Bipolar Disorder

Description/Etiology

Bipolar disorder (BD) is a chronic mental health disorder with a typical onset in the late teens for bipolar I disorder (BD I) and mid-20s for bipolar II disorder (BD II). BD I and BD II are distinct disorders that are differentiated in the *Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5)*, by:

› the requirement for a major depressive episode in BD II and the lack of any requirement for depressive episode(s) in BD I (although they may be present)
› different duration and severity of impact of mania

- BD I is characterized by at least one manic episode of at least 7 days’ duration that causes significant impairment in occupational or social functioning, may require hospitalization to avoid harm to self or others, and may include psychotic symptoms
- A BD II hypomanic episode(s) lasts at least 4 days and is noticeable as a change in normal levels of functioning, but does not cause disruption of functioning or require hospitalization (the symptoms of the required major depressive episode(s) do cause significant distress or dysfunction). If psychotic symptoms are present the episode becomes a manic episode and therefore BD I is diagnosed

BD features manic or hypomanic episodes that may occur before or after, or cycle with, episodes of major depression. Commonly, the episodes will persist for a week or more and occur at least 4 times a year when untreated. The depression present in BD II can be more severe and pervasive than the depression associated with BD I. BD often results in severe emotional and physical impairments, affecting the individual’s interpersonal relationships, school, and work. There is a high risk of suicide attempts and suicide completion with BD. Psychotic features may be present and need to be addressed. The client may experience mixed episodes, in which a manic or hypomanic episode contains elements of depression or a depressed episode contains elements of mania or hypomania. Clients may also be vulnerable to rapid cycling, in which there are at least four mood episodes within 12 months in which remission occurs for only 2 months or there is a switch to an episode that is the opposite polarity from what is currently being experienced (e.g., client is in a depressed mood and then rapidly switches to experiencing mania). There is also a high risk of relapse, which results in an overall decreased quality of life.

BD can be diagnosed in children and adolescents; *DSM-5* does not recommend diagnosis before age 6, however. A rapid increase in pediatric BD diagnoses has caused researchers to question if the increase is a true increase, is due to improved recognition of pediatric BD, or is due to misdiagnosis. The same diagnostic criteria are used for adults, adolescents, and children, but because of developmental differences BD may manifest differently in children, causing risks for misdiagnosis; to address concerns about overdiagnosis of BD in children and adolescents, *DSM-5* added a new diagnosis in the Depressive Disorders chapter, disruptive mood dysregulation disorder. (For more information on pediatric BD, please see Evidence-Based Care Sheet: Bipolar Disorder in Children and Adolescents.)

There is not a specific identified cause for BD, but various contributing factors to the development of BD exist. These include genetics, issues with the endocrine system and/or neurotransmitters, structural differences in the brain, and psychosocial stressors and conditions (e.g., childhood trauma, social class, social support, self-esteem). BD is diagnosed in women and men at roughly equal rates, but comorbidities and presentation of...
BD in men and women sometimes differ. Common comorbidities include anxiety disorders, drug and alcohol use disorders, personality disorders, and physical health problems.

The treatment regimen for BD will almost always contain a pharmacological component, which may include mood stabilizers (e.g., lithium), antipsychotics (e.g., risperidone, quetiapine, olanzapine), anticonvulsants (e.g., valproate, carbamazepine), and/or antidepressants (generally in combination with mood stabilizers). (For more information on pharmacological treatment of BD, please see Evidence-Based Care Sheet: Bipolar Disorder: Pharmacological Treatment.) Clients with BD will likely also require psychoeducation, family interventions, psychotherapy, and, in some instances, electroconvulsive therapy (ECT). Treatment that employs a team of professionals from different disciplines (e.g., mental health services, supportive living facilities, medical clinics, substance abuse treatment) who work together to provide services to clients in the community (e.g., in the client’s home, shelters for the homeless, neighborhood gathering places such as libraries or parks) are gaining acceptance. Such teams promote the goal of recovery and improvement of daily quality of life using hope, respect, and self-directed empowerment.

Facts and Figures

Based on data from the Global Burden of Disease Study 2013, researchers estimate that 48.8 million individuals had BD in 2013 (Ferrari et al., 2016). Prevalence of BD I in the United States is thought to be approximately 0.6% and prevalence of BD II approximately 0.8% (DSM-5, 2013). Data from the 2012 Canadian Community Health Survey: Mental Health and Well-Being indicated a lifetime prevalence for BD I of 0.87% and for BD II of 0.57%, with no difference in prevalence between women and men (McDonald et al., 2015).

