

## Bipolar Disorder Clinical Guidelines

Developed in collaboration with the mental health centers associated with NBHP and FBHP

DSM-IV-TR Diagnostic Code: 296.0x; 296.40; 296.4x; 296.6x; 296.5x; 296.7; 296.89; 301.13; 296.80

### Diagnostic considerations:

1. **Review diagnostic criteria** in DSM as bipolar disorder can be expressed in a variety of ways, and cycle in different manners, rates and frequencies (rapid, seasonal, etc.). Determine bipolar type: bipolar I, bipolar II, cyclothymic disorder, and other additional features or specifiers to facilitate understanding of presentation and course of treatment.
2. **Differential diagnoses** include schizoaffective disorder and other psychotic disorders, ADHD (see ADHD vs Bipolar disorder differential diagnosis addendum), substance-induced mood disorder, and mood disorder/personality change due to a general medical condition.
3. **For children and adolescents**, although core symptoms are the same their expression may be developmentally influenced, e.g. during manic episodes, children and adolescents are more likely to be irritable rather than elated, with destructive outbursts, antisocial behavior, and/or substance use and depressive periods may include somatic complaints, decreased school performance, social isolation, poor communication and extreme sensitivity to rejection or failure. Often behavior problems precede manic episodes and rapid cycling and mixed episodes are more common. Over-diagnosis, in youth must be guarded against; ensure DSM criteria (including careful evaluation of exclusionary criteria) have been met.
4. **Substance abuse/dependence** should be evaluated as a possible primary or secondary diagnosis with this disorder. At a minimum substance use/dependence should be evaluated every 6-months.
5. **Complete assessment using a variety of sources**, including brief checklists, such as the Mood Disorder Questionnaire. Obtain a history of symptoms from objective informants, as many persons with bipolar disorder may deny or not recognize their symptoms. Family and teacher informants are particularly important in assessing children and adolescents. Assess family history of bipolar disorder, as well as other psychotic or mood disorders.
6. **Review medical history and current health status.** Medical conditions that may cause mood lability and/or behavioral disinhibition and dyscontrol include endocrinologic disorders, hypothyroidism, hypoglycemia, seizure disorders, structural brain disorders, e.g. neoplasm, stroke, infectious brain disorders, toxic/metabolic disorders, and traumatic brain injuries. Urinary tract infections and electrolyte imbalances may also manifest as psychosis. Consider referral to PCP to rule out these medical conditions, particularly with late onset of symptoms. Individuals with bipolar disorder have an increased risk and may be in treatment for chronic and severe medical conditions, e.g. heart disease, and diabetes.
7. **Response to medication** should not be used as a diagnostic tool. A positive response to medication is not confirmation of the diagnosis, as similar medications are used to treat non-specific target symptoms such as over-activity, impulsivity, aggression, and lability. Pharmacological treatments for depression can sometimes precipitate a manic episode.
8. **Late life onset**, after age 40, of manic episodes is inconsistent with the natural history of bipolar illness. The average onset for both men and women is around 20 years of age. Consider alternate etiologies for symptoms beginning after the age of 40, e.g. substance use, medication side-effects or medical condition.

