

# Manic Episode

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## Manic Episode

**Primary Disciplinary Field(s):** Psychiatry, Clinical Psychology

### 1. Core Definition

A **manic episode** is a distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased goal-directed activity or energy, lasting at least one week and present most of the day, nearly every day, or any duration if hospitalization is necessary. This intense shift from a person's usual functioning is profound and often leads to marked impairment in social or occupational functioning, or necessitates hospitalization to prevent harm to self or others. It is a hallmark feature of bipolar I disorder, a severe and chronic mental illness characterized by significant mood swings. The experience of a manic episode is distinct from mere elation or excitement, representing a pathological state that requires clinical attention and management.

The diagnostic criteria for a manic episode, as outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), emphasize not only the mood disturbance but also a constellation of behavioral, cognitive, and physiological symptoms. These symptoms must be severe enough to cause marked impairment in functioning or to necessitate hospitalization. Importantly, the symptoms must not be attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition. The severity and persistence of these symptoms differentiate a manic episode from milder forms of mood elevation, such as hypomania, which is a less severe but still abnormal mood elevation that typically does not cause marked functional impairment or require hospitalization.

Understanding the core definition of a manic episode is crucial for accurate diagnosis and effective treatment of bipolar disorder. It underscores the profound disruption to an individual's life, moving beyond simple emotional states into a realm of clinical pathology. The recognition of these distinct symptom clusters allows clinicians to differentiate bipolar disorder from other mood disorders, such as major depressive disorder, and to implement targeted interventions designed to stabilize mood and prevent recurrence. The concept also highlights the cyclical nature of bipolar disorder, where periods of mania or hypomania are often followed by episodes of depression, creating a complex and challenging clinical picture.

### 2. Etymology and Historical Development

The term "manic" originates from the Greek word "mania," meaning "madness" or "frenzy." Historically, conditions exhibiting features akin to what we now call mania have been observed and documented since antiquity. Ancient Greek physicians like Hippocrates described states of extreme excitement and melancholia, recognizing a cyclical pattern in some individuals. Aretaeus

of Cappadocia, in the 2nd century AD, is often credited with providing one of the earliest clear descriptions of what would later be known as "manic-depressive illness," noting the recurrent nature of periods of elation and depression in the same individual. This early recognition laid the groundwork for future understanding of mood disorders.

In more modern psychiatric history, the concept of a single illness encompassing both manic and depressive states gained prominence in the 19th century. French psychiatrist Jean-Pierre Falret introduced the term *folie circulaire* (circular insanity) in 1854, describing an illness characterized by alternating episodes of melancholia and mania. Karl Ludwig Kahlbaum, a German psychiatrist, further refined this concept in the 1880s with his classification of *cyclothymia* and the broader category of "periodische Irrsinn" (periodic insanity). However, it was Emil Kraepelin, a pivotal figure in modern psychiatry, who significantly formalized the concept. In the late 19th and early 20th centuries, Kraepelin meticulously observed and categorized mental illnesses, coining the term "manic-depressive insanity" to describe a distinct illness characterized by the cyclical alternation of manic and depressive states, separating it from *dementia praecox* (later known as *schizophrenia*).

The evolution of diagnostic nomenclature continued into the late 20th century. With the publication of the DSM-III in 1980, "manic-depressive illness" was officially renamed "bipolar disorder," a term that more precisely reflected the two poles of mood disturbance (mania/hypomania and depression) without necessarily implying a psychotic component. The diagnostic criteria for manic and hypomanic episodes have been continually refined through subsequent editions of the DSM, including the DSM-IV and the current DSM-5, to enhance diagnostic reliability and validity. These revisions have sought to delineate the specific symptoms, duration, and severity thresholds required for a diagnosis, distinguishing a manic episode from other conditions with similar presentations and providing a more nuanced understanding of the spectrum of bipolar disorders.

