

Bipolar Disorder

A plain-English guide for you and your family

WHAT IS HAPPENING

In a healthy brain, three chemical messengers—dopamine (drives motivation and reward), serotonin (steadies mood), and norepinephrine (controls energy and alertness)—work together like a thermostat, keeping your mood, energy, sleep, and thinking inside a normal, steady range. In bipolar disorder, that thermostat breaks. During a manic or hypomanic episode, dopamine and norepinephrine flood the brain like a dam bursting, so you feel on top of the world, need almost no sleep (sometimes just two or three hours feels like plenty), talk so fast others can barely follow, believe you can do things you really can't (like starting three businesses in one night or spending thousands of dollars you don't have), and take dangerous risks—speeding, using drugs, or having sex with strangers—because your judgment is completely offline. During a depressive episode, those same chemicals drop to almost nothing, like a battery dying. You lose all interest in things you used to love, feel exhausted even after sleeping ten hours, think in slow motion, feel worthless or guilty for no real reason, and may think so seriously about ending your life that you make a plan. Sometimes both states collide in a mixed episode—you feel revved up and miserable at the same time, full of energy but hopeless, which is the most dangerous state of all because you have both the despair and the energy to act on it. None of this is weakness, laziness, or a character flaw. Every single symptom—the highs, the lows, the racing thoughts, the inability to feel joy—comes from real, measurable breakdowns in brain circuits. Treatment works: mood stabilizers like lithium or valproate, some anti-seizure medicines, and sometimes antipsychotics calm the swings by steadying those chemical messengers. But stress, skipped sleep, alcohol, street drugs, and even some antidepressants (when used alone) destabilize the circuits further and trigger new episodes, so sticking to a regular sleep schedule, avoiding substances, and working closely with your doctor are just as crucial as taking medication. With the right treatment and routine, most people with bipolar disorder live full, stable, meaningful lives.

What you might feel

- Mania: sky-high mood or explosive anger lasting at least one week, bad enough to wreck work or land you in the hospital

- Hypomania: noticeably higher mood and energy lasting at least four days—people see the change but you can still function
- Barely needing sleep—feeling fully rested after only two or three hours
- Pressured speech: talking fast, loud, and nonstop so it's almost impossible to interrupt
- Flight of ideas or racing thoughts—your mind jumps from topic to topic without finishing any one idea
- Grandiosity: blown-up self-esteem, believing you have special powers, are famous, or can do impossible things
- Risky behavior: wild spending sprees, hypersexuality, reckless driving, or drug and alcohol binges
- Major depressive episodes: no pleasure in anything (anhedonia), crushing fatigue, feelings of worthlessness, and suicidal thoughts
- Psychotic symptoms during mania: delusions like 'I can fly' or 'I am God,' or hallucinations (seeing or hearing things that aren't there)
- Mixed features: motor restlessness, racing thoughts, and suicidal thinking all at the same time

Call the doctor right away if...

- Suicidal thoughts or behavior, especially during mixed episodes or in the first weeks of starting an antidepressant
- Psychotic symptoms—delusions or hallucinations—during mania
- Severe insomnia (no sleep for three or more days) or complete loss of insight (the person cannot recognize they are sick)
- Lithium toxicity signs: coarse hand tremor, confusion, slurred speech, muscle twitching, or seizures
- Rapid cycling—four or more mood episodes in one year—signaling treatment resistance and worse long-term outcome

What the care team will do

- Screen for suicide risk every shift using a validated tool and ask directly about intent, plan, and access to means; escalate immediately if any positive answer
- Monitor lithium level, creatinine (kidney function test), and thyroid-stimulating hormone (TSH, a measure of thyroid gland activity) per protocol—typically every 3 to 6 months for stable patients or sooner if vomiting, diarrhea, fever, or new medications
- Enforce a fixed sleep-wake schedule with the same bedtime and wake time every day, even on weekends, and limit daytime naps to 20 minutes or less

- Teach the patient and family to recognize early warning signs of mania—such as sleeping less than four hours for two nights in a row, racing thoughts, or starting multiple projects—and to call the provider immediately when these appear
- Assess for metabolic side effects—weight, waist circumference, fasting glucose (blood sugar), and lipid panel (cholesterol tests)—at baseline, 3 months, and then yearly for patients on second-generation antipsychotics
- Hold lithium and notify the provider immediately if the patient develops vomiting, diarrhea, fever, or confusion, or if creatinine rises above baseline
- Coordinate contraception counseling and preconception planning for all patients of childbearing potential, because lithium, valproate, and carbamazepine are teratogens (substances that cause birth defects)
- Teach the patient to avoid alcohol and all recreational drugs, especially stimulants such as cocaine or methamphetamine, because these can trigger mania or interfere with mood stabilizers

