**Bipolar Disorder**

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**COURSE OBJECTIVE:** The purpose of this course is to enable healthcare professionals to deliver evidenced-based care to patients with bipolar disorder in multiple settings.

**LEARNING OBJECTIVES:**
Upon completion of this course you will be able to:

- Discuss the historical perspective and epidemiology of bipolar disorder.
- Examine the theories of bipolar disorder etiology.
- Identify the signs and symptoms of bipolar disorder.
- Describe the medical diagnostic process using DSM-5 diagnostic criteria.
- Outline treatment modalities.
- Explore interdisciplinary management during the acute, continuation, and maintenance phases of the disorder.
- Describe communication techniques effective for working with individuals with bipolar disorder.

**WHAT IS BIPOLAR DISORDER?**

Almost everyone has days when they feel discouraged, disheartened, and a bit grouchy and other days when they feel energetic, hopeful, and successful. These are normal up and down variations in mood that do not seriously affect how people function in relationships, at school, or at work.

Bipolar disorder, also known as manic-depressive illness, on the other hand, causes severe mood extremes very different from these normal ups and downs that most people experience. The disorder causes shifts in mood, energy, activity levels, and the ability to carry out activities of daily living. It can result in failed relationships, inadequate school or work performance, and
even suicide. It is, however, a condition that can be treated, allowing people with the disorder to lead full and productive lives (NIMH, 2014).

**Historical Overview of Bipolar Disorder**

The high and low mood extremes seen in bipolar patients were first recorded in Greece during the first century and were described as distinct diseases. During the second century, a Greek physician identified these symptoms as part of a single disease.

From the second century for over a thousand years, Hippocrates’ humoral hypothesis was the established theory of the cause for these mood extremes. Melancholia (depression) was due to a body fluid known as “black bile” and mania (insanity) was due to another body fluid called “yellow bile.”

Little more was written about this disorder until the seventeenth century, when a British physician referred to a disorder in which two mood extremes existed in a circular fashion within the same person, later to be known as “circular insanity” or “dual-form insanity.”

In the nineteenth century Emil Kraepelin, a German psychiatrist considered to be the father of the modern concept of bipolar disorder, provided a clinical description in which he identified symptom-free intervals between the two extremes of mania and depression, and he coined the term *manic-depressive psychosis*.

The similar term *manic-depressive illness* dates from the 1950s, and in the 1980s it was changed to bipolar disorder, which was considered a less stigmatizing diagnosis. However, both terms continue to be in use today (Burton, 2012; Krans, 2012; Baker, 2015).

Treatment for this mental illness was recorded by the Romans as early as the second century, when persons with symptoms of mania were described as being treated at lithium salt spas. It was believed the salts were absorbed by the body and provided a calming effect. From 300 to 500 A.D., however, persons who exhibited bipolar extremes were considered to be possessed by demons and were euthanized or executed.

Treatment during the Middle Ages was considered punishment for having a mental disorder brought about by one’s wrongdoings. These forms of “treatment” included bloodletting, the use of chains for restraints, administration of potions, and application of electric eels to the person’s scalp (Baker, 2015).

In the eighteenth century there was a change from religious authority to medical authority over people with mental illness. It was believed that insanity was caused by brain damage from outward influences, and a more humane way of dealing with those afflicted was sought. Patients were segregated from the rest of society, and treatment was based on the belief that behavior could change by appealing to a patient’s “moral capacities.” This treatment method was known as “moral treatment” or “moral therapy” and focused on a patient’s social, individual, and occupational needs.
By the middle of the eighteenth century, however, due to lack of success and overcrowding of hospitals, attitudes again changed, and many believed that weak family and vices such as alcoholism or masturbation could lead to insanity. Those with mental illness were now considered “genetically inferior” (ANP, 2015).

At the turn of the century, Sigmund Freud moved away from the purely medical approach and introduced the new field of psychiatry known as psychoanalysis, whose basic premise was that most psychological symptoms were the result of unconsciously avoiding unpleasant truths about one’s self. When patients come to understand their own deceptions, they can then manage to avoid being controlled by them.

By the middle of the nineteenth century, medical psychiatry began to treat patients in small asylums, and by the end of that century, treatments consisted of high-pressure showers, sheep thyroid injections, metallic salts, horse serum, arsenic, tooth extractions, and insulin comas (Whitaker, 2010).

Up until the 1950s, the treatments for bipolar disorder included sedation and barbiturate therapies, institutionalization, electroconvulsive therapy, and prefrontal lobotomies. Of these, electroconvulsive therapy continues to this day (Baker, 2015).

**BIPOLAR DISORDER AND CREATIVITY**

Researchers have found a strong correlation between bipolar disorder and creativity, especially in the arts. A team from Oregon State University looked at a large group of patients’ occupational status and found that those with bipolar disorder were disproportionately concentrated in the most creative occupational categories. They also found that engaging in creative activities on the job was significantly higher for individuals with bipolar disorder than without (Collingwood, 2015).

Mental health experts believe there is a “silver lining” to bipolar disorder because of the disproportionate number of famous and accomplished people throughout history that exhibited the behaviors and symptoms of the disorder (Srivastava & Ketter, 2010). These include:

**Musicians:** George Frideric Handel, Wolfgang Amadeus Mozart, Frank Sinatra, Ludwig van Beethoven, Richard Wagner

**Artists:** Pablo Picasso, Vincent van Gogh

**Entertainers:** Jim Carrey, Marilyn Monroe, Robin Williams, Carrie Fisher, Linda Hamilton, Mariette Hartley, Catherine Zeta-Jones, Jeremy Brett, Mel Gibson, Britney Spears, Kurt Cobain, Sinead O’Connor, Justin Furstenfeld, Mary Lambert, Charley Pride, Nina Simone, Dusty Springfield

**Authors:** Agatha Christie, Charles Dickens, Ernest Hemingway, Mark Twain, Emily Dickinson, Virginia Woolf

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Others: Buzz Aldrin, Sigmund Freud, Robert E. Lee, Florence Nightingale, Jane Pauley, Ted Turner


Epidemiology

Each year, bipolar disorder affects nearly 6 million adult Americans, or 2.6% of the U.S. population 18 years and older (NIMH, 2013). Of these cases, 82.9% are classified as severe. Worldwide 1.5% of the population has bipolar disorder (Deibler, 2013).

The median age of onset for this disorder is 25 years, but it can begin in early childhood or as late as the 40s and 50s. The Child and Adolescent Bipolar Foundation estimates that at least three quarters of a million American children and teens may suffer from bipolar disorder, although many are not diagnosed (Doheny, 2015).

Bipolar disorder is found in all races, ethnic groups, and social classes. It affects an equal number of women and men, but males may develop the illness earlier in life compared to females. Although equal in males and females, females are three times more likely to experience rapid cycling and may have more depressive episodes and more mixed episodes than men (NIMH, 2013).

Bipolar disorder is the sixth leading cause of disability in the world and the ninth leading cause of years lost to death or disability worldwide (Baker, 2015).

Both men and women with bipolar disorder have an increased risk for ischemic heart disease, diabetes, COPD, influenza, and pneumonia. This increased risk is believed to be due to genetic factors, unhealthy behaviors, pathophysiologic changes that occur in bipolar patients, and medications used to treat the disorders.

On average, women with bipolar disorder die 9.0 years earlier than women in the general population, and men die 8.5 years earlier. Bipolar disorder is associated with a tenfold increased risk for death from suicide in women and an eightfold increased risk for men (Cassels, 2013).