### 3. Key Characteristics

The defining characteristic of a manic episode is a sustained period of an abnormally and persistently elevated, expansive, or irritable mood. An **elevated mood** is often described as feeling euphoric, excessively cheerful, or "on top of the world," sometimes without any apparent reason. This can manifest as an exaggerated sense of well-being and confidence. An **expansive mood** is characterized by unceasing enthusiasm for interpersonal, sexual, or occupational interactions, often accompanied by an inflated sense of self-importance and an indiscriminate push for social contact, even with strangers. When the mood is primarily **irritable**, it often presents as exaggerated responses to minor provocations, becoming easily frustrated or angered when desires are thwarted, which can lead to arguments or aggression. This irritability can be particularly distressing for both the individual and their social circle, often driving away support systems.

Alongside mood disturbances, individuals experiencing a manic episode exhibit persistently

increased goal-directed activity or energy. This heightened energy often manifests as a significant decrease in the need for sleep, where a person might feel completely rested after only a few hours or even no sleep for several days, without experiencing fatigue. This reduced need for sleep is not merely insomnia but rather a physiological change where the body and mind operate on significantly less rest. The increase in activity can involve an escalation in social, occupational, or school activities, or an increase in sexual activity. Individuals may embark on numerous new projects simultaneously, often with little foresight or planning, driven by an overwhelming sense of capability and urgency. For instance, many artists describe this as a highly productive period, where they can work for extended durations, fueled by an internal drive that seems boundless.

Several other prominent symptoms accompany the core mood and energy changes. These include grandiosity or an inflated self-esteem, where individuals believe they possess exceptional abilities, wealth, or power far beyond reality. Thoughts may race, leading to flight of ideas or pressured speech, where the individual talks incessantly, rapidly, and loudly, often jumping from one topic to another with only superficial connections. There is often an increased distractibility, where attention is easily drawn to irrelevant stimuli. Furthermore, individuals in a manic episode often engage in excessive involvement in pleasurable activities that have a high potential for painful consequences, such as unrestrained buying sprees, sexual indiscretions, foolish business investments, or reckless driving, often showing a profound lack of judgment regarding the long-term repercussions of their actions.

#### 4. Associated Features and Differential Diagnosis

Beyond the core diagnostic criteria, a manic episode is frequently accompanied by a range of associated features that further underscore its clinical severity. These can include psychotic symptoms, such as delusions (e.g., grandiose delusions of immense wealth or power, paranoid delusions of being persecuted) and hallucinations (typically auditory, but can be visual or other sensory modalities). When present, these psychotic features are often mood-congruent, meaning their content aligns with the elated or irritable mood. For instance, an individual might believe they are a deity or have a special mission. In severe cases, the disorganization of thought and behavior can be so pronounced that it mimics other psychotic disorders like schizophrenia, necessitating careful differential diagnosis.

The challenge of differential diagnosis is significant, as several conditions can present with symptoms overlapping those of a manic episode. Hypomania, as mentioned, is a milder form of mania, lacking the severe functional impairment or psychotic features that define a full manic episode. Distinguishing between these two is critical for treatment planning, as the intensity and type of intervention often differ. Additionally, substance-induced mood disorders, particularly those involving stimulants like cocaine or amphetamines, can mimic manic symptoms. A thorough history, including substance use, is essential. Medical conditions such as hyperthyroidism,

neurological disorders, or certain medications (e.g., corticosteroids) can also induce manic-like states, requiring medical evaluation to rule out organic causes.

Another important distinction is from other psychiatric conditions. Attention-Deficit/Hyperactivity Disorder (ADHD) can share features like increased activity, distractibility, and impulsivity, especially in children and adolescents. However, in ADHD, these symptoms are typically chronic and pervasive, not episodic or associated with a distinct change in mood. Similarly, while Borderline Personality Disorder (BPD) involves mood instability and impulsivity, the mood shifts are generally rapid and reactive to interpersonal stressors, lasting hours rather than days or weeks, and without the sustained physiological and cognitive changes characteristic of a manic episode. Accurate diagnosis relies on a comprehensive clinical interview, collateral information from family or friends, and a careful assessment of symptom duration, severity, and functional impact.

