

Bipolar I Disorder

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THE STORY IN ONE SENTENCE

Bipolar I is defined by one thing: at least one manic episode — a week or more of sky-high or cranky mood with relentless energy severe enough to wreck daily life, land you in the hospital, or make you lose touch with reality. Depression usually shows up too, but mania alone makes the diagnosis.

“The mood system loses its ceiling: at least one full manic episode (a week or longer, or any length if the hospital is needed) with huge confidence, almost no need for sleep, nonstop fast talking and racing thoughts, and risky choices that cause real damage — usually swinging over a lifetime with crushing low episodes.”

Normal anatomy — the body's job

Mood runs between a floor and a ceiling. The ventral tegmental area and nucleus accumbens (deep brain reward centers) and the locus coeruleus (the brain's wake-up alarm in the brainstem) release dopamine and norepinephrine (brain messengers that drive confidence, energy, and reward-seeking). The prefrontal cortex (the front of the brain that judges risk and pumps the brakes) and the suprachiasmatic nucleus (the tiny brain clock in the hypothalamus that runs your sleep-wake cycle) keep the system inside the band. Sleep is both the thermostat's readout and one of its main inputs.

BODY'S JOB

Allow high-energy, confident states when life calls for them — and always bring mood, judgment, and sleep back inside the band.

1. Opportunity or challenge raises drive and confidence
2. The ventral tegmental area and nucleus accumbens (deep reward centers) release dopamine (the brain's 'go get it' messenger) to fuel goal pursuit

3. The prefrontal cortex (the front brake center) risk-checks the plans and weighs consequences
4. The suprachiasmatic nucleus (the brain's master clock in the hypothalamus) enforces sleep regardless of excitement by shutting down the wake signal
5. Mood, energy, and sleep return to baseline when the situation resolves

What breaks

In a manic episode the ceiling fails. For at least one week — or any length if the hospital becomes necessary — mood runs abnormally sky-high, wide-open, or cranky WITH nonstop increased energy, nearly all day, every day. Sleep need collapses (two hours feels like plenty — the single most specific sign). Huge confidence inflates, speech speeds up and won't stop, thoughts race, attention scatters to every noise or sight, goal-driven activity multiplies, and judgment fails at full speed: spending sprees, business gambles, sexual risk. In severe mania, psychosis joins — huge false beliefs (like thinking you are famous or being watched) or hearing voices. This is the defining episode of bipolar I; most patients also cycle into major low episodes, but the manic episode alone is enough and required for the diagnosis.

CLINICAL TERM

Manic episode (DSM-5-TR): at least one week (or any length if hospitalization required) of abnormally elevated, expansive, or irritable mood AND increased energy or activity, most of the day nearly every day, with at least three of seven symptoms (at least four if mood only irritable): inflated self-esteem or grandiosity, decreased need for sleep, more talkative than usual or pressure to keep talking, flight of ideas or subjective racing thoughts, distractibility, increased goal-directed activity or psychomotor agitation, excessive involvement in activities with painful consequences — causing marked impairment in social or occupational functioning, necessitating hospitalization to prevent harm, or with psychotic features. One lifetime manic episode equals bipolar I disorder.

How the body compensates

Early in the episode the person feels better than well — productive, magnetic, needing nothing. The body burns reserves silently: no sleep, skipped meals, escalating risk. Families compensate by cleaning up the damage — paying the debts, apologizing to employers — which delays care until the crash or the crisis. After the episode, depression typically arrives with the wreckage bill.

