QUICK LESSON ABOUT

Bipolar Disorders: an Overview

Description/Etiology

Bipolar disorders are a cluster of mental illnesses that can have a profound effect on the quality of life of affected persons and their families. Although increased awareness of the disorders and improvements in medications and psychotherapies have improved outcomes for many who have them, bipolar disorders continue to be some of the most severe and persistent mental illnesses.

Formerly known as manic depression, bipolar disorders are characterized by dramatic shifts in mood that negatively impact a person's ability to function in one or more areas of their life. Unlike normative mood changes, in bipolar disorder the mood changes are dramatic and severe. Mood changes are identified as episodes of depression, mania or hypomania, or a combination. Although bipolar disorders were previously classified with depressive disorders under the category of mood disorders, the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (*DSM-5*), separates bipolar disorders and depressive disorders into two distinct classifications (APA,2013). The*DSM-5* also recognizes bipolar disorders as being a bridge between depressive disorders and schizophrenia and other psychotic disorders. Diagnostic differences between bipolar disorders lie mainly in the type of episode(s) experienced by the client.

› Manic episode

- A manic episode is defined in the *DSM-5* as a distinct period during which the person's mood is abnormally elevated, expansive, or irritable, and during which the person engages in persistently and abnormally increased goal-directedactivity or energy. This mood state must be present most of the day, nearly every day. If the symptoms require hospitalization of the person, the duration of symptoms can be of any length of time. While the mood disturbance and increased energy or activity is taking place, three or more of the following must be present (four or more if the person's mood is irritable only): inflated self-esteem or grandiosity, a decreased need for sleep, pressured speech, racing thoughts or flight of ideas, distractibility, increased goal-directed activity or psychomotor agitation, or excessive involvement in activities that might result in painful negative consequences. The mood disturbance must be severe enough to cause significant impairment in social or occupational functioning, be severe enough to require hospitalization or include psychotic features, and cannot be attributed to a substance or medical condition (APA, 2013)
- In children, manic episodes may manifest as developmentally inappropriate sexual preoccupations, planning to engage in multiple unrealistic projects, or taking on too many tasks simultaneously. Children may exhibit grandiosity by an overestimation of their abilities, despite evidence to the contrary

› Hypomanic episode

- A hypomanic episode is similar to a manic episode in symptomology, but differs in terms of duration and severity. Like a manic episode, a hypomanic episode is a distinct period during which the person's mood is abnormally elevated, expansive, or irritable, and during which the person engages in persistently and abnormally increased goal-directed activity or energy, but must last at least four consecutive days and be present most of the day. As with a manic episode, three or more of the following symptoms must be present: inflated self-esteem or grandiosity, a decreased need for sleep, pressured speech, racing thoughts or flight of ideas, distractibility, increased

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goal-directed activity or psychomotor agitation, or excessive involvement in activities that might result in painful negative consequences. While a hypomanic episode is not severe enough to cause significant impairment, require hospitalization, or include psychotic features, it does represent a change in normal functioning for the person that is observable by others. As with a manic episode, the symptoms cannot be better attributed to a substance or medical condition (APA, 2013)

› Major depressive episode
  • A depressive episode must be present for at least a two-week period and must include five or more of the following symptoms: depressed mood most of the day nearly every day; decreased interest or pleasure in all or almost all daily activities; significant weight loss or weight gain; decrease or increase in appetite; insomnia or hypersomnia; psychomotor agitation or retardation; fatigue or loss of energy; feelings of worthlessness or guilt; inability to concentrate, think, or make decisions; or recurrent thoughts of death, suicidal ideation, or suicide attempts. The symptoms must be severe enough to impact social or occupational functioning and cannot be attributed to a substance or medical condition (APA, 2013)

› Mixed episode
  • A mixed episode contains within the same mood episode symptoms of both a manic or hypomanic episode and a depressive episode. A manic or hypomanic episode with mixed features occurs when the full criteria for a manic or hypomanic episode exist, but three or more of the following symptoms also occur during most days of the episode: dysphoria or depressed mood, decreased interest in normal activities, psychomotor retardation most days, loss of energy or fatigue, feelings of worthlessness or inappropriate guilt, or recurrent thoughts of death. A depressive episode with mixed features occurs when the full criteria for a depressive episode are met, but at least three of the following symptoms of a manic episode are also present: elevated or expansive mood, inflated self-esteemor grandiosity, increased speech or pressure to continue to speak, flight of ideas or racing thoughts, increase in energy or goal-directed activity, involvement in activities that are potentially harmful, or a decreased need for sleep (APA, 2013)