ETIOLOGY

The exact cause for bipolar disorder is unknown. Although there are no lab tests, brain scans, X-rays, or chemical imbalance tests that can verify bipolar disorder or any other mental disorder as a physical condition, the current theory is that it is principally a biologic disorder that occurs in a specific area of the brain and is due to a malfunction of the neurotransmitters. It may lay dormant and be activated spontaneously or be triggered by environmental stressors (Bressert, 2015).
Biologic theories include genetic, biochemical, and physiologic influences.

**Genetics**

Research has shown that bipolar disorder tends to run in families. A child with one parent with bipolar disorder has a 15% to 25% increased risk, and a child whose both parents have bipolar disorder has a 50% to 75% greater risk for the development of the disorder. A child with a nonidentical twin who has bipolar disorder has a 25% increased risk, whereas an identical twin has a 70% greater risk (Bressert, 2015).

Studies done by the Genome-Wide Association have made a connection between bipolar disorder susceptibility and two genes known as ANK3 and CACNA1C. ANK3 is involved in determining whether a neuron will fire, and CACNA1C regulates the influx and outflow of calcium from the cells.

These studies show that lithium carbonate, the most common medication for treatment of bipolar manic episodes, reduces expression of the ANK3 gene and that the CACNA1C gene provides instructions for making calcium channels, which play a key role in a cell’s ability to generate and transmit electrical signals. Calcium channel blockers have sometimes been found to be effective in the treatment of bipolar disorder.

These findings may help explain the heritability in this disorder. Further studies using large samples are needed, and the outcome could be personalized treatment for bipolar disorder based on susceptibility genotypes (Fiorentino et al., 2014; Soreff, 2015).

**Biochemical Factors**

Biogenic amine neurotransmitters are a group of biologically active organic compounds that naturally occur in the body. It is believed that bipolar disorder is associated with the faulty regulation of one or more amines at sites in the brain where the transmission of nerve impulses take place.

Neurotransmitters are necessary in just the right proportion to relay messages across the synapses between neurons. Studies show that individuals with symptoms of mental disorders have different amounts of various neurotransmitters than individuals without symptoms. Though dozens of neurotransmitters have been discovered, certain ones have been found to play significant roles in mental illness. The psychoactive neurotransmitters include the monoamines serotonin, dopamine, epinephrine, and norepinephrine.

Neurotransmitters are linked to the disorder based by-and-large on patients’ responses to psychoactive agents. For example, drugs used to treat depression can all potentially trigger mania, implicating all of the neurotransmitters in the etiology of bipolar disorder (Soreff, 2015).
SIGN AND SYMPTOMS

Bipolar disorder presents differently in different people. Signs and symptoms can vary widely in pattern, severity, and frequency. Some patients have more manic or depressive episodes, and others alternate between the two states equally.

**Mood and Affect**

People with bipolar disorder experience wide swings of mood. Those experiencing hypomania will be cheerful and expansive, and there is an underlying irritability that may rapidly surface when the person is impatient and denied whatever he or she wishes or desires.

During acute manic episodes, patients may say they feel fabulous, on top of the world, gifted, important, and famous. Sometimes those exaggerated positive feelings turn ugly, and patients become impatient, irritable, and belligerent. Most persons with acute mania show marked impairment in functioning and require hospitalization.

Although individuals in the manic state appear elated and joyful, it is important to remember that those symptoms may last a short time and that before long such clients may sink back into an underlying state of depression.

During depressive episodes patients may experience extended periods of feeling worried or empty, and often feel irritable. During depression they may think of death or suicide and even attempt suicide. Thus, it is vital to address self-harm directly.

**Cognition and Perception**

For individuals experiencing hypomania, thinking is flighty and ideas flow rapidly. The person has an exalted perception of the self, and the perception of the environment is heightened. Distractibility makes it difficult to perform goal-directed activities. For those experiencing acute mania, cognition and perception soon become fragmented. Psychosis may be present.

Thought processes are seriously affected during both manic and depressive phases. Thought processes refer to the way people think and manage information. Thought content refers to what people are thinking and saying. (Types of thinking are described in the box below.)

People experiencing a manic episode may exhibit the psychotic symptoms of delusions (false ideas), hallucinations (false perceptions), and illusions (false interpretations of real perceptions).

Delusions of grandeur are especially common, such as believing one is famous and wealthy. It is important, however, not to jump to the conclusion that patients are delusional about some aspect of their life. For example, the elderly patient with a history of mental illness who claims to have been a fighter pilot who has won two distinguished flying crosses for heroism may actually have done so.
Hallucinations are less common and include such things as hearing voices no one else hears or smelling odors no one else smells. Illusions include such things as interpreting the voice of another person as God.

During depressive episodes the patient may have problems concentrating, remembering, and making decisions.

<table>
<thead>
<tr>
<th>TYPES OF THINKING IN PEOPLE WITH BIPOLAR DISORDERS</th>
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<tbody>
<tr>
<td><strong>Circumstantial thinking</strong></td>
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<tr>
<td>Giving all manner of extraneous detail when answering a simple question</td>
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| **Delusion**                                      |
| False ideas or beliefs not based on reality, such as a delusion of grandeur, when a person believes he or she is famous or wealthy |

| **Flight of ideas**                               |
| Speech composed of fragments of unrelated ideas, delivered rapidly and excessively |

| **Ideas of reference**                            |
| Inaccurate interpretation of a general event as personally directed to a specific person, such as when a person hears something on the news and believes it is a coded message just for them |

| **Loose association**                             |
| Disorganized thought that jumps from one idea to another with little or no relationship among the content of such ideas |

| **Clang associations**                            |
| Stringing together words because of their rhyming sounds without regard to their meaning |

| **Suicidal ideation**                             |
| Thoughts of death and suicide                     |

| **Tangential thinking**                            |
| Wandering off the topic and never getting back to the original topic |

| **Thought blocking**                               |
| Stopping abruptly in the middle of a sentence or thought, unable to continue |

| **Thought broadcasting**                           |
| A delusional belief that others can hear or know what one is thinking |

| **Thought insertion**                              |
| A delusional belief that others are putting ideas or thought into one’s mind |
Thought withdrawal
A delusional belief that someone else is taking one’s thoughts away and that one is powerless to stop the other

Word salad
Flow of disconnected words that have no meaning to the listener

Activity and Behavior

Hypomaniac individuals exhibit motor activity increase. They appear to be very extroverted and sociable. Others are drawn to them, but they often fail to achieve close friendships because they lack depth of personality and warmth. They often have an increase in libido, and they may engage in inappropriate behaviors such as spending a great deal of money without resources to pay.

In a manic episode, judgment and insight are seriously affected. Excessive energy leads individuals to all manner of impulsive and destructive behaviors. They may start projects they cannot finish, go on shopping sprees they cannot afford, behave inappropriately, have promiscuous sex, take expensive trips, gamble compulsively, and engage in all kinds of extreme behaviors that have serious consequences.

During depressive episodes the person may experience a loss of interest in activities once enjoyed, including sex. They may feel tired or slowed down and may have changes in eating, sleeping, or other habits. They may experience anorexia, bulimia, or other eating disorders and may become dependent on sleeping pills. Substance abuse (self-medicating) often becomes a way to cope with their symptoms.

