-LIST STATUS

An accurate list may include prescribed and nonprescribed medicines, supplements and vitamins. The clinician or pharmacist performs medication reconciliation and interpretation.

- | | |
|---|---|
| ☐ accurate list ready | ☐ list needs updating |
| ☐ I need help obtaining the list | ☐ Nothing to record here |
| ☐ Prefer not to answer | |

RECORDS AND ACCESS NEEDS

Write what you actually need: a recent summary already requested, one prior record, another clinician's contact, an interpreter request, accessible information, help taking notes, or **Nothing to record here**. An access need is not an extra item competing with the others — if you need an interpreter and a record, you need both.

ONE RECORD OR ACCESS NEED

IF SOMEONE COMES WITH YOU

Decide the role before you get there, and tell them: listening, taking notes, helping you remember one observation, or waiting outside unless you invite them in. A role decided in the waiting room is a role nobody agreed to.

If privacy matters, split it: what you will discuss with them in the room, and what needs the door closed. You are allowed to ask for five minutes alone, and you do not owe a reason.

Going alone is the common answer, and it is a complete one.

WHAT I MIGHT REQUEST:

.....

.....

WHAT I WILL NOT ASK THEM TO DO:

.....

.....

Zone 3 — WHAT I ASK

MANDATORY PROFESSIONAL QUESTION

Copy or adapt this question:

What decision are we making today, what information do you still need, and what should I watch or do before the next review?

If no decision belongs in the visit, change the first part to: **What are we trying to understand today?**

.....

.....

.....

SHARED-DECISION PROMPT

- | | |
|---|---|
| ☐ What are the reasonable options, including waiting or gathering more information when appropriate? | ☐ What are the possible benefits and downsides for me? |
| ☐ How do my goals, values, responsibilities and previous experience affect the choice? | ☐ What remains uncertain, and when will we review it? |
| ☐ I prefer to bring this to a professional conversation | ☐ Nothing to record here |

Shared decision making does not mean deciding alone, and it does not make every option appropriate or available.

Zone 4 — WHAT I LEAVE WITH

After the appointment, write a compact exit record with four parts:

1. **DECIDED:** what was agreed or confirmed.
2. **STILL OPEN:** what remains uncertain or needs more information.
3. **NEXT:** what happens, who acts and when it will be reviewed; use **timing not confirmed** when needed.
4. **CONTACT:** the route the service gave you for questions, worsening symptoms or urgent concerns.

Use your own words, then check them with the professional when possible. Do not invent a deadline, monitoring rule or urgent route.

How this page stands

Choose exactly one: **Ready to use**, **Waiting for information**, or **Keeping this private**.

Mark **Ready to use** only when at least one field that does not depend on an external source is written. **Priority 1 – MUST COVER**, the mandatory professional question, or the **two lines of the low-energy route** each meet that floor on their own. The exit record may remain unfinished until the appointment.

Choose **Waiting for information** when the next usable step depends on the service, a record or a professional response. Choose **Keeping this private** when you intentionally do not retain the content here.

☐

Ready to use

☐

Waiting for information

☐

Keeping this private

Low-energy route

Copy exactly two lines. That is the whole route.

1. **My most important point today is:** [write here]
2. **The question I need answered before I leave is:** [write here]

MY MOST IMPORTANT POINT TODAY IS

THE QUESTION I NEED ANSWERED BEFORE I LEAVE IS

Those two lines are a complete route. They are not a failed version of the full card. You may stop here.

Worked fictional example

Marco is a fictional composite preparing for a follow-up after several weeks of low energy, fragmented sleep and trembling that began after a recent treatment change.

- **Appointment purpose:** review recent symptoms and what happens next.
- **Priority 1 — MUST COVER:** Lower mood and energy are now affecting meals and work.
- **Priority 2 — COVER IF TIME:** Trembling began after the recent change; relationship not known yet.
- **Priority 3 — CAN WAIT:** Ask where to find a local peer group.
- **One useful observation:** a seven-day sleep-and-energy summary.
- **Current medication-list status:** accurate list ready, including supplements.
- **One record or access need:** written instructions because multi-step information is hard to retain when low.
- **Mandatory professional question:** What decision are we making today, what information do you still need, and what should I watch or do before the next review?
- **Shared-decision prompt:** How do my goals, values, responsibilities and previous experience affect the choice?
- **What I might request:** enough morning functioning to help his children get ready for school.
- **What I leave with:** **DECIDED:** continue gathering information today; **STILL OPEN:** cause of trembling; **NEXT:** service will review the requested information, timing confirmed in writing; **CONTACT:** use the clinic's named urgent route if symptoms worsen.
- **How this page stands:** Ready to use.

Marco has not chosen a treatment or assigned a cause. He has made his observations, priorities and uncertainty usable in a professional conversation.

Before you close this page

Optional and private.

WHAT BECAME CLEARER ABOUT THE APPOINTMENT'S PURPOSE?

Which zone helped most: **THREE**, **BRING**, **ASK**, **LEAVE WITH**, or **Not known yet**?

☐ **THREE**
☐ **BRING**
☐ **ASK**
☐ **LEAVE WITH**

☐ **Not known yet**

WHAT WOULD MAKE THIS CARD EASIER TO USE NEXT TIME?

Where this page goes

Place the retained card in **Section 5 – My treatment**.

Transfer only:

- the highest-priority agenda line;
- the professional question;
- the concise exit record you want available later.

Detailed observations, private context and source pages can remain in their original lesson pages. The later treatment pages may add future agenda items but do not replace this card.

Privacy and safety

- Your workbook answers are not submitted, uploaded, collected, or monitored by Bipolar Clarity.
- The Program will never tell you to start, stop, taper, restart, select, or change a medication.
- A support person needs your consent and an agreed role; support is not surveillance.
- Keep prescription images, account details, access codes, unnecessary names and unsafe detail off the page.
- **Not known yet**, **Prefer not to answer**, **Nothing to record here**, **Private – not recorded here** and **I prefer to bring this to a professional conversation** are valid.
- Workbook completion never takes priority over professional, urgent or emergency help.

- The written emergency route appears in **Before you begin**; use that route whenever immediate danger may apply.

Help where you live

Crisis numbers for your country are at the back of this workbook, on page **287**.

Watch this lesson
bipolarclarity.com/program/l14



BIPOLAR STABILITY PROGRAM

14

I Feel Fine. Why Am I Still on Bipolar Medication?

Build a source-labelled page showing what each current medicine is intended to do, which phase that purpose belongs to, what you were actually told and what remains unknown.

Two routes: the full one, and a short one

PRINT • WRITE BY HAND • KEEP

Purpose

Build a source-labelled page showing what each current medicine is intended to do, which phase that purpose belongs to, what you were actually told and what remains unknown.

You leave with up to three medicines, each with the job it is doing now, the phase that job belongs to, and what you still need somebody to confirm.

This page helps prepare a professional conversation. It does not identify an indication from a medicine name, reconcile medication, assess effectiveness, compare options or change treatment.

What this chapter is about

This chapter goes with video lesson 14. It is the working half. The video does the teaching; this page is where you do the work.

A medicine name tells you what you take. It does not tell you what it is for. That gap is what this page closes. A name identifies a product. A class describes a broad family. Neither one states the job your prescriber intends for that medicine, in your care, now.

Which matters because the same medicine does different jobs for different people. One person may be taking it for an episode happening now. Another carries the same medicine forward into recovery. A third takes it between episodes to reduce the chance of the next one. Same name, three different plans — and only one of them is yours.

Three phase labels, and three answers that are not failures. *Current episode*, sometimes called acute. *Continuation or recovery* — a bridge, with no universal number of weeks inside it. *Maintenance or longer term*, where the work happens between episodes and prevention is the work. Then: *more than one*; *treating something else as well*, because a medicine can be doing a job that has nothing to do with bipolar disorder; and *not known yet*. Forcing an unclear answer into a tidy box produces a tidy page and unreliable information.

Record where your understanding came from. What a professional told you, and what you inferred, are different things and they go in different places. Without that separation, a search result or a friend's experience quietly becomes part of your treatment record.

You do not need to copy doses or timing here. Those live in the verified record you already use. This page neither rewrites nor interprets them — and an exact name can stay *private, not recorded here* while you still write your question.

Key ideas

1. A medicine name is not a complete explanation of its job in your care.
2. Current episode, continuation/recovery and maintenance/longer term describe treatment intent, not instructions.
3. More than one and Not known yet are valid phase answers.
4. Record the source of your understanding. Keep your own inference separate from what a professional or a verified plan actually said.

Watch the video first

The video holds three things this page leaves out.

- The work-order image, which is the fastest way to see why a tool name is not an instruction.
- What each medicine family is broadly for — carried over from the earlier medication lesson, and the reason the word on your label stops being frightening.
- Why not known yet is better data than a confident guess, argued rather than asserted.

Watch it before you fill in a row. The video lesson is *I Feel Fine. Why Am I Still on Bipolar Medication?* — lesson 14 of the Bipolar Stability Program.

Before you begin

If you may be in immediate danger, contact your local emergency services now. For crisis resources in your country, visit bipolarclarity.com/gethelp, or see the country-by-country crisis annex at the back of this workbook.

The Program will never tell you to start, stop, taper, restart, select, or change a medication.

Your workbook answers are not submitted, uploaded, collected, or monitored by Bipolar Clarity.

Use a current source when possible: a medication label, pharmacy list, recent clinic summary or list already checked with your care team. If sources disagree, write **sources differ** and take both to a pharmacist or clinician. Do not resolve the discrepancy here.

Answers you can always use:

- Not known yet
- Prefer not to answer
- Nothing to record here
- Private — not recorded here

- I prefer to bring this to a professional conversation

These are valid responses, not errors.

Where this chapter's claims come from. The clinical statements in this lesson are sourced, and the sources are public: bipolarclarity.com/program/sources, under lesson 14. A source shows what published guidance says. It does not show what applies to you, and it never overrules the clinician who knows your case.

Core route

Complete row 1. Rows 2 and 3 are optional. One honest row is enough.

Phase choices

These labels organize information. They do not determine duration, dose, effectiveness or when treatment should change.

Medication row 1 — core

VERIFIED NAME AND SOURCE

Write the exact name only from a current source. Add the source and, if useful, the date checked. You may keep the name private.

PURPOSE AS CURRENTLY UNDERSTOOD

Complete: **As I currently understand it, this medicine is intended to...**

If this is your inference rather than something you were told, label it **my current guess — not confirmed**.

MEDICATION 1 — PURPOSE

PHASE

Choose one phase option above.

- ☐ current episode / acute
- ☐ continuation / recovery
- ☐ maintenance / longer term
- ☐ more than one
- ☐ treating something else as well
- ☐ Not known yet
- ☐ Prefer not to answer

WHAT I WAS TOLD / WHAT REMAINS UNKNOWN

Write two concise clauses:

TOLD:

STILL UNKNOWN:

MEDICATION 1 – TOLD AND UNKNOWN

Medication row 2 — optional

VERIFIED NAME AND SOURCE.

PURPOSE AS CURRENTLY UNDERSTOOD.

PHASE.

- ☐ current episode / acute
- ☐ continuation / recovery
- ☐ maintenance / longer term
- ☐ more than one
- ☐ treating something else as well
- ☐ Not known yet
- ☐ Prefer not to answer

TOLD: / STILL UNKNOWN:.

.....

.....

Medication row 3 — optional

VERIFIED NAME AND SOURCE.

.....

.....

PURPOSE AS CURRENTLY UNDERSTOOD.

.....

.....

PHASE.

- | | |
|--|--|
| ☐ current episode / acute | ☐ continuation / recovery |
| ☐ maintenance / longer term | ☐ more than one |
| ☐ treating something else as well | ☐ Not known yet |
| ☐ Prefer not to answer | |

TOLD: / STILL UNKNOWN:.

.....

.....

Optional professional question

This page does not require a professional question. If one would help, write it here:

Could we review what this medicine is intended to do now, what its longer-term job is, and when that purpose will be reviewed?

.....

You may transfer this one line to the **WHAT I ASK** zone of the retained Appointment Agenda Card (lesson 13, page 154).

How this page stands

Choose exactly one: **Ready to use**, **Waiting for information**, or **Keeping this private**.

Mark **Ready to use** only when at least one row-1 core field that does not depend on an external response is written. Other answers may still be unknown.

Choose **Waiting for information** when the next usable step depends on a medication source or professional response. Choose **Keeping this private** when you intentionally retain the content elsewhere.

☐ Ready to use

☐ Waiting for information

☐ Keeping this private

Low-energy route

Copy exactly two lines. That is the whole route.

1. This medicine's job, as I currently understand it, is: [write here]
2. What I need confirmed about its purpose or phase is: [write here]

LOW-ENERGY ROUTE: THIS MEDICINE'S JOB

LOW-ENERGY ROUTE: WHAT I NEED CONFIRMED

14

These two lines are a complete route. You may stop here.

Worked fictional example

Jon is a fictional composite. He copies a medicine name from a current pharmacy list but keeps the name private in this workbook.

- **Medication 1** — verified name and source: **Private** — not recorded here; current pharmacy list checked this week.
- **Medication 1** — purpose: As I currently understand it, this is intended to reduce the chance of another elevated episode.
- **Medication 1** — phase: maintenance / longer term
- **TOLD:** The prescriber described a preventive role after the recent episode.
- **STILL UNKNOWN:** Whether it also has a job during low mood and when its purpose will be reviewed.

- **Optional professional question: Could we review what this medicine is intended to do now, what its longer-term job is, and when that purpose will be reviewed?**
- **How this page stands: Ready to use**

Jon has not decided whether the medicine works, chosen a treatment or created a stopping date. He has separated verified source, intended purpose, phase and uncertainty.

Before you close this page

Optional and private.

WHAT BECAME CLEARER ABOUT PURPOSE?

WHICH PHASE LABEL HELPED MOST?

- | | |
|--|--|
| ☐ current episode / acute | ☐ continuation / recovery |
| ☐ maintenance / longer term | ☐ more than one |
| ☐ Not known yet | |

WHAT NEEDS PROFESSIONAL CONFIRMATION NEXT?

14

Where this page goes

Place this page in **Section 5 – My treatment**.

This v2 page supersedes the Medication Questions Page (lesson 5, page **49**) only for the retained purpose/phase summary and its related questions. Do not destroy or rewrite:

- the verified medication list and directions used by you and your care team;
- source documents still needed for reconciliation;
- private detail stored more safely elsewhere.

Transfer one concise professional question to the Appointment Agenda Card if useful. The Side-Effect & Monitoring Sheet (lesson 15, page **174**) will add a separate side-effect and monitoring page; it will not replace this purpose/phase page.

Privacy and safety

- Your workbook answers are not submitted, uploaded, collected, or monitored by Bipolar Clarity.

- The Program will never tell you to start, stop, taper, restart, select, or change a medication.
- Do not use a medicine name, class, online search or another person's experience to assign your individual purpose.
- Keep prescription images, account details, access codes and unnecessary identifiers off the page.
- **Not known yet, Prefer not to answer, Nothing to record here, Private — not recorded here and I prefer to bring this to a professional conversation** are valid.
- Workbook completion never takes priority over professional, urgent or emergency help.
- The written emergency route appears in **Before you begin**; use it whenever immediate danger may apply.

Help where you live

Crisis numbers for your country are at the back of this workbook, on page **287**.

Watch this lesson
bipolarclarity.com/program/l15



BIPOLAR STABILITY PROGRAM

15

Bipolar Side Effects: What to Track and When to Call

Describe one possible medication-related problem without claiming causality, choose a route to communicate it, and record a monitoring check only when a clinician has confirmed it for you.

Two routes: the full one, and a short one

PRINT • WRITE BY HAND • KEEP

Purpose

Describe one possible medication-related problem without claiming causality, choose a route to communicate it, and record a monitoring check only when a clinician has confirmed it for you.

You leave with one observation a clinician can act on, the route you will use to report it, and one question worth asking.

What this chapter is about

This chapter goes with video lesson 15. It is the working half. The reasoning, the examples and the reason any of it matters are in the video, and this page assumes you have watched it — or that you are about to. What is printed here is what you need in front of you while you write, and what you will want to find again in six months without watching anything.

The problem is small and it costs a lot. You notice something — unsteady hands, two missed alarms, a dry mouth all day — and you write *felt strange*, or you write nothing. Weeks later, in an appointment with fifteen minutes in it, you try to reconstruct what happened. The clinician can only work with what reaches them, and *felt strange* does not reach anybody.

So this page keeps three things apart. What you noticed. What else was going on at the same time. Where the information should go. The moment you decide the cause, you stop recording the evidence — which is why the order matters. *My hands shook while I held a mug* travels into a clinic; *bad reaction* does not.

Impact, not a score. A homemade one-to-ten rating means nothing outside your own head. What travels is what the problem costs you in an ordinary day: *I need the handrail on the stairs, I can't keep fluids down, the dry mouth is uncomfortable but I can eat and drink*. In the lesson, Clara works through why that last one still deserves a conversation.

Destinations, not severities. Track it for a planned review. Contact your care team promptly. Use urgent or emergency help now. And—the one worth knowing about—*route not known yet*, for when the honest answer is that you cannot tell which of the other three this is. Choosing a destination is easier than deciding how bad something is, and the red-flag pages that follow tell you where the urgent one starts.

A blood level, in one paragraph. A few of the medicines used in bipolar disorder are followed with a blood test that measures how much of the medicine is actually in your blood — not all of them, only a few. Where it applies, testing is usually anchored to starting the medicine and to any change in dose, then repeated on some rhythm once things are steady, because there is a range the level is meant to sit inside. **A level describes the day it was taken.** With some medicines a problem can

develop even when the last result looked fine, so an old test is not a reason to stay quiet about something happening now.

A calendar records a plan; it never invents one. If nobody has confirmed a check for you, the honest entry is *Waiting for information*. A blank due date is safer than a guessed one.

Key ideas

1. **An observation can support review;** it cannot prove what caused a change.
2. **Impact is more useful than a homemade severity score.**
3. **Tracking, contacting the care team and using urgent help are different destinations.**
4. **Physical red flags take priority** over finishing this page.
5. **Monitoring varies.** A blank date is safer than an invented schedule.

Watch the video first

Three things are only in the video, and this page does not repeat them.

- **Why a description beats a conclusion,** worked through on a real-sounding note rather than asserted. It is the difference between believing the rule and using it at eleven at night.
- **René's habit of reporting the good side effects too** — the changes that make him feel unusually well, sharp or productive go to the prescriber as fast as a rash. He explains why in his own words, and it is not modesty.
- **Where the four easy-to-miss changes come from** — emergent thoughts of self-harm, akathisia, a switch upward after a treatment change, and the lithium warning picture. The pages here list them so you can find them under pressure. The lesson explains why each one gets missed.

Watch it first if you can. The video lesson is *Bipolar Side Effects: What to Track and When to Call* — lesson 15 of the Bipolar Stability Program.

Before you begin

If you may be in immediate danger, contact your local emergency services now. For crisis resources in your country, visit bipolarclarity.com/gethelp, or see the country-by-country crisis annex at the back of this workbook.

The Program will never tell you to start, stop, taper, restart, select, or change a medication.

Physical red flags

Use emergency help now for trouble breathing; sudden swelling of the lips, mouth, tongue or throat; collapse, loss of consciousness, inability to wake; or a seizure that is new for you, lasts longer than usual, or is followed by another before you fully wake — whatever the suspected cause.

