

Bipolar Mania

Mania happens when dopamine (a brain chemical that drives energy and reward) floods the control centers, shuts down sleep and judgment, and makes the person feel unstoppable even as they race toward danger.

THE ONE-LINE TRUTH

Mania is a medical emergency when the person cannot think clearly, acts dangerously, or loses touch with reality.

The chain — how it unfolds

1. Dopamine floods the mesolimbic reward pathway (the circuit running from the brain's dopamine factory to the reward center). — why: Genetic vulnerability (inherited variations in dopamine-regulating genes), major stress, sleep deprivation, stimulant use (cocaine, methamphetamine), or stopping mood stabilizers trigger excessive dopamine release that the prefrontal cortex cannot shut down. The system loses its normal off-switch.
2. Sleep drive disappears; the person needs only two to three hours per night or none at all and feels fully energized. — why: High dopamine blocks adenosine (the brain chemical that builds up to make you sleepy) and overrides the hypothalamus (the master sleep-wake regulator), so the brain never signals it is time to sleep. The person truly does not feel tired.
3. Pressured speech: talking is rapid, loud, hard to interrupt, and pours out in a continuous stream. — why: Dopamine speeds up thought generation and motor output (the signals that move your mouth and vocal cords). The prefrontal cortex normally pauses speech to organize ideas and listen; in mania that system is offline, so words flow without editing or turn-taking.
4. Flight of ideas: thoughts race and jump from topic to topic with loose or no logical connections. — why: The same dopamine surge speeds up associative thinking (how your brain links one idea to the next) but shuts down executive function (the ability to organize, sequence, and filter thoughts). Ideas scatter faster than the person can follow, and barely related links feel deep and meaningful.

5. Euphoria or irritability: mood is abnormally elevated (feeling on top of the world) or explosively angry. — why: Dopamine and other monoamines (chemical messengers including norepinephrine and serotonin) flood the limbic system, producing intense positive emotion. If a goal is blocked or someone disagrees, the same overactive circuit flips instantly to rage because the brakes are gone.
6. Risky behaviors: spending sprees, reckless driving, hypersexuality (abnormally increased sexual desire or activity), impulsive business deals, or aggressive confrontations. — why: The prefrontal cortex normally stops impulses by imagining future consequences. In mania that system is silent, so every urge feels urgent, brilliant, and consequence-free. The person acts on desires immediately without weighing danger or social cost.
7. Psychotic symptoms appear in severe mania: delusions (fixed false beliefs, such as I have special powers or the FBI is following me) or hallucinations (hearing voices, seeing things not present). — why: Extreme dopamine excess in the mesolimbic pathway disrupts reality testing (the brain's ability to tell real from false signals) and generates false sensory input, the same mechanism that drives psychosis in schizophrenia. The person loses the ability to recognize that these experiences are not real.
8. Crash risk: After days to weeks of mania, the brain exhausts its resources and mood plunges into severe depression, often with suicidal thoughts. — why: The manic surge drains neurotransmitter stores and throws receptors (the docking sites on brain cells that receive chemical signals) out of balance. The same circuits that were stuck in overdrive now cannot generate normal mood or energy, and the person faces the wreckage—financial, social, legal—left by manic decisions. Suicide risk is highest in this post-manic phase.

Spot it — what you see, and why

- Decreased need for sleep: High dopamine (a brain messenger that drives energy and alertness) blocks adenosine (the molecule that piles up during the day to make you sleepy) and shuts down the sleep switch in the hypothalamus (the brain's control center for sleep and wake). The person feels fully rested on 2–3 hours of sleep, or sometimes none at all.
- Pressured speech: Dopamine speeds up thought and movement commands from the motor cortex (the strip of brain that controls voluntary movement), while the prefrontal cortex (the brain's pause button at the front) goes offline. The person talks fast, loud, and nonstop—like a runaway train with no brakes.
- Racing thoughts or flight of ideas: Too much dopamine makes connections between ideas happen at high speed, but the dorsolateral prefrontal cortex (the part of the front brain that organizes and finishes one thought before jumping to the next) is disabled. Thoughts pile up, skip around, and scatter like a deck of cards spilling onto the floor.