Self-Esteem, Roles, and Relationships

Though people in a manic phase may have an inflated sense of personal power and entitlement, rarely do they understand the relationship of exaggerated behavior to their chronic low self-esteem. Although mania builds them up for a time, the depression that follows confirms their sense of worthlessness and failure.

People in the manic phase seldom fulfill role responsibilities expected of them. They may be too distracted to attend to the duties of student, employee, spouse, or parent. Thus, they may drop out of school, fail to perform job expectations, leave personal relationships, and neglect their children.

Often, these individuals have a great need to socialize and be accepted by others, but they do not recognize their own inappropriate interpersonal interactions, violate conventional boundaries, and invade the intimate space of others. The need for acceptance may lead to sexual promiscuity, with all the attendant problems that may follow.
Although elation is the usual mood of people in the manic phase, any delay of gratification may trigger a hostile outburst toward anything or anyone who blocks their desire or criticizes them.

During a depressive episode the person may isolate from family and friends.

**Physiologic Responses and Self-Care**

Individuals in the manic phase seem to be in constant motion. They are unable to stay still long enough to eat, drink, or sleep adequately, and they may become exhausted, dehydrated, and malnourished. Often, they neglect personal hygiene, injuries, and other health needs because the energy of mania drives them on and on. Thus, ongoing assessment of how well patients attend to physical and personal needs provides critical information about patients in both manic and depressive phases of bipolar disorder.

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**CASE**

Delphine is a 28-year-old female with a history of bipolar disorder. She was brought to the emergency department (ED) after being removed from a local restaurant where she had created a disturbance by entering the kitchen and demanding that the chef cook “crawfish étouffée the way I learned to make it in Paris!” When the kitchen staff attempted to escort her out to the dining room, she became verbally hostile and aggressive, grabbed a pan of sauce from the stove, and threw it at them, burning one of them on the face and arms. Two employees held her to the floor until police arrived.

Delphine was handcuffed and taken to the patrol car. On the ride to the hospital, she became overly cheerful, making jokes and laughing. At one point she pulled up her dress and asked the police officers if they “want some?”

When Delphine was admitted to the ED, the nurse assigned to her, Agnes, established rapport using active listening techniques and validation. Her history was obtained, as were her medical records, which indicated a long history of bipolar manic episodes and treatment noncompliance.

The psychiatrist on call arrived to assess her, and Agnes contacted Delphine’s brother Antoine. Antoine told the nurse that Delphine stopped taking her lithium about five weeks ago and has become more and more agitated and out of control. She has not been eating or sleeping for several days and has been telling everyone she is a French-trained chef hired to cook at celebrity chef Paul Prudhomme’s Creole restaurant.

Antoine went on to say that the day before yesterday he had checked in on Delphine to find she had built a wood fire in a metal washtub in the living room. She said she was getting ready to barbecue a piece of chicken. When he intervened, she became very angry and abusive, screaming at him to leave. He was able to put the fire out, but she refused to go with him for medical treatment. He said he probably should have called the police but didn’t want to make her any angrier than she already was.
The ED psychiatrist contacted Delphine’s physician for previous treatment history and to discuss her medical management. She was admitted to the mental health inpatient unit.

Discussion
Delphine’s symptoms demonstrate a classic acute manic episode:

- She has been experiencing increased agitation and loss of control over her behaviors and responses.
- She has rapid changes in mood from anger to overly cheerful.
- Her response to being challenged leads to outbursts and aggression.
- She has not been sleeping or eating over a period of days.
- She has been involved in highly risky goal-directed behaviors.
- She is sexually inappropriate.
- Her thinking is delusional in that she believes she is a French-trained chef who has been hired to cook at a famous restaurant.

(continues)

DIAGNOSIS

Bipolar disorder is difficult to diagnose because symptoms present in so many different forms and patterns with variances in acuity, duration, and manifestations. In addition, the disorder may coexist with other psychiatric diagnoses, which further complicates the picture. The reality is that the average time from initial onset of symptoms to an accurate bipolar diagnosis is ten to twelve years (Federman, 2014).

The Connecticut Behavioral Health Partnership (CTBHP, 2012) offers a comprehensive guideline for assessing adults ages 18 years and over for bipolar disorder. It is important that all major areas be addressed to aid in making a diagnosis. These include:

Psychological Evaluation
- History of the person’s symptoms and when they first began
- Description of manic and depressive symptoms and cycling pattern
- Family behavioral health history, including the presence or absence of bipolar disorder
- Use and/or abuse of chemicals such as drugs, alcohol, cannabis, or caffeine
- Social and relationship issues
- Occupational history
- Current ability to function at work or school
Mental Status Examination

- General appearance and behavior
- Subjective and objective evaluation of speech and thought process
- Objective evaluation of memory
- Mood and affect
- Screening for psychotic symptoms

Risk Assessment

- Presence of suicidal ideation and risk
- Self-injurious behaviors
- Homicidal ideation and risk
- Potential for coping
- Impulsivity and behavioral control
- Behavioral self control impairment due to substance abuse

Physical Examination

- To rule out medical explanations for bipolar-like symptoms

DSM-5 Bipolar Disorder Diagnostic Criteria

Bipolar disorder is a complex illness characterized by swings from profound depression to extreme euphoria (mania), with intervening periods of normalcy (euthymia). There are many different symptoms and types of bipolar, ranging from mild to severe.

MANIC EPISODES

The Diagnostic and Statistical Manual of Mental Disorders, 5th ed., (DSM-5) describes a manic episode as 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)” (APA, 2013).

During this manic episode there is marked impairment in the ability to function at work or in normal social activities or relationships. Hospitalization may be required to prevent harm to self or others. Physical activities are excessive and frenzied, and the person may experience psychotic features such as delusions (false ideas or beliefs), hallucinations (false perceptions), and illusions (false interpretations of perceptions).

The DSM-5 identifies a somewhat milder form of mania known as hypomania, a “distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least four consecutive days and present most of the day, nearly every day” (APA, 2013). Hypomania is not severe in that it does not cause
impaired social or occupational functioning or require hospitalization. Hypomania does not include psychotic features.

DSM-5 indicates that persons with mania or hypomania must also have three or more of the following symptoms:

1. Inflated self-esteem or grandiosity (delusions of grandeur)
2. Decreased need for sleep; feeling rested after only three hours of sleep
3. Pressured speech that is rapid, relentless, and often loud without pauses
4. Flight of ideas which are disconnected and racing
5. Distractibility with attention easily drawn to irrelevant external stimuli
6. Psychomotor agitation in which there is increased goal-directed activity
7. Risky activities with a high potential for serious consequences, such as sexual indiscretion, buying sprees, and foolish business investments

DEPRESSIVE EPISODES

The DSM-5 (APA, 2013) states that a major depressive episode “must have five or more of the following symptoms present during the same two-week period and represent a change from previous functioning; at least one of the symptoms is either 1) depressed mood or 2) loss of interest or pleasure”:

1. Depressed mood most of the day, nearly every day
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day
3. Significant changes in weight or appetite
4. Insomnia or hypersomnia nearly every day
5. Psychomotor agitation or retardation nearly every day
6. Fatigue or loss of energy nearly every day
7. Feelings of worthlessness or excessive or inappropriate guilt nearly every day
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day
9. Recurrent suicidal ideation without a plan, or suicide attempt or specific plan for committing suicide

Types of Bipolar Disorder

According to the DSM-5 (APA, 2013), there are several types of bipolar disorder differentiated by the varying symptoms individuals present with and the history of the person’s experience.
• **Bipolar I Disorder.** The individual who receives this diagnosis is experiencing a manic episode or has a history of one or more episodes. The person may or may not have experienced depressive episodes, and psychotic features or catatonia (stupor and either rigidity or extreme flexibility of the limbs) may be present.