Use emergency or urgent care now for a rapidly spreading painful rash, blistering or peeling skin, or sores involving the mouth, eyes or genitals. Do not wait for a routine appointment. Fever with severe muscle stiffness and marked confusion is a medical emergency.

Changes in how you feel and think are reportable too

The list above is physical. This one is not, and it is the one people leave out — because it feels like the illness rather than the medicine, and because it is harder to say out loud.

New or worsening thoughts of ending your life or harming yourself. Some people have these when a medicine is started or a dose is increased. It is not common, and it does not mean you are getting worse as a person or that treatment has failed. **Tell the person who prescribes it straight away, whatever you think is causing it.** If you feel you might act on it at any point, use your local emergency number now. And this is not a reason to stop a medicine on your own overnight: that conversation can happen today, before anything changes.

A restlessness you cannot sit out. An urge to keep moving that is felt in the body, often in the legs — pacing, rocking, shifting, unable to stay in a chair — together with a feeling of unease you cannot settle. It usually begins within the first couple of weeks of starting an antipsychotic, or after a dose goes up, and rarely with antidepressants. It has a name, akathisia, and it is worth knowing that name for one reason: **it is easily mistaken for anxiety, for agitation, or for the illness getting worse,** and it can be very distressing while it is happening. Describe the body part, not just the mood: “*I can't keep my legs still*” travels better than “*I'm anxious*.” And worth knowing while it is happening: this is something a prescriber can usually do something about.

Sleep need dropping, thinking speeding up, or drive rising after a treatment change. Guidelines weigh this risk when they choose between treatments, so it is a recognized thing to report, not a complaint about your own willpower. Note when the change to your treatment happened and when you first noticed the shift. Recording the sequence is not the same as proving the cause, and your prescriber is the one who reads it.

None of this is a reason to change anything by yourself. It is a reason to make contact sooner than the next routine appointment.

(Sources: NHS, Antidepressants, reviewed 12 June 2025 — suicidal thoughts on starting or increasing, and not stopping suddenly. Patel J, Marwaha R, Akathisia, StatPearls, updated 24 July 2023 — onset within the first two weeks, and how easily it is mistaken for anxiety or for the illness. Yatham et al.,

CANMAT and ISBD guidelines, 2023 update – treatment-emergent affective switch as a factor weighed in treatment choice. Listed at bipolarclarity.com/program/sources under lesson 15.)

If you take lithium

Lithium is named here for one reason: its warning picture is easy to mistake for a stomach bug, and it can appear even when your last blood level was normal.

A word about tremor. A light tremor is common, and on its own it does not mean lithium toxicity. The one that matters here is **coarse** – big enough to see across a room, enough to spill a full cup or make handwriting change. If yours has always been fine and small, that is not this – but if it has changed from your usual, or got worse, tell your care team.

Get urgent advice the same day for a **coarse tremor of the hands or the lower jaw**, unsteady walking or clumsiness, slurred speech, blurred vision, ringing in the ears, marked drowsiness or muscle weakness, or **diarrhoea and vomiting that keep going**. Contact your care team sooner during illness with fever, in hot weather, or any time you are losing fluid or have changed how much salt you eat or drink.

Ask for a lithium level, not just an appointment. Toxicity can occur despite an apparently normal level, so a normal result from last month does not rule today out.

Two things worth knowing before you need them. **Anti-inflammatory painkillers can raise lithium** – that means ibuprofen and naproxen, sold under many brand names, the ones people buy without thinking for period pain, a headache or a bad back. The box will not say “anti-inflammatory”: ask the pharmacist which painkiller is right for you, and tell them you take lithium. Dehydration raises it too.

This page never tells you to change a dose. The decision about your lithium belongs to the person who prescribes it – but the call asking for a level is yours to make, and making it early is the whole point.

(Source: NHS Specialist Pharmacy Service, Lithium monitoring, reviewed 6 December 2024, drawing on NICE CG185, the BNF and the Maudsley Prescribing Guidelines. Listed at bipolarclarity.com/program/sources under lesson 15.)

This list is illustrative, not exhaustive. Follow the urgent instructions supplied with your medicine and by local healthcare professionals. If something feels life-threatening, rapidly worsens or makes you unable to stay safe, use the local emergency route. Do not wait to prove medication causality.

Your workbook answers are not submitted, uploaded, collected, or monitored by Bipolar Clarity.

Answers you can always use:

- **Not known yet**
- **Prefer not to answer**

- Nothing to record here
- Private — not recorded here
- I prefer to bring this to a professional conversation

Where this chapter's claims come from. The clinical statements in this lesson are sourced, and the sources are public: bipolarclarity.com/program/sources, under lesson 15. A source shows what published guidance says. It does not show what applies to you, and it never overrules the clinician who knows your case.

Core route

Part A — One observation

WHAT I OBSERVED

Describe a sensation, visible change, action, measurement already taken correctly, or functional effect. Avoid assigning cause.

WHEN AND PATTERN

When did you first notice it? Is it constant, occasional, improving, worsening or unclear?

SAME-TIME CONTEXT

Record relevant changes around the same time. Use **relationship not established** when needed.

IMPACT

What has become harder, unsafe, painful, embarrassing or impossible?

THE OTHER KIND OF CHANGE

A change that makes you feel unusually well, unusually sharp or unusually productive belongs on this sheet too, and it travels to the prescriber at the same speed as a rash. The effects that feel

excellent are the ones nobody thinks to mention, and they can carry as much information as the ones that hurt. Neither column is the important one.

Write it plainly, the same way: what you noticed, and what it reached. **Nothing to record here** is a complete answer.

CURRENT ROUTE

Use existing professional instructions, the medicine's official information and local services. This control does not compute urgency.

- | | |
|--|--|
| ☐ track for a planned review | ☐ contact my care team promptly |
| ☐ use urgent or emergency help | ☐ route not known yet |
| ☐ I prefer to bring this to a professional conversation | |

OPTIONAL PROFESSIONAL QUESTION

This page does not require a professional question. If one would help, write:

I noticed this change, this is when it began, and this is how it affects me. How soon should it be reviewed, and what should I do if it changes before then?

Part B — One professionally confirmed monitoring entry

CHECK AND REASON

Write the name your service used and why it is being checked, as explained to you.

CONFIRMED SOURCE

Who or what confirmed the plan: prescriber, pharmacist, primary-care clinician, specialist team, laboratory request or another verified source?

CONFIRMED DATE OR TRIGGER

Enter only the date, interval or clinical trigger you were actually given. Use **timing not confirmed** rather than guessing.

COMPLETION AND FOLLOW-UP

Was it completed? Who reviews the result, and how will you learn what happens next?

How this page stands

Choose exactly one: **Ready to use**, **Waiting for information**, or **Keeping this private**.

Mark **Ready to use** only when at least one independent observation field in Part A is written. Monitoring may still await confirmation. Choose **Waiting for information** when the next usable step depends on a source, route, test or professional response. Choose **Keeping this private** when you intentionally retain the detail elsewhere.

☐

Ready to use

☐

Waiting for information

☐

Keeping this private

Low-energy route

Copy exactly two lines. That is the whole route.

1. I noticed this change, starting around this time, and it affects me in this way: [write here]
2. The route or monitoring detail I need confirmed is: [write here]

LOW-ENERGY ROUTE: THE CHANGE I NOTICED**LOW-ENERGY ROUTE: THE DETAIL I NEED CONFIRMED**

These two lines are a complete route. You may stop here.

Worked fictional example

Hana is a fictional composite.

- **What I observed:** trembling when holding a mug and using a phone keyboard.
- **When and pattern:** began four days after a documented treatment change; appears most mornings; pattern still unclear.
- **Same-time context:** recent treatment change and two nights of poor sleep; relationship not established.
- **Impact:** spills hot drinks and types more slowly at work.
- **Current route:** contact my care team promptly.
- **Optional professional question:** How soon should this be reviewed, and what should I do if it changes before then?
- **Check and reason:** blood test named on the clinic request; reason not yet explained.
- **Confirmed source:** clinic request.
- **Confirmed date or trigger:** timing not confirmed.
- **Completion and follow-up:** ask who reviews the result and how Hana will receive advice.
- **How this page stands:** Ready to use.

The example records sequence and impact. It does not diagnose a side effect or suggest a medication change.

15

Before you close this page

Optional and private. Never submitted, uploaded, collected or monitored.

WHAT BECAME CLEARER ABOUT OBSERVATION VERSUS CAUSE?

WHICH ROUTE NEEDS CLARIFICATION?

WHAT MONITORING DETAIL IS STILL MISSING?

Where this page goes

Place this sheet beside the Medication Questions Page (lesson 5, page **49**) and its v2 (lesson 14, page **165**) in **Section 5 – My treatment**.

Transfer only:

- the concise observation and impact;
- the route or question you want available;
- professionally confirmed monitoring details.

The Medication Questions Page v2 remains the purpose/phase authority. This page adds effects and monitoring; it replaces neither the Medication Questions Page v2 nor the verified medication record. If an effect contributes to wanting to stop, carry that concern to the Stop-Decision Worksheet (lesson 16, page **184**) and a professional conversation — do not turn this sheet into a stopping plan.

Privacy and safety

- Your workbook answers are not submitted, uploaded, collected, or monitored by Bipolar Clarity.
- The Program will never tell you to start, stop, taper, restart, select, or change a medication.
- Observation does not establish causality.
- The route control does not assess urgency; existing instructions and local services govern.
- A monitoring calendar never invents a test, interval, target or date.
- Keep prescription images, account details, access codes and unnecessary identifiers off the page.
- Workbook completion never takes priority over urgent or emergency help.

Help where you live

Crisis numbers for your country are at the back of this workbook, on page **287**.

Watch this lesson
bipolarclarity.com/program/l16



BIPOLAR STABILITY PROGRAM

16

Thinking About Stopping Bipolar Medication? Start Here

Turn a wish to stop, reduce or skip medication into a clear conversation brief – without this page deciding anything for you.

16 • LESSON

Two routes: the full one, and a short one

PRINT • WRITE BY HAND • KEEP

Purpose

Turn a wish to stop, reduce or skip medication into a clear conversation brief — without this page deciding anything for you.

You leave with the reason you want change, what you still want treatment to protect, what you need to know first, and who you will ask.

What this chapter is about

This chapter goes with video lesson 16. It is the working half. The video does the teaching; this worksheet is where you do the work — and this is the chapter where the two halves matter most.

Wanting to stop is not a betrayal of anything. It is one of the most common experiences in bipolar treatment and one of the least often said out loud, usually because saying it sounds like an announcement. This page exists to turn it into a conversation instead of a decision made alone on a Tuesday.

Two chairs, and neither gets to be the whole decision. One holds what you want relief from — an effect, flatness, cost, burden, stigma, feeling well, feeling unheard. The other holds what you still want treatment to protect. Both can be entirely true at the same time, and a page that forces them into a single verdict is no use to anybody.

Stopping carries a real risk that your episodes come back. Health services say this directly, and so does the guidance clinicians work from: the conversation after an episode is meant to cover the risk of relapse if medication is reduced or stopped. **And feeling well is not evidence that the risk has gone** — feeling well is usually what puts the idea there in the first place, which is exactly why that is the moment it is easiest to underestimate.

The nuance is real, and it is not a retraction. What a change actually brings depends on the medicine and on your situation, and this chapter deliberately avoids the flat rule *never stop anything abruptly*, because that sentence collides with urgent instructions that apply to particular reactions. The useful question is narrower: what risks apply to **this** medicine, for me, now — and what would a clinician-led change and follow-up involve?

If something has already changed, say so. A missed dose, a reduction, a stop, a restart, a different time of day. Accuracy makes better advice possible; silence takes the facts off the table. There is no prize for a tidy timeline.

Key ideas

1. **Ambivalence is information.** You can record it without defending it or acting on it.
2. **A reason to want change and a reason to keep part of treatment can both be real.**
3. **Stopping and reduction risks vary** by medicine and by clinical context.
4. **A general lesson cannot supply a taper, a restart plan or a missed-dose instruction.**
5. **A change that has already happened can be disclosed without shame.** Accurate information makes individual advice safer.

Watch the video first

Three things are only in the video, and this is the chapter to watch rather than skim.

- **The risk of stopping, said plainly and more than once,** in a tone that is neither a warning finger nor a shrug.
- **Why a confident one-line rule about a missed dose can be dangerously wrong,** worked through instead of stated.
- **The question that most changes a stopping conversation,** held open until the end and then paid.

Watch it before you write anything here. The video lesson is *Thinking About Stopping Bipolar Medication? Start Here* — lesson 16 of the Bipolar Stability Program.

Before you begin

If you may be in immediate danger, contact your local emergency services now. For crisis resources in your country, visit bipolarclarity.com/gethelp, or see the country-by-country crisis annex at the back of this workbook.

The Program will never tell you to start, stop, taper, restart, select, or change a medication.

This page makes room for ambivalence. It does not give permission to change treatment or order you to continue it unchanged. The effects of stopping or reducing a medicine depend on the medicine and your clinical context; this worksheet cannot turn general information into a personal forecast or tapering plan.

If a dose has already been missed, delayed, reduced, stopped or changed, use the medicine-specific patient information and contact a pharmacist or your prescriber for individual advice, and if neither is reachable, the out-of-hours route your local health system uses when a clinic is closed. Do not double, skip, restart or change timing because of a rule from this workbook.

If you have severe or rapidly worsening symptoms, marked confusion, trouble staying awake, a seizure, trouble breathing or another possible emergency, use your local emergency service now. Workbook completion waits.

Your workbook answers are not submitted, uploaded, collected, or monitored by Bipolar Clarity.

Answers you can always use:

- **Not known yet**
- **Prefer not to answer**
- **Nothing to record here**
- **Private — not recorded here**
- **I prefer to bring this to a professional conversation**

Where this chapter's claims come from. The clinical statements in this lesson are sourced, and the sources are public: bipolarclarity.com/program/sources, under lesson 16. A source shows what published guidance says. It does not show what applies to you, and it never overrules the clinician who knows your case.

Core route

Two sentences, before anything else

The rest of this page is for you. These two are for saying out loud:

"I'm thinking about changing this because..."

"What I still want protected is..."

They work because they put both sides on the table at once, and because neither of them asks anyone's permission. You are reporting a position, not requesting one.

If you have already missed doses or changed something, the sentence is different and more urgent:

"I missed or changed this, at about this time, and I've noticed this since. I need medicine-specific advice about what to do now."

That one is not a confession. It is the sentence that gets you the right advice fastest.

What is making change feel important?

Use your own words. Possible domains include effects, burden, cost, access, identity, stigma, uncertainty, feeling well, feeling unheard or something else. You do not need to justify the reason.

WHY CHANGE FEELS IMPORTANT

What do I still want treatment to protect?

Record any benefit, function, stability, sleep, relationship, safety or future goal that still matters.

Nothing to record here is valid.

WHAT I STILL WANT PROTECTED

What have I already tried or discussed?

Record only what happened: a conversation, monitoring, timing adjustment made by a professional, support with routine, an agreed review or no prior attempt. Do not design a new medication change here.

WHAT I ALREADY TRIED OR DISCUSSED

Where does the situation stand now?

Tick everything that is true today. More than one can be:

- I am thinking about a future change
- a dose was missed or delayed
- I have already reduced, stopped, restarted or changed timing

Or, instead of the three above:

- **Not known yet**
- **Prefer not to answer**
- **I prefer to bring this to a professional conversation**

More than one can be true at once. You can be turning a future change over in your mind, have missed a dose on Tuesday, and have already shifted your timing last month. Ticking one does not cancel the others, and the second and third boxes are the ones that send you to the line below, so leaving either unticked to keep the page tidy is the one thing worth avoiding here.

This choice routes a conversation. It does not calculate risk or recommend an action.

WHERE THE SITUATION STANDS

☐ I am thinking about a future change

☐ a dose was missed or delayed

☐ I have already reduced, stopped, restarted or changed timing

☐ Not known yet

☐ Prefer not to answer

☐ I prefer to bring this to a professional conversation

What has already happened?

If a change has already occurred, record the medicine as named on the label, what changed, approximately when, and any symptoms or functional change you directly noticed. Leave this blank for a future-change conversation.

What do I need to know before a decision?

Write the missing medicine-specific information: possible consequences of a change, how a clinician-led plan would work, what to monitor, who to contact, or what alternatives could be discussed. Questions are enough; do not fill the gaps from memory or another person's experience.

WHAT I NEED TO KNOW

Who will I contact?

Name the prescriber, pharmacist, clinic or other local service you can actually reach, by name. Add the verified contact route if you have it. If access is the barrier, write that barrier plainly.

WHO I WILL CONTACT

What is my next conversation step?

Write a contact action such as sending a message, requesting an appointment or asking a pharmacist which medicine-specific source applies. Do not enter a stopping date, dose or taper.

NEXT CONVERSATION STEP

16

Optional professional question

This page does not require a professional question. If one would help, write it here:

Could we review what I want to change, what I still want treatment to protect, the medicine-specific risks, and what a clinician-led plan and follow-up would involve if we agree on a change?

How this page stands

Choose exactly one: **Ready to use**, **Waiting for information**, or **Keeping this private**.

Mark **Ready to use** only when you have written something in at least one of these three: why you want the change, what you want to protect, or what you have already tried or discussed. Choose

Waiting for information when the next usable step depends on medicine-specific advice, access or a professional response. Choose **Keeping this private** when you intentionally keep the detail elsewhere.

☐

Ready to use

☐

Waiting for information

☐

Keeping this private

Low-energy route

Copy exactly two lines. That is the whole route.

1. I want to discuss a medication change because: [write here]
2. Before I change anything, the person or service I will contact and the question I will ask are: [write here]

I WANT TO DISCUSS A CHANGE BECAUSE

CONTACT AND QUESTION

Those two lines are a complete route. You may stop here.

Worked fictional example

Tomas is a fictional composite.

- **Why change feels important:** morning heaviness is affecting the school run and the first two hours of work.
- **What I still want protected:** steadier sleep and fewer periods of escalating speed still matter.
- **What I already tried or discussed:** described the morning impact in the Side-Effect & Monitoring Sheet (lesson 15, page **174**); no medication change was agreed.
- **Where the situation stands:** thinking about a future change.
- **What has already happened:** blank.
- **What I need to know:** what options can be reviewed, what risks apply to this medicine, and what should be monitored if a change is agreed?
- **Who I will contact:** prescribing clinic through its verified patient portal.
- **Next conversation step:** request a medication review and attach the concise observation, without proposing a dose or schedule.

- **Optional professional question: Could we review what I want to change, what I still want treatment to protect, the medicine-specific risks, and what a clinician-led plan and follow-up would involve if we agree on a change?**
- **How this page stands: Ready to use.**

Tomas's page does not decide whether treatment changes. It makes the real trade-off visible to the person qualified to decide with Tomas.

Before you close this page

Optional and private. Never submitted, uploaded, collected or monitored.

WHICH REASON BECAME EASIER TO SAY PLAINLY?

WHAT STILL MATTERS ENOUGH TO PROTECT?

WHICH MEDICINE-SPECIFIC ANSWER IS STILL MISSING?

Where this page goes

Place this worksheet beside the Medication Questions Page (lesson 5, page **49**) and its v2 (lesson 14, page **165**) and the Side-Effect & Monitoring Sheet in **Section 5 – My treatment**.

Transfer only:

- the concise reason for wanting change;
- the benefit or value you still want protected;
- the missing information and verified contact route;
- the agreed plan only after it has been confirmed by the prescriber or clinician who agreed it.

