Bipolar Disorder

Assessment/Diagnosis of Bipolar Disorder

Complicated; mimicking other disorders and has comorbidity (presents with other disorders)

Half of bipolar children have relatives with bipolar disorder

Other Organic Diagnoses

It is important to first rule out the possibility of any other organic diagnosis:

- Thyroid disorder
- Seizure disorder
- Multiple sclerosis
- Infectious, toxic, and drug-induced disorders

Genetics

30-70%	Identical twins
75%	Both parents bipolar

Mood history

Mania

- Giddy, goofy, laughing fits, class clown
- Explosive (how often, how long, how destructive and aggressive)
- Irritable, cranky, angry, disrespectful, threatening
- Grandiosity may present as EXTREME defiance and oppositionality

Depression

- Low frustration tolerance, self-destructive, no pleasure, lower level of irritability

Preview of Coming Attractions:
Bipolar Disorder

Who – Prevalence
What – Symptoms & types
Where – Brain & Body
When – Onset & life course trajectory
Why – Assessment & causes

TREATMENT

HealthyPlace.com – Bipolar Disorder Center Videos

Which is *not* a distinguishing factor between bipolar & unipolar depression?

a) Bipolar depressive episodes typically last for a shorter duration than unipolar depressive episodes
b) Individuals with unipolar depression will not experience a manic mood state.
c) Unipolar depression is more severe than bipolar depression.
d) Bipolar depressive episodes episodes develop more gradually than unipolar depressive episodes

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✔ c) Unipolar depression is more severe than bipolar depression.
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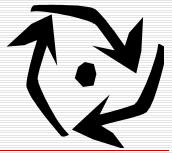
Bipolar disorder always follows the same, predictable pattern/cycle of symptoms.

True
False



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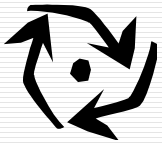

Characteristic is associated with early-onset Bipolar disorder?

a. Gender
b. Family history
c. Coexisting conditions
d. Frequent cycles of symptoms
e. All of the above

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Manic episodes are less severe than depressive episodes.

True
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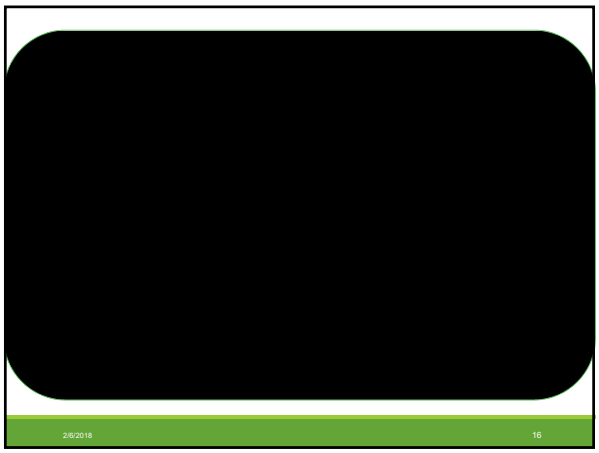


DSM Criteria

A distinct period of abnormally and persistently elevated, expansive, or irritable mood

DIGFAST acronym (at least 3 of 7 symptoms)

DIGFAST – Mental Status Exam

Distractible

Increased activity/psychomotor agitation

Grandiosity/Super-hero mentality

Flight of ideas or racing thoughts

Activities that are dangerous or hypersexual

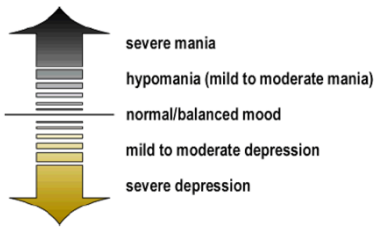
Sleep decreased

Talkative or pressured speech

Prevalence

- 5.7 million American adults
- 2.6% of the U.S. age 18+ in a given year
- Typically develops in late adolescence or early adulthood
- Some have 1st symptoms in childhood

Bipolar Disorder: Continuous Range



DSM-5 Bipolar I Disorder

- One or more Manic Episode or Mixed Manic Episode
- Minor or Major Depressive Episodes often present
- May have psychotic symptoms
- Specifiers: anxious distress, mixed features, rapid cycling, melancholic features, atypical features, mood-congruent psychotic features, mood incongruent psychotic features, catatonia, seasonal pattern
- Severity Ratings: Mild, Moderate, Severe (DSM-5, p. 154)