• **Bipolar II Disorder.** The individual given this diagnosis has had recurrent bouts of major depression with episodic hypomania. The person may present with or have a history of depression or hypomania but has never had a full manic episode. Psychotic or catatonic features may be evident.

• **Cyclothymic Disorder.** This diagnosis is given to an individual who has had a chronic mood disturbance of at least two years’ duration (one year in children) without symptom relief for longer than two months that includes many bouts of elevated mood that do not meet the criteria for hypomania. The person will have had many periods of depressed mood sufficiently severe or of a duration that meets the criteria for major depressive disorder.

• **Substance/Medication-Induced Bipolar Disorder.** The mood disturbances characteristic of this disorder are considered to be the direct result of the physiologic effects of a substance of abuse or a medication. Symptoms can occur due to either intoxication or withdrawal.

• **Bipolar Disorder Due to Another Medical Condition.** This disorder is characterized by symptoms of manic episodes considered to be due to the physiologic consequence of another medical condition and results in distress or impaired functioning. Such medical conditions include:
  - AIDS
  - Brain tumors
  - Cushing syndrome
  - Encephalitis
  - Head injury
  - Huntington’s chorea
  - Hyperthyroidism or hypothyroidism
  - Influenza
  - Lyme disease
  - Multiple sclerosis
  - Neurosyphilis
  - Stroke
  - Systemic lupus erythematosus
  - Temporal lobe seizures

(Coryell, 2014; Soreff, 2015)
TREATMENT MODALITIES

Patients with bipolar disorder are often ambivalent about receiving treatment, and compliance with treatment is often difficult. The major cause of relapse is nonadherence with mood-stabilizing medications (Halter, 2014).

Psychopharmacology

Medications are prescribed by primary care physicians, psychiatrists, and advanced practice psychiatric nurses in all 50 states and by appropriately trained doctoral-level psychologists in three states (New Mexico, Louisiana, and Illinois) (APA, 2014).

Because of the diverse nature of bipolar disorder symptoms, a variety of drugs are used in its treatment. The table below lists those used to treat bipolar mania. The mechanism of all medications administered to the patient for treatment of bipolar disorder remains unclear.

<table>
<thead>
<tr>
<th>BIPOLAR MANIA MEDICATIONS</th>
<th>Medications</th>
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<tbody>
<tr>
<td>Type</td>
<td>Medications</td>
</tr>
<tr>
<td>Antianxiety</td>
<td>Benzodiazepines (Lorazepam and Clonazepam)</td>
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<tr>
<td>Antimanics</td>
<td>Lithium carbonate (Eskalith, Lithobid)</td>
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<tr>
<td>Anticonvulsants</td>
<td>Carbamazepine (Tegretol)</td>
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<td>Clonazepam (Klonopin)</td>
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<td></td>
<td>Valproic acid (Depakene, Depakote)</td>
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<td>Lamotrigine (Lamictal)</td>
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<td>Topiramate (Topamax)</td>
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<td></td>
<td>Oxcarbazepine (Trileptal)</td>
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<td>Calcium channel blockers</td>
<td>Verapamil (Calan, Isoptin)</td>
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<tr>
<td>First-generation antipsychotics</td>
<td>Inhaled loxapine</td>
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<td>Haloperidol (Haldol)</td>
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<tr>
<td>Second-generation antipsychotics</td>
<td>Olanzapine (Zyprexa)</td>
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<td>Olanzapine and fluoxetine (Symbyax)</td>
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<td>Aripiprazole (Abilify)</td>
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<td>Chlorpromazine (generic Thorazine)</td>
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<td>Risperidone (Risperdal)</td>
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<td>Ziprasidone (Geodon)</td>
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<td>Asenapine (Saphris)</td>
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<td></td>
<td>Paliperidone (Mirapex, Mirapex ER)</td>
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</tbody>
</table>

Source: Soreff, 2015.
Fluoxetine (Prozac, Sarafem) is the only antidepressant that is effective in treating bipolar depression, and only in combination with the atypical antipsychotic olanzapine (Zyprexa, Zyprexa Zydis, Zyprexa Relprevv) (Lawrence, 2014).

Lamotrigine (Lamictal) is used for maintenance treatment of adults and has been found to be beneficial in helping to delay depression, mania, and hypomania. It is especially effective in preventing bipolar depression. It is the first FDA-approved treatment since lithium for bipolar disorder maintenance (Goldberg, 2014a).

MEDICATION SIDE EFFECTS

The effectiveness of a medication depends on its concentration in the plasma or at the site of action. All drugs have effects that are desired, but they also have undesired effects even when administered at the usual recommended dosage. These undesired effects can be harmless or harmful.

**Antianxiety Medications**

Benzodiazepines have comparatively few undesired effects. The most common are drowsiness and loss of coordination. Patients may complain of fatigue, and mental slowing may occur. Some persons may experience confusion. Regular use of these medications is also known to cause memory impairment in some people.

These medications carry a risk for paradoxical disinhibition, which is an increase in excitability, irritability, aggression, hostility, and impulsivity. This adverse effect occurs most commonly in children, older adults, and in those with developmental disabilities.

Benzodiazepines should not be stopped abruptly, as there is a risk of seizures and other serious effects (Morelli, 2015).

**Lithium**

The more common side effects that may be experienced with lithium include:

- Hand tremors
- Increased thirst, dry mouth
- Increased urination
- Diarrhea
- Vomiting
- Weight gain
- Poor concentration
- Drowsiness
- Hair loss
• Acne
• Muscle weakness
• Decreased thyroid function

The margin between the therapeutic and toxic levels of lithium carbonate is very narrow. Since there is only a small difference between a therapeutic dose and a toxic dose of lithium, periodic serum levels are measured with these criteria:

• Treatment serum levels during acute mania (0.8 to 1.5 mEq/L)
• Ongoing maintenance serum levels (0.5 to 1.5 mEq/L)
• Toxic serum levels (1.5 mEq/L and above)

The toxic effects of lithium begin to appear at blood levels greater than 1.5 mEq/L and include blurred vision, ataxia, tinnitus, persistent nausea and vomiting, and severe diarrhea.

With serum levels of 2.0 to 3.5 mEq/L, toxic effects include excessive output of dilute urine, increasing tremors, muscular irritability, psychomotor retardation, mental confusion, and giddiness.

When serum levels are over 3.5 mEq/L, the effects include impaired consciousness, nystagmus, seizures, coma, oliguria/anuria, arrhythmias, myocardial infarction, and cardiovascular collapse.

Lithium carbonate is not metabolized. Instead, it is reabsorbed by the proximal tubules of the kidneys and excreted in the urine. Thus, baseline and periodic assessment of renal function is essential. Lithium is contraindicated in people with compromised renal function, urinary retention, and in pregnant women because it can cause first-trimester fetal abnormalities.

When first prescribed, serum levels are measured weekly or biweekly until a therapeutic level is attained. After that, they are determined every month. After a year of stability, serum lithium levels are measured every 3 months.

Because lithium competes with sodium at various sites in the body, it is important that the patient consume a diet adequate in sodium as well as 2,500 ml to 3,000 ml of fluid per day. Accurate records of intake and output and weight should be kept on a daily basis.