The Stop-Decision Worksheet replaces neither the Medication Questions Page v2 nor the Side-Effect & Monitoring Sheet. It does not become the warning ladder in the Full Early-Warning Ladder (lesson 19, page **214**) or the crisis-plan draft in the Crisis-Response Draft (lesson 20, page **223**). A blank change date is safer than a date invented without professional agreement.

Privacy and safety

- Your workbook answers are not submitted, uploaded, collected, or monitored by Bipolar Clarity.

- The Program will never tell you to start, stop, taper, restart, select, or change a medication.
- This page does not give permission to change treatment or order you to continue it unchanged.
- No workbook answer produces a dose, taper, restart instruction, missed-dose instruction or stopping date.
- Medicine-specific patient information and qualified local professionals govern.
- Record a change that has already happened accurately and without shame; prompt individual advice is more useful than hiding it.
- Keep prescription images, account details, access codes and unnecessary identifiers off the page.
- Workbook completion never takes priority over urgent or emergency help.

Help where you live

Crisis numbers for your country are at the back of this workbook, on page **287**.

Watch this lesson
bipolarclarity.com/program/117



BIPOLAR STABILITY PROGRAM

17

Bipolar Disorder and Pregnancy: Questions to Ask Early

Prepare the questions, the roles and the urgent routes for contraception, pregnancy, postpartum, feeding and genetics – before time pressure decides what gets discussed.

Two routes: the full one, and a short one

PRINT • WRITE BY HAND • KEEP

Purpose

Prepare the questions, the roles and the urgent routes for contraception, pregnancy, postpartum, feeding and genetics — before time pressure decides what gets discussed.

You leave with the questions that apply to you, the person who owns each answer, and a postpartum route that exists before the birth.

What this chapter is about

This chapter goes with video lesson 17. It is the working half. The video does the teaching; this question set is where you do the work — and it is designed to be filled in long before anybody needs it.

Send the questions ahead of you. Reproductive care gets decided under time pressure more often than almost anything else in bipolar treatment, and time pressure narrows what gets discussed. Preparing early is not planning a pregnancy. It is refusing to have the conversation for the first time on the day it becomes urgent.

Fill in only the tabs that apply. Contraception, before pregnancy, during pregnancy, birth and postpartum, feeding and genetics. Your body, your treatment, your reproductive role and your choices decide which of those are yours. Blank tabs are correct answers, and one accurate question beats a page filled in to look complete.

Every interaction needs a subject and a direction. *These interact* is not usable. A hormonal method can change the effect of a medicine; a medicine can reduce the effectiveness of some hormonal methods. Those are two different sentences with two different answers, and they get reversed constantly — in memory, and in translation. Write which one affects which, for the exact medicine and the exact method.

Postpartum is its own phase, and it needs a route written before the birth. Who the contacts are. Who knows the plan and can notice sudden change without becoming a monitor. How protected sleep and practical night support will actually work. And the urgent route for sudden severe confusion, loss of contact with reality, or rapidly escalating symptoms after birth — because that is not a phase to start planning in.

Feeding is individualised care, never a moral test. And genetics informs a conversation without predicting a child: family history raises a question, and it does not calculate an outcome.

Key ideas

1. **Complete only the tabs that apply** to your body, treatment, reproductive role and choices.
2. **Every interaction needs an explicit subject and direction.**
3. **Pregnancy decisions weigh several things at once:** medicine-specific evidence, the value of treatment, and the risks of becoming unwell.
4. **Postpartum is a separate phase.** It needs its own people, sleep support and urgent route, written before the birth.
5. **Feeding is individualized care,** never a moral test.
6. **Bipolar genetics is complex;** family history informs a question, not a prediction.

Watch the video first

Two things belong to the video.

- **A real interaction, with its direction made explicit,** and what it costs when the direction gets remembered backwards — including how easily that looks like the condition returning.
- **Why the phase after birth is the one most often left out of the plan,** and what naming its route actually involves.

Watch it before you fill in a tab. The video lesson is *Bipolar Disorder and Pregnancy: Questions to Ask Early* — lesson 17 of the Bipolar Stability Program.

Before you begin

If you may be in immediate danger, contact your local emergency services now. For crisis resources in your country, visit bipolarclarity.com/gethelp, or see the country-by-country crisis annex at the back of this workbook.

The Program will never tell you to start, stop, taper, restart, select, or change a medication.

This question set never chooses contraception, pregnancy treatment, feeding or a medicine change. If pregnancy is possible, planned or confirmed, contact your prescriber and pregnancy-care team for medicine-specific advice; do not use this page as the basis for changing treatment.

Postpartum emergency route

Sudden severe confusion, loss of contact with reality, hallucinations, delusional beliefs, or rapidly escalating manic or psychotic symptoms after birth is a medical emergency. Contact local

emergency services or the urgent perinatal route now. Do not wait for a routine appointment or finish the workbook first.

Your workbook answers are not submitted, uploaded, collected, or monitored by Bipolar Clarity.

Answers you can always use:

- Not known yet
- Prefer not to answer
- Nothing to record here
- Private — not recorded here
- I prefer to bring this to a professional conversation

Where this chapter's claims come from. The clinical statements in this lesson are sourced, and the sources are public: bipolarclarity.com/program/sources, under lesson 17. A source shows what published guidance says. It does not show what applies to you, and it never overrules the clinician who knows your case.

Core route

Only the tabs that apply to you. Contraception, pregnancy, postpartum, feeding and genetics are separate questions, and most people need one or two of them. The rest can stay blank, and the page still counts as done. One accurate question is worth more here than a page filled out of duty.

My current reproductive context

CURRENT REPRODUCTIVE CONTEXT

- | | |
|--|--|
| ☐ pregnancy is possible for me | ☐ I am planning a pregnancy |
| ☐ I am currently pregnant | ☐ I am preparing for birth or postpartum |
| ☐ I am postpartum | ☐ I am considering or using contraception |
| ☐ I may contribute sperm to a pregnancy | ☐ feeding questions apply to me |
| ☐ genetics questions apply to me | ☐ Nothing to record here |
| ☐ Prefer not to answer | |

My time horizon

Record whether this is a question for now, before a future change, at a known pregnancy stage, before birth, after birth or with no date yet. A question can be useful long before a decision.

TIME HORIZON

Verified treatment source

Name the verified medicine list or professional record that should be reviewed. Do not reconstruct doses from memory or copy prescription images into this sheet.

Contraception and interaction question

Write both directions explicitly:

Can this exact contraceptive method change the exposure or effect of any medicine on my list?

Can any medicine on my list reduce the effectiveness of this exact contraceptive method?

Add: **Which current product information or specialist source confirms each answer?**

CONTRACEPTION INTERACTION QUESTIONS

Before and during pregnancy question

Write what you need reviewed: treatment benefits, medicine-specific pregnancy evidence, risks of becoming unwell, monitoring, physical-health needs, obstetric coordination, unplanned-pregnancy contact route or another concern.

PREGNANCY REVIEW QUESTION

Named care roles

Record who owns psychiatric prescribing, pregnancy care, primary care, pharmacy advice and infant/newborn questions. One professional may cover more than one role. Use **role not assigned yet** rather than guessing.

Who may be told, and how much

A partner, a family member or a friend may be part of this. That is your decision, and it is not all-or-nothing: someone can be included in one part and left out of another.

Name only the people you want included, and for each one write the role you want them to have and the limit you want respected. “Comes to the appointment, does not read this page” is a limit. “Can be called if I am admitted” is a limit. Somebody you leave off this page stays off it.

WHO MAY BE TOLD, AND ABOUT WHAT

WHAT STAYS PRIVATE, OR WITH ME

Nothing here is a legal document, and nobody is notified by your writing their name. If your situation involves risk at home, the crisis annex at the back of this workbook has a separate section for that.

Postpartum urgent route

Write the verified urgent perinatal or emergency route, who has a copy, and where it will be accessible after birth. This field stores a route; it does not diagnose symptoms.

Postpartum sleep and practical support question

Ask how protected sleep, night support, feeding logistics and early professional follow-up will be planned without placing an open-ended monitoring duty on one supporter.

Feeding question

Ask which options fit the exact medicine, the infant's health, your mental and physical health, sleep needs, monitoring and available specialist support. Keep every feeding option free of moral ranking.

Genetics question

Write what you want explained about family history, complex genetic contribution, limits of prediction and whether genetic counseling is available or useful. Do not request a percentage from this workbook.

Optional professional question

This page does not require a professional question. If one would help, write it here:

Could we review which reproductive-health questions apply to my current treatment, who owns each answer, and what plan should already be in place for pregnancy, birth, postpartum, feeding, and urgent change?

How this page stands

Choose exactly one: **Ready to use**, **Waiting for information**, or **Keeping this private**.

Mark **Ready to use** only when at least one independent question or named route is written. Choose **Waiting for information** when the next usable step depends on a professional answer, assigned role or verified route. Choose **Keeping this private** when you intentionally keep the detail elsewhere.

☐ Ready to use ☐ Waiting for information ☐ Keeping this private

Low-energy route

Copy exactly two lines. That is the whole route.

1. The reproductive-health question I need answered before time pressure is: [write here]
2. The professional or service I will ask — and the postpartum urgent route if pregnancy applies — is: [write here]

QUESTION BEFORE TIME PRESSURE

PROFESSIONAL AND ROUTE

Those two lines are a complete route. You may stop here.

Worked fictional example

Sofia is a fictional composite.

- **Current reproductive context:** considering contraception now and a possible pregnancy later.
- **Time horizon:** contraception review this month; pregnancy has no date.
- **Verified treatment source:** verified list in the prescribing clinic portal.

- **Contraception interaction questions:** Can this method change any medicine exposure, and can any medicine reduce this method's effectiveness? Which source confirms each direction?
- **Pregnancy review question:** benefits of current treatment, medicine-specific evidence, monitoring and what to do after an unplanned positive test.
- **Named care roles:** prescriber named; pregnancy-care and perinatal roles await assignment.
- **Postpartum urgent route:** awaiting local perinatal-service information.
- **Postpartum sleep and practical support question:** ask who plans protected sleep, early follow-up and practical night support before birth.
- **Feeding question:** ask for a medicine-, infant- and sleep-specific review without ranking feeding choices.
- **Genetics question:** ask what complex inheritance means and what cannot be predicted for one child.
- **How this page stands:** Ready to use.

Sofia's page prepares coordinated questions. It makes no contraceptive, pregnancy, medication or feeding decision.

Before you close this page

Optional and private. Never submitted, uploaded, collected or monitored.

WHICH PHASE HAD BEEN MISSING FROM MY QUESTIONS?

WHICH CARE ROLE STILL NEEDS AN OWNER?

Which answer depends on a verified medicine-specific source?

Where this page goes

Place this Question Set beside the Medication Questions Page (lesson 5, page **49**) and its v2 (lesson 14, page **165**), the Side-Effect & Monitoring Sheet (lesson 15, page **174**) and the Stop-Decision Worksheet (lesson 16, page **184**) in **Section 5 – My treatment**.

Transfer only:

- the questions that apply now;
- named professional roles and verified contact routes;

- the postpartum urgent route and support questions if pregnancy applies;
- agreed answers with their source and review date.

This page replaces none of the earlier pages. It closes the reproductive-health branch. The Full Early-Warning Ladder (lesson 19, page **214**) will build the general warning ladder and the Crisis-Response Draft (lesson 20, page **223**) the crisis-plan draft; this worksheet carries only the reproductive/postpartum questions and urgent route.

Privacy and safety

- Your workbook answers are not submitted, uploaded, collected, or monitored by Bipolar Clarity.
- The Program will never tell you to start, stop, taper, restart, select, or change a medication.
- The workbook never selects contraception, pregnancy treatment, feeding or genetic testing.
- Every interaction record must name the subject, effect direction, exact method/medicine and source.
- Country-specific regulatory requirements need current local verification.
- Sudden severe confusion, loss of contact with reality or rapidly escalating manic/psychotic symptoms after birth uses the emergency route now.
- Feeding options remain equal in dignity and are reviewed against medicine-, infant- and health-specific evidence.
- Keep prescription images, genetic reports, account details, access codes and unnecessary identifiers off the page.
- Workbook completion never takes priority over urgent or emergency help.

Help where you live

Crisis numbers for your country are at the back of this workbook, on page **287**.

Watch this lesson
bipolarclarity.com/program/118



BIPOLAR STABILITY PROGRAM

18

Does Therapy Help Bipolar Disorder? What the Evidence Says

Sort one psychotherapy, psychosocial or complementary option by the evidence that actually applies to it, then prepare the questions about target, fit, safety, coordination and review.

Two routes: the full one, and a short one

PRINT • WRITE BY HAND • KEEP

Purpose

Sort one psychotherapy, psychosocial or complementary option by the evidence that actually applies to it, then prepare the questions about target, fit, safety, coordination and review.

You leave with one candidate described precisely enough to discuss, its evidence lane, and the questions that decide whether it fits you.

What this chapter is about

This chapter goes with video lesson 18. It is the working half. The video does the teaching; this sheet is where you do the work.

A therapy name is a container, and the evidence is not inside the name. Two things called the same thing can differ in what they target, how long they run, who delivers them and what they were tested on. So the question is never *is this therapy good* — it is *what exactly is this, for what, delivered by whom*.

Psychotherapy in bipolar disorder is adjunctive. The approaches supported by guidelines sit alongside pharmacological care rather than instead of it, and a page that blurs that is doing harm dressed as open-mindedness.

Four lanes, and no podium. Bipolar-specific evidence. Evidence for a defined problem — sleep, anxiety, a relationship. General wellbeing. And the lane with no evidence behind it at all. Something can sit honestly in the second lane and be worth doing, and still not be evidence of relapse prevention. Keeping the lanes apart is the whole exercise.

Complementary and natural are relationship and marketing words. They describe how something sits beside conventional care, or how it is sold. Neither is a safety rating, and neither tells you about interactions.

Name the product, the device or the practitioner precisely. Anything unnamed cannot be checked by anybody, including your prescriber.

And red flags belong to claims, not to disciplines. Promises of a cure, pressure to stop existing treatment, secrecy about ingredients, urgency about payment — those are properties of a claim, and they appear inside conventional and unconventional settings alike.

Key ideas

1. **A therapy name is a container.** The evidence belongs to the exact intervention and context.

2. **Guideline-supported bipolar psychotherapies are adjunctive** to pharmacological care.
3. **No single approach is best** for every person, target, phase or access need.
4. **Evidence for a defined problem does not prove bipolar relapse prevention.**
5. **“Complementary” and “natural” are relationship or marketing words**, not safety ratings.
6. **One accurately described candidate is a complete route.**

Watch the video first

The video does two things a sorting sheet cannot.

- **Two things with the same name, placed at different addresses**, so the container problem stops being abstract.
- **The open question about what evidence for one problem does and does not prove**, paid at the end rather than assumed at the start.

Watch it before you sort anything. The video lesson is *Does Therapy Help Bipolar Disorder? What the Evidence Says* — lesson 18 of the Bipolar Stability Program.

Before you begin

If you may be in immediate danger, contact your local emergency services now. For crisis resources in your country, visit bipolarclarity.com/gethelp, or see the country-by-country crisis annex at the back of this workbook.

The Program will never tell you to start, stop, taper, restart, select, or change a medication.

This sheet sorts evidence and prepares questions. It never selects a therapy, complementary approach, supplement, device or medication change. **Nothing on this sheet is a reason to change established treatment**, and any proposed change belongs with the professionals who review it.

If severe activation, psychosis, major loss of functioning or immediate danger is present, use any route you have already agreed, the care contact you have already named, or your local emergency services, instead of waiting for a routine therapy session or completing this page.

Your workbook answers are not submitted, uploaded, collected, or monitored by Bipolar Clarity.

Answers you can always use:

- **Not known yet**
- **Prefer not to answer**
- **Nothing to record here**
- **Private — not recorded here**

- I prefer to bring this to a professional conversation

Where this chapter's claims come from. The clinical statements in this lesson are sourced, and the sources are public: bipolarclarity.com/program/sources, under lesson 18. A source shows what published guidance says. It does not show what applies to you, and it never overrules the clinician who knows your case.

Core route

Candidate option or question

Name one exact approach, program, practice, product, device or question. Avoid broad labels when a more precise description is available.

My target

Write what you want help with in ordinary language: recurrence prevention, depressive symptoms, routines, family communication, trauma symptoms, insomnia, anxiety, grief, substance use, functioning, stress, general wellbeing or another target.

When to use the fourth lane

Some claims tell you to pause before you decide anything. Listen and look for: **cures bipolar · works for everyone · replace your medication · detoxes psychiatric treatment · guaranteed · claims that your care team is hiding something from you.**

Testimonials, professional-looking graphics and scientific vocabulary are not evidence. If the method or the source is missing, it is still missing.

A red flag does not prove the whole thing is a fraud. It tells you three things: pause the decision, **change nothing on the strength of the claim**, and verify it with a qualified professional or a reliable source.

Four checks do most of the work. Does the study cited match the thing being sold? Did it include people with bipolar disorder? What did it measure — symptoms, recurrence, functioning, sleep, stress, something else? And was it tested **alongside** usual treatment or **instead of it**?

Then the cost of being wrong: money, privacy, sleep, delayed care, interaction risk, or pressure to cut off your treatment team.

Provisional evidence lane

The lane organizes the question. It does not rank people, guarantee benefit or select treatment.

- | | |
|--|--|
| ☐ bipolar-specific guideline-supported adjunctive psychotherapy | ☐ targeted psychological or psychosocial help |
| ☐ wellbeing or complementary support | ☐ unclear evidence or claim to verify |
| ☐ Waiting for information | ☐ Nothing to record here |
| ☐ Prefer not to answer | |

Evidence address

Record what is known about the exact intervention, target, population, phase, format, outcome, source and date. Use **Waiting for information** for any part that still needs verification.

What happened for me

The evidence answers what happened for people in a study. This line answers what happened for you, and the two are not the same question — which is exactly why they get separate lines.

Comfort, enjoyment, pain, fatigue, sensory effects, sleep, whether it fits your body, whether you looked forward to it or dreaded it. **Nothing yet — I have not tried it** is a complete answer.

Your experience does not overrule the evidence, and the evidence does not overrule your experience. One tells you what tends to happen; the other tells you what happened in your life. A professional needs both.

.....

.....

.....

What it sits alongside

Record the existing treatment, service or self-management work this option would complement. If a claim says it replaces medication or professional care, place that claim in the verify-or-pause lane.

.....

.....

.....

Provider or reviewer

Name the therapist, program, prescriber, pharmacist, primary-care professional or other qualified reviewer who can answer the evidence and safety questions. Record relevant bipolar experience or credentials only when verified.

.....

.....

.....

Fit and access

Record the format, language, disability access, sensory load, travel, schedule, cost, privacy and family-boundary factors that determine whether the option is workable for you.

.....

.....

.....

.....

.....

Coordination and safety question

Ask how the provider coordinates with existing care; what happens if sleep reduces, activation rises, psychosis appears or functioning changes sharply; and who reviews supplements, products or devices for interactions and physical-health limits.

COORDINATION AND SAFETY

Progress and review

Write the outcome you would review, how it could be observed without constant surveillance, who reviews it and when the plan will be reconsidered. Progress can include skills, symptoms, recurrence, functioning, sleep, relationships, access burden or another agreed target.

Optional professional question

This page does not require a professional question. If one would help, use:

Could we review whether this exact non-medication approach fits my target and current phase, what evidence applies, what it adds to my treatment, and how we will review benefit, burden, and safety?