DSM-5 Bipolar II Disorder

- One or more Major Depressive Episode
- One or more Hypomanic Episode
- No full Manic or Mixed Manic Episodes
- Specifiers: anxious distress, mixed features, rapid cycling, melancholic features, atypical features, mood-congruent psychotic features, mood incongruent psychotic features, catatonia, seasonal patter
- Severity Ratings: Mild, Moderate, Severe (DSM-5, p. 154)

DSM-5 Cyclothymia

For at least 2 years (1 in children and adolescents), numerous periods with hypomanic *symptoms* that do not meet the criteria for hypomanic

- Present at least ½ the time and not without for longer than 2 months

Criteria for major depressive, manic, or hypomanic episode have never been met

DSM-5 Unspecified Bipolar

- Bipolar features that do not meet criteria for any specific bipolar disorder.

DSM-5 Manic Episode Criteria

- A distinct period of abnormally and persistently elevated, expansive, or irritable mood.
- Lasting at least 1 week.
- Three or more (four if the mood is only irritable):
  1. Inflated self-esteem or grandiosity
  2. Decreased need for sleep
  3. Pressured speech or more talkative than usual
  4. Flight of ideas or racing thoughts
  5. Distractibility
  6. Psychomotor agitation or increase in goal-directed activity
  7. Hedonistic interests

 APA (2013

DSM-5 Manic Episode (cont.)

- Causes marked impairment in occupational functioning in usual social activities or relationships, **or**
- Necessitates hospitalization to prevent harm to self or others, **or**
- Has psychotic features
- Not due to substance use or abuse (e.g., drug abuse, medication, other treatment), or a general medial condition (e.g., hyperthyroidism).
- A full manic episode emerging during antidepressant treatment

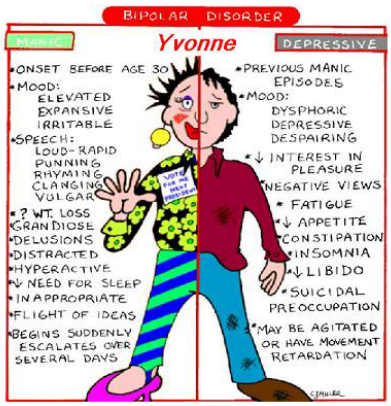
 APA (2013)

Bipolar: Across the Life Span

Bipolar I disorder – Classic form; recurrent episodes of mania & depression

Bipolar II disorder – Milder episodes of hypomania that alternate with depression

Rapid-cycling bipolar disorder – 4+ episodes occur within a 12-month period



Juvenile Bipolar Disorder

Adults

- Discrete episodes of mania or depression lasting to 2 to 9 months
- Clear onset and offset
- Significant departures from baseline functioning

Juveniles

- Longer duration of episodes
- Higher rates or rapid cycling
- Lower rates of inter-episode recovery
- Chronic and continuous.

AACAP (2007); NIMH (2001)

Adults, Adolescents, Children Mania Exposed

Adults

- Mania includes marked euphoria, grandiosity, and irritability
- Racing thoughts, increased psychomotor activity, and mood lability

Adolescents

- Mania is associated with psychosis, mood lability, and depression
  - More chronic and difficult to treat than adult BPD
  - Prognosis similar or worse than adult BPD

Prepubertal Children

- Mania involves markedly labile/erratic mood, energy levels, and behavior.
  - VERY severe irritability (associated with violence) rather than euphoria
  - Irritability, anger, belligerence, depression, and mixed features are more common
- Mania is commonly mixed with depression

AACAP (2007); NIMH (2001); Wozniak et al. (1995)

Unique Features of Pediatric Bipolar Disorder

- Chronic with long episodes
- Predominantly mixed episodes (20% to 84%) and/or rapid cycling (46% to 87%)
- Prominent irritability (77% to 98%)
- High rate of comorbid ADHD (75% to 98%) and anxiety disorders (5% to 50%)

Pavuluri et al. (2005)