## Treatment Guidelines:

1. **Psychoeducation**, for clients and families, is key to improved recovery from acute episodes, relapse prevention and maintenance, including information about bipolar disorder and its treatment, skills for coping with psychosocial stressors, how to engage in treatment, and monitor occurrence and severity of symptoms. Identify, with the client, past effective strategies and support continued use of these methods. Help educate about the importance of consistent medication use. (See practical strategies addendum)
2. **Integration of multiple treatment approaches** is most effective in promoting long term recovery: medication management, psychotherapy, psychosocial approaches, psychoeducation, case management, and peer services. If substance abuse is present, consider referral for co-occurring treatment. Recovery is positively correlated with family support and attitude, employment, social activity and social skills training. For depression, promote simple social activities, e.g. going for a walk, making eye contact or saying hello to others.
3. **Medication is one of the treatment foundations.** The treatment team should have regular contact to discuss medication effectiveness, monitor side effects, improve medication adherence, and provide psychoeducation. A focus on client's attitudes and behaviors related to medications is more effective in treatment adherence than psychoeducation alone. Medications often require ongoing monitoring, such as blood tests, as side effects and complications can be serious, in terms of short term toxicity, and long term medical conditions. Note that going on and off medications can reduce efficacy (See attached medication algorithms).
4. **Evidence-based therapeutic approaches**, including psycho-educational, cognitive behavior therapy, interpersonal and social rhythm therapy, are recommended in combination with pharmacologic treatment and family involvement, especially with youth. See resources for clinicians for more specific therapeutic interventions.
5. **Attend to the client's physical health** by coordinating with the primary care physician (PCP) to identify medical risk factors and coordinate efforts to reduce those risks including regular medical check-ups. Be knowledgeable about medication side effects and lifestyle risk factors, such as smoking, substance abuse/dependence, physical activity level and nutrition, as these can negatively impact health status, complicate treatment, and decrease medication effectiveness. Set health goals with the client around managing or improving these lifestyle factors.
6. **Regularly assess** suicidal ideation, manic symptoms, especially high-risk behaviors, depression, hopelessness, presence of command hallucinations, and substance use. Suicide attempts are more likely to occur during a depressive or mixed state.
7. **Plan ahead.** Work with the client to develop an individualized relapse prevention plan, identifying unique warning signs and what to do when they arise and a crisis plan to assist in dealing with signs of suicide and provide guidance in seeking help immediately. Encourage clients to share these plans with support systems.
8. **Consistency of routine and structure in daily activities**, including regular sleep-wake cycles, meal times, physical activity, and emotional stimulation are important for recovery. Disruption in these social rhythms, with disrupted sleep-wake cycles may trigger manic episodes and other relapse symptoms.

\*Adapted from American Psychiatric Association (2002). Practice Guidelines for the Treatment of Patients with Bipolar Disorder (Second Edition). Washington D.C.: Author

## Resources for Clinicians

### Psychoeducational manuals for bipolar disorder

- Bauer, M. & McBride, L. (1996). *Structured Group Psychotherapy for Bipolar Disorder: The Life Goals Program*. New York: Springer.
- Colm, F., Vieta, E. & Scott, J. (2006). *Psychoeducation Manual for Bipolar Disorder*. Cambridge: Cambridge University Press.

### Cognitive behavior therapy manuals for bipolar disorder

- Lam, D., Hayward, P., Bright, J. & Jones, S. (1999). *Cognitive Therapy for Bipolar Disorder*. Chichester: John Wiley.
- Newman, C., Leahy, R., Beck, A., Reilly-Harrington, N. & Gyulai, L. (2002). *Bipolar Disorder: A Cognitive Therapy Approach*. Washington, DC: American Psychological Association.
- Otto, M., Reilly-Harrington, N., Kogan, J., et al. (1999). *Cognitive Behaviour Therapy for Bipolar Disorder: Treatment Manual*. Boston: Massachusetts General Hospital.
- Ramirez Basco, M. & Rush, A. (2007). *Cognitive Behavioural Therapy for Bipolar Disorder* (Second Edition). New York: Guilford Press.

### Interpersonal therapy manual for bipolar disorder

- Frank, E. (2005). *Treating Bipolar Disorder: A Clinician's Guide to Interpersonal and Social Rhythm Therapy*. New York: Guilford Press.

### Family therapy manual for bipolar disorder

- Miklowitz, D. J. & Goldstein, M. (2008). *Bipolar Disorder: A Family-Focused Treatment Approach* (2<sup>nd</sup> edition). New York: Guilford Press.

### Memoirs

- Jamison, K.R. (1995). *An unquiet mind: A memoir of moods and madness*
- Manning, Martha (1994). *Undercurrents: A life beneath the surface*

### Websites

- [www.mcmanweb.com](http://www.mcmanweb.com)
- [www.psycheducation.org](http://www.psycheducation.org)
- [www.rdsfoundation.org](http://www.rdsfoundation.org)