How this page stands

Choose exactly one: **Ready to use**, **Waiting for information**, or **Keeping this private**.

Mark **Ready to use** only when one candidate or question, one target and one verification or review route are recorded. Choose **Waiting for information** when evidence, provider, access, coordination or safety information still lives outside the page. Choose **Keeping this private** when you intentionally keep the detail elsewhere.

☐

Ready to use

☐

Waiting for information

☐

Keeping this private

Low-energy route

Copy exactly two lines. That is the whole route.

1. The non-medication option or question I want to understand is: [write here]
2. I want it for this target — and I will verify its evidence, fit, and safety with: [write here]

OPTION OR QUESTION

TARGET AND VERIFICATION ROUTE

Those two lines are a complete route. You may stop here.

Worked fictional example

Ayesha is a fictional composite.

- **Candidate option or question:** a remote group described as CBT for bipolar disorder.
- **My target:** recognize early depressive changes and protect daily functioning.
- **Provisional evidence lane:** Waiting for information.
- **Evidence address:** CBT label known; bipolar adaptation, manual, phase, group format and reviewed outcome still need confirmation.
- **What it sits alongside:** current psychiatric treatment and the existing Stability Plan.
- **Provider or reviewer:** program coordinator for protocol details; prescriber for coordination.
- **Fit and access:** remote format and evening schedule fit; captioning and cost await confirmation.
- **Coordination and safety:** ask how the group responds to reduced sleep, activation or urgent change and how information reaches the prescriber.
- **Progress and review:** review practical use of early-change skills and daily functioning after an agreed period.
- **How this page stands:** Ready to use.

Ayesha's page makes no therapy decision. It turns a broad label into questions that can be answered.

Before you close this page

Optional and private. Never submitted, uploaded, collected or monitored.

WHICH MISSING DETAIL CHANGED THE EVIDENCE LANE?

Which outcome belongs to the exact target rather than bipolar disorder generally?

Which fit or safety question should reach the Appointment Agenda Card (lesson 13, page 154)?

Where this page goes

Place this sheet in **Section 5 – My treatment**, beside the Appointment Agenda Card and the other treatment pages.

Transfer only:

- one candidate or question and its target;
- the provisional evidence lane and source gap;
- the named provider or reviewer;
- fit, access, coordination and safety questions;
- the agreed outcome and review point.

This sheet completes the **Treatment-Ready Stability Plan**. It replaces none of the earlier treatment pages. The Full Early-Warning Ladder (lesson 19, page **214**) will build the full warning ladder; the Crisis-Response Draft (lesson 20, page **223**) will build the crisis-response draft; the Rhythm & Problem-Solving Sheet (lesson 22, page **243**) will build the sustainable rhythm system; the Functioning & Rebuild Plan (lesson 23, page **252**) will address functioning and recovery.

Privacy and safety

- Your workbook answers are not submitted, uploaded, collected, or monitored by Bipolar Clarity.
- The Program will never tell you to start, stop, taper, restart, select, or change a medication.
- Guideline-supported psychotherapy remains adjunctive where the source describes it that way.
- A therapy name alone never proves that a protocol, target, population, phase or format matches the evidence.

- Family involvement requires consent and a bounded role; it never authorizes surveillance or control.
- Put every supplement, herb, non-prescription product and light-based device on the verified list taken to the prescriber or pharmacist.
- This workbook provides no supplement dose, light schedule, device setting, exercise prescription or treatment ranking.
- Severe activation, psychosis, major loss of functioning or immediate danger takes priority over workbook completion.
- Keep health records, account details, access codes, payment data and unnecessary identifiers off the page.

Help where you live

Crisis numbers for your country are at the back of this workbook, on page **287**.

Watch this lesson
bipolarclarity.com/program/l19



BIPOLAR STABILITY PROGRAM

19

Bipolar Warning Signs: Subtle, Clear, and Urgent

One personal ladder: separate upward and downward rows, three response levels, and an action and a contact attached to every observation you choose to keep.

Two routes: the full one, and a short one

PRINT • WRITE BY HAND • KEEP

Purpose

One personal ladder: separate upward and downward rows, three response levels, and an action and a contact attached to every observation you choose to keep.

You leave with one ladder — upward and downward rows, three response levels, an action and a contact on every rung you keep — and it replaces every earlier warning-sign page you have made.

What this chapter is about

This chapter goes with video lesson 19. It is the working half. The video does the teaching; this ladder is where you do the work — and it replaces every earlier warning-sign page you have made.

A list says what you noticed. A ladder says what to do about it. That is the difference this chapter turns on. Six cells: upward and downward, each at subtle, clear and urgent. And on every rung you keep, an action and a contact — because six beautifully labelled boxes with no number attached still leave you alone with a judgement call.

Subtle, clear and urgent are responses, not scores. They are not three grades of how unwell you are. They mark how quickly the route starts.

Not every change you have noticed earns a rung, and choosing between them is most of the work. A change belongs here when it has come before every episode of that kind rather than one, when somebody else could have seen it, when it can be raised without starting the argument you were trying to head off, and when you know roughly how far ahead it arrives.

Then push it earlier. Behind the change you notice first there is usually another one. The first thing you notice is rarely the first thing that happened, and the earliest one you can honestly describe is the one that buys you time.

Keep the two directions separate, and never average them. If upward and downward changes arrive together, the highest applicable agreed route wins. A subtle observation cannot cancel a clear one, and a downward label cannot make dangerous activation less urgent.

A supporter contributes behavior, with consent and a boundary. *You sent twelve project messages overnight* is observable. *You're obviously manic again* is a conclusion. The ladder defines what somebody may report, where, and what stays private — and it never authorizes surveillance.

And a false alarm adds information. So does a missed change. The ladder is a living agreement, not a frozen prediction, and editing it is using it correctly.

Key ideas

1. **This ladder organizes possible warning signs and routes.** It never diagnoses, confirms, predicts or rules out an episode.
2. **No single sign, count, score or duration puts everyone on the same rung.**
3. **A rung depends on change from your own baseline,** the pattern around it, impact, certainty, history and your agreed route.
4. **A change earns a rung when it has come before every episode of that kind, when somebody else could have seen it, when it can be said out loud without starting a row, and when you know roughly how far ahead it arrives.**
5. **Keep upward and downward rows separate.** If changes combine, use the highest applicable agreed route rather than averaging the concern away.
6. **Every action records an existing agreement** or a question for your care team.
7. **After transfer, this becomes your only active warning-sign page.**

Watch the video first

Three things stay off this page on purpose, and live in the video.

- **Why somebody else's identical wording lands on a different rung,** shown with two entries that read the same and mean different things.
- **René's twenty-five years read one moment at a time,** and why a ladder is how a run of years gets written down before anybody needs it.
- **The supporter boundary, drawn out loud** — what bounded support sounds like, and where it turns into a cage.

Watch it before you build yours. The video lesson is *Bipolar Warning Signs: Subtle, Clear, and Urgent* — lesson 19 of the Bipolar Stability Program.

Before you begin

If you may be in immediate danger, contact your local emergency services now. For crisis resources in your country, visit bipolarclarity.com/gethelp, or see the country-by-country crisis annex at the back of this workbook.

Immediate danger, suicidal intent, plan or imminent self-harm risk, intent to harm someone else, loss of contact with reality, severe confusion, inability to meet basic needs, or rapidly escalating dangerous behavior uses urgent clinical or emergency help now.

Your care plan may add personal urgent thresholds.

The Program will never tell you to start, stop, taper, restart, select, or change a medication.

Your workbook answers are not submitted, uploaded, collected, or monitored by Bipolar Clarity.

Answers you can always use:

- Not known yet
- Prefer not to answer
- Nothing to record here
- Private — not recorded here
- I prefer to bring this to a professional conversation

Where this chapter's claims come from. The clinical statements in this lesson are sourced, and the sources are public: bipolarclarity.com/program/sources, under lesson 19. A source shows what published guidance says. It does not show what applies to you, and it never overrules the clinician who knows your case.

Core route

Before you write anything: this page is a copy, not a fresh start.

Everything you need is already in three pages you have filled in — the early-change card from **lesson 4**, the elevated-state inventory from **lesson 8**, and the low-and-mixed inventory from **lesson 9**. Put those three in front of you and copy across: the observations you want to keep, the certainty you gave them, whether it was you or somebody else who noticed, and the point at which you would ask for help.

You are not being asked to remember any of it again. When this page is done, those three are archived and this is the one that stays live.

Not every change you have noticed earns a rung. You will arrive with more candidates than the ladder holds, and choosing between them is the work of this page. Hold each one up against these four questions before you write it down.

Has it come before every episode of that kind you can remember, or before just one? Something that happened once is a memory. Something that happened each time is a signal.

Could somebody else have seen it? *Eleven messages sent after midnight* is visible. A *vague sense of being off* is yours alone, and a supporter can only act on what reaches them.

Would raising it start the very argument you are trying to head off? Some observations are accurate and still unusable. If *you are spending too much* has always ended badly between you, that wording stays off the ladder; write instead the change you both saw.

How far ahead does it arrive — hours, days, or weeks? That answer is the difference between a warning and a commentary.

Then push it earlier. Whatever you have just written, ask what was going on the week before that. Behind *I started three projects* there is often a night somebody decided to skip, and behind that night, an afternoon when everybody else seemed to be talking slowly. The change you notice first is rarely the change that came first, and the earliest one you can honestly describe is the one that buys you time. That earlier one belongs on the subtle rung.

For each cell, write one observable change, its certainty (**known**, **possible**, or **uncertain**), how far ahead it tends to arrive, the existing agreed action or care-team question, and the contact or verified destination. Add baseline, source and date when useful.

Upward — subtle

An early, small, ambiguous or lightly supported upward change. Write how far ahead it tends to arrive, the action you have already agreed for it, and who you would contact.

Upward — clear

An upward pattern that reaches your agreed stronger or prompt-contact point. Write how far ahead it tends to arrive, the action you have already agreed for it, and who you would contact.

Upward — urgent

Your verified urgent destination and any clinician-defined personal threshold. Do not delay urgent help to complete this field.

Downward — subtle

An early, small, ambiguous or lightly supported downward change. Write how far ahead it tends to arrive, the action you have already agreed for it, and who you would contact.

Downward — clear

A downward pattern that reaches your agreed stronger or prompt-contact point. Write how far ahead it tends to arrive, the action you have already agreed for it, and who you would contact.

Downward — urgent

Your verified urgent destination and any clinician-defined personal threshold. Do not delay urgent help to complete this field.

Both, mixed or uncertain

Record which cells are active and the highest applicable agreed route. Keep the state descriptive; this field does not diagnose mixed features.

Supporter boundary

With consent, record what a named supporter may observe, what they may report, the destination, and what remains private. This never authorizes surveillance, control or diagnosis.

Review and provenance

Date the ladder. Record whether a revision came from your observation, a supporter, a care-team review or later experience.

Optional professional question

Could we review where these observations belong for me and agree one action and contact for each level?

How this page stands

Choose exactly one: **Ready to use**, **Waiting for information**, or **Keeping this private**.

Mark **Ready to use** only when at least one observation has an action and a contact, or a verified urgent route is recorded.

☐ Ready to use

☐ Waiting for information

☐ Keeping this private

Low-energy route

Copy exactly two lines:

1. The change I most want to place on my ladder is: [write here]

2. The action and contact I need agreed for that change are: [write here]

Those two lines are a complete route. You may stop here.

Worked fictional example

Ravi is a fictional composite. Ravi records an upward subtle observation: **starting several new projects after two shorter nights**; certainty: **possible**; lead time: **about a week, both times**; action: **use the existing sleep-protection agreement and note the pattern**; contact: **care-team portal if the agreed clear threshold appears**. The downward clear cell says **meals irregular, work messages unopened and two agreed commitments missed**; certainty: **known**; lead time: **two to three weeks**; action and contact: **use the existing prompt-contact agreement with the named clinician**.

Ravi also drops one candidate. **Feeling irritable** had seemed obvious, and it failed two of the four questions: nobody else could see it, and every past attempt to raise it turned into the argument. What went on the ladder instead was the behavior Ravi's partner had actually noticed — **answering in one word and leaving the room mid-conversation**. Same week, same pattern, and this one can be said out loud.

The example stays personal and descriptive; it predicts no episode.

Before you close this page

Optional and private. Never submitted, uploaded, collected or monitored.

What information made a rung personal rather than universal?

WHERE DID HONEST UNCERTAINTY IMPROVE THE PAGE?

Which action, contact or threshold still needs external agreement?

Where this page goes

Transfer selected observations, certainty tags, self/other viewpoints and help thresholds from the Starter Early-Change Card (lesson 4, page **40**), the Elevated-State Inventory (lesson 8, page **77**) and the Low & Mixed-State Inventory (lesson 9, page **89**). Date the transfer, archive those three earlier active formats, and place this ladder in **Section 2 – My signals**.

The Three-Period Life Chart (lesson 6, page **57**) and the Vulnerability & Protection Map (lesson 12, page **132**) remain active source pages. The crisis-response chapter creates the Crisis-Response Draft (lesson 20, page **223**); the first-72-hours chapter creates the First-72-Hours Action Draft (lesson 21, page **234**). They use this ladder but do not replace it.

Privacy and safety

- Urgent conditions use verified urgent clinical or emergency help now; workbook completion waits.
- The Program will never tell you to start, stop, taper, restart, select, or change a medication.
- Your workbook answers are not submitted, uploaded, collected, or monitored by Bipolar Clarity.
- Support involvement requires consent, concrete observations and a bounded role.
- Avoid passwords, access codes, unnecessary identifiers and continuous monitoring data.

Help where you live

Crisis numbers for your country are at the back of this workbook, on page **287**.

Watch this lesson
bipolarclarity.com/program/120



BIPOLAR STABILITY PROGRAM

20

How to Draft a Bipolar Crisis Plan—Before You Need It

Prepare one short, findable draft: verified urgent routes, the people to contact, the minimum somebody would need to know, your preferences, and how current all of it is.

Two routes: the full one, and a short one

PRINT • WRITE BY HAND • KEEP

Purpose

Prepare one short, findable draft: verified urgent routes, the people to contact, the minimum somebody would need to know, your preferences, and how current all of it is.

You leave with a draft somebody could actually use on a bad day, and the list of what still needs professional or local review.

What this chapter is about

This chapter goes with video lesson 20. It is the working half. The video does the teaching; this draft is where you do the work.

A filled-in page can still be unsafe, and that is the risk this chapter is built around. A crisis document that looks complete, sounds authoritative and contains a number nobody has checked is worse than a blank one, because somebody will trust it on the day they can least afford to.

Three documents look alike and are not. A clinician-authored safety or crisis plan. A legal or advance document, which follows the rules where you live. And this — a personal draft that prepares both conversations. If a clinical plan already exists, this page **links to it and never overwrites it**.

Anything that reads like an instruction carries four things: its source, its status, the date, and when it gets reviewed. An unlabelled instruction on a crisis page is the exact failure this chapter exists to prevent.

Build the front pocket first — the part somebody reaches for in thirty seconds. Verified urgent routes. Who to contact. The minimum somebody would actually need to know. Everything else can be further in.

One informed person, with a bounded role. Not the whole safety plan, and not somebody who has been volunteered without being asked. What they may do, what they may see, what stays private, and what happens if they are unreachable.

Preferences need honest labels. *Agreed with my team* is a different status from *what I would prefer* and from *not discussed yet*. Writing a preference down does not make it binding, and pretending otherwise is how a draft misleads.

And current danger bypasses this page entirely. Use your verified urgent route now. The draft waits.

Key ideas

1. **Current danger bypasses this page.** Use your verified urgent route now.
2. **This draft does not assess risk,** create a clinical safety plan, or carry automatic legal effect.
3. **Link to an existing clinician-authored plan.** Never overwrite it.
4. **Anything that reads like an instruction needs its source, status, date and review point.**
5. **A trusted person has a consented, bounded role** and is never the whole safety plan.
6. **Your earlier Safety Plan and Starting Point (lesson 1, page 11) stays active** until the fields here have been reviewed.

Watch the video first

The video carries three things this draft cannot.

- **A page that is completely filled in and still dangerous,** taken apart so the failure becomes obvious.
- **The three lookalike documents,** separated properly — which is the distinction that decides whether this draft helps or misleads.
- **How to ask one person to hold a bounded role,** including the sentence to use.

Watch it before you draft. The video lesson is *How to Draft a Bipolar Crisis Plan—Before You Need It* — lesson 20 of the Bipolar Stability Program.

Before you begin

If you may be in immediate danger, contact your local emergency services now. For crisis resources in your country, visit bipolarclarity.com/gethelp, or see the country-by-country crisis annex at the back of this workbook.

Immediate danger, suicidal intent, plan or imminent self-harm risk, intent to harm someone else, loss of contact with reality, severe confusion, inability to meet basic needs, or rapidly escalating dangerous behavior uses urgent clinical or emergency help now.

Your current care plan may name another urgent threshold. Use urgent or emergency help instead of completing this page.

This page is an educational crisis-response draft; it does not assess your risk, create a clinical safety plan, or give legal effect to your preferences.

The Program will never tell you to start, stop, taper, restart, select, or change a medication.

Your workbook answers are not submitted, uploaded, collected, or monitored by Bipolar Clarity.

Answers you can always use:

- Not known yet
- Prefer not to answer
- Nothing to record here
- Private — not recorded here
- I prefer to bring this to a professional conversation

Status vocabulary for instruction-like information: **PERSONAL DRAFT; DISCUSS WITH CLINICIAN; PRESCRIBER-CONFIRMED; LOCAL RESOURCE VERIFIED; LEGAL STATUS REQUIRES LOCAL REVIEW; OUT OF DATE; Waiting for information.**

Where this chapter's claims come from. The clinical statements in this lesson are sourced, and the sources are public: bipolarclarity.com/program/sources, under lesson 20. A source shows what published guidance says. It does not show what applies to you, and it never overrules the clinician who knows your case.

Core route

Current professional plan

If a clinician-authored crisis or safety plan exists, record its exact location, author or service, version/date, access route and review point. This worksheet never overwrites it.

Verified urgent routes

Record the locally verified emergency and crisis routes, their purpose, availability, jurisdiction, source and verification date. Do not delay urgent help to complete this field.

Professional and service contacts

Keep routine, urgent and emergency contacts distinct. For each route, record owner, purpose, hours or availability, confirmation date and review trigger.

One informed person

With consent, record one person's accepted role, contact route, what may be shared, ordinary privacy boundary, emergency boundary, backup route and their right to seek help for their own safety.

Minimum handoff

Prepare five short lines: what changed; current location; immediate safety concern; current service/clinician; and where authoritative clinical information is stored. Add language or accessibility needs when relevant.

Communication and approach preferences

Record how you prefer concern raised, what supports communication, what increases friction, who you prefer present, and which requests are strongly important, helpful when available or still questions. Label these PERSONAL DRAFT until reviewed.

Anchors and safer-environment reference

Record selected anchors and the location of any safer-environment steps already reviewed with a qualified professional. Do not list methods or invent operational steps. Use DISCUSS WITH CLINICIAN for missing guidance.

Current clinical-information location

Record where the current medication list, allergies, physical-health information, prescriber contact and monitoring instructions live. Medication and monitoring actions belong only in a current PRESCRIBER-CONFIRMED source with owner and date.

