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Bipolar Disorders

A chronic, recurrent mood disorder marked by alternating episodes of mania or hypomania and depression — high suicide risk, complex pharmacology, and a top-tier NCLEX safety priority topic.

SYSTEM: MENTAL HEALTH | PRIORITY: SAFETY / RISK | PHARM: MOOD STABILIZERS | NCJMM: ALL 6 STEPS

📚 **SOURCE TRANSPARENCY:** Bipolar Disorders is not in Diane's uploaded notes. Content for this infographic is drawn from standard NGN NCLEX 2026 references — **Saunders Comprehensive Review (9th ed.), ATI Mental Health, Lippincott NCLEX-RN, DSM-5-TR (APA), and current bipolar treatment guidelines.** Lithium toxicity threshold cross-references the Drug Toxicities flashcard set already in the library.

01 Definition & Overview

What It Is

- A chronic, lifelong, recurrent **mood disorder** with cycling episodes of mania/hypomania and depression.
- Caused by neurotransmitter dysregulation + strong genetic predisposition.
- Onset typically **late teens to mid-20s**; equally affects men and women.

Why It Matters (NCLEX Lens)

- **Highest suicide risk** of any psychiatric disorder.
- Safety, harm reduction, and prioritization questions dominate.
- Lithium has a **narrow therapeutic window** — tested on every exam.
- Manic episodes can be life-threatening (exhaustion, dehydration, psychosis).

TYPE	HALLMARK	KEY DISTINCTION
Bipolar I	At least **one full manic episode** (≥7 days OR requires hospitalization)	Depression not required for diagnosis. Mania is the defining feature.
Bipolar II	**Hypomania** + at least one major depressive episode	Never had a full manic episode. Hypomania ≥4 days; less severe; no psychosis.
Cyclothymic	Chronic mood instability ≥2 years (1 year in youth)	Symptoms milder than full mania/depression but persistent.
Mixed Features	Mania + depressive symptoms occurring simultaneously	**Highest suicide risk subtype** — energy of mania + hopelessness of depression.

02 Pathophysiology (Simplified)

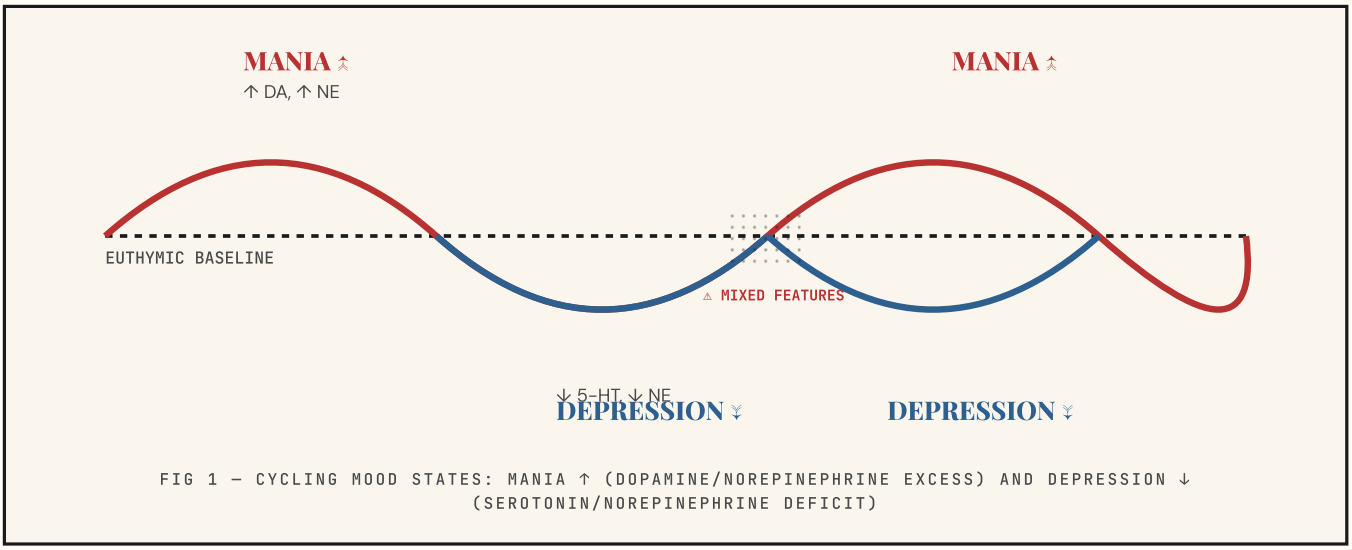

FIG 1 — CYCLING MOOD STATES: MANIA ↑ (DOPAMINE/NOREPINEPHRINE EXCESS) AND DEPRESSION ↓ (SEROTONIN/NOREPINEPHRINE DEFICIT)