- Euphoria or irritability: Dopamine and norepinephrine (a stimulating brain messenger) flood the nucleus accumbens and ventral tegmental area (the brain's main pleasure and reward centers deep inside). This creates extreme highs and a feeling that everything is amazing. When goals are blocked or someone says no, the same overcharged circuit flips to anger and irritability.
- Grandiosity: The prefrontal cortex (the brain's reality-checker at the front) loses its power to test beliefs against facts. Inflated ideas—like 'I am famous,' 'I have special powers,' or 'I can do anything'—feel absolutely true and unshakable, even when they are not.
- Increased goal-directed activity or agitation: The dopamine surge drives intense motivation and motor activity (movement drive) from the basal ganglia (clusters of nerve cells deep in the brain that control movement). The person starts many projects at once, cannot sit still, and may pace, fidget, or become physically aggressive—like an engine revving too high with no way to slow down.

Red flags — act now

- 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

Treat it — in this order

1. Start an antipsychotic medication immediately — first-line choices include olanzapine, risperidone, quetiapine, or aripiprazole (oral or, if needed, intramuscular injection for severe agitation) → Antipsychotics block dopamine receptors (specifically the D2 type) in the brain's reward and perception circuits (mesolimbic and mesocortical pathways), which are firing too fast during mania. This slows down racing thoughts, pressured speech, agitation, and psychotic symptoms like hallucinations or delusions. You can see improvement within hours to a few days.

2. Add a mood stabilizer — lithium or valproate (divalproex sodium) — within 24 to 48 hours of starting the antipsychotic → Lithium works inside brain cells to calm overactive signaling pathways (like inositol and glycogen synthase kinase-3) that control how excitable neurons are. Valproate boosts GABA (the brain's main calming chemical), which quiets abnormal electrical storms in mood-regulating brain areas like the limbic system (emotion control center). Both medicines stabilize mood over 1 to 2 weeks and reduce the chance of future manic or depressive episodes.
3. Give a benzodiazepine — lorazepam or clonazepam — for severe agitation and insomnia (short-term use only, typically 3 to 7 days) → Benzodiazepines turn up GABA-A receptors, which are the brain's emergency brake. This quiets overactive neurons in the amygdala (fear and stress center) and cortex (thinking center), helping the person calm down and sleep. Sleep is critical because it helps reset the body's day-night clock (circadian rhythm), which is completely out of sync during mania.
4. Admit the patient to an inpatient psychiatric unit if they are a danger to themselves or others, have no stable place to live or support system, or are so impulsive they cannot follow outpatient treatment → The hospital provides 24-hour monitoring to prevent suicide, violence, financial disaster (like emptying bank accounts), legal trouble (like arrests), or sexually transmitted infections. It also removes access to things that enable impulsive behavior (credit cards, car keys, drugs, alcohol) and makes sure the patient takes medications every day during the highest-risk window while waiting for medicines to work.
5. Stop all antidepressant medications immediately if the patient is currently taking them (such as SSRIs, SNRIs, or tricyclics) → Antidepressants can flip the brain from depressed to manic by increasing serotonin or norepinephrine in circuits that are already overactive, making mania worse or causing rapid cycling (mood switching back and forth quickly). Stopping these medicines removes fuel from the fire.

Your top priorities at the bedside

1. 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 — why: Mania impairs judgment and impulse control, so the brain cannot evaluate danger normally — constant observation prevents self-harm, aggression, or elopement (running away) before medication takes effect
2. Monitor for severe agitation or violence and prepare for rapid chemical or physical restraint if the patient cannot be redirected and poses imminent danger — why: Severe agitation activates the sympathetic nervous system (fight-or-flight response), raising heart rate and blood pressure dangerously high and increasing injury risk to the patient and staff — early intervention with medication or safe restraint prevents escalation

3. 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 — why: Antipsychotics block dopamine receptors in the brain to reduce psychosis and agitation, while benzodiazepines enhance GABA (a calming brain chemical) to provide rapid sedation — both can lower blood pressure and slow breathing, especially when combined