Advance preferences and status

Record a preference, who reviewed it, the reviewed scope, date and unresolved questions. Mark legal questions LEGAL STATUS REQUIRES LOCAL REVIEW. This field never creates a psychiatric advance directive.

Review, distribution and replacement

Record the reviewer for each domain, next date or trigger, who holds which section, how obsolete copies are identified, the Safety Plan and Starting Point (lesson 1, page 11) transfer status and any information still awaited.

Before you call this usable

Not whether the page looks finished. Whether it works. Try them now, while nothing is wrong:

- **Does the route open?** Follow it once, from the first line to the destination.
- **Does the contact still answer?** A number that rang out last year is not a route.
- **Is the source still current?** Look at the date you wrote beside it.
- **Is the reviewer named?** “My doctor” is not a name.
- **If you named someone, do they know where this page is?** If you have named nobody, that is a complete answer and this check is done.

Then the version where it goes wrong: your phone is locked, your battery is empty, your usual clinic is closed, you are away from home. Which one breaks your route first, and what is the smallest thing that would fix it? You will not solve all four, and you are not meant to. Seeing the weak link is the whole point.

Write what you found, and what you would change. A check that failed is the most useful line on this page.

How this page stands

Choose exactly one: **Ready to use**, **Waiting for information**, or **Keeping this private**.

Mark **Ready to use** only when at least one verified urgent route plus one usable contact or current professional-plan location is recorded. The label means the educational draft meets its floor. It never means clinically approved, legally valid or adequate for every crisis. Choose **Waiting for information** when an external route, contact, instruction, review or legal answer is missing. Choose **Keeping this private** when the relevant detail is intentionally stored elsewhere.

☐ Ready to use ☐ Waiting for information ☐ Keeping this private

Low-energy route

Copy exactly two lines:

1. My verified urgent or emergency route is stored here: [write here]

2. The person or professional I want to review this draft with is: [write here]

Those two lines are a complete draft route; they are not proof that the plan has been professionally reviewed. You may stop here.

Worked fictional example

Karim is a fictional composite.

- **Current professional plan:** clinician-authored plan stored in the patient portal; author and review date recorded.
- **Verified urgent routes:** localized workbook route marked **LOCAL RESOURCE VERIFIED**; local emergency route on the front page.
- **One informed person:** Karim's sister agreed to hold the front pocket and contact the named service; she will not inspect Karim's phone or monitor daily behavior.
- **Minimum handoff:** a concise current-change description, location, safety question, service name and portal location.
- **Communication preferences:** one question at a time and written follow-up when available; marked **PERSONAL DRAFT** until the next appointment.
- **Clinical-information location:** current list lives in the portal; no medication instruction copied.
- **How this page stands:** **Ready to use** as an educational draft. The legal-status question remains **Waiting for information** inside its own field.

Karim's page routes information. It does not declare him safe or authorize his sister to manage treatment.

And one with almost nothing in place

Dilan is a fictional composite who has told nobody. Diagnosed eighteen months ago, no patient portal, no clinician-authored plan, no family nearby, and no one at work who knows. This page is written as if everybody has a sister and an app, and most people do not.

- **Current professional plan:** none exists. Dilan writes “*no plan written with anybody yet*” and marks the page **Waiting for information**. That is the honest state, and it is a finished answer.
- **Verified urgent routes:** the national crisis line from the annex at the back, copied out by hand, and the local emergency number. Two lines. That is a route page.
- **One informed person: left blank.** Dilan is not ready and is not going to invent somebody. Instead: “*the crisis line does not need to know me beforehand, and it does not need my permission to be there.*”
- **Minimum handoff:** the five lines, written once, kept folded in a wallet rather than in a folder at home.
- **Review and distribution:** “*in my wallet, because there is nobody at home to hand it to.*”

Dilan's page has three of the ten fields filled in. **It works.** The point of this chapter is not a complete document: it is that on the worst night, the thing you need is findable without you having to think. Three lines in a wallet do that. Ten empty boxes in a folder do not.

If you are reading this with no plan, no portal and nobody told, you are not behind. You are the reader this page was hardest to write for.

Before you close this page

Optional and private. Never submitted, uploaded, collected or monitored.

WHICH FIELD NEEDED A SOURCE-AND-STATUS LABEL MOST?

WHICH SUPPORT BOUNDARY BECAME CLEARER?

What must happen before the Safety Plan and Starting Point can be archived?

Where this page goes

Place this draft in **Section 1 – If this is an emergency**. Keep the Safety Plan and Starting Point active while relevant professional or local review is pending.

After review, transfer only the current Safety Plan and Starting Point routes and contact information, record the replacement date, archive the Safety Plan and Starting Point page and keep one active crisis-response version. If a clinician-authored plan exists, this draft links to it and never replaces it.

The Full Early-Warning Ladder (lesson 19, page **214**) remains the warning-sign authority, and the first-72-hours chapter creates the First-72-Hours Action Draft (lesson 21, page **234**). The final review chapter checks sharing, rehearsal and currency; none of those artifacts takes ownership of this page.

Privacy and safety

- Current danger uses verified urgent or emergency help; worksheet completion waits.
- Never record self-harm methods, access details or operational rehearsal detail.
- Share section by section with named recipients and consent.
- An informed person is not a clinician, monitor, enforcer or sole safety plan.
- Ordinary privacy preferences do not promise silence during perceived immediate danger or redefine local duties.
- Store the page with appropriate device, print, backup and obsolete-copy controls.
- The Program will never tell you to start, stop, taper, restart, select, or change a medication.
- Your workbook answers are not submitted, uploaded, collected, or monitored by Bipolar Clarity.

Help where you live

Crisis numbers for your country are at the back of this workbook, on page **287**.

Watch this lesson
bipolarclarity.com/program/121



BIPOLAR STABILITY PROGRAM

21

I Think a Bipolar Episode Is Starting—What Should I Do?

Turn one warning rung and one route into a small sequence of actions you could actually run in the first days of a possible early change.

Two routes: the full one, and a short one

PRINT • WRITE BY HAND • KEEP

Purpose

Turn one warning rung and one route into a small sequence of actions you could actually run in the first days of a possible early change.

You leave with a short, ordered set of steps, each with a named owner and a review point.

What this chapter is about

This chapter goes with video lesson 21. It is the working half. The video does the teaching; this sequence is where you do the work.

The first seventy-two hours is a planning window, not a verdict. Nothing here decides whether an episode is starting. What it does is remove improvisation from the days when improvising is hardest — you take one rung off your ladder and turn it into an ordered set of small actions with names attached.

Copy the rung as it stands. Direction, level, certainty, action, contact — transferred, not re-diagnosed. Deciding all over again what the observation means is precisely how these three days get spent.

Start the contact before you are certain. Waiting for confidence is the most common way this window closes unused, and *I am not sure, and I wanted to tell somebody early* is a complete reason to make a call.

A good action has six properties, and it is worth checking each one: agreed in advance, actually available, proportionate to what you have observed, low-friction or reversible, owned by a named person, and with a point at which somebody looks at it again. An action that fails one of those tends to fail on the day.

Protect one rhythm, without prescribing anything. One anchor — sleep opportunity, a meal, going outside. Not a regime, and not a substitute for care.

Preselect one high-consequence pause. A purchase over a certain size, a message to a particular person, a resignation. Chosen now, while it costs nothing to choose.

Medication authority stays attached to its source. Anything involving medicine or monitoring comes from a current prescriber-confirmed instruction and from nowhere else — not from this page, and not from what worked last time.

And urgent change leaves immediately. It does not run the sequence.

Key ideas

1. **The first 72 hours is a planning window.** It is not a diagnostic threshold, a treatment deadline, or a safe period to wait out.
2. **Urgent change bypasses this page** and uses verified urgent or emergency help now.
3. **Copy your ladder as it stands** — direction, rung, certainty, action, contact — without reclassifying anything here.
4. **A suitable action is agreed, available, proportionate, low-friction or reversible, owned, and linked to review.**
5. **Medication and monitoring actions come only from a current prescriber-confirmed source.**

Watch the video first

Two things make more sense watched than read.

- **The airlock image**, which is what makes a planning window feel different from an alarm.
- **The six properties of a workable action**, tested against real ones that fail — because reading the list is not the same as seeing one collapse.

Watch it before you build the sequence. The video lesson is *I Think a Bipolar Episode Is Starting—What Should I Do?* — lesson 21 of the Bipolar Stability Program.

Before you begin

If you may be in immediate danger, contact your local emergency services now. For crisis resources in your country, visit bipolarclarity.com/gethelp, or see the country-by-country crisis annex at the back of this workbook.

Immediate danger, suicidal intent, plan or imminent self-harm risk, intent to harm someone else, loss of contact with reality, severe confusion, inability to meet basic needs, or rapidly escalating dangerous behavior uses urgent clinical or emergency help now.

Your current care plan may name another urgent threshold. Use urgent or emergency help instead of completing this page.

This draft organizes possible early change and agreed routes; it never confirms that an episode is starting.

The Program will never tell you to start, stop, taper, restart, select, or change a medication.

Your workbook answers are not submitted, uploaded, collected, or monitored by Bipolar Clarity.

Answers you can always use:

- Not known yet
- Prefer not to answer
- Nothing to record here
- Private — not recorded here
- I prefer to bring this to a professional conversation

Where this chapter's claims come from. The clinical statements in this lesson are sourced, and the sources are public: bipolarclarity.com/program/sources, under lesson 21. A source shows what published guidance says. It does not show what applies to you, and it never overrules the clinician who knows your case.

Core route

Active or possible rung

Copy the direction (upward / activated, downward / low, or both / mixed / uncertain), rung (subtle, clear, or urgent), certainty (known, possible, or uncertain), action and contact from the Full Early-Warning Ladder (lesson 19, page 214). Add one baseline change and who noticed. Do not reclassify the rung here.

Current route

Copy the highest applicable agreed route. When upward and downward changes combine, do not average concern away. Record the source page and its review status.

First contact

Record the contact, purpose, channel, time sent, real status (drafted, sent, acknowledged, appointment arranged, or backup used) and next route if no response arrives under the agreed rule.

One rhythm protection

Choose one protection already in your plan. Record the changed rhythm, smallest available version, owner, start condition and access gap. This field creates no sleep target or treatment instruction.

One friction reduction

Choose one short, reversible adjustment. Record what starts, what remains, the owner, review point and smallest backup.

One high-consequence decision pause

If relevant, name one precise decision domain, your voluntary pause or second-check process, reviewer, backup and review point. This creates no legal restriction, capacity decision or supporter control.

One bounded support task

Record only a task the supporter accepted with your consent. Add trigger, destination, limit, privacy boundary and backup route. The task creates no monitoring, diagnosis or sole responsibility for safety.

Prescriber-confirmed source

Record only the location, owner, confirmation date and review point of a current medication or monitoring instruction. Never reconstruct an instruction from memory. Use Waiting for information if unavailable.

Escalation backup

Record the condition or review point that moves the plan to its next agreed route, the destination, owner and source. Immediate danger always bypasses this sequence.

Three review positions

Complete three positions. They are equals, not a countdown — none of them is the failed one:

- **NOW:** active rung, urgent override, first contact and smallest agreed action.
- **NEXT CHECK:** the review time already in your plan; note any change in observation, impact, access or route.
- **BEFORE THE WINDOW CLOSSES:** record whether professional review occurred and whether the draft stops, continues under guidance or escalates.

REVIEW POSITIONS

How this page stands

Choose exactly one: **Ready to use**, **Waiting for information**, or **Keeping this private**.

Mark **Ready to use** only when at least one active or candidate rung and current route, one agreed or selected action, and one review or escalation point are usable. **Ready to use** never confirms an episode, declares safety or represents clinical approval.

☐ Ready to use ☐ Waiting for information ☐ Keeping this private

Low-energy route

Copy exactly two lines:

1. My active or possible rung and current route are: [write here]

2. My first contact and smallest agreed action are: [write here]

Those two lines are a complete action draft; they do not confirm an episode or replace professional review. You may stop here.

Worked fictional example

Malik is a fictional composite. Malik copies **upward / activated • subtle • possible** from the current Full Early-Warning Ladder after noticing reduced sleep and faster messaging. The Crisis-Response Draft (lesson 20, page **223**) routine contact is sent and marked **sent**, while the agreed backup remains visible. Malik protects an existing sleep opportunity, defers one optional late event, and uses a voluntary second check before a large purchase. A friend has accepted one bounded task: help Malik reach the named service if the agreed phrase arrives. The current medication instruction is linked by source and date; no dose is copied. The three review positions preserve uncertainty. The draft is marked **Ready to use** as an educational artifact, not as episode confirmation.

Before you close this page

Optional and private. Never submitted, uploaded, collected or monitored.

WHICH ACTION BEST MET ALL SIX QUALITY CONDITIONS?

WHICH DEPENDENCY OR AVAILABILITY GAP BECAME VISIBLE?

WHAT WOULD MOVE THIS DRAFT TO THE NEXT ROUTE?

Where this page goes

Place this page in **Section 1 – If this is an emergency**, beside the Crisis-Response Draft. Keep the Full Early-Warning Ladder as the warning-sign authority and the Crisis-Response Draft as the crisis-route and preferences authority. Link to both by current version and storage location. The

final review chapter may assemble, share and rehearse the page; it does not replace its source artifacts.

Privacy and safety

- Current danger uses verified urgent or emergency help; worksheet completion waits.
- Record no self-harm method, access detail or operational rehearsal detail.
- Share only named sections with named recipients and consent.
- A supporter is not a clinician, monitor, enforcer or sole safety plan.
- A voluntary pause never creates legal control or a finding about capacity.
- The Program will never tell you to start, stop, taper, restart, select, or change a medication.
- Your workbook answers are not submitted, uploaded, collected, or monitored by Bipolar Clarity.

Help where you live

Crisis numbers for your country are at the back of this workbook, on page **287**.

Watch this lesson
bipolarclarity.com/program/122



BIPOLAR STABILITY PROGRAM

22

How to Build a Routine That Helps With Bipolar Disorder

Build one routine anchor that matters to you, in three versions — normal, minimum, and what you do when the day falls apart — then run one small experiment against a real pressure.

Two routes: the full one, and a short one

PRINT • WRITE BY HAND • KEEP

Purpose

Build one routine anchor that matters to you, in three versions — normal, minimum, and what you do when the day falls apart — then run one small experiment against a real pressure.

You leave with an anchor that survives a bad week, and one experiment small enough to finish.

What this chapter is about

This chapter goes with video lesson 22. It is the working half. The video does the teaching; this sheet is where you do the work.

A routine that only survives a good week is not a routine. So this chapter builds one anchor in three versions: the normal one, a minimum one, and what you do when the day has already fallen apart. All three are the design. The minimum version is not a failure of the plan — it is the part of the plan that gets used.

There is no universal bipolar schedule, and nothing here is a timetable to pass. What you are protecting is a *function*, not a form: the thing the anchor does for you. Name the function and you can change the form whenever life demands it — a walk becomes a window, a cooked meal becomes something out of a packet, and the anchor survives.

Sleep and rhythm are where this connects to everything else in the book. Regular timing supports care; it does not replace treatment and it guarantees nothing. Both halves of that sentence matter.

Then bring in one real pressure — without blaming it. A shift pattern, a small child, travel, a season. The point is not to identify a culprit. It is to test the anchor against something that actually happens to you.

One small experiment, and it produces information rather than certainty. Small enough to finish is the only size that works, and reviewing it means reviewing the experiment — not your worth as a person.

And your safety routes sit above all of this. Warning signs, clinical change and urgency use the routes you already wrote. They never wait for a routine to be working.

Key ideas

1. **A routine can support care.** It cannot replace treatment or guarantee stability.
2. **There is no universal bipolar schedule** and no perfect routine to pass.
3. **Keep the anchor's function** even when its visible form has to change.

4. The minimum version and the disruption backup are part of the design, not a failure of it.
5. One small experiment produces information, not certainty.
6. Warning signs, clinical change and urgency use your existing routes rather than waiting for the experiment to finish.

Watch the video first

The video does two things a printed sheet flattens.

- An anchor changing form without losing its function, demonstrated rather than described — which is the move the whole sheet depends on.
- Why a routine is support and not a test, said in a way that survives the week you fail it.

Watch it before you design yours. The video lesson is *How to Build a Routine That Helps With Bipolar Disorder* — lesson 22 of the Bipolar Stability Program.

Before you begin

If you may be in immediate danger, contact your local emergency services now. For crisis resources in your country, visit bipolarclarity.com/gethelp, or see the country-by-country crisis annex at the back of this workbook.

Immediate danger, suicidal intent, plan or imminent self-harm risk, intent to harm someone else, loss of contact with reality, severe confusion, inability to meet basic needs, or rapidly escalating dangerous behavior uses urgent clinical or emergency help now.

Your current care plan may name another urgent threshold. Use urgent or emergency help instead of completing this page.

If a warning rung applies, use its agreed route instead of waiting for this experiment to finish.

Where this chapter's claims come from. The clinical statements in this lesson are sourced, and the sources are public: bipolarclarity.com/program/sources, under lesson 22. A source shows what published guidance says. It does not show what applies to you, and it never overrules the clinician who knows your case.

Why timing is worth the paper

Disrupted sleep and irregular daily timing are associated with mood episodes in bipolar disorder, and that association is the reason an anchor is worth building at all. This is association, not

prediction: one short night does not mean an episode is starting, and no routine can promise that one will not.

The Program will never tell you to start, stop, taper, restart, select, or change a medication.

Your workbook answers are not submitted, uploaded, collected, or monitored by Bipolar Clarity.

Answers you can always use:

- Not known yet
- Prefer not to answer
- Nothing to record here
- Private — not recorded here
- I prefer to bring this to a professional conversation

Core route

Baseline source

Record the location and version of your 7-Day Sleep & Rhythm Baseline (lesson 3, page 30). Copy only the relevant observation and its context. Do not turn timing into cause, diagnosis or prediction. Your 7-Day Sleep & Rhythm Baseline (lesson 3, page 30) stays attached to your Plan as the observation record this sheet was built from.

Anchor function

Write the useful function you want to preserve, then name one observable anchor. Examples may include first contact with the day, a meal opportunity, movement, social contact, transition, winding down or sleep opportunity. There is no universal time.

Three valid versions

Record three versions. All three are equally valid — the smallest is not the failed one:

- **NORMAL VERSION** — what fits an ordinary day;
- **MINIMUM VERSION** — the smallest form that preserves the function;
- **DISRUPTION BACKUP** — the route used when the normal version is unavailable.

Add owner and review point. The minimum and backup are parts of the design, not failure states.

Availability check

For all three versions, record relevant dependencies: energy, pain, mobility, money, privacy, transport, childcare, permission, equipment, housing, weather, service access or a named supporter's accepted role. Add a different route when the same dependency blocks every version.

One candidate pressure

Copy one pressure and earliest observable effect from the Vulnerability & Protection Map (lesson 12, page 132). Preserve its label exactly: known, possible, or uncertain. Sequence does not prove cause.

Problem statement

Complete: When [pressure or condition] happens, [anchor function] becomes harder because [observable barrier].
Keep the problem small enough for one experiment.

Margin of influence

Choose one: I can change part; I can prepare; I need a named supporter or service; uncertain. The position may change after review.

- ☐ I can change part
- ☐ I can prepare
- ☐ I need a named supporter or service
- ☐ uncertain

Options

Generate at least two realistic options, including one smaller version. For each, note function, availability, owner, cost or burden, reversibility and what would make it unsuitable.