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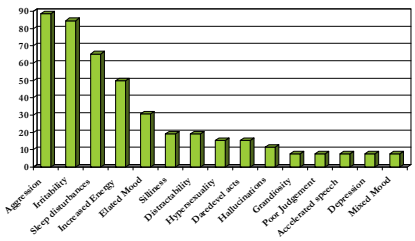
Diagnosis: Juvenile Bipolar Disorder

Frequent presenting symptoms among outpatient clinic referred 3 to 7 year olds with mood and behavioral symptoms



Danielyan et al. (2007)

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ADHD Criteria Comparison

Bipolar Disorder (mania)		AD/HD
1. More talkative than usual, or pressure to keep talking	→	1. Often talks excessively
2. Distractibility	→	2. Is often easily distracted by extraneous stimuli
3. Increase in goal directed activity or *psychomotor agitation*	→	3. Is often "on the go" or often acts as if "driven by a motor"

Differentiation = irritable and/or elated mood, grandiosity, decreased need for sleep, hypersexuality, and age of symptom onset (Geller et al., 1998).

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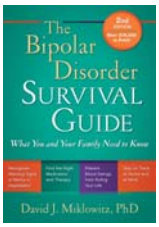
Randomized Control Trials

Combination of Pharmacotherapy and Family-Focused Therapy

- Two year follow-up
  - Delays relapse
  - Reduces symptoms



Context of Family-Focused Treatment (FFT)

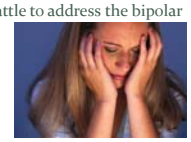
1. Integrating the experiences
2. Accepting vulnerability to future episodes
3. Accepting a dependency on medication
4. Distinguishing personality & the disorder
5. Recognizing/learning to cope with triggers
6. Reestablishing functional relationships

Treatment: Begins with Mourning

Anticipatory grief - Anticipation of what the news may be about the illness.

Acute grief - When the patient experiences a clear onset of the disorder.

Chronic grief - Reflected in the never-ending battle to address the bipolar illness.



Bipolar Illness and the Family Journal,
Psychiatric Quarterly, Volume 72, Number 2 / June, 2001

Adjusting to Bipolar Disorder

- Time, energy and patience unbranching old behaviors
  - New and different coping skills
  - Family efforts is flexible and adjusting
  - Educated about the course of the illness
  - Learning treatment protocols and adaptations
    - Hospitalization
    - Reentry into the family and community systems
- Emotionally, mentally and physically exhausted
  - Loss of one's identity and roles
  - Medication side effects impacts one's body

Grief Work in families

- Addressing grief and multiple losses
- Complicated mourning becomes "chronic sorrow"
- Terror to the process that can dominate and overwhelm
- Families redefine themselves as different from "normal" families or "different."
  - These redefinitions lead to isolation and fear of rejection.

Healthy Family Functioning

- Characteristics of Mutual affection and trust in one another and the community
- Respect for differences in perception/feelings
- The ability to communicate
- The ability to accept loss
- Clear-cut boundaries between parents/children
- *Empathy*

Expressed Emotion

Developmental Psychopathology Approach to Expressed Emotion

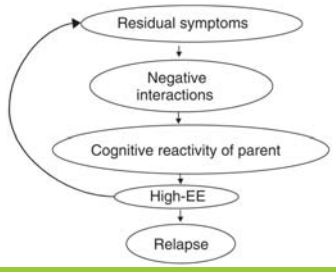
- Connection between EE and relapse

Question

- How do caregiving relatives become high-EE?
- What variables mediate EE and patient relapses?
- Dealing with children who have irritability, low frustration tolerance, mood instability, high anxiety

Expressed Emotion

Child behaviors fuel High-EE in parents and siblings



High-EE Parents

- Not just yelling, cursing, screaming, and name calling
- Soft spoken parents can be High-EE
  - Responding with Criticism
  - Rejection and silent treatment
- Criticism and rejection impact
  - Higher depression and fewer well days
  - Mood dysregulation
- Parental Denial or Ignorance
  - Related to higher-EE
  - Related to lower medication compliance
  - Lowered with psychoeducation, communication, and problem solving

Stabilization Phase Psychoeducation	**Communication enhancement training** Resolve family conflict
Problem-solving skills training Conflict related to illness Drug Maintenance	**Final stage** Intermittent