STEP 1
Genetic Predisposition
Strong family hx; multiple genes implicated

→

STEP 2
Trigger
Stress, sleep loss, substance use, life events

→

STEP 3
Neurotransmitter Dysregulation
↑↓ DA, NE, 5-HT; HPA axis dysfunction

→

STEP 4
Mood Episode
Mania ↑ or Depression ↓

Manic State (↑ Neurotransmitters)

- ↑ **Dopamine** → euphoria, grandiosity, psychosis
- ↑ **Norepinephrine** → agitation, racing thoughts
- ↓ **GABA** → reduced inhibition, risk-taking
- HPA axis overactive → cortisol surge

Depressive State (↓ Neurotransmitters)

- ↓ **Serotonin** → low mood, hopelessness
- ↓ **Norepinephrine** → low energy, anhedonia
- ↓ **Dopamine** → loss of pleasure/motivation
- Disrupted circadian rhythm → sleep changes

03 Signs & Symptoms

MANIC EPISODE ↑

"DIG FAST"

- **D**istractibility — can't focus, easily diverted
- **I**nsomnia / decreased need for sleep (red flag)
- **G**randiosity — inflated self-esteem, delusions
- **F**light of ideas — racing, jumping thoughts
- **A**ctivity ↑ — psychomotor agitation, goal-directed
- **S**peech pressured — loud, rapid, hard to interrupt
- **T**houghtless behavior — spending sprees, hypersexuality, risky decisions
- **Psychosis** (severe mania only) — hallucinations, delusions

DEPRESSIVE EPISODE ↓

"SIG E CAPS"

- **S**leep changes — insomnia or hypersomnia
- **I**nterest loss — anhedonia
- **G**uilt — excessive, inappropriate, worthlessness
- **E**nergy ↓ — fatigue, lethargy
- **C**oncentration ↓ — indecisiveness
- **A**ppetite changes — weight gain or loss
- **P**sychomotor changes — retardation or agitation
- **S**uicidal ideation — must assess every encounter

RED FLAG — **Suicide risk is HIGHEST when depression begins to lift — the patient now has the energy to act on suicidal thoughts they had during severe depression. Maintain close observation during this transition.**

MIXED FEATURES

Why Mixed Episodes Are the Most Dangerous

- Symptoms of mania **AND** depression occur at the same time
- Patient has the **energy and impulsivity of mania** with the **hopelessness of depression**
- Highest completed suicide rate of all bipolar presentations
- Often presents as irritability, agitation, dysphoria — not classic "euphoric" mania

04 Priority Nursing Interventions (ABCs + Safety)

A — Safety (Top Priority)

- **Assess suicide risk** every shift — direct questioning
- Remove harmful objects from environment
- 1:1 observation if actively suicidal
- Set **limits** on dangerous/intrusive behavior
- Protect from exhaustion, dehydration during mania

B — Environment

- **Decrease stimulation** — quiet, low-light room
- Limit visitors during acute mania
- Avoid group activities initially
- Calm, firm, consistent staff approach
- Short, frequent, direct interactions

C — Basic Needs

- **Finger foods** & high-calorie drinks (mania = won't sit still to eat)
- Monitor I&O, weight, hydration
- Promote rest periods even if patient resists
- Hygiene — assist as needed during mania
- Monitor for exhaustion / cardiac strain

Therapeutic Communication During Mania

- **Do**: speak calmly, use short sentences, redirect to neutral topics
- **Do**: set clear, consistent limits ("It is not okay to touch other clients")
- **Don't**: argue with grandiose delusions or try to reason them out
- **Don't**: engage with rapid-fire questioning — redirect calmly
- **Don't**: take threats or insults personally — they are symptoms