One small experiment

Choose one low-cost, reversible or low-friction option. Record owner, start condition, smallest version, backup and what you will observe. This creates no clinical instruction.

Review or escalation

Use a review point from your plan or ordinary context; this worksheet supplies no universal interval. At review choose: continue for now; adapt one element; stop; seek external information; use early-warning or clinical route. Immediate danger bypasses review.

How this page stands

Choose exactly one: **Ready to use**, **Waiting for information**, or **Keeping this private**.

Mark **Ready to use** only when one anchor has at least a minimum or backup version, and one problem statement, chosen experiment and review or escalation point are usable. **Ready to use** never means clinically approved, protective against relapse or suitable for every mood state.

☐ Ready to use ☐ Waiting for information ☐ Keeping this private

Low-energy route

Copy exactly two lines:

1. The function and smallest version of my anchor are: [write here]

2. The disruption, one small test, and my review or help route are: [write here]

Those two lines are a complete rhythm draft; they do not guarantee stability or replace professional care. You may stop here.

Worked fictional example

Yuki is a fictional composite working changing shifts. The 7-Day Sleep & Rhythm Baseline shows that the first meal opportunity becomes unpredictable after a late finish; this is copied as observation, not cause. Yuki chooses the function **reliable access to food and a transition into the day**. The normal version uses a prepared meal after waking, the minimum uses one accessible

ready-to-eat option, and the disruption backup identifies an available workplace option. The Vulnerability & Protection Map pressure **late shift change** remains **possible**. The problem is limited to food access after transport closes. Yuki generates two options, tests preparing the minimum version earlier and reviews access, effort and next-day burden at the planned check. No episode, treatment effect or moral success is inferred.

Before you close this page

Optional and private. Never submitted, uploaded, collected or monitored.

Which function stayed visible across all three versions?

WHICH AVAILABILITY GAP CHANGED THE DESIGN?

What did the experiment teach you about the next review or help route?

Optional care question

This page does not require a professional question. If one would help, write it here:

Could we review whether this anchor and backup are realistic in my care context, and which changes should use my warning-sign route?

Where this page goes

Transfer one concise anchor block — function, normal/minimum/backup versions — and one problem-solving block — pressure label, experiment and review/help route — to **Section 3 – My baseline**.

Keep the 7-Day Sleep & Rhythm Baseline attached and linked by version: it is the record this sheet was built from, so it stays with it and is never archived. Keep the Vulnerability & Protection Map as the pressure authority. The Full Early-Warning Ladder (lesson 19, page **214**), the Crisis-Response Draft (lesson 20, page **223**) and the First-72-Hours Action Draft (lesson 21, page **234**) remain the warning, crisis and early-change routes. The Functioning & Rebuild Plan (lesson 23, page **252**) may use the tested small-step method for functioning; the final assembly and review may assemble and rehearse without replacing this sheet.

Privacy and safety

- Current danger uses verified urgent or emergency help; worksheet completion waits.
- Warning signs use the current ladder and agreed route; an experiment never delays care.
- Record no self-harm method, access detail or operational rehearsal detail.
- Routine regularity is support, not a diagnostic test, treatment or guarantee.
- Never use this page to force or restrict sleep, deprive yourself of sleep, begin light treatment, change substances as treatment or reconstruct an old instruction.
- A named supporter performs only an accepted bounded task and is never the sole safety plan.
- The Program will never tell you to start, stop, taper, restart, select, or change a medication.
- Your workbook answers are not submitted, uploaded, collected, or monitored by Bipolar Clarity.

Help where you live

Crisis numbers for your country are at the back of this workbook, on page **287**.

Watch this lesson
bipolarclarity.com/program/123



BIPOLAR STABILITY PROGRAM

23

Life After a Bipolar Episode: Work, Money, and Relationships

*Choose one area of life and build one workable step in it —
without scoring your recovery, and without this page
making a disclosure, treatment, legal, financial or
relationship decision for you.*

Two routes: the full one, and a short one

PRINT • WRITE BY HAND • KEEP

Purpose

Choose one area of life and build one workable step in it — without scoring your recovery, and without this page making a disclosure, treatment, legal, financial or relationship decision for you.

You leave with one step sized to the capacity, access and permission you actually have right now.

What this chapter is about

This chapter goes with video lesson 23. It is the working half. The video does the teaching; this page is where you do the work.

Functioning is not a character score. After an episode there is often a gap between the life you had and the life you can currently run, and the standard advice — *take it slowly* — is useless because it does not say slowly at what. This chapter picks one thing and sizes it honestly.

Scan three areas, then choose one. Work or study. Money. Relationships. Looking at all three is how you find the one worth reopening; working on all three at once is how the step never gets taken.

Define the function before the solution. *What has to work* is a different question from *how it used to be done*, and answering the first one opens options that the second one closes. A room can be reopened through a different door.

Match the step to what you actually have now: capacity, access, authority, consent and safety. Not to what you had, and not to what you think should be possible by now. A step that assumes last year's capacity is not ambition — it is a step that fails and then gets read as evidence about you.

Disclosure is a separate decision, and it belongs to you. Whether you tell an employer, a colleague, a landlord or a family member is not part of taking the step, and the rules that protect you differ enormously by country. Check where you live before you decide, and never let a worksheet rush that.

And review the experiment, not yourself. Whether the step fitted, what it cost, and what you would size differently.

Key ideas

1. **Scan three areas of life, then choose one.** Working on everything at once is how the step stops happening.

2. **Define the function before the solution.** What has to work is a different question from how you will make it work.
3. **Match the step to what you have now:** capacity, access, authority, consent and safety.
4. **Keep disclosure a separate decision,** and check the rules where you live before you make it.
5. **Review the experiment, not your worth as a person.**

Watch the video first

The video holds three things a worksheet flattens.

- **Three areas of life scanned without ranking any of them,** which is harder than it sounds and easier to watch than to read.
- **Why the money and work lanes need their own care,** including where this Program stops and a qualified adviser starts.
- **One step sized out loud,** including the moment it is too big and gets made smaller.

Watch it before you choose. The video lesson is *Life After a Bipolar Episode: Work, Money, and Relationships* — lesson 23 of the Bipolar Stability Program.

Before you begin

This page helps you scan work, money and relationships, choose one domain, and design one bounded step. It does not score recovery or predict what will happen.

If you may be in immediate danger, contact your local emergency services now. For crisis resources in your country, visit bipolarclarity.com/gethelp, or see the country-by-country crisis annex at the back of this workbook.

Immediate danger, suicidal intent, plan or imminent self-harm risk, intent to harm someone else, loss of contact with reality, severe confusion, inability to meet basic needs, or rapidly escalating dangerous behavior uses urgent clinical or emergency help now.

If a warning rung applies, use its agreed route instead of waiting for this page.

If abuse, threats, coercion, exploitation or fear about contact is present: the crisis annex at the back of this workbook has a separate section, “If you’re not safe at home”, with lines country by country. The same list is at bipolarclarity.com/gethelp. For unsafe housing or food insecurity, the review route in section 10 is where you name a local service by name.

Do not record account numbers, passwords, self-harm method/access details, another person's diagnosis, or information you do not want here.

Answers you can always use:

- Not known yet
- Prefer not to answer
- Nothing to record here
- Private — not recorded here
- I prefer to bring this to a professional conversation

Where this chapter's claims come from. The clinical statements in this lesson are sourced, and the sources are public: bipolarclarity.com/program/sources, under lesson 23. A source shows what published guidance says. It does not show what applies to you, and it never overrules the clinician who knows your case.

Core route

Scan all three domains

Choose one status for each: **STEADY, STRAINED, DISRUPTED, UNCERTAIN, or PRIVATE**. Add one observable note if useful. Work includes paid work, study, caring, household work, volunteering or meaningful activity. Money means practical access and protection, not income as a score. Relationships means one connection, boundary or coordination function — not a verdict on a whole relationship.

Choose one domain

Choose **WORK / STUDY / CARING**, **MONEY**, **RELATIONSHIPS**, **NOTHING OPEN RIGHT NOW**, or **AWAITING A SAFE ROUTE**.

If your scan came back steady in all three, **NOTHING OPEN RIGHT NOW** is the honest answer and it finishes this page. Not everyone reading this has something to rebuild today, and being asked to pick one anyway would only invent a problem. Write one line about what you would want to protect if that changed, and stop. Select one because a meaningful function, an available step and a review/help route can be named — not because it produces the most shame.

☐

WORK / STUDY /
CARING

☐

MONEY

☐

RELATIONSHIPS

☐

NOTHING OPEN
RIGHT NOW

☐

AWAITING A SAFE
ROUTE

Define one function

Complete: The function I want to make more available is... Keep it observable and current.

Describe current capacity and context

What can you currently do or access? What becomes harder? What important context belongs beside that observation? A functioning change is information, not proof of effort, character or diagnosis.

Name the main barrier and support

Separate the barrier from capacity. Note dependencies — permission, money, transport, privacy, childcare, language, technology, consent, equipment, recovery time or qualified advice — and whether each is actually available.

Disclosure decision gate

Complete only if work, study, caring, benefits or another formal system raises a disclosure question. Choose: NO DISCLOSURE DECISION NEEDED, NO DECISION TODAY, NEEDS QUALIFIED LOCAL INFORMATION, DECIDED OUTSIDE THIS WORKBOOK, or PRIVATE. If information may be shared, first identify jurisdiction, purpose, recipient, minimum necessary detail, possible consequences/uncertainties and a qualified local source. The Program never tells you to disclose or conceal a diagnosis.

- | | |
|--|--|
| ☐ NO DISCLOSURE DECISION NEEDED | ☐ NO DECISION TODAY |
| ☐ NEEDS QUALIFIED LOCAL INFORMATION | ☐ DECIDED OUTSIDE THIS WORKBOOK |
| ☐ PRIVATE | |

Build one step

Write a NORMAL STEP, MINIMUM STEP, and BACKUP OR HELP ROUTE. Use the Rhythm & Problem-Solving Sheet (lesson 22, page 243)'s small-step method. Keep the three as equals — none of them is the failed one — observable and separate from treatment, legal or financial instructions.

Set one boundary

Name the maximum scope/time, information you will not share, excluded decisions, consent condition, or stopping condition. A supporter has only the bounded role they accepted.

Name owner and available support

Who owns the step? Who has agreed to help, and with what exact task? What happens if that support is unavailable?

Review or help route

Name the review point and one destination if capacity, symptoms, consent, access, risk or authority changes. Choose at review: continue for now, reduce, adapt one element, stop, seek external information, or use the route I named above. Name it here rather than leaving it as a category: a warning rung and its agreed route, a care contact, a named local service, or the crisis annex at the back.

How this page stands

Choose exactly one: **Ready to use**, **Waiting for information**, or **Keeping this private**.

Mark **Ready to use** only when at least one chosen function, a step, a boundary and a review or help route are recorded, together with the scan. It never means recovered, legally protected, financially secure, reconciled or clinically approved.

☐

Ready to use

☐

Waiting for information

☐

Keeping this private

Low-energy route

Copy exactly two lines:

1. My chosen domain and smallest useful step are: [write here].

2. My boundary and review or help route are: [write here].

Those two lines are a complete rebuild draft; they do not prove recovery, create a legal or financial decision, or replace professional support. You may stop here.

Worked fictional example

Dana is a fictional composite. The scan says work **STRAINED**, money **UNCERTAIN**, and one relationship **STEADY**. Dana chooses work because one function — receiving the week's essential task information — has a bounded step. Current capacity allows one short written request; the barrier is unclear routing. No diagnosis disclosure is needed for the procedural question, and Dana records **NO DISCLOSURE DECISION NEEDED**. The minimum step is to locate the existing task channel; the backup is to ask the named procedural contact. The boundary excludes health information. Review checks whether the information became accessible and what effort it cost. The result does not establish work capacity generally.

Before you close this page

Optional and private. Never submitted, uploaded, collected or monitored.

Which function became clearer when you separated it from status or identity?

Which capacity, access, consent or authority limit changed the step?

WHAT WILL THE NEXT REVIEW OR HELP ROUTE NEED TO ANSWER?

Optional professional question

This page does not require a professional question. If one would help:

Could we review whether this one functioning step fits my current capacity, and which qualified route should answer the parts outside your role?

Where this page goes

Transfer one concise block — chosen domain, function, smallest step, boundary and review/help route — to the functioning section of your Plan. Link back to this artifact by version. The Rhythm & Problem-Solving Sheet remains the small-step method authority; its 7-Day Sleep & Rhythm Baseline (lesson 3, page **30**) is the record it was built from and is never archived. The final review chapter may use this block during final assembly without replacing it.

Privacy and safety

- Current danger uses verified urgent or emergency help; worksheet completion waits.
- Warning signs use the current ladder and agreed route.
- Abuse, coercion, exploitation or fear uses the “If you’re not safe at home” section of the crisis annex at the back, or local emergency services, rather than a contact experiment.
- The Program will never tell you to disclose or conceal a bipolar diagnosis.
- The Program will never tell you to start, stop, taper, restart, select, or change a medication.
- Your workbook answers are not submitted, uploaded, collected, or monitored by Bipolar Clarity.
- Do not put passwords, account numbers, identifying workplace records or another person's private health information here.

Help where you live

Crisis numbers for your country are at the back of this workbook, on page **287**.

Watch this lesson
bipolarclarity.com/program/124



BIPOLAR STABILITY PROGRAM

24

Grieving the Person You Were: Bipolar and Identity

Make room for identity, loss and personal recovery. Then assemble the Stability Plan into something navigable, check who owns what and which routes are still current, rehearse using it once, and set the next review.

Two routes: the full one, and a short one

PRINT • WRITE BY HAND • KEEP

Purpose

Make room for identity, loss and personal recovery. Then assemble the Stability Plan into something navigable, check who owns what and which routes are still current, rehearse using it once, and set the next review.

You leave with a finished plan you can find your way around under pressure, and a date to come back to it.

What this chapter is about

This chapter goes with video lesson 24. It is the working half. The video does the teaching; this page is where you do the work — and it is the last one, so it does two things at once.

First: identity, and the part nobody prepares you for. After a diagnosis you can find yourself looking backwards and asking which memories were *really you*. Whether ambition was illness. Whether confidence can be trusted. Those questions deserve care, and the diagnosis alone cannot answer them.

You do not have to divide your life into a well self and an ill self. Episodes are real; so are consequences. And so are your values, humour, culture, relationships, skills, contradictions and the private ways you understand yourself. The page offers five equal words — still mine, changed, uncertain, chosen now, private — and they are descriptions, not ranks. More than one can apply to the same part of your life.

Loss is allowed to stay a loss. No silver lining is required, no complete narrative, no timetable, and no obligation to become inspiring about it.

Second: assemble the Plan so you can find things in it. Indexed by use, not by lesson order — because on the day you need it you will be looking for *something specific*, not for chapter eleven. Then you test that index once, on a mild fictional scenario, to find the friction before a real day does.

Complete means findable, current, owned and honestly labelled. It does not mean clinically stable, recovered, safe in every circumstance, or able to handle an episode alone.

And then the Program ends, which is not the same as the work ending. Three things stay live: your sleep and rhythm record, your warning ladder, and this Plan at the review point you choose here. The twenty-four chapters stop being a course and become a shelf you come back to because something happened — which is what the index you just built is for.

There is also a second Program on the way, for the people around you. Partners, parents, adult children, close friends: the ones who notice things and have never been taught what to do with what they notice. When it exists it will be at bipolarclarity.com/family. It is not there yet.

Key ideas

1. **Identity holds continuity, change, uncertainty, choice and privacy at the same time.**
2. **Loss requires no silver lining**, no complete narrative and no timetable.
3. **Personal recovery is broader than symptoms**, and it never promises a cure.
4. **The finished Plan is indexed by use, not by lesson order.** You will be looking for something, not revising a course.
5. **Complete means findable, current, owned and honestly labelled.** It does not mean clinically certified.
6. **The rehearsal is fictional and deliberately mild.** It tests navigation and friction, never emergency performance.

Watch the video first

Three things are only in the last video.

- **The constellation**, and the permission it gives: keep every star, change the lines, erase nothing.
- **René on the hardest stretch of his year**, and how he tells ordinary sadness apart from a symptom without dismissing either.
- **What week twenty-five looks like**, said properly rather than listed.

Watch it before you assemble anything. The video lesson is *Grieving the Person You Were: Bipolar and Identity* — lesson 24 of the Bipolar Stability Program.

Before you begin

If you may be in immediate danger, contact your local emergency services now. For crisis resources in your country, visit bipolarclarity.com/gethelp, or see the country-by-country crisis annex at the back of this workbook.

Immediate danger, suicidal intent, plan or imminent self-harm risk, intent to harm someone else, loss of contact with reality, severe confusion, inability to meet basic needs, or rapidly escalating dangerous behavior uses urgent clinical or emergency help now.

If a current warning rung applies, use its agreed route instead of continuing the reflection or rehearsal.

Ordinary grief and a depressive episode can overlap; this workbook cannot decide which is happening. Marked worsening, loss of function, activation, mixed change, fear or concern belongs with the care contact you have already named, or the agreed route on your warning ladder.

The Program will never tell you to start, stop, taper, restart, select, or change a medication.

Your workbook answers are not submitted, uploaded, collected, or monitored by Bipolar Clarity.

Answers you can always use:

- **Not known yet**
- **Prefer not to answer**
- **Nothing to record here**
- **Private — not recorded here**
- **I prefer to bring this to a professional conversation**

Where this chapter's claims come from. The clinical statements in this lesson are sourced, and the sources are public: bipolarclarity.com/program/sources, under lesson 24. A source shows what published guidance says. It does not show what applies to you, and it never overrules the clinician who knows your case.

Core route

Owner, version and location

Record preferred name or initials, Plan version, date, jurisdiction, language, current storage location, and where you keep your Crisis-Response Draft — the page that has to work under stress.

Identity status scan

For any domains you choose — values, roles, abilities, relationships, body, confidence, hopes, language, culture, community or daily life — use STILL MINE, CHANGED, UNCERTAIN, CHOSEN NOW, or PRIVATE. No domain is required and no score is calculated.

Acknowledge one loss or change

Complete only what feels safe: Something I miss, or something that changed, is... You may name only its cost — energy, belonging, opportunity, certainty, dignity, connection — or choose PRIVATE. No story, explanation or silver lining is required.

Write one identity-continuity line

Complete: I still carry [x]; [y] has changed or remains uncertain; now I want to protect or choose [z]. Alter the wording to fit you. Continuity, change and choice do not have to agree.

Define recovery for now

Complete: For now, recovery means... Use your current values and conditions. Recovery may coexist with symptoms, disability, support, uncertainty, treatment and grief. It does not mean cure, symptom absence or returning to the past.

That is the chapter. What follows is the assembly: putting the pages in order, recording which one now takes over from which, and setting a review date. It is worth doing and it is not the same kind of work — it is filing, and filing can wait for a different afternoon than the one where you wrote about who you used to be.

If you stop here, you have finished the twenty-four. The next page is the one that says so.

Putting the plan together

The rest of this chapter is housekeeping. Do it now if you have the energy, or come back to it. Nothing else in the Program depends on it being done today.

Build the seven-section index

For Sections 0–6, record the current artifact location and choose one status: **CURRENT**, **NEEDS UPDATE**, **AWAITING PROFESSIONAL REVIEW**, **AWAITING LOCAL VERIFICATION**, **PRIVATE**, or **NOT APPLICABLE**.