1. Feels 'better than ever' — insight is the first casualty; the person does not see the problem
2. Body runs on borrowed energy: no sleep, little food, no fatigue signal — the system is draining reserves it does not have

3. Family absorbs consequences: debts, apologies, cover stories — keeping the person out of the hospital short-term but letting the episode climb higher
4. Risk compounds until a crisis forces contact with care — job loss, arrest, psychosis, or danger to self or others
5. Post-manic depression lands on top of the real-world wreckage — the person wakes up to lost relationships, empty accounts, and shame

Domino effect

1. Sleep loss accelerates the mania — Sleep deprivation (less than four hours per night or skipping sleep entirely) is both symptom and fuel — each sleepless night pushes dopamine and norepinephrine higher and the prefrontal brake weaker; protecting sleep (with sedating medications like benzodiazepines or antipsychotics in the acute phase) is a treatment target, not a comfort measure.
2. Judgment failure creates real-world damage at speed — A single week of mania can end careers, marriages, and savings — maxing out credit cards, quitting a job on impulse, risky sexual encounters, or reckless driving — the impairment criterion in the DSM is written in life consequences.
3. Psychosis can join at the peak — Grandiose delusions (believing you are famous, have special powers, or are on a divine mission) or paranoid delusions (believing you are being watched or poisoned) occur in severe mania when dopamine in the mesolimbic pathway (the brain's reward and salience circuit) spikes beyond the threshold for reality testing; psychosis always makes the episode manic (never hypomanic) and often forces hospitalization.
4. The crash: post-manic major depressive episode — Depressive episodes (low mood, no energy, guilt, thoughts of death) dominate the long-term course of bipolar I — patients spend three times as many weeks depressed as manic — and carry the suicide risk; lifetime suicide attempt rates in bipolar disorder reach fifteen to twenty percent, among the highest in psychiatry.
5. Each untreated episode makes the next more likely and harder to stop — Kindling hypothesis: repeated mood episodes sensitize the limbic system (the emotional brain centers including the amygdala and hippocampus) so that future episodes come easier, closer together, and with less external trigger — the biological argument for staying on a mood stabilizer (lithium, valproate, or an atypical antipsychotic like quetiapine) between episodes, not just during them.

Symptoms · what the patient feels, and why

- Elevated, expansive, or irritable mood with increased energy or activity, lasting at least 1 week (or any length if hospitalized): In mania, the limbic system (the brain's emotion center, including the amygdala and reward circuits) becomes overactive, and the prefrontal cortex (the front of the brain that pumps the brakes on impulses) loses its normal control. Dopamine (a brain messenger linked to drive, reward, and movement) floods key circuits. This runaway activity lifts mood sky-high or makes a person very irritable, and cranks up energy and goal-chasing behavior. Both the mood change AND the extra energy must be there, most of the day nearly every day, for the episode to count as manic.
- Decreased need for sleep — feeling fully rested after only 2 or 3 hours: The brain's internal clock (controlled by the suprachiasmatic nucleus in the hypothalamus) and its sleep-pressure system (using adenosine, a chemical that builds up when you are awake and makes you tired) both get thrown off. In mania, the person does not build up that sleepy feeling the way they should, so they wake up after a tiny amount of sleep and feel wide awake and ready to go. This is very different from insomnia, where someone wants to sleep but cannot — here the person simply does not feel the need. It is often the very first sign that mania is starting, and one of the most specific clues that what you are seeing is true mania.
- Three or more of the DIGFAST symptoms (or four if the mood is only irritable): Distractibility, Impulsivity or risky behavior, Grandiosity (inflated self-esteem), Flight of ideas or racing thoughts, increased goal-directed Activity, pressured Speech, decreased need for sleep (Tachypsychia means speeded-up thinking): The overactive dopamine and norepinephrine (another brain messenger that drives alertness and action) circuits speed up thinking, talking, and movement. The person's attention jumps from thing to thing (distractibility), thoughts race faster than they can speak them (flight of ideas), speech comes out in a fast torrent that is hard to interrupt (pressured speech), and they start many projects at once (increased goal-directed activity). The weakened prefrontal brake means poor judgment, so they do risky things — wild spending, reckless driving, hypersexual behavior — without thinking through the harm. Grandiosity (believing you have special powers, connections, or talents far beyond reality) comes from the reward circuits telling the person they are on top of the world. You need at least three of these riding along with the mood and energy change to diagnose a manic episode (or four if the mood is only irritable, not elevated or expansive).