The expression and functional impairment of BD have been found to be similar across racial and ethnic groups; past studies that showed differences may have been the result of provider bias in diagnosis (Perron et al., 2010). BD frequently is misdiagnosed as a different mental health condition: in one study, 52% of study participants who had BD had their first episode misdiagnosed, resulting in treatment delays as well as the risk of receiving the wrong pharmacological treatment (Knezevic & Nedic, 2013). Women with BD are at higher risk than men with BD of rapid cycling, having less time between recurrences, and having more severe mood episodes (Erol et al., 2015). Panic disorder, obsessive-compulsive disorder, and specific phobias have been found to be more common in women with BD (Saunders et al., 2012). Women also have been found to have a higher risk of co-occurring eating disorders but a decreased risk for substance use disorders when compared to men with BD (Suominen et al., 2009). Women with BD are at greater risk of suicide attempts than men with BD. In a meta-analysis of data from 25 international studies, researchers found that 33.7% of women with BD had attempted suicide compared with 25.5% of men with BD (Tondo et al., 2016). Up to 50% of children and adolescents with BD attempt suicide (Goldstein, 2012). The most common symptoms of mania in children are episodically increased energy, irritability, and rapid mood changes (Van Meter et al., 2016).

In a meta-analysis of data from over 50 studies, investigators concluded that psychological interventions are associated with lower risk of recurrence in individuals with BD; family psychoeducation is associated with reduction in manic and depressive symptoms (Oud et al., 2016). Family-focused therapy in conjunction with medication has been linked with improved recovery time and reduced severity and recurrences of episodes, particularly for individuals whose families show a pattern of high-expressed emotion characterized by critical comments, expressed hostility, and emotional over-involvement in response to having a family member with BD (Miklowitz & Chung, 2016).

Risk Factors

A family history of BD is one of the strongest risk factors for development of BD, which has led to theories of a genetic component to the disorder. There is a higher risk for BD in individuals who are separated, divorced, or widowed when compared to individuals who are married or who have never been married. Childhood trauma and social or environmental stressors can increase risk as well. Gender does not seem to present a risk factor for BD.

Signs and Symptoms/Clinical Presentation

› Signs and symptoms will vary depending on where in the cycle of symptoms the client is at the time of assessment
› Signs and symptoms of depression may include a loss of interest in pleasurable activities, daily sadness, tearfulness, hopelessness, decrease or increase in appetite, weight loss or gain, insomnia or hypersomnia, fatigue, feelings of guilt or worthlessness, trouble concentrating, and/or recurrent thoughts related to death or suicide, possibly including specific suicide plans or an actual suicide attempt
› Signs and symptoms of mania may include an elevated or irritable mood accompanied by grandiosity, increased energy or activity, a decreased need for sleep, distractibility, poor judgment, irritability, difficulty controlling temper, talkativeness,
racing thoughts, and lack of self-control and/or engaging in risk-taking behaviors (e.g., compulsive shopping, substance use, driving after drinking). Psychotic features also may be present with BD I

Social Work Assessment

› Client History

• Complete a biopsychosocial/spiritual assessment of the client, including family history. Observe client for irregularities in appearance, mood, affect, thought processes, speech, and any obvious agitation
• Assess client for current and past symptoms of mania, hypomania, and depression; ask about past treatment and responses to treatment
• Assess client for substance use disorders
• Assess client for suicidal ideation, intent, or plan
• Assess client for risk of self-harm or harm to others
• With appropriate consent from client, obtain information from family members and other collaterals

› Relevant Diagnostic Assessments and Screening Tools

• The Structured Clinical Interview for DSM Disorders
• The Mood Disorder Questionnaire (MDQ), which is a single-page inventory that screens for any client history of mania or hypomania
• Hypomania/Mania Symptom Checklist (HCL-32) screens for BD II and for past episodes of mania and is available in over 15 languages
• The Hypomanic Attitudes and Positive Predictions Inventory (HAPPI) is designed to assess multiple, personalized, extreme beliefs the client may have that are considered to be key to his or her cognitions and mood swings as related to BD

› Laboratory and Diagnostic Tests of Interest to the Social Worker

• Screening for substance use may be appropriate
• For clients who are of childbearing age, a pregnancy test may be appropriate since there can be risk to the fetus with BD medications