05 Pharmacology — Mood Stabilizers & Adjuncts

DRUG / CLASS	MECHANISM (SIMPLE)	SIDE EFFECTS	NURSING CONSIDERATIONS
Lithium (Eskalith) — GOLD STANDARD	Stabilizes mood; exact mechanism unclear — alters Na^+ transport in neurons	Tremor, polyuria, polydipsia, weight gain, hypothyroidism, nephrogenic DI	• **Therapeutic: 0.6–1.2 mEq/L** • **Toxic: >1.5 mEq/L** (severe >2.0) • Take with food • Maintain consistent Na^+ & fluids (2–3 L/day) • Avoid NSAIDs, thiazides, dehydration • Onset 1–3 weeks
Valproic Acid (Depakote)	Anticonvulsant mood stabilizer; ↑ GABA	Hepatotoxicity, thrombocytopenia, weight gain, alopecia, pancreatitis	• Monitor LFTs, CBC, platelets • **Teratogenic** — neural tube defects • Therapeutic level 50–125 mcg/mL • Take with food
Carbamazepine (Tegretol)	Anticonvulsant; blocks Na^+ channels	**Agranulocytosis**, aplastic anemia, Stevens-Johnson, hyponatremia	• Monitor CBC weekly initially • Watch for sore throat, fever, bruising • Many drug interactions (CYP450) • Therapeutic 4–12 mcg/mL
Lamotrigine (Lamictal)	Anticonvulsant; useful for bipolar depression	**Stevens-Johnson syndrome** (life-threatening rash), dizziness	• **Slow titration over weeks** — never increase fast • Stop immediately if ANY rash • Especially watch first 8 weeks
Atypical Antipsychotics Olanzapine, Quetiapine, Risperidone, Aripiprazole	Dopamine + serotonin blockade; for acute mania, psychosis, maintenance	Metabolic syndrome, weight gain, sedation, EPS, ↑ prolactin	• Monitor glucose, lipids, weight • Assess for EPS, tardive dyskinesia • Quetiapine often used for bipolar depression
Benzodiazepines (Lorazepam, Clonazepam) — Short-term only	↑ GABA; for acute agitation, sleep restoration	Sedation, dependence, respiratory depression	• Short-term bridge only • Risk of dependence • Caution with elderly

🚨 **RED FLAG — LITHIUM TOXICITY — KNOW THE LEVELS**

- **Mild (1.5–2.0): Coarse tremor, N/V, diarrhea, slurred speech, ataxia**
- **Moderate (2.0–2.5): Confusion, muscle twitching, blurred vision, hypotension**
- **Severe (>2.5): Seizures, coma, cardiovascular collapse → HOLD DRUG, NOTIFY HCP, dialysis may be needed**

⚠️ **Cross-reference: matches the "toxic >2 mEq/L" rule from the Drug Toxicities flashcard set.**

⚠️ Antidepressants — A Caution

- SSRIs and other antidepressants used **alone** in bipolar disorder can **trigger mania** ("manic switch").
- Always paired with a mood stabilizer or atypical antipsychotic.
- Common NCLEX trap: a patient with depression who is started on an SSRI and then becomes "very energetic, talkative, and sleepless" — that's a manic switch, not treatment success.

06

NCLEX Test Traps — Wrong vs. Right

✗	**WRONG:** "Try to reason with the manic patient about why their plans aren't realistic."
✓	**RIGHT:** Redirect calmly to a neutral activity. Do not argue with grandiose thinking — it escalates agitation.
✗	**WRONG:** "Suicide risk is highest during the deepest depression."
✓	**RIGHT:** Risk is **highest when depression begins to lift** — energy returns before mood does, enabling acting on plans.
✗	**WRONG:** "Tell the patient on lithium to drink more water and restrict salt."
✓	**RIGHT:** Maintain **consistent** sodium and fluid intake. Restricting sodium or dehydration **raises lithium levels** → toxicity.
✗	**WRONG:** "Mania means the patient is happy and feeling good."
✓	**RIGHT:** Mania can be **irritable, agitated, hostile, or psychotic** — not "happy." Dysphoric mania is common.
✗	**WRONG:** "Place the manic client in a group therapy session immediately to socialize."
✓	**RIGHT: Decrease stimulation** — quiet environment, 1:1 staff interaction, no large groups during acute mania.
✗	**WRONG:** "Bipolar I requires hypomania to diagnose."
✓	**RIGHT: Bipolar I = full mania.** Bipolar II = hypomania + major depression. Never confuse the two.
✗	**WRONG:** "Give an SSRI alone to a bipolar patient who appears depressed."
✓	**RIGHT:** Antidepressants **alone can trigger mania**. Must be combined with a mood stabilizer.
✗	**WRONG:** "Plan a high-protein, sit-down meal at the dining table for the manic client."
✓	**RIGHT:** Offer **finger foods** and high-calorie drinks the patient can eat while moving — they cannot sit still.

07 Patient & Family Education

Medication Adherence

- Bipolar disorder is **lifelong** — medications are too
- Never stop abruptly — can trigger relapse
- Lithium: **Maintain consistent salt and fluid intake** (2–3 L/day)
- Avoid NSAIDs, diuretics, dehydration with lithium
- Get scheduled lithium levels and TSH
- Report any rash on lamotrigine immediately

Lifestyle & Triggers

- **Sleep hygiene is critical** — sleep loss can trigger mania
- Avoid alcohol, marijuana, stimulants (cocaine, amphetamines)
- Maintain regular daily routine (meals, sleep, activity)
- Stress management — therapy, exercise, mindfulness
- Avoid caffeine excess
- Family involvement helps recognize early warning signs

Warning Signs to Report

- Suicidal thoughts or plans
- Decreased need for sleep (early mania)
- Increased spending, risk-taking, sexual activity
- Rapid speech, racing thoughts
- Worsening depression, hopelessness
- Tremor, confusion, severe N/V on lithium