- Psychotic features — grandiose or paranoid delusions (fixed false beliefs) or hallucinations (seeing or hearing things that are not there): In severe mania, the overactive dopamine in the mesolimbic pathway (the brain's reward and salience circuit) can reach such high levels that it breaks the person's grip on reality. They may believe they have godlike powers, are secretly famous, or are on a divine mission (grandiose delusions), or that others are plotting against them (paranoid delusions). Some hear voices or see visions. Psychosis during a mood episode automatically makes the episode manic (never hypomanic) and usually means the person needs hospital-level care for safety.
- Major depressive episodes — at least 2 weeks of low mood or loss of interest, plus at least five of nine symptoms (sleep change, appetite or weight change, low energy, trouble concentrating, feelings of worthlessness or guilt, thoughts of death or suicide, slowed movements or restlessness): Bipolar I disorder does not require a depressive episode for diagnosis — one manic episode is enough — but most people with bipolar I do have major depression at some point, and depressive episodes often take up more of their lifetime than manic ones. In the depressive pole, serotonin (a brain messenger that steadies mood, sleep, and appetite) and norepinephrine drop, and the prefrontal cortex and hippocampus (a memory and emotion-regulation center) show lower activity. This creates the opposite picture from mania: low energy, too much or too little sleep (but with fatigue, not the rested feeling of mania), dark hopeless thoughts, and sometimes the dangerous thought that life is not worth living.
- Mixed features — depressive mood with manic energy, or manic mood with depressive thoughts, in the same episode: Sometimes the overactive and underactive circuits fire at the same time, or an episode shifts partway from one pole toward the other without fully flipping. The person may feel desperately sad or hopeless (depressive mood and thoughts) but also revved up, unable to sleep, and agitated (manic energy). This is the most dangerous state in all of psychiatry for suicide, because the person has dark, life-ending thoughts and the fuel and impulsivity to act on them quickly. It requires urgent intervention and close monitoring.
- Significant impairment in work, relationships, or daily function, or need for hospitalization to prevent harm: By definition, a manic episode causes marked problems — the person cannot do their job safely, damages key relationships through reckless or hostile behavior, or puts themselves or others at risk (e.g., dangerous driving, spending the family into debt, aggressive confrontations). If the impairment is mild and the person can still function reasonably well, the episode is hypomanic, not manic. Hospitalization is often needed during mania to prevent harm, protect the person's safety and finances, and bring the episode under control with medication.

Focused exam

- Pressured speech that you cannot interrupt; thoughts jump from idea to idea without finishing (flight of ideas): When someone talks so fast you cannot break in and their ideas keep skipping ahead, that marks a full manic episode—not hypomania. Hypomania lets you redirect the conversation; mania does not.
- Cannot sit still—pacing, fidgeting, jumping up from the chair (psychomotor agitation): Seeing the person move nonstop during the visit proves the energy boost is real and warns you that things can spiral quickly.
- Believes they have special powers, a secret mission, or that others are plotting against them (grandiose or paranoid delusions): Losing touch with reality during a high means manic episode with psychosis, which equals bipolar I disorder, and almost always means the person needs to be in the hospital for safety.
- Body shows wear—dry lips and skin from not drinking, weight loss from not eating, bruises or cuts from risky behavior: Going days without sleep, food, or water while moving at high speed damages the body. You must treat the medical problems at the same time you treat the mood.
- During a low phase months later: moving and talking slowly, flat face, talking about wanting to die (psychomotor retardation and suicidal thoughts): The same person can swing to deep depression that looks just like major depression. The diagnosis comes from the chart showing the manic episode in the past—not from what you see today.
- Decreased need for sleep—feels fully rested after only 2 to 3 hours per night for several days in a row: This is different from insomnia where someone cannot sleep but still feels tired. In mania, the person truly does not need sleep and still has huge energy. The brain's sleep-wake system in the hypothalamus (the control center for sleep and alertness) is overridden by abnormal bursts of activity in circuits involving dopamine (a brain messenger that drives motivation and reward) and norepinephrine (a messenger that amps up alertness and energy). Seeing this pattern for days confirms mania.