- **Section 0 — Cover and permissions:** cover, owner, version, permissions and review.
- **Section 1 — If this is an emergency:** urgent-use pages and routes.
- **Section 2 — My signals:** warning ladder and supporting sign records.
- **Section 3 — My baseline:** baseline, rhythm, pressures/protections and optional substance note.
- **Section 4 — My diagnosis, in my words:** diagnosis wording, language, alternatives and history.
- **Section 5 — My treatment:** treatment, monitoring, questions and appointment preparation.
- **Section 6 — My life:** functioning, identity, loss, recovery and final review.

SEVEN-SECTION INDEX

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Record which page now takes over from which

Record the current/archived status and date for these relationships:

- The Full Early-Warning Ladder (lesson 19, page **214**) replaces three earlier pages after checked transfer, and all three move to archive: the Starter Early-Change Card (lesson 4, page **40**), the Elevated-State Inventory (lesson 8, page **77**) and the Low & Mixed-State Inventory (lesson 9, page **89**).
- The Medication Questions Page v2 (lesson 14, page **165**) replaces the purpose summary of the original Medication Questions Page (lesson 5, page **49**) after verified transfer; the original moves to archive.
- The Crisis-Response Draft (lesson 20, page **223**) replaces the Safety Plan half of the Safety Plan and Starting Point (lesson 1, page **11**) only after a professional and local review. Until then the Safety Plan and Starting Point (lesson 1, page **11**) stays active and the Crisis-Response Draft stays a draft.
- The 7-Day Sleep & Rhythm Baseline (lesson 3, page **30**) and the Rhythm & Problem-Solving Sheet (lesson 22, page **243**) remain linked: the baseline is the record the sheet was built from, so it stays with it and is never archived.

Archive means remove from current authority – not destroy.

Check the crisis page: usable, current and owned

Confirm or status-label: current version and location; your upward and downward observations; the subtle and clear rungs of your ladder, each with its route; a locally verified urgent route; routine and urgent contacts kept distinct; a prescriber-confirmed source and date for any medication action; and one low-energy backup. This checks navigation and currency, not clinical adequacy.

Run one fictional subtle-rung rehearsal

Use the fictional example below or create a neutral fictional early-change situation. Record: first observable change; alternative explanation; page location; first contact/current route; feasible

action; low-energy backup; professional/local dependency; consent boundary; friction point; and one edit.

Never use your most dangerous memory, a graphic self-harm scenario, real emergency, medication action or countdown. Real change or danger stops the rehearsal.

[illegible]

Review permissions, copies and next review

For each shared section, record the named recipient, agreed purpose, permission level and whether they hold the current version. Mark obsolete copies. Choose a next review date or trigger; triggers may include a move, changed jurisdiction/contact, treatment change, episode, major transition, access change or rehearsal friction.

[illegible]

How this page stands

Choose exactly one: **Ready to use**, **Waiting for information**, or **Keeping this private**.

Mark **Ready to use** only when at least one core field is written in your own words that does not wait on anybody else: owner, version and location, plus the seven-section index. Add the Crisis-page

check, the permissions and current-copy review, the fictional subtle-rung rehearsal or its safe deferral route, and your next review point.

The urgent route in Section 1 is deliberately outside that floor. If it has not yet been checked against a current local source, that one field stays **Waiting for information** – the Plan itself does not. A Plan you have written cannot be held hostage by a phone number you have not been able to confirm yet, and a floor that waits on somebody else is a ceiling.

Clearly labeled private, not-applicable and non-urgent pending fields are acceptable. **Ready to use** never means clinically approved, stable, recovered, safe in every situation, independent or finished forever.

HOW THIS PAGE STANDS

☐

Ready to use

☐

Waiting for information

☐

Keeping this private

Low-energy route

Copy exactly two lines:

1. What I still carry or want to protect is: [write here].

2. My Plan is stored where I noted; my next review or trigger is [write here]; the route or update still missing is [write here].

Those two lines are a complete final-review draft; they do not certify recovery or complete your Stability Plan. You may stop here.

Worked fictional example

Ines is a fictional composite. Ines's identity line says: **I still carry curiosity; confidence feels changed and uncertain; now I want to protect a slower decision pace.** Recovery currently means staying connected, using care and making fewer high-consequence decisions alone.

Ines's index marks Sections 0, 2, 3, 4 and 6 **CURRENT**; Section 5 **NEEDS UPDATE**; and Section 1 **AWAITING PROFESSIONAL REVIEW** because the Crisis-Response Draft has not replaced the Safety Plan and Starting Point. The fictional subtle-rung rehearsal uses two shorter nights, faster messages and more plans, while a deadline and travel remain alternative explanations. Ines finds the rising-sign page but discovers the first contact route is outdated. The single edit is to mark that route **NEEDS UPDATE** and place the verified replacement destination on the review list. No episode, recovery state or clinical adequacy is inferred.

Before you close this page

Optional and private. Never submitted, uploaded, collected or monitored.

Which part of identity felt continuous without needing proof?

Which status, authority or route made the Plan more honest?

WHICH ONE EDIT REDUCED NAVIGATION FRICTION?

Optional professional question

This page does not require a professional question. If one would help:

Would you review the sections that depend on clinical authority and tell me which routes or instructions need updating?

Where this page goes

Place this page in **Section 0 – Cover and permissions** and **Section 6 – My life**. Use its index as the navigation authority for Sections 0 to 6. Keep sensitive source pages where you chose; the index references them without copying their content.

Transfer the current version/location, identity-continuity line if desired, personal recovery definition, seven-section statuses, the record of which page takes over from which, Crisis-Response Draft result, permissions/current-copy record, one rehearsal edit and next review. Keep the link between the 7-Day Sleep & Rhythm Baseline (lesson 3, page **30**) and the Rhythm & Problem-Solving Sheet open. Do not upgrade a personal draft, professional dependency or local route through transfer.

Privacy and safety

- Real immediate danger uses local emergency services/current urgent routes; the exercise stops.
- A real warning rung uses the agreed route; do not continue a fictional rehearsal.

- Identity and loss responses default to private and may be stored separately.
- Share section-by-section, never the full Plan by default.
- Record no self-harm method/access detail, account credential, another person's diagnosis or private information you do not own.
- A support role requires consent and does not assign diagnosis, medication management, surveillance or guaranteed safety.
- The Crisis-Response Draft remains a draft until a professional and local review.
- Medication actions exist only by reference to a current prescriber-confirmed source.
- The Program will never tell you to start, stop, taper, restart, select, or change a medication.
- Your workbook answers are not submitted, uploaded, collected, or monitored by Bipolar Clarity.

Help where you live

Crisis numbers for your country are at the back of this workbook, on page **287**.

You got to the end

Twenty-four lessons. However long it took — six months, a year, three chapters and then a long gap — you did something most people with this diagnosis never get the chance to do, and nobody made you do it. On a bad week that is harder than it sounds. Well done.

What you have now

Turn back through the pages you filled in. You are holding documents that did not exist before you started:

- a safety plan, with the routes you would use written down before you need them
- a life chart of your own history
- your triggers and your protections
- your warning-sign ladder: subtle, clear, urgent
- a crisis-response draft, with your contacts and your preferences
- a plan for the first seventy-two hours after something changes

That is the part that keeps working after today. Not what you remember from the videos. What is on the paper, in your handwriting, where somebody can find it.

Three things worth doing this week

Decide whether to tell one person where this is. A plan nobody else knows about only works while you are well enough to go and get it, which is exactly when you may not be. If it feels safe and useful, choose one person and one page — you do not have to show them the whole thing — and tell them what you would want them to do with it. They should agree to that.

Take one page to your next appointment. The crisis-response draft and the medication questions page were written to be read by somebody else. They make a twenty-minute conversation into a different conversation.

Put a date on it. These pages go out of date. Treatment changes, work changes, an early sign you had never seen before shows up. Write on your warning-sign ladder and on your crisis draft the review date or the moment already agreed in your care or your local instructions, and read them again then. If nobody has given you one, write the question you want to ask instead. Nothing else in here needs a schedule. Those two do.

If it gets bad again

It might. The trial described in “Evidence and limitations”, at the back, found fewer recurrences and less time unwell. Fewer, not none. If you have another episode after finishing this, it is not proof that the work was wasted or that you did it wrong. It is the illness doing what it does, and you are meeting it with a plan you wrote yourself, on a day when you were steady enough to think clearly. That page holds what you worked out when you had more room to think. You can change it later without deciding that the person who wrote it was wrong.

Coming back

Nothing here expires, and none of it has to be done in order a second time. People come back to different chapters for different reasons: the ladder after a scare, the medication chapters before an appointment, the chapter on identity when the diagnosis stops being new and starts being permanent. If you skipped most of this and turned to the back, that counts too. Chapter 1 is the one to start with: it is the page that holds your emergency route, and it takes a few minutes. If what you mainly need is to catch things earlier, chapter 19 comes next. Print whatever you need again. It is free and it will still be there.

New material

Everything in this program is already free and already published. Nothing is held back for an email address. What the list adds is the rhythm: one new one-page tool a week. If that would be useful:

bipolarclarity.com/newsletter



Thank you for staying with it.

— René

If you stopped, and you have come back

Most people who start this do not finish it in twenty-four straight weeks. Life, or the illness, or both. If there is a gap between the last page you filled in and today, this page is the one to read first.

You do not start again. What you wrote is still yours and most of it is still true. A baseline you described in March did not stop being your baseline because you missed April.

Three things to check before you carry on

1. Your routes and your contacts. Phone numbers change, clinics move, people leave. Turn back to your Safety Plan and read the three routes out loud: help early, urgent professional help, immediate danger. If any of them is out of date, fixing that is more important than any other page in this book.

2. Anything you labelled as reviewed. Some pages carry a note about who checked them and when. A review from a year ago is a record of what was true a year ago. If a page says **reviewed** and you cannot remember the conversation, treat it as a draft again.

3. Whether your baseline still describes you. Read it as if somebody else had written it. If it no longer sounds like your ordinary week, that is worth knowing, and it is worth saying out loud at your next appointment.

That is the whole re-entry. Those three checks are enough to start using the pages again; mark anything that is still waiting for a review.

Then go where you actually need to go

You can pick up at the chapter you stopped at. You can also skip to the one that matches what is happening right now, and come back for the rest later. The map at the front shows which chapter feeds which part of your plan, so you can find the page you need without reading the twenty-three you do not.

Both are legitimate ways to use this. The order helps, but it is not a rule, and nothing later depends on you having done everything earlier.

One thing worth naming

If you stopped because you became unwell, this workbook is not the first thing to pick up. Use the route you would use for that, and come back to these pages when the acute part has passed. Working through a chapter is not a substitute for care, and it never was.

And if you stopped because it was too much: that is not a failure of yours. Twenty-four chapters about your own illness is a lot to ask of anyone. The book waited. It will wait again if it needs to.

Glossary

Two kinds of word turn up in this workbook: a handful the Program uses in its own particular way, and the clinical vocabulary you will meet in appointments and letters. Both are here.

Where a word belongs to one lesson, that lesson is named, so you can go back to what explains it properly. Nothing on this page can diagnose anything, and none of it replaces what your own clinicians tell you about your own case.

Words this workbook uses in a particular way

Anchor (lesson 22, page 243) — one routine that holds a day together, designed in three versions: normal, minimum, and what you do when the day falls apart. Its job is to keep working when its shape has to change.

Answers you can always use (*the Program's escapes*) — the five answers that are always available on any page: **Not known yet**, **Prefer not to answer**, **Nothing to record here**, **Private — not recorded here**, **I prefer to bring this to a professional conversation**. They are real answers, not blanks. A page filled with three lines that are true is worth more than a page filled in to look complete.

Baseline (*lessons 2 and 3*) — what is usual **for you**, described in enough detail that a change from it is visible. Not a flat or emotionless state, and not anybody else's normal. Most of this Program compares against your baseline rather than against an average.

Candidate pressure (lesson 12, page 132) — what this Program calls a “trigger”. The change of word is the point: a pressure is something worth watching, not a switch that causes an episode. Naming one is not assigning blame, and structural pressures like money, housing or discrimination belong on the map as much as anything else.

Certainty (*known / possible / uncertain, lesson 12*) — how sure you are about an observation, recorded separately from the observation itself. Being unsure is information worth writing down, not a reason to leave the line blank.

Core route — the full version of a chapter. It is the one to use on an ordinary day.

How this page stands — the line at the end of a chapter where you say where the page has got to. There are three: **Ready to use** (there is something written that does not depend on anybody else), **Waiting for information** (the next useful step needs a record, a date or a phone number you do not have yet, so the page is pending rather than

suspended) and **Keeping this private** (you decided not to write it down, and that is a finished decision, not a gap).

Impact — what a change actually did to sleep, work, money, relationships or safety. Throughout this Program, impact is more useful than a severity score you invent yourself, because impact is something another person can act on.

Low-energy route — the short version of the same chapter. It exists because the shorter route, finished on a hard week, is worth more than a chapter skipped waiting for a good one. What it produces is not a lesser answer; it is a smaller one.

Protection (lesson 12, page **132**) — something that supports stability by doing a specific job: steadying rhythm, reducing load, helping you notice, helping you act, keeping you connected, keeping care reachable. A protection helps. It never guarantees.

Route — a way of getting help, written down before you need it. The Program keeps three of them separate on purpose: help early, urgent professional help, and immediate danger. They are different destinations with different phone numbers, and mixing them is what makes a plan unusable at the moment it matters.

Rung (lesson 19, page **214**) — one step on your warning ladder, with an action and a contact attached to it. A rung depends on change from your own baseline, the pattern around it, impact, certainty and history. No fixed count or score puts everyone on the same rung.

Stability Plan — the document you are building across the twenty-four chapters, assembled in lesson 24. It is organized by what you need to find, not by lesson order, because you will be looking something up rather than revising a course.

Transfer — the moment at the end of a chapter when what you have written moves into your Stability Plan. The chapter is the workshop; the Plan is where the finished thing lives.

Clinical words you will meet

Read this block for orientation. Do not use these descriptions as criteria. They are deliberately high level, because deciding which of them applies to a person is assessment, and assessment is not something a workbook can do. Lesson 7 is where this vocabulary is actually taught.

Activation — increases in energy, speed, drive or restlessness. Worth naming separately from mood, because activation can rise while mood falls.

Acute and maintenance (lesson 14, page 165) — two different jobs a treatment can be doing. Acute means settling an episode that is happening now; maintenance means reducing the chance of the next one. The same medicine can be doing either, and knowing which is a question worth asking.

Adherence — whether medicine is taken as prescribed. It appears in records about you. It is a description of what happened, not a verdict on you, and it goes better when it can be said out loud.

Adjunctive (lesson 18, page 204) — added alongside, rather than instead of. Guideline-supported psychotherapies for bipolar disorder are described this way: they are added to pharmacological care.

Akathisia (lesson 15, page 174) — a restlessness felt in the body rather than only in the mood: an urge to keep moving, often in the legs, with a sense of unease you cannot settle. It can begin in the first weeks of an antipsychotic or after a dose increase. It has an entry here because **it is easily mistaken for anxiety or for the illness getting worse**, and describing what you are noticing gives a professional something specific to assess.

Antidepressant — a class of medicine used for depression. In bipolar disorder their use is debated, because for some people they can tip mood upward. Guidelines weigh this carefully and your prescriber decides what applies to you.

Antipsychotic — a class of medicine used in bipolar disorder for acute episodes and, for some people, longer term. The name is misleading: they are used well beyond psychosis. Akathisia, above, is one of the effects worth knowing about.

Bipolar I disorder (lesson 7, page 67) — the assessed history includes mania. Depression is common in bipolar I, but it is not what defines it.

Bipolar II disorder (lesson 7, page 67) — the assessed history includes hypomania and major depression, without mania. This does not mean the overall condition is mild.

Blood level (lesson 15, page 174) — the amount of a medicine in your blood at the moment the sample was taken. When the sample is taken can change how the result is read, which is why the appointment time matters; follow the instructions for your own medicine from whoever arranges the test. A level is one piece of information next to how you actually feel; symptoms can matter even when a level reads normal.

Cluster (lessons 2, 4, 8, 9) — the point that an episode involves several things changing together: mood, energy, activity, thinking, sleep, behavior and functioning. One feeling on one day is not a cluster.

Comorbidity — another condition present alongside bipolar disorder: anxiety, ADHD, a substance problem, a physical illness. Common, and not a complication of your character.

Cyclothymia (lesson 7, page 67) — a longer-term pattern of recurring hypomanic and depressive symptoms that does not form the same episode history as bipolar I or II.

Differential diagnosis — the work of telling apart conditions that look alike. Lesson 10 is about this. It is a professional's job, and the useful thing you can bring is description.

DSM and ICD — the two systems clinicians use to name conditions. DSM is mostly used in the United States, ICD internationally. They mostly agree and sometimes word things differently, which is why the same person can meet slightly different descriptions in different records.

Episode — a recognizable period in which several things change together and stay changed, rather than a single bad day or a strong feeling. Every framework sets its own thresholds for duration and severity, and **a professional decides whether a period counts as one**. This workbook describes periods; it never classifies them.

Euthymia — the word that appears in letters and notes to mean “no episode at the moment”. It does not mean nothing is happening, and it is not the same as your baseline: baseline is what is usual for you, euthymia is a clinical description of a period.

Functioning (lesson 23, page 252) — what you are able to do in daily life: work, study, care, relationships, admin. The Program treats functioning as something to describe and rebuild in one place at a time, never as a score of your worth as a person.

Lithium (lesson 15, page 174) — a mineral salt used in bipolar disorder for a long time. Two facts belong to you rather than to your prescriber: it needs periodic blood tests, and its warning picture — coarse tremor, unsteadiness, slurred speech, persistent vomiting or diarrhoea — can look like an ordinary illness and can appear even when the last level was normal. Lesson 15 says what to do about that. **Whether lithium is right for you, and at what dose, is a decision for the person who prescribes it.**

Mania and hypomania (lessons 7, 8) — mania is the central distinction for bipolar I. Hypomania is the less severe form, and it is what appears in bipolar II. “Less severe” describes the episode, not the illness and not the person.

Mixed features (lessons 7, 9) — activated and depressive features occurring together or overlapping within an episode or period. Exact wording varies between frameworks. The

combination deserves attention, which is a different statement from saying every mixed symptom is an emergency.

Mood stabilizer — an umbrella term for medicines used in the longer-term management of bipolar disorder. It is a category with soft edges, not a precise class, and the same medicine can be doing different jobs at different times. What yours is for in your case belongs in your own verified information, from the person who prescribes for you.

Personal recovery (lesson 24, page 261) — building a life you value, which is a broader thing than the absence of symptoms and is not a promise of cure.

Postpartum psychosis — a rare and serious emergency in the weeks after birth, and a risk that is higher in bipolar disorder. Sudden confusion, losing contact with reality, or symptoms escalating fast after a birth means emergency help now, not a routine appointment.

Prodrome — the clinical word for early warning signs: the changes that come before an episode is obvious. The warning ladder of lesson 19 is a prodrome map written in your own words.

Psychosis (lesson 8, page 77) — losing contact with shared reality: for example believing things others do not believe, or hearing or seeing things others do not. It can occur in severe mania and in severe depression. It is a reason to seek help quickly, and it says nothing about whether a person is dangerous.

Rapid cycling (lesson 7, page 67) — in common DSM-oriented information, four or more distinct mood episodes within twelve months. A professional determines what counts as an episode. It describes frequency over a period, not a permanent type of person.