› Rapid cycling
  • Rapid cycling refers to the presence of at least four depressive, manic, or hypomanic episodes within one year. The episodes can occur in any combination, but must be demarcated by either a change to a new mood episode of the opposite polarity or by full remission. The term can be applied to either bipolar I or bipolar II disorder (APA, 2013)

The *DSM-5* chapter on bipolar and related disorders includes the following diagnoses:

› Bipolar I
  • In order for bipolar I disorder to be diagnosed, the person must have experienced at least one manic episode, but the episode may have been preceded or followed by one or more hypomanic or major depressive episodes. If the symptoms are better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, or delusional disorder, then bipolar I is not diagnosed. When diagnosing bipolar I disorder, specifiers are used to indicate the most recent episode (manic, hypomanic, depressed, or unspecified) and severity (mild, moderate, or severe) (APA, 2013)
  • Persons experiencing a manic episode as part of bipolar I disorder may be described as being euphoric, and may engage in haphazard and overly enthusiastic interactions with others (e.g., talking excessively with strangers). Mood lability may be present: the person's mood may shift quickly over brief periods of time. Irritability may be the primary mood state, particularly if the person is using any substances. During a manic episode, persons may take on many new projects even if they are beyond the person's skill set, talents, or ability to complete, and may work on these projects excessively and at odd hours of the day. Self-esteem may be inflated to the point that the person experiences delusions of his or her own grandeur, such as believing that they are close friends with a celebrity or politician. Persons may go for several days without sleep and still feel full of energy. Speech may be rapid, loud, forceful, or pressured and persons may talk ceaselessly, not allowing others to contribute to the communication. Thoughts may race faster than the person is able to express them, resulting in a flight of ideas, abrupt shifts between topics, disorganization, or incoherency. Persons may experience an increased sex drive, increased sociability, and excessive physical activity such as pacing or restlessness. Poor judgment may lead to excessive spending, engaging in sexual activities that they would not normally engage in, or other activities with potentially catastrophic consequences such as criminal activity, extreme debt, or hospitalization. Persons may dress more flamboyantly. Some experience heightened sensory experiences such as sharper hearing, vision, or smell. Persons who are in a manic episode may not see their behavior as unusual and may not see a need for intervention
  • Development and course
    – Onset of bipolar I usually is around 18 years of age, although children and adolescents can be affected as well. Some persons do not develop bipolar I until their 60s or 70s. However, if a person is experiencing their first manic episode in middle age or later, medical conditions or substance use should be evaluated. The vast majority of persons who experience one manic episode will go on to experience more mood episodes

- Co-occurring conditions
  - Nearly three quarters of persons with bipolar I disorder also meet the criteria for an anxiety disorder. ADHD, conduct disorder, or other impulse control disorders also are common

› Bipolar II

- In order for bipolar II disorder to be diagnosed, the person must meet the criteria for a current or past hypomanic episode and a current or past major depressive episode. If a manic episode has ever been present then a diagnosis of bipolar I is made instead. If the symptoms are better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, or delusional disorder, then bipolar II is not diagnosed. Symptoms of the alternating hypomanic episodes and major depressive episodes or the symptoms of depression must cause clinically significant impairment or distress in social, occupational, or other areas of functioning. Bipolar II specifiers include the current or most recent episode (hypomanic or depressed) and specific features (anxious distress, mixed features, rapid cycling, mood-congruent psychotic features, mood-incongruentpsychotic features, catatonia, peripartum onset, and seasonal pattern). Additional specifiers include in partial or full remission and severity (mild, moderate, or severe) (APA, 2013)
- In persons with bipolar II disorder, the depressive episode is usually the symptom that is causing the most impairment and is the reason for seeking treatment. Persons with bipolar II may not recognize the hypomanic episodes as problematic, but rather as their normative mood state. Upon assessment, however, it may become apparent that the unpredictable mood changes and unstable interpersonal and occupational functioning are causing the impairment the person is experiencing
- Development and course
  - Bipolar disorder II usually begins in the mid-20s, although the disorder can begin in childhood or adolescence. Onset at an early age usually indicates a more severe lifetime course of the disorder. Persons with bipolar II usually experience a major depressive episode first, and often major depression is diagnosed until a hypomanic episode occurs and is identified. Anxiety, substance use, and eating disorders may also precede the onset of bipolar II. Persons with bipolar II are likely to have more frequent episodes than persons with bipolar I
- Co-occurring conditions
  - 60% of persons with bipolar disorder have at least three other co-occurring disorders (APA, 2013), most commonly anxiety, eating disorders, and substance use disorders

