

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.

LESSON 7 OF TWENTY-FOUR



Watch this lesson
bipolarclarity.com/program/I07

This is one lesson of twenty-four

The **Bipolar Stability Program** is twenty-four free lessons for people who already have a bipolar diagnosis. Each lesson is a video; each chapter is the paper that goes with it. Fifteen languages, no email, no account, no paid version.

Before you start

Nothing here will ever tell you to start, stop, taper, restart, select or change a medication. Blank is allowed, «not sure yet» is an answer, and there is no version of this you can fail. If a chapter sends you to another lesson, the lesson number is in brackets. The crisis numbers for your country are at the back of this chapter.

Why this exists

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

Then I got lucky. A hospital near me ran a psychoeducation group: a psychiatrist, 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. What stayed with me wasn't any single fact — it was that somebody had put the facts *in an order*. I had spent twenty-five years collecting pieces; in that room, for the first time, they were a sequence.

Almost nobody gets that room. Mine needed two clinicians, a group, a waiting list, and all of it close enough to my home to attend every week for a year. It also cost me thousands of dollars.

So I rebuilt it as something you can start tonight, wherever you are, in fifteen languages, free — now and later. Not a trial, not a sample, nothing held back for a paid version.

— René, Bipolar Clarity

What twenty-four chapters build that one cannot

Every chapter writes a piece of the same document. Lesson 1 starts your safety page, lesson 4 names your first warning signs, lesson 19 turns them into a ladder with an action and a contact on each rung, and lesson 24 assembles all of it into your **Stability Plan**: one thing you can hand to somebody on a bad day, or take into an appointment when you cannot find the words.

A single chapter gives you a page. The twenty-four give you the plan.

The twenty-four

You can do this chapter on its own — it was written that way. The numbers are the order we recommend, not a lock.

01	Newly Diagnosed With Bipolar? Write This Page First	
02	What Is Bipolar Disorder? (And What It Isn't)	
03	Bipolar Sleep: 3 Short Nights That Mean Different Things	
04	Bipolar Early Warning Signs: Pick 4 That Are Yours	
05	What Is My Bipolar Medication Actually For?	
06	Bipolar Life Chart: How to Map Your Mood History	
07	Bipolar 1 vs Bipolar 2: What the Number Really Means	YOU ARE HERE
08	Hypomania Signs Others Often Notice Before You Do	
09	Manic and Depressed at the Same Time? Mixed Features	
10	Bipolar Disorder or Something Else? Thyroid, Trauma, ADHD	
11	Alcohol, Cannabis, and Bipolar Disorder: What to Notice	
12	Bipolar Triggers: What Adds Pressure—and What Protects You	
13	Bipolar Psychiatry Appointment: Make the Short Visit Count	
14	I Feel Fine. Why Am I Still on Bipolar Medication?	
15	Bipolar Side Effects: What to Track and When to Call	
16	Thinking About Stopping Bipolar Medication? Start Here	
17	Bipolar Disorder and Pregnancy: Questions to Ask Early	
18	Does Therapy Help Bipolar Disorder? What the Evidence Says	
19	Bipolar Warning Signs: Subtle, Clear, and Urgent	
20	How to Draft a Bipolar Crisis Plan—Before You Need It	
21	I Think a Bipolar Episode Is Starting—What Should I Do?	
22	How to Build a Routine That Helps With Bipolar Disorder	
23	Life After a Bipolar Episode: Work, Money, and Relationships	
24	Grieving the Person You Were: Bipolar and Identity	



Start at lesson 1
bipolarclarity.com/program/I01



All 24 in one book
bipolarclarity.com/workbook

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.

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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

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.

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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.

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

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.

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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.

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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 end of this chapter.

Words used in this chapter

Only the ones this chapter actually uses. The full glossary is in the complete workbook.

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.

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.

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.

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.

Activation — increases in energy, speed, drive or restlessness. Worth naming separately from mood, because activation can rise while mood falls.

Bipolar I disorder (lesson 7) — the assessed history includes mania. Depression is common in bipolar I, but it is not what defines it.

Bipolar II disorder (lesson 7) — the assessed history includes hypomania and major depression, without mania. This does not mean the overall condition is mild.

Cyclothymia (lesson 7) — a longer-term pattern of recurring hypomanic and depressive symptoms that does not form the same episode history as bipolar I or II.

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.

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.

Psychosis (lesson 8) — 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) — 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.

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.**

If this chapter was worth the time

You have just finished one of twenty-four. The rest are written the same way, they are free in the same way, and they build one thing: a plan you can hand to somebody on a bad day.

The complete workbook has all twenty-four chapters in one book, plus the map of how they fit together and the full glossary. bipolarclarity.com/workbook

No email address, no account, no paid version. If you would rather take it one chapter at a time, that works too — each lesson has its own.

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



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.

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

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.

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?

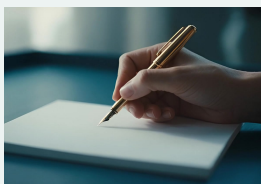
In a randomized trial in Barcelona, relatives of people with bipolar disorder attended twelve group sessions on their own; the patients didn't attend. Compared with families who received no extra sessions, fewer of those patients had a new episode during the study, mainly fewer manic and hypomanic episodes.¹ 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 – Självordslinjen (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.