## 5. Clinical Significance and Impact

The clinical significance of a manic episode cannot be overstated, as it represents a period of profound instability and potential danger for the individual. During a manic episode, judgment is severely impaired, leading to decisions with far-reaching and often devastating consequences. Financial ruin from impulsive spending or ill-conceived investments is common. Legal problems can arise from reckless behavior, aggression, or sexual indiscretions. Relationships with family, friends, and colleagues can be severely strained or irrevocably damaged due to irritability, grandiosity, and disinhibited behavior. The high energy and reduced need for sleep can lead to physical exhaustion and neglect of personal health, further exacerbating the clinical picture.

Beyond individual consequences, manic episodes place a significant burden on public health systems. The severity of symptoms often necessitates hospitalization, which is both costly and disruptive to an individual's life. The risk of suicide, although more commonly associated with depressive episodes in bipolar disorder, is also elevated during mixed episodes (where manic and depressive symptoms coexist) and can occur during severe manic phases, particularly if accompanied by psychotic features or extreme irritability. The long-term impact of recurrent manic episodes includes potential neurocognitive deficits, such as impaired executive function and memory, which can persist even during periods of remission and contribute to functional impairment.

Early and accurate diagnosis, followed by consistent pharmacological and psychotherapeutic interventions, is crucial for mitigating the impact of manic episodes. Mood stabilizers, such as lithium and various anticonvulsants, are the cornerstone of treatment, often supplemented by antipsychotics to manage acute manic symptoms, especially those with psychotic features. Psychotherapy, particularly psychoeducation and cognitive-behavioral therapy, helps individuals understand their illness, identify triggers, develop coping strategies, and adhere to treatment plans,

thereby reducing the frequency and severity of future episodes. Effective management aims not only to alleviate acute symptoms but also to restore functional capacity and improve the overall quality of life for individuals living with bipolar disorder.

## 6. Debates and Criticisms

While the concept of a manic episode is well-established in psychiatry, there are ongoing debates and areas of criticism, particularly concerning diagnostic boundaries and the potential for misdiagnosis. One significant area of discussion revolves around the distinction between hypomania and full mania, especially given the subjective nature of mood and the reliance on self-report or collateral information. The line between severe hypomania and mild mania can sometimes be blurry, leading to variability in diagnosis and treatment approaches. Furthermore, the role of irritability versus euphoria as a primary mood presentation in mania is debated, with some arguing that irritable mania might be under-recognized or confused with other conditions.

Another point of contention involves the potential for overdiagnosis or misdiagnosis of bipolar disorder, particularly in children and adolescents. Critics argue that the broadening of diagnostic criteria for bipolar disorder in earlier DSM editions, combined with increased awareness and perhaps an over-reliance on symptom checklists, led to an increase in diagnoses that might otherwise have been attributed to ADHD, conduct disorder, or severe mood dysregulation. This concern prompted the inclusion of Disruptive Mood Dysregulation Disorder (DMDD) in the DSM-5, specifically to address children who exhibit persistent irritability and frequent temper outbursts but do not meet full criteria for a manic or hypomanic episode.

The categorical approach of the DSM-5, which defines a manic episode as a distinct, separate category, has also faced criticism. Some researchers and clinicians advocate for a more dimensional approach, recognizing that mood and energy exist on a spectrum, and that strict categorical cutoffs may not fully capture the nuanced reality of an individual's experience. This perspective suggests that while a categorical diagnosis is necessary for treatment, understanding the individual's position on a continuum of mood and energy could lead to more personalized and effective interventions. Despite these debates, the concept of a manic episode remains a critical component of psychiatric diagnosis, providing a framework for understanding and treating a severe and debilitating aspect of bipolar disorder.

## 7. Further Reading

Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR). American Psychiatric Association.

[Bipolar disorder - Wikipedia](#)

[Mania - Wikipedia](#)

[Hypomania - Wikipedia](#)

[Bipolar Disorder - National Institute of Mental Health \(NIMH\)](#)

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