

Bipolar I Disorder

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.

THE ONE-LINE TRUTH

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 chain — how it unfolds

1. Sleep loss accelerates the mania — why: 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 — why: 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 — why: 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 — why: 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 — why: 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.

Spot it — what you see, 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.

Red flags — act now

- 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

Treat it — in this order

1. 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.
2. 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.

3. 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.
4. 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.
5. 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).

Your top priorities at the bedside

1. Safety first in acute mania: reduce stimulation, prevent exhaustion and dehydration, protect from consequential decisions — why: 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 — why: 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 — why: Bipolar disorder carries one of psychiatry's highest suicide rates, concentrated in depressive and mixed states.