Diagnostics · every test answers a question

- DSM-5 manic-episode checklist (interview and chart review) → Did the person have at least one week (or any length if hospitalized) of feeling way too high, way too irritable, or way too expansive PLUS more energy than usual, with at least three DIGFAST symptoms (Distractibility, Insomnia with decreased need for sleep, Grandiosity, Flight of ideas, Activity increase, Speech pressured, Thoughtless risky behavior)—or four symptoms if the mood was only irritable—bad enough to cause serious problems at work or home, need hospitalization, or include delusions or hallucinations?

- Depression history (PHQ-9 score, timeline of past lows) → Has the person had major depressive episodes, and do the lows outnumber the highs over their lifetime?
- Urine drug screen (cocaine, amphetamines, methamphetamine) and full medication list → Are stimulant drugs, cocaine, or steroid medicines (like prednisone) causing the high mood?
- TSH (thyroid-stimulating hormone), basic metabolic panel (sodium, potassium, creatinine, glucose), and complete blood count (CBC) → Is an overactive thyroid (hyperthyroidism) copying the signs of mania, and what are the kidney, thyroid, liver, and blood-cell starting numbers before you start lithium or valproate?
- Mood Disorder Questionnaire (MDQ) and interview with family or close friend → When the person comes in looking depressed, is there a hidden history of manic highs that they forgot to mention or did not think mattered?
- Urine or serum pregnancy test (hCG) before starting a mood stabilizer in anyone who can become pregnant → Is the person pregnant, which changes which mood medicines you can safely use?
- Lithium level (drawn 12 hours after the last dose) once treatment starts → Is the lithium dose high enough to work but not so high that it poisons the person?
- Creatinine and estimated glomerular filtration rate (eGFR) every 6 to 12 months if on lithium → Is lithium hurting the kidneys over time?

Treatment logic

- Acute mania: keep the person safe (often in the hospital) and start fast mood control with lithium or valproate AND/OR an antipsychotic (olanzapine, risperidone, quetiapine, or aripiprazole) → Antipsychotics calm the agitation and psychosis within days while the mood stabilizer builds up over weeks. Severe mania usually needs both at once. Hospitalization protects the person from the dangerous choices mania pushes them to make.
- STOP any antidepressant (SSRI, SNRI, bupropion) as soon as mania starts → Antidepressants can pour fuel on a manic fire by increasing serotonin (a brain messenger that helps mood but can tip someone into mania when circuits are already unstable) or norepinephrine (a messenger that amps up energy and alertness). Taking them away helps the mania calm down faster.
- Bipolar depression: use quetiapine, lurasidone, cariprazine, lamotrigine, or the olanzapine-fluoxetine combination—NOT an antidepressant by itself → These medicines lift the depression without flipping the person into mania. Lamotrigine is especially good at preventing depression from coming back.

- Long-term prevention: lithium is first choice (the only mood stabilizer proven to lower suicide risk), plus keep a regular sleep schedule and teach the person and family about the illness → Lithium cuts down relapses into both mania and depression and is the only mood medicine shown to prevent suicide. A steady sleep-wake rhythm acts like medicine—it keeps the brain's internal clock (the suprachiasmatic nucleus in the hypothalamus, which controls sleep and wake cycles) stable, and that steadies mood circuits involving serotonin and norepinephrine.
- Electroconvulsive therapy (ECT) for mania or depression that does not respond to medicine, includes psychosis, or is immediately life-threatening → ECT works fast in both mania and severe bipolar depression when medicines fail or when you cannot wait for them to work. It resets abnormal electrical activity across the brain, especially in the prefrontal cortex (the front of the brain that pumps the brakes on big feelings) and limbic areas like the amygdala (the alarm center that flags danger and drives emotional intensity).
- Psychotherapy (cognitive-behavioral therapy, family-focused therapy, or interpersonal and social rhythm therapy) alongside medicine → Therapy helps the person spot early warning signs of a new episode, stick to medicine, keep a regular daily routine (sleep, meals, activity), and repair relationships damaged by past episodes. Family therapy teaches loved ones how to support without enabling and how to lower conflict at home (high stress and irregular schedules are two of the biggest triggers for relapse).