Support Resources

- **988 Suicide & Crisis Lifeline** — call or text
- Depression and Bipolar Support Alliance (DBSA)
- NAMI (National Alliance on Mental Illness)
- Outpatient therapy + psychiatrist follow-up
- Family psychoeducation programs
- Mood-tracking apps to identify patterns

08 Memory Boosters & Mnemonics

DIG FAST

MANIA SYMPTOMS — 7 CARDINAL SIGNS

D istractibility	**I** nsomnia ↓	**G** randiosity	**F** light of ideas	**A** ctivity ↑
S peech pressured	**T** houghtless / risky			

SIG E CAPS

DEPRESSION SYMPTOMS — 8 CARDINAL SIGNS

S leep changes	**I** nterest ↓	**G** uilt	**E** nergy ↓	**C** oncentration ↓
A ppetite Δ	**P** sychomotor Δ	**S** uicidal ideation		

Lithium "2-3-4" Rule

QUICK SAFETY CHECK

2 mEq/L = toxic	**3** L fluid daily
4 times/yr levels	

"Mania = Mayhem"

ALWAYS THINK SAFETY FIRST

M ove fast / agitated	**A** ssess for harm
Y ield to limits	**H** ydrate + feed
E nvironment quiet	**M** eds: stabilize mood

"LITHIUM TOX" — Quick Recognition

EARLY SIGNS OF LITHIUM TOXICITY

L ethargy / Level >1.5	**I** ntention tremor (coarse)	**T** hirst & polyuria worsen	**H** yperreflexia	**I** rregular gait (ataxia)
U rine output changes	**M** uscle twitching	**T** alking slurred	**O** rientation lost	**X** = HOLD med, call HCP

09 NCJMM — Next Generation Clinical Judgment Walkthrough

CLINICAL SCENARIO

Client: 32-year-old female, history of **Bipolar I disorder**, admitted to inpatient psych unit by family. Has not slept in 4 days. Speech is rapid and pressured. Reports she "spent $15,000 on online purchases this week to start a business empire." Currently pacing the hallway, irritable, and shouting at staff. Refuses food. **VS: BP 148/92, HR 118, RR 22, T 99.4°F.** Lithium carbonate 600 mg PO TID ordered. Family states she stopped her lithium 6 weeks ago because she "felt fine."

1 RECOGNIZE CUES

What data is relevant?

Critical cues: 4 days without sleep, pressured speech, grandiosity (business empire), excessive spending, psychomotor agitation, irritability, refusing food, BP 148/92, HR 118, recently stopped lithium. **All consistent with acute manic episode (Bipolar I).**

2 ANALYZE CUES

What do these cues mean together?

Cues form a clear pattern of **acute mania with medication non-adherence**. Sleep deprivation, dehydration risk (refusing intake, ↑ HR), and impaired judgment all increase safety risk. Tachycardia and elevated BP suggest physical exhaustion from sustained mania. **Pattern recognition:** classic relapse after stopping mood stabilizer.

3 PRIORITIZE HYPOTHESES

Which problem is most urgent?

Priority 1 — Safety: Risk of harm to self/others, exhaustion, dehydration.
Priority 2 — Acute mania requiring pharmacologic stabilization.
Priority 3 — Medication non-adherence contributing to relapse.
Priority 4 — Nutritional/fluid deficit from inability to sit still.

4 GENERATE SOLUTIONS

What interventions should the nurse plan?

- Place in **quiet, low-stimulation room**; 1:1 observation
- Set **firm, consistent limits** on intrusive behavior
- Offer **finger foods + high-calorie drinks** she can carry while pacing
- Restart **lithium per HCP order**; obtain baseline level, renal function, TSH
- Anticipate **short-term benzodiazepine** for acute agitation/sleep
- Monitor vitals q4h; watch for exhaustion, dehydration
- Educate family about relapse prevention and adherence

5 TAKE ACTION

What does the nurse do first?

First action: ensure safety. Place client in a quiet single room with 1:1 observation. Remove harmful objects. Approach calmly, use short sentences, avoid challenging her grandiose statements. Offer water and a high-calorie finger food. Notify provider, draw baseline labs (lithium level, BMP, TSH, β-hCG), and prepare to administer ordered lithium with food. Document closely.

6
EVALUATE OUTCOMES

How will the nurse know it's working?

Expected outcomes within 48–72 hrs: ↓ psychomotor agitation, sleep restored to ≥4 hrs/night, intake adequate (≥1500 mL fluid), VS trending toward baseline, no harm to self/others, lithium level reaching 0.6–1.2 mEq/L (with no toxicity signs).

If not improving: reassess — verify medication intake, consider adding atypical antipsychotic, re-evaluate for mixed features or psychosis, screen suicide risk again as energy returns.