

Bipolar I Disorder

A plain-English guide for you and your family

WHAT IS HAPPENING

Bipolar I disorder means a person has had at least one manic episode: a week or more (or any length if they needed the hospital) of abnormally high or cranky mood with huge energy — sleeping two hours and feeling fine, talking nonstop, grand plans, risky spending or decisions, sometimes losing touch with what is real. Most people also have episodes of deep depression, but one true manic episode is enough for the diagnosis. It is treated with mood stabilizers like lithium, and treating only the depression with an antidepressant can accidentally trigger mania.

What you might feel

- Elevated, expansive, or irritable mood with increased energy or activity, lasting at least 1 week (or any length if hospitalized)
- Decreased need for sleep — feeling fully rested after only 2 or 3 hours
- 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)
- Psychotic features — grandiose or paranoid delusions (fixed false beliefs) or hallucinations (seeing or hearing things that are not there)
- 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)
- Mixed features — depressive mood with manic energy, or manic mood with depressive thoughts, in the same episode
- Significant impairment in work, relationships, or daily function, or need for hospitalization to prevent harm

Call the doctor right away if...

- 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

What the care team will do

- Safety first in acute mania: reduce stimulation, prevent exhaustion and dehydration, protect from consequential decisions
- Guard the sleep signal: monitor and report hours slept every shift
- Suicide assessment in every depressive or mixed presentation
- Lithium literacy: levels, hydration, drug interactions (NSAIDs, ACE inhibitors, thiazides), toxicity signs
- Flag any antidepressant-without-stabilizer order in a bipolar chart
- Teach episode early-warning plans to patient AND family

Medicines you may be given — and why

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

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.

Valproate (also called divalproex) — for mania (right now), rapid cycling, and mixed features

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.

Olanzapine, Risperidone, Quetiapine, or Aripiprazole — for mania (right now, especially severe agitation and psychosis)

These medicines block dopamine receptors (the D2 type) and serotonin receptors (the 5-HT_{2A} 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.

Quetiapine, Lurasidone, or Cariprazine — for bipolar depression (the low pole)

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?'

Lamotrigine — for long-term prevention of bipolar depression

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.

Antidepressants (SSRIs, SNRIs) — use with extreme caution in bipolar depression, never alone

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.

Where this information comes from

- American Psychiatric Association DSM-5-TR (2022)
- CANMAT and ISBD 2018 guidelines for bipolar disorders
- American Psychiatric Association Practice Guideline for the Treatment of Patients With Bipolar Disorder (2nd edition, 2002; updated regularly)
- Goodwin & Jamison, Manic-Depressive Illness: Bipolar Disorders and Recurrent Depression (3rd ed.)

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