**Anticonvulsants**

Each anticonvulsant may have somewhat different side effects, but the most common include:

• Dizziness
• Drowsiness
• Fatigue
• Nausea
• Tremor
• Rash
• Weight gain

Anticonvulsant drugs can cause liver or kidney damage or a decrease in blood platelets. Persons taking these medications require blood test monitoring (Goldberg, 2014b).

**Calcium Channel Blockers**

Most people tolerate calcium channel blockers well, and in most instances side effects are minor. Those that are common to calcium channel blockers include:

• Headache
• Constipation
• Rashes
• Nausea
• Flushing
• Edema
• Drowsiness
• Hypotension
• Dizziness

Rarely, calcium channel blockers have been known to cause sexual dysfunction, overgrowth of the gums, and liver dysfunction.

More serious side effects are less common and include chest pain, signs and symptoms of hypotension, and heart attack. Calcium channel blocks can worsen heart failure, as they affect the ability of the heart to contract and pump blood (Ogbru, 2015).

**First-Generation Antipsychotics**

First-generation antipsychotics have a high incidence of causing neurological side effects. These include:

• Dystonia (a reversible condition characterized by involuntary slow, repetitive movements or abnormal postures)
• Akathisia (restlessness, inability to sit still; often referred to as “happy feet”)
• Pseudoparkinsonism (a drug-induced condition with symptoms similar to Parkinson’s disease)
• Tardive dyskinesia (an irreversible disorder of involuntary movements due to long-term use of antipsychotics)

A very uncommon but life-threatening side effect of first-generation antipsychotic medications is **neuroleptic malignant syndrome**. This is a drug-induced disorder that causes high fever, muscle stiffness, altered mental status, and dysfunction of the autonomic system causing wide swings in blood pressure, excessive sweating, and excessive salivation.

Other side effects may include:

• Anticholinergic effects (blurred vision, dry mouth, constipation, urinary retention)
• Sexual dysfunction
• Reduced seizure threshold
• Orthostatic hypotension
  (Guzman, 2015)

**Second-Generation Antipsychotics**

The undesired effects of second-generation antipsychotics include an increased risk for metabolic side effects such as hyperglycemia, weight gain, and abnormal amounts of lipids in the blood (dyslipidemia). The most common side effects are sedation, drowsiness, and weight gain.

These medications have a lower incidence of causing abnormal movements than first-generation antipsychotics but are also known to cause neuroleptic malignant syndrome.

A possible fatal side effect of Clozaril (clozapine) is bone marrow suppression and agranulocytosis (the inadequate production of neutrophils required to fight infections). Regular blood testing is required to monitor for this adverse effect (Guzman, 2015).

**Electroconvulsive Therapy (ECT)**

Electroconvulsive therapy is one of the most effective yet most stigmatized remedies for mood disorders. Episodes of acute mania are occasionally treated with ECT when the patient does not tolerate or fails to respond to drug treatment or when life is threatened by dangerous behavior or exhaustion. ECT involves the passage of an electric current through the brain to artificially create a seizure and is primarily reserved for treatment-resistant forms of acute mania and depression (Brooks, 2015).

ECT was developed and first performed in 1938. Historically, patients did not receive sedation or anesthesia. They were placed on a narrow table, electrodes were attached to the head, and attendants held them down as the electric current produced a grand mal seizure. After a long,
deep sleep, patients gradually awoke, confused and disoriented with significant memory loss and sometimes fractured bones and other injuries.

Today, ECT is prescribed by a psychiatrist and is administered to anesthetized patients who have received muscle relaxants. It causes a carefully controlled seizure that lasts 20 to 90 seconds. Patients awaken in five to ten minutes. Commonly, a course of treatment is three times a week for two to five weeks. After an initial course of treatment, ECT may be given on an outpatient basis.

Although an electric current is passed through the brain and body, this current is modulated carefully for safety and maximal therapeutic effect. The results from ECT treatment are often fairly remarkable, resulting in the emergence of a normal mood.

The mechanism of action of ECT is not fully understood. Positron emission tomography (PET) studies have shown that ECT affects multiple central nervous system components and nearly every neurotransmitter system (Kalapatapu, 2015).

The procedure has one significant negative side effect, however. Virtually all patients experience some memory loss, and sometimes the memory loss is permanent. Most people experience retrograde amnesia, which is a loss of memory for the events leading up to and including the treatment. Some have trouble recalling events that occurred during the weeks leading up to treatment or the weeks after treatment. Others may lose memories of events and experiences in their past. These memory problems usually improve within a couple of months (Hauser, 2013).

Bilateral ECT results in more memory problems than unilateral ECT to the right side of the head, which is opposite the brain’s learning and memory areas (Berman, 2013).

**Transcranial Magnetic Stimulation (TMS)**

For patients with bipolar depression who have not responded to antidepressants, TMS may be a treatment option ordered by a psychiatrist. During this treatment, the patient sits in a reclining chair and a treatment coil is placed against the scalp. The coil sends brief magnetic pulses to stimulate nerve cells in the brain that are involved in mood regulation and depression. The treatment lasts 30 minutes, and the typical course is five treatments a week for up to six weeks (Mayo, 2015a).

TMS may cause minor short-term side effects that typically improve after the first or second week of treatment. These include:

- Headache
- Scalp discomfort at the site of stimulation
- Tingling, spasms, or twitching of facial muscles
- Lightheadedness
- Discomfort from noise during treatment
More serious but very rare side effects can include seizures, mania in persons with bipolar disorder, and hearing loss due to inadequate ear protection during treatment. No studies have been done as yet to determine whether TMS may have any long-term side effects (Mayo, 2015b).

**Psychotherapy**

Psychotherapy is provided by healthcare professionals with advanced education, such as psychologists, psychiatrists, advanced practice psychiatric nurses, marriage and family therapists, and social workers.

Patients with mania have historically been difficult candidates for psychotherapy. They easily form a therapeutic relationship because they want to please and are happy to receive the therapist’s attention, but it often remains shallow and rigid. There are, however, three major approaches that have been shown to be of benefit for bipolar disorder patients when added to medications.

- **Bipolar-specific cognitive behavioral therapy.** Cognitive therapy is based on the theory that much of what we feel is determined by what we think. This therapy challenges thinking errors and points out alternative ways of viewing situations and thinking about them.

- **Interpersonal combined with social rhythm therapy.** Social rhythm therapy is a type of psychotherapy that focuses on helping people identify and maintain the regular routines of everyday life, and interpersonal therapy focuses on the interpersonal relationships of the person to improve communication patterns and how the patient relates to others.

- **Family-focused therapy.** Family therapy views a person’s symptoms as taking place in a larger context of family. It is most often used along with interpersonal therapy.

All of these therapies have similar emphases:

- Identifying the signs of relapse and making plans for early detection and response (prodrome detection)

- Utilization of education (psychoeducation) to increase conformity between practitioner, patient, and family about what is being treated and why

- Emphasizing the need to stay on medications even when well

- Teaching stress management, problem solving, and improving relationships

- Identifying dysfunctional patterns of thinking and behavior

- Maintaining a regular daily rhythm for sleep, exercise, eating, and activities (Phelps, 2014)
Occupational Therapy

Occupational therapists are essential members of the mental healthcare team. For individuals with bipolar disorder and other mental health illnesses, occupational therapy interventions can include:

- Social skills training and social participation
- Instrumental activities of daily living (IADLs), specifically health management and maintenance, community reintegration, money management, home management, and life skills programs
- Work and education
- Neurocognitive training
  (Jackman, 2013)

These interventions involve assessment and:

- Evaluation of work and self-care abilities
- Client-centered short- and long-term goals and treatment plan
- Adaptation of activities and environment to allow for participation in meaningful occupations
- Monitoring patient response to medication
- Education of family and caregiver(s)

MANAGEMENT

Management of care for the person with bipolar disorder depends on the phase of mania.