Medications

Lithium — for mania (right now and long-term) and the only medicine proven to lower suicide risk · Mood stabilizer

Lithium changes how signals move inside brain cells that control mood. It slows down certain chemical messengers (inositol and an enzyme called GSK-3 β) so the brain's mood dial stops swinging too high or too low. Over weeks, it rebuilds stable upper and lower limits on mood. No other bipolar medicine has been shown to cut suicide risk — lithium is unique in that.

1. Lithium enters brain cells and gradually shifts the inner chemical signals over days to weeks.
2. The manic energy, racing thoughts, and wild mood swings start to settle as the brain's mood ceiling drops back down.
3. With steady daily doses, lithium holds both the ceiling and the floor in place long-term, preventing future manic and depressive episodes and lowering the chance of suicide.

SAFETY WATCH

Blood level must stay in a safe window: 0.8–1.2 mEq/L when treating active mania, 0.6–1.0 mEq/L for long-term prevention. Levels above 1.5 mean toxicity — you may see a shaky tremor (coarser than the fine tremor at normal levels), throwing up, stumbling walk (ataxia, which means your muscles lose coordination), and confusion. If that happens, stop the lithium, drink fluids, and get a blood level checked right away. · Anything that dehydrates you or lowers how much you pee — such as sweating heavily, vomiting, diarrhea, NSAIDs like ibuprofen, blood-pressure pills called ACE inhibitors or thiazide diuretics — can push lithium levels up into the danger zone. · Long-term use can slow down the thyroid gland (hypothyroidism, which means your thyroid does not make enough hormone to keep your energy and metabolism normal) or make the kidneys unable to hold onto water properly (nephrogenic diabetes insipidus, which means you pee a lot and get very thirsty). Doctors check thyroid (TSH) and kidney function (creatinine) regularly. Lithium in early pregnancy raises the risk of a heart defect in the baby called Ebstein anomaly (where one of the heart valves does not form correctly), so pregnancy planning and birth control are important topics.

Valproate (also called divalproex) — for mania (right now), rapid cycling, and mixed features · Mood stabilizer (anticonvulsant — originally a seizure medicine)

Valproate does two things: it turns up GABA (the brain's main calming chemical messenger) and it blocks sodium gates on nerve cells (like flipping a circuit breaker). Together these actions slow down the overexcited electrical firing that drives mania. Valproate can be loaded faster than lithium — you can reach helpful levels in a few days instead of weeks — which is why doctors reach for it when mania is severe, mixed with depression, or cycling rapidly between poles.

1. Valproate can be started at a higher dose (loading dose) and reach working levels within days.
2. The runaway energy, racing thoughts, risky behavior, and agitation of mania begin to settle as the brain's brakes strengthen and the overactive firing slows.
3. After the manic episode ends, a maintenance dose helps prevent future manic swings.

SAFETY WATCH

Valproate can damage the liver (hepatotoxicity, which means the liver cells get inflamed and stop working right) or inflame the pancreas (pancreatitis, a painful and dangerous swelling of the organ that makes digestive enzymes). Doctors check liver tests (ALT, AST, bilirubin) before you start and then periodically. · It can lower platelet counts (thrombocytopenia — platelets help your blood clot), so a complete blood count (CBC) is monitored. · Valproate is HIGHLY TERATOGENIC — it causes serious birth defects, especially of the brain and spine (neural-tube defects like spina bifida, where the backbone does not close all the way), much more often than most other medicines. It should be avoided in pregnancy whenever possible, and anyone who can become pregnant must use reliable birth control and discuss the risks.

Olanzapine, Risperidone, Quetiapine, or Aripiprazole — for mania (right now, especially severe agitation and psychosis) · Second-generation antipsychotic (also called atypical antipsychotic)

These medicines block dopamine receptors (the D2 type) and serotonin receptors (the 5-HT2A type) in the brain. Mania involves too much dopamine activity, like a car with the gas pedal stuck down. Blocking D2 receptors is like easing off that pedal — it cools the overheated reward and emotion circuits within hours to days. These antipsychotics are the fast lane: they calm agitation, restore sleep, and stop psychotic symptoms (delusions, hallucinations) while lithium or valproate slowly builds up. Some patients stay on them long-term, often combined with a mood stabilizer.