› Cyclothymic disorder

- Cyclothymic disorder is characterized as a chronic, fluctuating mood disturbance involving multiple periods of hypomanic and depressive symptoms that are distinct from one another, but do not meet the full criteria for bipolar II disorder. The symptoms must be present for at least two years, or one year in children and adolescents, must be present for at least half the time, and the person cannot have been without the symptoms for more than two months at a time. The symptoms cannot be attributed to a substance or other medical condition and they cause significant distress or impairment in important areas of the person's functioning. If the person has ever had a manic episode, hypomanic episode, or major depressive episode, the diagnosis of cyclothymic disorder cannot be given, and if the person experiences a manic, hypomanic, or depressive episode after diagnosis of cyclothymic disorder, the diagnosis must be changed to reflect the appropriate criteria (e.g., bipolar I, bipolar II, or major depressive disorder)(APA, 2013)
- Development and course
  - Cyclothymic disorder usually begins in adolescence or young adulthood, but can begin in childhood. Cyclothymic disorder may develop into bipolar I or bipolar II disorder over time
- Co-occurring conditions
  - Substance use disorders and sleep disorders are common in persons with cyclothymic disorder. Children with cyclothymic disorder often have ADHD as well

› Substance/medication-induced bipolar and related disorder

- Substance-induced bipolar and related disorder is characterized by a prominent and persistent mood disturbance that includes expansive, elevated, or irritable mood with or without depressed mood, and evidence that the mood disturbance began during or shortly after substance intoxication or withdrawal, or exposure to medication that might cause the mood symptoms. If the symptoms can be better explained by bipolar I or II, or another related disorder, then the diagnosis of substance-induced medication and related disorder is not given. Evidence of this might include onset of symptoms prior to substance or medication use or exposure, or if the symptoms persist for a significant amount of time (e.g., one month) after discontinuation of the substance or medication use or exposure. The symptoms cannot exist only during delirium, and must cause significant distress or impairment (APA, 2013)

› Bipolar and related disorder due to another medical condition

- The essential feature of bipolar and related disorder due to another medical condition is prominent and persistent mood disturbance that includes expansive, elevated, or irritable mood and abnormally increased energy or activity level that is

directly attributed to a medical condition. The disturbance cannot be better explained by another mental disorder and does not occur only during delirium. The symptoms must cause significant distress or impairment

› Other specified bipolar disorder and unspecified bipolar disorder
  • The social worker or other clinician may use these classifications when mood disturbance is present, causes impairment, and is clinically significant, but the symptoms are not sufficient to meet the full criteria for bipolar I, bipolar II, cyclothymic, or substance or medical condition induced bipolar disorder. If the clinician wants to specify the reason the person does not meet full criteria for another disorder, theywould use the other specified bipolar and related disorders diagnosis, and include an "other specified" designation. As an example, the clinician might specify "short-duration cyclothymia" for a person who does not meet the 2-year criterion for diagnosis of cyclothymic disorder. If the clinician chooses not to specify a reason, then unspecified bipolar disorder is used as the diagnosis

Bipolar Disorder in Women

› Women with bipolar disorder tend to experience more depressive episodes than men, and women experiencing depressive episodes report more weight and appetite changes and sleep disturbances than men (Miller et al., 2015). Bipolar disorder can create unique challenges for women who are pregnant or who are postpartum. While pregnancy itself does not seem to affect the frequency, intensity, or duration of bipolar episodes, women who discontinue mood stabilizers during pregnancy are likely to have an increase in episodes, which can lead to high-risk behaviors such as poor self-care,substance use, suicide attempts, and impulsive behavior. Untreated bipolar disorder is associated with premature delivery and low birth weight (Rusner et al., 2016). Women with bipolar disorder are at a much higher risk of developing depression postpartum than women without bipolar disorder, and are also at risk for developing postpartum psychosis(Bergink et al., 2016)
› Bipolar disorder can also impact family planning. Impulsivity may lead to unintended pregnancy or may hinder the woman's ability to adhere to contraceptive methods that require daily medication regimens. The effectiveness of hormone-based contraceptive methods can be compromised by the use of mood stabilizers. Likewise, contraception may alter the effectiveness of mood stabilizers, particularly contraceptives with estrogen (Miller et al., 2015). Some medications such as valproate and carbamazepine can cause birth defects, including spina bifida and borderline intellectual functioning (Grande et al., 2016). Use of progesterone-only contraceptives or long-term contraceptive methods such as IUDs can be good alternatives. Menopause increases risk for depressive symptoms (Miller et al., 2015)