- **Acute phase.** During this phase, steps are taken to medically stabilize the patient as well as to maintain safety. In this phase of the disorder, hospitalization is usually the safest place for the patient.

- **Continuation phase.** During this period that lasts from four to nine months, care includes taking measures to help maintain medication compliance and prevent relapse.

- **Maintenance phase.** During this phase, goals are to continue to prevent relapse and to limit the severity and duration of future episodes. Medication management may be required for long periods of time, if not a lifetime.
  (Halter, 2014)

Acute Phase Management

During an acute episode, the safest intervention for the patient may be hospitalization, where management is directed toward treatment, decreasing activity, increasing food and fluids, and
ensuring adequate sleep. The main goal for inpatient treatment is to get the patient through the immediate crisis, which could last up to a couple of weeks and sometimes longer.

When following a patient with bipolar disorder, the need for hospitalization should be assessed at each visit. Hospitalization is an emergency step in bipolar care, and this step is taken when the disorder is causing someone to be an immediate threat to themselves or others or when there is a need for medication adjustment and monitoring.

**CASE (continued)**

On Delphine’s admission to the inpatient mental health unit, Gerardo was the RN assigned as her primary nurse. Delphine was unable to sit down, could not stop talking, made loud hostile and sexual comments about other patients, and asked Gerardo if he wanted to be her lover and sleep with her. Gerardo suggested they go to a quiet area of the unit, but Delphine became angry and said, “The FBI will hear about this. I’m an agent, you know!”

Following his interview and nursing assessment, Gerardo divided the data into subjective and objective components. Objectively he wrote:

- Nothing to eat for several days
- Little if any sleep for days
- History of mania treated with lithium
- History of lithium discontinuance
- Constant activity, can’t sit down
- Very loud and distracting
- Angry when her wishes are denied
- Other-directed violence
- Flight of ideas
- Inappropriate sexual remarks and behaviors
- Poor judgment, fire in the living room
- Remarks suggesting grandiose thinking

Subjectively, Gerardo recorded:

- “I’m a French-trained chef”
- “I’ve been hired by Paul Prudhomme”
- “The FBI will hear of this. I’m an agent, you know.”

(continues)
NURSING DIAGNOSES

Nursing diagnoses are based on the admitting RN’s nursing assessment and can vary for the patient with bipolar disorder. The primary considerations for a client experiencing acute mania are safety and the prevention of exhaustion.

Because of patients’ poor judgment, excessive and constant motor activity, and difficulty evaluating reality, the following diagnoses are appropriate:

• **Risk for injury** as manifested by:
  o Extreme hyperactivity
  o Increased agitation
  o Lack of control over purposeless and potentially injurious movements

• **Risk for self-directed or other-directed violence** as evidenced by:
  o Manic excitement
  o Delusional thinking
  o Hallucinations
  o Impulsivity

• **Imbalanced nutrition less than body requirements** as evidenced by:
  o Loss of weight
  o Anorexia
  o Inability to sit still long enough to eat

• **Disturbed thought processes** as evidenced by:
  o Delusions of grandeur and persecution
  o Inaccurate interpretation of the environment

• **Disturbed sensory perception** as evidenced by:
  o Auditory and visual hallucinations
  o Disorientation

• **Impaired social interaction** as evidenced by:
  o Inability to develop satisfying relationships
  o Manipulation of others for own desires
  o Use of unsuccessful social interaction behaviors

• **Insomnia** as evidenced by:
  o Difficulty falling asleep
  o Sleeping only short periods

(NANDA-I, 2012)
NURSING OUTCOME CRITERIA

During an acute mania phase, the nursing outcomes will be focused on safety. The patient will:

- Remain free of physical injury
- Remain well-hydrated
- Exhibit no harm to self or others
- No longer have signs of physical agitation
- Provide for own hygiene needs
- Eat a well-balanced diet with snacks to prevent weight loss and maintain nutritional status
- Verbalize an accurate interpretation of the environment
- Verbalize and demonstrate an absence of delusions and hallucinations
- Obtain a balanced sleep and rest pattern with activity
- Demonstrate an absence of destructive behaviors, including sexual activity
- Accept responsibility for own behaviors
- Not manipulate others for self-gratification
- Interact appropriately with others

INTERVENTIONS

During the acute phase of the illness, the most important responsibilities of caregivers are to provide a safe environment and to guide patients toward socially appropriate behavior and increased self-esteem.

Safety

An ever-present concern for bipolar patients is suicide. Although individuals in the manic phase are temporarily energized and elated, their underlying depression makes them vulnerable for self-injury. For this reason, caregivers take suicide precautions according to the facility’s policies and procedures, which should include:

- Observing patients frequently throughout the day and night
- Removing all injury-producing sharps, drugs, or ropes and cords
- Making sure patients take medications and do not hoard them
- Discussing suicide ideation with patients openly and regularly

It is also the healthcare professional’s responsibility to provide a safe environment for other patients on the inpatient unit. Patients in the manic phase have little understanding of how their agitation and anger affect others. They must be monitored continuously and be informed that staff members will help them control their behavior. Such external controls reassure patients that even though they may be angry and feel like harming
others, staff members will help them respect others by identifying unacceptable behavior and clearly stating appropriate behavior. For example:

“THEO, YOU’re standing too close to my face. Please stand back two feet.”
“Howard, it is not okay to hug other patients. You may talk to them, but you may **not** touch them.”

If a patient is unable to be calmed by “talking down” or by medication, it may be necessary to utilize seclusion and/or **mechanical restraints**. When mechanical restraints are used, it is important that adequate staff is available to assist and that staff comply with the protocol established by the institution following the Joint Commission’s standards and requirements (Townsend, 2015) *(see “Resources” at the end of this course).*

**Physiologic Needs**

Even though they are on the brink of exhaustion, patients in the manic phase of bipolar disorder may get little rest and sleep. Sedatives may be prescribed; however, other measures can provide a sense of peace and control. These include:

- Reducing stimuli (e.g., by providing a calming environment or assigning a private room)
- Including relaxing measures to the bedtime routine such as a nonstimulating beverage, warm bath, or soothing massage
- Scheduling “quiet times” with soft, gentle music or just silence

Adequate hydration and nutrition are essential. Manic patients may be too agitated to sit down and eat. Depressed individuals may be too despondent. One option for hyperactive patients is to provide food that can be eaten while moving around, such as snack foods, sandwiches, and beverages they can hold in their hands. These foods should be high in protein and calories and available throughout the day, not just at mealtimes.

Personal hygiene affects the physical and mental health of both depressed and manic patients. For this reason, patients may need assistance to do the things that promote health and provide physical comfort, such as brushing teeth, combing hair, washing hands, bathing, and keeping track of elimination.