Relapse and recurrence — the return of symptoms, or a new episode after a period of stability. Both are events, not verdicts on how well you have worked.

Remission — a period without significant symptoms. The other half of relapse and recurrence, and the state most of this workbook is written to protect.

Shared decision (lesson 13, page 154) — a decision that has two halves: professional evidence and judgment, and your own goals, values, circumstances and preferences. Both halves have to be in the room.

Suicidal ideation — thoughts about ending your life. Clinicians distinguish thoughts from intent and from a plan, because the response differs. All three are reportable, and none of them is a failure of yours.

Taper — reducing a medicine gradually, on a schedule set by the person who prescribes it. It appears in this workbook only so you can recognize the word. **The Program will never tell you to start, stop, taper, restart, select, or change a medication.**

Teratogenic — capable of affecting a developing pregnancy. Some medicines used in bipolar disorder carry this risk and some do not, and the balance is individual. Lesson 17 is about the questions, not the answers.

Treatment-resistant depression — the term used when depression has not responded to treatments that usually work. It is worth knowing that the label sometimes prompts a fresh look at the diagnosis. On its own it does not mean bipolar disorder.

If you came looking for a word

Some things are called something else here, on purpose. These point you to the entry.

- **Trigger** → see *Candidate pressure*. The Program avoids “trigger” because it sounds like a switch, and a pressure is something to watch, not a cause.
- **Warning signs** → see *Rung*, and the ladder of lesson 19.
- **Prodrome** → see the clinical entry, and *Rung*.
- **Cumplimiento, compliance** → see *Adherence*.
- **Lithium level, litemia** → see *Blood level*, and lesson 15.

How this stays free

You did not pay for this workbook, and nobody asked you for an email address to get it. There is no paid version and no premium tier. That is deliberate. I paid for my own psychoeducation, and the whole reason Bipolar Clarity exists is that your postcode and your salary should not decide whether you ever get taught your own illness.

It does mean the project runs on one thing: whether people find it.

If this was useful, three things help. All three are free.

Subscribe to the channel. For a small channel, subscribers and watch time are what decide whether YouTube shows a lesson to the next person searching at two in the morning. That person will not find this workbook first. They will find a video, or they will find nothing.

Give it to one person you have actually thought about. Someone with the diagnosis, someone who loves somebody who has it, someone who was handed a leaflet and nothing else. This travels the way a good doctor's name travels, one person telling one other person, and that beats a post everybody scrolls past.

Tell a professional that it exists. A clinic, a peer group, an association, the psychiatrist you see in three weeks. They can give away something free, in fifteen languages, that nobody has to sign up for. Most of them have nothing like it to hand out.

One thing I am not asking for: your answers. The pages you filled in are yours. Recommending the workbook and telling people about your own health are two different decisions, and you only have to make the first one.

Everything is at bipolarclarity.com/support.

Thank you for getting this far. It is not a small thing to work through twenty-four chapters about your own illness.

— René, Bipolar Clarity

Evidence and limitations

Structured psychoeducation is not a soft extra. It is one of the best-studied things you can add to medication in bipolar disorder, and the trial most often cited is the one from Barcelona.

One hundred and twenty people with stabilized bipolar disorder were randomly assigned either to a six-month group psychoeducation program or to an unstructured group. Ninety-nine of them were still being followed five years later. Over those five years, the people who had done the psychoeducation had fewer recurrences — 3.9 against 8.4 — and spent 154 days acutely ill instead of 586. That is roughly five months unwell across five years, instead of nineteen.

Colom F. et al. Group psychoeducation for stabilised bipolar disorders: 5-year outcome of a randomised clinical trial. *British Journal of Psychiatry*, 2009; 194: 260-265.

Three things that trial does not say, and it matters that you read them.

It does not say education replaces medication. Everyone in that study was on treatment, and the learning was built on top of it.

It does not say a workbook produces that result. What was studied was a clinician-led group, meeting weekly for six months, in a room.

And it does not say anything about you in particular. It is an average across a hundred and twenty people, and averages describe groups, not the person reading them.

What it does say is that for those hundred and twenty people, being taught their own illness, on purpose and in order, changed how the years afterwards went. That is the whole reason this exists. This is the syllabus from a room like that one — not the room, and not tested as if it were.

Everything else this Program states clinically is sourced the same way, and the sources are public. They are listed at bipolarclarity.com/program/sources, lesson by lesson, each one named: the guideline, the article, the book. If a source does not say what we say it says, that is our error and we want to hear about it.

FOR YOU, AND THE PEOPLE AROUND YOU

Your plan already exists. Who else knows how to use it?

You're using this workbook to understand what happens to you, to see an episode coming, and to have a plan before you need it. But you don't live inside that plan alone. The people who love you notice things: that you're sleeping less, talking faster, going quiet. Almost nobody has shown them what to do with it. So they watch, they argue, or they say nothing.



In November 2026 we're launching **the Bipolar Support Roadmap**: the program for your family, your partner and your friends.

What can change at home

TODAY, OFTEN	WITH THE ROADMAP
"Have you taken your meds?", three times a day.	They help with treatment without taking over , and agree with you how.
One sleepless night and everyone's on alert... or nobody notices until it's late.	They can tell a warning sign from a bad day, and know what to do first.
In a crisis, everyone improvises.	They've made a crisis plan before it's needed , one that can sit next to the routes you write in this workbook.
An argument that escalates.	They know when to pause a conversation, and how to come back to it.

Built to sit next to this program

Warning signs, a plan made before a crisis, asking before stepping in: the Roadmap covers the same ground as your workbook, from their side of the table.

You decide

Passing on the next page is optional: to whom, when, and whether. It contains nothing you've written. And the Roadmap doesn't ask them to watch you. It teaches them to ask before stepping in, and to take "no" for an answer.

For fourteen months I sat in a room that taught me my own illness. The people I live with never had a room like that. This is the one I'd have wanted for them.

— René

Do I have to tell them what I write here?
No. The Roadmap doesn't need it.

Does it cost anything?
No. It's free, like this program. No paid version, no account.

→ Tear off the next page, or forward it. It's for them.



BIPOLAR SUPPORT ROADMAP · FOR FAMILY, PARTNERS AND FRIENDS

For you, supporting someone with bipolar disorder

Someone who cares about you is following a program to look after their stability, and they thought of you. You notice things. Nobody taught you what to do with them. That's what the Bipolar Support Roadmap is for.

WHAT YOU'LL LEARN

- **Understanding what you see**, without watching every move.
- **Helping without taking over**: with treatment, with sleep, with alcohol or cannabis.
- **Noticing when an episode may be starting**, and what to do first.
- **Talking during conflict**, and when to pause the argument.
- **A crisis plan made before you need it**, with two routes.
- **Limits, children and rebuilding trust**.
- **Looking after yourself**, so you can keep going.

Does learning this actually help?

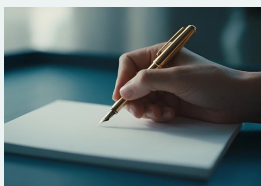
In a randomized trial in Barcelona, relatives of people with bipolar disorder attended twelve group sessions on their own; the patients didn't attend. Compared with families who received no extra sessions, fewer of those patients had a new episode during the study, mainly fewer manic and hypomanic episodes.¹ The Roadmap is not that trial. It is built on the same idea: what the people at home know matters.

¹ Reinares M, et al. *Bipolar Disorders* 2008;10(4): 511–519.

THE 19 LESSONS

- | | |
|--|--|
| <p>1 Someone You Love Was Diagnosed With Bipolar—What Now?</p> <p>2 Helping Someone With Bipolar: What's Actually Your Role?</p> <p>3 Understanding Bipolar Behavior: What Can You Really Know?</p> <p>4 Did You Cause Their Bipolar Episode?</p> <p>5 How to Help With Bipolar Treatment—Without Taking Over</p> <p>6 Bipolar and Sleep: How to Help Without Taking Over</p> <p>7 Bipolar Warning Sign or Just a Bad Day?</p> <p>8 Bipolar, Alcohol and Cannabis: How Can You Help?</p> <p>9 Early Signs of Mania and Hypomania Loved Ones May Notice</p> | <p>10 Bipolar Depression and Mixed States: What to Notice</p> <p>11 A Bipolar Episode May Be Starting—What Should You Do?</p> <p>12 How to Talk to Someone With Bipolar During Conflict</p> <p>13 How to Respond to Mania Without Adding to the Conflict</p> <p>14 How to Help Someone With Bipolar Depression</p> <p>15 Make a Bipolar Crisis Plan Before You Need It</p> <p>16 Bipolar, Boundaries and Children: Where to Draw the Line</p> <p>17 When Bipolar Strains the Family: Where Do You Start?</p> <p>18 How to Rebuild Trust After a Bipolar Episode</p> <p>19 Support Someone With Bipolar Without Losing Yourself</p> |
|--|--|

HOW IT WORKS One short video and one worksheet per lesson · a two-minute route for the weeks when that's all you have · built *with* the person you support, not around them · free, no account · not therapy and not a crisis service.



Out in November 2026. Sign up and we'll tell you on day one.

I'm passing this on because...



bipolarclarity.com/family

If you're worried about their safety right now: bipolarclarity.com/gethelp. The crisis lines for every country are also on the last pages of this document.

If you're in immediate danger

Call your local emergency number right now (for example, 911 in the US, 999 in the UK, 112 across the EU).

Crisis lines by country

COUNTRY OR REGION	LINE
Algeria	no national crisis line we could verify – in an emergency call 14 (ambulance) or 17 (police); to find a line, see findahelpline.com .
Argentina	call 135 (Buenos Aires) or 0800 345 1435 – Centro de Asistencia al Suicida.
Australia	call 13 11 14 – Lifeline (24/7).
Bahrain	no national crisis line we could verify – in an emergency call 999; to find a line, see findahelpline.com .
Belgium	call 1813 – Zelfmoordlijn 1813 (24/7).
Brazil	call 188 – CVV, Centro de Valorização da Vida (24/7).
Chile	call *4141 (24/7).
China (mainland)	call 12356 – 全国心理援助热线, National Psychological Assistance Hotline (daily, hours vary by province, at least 18h/day).
Denmark	call 70 201 201 – Livslinien.
Egypt	call 0800 888 0700 – Ministry of Health and Population mental health hotline (24/7).
Finland	call 09 2525 0111 – MIELI (24/7) · English 09 2525 0116.
France	call 3114 – Numéro national de prévention du suicide (24/7).
Germany	call 0800 111 0 111 – Telefonseelsorge (24/7). Austria 142 · Switzerland 143.
Hong Kong	call 2896 0000 – The Samaritan Befrienders Hong Kong (24/7, Cantonese); multilingual 2389 2222 – The Samaritans (24/7).
India	call 14416 or 1800-89-14416 – Tele-MANAS (24/7, 20 languages).
Iraq	no national crisis line we could verify – in an emergency call 122 (ambulance) or 104 (police); to find a line, see findahelpline.com .
Israel	call 1201 – ERAN, Emotional First Aid (24/7).
Italy	call 02 2327 2327 – Telefono Amico Italia; emergencies 112.
Japan	call 0120-279-338 – よりそいホットライン (24/7).
Jordan	call 079 544 0416 – JCPA Suicide & Crisis Line (24/7); emergencies 911.
Kuwait	no national crisis line we could verify – in an emergency call 112; to find a line, see findahelpline.com .
Lebanon	call 1564 – Embrace Lifeline, National Lifeline (24/7, Arabic/English/French).
Mexico	call 800 911 2000 – Línea de la Vida (24/7).
Morocco	no national crisis line we could verify – in an emergency call 15 (ambulance) or 19 (police); to find a line, see findahelpline.com .

COUNTRY OR REGION	LINE
Netherlands	call 0800-0113 – 113 Zelfmoordpreventie (24/7) · 113.
New Zealand	call or text 1737 (24/7) · Lifeline 0800 543 354.
Norway	call 116 123 – Mental Helse (24/7).
Oman	no national crisis line we could verify – in an emergency call 9999; to find a line, see findahelpline.com.
Poland	call 116 123 – Telefon Zaufania dla Osób Dorosłych w Kryzysie Emocjonalnym – hours: see 116sos.pl.
Portugal	call 808 24 24 24 – SNS 24.
Qatar	call 919 – AMAN Centre, Protection and Social Rehabilitation Centre (24/7).
Russia	no national crisis line we could verify – in an emergency call 112; to find a line, see findahelpline.com.
Saudi Arabia	call 920033360 – National Center for Mental Health Promotion, psychological support helpline (not 24/7; set daytime hours).
Singapore	call 1771 – national mindline (24/7) · SOS 1767.
South Africa	call 0800 567 567 – SADAG.
South Korea	call 109 – 자살예방 상담전화 (24/7).
Spain	call 024 – Línea de atención a la conducta suicida (24/7).
Sweden	call 90 101 – Självvmordslinjen (Mind).
Taiwan	call 1925 – 安心專線, Anxin Hotline, Ministry of Health and Welfare (24/7).
Tunisia	call 8010 3666 – Association Tunisienne de Prévention du Suicide (ATPS).
United Arab Emirates	call 800-HOPE (800 4673) – National Mental Support Line, MOHAP (8am–8pm daily).
UK & Ireland	call 116 123 – Samaritans (24/7); in the UK you can also text SHOUT to 85258.
US & Canada	call or text 988 – Suicide & Crisis Lifeline (24/7).
Europe (any country)	call 112 for emergencies.

Numbers can change, and many countries aren't listed here. If yours is missing, find a verified local line in seconds at findahelpline.com.

If you're not safe at home

The lines below are for violence or abuse at home – from a partner, a family member, anyone you live with. An illness can explain a behaviour; it never excuses it. You don't have to have decided anything to call.

COUNTRY OR REGION	LINE
Algeria	call 0560 100 105 – Réseau Wassila-AVIFE (Sunday–Thursday, daytime hours).
Argentina	call 144 – Línea 144 (24/7).

COUNTRY OR REGION	LINE
Australia	call 1800 737 732 – 1800RESPECT (24/7); or text 0458 737 732.
Bahrain	call 80001488 – Aisha Yateem Family Counseling Centre (hours not confirmed).
Belgium	call 1712 – Hulplijn 1712 (Dutch, weekdays) · call 0800 30 030 – Écoute Violences Conjugales (French).
Brazil	call 180 – Ligue 180, Central de Atendimento à Mulher (24/7).
Chile	call 1455 – Fono Orientación, SernamEG (24/7).
China (mainland)	call 12338 (dial with your local area code) – All-China Women's Federation Rights Protection Hotline (24/7).
Denmark	call 1888 – Lev Uden Vold (24/7).
Egypt	call 15115 – National Council for Women, Complaints Office (24/7).
Finland	call 116 016 – Nollalinja (24/7); the old number 080 005 005 still works.
France	call 3919 – Violences Femmes Info (24/7); the call doesn't show on your phone bill.
Germany	call 116 016 – Hilfetelefon Gewalt gegen Frauen (24/7). Austria 0800 222 555 · Switzerland 142.
Hong Kong	call 2522 0434 – Harmony House 24-hour Woman Hotline (24/7).
India	call 181 – Women Helpline (24/7).
Iraq	no national domestic-violence line we could verify – in an emergency call 122 (ambulance) or 104 (police); to find a line, see findahelpline.com.
Israel	call 118 – national domestic violence hotline (24/7, Hebrew, Arabic, English, Russian, Amharic).
Italy	call 1522 – numero antiviolenza e stalking (24/7).
Japan	call 0120-279-889 – DV相談+ (24/7).
Jordan	call 110 – National Family Protection Hotline, Family Protection Department (24/7).
Kuwait	no national domestic-violence line we could verify – in an emergency call 112; to find a line, see findahelpline.com.
Lebanon	call 03-018019 – KAFA Helpline (24/7, Arabic/English).
Mexico	call 079, option 1 – Línea de las Mujeres (24/7).
Morocco	call 8350 – Union Nationale des Femmes Marocaines (UNFM), "Koulounamaak" green line (Arabic/French; hours not confirmed).
Netherlands	call 0800-2000 – Veilig Thuis (24/7).
New Zealand	call 0800 456 450 – Are You OK (24/7) · Women's Refuge 0800 733 843.
Norway	call 116 006 – VO-linjen (24/7).
Oman	no national domestic-violence line we could verify – in an emergency call 9999; to find a line, see findahelpline.com.
Poland	call 800 120 002 – Niebieska Linia, Blue Line (24/7); English Mondays 6–10pm, Russian Tuesdays 6–10pm.
Portugal	call 800 202 148 – Linha de Informação às Vítimas de Violência Doméstica (24/7); or text 3060.
Qatar	call 919 – AMAN Centre, Protection and Social Rehabilitation Centre (24/7).

COUNTRY OR REGION	LINE
Russia	call 8-800-7000-600 – ANNA Center, National Center for the Prevention of Violence (9am–9pm).
Saudi Arabia	call 1919 – Domestic Violence Reporting Center, Ministry of Human Resources and Social Development (24/7).
Singapore	call 1800-777-0000 – National Anti-Violence and Sexual Harassment Helpline (24/7).
South Africa	call 0800 428 428 – GBV Command Centre (24/7).
South Korea	call 1366 – 여성긴급전화 1366 (24/7).
Spain	call 016 (24/7) – the call doesn't show on your phone bill · WhatsApp 600 000 016.
Sweden	call 116 016 – Kvinnofridslinjen (24/7); the old number 020-50 50 50 still works.
Taiwan	call 113 – Protection Hotline 113, for domestic violence, sexual assault and abuse (24/7, multilingual).
Tunisia	call 1899 – Ligne Verte 1899, National Observatory to Combat Violence Against Women (24/7, Arabic/French).
United Arab Emirates	call 800111 – Dubai Foundation for Women and Children (DFWAC) (24/7).
UK & Ireland	UK 0808 2000 247 – National Domestic Abuse Helpline (24/7) · Ireland 1800 341 900 – Women's Aid (24/7).
US & Canada	US, call 1-800-799-7233 – National Domestic Violence Hotline (24/7), or text START to 88788. In Canada, find your nearest shelter at sheltersafe.ca.
Europe (any country)	call 112 for emergencies.

Numbers can change, and many countries aren't listed here. If yours is missing, the NO MORE Global Directory lists services in more than 190 countries. If you're in immediate danger, call your local emergency number first.

Anywhere in the world

Find a free helpline in your country here: findahelpline.com or befrienders.org. You can also tell someone you trust what you're feeling, and ask them to stay with you.

If it's not an emergency, but you're struggling

Call your clinician or care team, or book the soonest appointment you can. If you have a crisis plan or a safety contact, now is the moment to use it. Getting through the next hour is enough – you don't have to solve everything today.

Bipolar Clarity is educational content and cannot provide emergency help or personal medical advice. Please use the resources above for urgent support.

About Bipolar Clarity

Bipolar Clarity is written by René, who has lived with bipolar disorder since 1993 and was diagnosed in 2018. The lessons are presented by Clara, an AI host — he uses one to protect his privacy while sharing his real experience. The face is synthetic; the story is real.

The Bipolar Stability Program is twenty-four lessons, free, in fifteen languages. The videos, this workbook and every chapter of it are at bipolarclarity.com. A new one-page tool goes out by email once a week, at bipolarclarity.com/newsletter.

Educational content only. It is not a substitute for professional diagnosis or treatment, and nothing in it tells you to start, stop, taper, restart, select or change a medication. If you need help right now, the crisis lines are on page **287**.

bipolarclarity.com