1. The medicine blocks dopamine D2 receptors and serotonin 5-HT2A receptors within hours to days.
2. Agitation, dangerous impulsivity, and wild energy settle first. Sleep returns. If psychosis is present (delusions like believing you have special powers, or hallucinations), those fade too.
3. The antipsychotic can be continued alone through the manic episode or paired with lithium or valproate for stronger, two-sided protection.

SAFETY WATCH

Metabolic syndrome: weight gain, rising blood sugar (which can lead to type 2 diabetes), and high cholesterol and triglycerides. Olanzapine causes the most; quetiapine and risperidone are in the middle; aripiprazole causes the least. Doctors check weight, fasting glucose (or hemoglobin A1c), and lipid panel regularly. · Extrapyramidal symptoms (EPS) — stiffness, slow shuffling walk, inner restlessness (akathisia, which feels like you cannot sit still) — are more common with risperidone and aripiprazole. · Quetiapine causes more sedation (drowsiness) and can drop blood pressure when you stand (orthostatic low blood pressure (hypotension), which can make you dizzy or faint). Risperidone raises prolactin (a hormone made by the pituitary gland in the brain), which can cause missed periods, breast discharge, or sexual problems.

Quetiapine, Lurasidone, or Cariprazine — for bipolar depression (the low pole)
· Second-generation antipsychotic (FDA-approved specifically for bipolar depression)

These three antipsychotics lift the depressive pole of bipolar disorder by adjusting both dopamine and serotonin receptors in the brain — not by blocking them completely like in mania, but by fine-tuning the balance. The critical difference from regular antidepressants (SSRIs, SNRIs) is that these do NOT push you into mania. Bipolar depression is the pole where people spend most of their sick time and face the highest suicide risk, and for years doctors had no good answer. These medicines are now the FDA-approved answer to 'What do we give for bipolar depression?'

1. The medicine modulates (fine-tunes) dopamine and serotonin receptors over one to four weeks.
2. The heavy sadness, hopelessness, low energy, and inability to feel pleasure (anhedonia) begin to lift, without flipping the brain into a manic state.
3. If the medicine works, it is often continued long-term to prevent depressive episodes from returning.

SAFETY WATCH

All three require metabolic monitoring: weight, blood sugar (fasting glucose or hemoglobin A1c), and cholesterol (lipid panel) checked regularly. · Cariprazine and lurasidone can cause akathisia — a very uncomfortable inner restlessness that makes you feel like you have to keep moving. · Quetiapine causes sedation (it can knock you out) and orthostatic low blood pressure (hypotension) (dizziness or fainting when you stand up because blood pressure drops).

Lamotrigine — for long-term prevention of bipolar depression · Mood stabilizer (anticonvulsant — originally a seizure medicine)

Lamotrigine blocks voltage-gated sodium channels on nerve cells (like closing the floodgates on electrical surges) and damps down glutamate (the brain's main 'go' signal). The result is that it stabilizes mood from below — it raises the floor so depressive episodes become rarer, shallower, and shorter. Most people with bipolar I spend far more time depressed than manic, and that is where the real disability and suicide risk live. Lamotrigine is the maintenance drug that guards the depressive pole, often combined with lithium to cover both directions.

1. Lamotrigine must be started low and raised slowly over about six weeks to reach the target dose. This slow climb is critical to avoid a dangerous rash.
2. Once at the maintenance dose, depressive relapses become less frequent, less severe, and shorter. The dark valleys that used to swallow months of your life shrink.
3. Lamotrigine is often layered with lithium so you have two-direction coverage: lithium guards the manic ceiling, lamotrigine guards the depressive floor.