**Behavior Modification**

Patients are hospitalized for their protection and care. Such care involves treating them with dignity and respect, even as their inappropriate behaviors are addressed. Behavior modification uses positive feedback to reward, encourage, and leave unchanged certain behaviors. It uses negative feedback to discourage and change inappropriate behaviors. Thus, negative feedback makes for change.
A common inappropriate behavior in manic patients is violation of the personal space of others. For example, if a caregiver sees a patient named Sheree invading the personal space of a nursing assistant named Brad, the caregiver may say:

“Sheree, Brad needs to focus on doing his work now. Let’s leave him alone and go to another room for a while to review your treatment goals.”

Such a suggestion may not only stop inappropriate behavior but may also reward Sheree by giving her encouragement for her successful treatment.

Patients experiencing acute mania often display inappropriate sexual behavior, exposing themselves, talking graphically about sex acts, and even asking for sex from staff members and other patients. Caregivers need to handle such behavior in a nonjudgmental and matter-of-fact way. They clearly state which specific behaviors are unacceptable and which are acceptable. For example, the caregiver may say:

“Chandra, it is not okay to unbutton your shirt and show your breasts. Everyone here respects the privacy of everyone else. We keep our bodies covered, our shirts buttoned, and our zippers zipped.”

Patients with pressured speech may just keep talking, ignoring nonverbal and verbal signals that others want to speak. To overcome this problem, caregivers may introduce rules, whereby people take turns speaking and listening. By so doing caregivers create an environment of order, support the concept of delayed gratification, and modify patient behavior.

**CHALLENGES TO STAFF CONTROL**

Manic patients can be challenging to work with and can elicit numerous intense emotions in a caregiver. A manic patient is out of control and strongly resists being controlled. The behavior of the manic patient is often meant to decrease the effectiveness of staff control. “Power plays” may occur, such as pointing out to staff their faults or oversights, drawing negative attention to one or more staff.

This behavior is usually done in a loud and disruptive manner that causes staff to become defensive. Because the patient can become aggressively demanding, this can also trigger frustration and exasperation in caregivers. The person with mania is effective in distracting staff and setting up an environment that allows the mania to go unchecked.

When staff members start to feel confused and angry with each other, it is often an indication that a patient is successfully splitting the staff. Frequent staff meetings to discuss how to respond to these behaviors are necessary.

Setting limits is an important skill for staff to develop, and because the main theme for a
CASE (continued)

Gerardo has worked as a nurse on the psychiatric unit for three years now and has learned how to deal with behaviors displayed by patients experiencing a manic episode. Although verbal insults may hit very close to home, he no longer takes them personally. He has also learned to recognize and set limits on behaviors that attempt to split staff. Likewise, communication is good among the unit’s staff, resulting in consistency in nursing care and maximizing external controls.

Gerardo, however, thought he might have some difficulty dealing with Delphine’s sexual comments and behavior toward him, as it made him feel anxious and uncomfortable. He did not want Delphine to pick up on this anxiety.

This was discussed with the staff, and it was decided that two nurses would provide Delphine’s care. A female nurse would work with her in her room, and Gerardo would work with her on the unit. Also, it was decided that no male staff member would be alone with Delphine in her room at any time.

EFFECTIVE COMMUNICATION WITH PATIENTS

Caring for patients with bipolar disorder requires the same techniques for effective communication that are used with all patients. However, patients with mania have short attention spans and may not be able to comprehend complex questions or instructions. For this reason, caregivers communicate in clear, concise, and simple language and to ask patients to repeat important messages back to them.

Ideas and thoughts may be flooding the minds of patients, and their speech may be pressured, circumstantial, and confusing. To keep the channels of communication open and overcome such speech patterns, caregivers use an assertive communication triad in which the caregiver:

1. Describes what is seen or **heard**.
2. States what is **felt**.
3. Affirms what is **wanted**.

For example, the caregiver may say:

1. “I hear you are speaking, but the words are mumbled and spoken too fast for me to understand.”
2. “This makes me feel puzzled and confused.”
3. “Please repeat what you just said, but speak slowly and distinctly.”

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Such statements put responsibility for communication on the caregiver, avoid blame, and give specific instructions to the patient. Caregivers may need to repeat such statements many times.

Patients may use pronouns to refer to others, making it difficult to understand who is being discussed and when the conversation has moved to a new topic. To overcome this problem, caregivers ask patients to identify each person, place, or thing being discussed. For example, the caregiver may say:

“When you say, ‘She came into my room,’ I am not sure whom you mean. Please tell me the name of the person who came into your room.”

When speech includes flight of ideas, caregivers ask patients to explain the relationship between topics. For example, the caregiver may say:

“What happened then?” or “Was that before or after Nalgis came into your room?”

**PRINCIPLES OF SUPPORTIVE CARE**

In order to give supportive care to individuals in a manic phase, caregivers:

- **Establish a connection.** No matter how distracted patients may be, they will know someone is there, that there is order and stability, and that they can trust someone.

- **Demonstrate sincere concern.** The caregiver may not be able to “do anything” and may feel quite useless or even frustrated. Yet, by simply “being there,” a message of genuine interest and concern is conveyed, giving manic patients the recognition they crave and depressed individuals the nurturance they need.

- **Affirm there is hope.** Caregiver behavior can assure individuals in a manic or depressive episode that they are valuable—the very opposite of the confusion, worthlessness, helplessness, and hopelessness they may feel. These messages can be offered in simple ways, such as giving patients choices, affirming their value, and mentioning future events. If patients begin to communicate, allow them to lead the conversation.

- **Set reasonable limits** for patients in a manic episode and clearly define expectations for severely depressed individuals while at the same time conveying respect.

- **Demonstrate genuineness,** empathy, unconditional positive regard, and nonpossessive warmth. These attributes are the very essence of therapeutic communications.

Continuation Phase

The continuation phase, also known as the “early stable phase,” begins once the patient’s mood is euthymic and symptoms have abated. This phase can last from four to nine months, and management involves taking measures to help maintain medication compliance and prevent relapse.

During this phase there should be a comprehensive approach to treatment that includes the patient, family, and support team, which may consist of:

- Psychologist
- Social worker
- Psychiatric nurse
- Physician
- Occupational therapist
- Other community resources

All patients in this phase of the illness require medication monitoring as well as psychotherapy (see “Psychotherapy” earlier in this course). Their monitoring schedule should be regular, and they should be given extra therapy sessions as needed.

ROUTINE MONITORING

Patients should be evaluated routinely for their response to medication and be offered support to assist with medication compliance. It is very important for the outpatient professionals to develop a therapeutic alliance, which can help minimize symptoms and avoid hospitalization.

Medical follow-up should be done to deal with the ever-present somatic health problems that patients with bipolar disorder have and which are often not recognized or are undertreated. This is due in part to the difficulty these patients have obtaining primary physician care.

When following an outpatient with bipolar disorder, the need for hospitalization should be assessed at each visit. It is good practice to discuss with the patient and family beforehand what level of symptoms or behavior would result in the patient agreeing to a voluntary hospitalization.

Evaluation for referrals is ongoing to assess the need for support regarding co-occurring disorders (e.g., substance abuse or problems with work, family, and social life). More specific psychotherapy and support may be required to address the residual problems caused by behaviors that occurred during the acute manic phase (Soreff, 2015; Rakofsky & Dunlop, 2014).