Medicines you may be given — and why

Lithium

Lithium is a simple metal that slips into brain cells and shifts how they handle signals. It blocks an enzyme called inositol monophosphatase (a protein that recycles a building block for signals inside the cell), which slows down a chemical relay inside nerve cells. This calms the wild electrical storms that fuel mania and steadies the brain against deep dips into depression. Think of it like a voltage regulator that keeps power steady instead of spiking high or dropping low.

Valproate (divalproex, valproic acid)

Valproate calms the brain by boosting GABA (gamma-aminobutyric acid, the main brake chemical that slows nerve firing) and blocking sodium channels (gates on nerve cells that spark electrical signals). More GABA means less wild firing, which stops the racing thoughts and impulsive acts of mania. It works faster than lithium for active mania, often within 5 to 7 days.

Quetiapine

Quetiapine blocks dopamine D₂ receptors (which calm overactive reward and motivation circuits) and serotonin 5-HT_{2A} receptors (which smooth out mood and reduce agitation). It also blocks histamine H₁ receptors (causing drowsiness and helping sleep). Unlike older antipsychotics, it does not clamp down as hard on dopamine, so it causes fewer stiffness and movement side effects. It is FDA-approved for both bipolar mania and bipolar depression, making it very flexible.

Lurasidone

Lurasidone blocks dopamine D₂ receptors (calming overactive reward circuits) and serotonin 5-HT_{2A} receptors (smoothing mood), but it also activates 5-HT_{1A} receptors (which lifts mood and reduces anxiety). This unique serotonin boost makes it especially good for bipolar depression. Think of it as turning down the too-much signals and turning up the feel-better signals at the same time.

Lamotrigine

Lamotrigine blocks sodium channels on nerve cells, stopping the rapid-fire electrical bursts that trigger mood swings. It is the best medication for preventing bipolar depression (the depressive episodes in bipolar disorder) but does not work well for active mania. Think of it as a long-term shield against down swings, not a fast rescue for up swings.

Olanzapine

Olanzapine blocks dopamine D₂ receptors (calming overactive emotion and thought circuits) and serotonin 5-HT_{2A} receptors (smoothing mood and reducing agitation). It is one of the most powerful drugs for active mania, often calming symptoms within 3 to 5 days. However, it has the highest risk of weight gain and metabolic problems of any antipsychotic, so doctors usually save it for severe mania or when other drugs fail.

Carbamazepine

Carbamazepine blocks sodium channels on nerve cells, stopping the rapid firing that triggers mood swings and seizures. It is an older mood stabilizer, effective for mania but less used now because of drug interactions and side effects. It speeds up the liver's breakdown of many other drugs (including birth control pills and other psych meds), making dosing tricky.

Aripiprazole

Aripiprazole is a partial agonist at dopamine D₂ receptors, which means it acts like a dimmer switch instead of an on/off switch. When dopamine is too high (like in mania), it blocks some of the signal, calming you down. When dopamine is too low (like in depression or flat mood), it gently boosts the signal. It also partially activates serotonin 5-HT_{1A} receptors (which lifts mood) and blocks 5-HT_{2A} receptors (which reduces agitation). This balancing act treats mania without completely flattening motivation or emotion.

Asenapine

Asenapine blocks dopamine D₂ receptors (calming mania) and serotonin 5-HT_{2A} receptors (smoothing mood and irritability). It is given under the tongue (sublingual tablet) because it is poorly absorbed if swallowed. It works for acute mania and mixed episodes (mania and

depression at the same time). It has a lower risk of weight gain than olanzapine but can cause mouth numbness and an unpleasant taste.

Where this information comes from

- American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, Text Revision (DSM-5-TR), 2022
- CANMAT and International Society for Bipolar Disorders (ISBD) 2018 Guidelines for the Management of Patients with Bipolar Disorder
- National Institute of Mental Health (NIMH): Bipolar Disorder
- American Academy of Child and Adolescent Psychiatry (AACAP) Practice Parameter for Bipolar Disorder in Children and Adolescents, 2023

Last reviewed: 2026-07-07