SAFETY WATCH

Stevens-Johnson syndrome (SJS) and toxic epidermal necrolysis (TEN) — rare but life-threatening rashes that can blister and peel the skin and inside of the mouth. The risk is highest in the first eight weeks and if you raise the dose too fast. STOP lamotrigine immediately at the first sign of any rash and call your doctor. · Valproate doubles lamotrigine blood levels (valproate slows down how the liver breaks lamotrigine apart), so if you are on both, the lamotrigine dose must be cut in half. · Estrogen-containing birth control pills lower lamotrigine levels (they speed up how the liver clears it), so the dose may need to be higher. Conversely, lamotrigine can make some birth control less reliable — discuss with your doctor.

Antidepressants (SSRIs, SNRIs) — use with extreme caution in bipolar depression, never alone · SSRI (selective serotonin reuptake inhibitor) or SNRI (serotonin-norepinephrine reuptake inhibitor) — used only as an add-on, if at all

Antidepressants like SSRIs and SNRIs boost serotonin (and sometimes norepinephrine) in the brain by blocking the pumps that suck these chemical messengers back into the nerve cell. In regular depression (major depressive disorder), that helps. But in bipolar I, the same serotonin boost can flip the brain from depression into mania or make the mood cycle faster and faster (rapid cycling). Think of it like pressing the gas when the brakes are already weak — you can spin out of control. Antidepressants are NEVER used alone in bipolar I. They are only added

cautiously, on top of a strong mood stabilizer, in carefully selected patients, and only when other options have failed.

1. If an antidepressant is used: a mood stabilizer (lithium, valproate, or lamotrigine) must be on board first, holding the manic ceiling down.
2. The antidepressant is added second, and the person is watched very closely for any warning signs of mania — especially needing less sleep, racing thoughts, talking faster, or sudden bursts of energy and big plans.
3. At the first hint of mania, the antidepressant is stopped immediately.

SAFETY WATCH

Manic switch: the earliest alarm is sleep need dropping — if you suddenly feel fine on four hours of sleep and your mind is racing, that is mania starting. Call your doctor right away. · Rapid cycling: long-term antidepressant use can speed up the back-and-forth swings between depression and mania, making the illness harder to control. · Never continue an antidepressant through a manic episode — it will pour gasoline on the fire.

Red flags

- Decreased need for sleep with rising energy and mood — the classic early warning sign that a manic episode is starting; contact the treatment team the same day to adjust medication and prevent full relapse
- Psychotic symptoms such as grandiose delusions (believing you are God, a celebrity, or have superpowers) or paranoid delusions (believing others are plotting to harm you) — hospitalize immediately for safety and to start or increase antipsychotic medication
- Mixed features — depressive hopelessness or suicidal thoughts combined with manic energy, agitation, or sleeplessness — the highest-risk state for suicide in psychiatry; requires emergency evaluation, close monitoring, and often hospitalization
- Active suicidal plan or intent, especially during a depressive or mixed episode — emergency psychiatric evaluation and safety planning today; never send the person home alone
- Manic patient making irreversible decisions — signing contracts, quitting a job, giving away money, risky sexual behavior, reckless driving — intervene immediately to protect the person and assess decision-making capacity; involve family or legal safeguards as needed

Nursing priorities

1. Safety first in acute mania: reduce stimulation, prevent exhaustion and dehydration, protect from consequential decisions — Manic patients can die of exhaustion, injury, or the aftermath of their week's choices — a quiet room and finger foods they can eat on the move are clinical interventions.
2. Guard the sleep signal: monitor and report hours slept every shift — Sleep is the earliest relapse indicator in both directions and a treatment lever — falling sleep need predicts mania days ahead.
3. Suicide assessment in every depressive or mixed presentation — Bipolar disorder carries one of psychiatry's highest suicide rates, concentrated in depressive and mixed states.
4. Lithium literacy: levels, hydration, drug interactions (NSAIDs, ACE inhibitors, thiazides), toxicity signs — The margin between therapeutic and toxic is narrow; patient education prevents most toxicity events.
5. Flag any antidepressant-without-stabilizer order in a bipolar chart — Unopposed antidepressants risk manic switch — this is a classic medication-safety catch.
6. Teach episode early-warning plans to patient AND family — Insight fails first in mania; the family often sounds the alarm the patient cannot.

Sources

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