Social Work Treatment Summary

Treatment for BD consists of two phases: acute stabilization and maintenance. Psychiatric hospitalization often is required to stabilize individuals who are manic or severely depressed and suicidal. Treatment for BD may include a combination of pharmacotherapy, psychoeducation, cognitive-behavioral therapy (CBT), family-focused therapy (FFT), interpersonal and social rhythm therapy (IPSRT), and/or ECT. Pharmacotherapy may involve the use of lithium, antipsychotics, anticonvulsants acting as mood stabilizers, or antidepressants (generally in combination with mood stabilizers). Social workers can play an important role in reinforcing the importance of adhering to treatment and monitoring for negative side effects of medication. Psychoeducation for clients with BD is important to help clients and their family members recognize the signs and symptoms of relapse (i.e., prodromal symptoms) and learn about BD, treatment options, and medication. CBT examines the influence of a client’s thoughts and cognitions on mood and behavior and targets change accordingly. With BD, CBT focuses on decreasing maladaptive thoughts and behaviors, improving the client’s self-monitoring of mood instability, and managing stress. Additionally, CBT approaches that are customized for working toward medication compliance, such as customized adherence enhancement (CAE), may be useful. FFT is a common psychosocial intervention for adults and children with BD and includes psychoeducation, communication enhancement training, and problem-solving skills training components. IPSRT is based on social rhythms theory, which views affective disorders such as BD as occurring in persons who are more vulnerable to disrupted sleeping, eating, and energy rhythms. The client identifies problem areas, including medication non-adherence and stressful life events. The client is then to record sleep, mood, exercise, and diet using a particular metric and work on plans to enhance rhythm stability even when faced with disrupting events (e.g., job loss, relationship breakup). Clients also work on preventive strategies. ECT consists of electrically induced seizures and is utilized as an alternative treatment for clients who have been nonresponsive to medication or experience medication side effects that are intolerable.

Social workers should be aware of their own cultural values, beliefs, and biases and develop specialized knowledge about the histories, traditions, and values of their clients. Social workers should adopt treatment methodologies that reflect their knowledge of the cultural diversity of the communities in which they practice.

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<thead>
<tr>
<th>Problem</th>
<th>Goal</th>
<th>Intervention</th>
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<tbody>
<tr>
<td>Client is exhibiting signs and symptoms of an initial manic episode and is meeting diagnostic criteria for BD</td>
<td>Client will be stabilized and will be educated on bipolar diagnosis</td>
<td>Assess risk to self and others and ensure safety. Consult with physician to assist in having client evaluated for appropriate medications to stabilize mood. Provide psychoeducation on BD and treatments for BD. Provide support and reassurance to client</td>
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<tr>
<td>Client is experiencing the negative signs and symptoms of bipolar depression</td>
<td>Client will have a reduction in negative symptoms</td>
<td>Assess risk to self and others and ensure safety. Evaluate client’s medication treatment plan. Advocate for client as needed with physician for appropriate combination therapy. Determine best evidence-based therapeutic intervention (e.g., CBT, FFT, IPSRT) to reduce signs and symptoms of depression. Locate supports and resources for client</td>
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<tr>
<td>Client has expressed that he or she is experiencing suicidal ideation</td>
<td>Client will no longer be feeling suicidal</td>
<td>Evaluate the level of threat to self and others; discuss if there is a plan for suicide; refer for hospitalization if there is a plan in place and the client intends to follow through. Refer to psychiatrist for medication evaluation; use exploration, encouragement of affect, clarification, and CBT to try to manage suicidal ideation</td>
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**Applicable Laws and Regulations**

- Each country has its own standards for cultural competence and diversity in social work practice. Social workers must be aware of the standards of practice set forth by their governing body (e.g., National Association of Social Workers in the United States, British Association of Social Workers in England) and practice accordingly.
- Social workers should practice with awareness of and adherence to the social work principles of respect for human rights and human dignity, social justice, and professional conduct as described in the International Federation of Social Workers (IFSW) Statement of Ethical Principles, as well as the national code of ethics that applies in the country in which they practice. For example, in the United States, social workers should adhere to the National Association of Social Workers (NASW) Code of Ethics core values of service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence; and become knowledgeable of the NASW ethical standards as they apply to individuals with bipolar disorder and practice accordingly.
- In the United States, every state has its own criteria for involuntary psychiatric holds on persons who may be a danger to themselves or others. Clinicians must be familiar with applicable laws and regulations for when a client is making threats of self-harm or harm to others.
- Laws and professional association requirements for reporting neglect and abuse must be known and observed.
Available Services and Resources
› Depression and Bipolar Support Alliance, for clinicians and for clients with BD, https://secure2.convio.net/dabsa/site/SPageServer;jsessionid=00000000.app274a?
NONCE_TOKEN=E03BCC59A53EAA4E46238FC2EA00E3FE&page_name=home
› Anxiety and Depression Association of America has sections for clients and professional resources, https://adaa.org/understanding-anxiety/related-illnesses/bipolar-disorder
› National Alliance on Mental Illness (NAMI), https://www.nami.org/Learn-More/Mental-Health-Conditions/Bipolar-Disorder