OUTCOME CRITERIA

Outcome criteria for the continuation phase focus on the goal of preventing a relapse. The patient will:
• Recognize stressors and learn new ways for dealing with them
• Participate in education along with family to learn about:
  o The nature of the illness
  o Medications prescribed and their benefits and possible side effects
  o The dangers of substance abuse on precipitating future manic episodes
• Verbalize a clear understanding of the early signs and symptoms of relapse
• Attend a support group or individual therapy
  (Townsend, 2015)

Maintenance Phase

This phase begins at about six to nine months after a manic episode, and the most important long-term treatment goals for this phase are:

• Remission and return to full function
• Reduction of subthreshold symptoms
• Reduction of suicide risk
• Prevention of recurrence

Maintenance treatment of bipolar disorder is very important, since approximately 90% or more of patients who have experienced a manic episode will have a recurrence (Leelahanaj et al., 2013).

During the maintenance phase, medications may be tapered or discontinued and new medications may be added. Psychosocial interventions play an important role during this phase and are known to decrease the onset of new episodes, decrease hospitalization, and improve the management of the disease. For those whose acute manic episode responded to ECT, maintenance ECT may also be considered (Goldberg, 2014b).

TREATMENT COMPLIANCE

The major cause of recurrence during the maintenance phase is noncompliance with medication and other treatments. Many patients are ambivalent about taking medications and often deny they have a serious illness. A very significant factor involved in noncompliance is the reluctance to relinquish the enjoyable effects of hypomania or mania. The increased energy, sense of euphoria, heightened self-esteem, and ability to focus are viewed as desirable.

Patients often may minimize or deny completely the distressing results of a full-blown manic episode or the long-term demoralization of a depressive episode and may fail to keep follow-up appointments for medication monitoring and psychotherapy.
During the maintenance phase, other issues that may need to be addressed that can affect compliance are medication side effects, cost, and other demands of long-term treatment. These may be viewed as burdensome and should be realistically addressed with both patient and family.

**OUTCOME CRITERIA**

Once stabilized, outcome criteria for the maintenance phase indicate the patient will:

- Along with family/friends, be able to recognize prodromal signs of escalating mood or depression
- Adhere to follow-up appointments
- Participate in learning interpersonal strategies dealing with work, school, family, and friends
- Be medication compliant
- Participate in psychotherapy, group, or other ongoing supportive therapy modality (Townsend, 2015)

**CONCLUSION**

Bipolar disorder is a brain disorder that causes unusual shifts in mood, energy, and activity levels. It can affect one’s ability to function at work, school, and in relationships. Often the condition develops in the late teens and continues for a lifetime.

The great variation of symptoms as well as self-medication with substances of abuse often obscures the diagnosis, and it may take many years before an accurate diagnosis is made. The same substance abuse often complicates its treatment.

Care of bipolar individuals includes providing a safe environment, meeting physical and emotional needs, communicating effectively, administering medications and treatments, providing psychotherapy, and educating clients and their families.

Bipolar disorder’s effects can be far-reaching, causing negative consequences in the lives of patients and those around them, the most severe being suicide. Although many persons with bipolar disorder can return to a normal life once they have obtained medical care, others have such extreme episodes of mania and depression that they are unable to function even though they receive ongoing treatment.
RESOURCES

Bipolar Disorder (Mayo Clinic)
http://www.mayoclinic.com/health/bipolar-disorder/DS00356/

Bipolar Disorder (U.S. National Library of Medicine)

Bipolar Disorder in Adults (National Institute of Mental Health)

Bipolar Disorder Health Center (WebMD)
http://www.webmd.com/bipolar-disorder/

Joint Commission Standards on Restraint and Seclusion (PDF)

REFERENCES


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TEST

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1. Which is a true statement about bipolar disorder?
   a. The disorder cannot be successfully treated in the majority of persons.
   b. There is a strong correlation between bipolar disorder and creativity.
   c. It was not identified as a mental disorder until the twentieth century.
   d. The first recorded treatment for bipolar disorder is from the nineteenth century.

2. The onset of bipolar disorder in most patients occurs in:
   a. Childhood.
   b. Adolescence.
   c. Early adulthood.
   d. Middle adulthood.

3. The current theory for the etiology of bipolar disorder is that it is primarily a:
   a. Genetic disorder.
   b. Physiologic disorder.
   c. Neurotransmitter disorder.
   d. Biologic disorder.

4. An especially common psychotic symptom exhibited in patients with bipolar disorder is:
   b. Delusions of grandeur.
   c. Auditory hallucinations.
   d. Sensory hallucinations.

5. A patient who talks endlessly, jumping from one idea to another with little or no relationship between the topics, is exhibiting:
   a. Loose association.
   b. Thought insertion.
   c. Thought withdrawal.
   d. Circumstantial thinking.
6. During a hypomanic episode, the patient experiences:
   a. Marked impairment in work and social functioning.
   b. Delusions and hallucinations.
   c. Increased activity and energy lasting at least four consecutive days.
   d. Impairment dysfunction requiring hospital admission.

7. According to the DSM-5, the person who is experiencing a manic episode or has a history of one or more manic episodes is given a diagnosis of:
   a. Bipolar I Disorder.
   b. Bipolar II Disorder.
   c. Cyclothymic Disorder.
   d. Hypomanic Episode.

8. The mechanism of action for all medications used to treat bipolar disorders is:
   a. Inhibition of enzyme activity.
   b. Unclear.
   c. The placebo effect.
   d. Cytotoxicity.

9. Patients taking lithium must have periodic serum levels drawn because:
   a. They commonly do not take their medication as ordered.
   b. The toxic effects of lithium are not easily observed.
   c. There is a gradual development of tolerance with this drug.
   d. There is a narrow range between toxic and therapeutic doses of lithium.

10. Which statement is correct regarding electroconvulsive therapy (ECT) treatment?
    a. ECT sends brief magnetic pulses to stimulate brain cells.
    b. There are no negative side effects with ECT.
    c. The mechanism of action of ECT is not understood.
    d. Unilateral ECT results in more memory problems for the patient.

11. A psychotherapeutic approach that has shown to be of benefit for bipolar disorder patients is:
    a. Interpersonal therapy with social rhythm therapy.
    b. Interpersonal therapy with group therapy.
    c. Group psychotherapy.
    d. Individual psychotherapy.
12. Occupational therapy treatment for patients with bipolar disorders most likely will include:
   a. Equipment prescription.
   b. Maximizing mobility and comfort.
   c. Strength and endurance training.
   d. Social and interpersonal skills training.

13. Behavior modification is a treatment modality in which negative feedback:
   a. Discourages an appropriate behavior.
   b. Supports an unwanted behavior.
   c. Changes inappropriate behavior.
   d. Results in unexpected behavioral change.

14. According to the assertive communication triad, the purpose of the caregiver affirming what
    he or she wants the patient to do is to:
    a. Provide a general overview of good communication technique.
    b. Place responsibility for communication on the caregiver.
    c. Describe how the patient’s speech is unintelligible.
    d. Use repetition for reinforcement of desired behavior.

15. The continuation phase of bipolar management involves:
    a. Reducing stimuli and setting limits.
    b. Mechanical restraint or seclusion use when necessary.
    c. Developing a therapeutic alliance to reduce hospitalization.
    d. Tapering off of medications.

16. Patient-centered outcome criteria for the maintenance phase of bipolar treatment include:
    a. Demonstrating an absence of destructive behaviors.
    b. Adhering to follow-up appointments.
    c. Verbalizing a clear understanding of the early signs and symptoms of relapse.
    d. Accepting responsibility for one’s own behavior.