

Bipolar Mania

A plain-English guide for you and your family

WHAT IS HAPPENING

In a healthy brain, chemical messengers called neurotransmitters keep mood, energy, and thinking balanced. In mania, dopamine surges out of control and the brain's brakes fail. The person needs almost no sleep yet feels more energized every day. Thoughts race. Speech pours out fast and loud. Mood soars to euphoria (feeling on top of the world) or flips to explosive anger. Judgment disappears, so risky behavior—spending money recklessly, driving dangerously, hypersexual acts—feels brilliant in the moment. In severe mania, the person may hear voices or believe grandiose things (I can fly, I am a millionaire, the government is after me) that are not real. None of this is a choice. It is a biological storm in specific brain circuits. Skipping medication, using stimulants like cocaine or methamphetamine, or losing sleep can trigger or worsen an episode. Treatment starts with restoring sleep, because sleep resets the circuit. Medication, a safe environment, and family support work together; treating only the biology or only the stress will fail. Recognize mania early and act fast. It can escalate to psychosis, violence, or life-threatening choices within days.

What you might feel

- Decreased need for sleep
- Pressured speech
- Racing thoughts or flight of ideas
- Euphoria or irritability
- Grandiosity
- Increased goal-directed activity or agitation
- Risky behavior (excessive spending, hypersexuality, substance use, reckless driving)
- Psychotic symptoms (delusions or hallucinations)
- Distractibility

Call the doctor right away if...

- Psychotic symptoms: delusions (fixed false beliefs) or hallucinations (seeing or hearing things that are not there), especially command hallucinations (voices ordering self-harm or violence)
- Suicidal or homicidal thoughts, severe agitation that cannot be calmed, or violent behavior putting the person or others in danger
- Severe insomnia lasting more than 3–5 days straight with escalating energy, impulsivity, and loss of judgment (major crash risk)
- Catatonia (rigid immobility or bizarre posturing), stupor (extreme unresponsiveness), or inability to care for basic needs like eating, drinking, or hygiene
- Signs of lithium toxicity if taking lithium: confusion, coarse tremor (big shaking), loss of coordination (ataxia) (unsteady walking), slurred speech, nausea, vomiting, or seizures

What the care team will do

- Assess immediate safety: remove harmful objects, assign one-to-one observation if suicidal or psychotic, and place the patient in a quiet low-stimulation room near the nurses' station
- Monitor for severe agitation or violence and prepare for rapid chemical or physical restraint if the patient cannot be redirected and poses imminent danger
- Administer the first dose of antipsychotic medication and benzodiazepine as ordered, monitor vital signs every 15 to 30 minutes after injection, and watch for over-sedation or breathing problems
- Ensure the patient eats regular meals and drinks at least 2 liters of fluid daily, offering high-calorie snacks and drinks every 2 hours if the patient is too active to sit for meals
- Monitor sleep duration every shift and report if the patient sleeps less than 4 hours in 24 hours, because ongoing insomnia signals the mania is not controlled
- Check vital signs and watch for fever, muscle rigidity, confusion, or tremor after starting antipsychotic medication, as these are signs of neuroleptic malignant syndrome (a rare life-threatening reaction)
- Set firm, calm limits on disruptive behavior using short clear sentences, redirect the patient to safe activities, and avoid arguing about grandiose or delusional beliefs
- Teach the family that mania is a brain-based medical illness, not willful bad behavior, and give them crisis contact numbers and a follow-up appointment before discharge

Medicines you may be given — and why

Olanzapine

Olanzapine blocks dopamine D₂ receptors (tiny landing pads on brain cells where dopamine delivers its signal) in the brain's reward and emotion centers. When dopamine is too active in mania, thoughts race, judgment breaks down, and mood shoots sky-high. Blocking these receptors calms that overactivity. It also blocks serotonin 5-HT_{2A} receptors (docking sites for serotonin, another brain messenger), which helps smooth out mood swings and reduces irritability.

Risperidone

Risperidone blocks dopamine D₂ receptors (tiny landing pads on brain cells where dopamine delivers its 'speed up' signal) in the brain's emotion and reward centers. Too much dopamine activity in mania makes thoughts race, mood soar too high, and impulses dangerous. Blocking these receptors slows that runaway signaling. It also blocks serotonin 5-HT_{2A} receptors (docking sites for serotonin, a mood-steadying messenger), which helps stabilize mood and reduce irritability.

Quetiapine

Quetiapine blocks dopamine D₂ receptors (docking stations on brain cells that receive dopamine, a chemical messenger) in the brain's emotion and reward circuits. In mania, dopamine is overactive, driving racing thoughts, sky-high mood, and poor judgment. Blocking these receptors tamps down that runaway activity. Quetiapine also blocks histamine H₁ receptors (which keep you awake—the same chemical your body releases during allergies) and serotonin 5-HT_{2A} receptors (sites for serotonin, a mood-balancing messenger), helping restore sleep and smooth out mood.

Aripiprazole

Aripiprazole is a partial agonist at dopamine D₂ receptors (it sits on the receptor and turns it on just a little, not all the way). When dopamine is too high (like in mania), aripiprazole acts like a brake, blocking some of the overactive dopamine signal. When dopamine is too low, it gently nudges the receptor to keep some activity going. This balancing act calms mania without shutting dopamine down completely. It also partially activates serotonin 5-HT_{1A} receptors (which help stabilize mood) and blocks serotonin 5-HT_{2A} receptors (which reduces agitation).

Lithium

Lithium is a simple salt (like table salt, but a different element) that changes the way brain cells send signals to each other. It reduces overactivity in the brain circuits that control mood

and impulse. Exactly how it works is not fully known, but it seems to calm the 'amplifier' inside brain cells (enzymes and signaling proteins that boost signals) so mood swings are less extreme. It also protects brain cells from damage over time by boosting growth factors (proteins that help cells survive and repair).

Valproate (divalproex sodium)

Valproate increases GABA (gamma-aminobutyric acid, the brain's main calming chemical) by blocking the enzyme GABA transaminase that breaks GABA down, so more GABA stays around to quiet overactive brain circuits. It also blocks voltage-gated sodium channels (tiny gates on brain cells that let electrical signals fire rapidly), which slows down runaway electrical activity. Together, these actions calm the overexcited brain circuits that drive mania.

Carbamazepine

Carbamazepine blocks voltage-gated sodium channels (tiny gates on brain cells that let electrical signals fire rapidly). By blocking these channels, it stops brain cells from firing too fast and too often, which calms the overactive circuits that drive mania. It also reduces the release of glutamate (the brain's main excitatory chemical, which speeds up activity) and modulates other pathways that control mood and impulse.

Lorazepam (a benzodiazepine, used short-term)

Lorazepam boosts the effect of GABA (gamma-aminobutyric acid, the brain's main calming chemical) by making GABA-A receptors (tiny gates on brain cells) more sensitive to GABA. When GABA opens these gates, negatively charged chloride ions rush into the cell, making it harder for the cell to fire. This calms overactive circuits, reducing anxiety, agitation, and insomnia. It works fast—within 30 minutes to an hour.

Where this information comes from

- American Psychiatric Association DSM-5-TR (2022)
- CANMAT and ISBD 2018 guidelines for the management of patients with bipolar disorder
- APA Practice Guideline for the Treatment of Patients with Bipolar Disorder (2021 update)
- Yatham LN et al., Bipolar Disord 2018 (CANMAT/ISBD)

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