Stabilization Phase

- About seven sessions are devoted to psychoeducation
  - Patients and their relatives become acquainted with the nature, course, and treatment of bipolar disorder
- The psychoeducation attempts to hasten clinical stabilization
  - Reducing the family tensions that often accompany the stabilization phase

Stabilization Phase

- Teaching the patient and the family members about the origin, nature and course of bipolar illness
  - The treatment plan is described and a rationale for the different modules is taught
  - A highly directive style of leadership and requires initiative on the part of the family therapist to train the participants
  - Acquisition of information about bipolar and understanding of that information is a central goal of this module.
- Support, encouragement and hope

Knew Something Wrong

"I started using drugs and alcohol as a teenager in an attempt to somehow "fix" what was wrong with me. Although I didn't understand it, I knew that I had mental problems."

https://www.healthyplace.com/bipolar-disorder/

Medication Adherence

- 39% were not concerned with medication
  - Hope for decrease in symptoms (23%)
  - Hope for stabilization of mood (23%)
  - Becoming normal (20%)
  - Desire to be "cured" (20%)
- No difference in 1st or 2nd generation anti-psychotics
- Healthy Alliance with Client/Family/Physician
- Family involvement (80% adherence)

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4932152/

Non Adherence

- 50% of prescribed long-term medication are not finished
  - 42% medication adherence rate
    - Adverse effects of medication
    - Family support and therapy alliance
    - Impaired memory or attention
    - Health service system
    - Financial costs

Prioritizing Target Symptoms

1. Treat mania and/or psychosis
2. Treat depression
3. Anxiety and ADHD

Medications

Improvement is seen when mood stabilizers are used

Lithium (38%)

Divalproex Sodium (Depakote) (53%)

Carbamezapine (38%)

Kowatch et al (*JAACAP* 2000)

Fear Factors

- Afro-American & Hispanic more missed days
  - Controlling for income and education
    - Fear of becoming addicted
    - Medication feels bad
    - Use and abuse of cannabis and alcohol
- Education impacts medication compliance
  - Cognitive impairment
- Fear of Weight gain
  - More than excessive sedation and tremors

Communication Enhancement Training

- The CET module, is to fully stabilized from the acute episode
  - he/she may still have residual mood symptoms
- Family focuses on tolerating exercises oriented toward resolving family conflict
- Marital/family treatment vs. Comparison
  - Better drug adherence
  - Better global functioning scores over 11 months of treatment

Communication Enhancement Training

- Stress affects the communication patterns in families.
  - Assess the level of stress and its effect on the communication between the family and patient
  - Establishing and reestablishing effective patterns of communication is the central task
  - Therapist creates a safe context to empower the family to have effective communication.

Problem-Solving Skills Training

- Mood episode is largely remitted and the patient has moved into the maintenance phase of drug treatment
  - Patient and family are motivated to identify specific family problems related to the illness.
  - T*he problem solving phase*, focuses on a conflict resolution process
  - Intervention techniques for solutions to conflict
  - Understanding the nature and course of the illness
    - Important to the success of this model

Identify Impasses and Conflict Sources

- Identifying and confronting resistance to accepting the illness and medical intervention
- Family is taught to prepare for recurrence
  - Intervention strategies delay, minimize and/or prevent the recurrence
- Learning to understand the illness and patterns
  - Functional communication patterns
  - Empowered to maintain a healthy balance and safe context for the patient

Final Stage

- The last few sessions of FFT are held monthly
  - Consolidate gains during 9-month treatment

Special Education & Programming Issues

Developing an IEP

- Student strengths?
- Student challenges?
- Needs for successful completion of the day?
  - Typical
  - Worst Case Scenario
- Accommodations/Considerations
- Is student's behavior impeding his/her education?
  - Behavior Support Plan (BSP) needed?

School-Based Interventions

Possible elements of a counseling program

- Education
- Coping skills
- Social skills
- Suicidal ideation/behaviors
- Substance use

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School-Based Interventions

Specific Recommendations

1. Build, maintain, and educate the school-based team.
2. Prioritize IEP goals
3. Provide a predictable, positive, and flexible classroom environment
4. Be aware of and manage medication side effects.
5. Develop social skills
6. Be prepared for episodes of intense emotion
7. Consider alternatives to regular classroom

Lofthouse & Fristad (2006, pp. 220-221)

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