Food for Thought
› A National Institute of Mental Health study on psychosocial treatment found that individuals receiving any of the three intensive psychotherapies (i.e., CBT, FFT, IPSRT) had a higher recovery rate of 64% compared to 52% in the control group, recovered more quickly than the control group, and had a greater likelihood of staying well. There were not statistically significant differences between the intensive therapies (NIMH, 2016)
› A study in France, Germany, Ireland, and the United States of the brain structure of BDI patients with psychotic symptoms and those without psychotic symptoms identified differences in the connectivity between the hemispheres of the brain in the two groups (Sarrazin et al., 2015)
› Existing screening tools for BD lack sensitivity and fail to identify approximately 25% of individuals with BD (Bobo, 2017)
› Studies of psychosocial interventions with women in India with BD concluded that treatments such as psychoeducation, psychotherapy, family therapy, and interpersonal and social rhythm therapy all contributed to reduced relapse rates, stabilization of episodes, and improved daily functioning (Naik, 2015)
› In a study published in 2016, researchers found that in individuals with BD, instability of depressive and manic symptoms was associated with longer recovery times and poorer outcomes. Researchers suggested that clients with affective instability may benefit from interventions that emphasize regulation of aversive emotions, for instance dialectical behavioral treatment (Stange et al., 2016)
› In a 2016 study, functional remediation, an intervention that focuses on improving functioning in individuals with BD through training in neurocognitive skills (e.g., executive functions, attention, memory), was compared to psychoeducational treatment and treatment as usual. Investigators found that participants who received the functional remediation intervention showed more improvement in functioning and increased autonomy and that these effects continued to be evident a year after intervention (Bonnin et al., 2016)

Red Flags
› Individuals with BD are at increased risk of mortality from suicide as well as from medical conditions related to cardiovascular and metabolic diseases, complications from smoking and substance use, and obesity
› Co-occurrence of BD and metabolic syndrome is associated with poorer outcomes including higher rates of hospitalization, lower global functioning and insight, and greater impairment in executive functions (Bai et al., 2016)
› In the majority of clients with BD, depression will occur more often and for longer periods than mania. Bipolar depression in turn accounts for a greater proportion of the morbidity and mortality associated with BD (Vieta & Valenti, 2013)
› Suicide risk is high in those with BD. Clients with BD may need careful monitoring and ongoing suicide risk assessments
› Lithium is associated with a reduced risk of self-harm and suicide in individuals with BD (Goodwin et al., 2016)
› Clients taking lithium need regular blood tests for thyroid functioning and lithium levels. Clients need to be assessed to determine if they can follow this regimen and understand the risks of abrupt termination or nonadherence
› Antidepressants should be used with caution for BD depression because they may trigger a switch from depression to mania, carry a higher suicide risk, and increase the risk for mixed states; instead, mood stabilizers, atypical antipsychotics, and anticonvulsants are recommended for acute treatment of depressive episodes in BD (Vieta & Valenti, 2013). Most practice guidelines recommend that antidepressants be used to treat BD depression only in cases of severe depression that does not respond to mood stabilizers or antipsychotics (Liu et al., 2017)
› For women with BD, pregnancy may carry a higher risk of complications, preterm birth, and giving birth to infants who are small for their gestational age; it may also serve as a trigger for an episode of BP-related mania or depression. Pharmacological management of BD also becomes more complicated during pregnancy. Potential impacts of medications on fetal development and childhood outcomes, the impact of pregnancy and postpartum on drug metabolism, and the relative risks of not treating BD during pregnancy have to be weighed when making treatment decisions
Individuals with BD often face challenges at work as a result of both stigma and issues with work functioning; interventions that address employment difficulties are needed to improve financial security, social functioning, and quality of life for individuals with BD (O’Donnell et al., 2017)

Sleep loss has been found to trigger BD symptoms, especially in females and individuals with BD I; shift work and international travel can be particularly challenging for vulnerable individuals (Lewis et al., 2017)

**Discharge Planning**

- Educate the client and family on the importance of postponing all major decisions until acute symptoms have resolved
- Educate the client and family on the importance of adherence to the plan of care and maintaining good sleep hygiene and regular schedules and routines when possible
- Provide the client with self-regulation and self-monitoring tools
- Provide information on local resources and available supports
- Prior to discharge or termination of services, screen client for risk of self-injury or harm to others

**DSM 5 Codes**

- [Bipolar I disorder, 296.xx (code based on type, severity, presence of psychotic features, and remission status)]
- Bipolar II disorder, 296.89

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**References**