Bipolar Disorder in Children and Adolescents

› Bipolar disorder can severely impact a child or adolescent's development and psychosocial functioning. Children and adolescents with bipolar disorder are at an increased risk for suicide, substance misuse, academic and behavioral problems, and involvement with law enforcement. Because bipolar disorder often develops before age 21, early identification and treatment of the disorder is important in order to reduce these risks (Grande et al., 2016). While diagnostic criteria for children and adolescents are the same as those for adults, diagnosis should be made cautiously, as symptoms of mania and hypomania must be assessed within the context of the child's social and emotional development. Concern should arise when these symptoms mark a significant change from the child's normal behavior, if they are incongruent with the environmental context, or if they are in excess of what would be considered developmentally appropriate. Identification of elation and grandiosity can be particularly difficult. For example, it may be developmentally appropriate for children to express elation or excessive silliness or hyperactivity when at a party, but sadness when the party ends. A vivid imagination and fantasizing may also be developmentally appropriate and not symptoms of grandiosity. Irritability, temper outbursts, and impulsivity may also be considered developmentally normative for younger persons, particularly adolescents. For children and adolescents with bipolar II, symptoms of hypomania may represent an improvement of functioning as the previously depressed child becomes more socially engaged, creative, and outgoing. Children and adolescents are more likely to experience rapid cycling and mixed episodes than adults. In fact in young persons symptoms of mania and depression may occur simultaneously, but represent a distinctly different state from the child or adolescent's normative behavior (Rizvi et al., 2014)
› Symptoms of mania and hypomania also overlap with those of other disorders common in childhood and adolescence, such as ADHD, conduct disorder, oppositional defiant disorder, and emerging personality disorders, and may in fact co-occur with these disorders, further complicating differential diagnosis. Perhaps because of the difficulty in accurately identifying bipolar disorders in young persons, there has been a great deal of concern that bipolar disorder has been overdiagnosed in children and adolescents (Rizvi et al., 2014; Grande et al., 2016). As a result, a new classification, disruptive mood dysregulation disorder (DMDD), was included in the *DSM-5*. The primary feature of DMDD is severe, chronic, and persistent irritability. Unlike bipolar disorder, DMDD is not episodic, but characteristic of the child or adolescent's mood. It was included in the *DSM-5* under depressive disorders rather than bipolar disorders to reflect findings that indicate that children and adolescents with this symptom presentation usually go on to develop unipolar depression or anxiety rather than bipolar disorders in adulthood (APA, 2013)

› Despite diagnostic challenges, current treatment recommendations are the same for children and adolescents as they are for adults (Birmaher, 2013; Grande et al., 2015). While psychopharmacology is the primary treatment modality, it should be noted that few psychotic medications used for the treatment of bipolar disorder have been approved for use in children and adolescents. Psychotropic medications may pose additional risks for younger clients. In particular, antipsychotic medications pose an increased risk for the development of metabolic syndrome in children and adolescents as compared to adults (Grande et al., 2015). Because bipolar disorder is highly heritable, many children and adolescents with bipolar disorder have a parent who experiences bipolar disorder or another mental health disorder(Forstner et al., 2017). If a parent's own mental health is compromised, it may be difficult for them to provide the support, structure, and guidance the child or adolescent needs. As often as is clinically appropriate, the parents or caregivers of children and adolescents with bipolar disorder should be included in psychosocial interventions, including psychoeducation, family therapy, and/or support groups

Bipolar Disorder in Older Adults

› Between 10 and 15% of older adults with bipolar disorder experience onset after age 50 (Chou et al., 2015). The aging of the world population has made identification and management of bipolar disorders in older adults an important area of healthcare practice, yet little conclusive evidence on the unique needs of this population exists (Sajatovic et al., 2015). In older adults with bipolar disorder, schizophrenia, dementia, or unipolar depression often is mistakenly diagnosed. Many may have experienced depressive episodes for years but do not experience their first manic episode until late in life. Most older adults with bipolar disorder will also have comorbid medical or neurological conditions that can both complicate accurate diagnosis and limit treatment options. Use of mood-stabilizing medications, particularly lithium, can be riskier for this population than for younger persons because preexisting and comorbid diseases may decrease kidney function. Older adults who have been living with bipolar disorder for many years may begin to experience the physical effects of long-term mood-stabilizer use such as renal disease, hyperglycemia, or hypothyroidism. Cognitive impairments and mobility limitations can lead to poor adherence to medication regimens. Despite these risks, psychopharmacology remains the primary treatment modality for older adults. Psychosocial interventions should include psychoeducation about the disorder, developing an acceptance of the disorder, development of daily routines and sleep patterns, and enhancing communication with others. Family members should be included in the treatment process as often as is clinically appropriate so that they can help identify early signs of relapse and provide social supports to the client

Suicide

› Suicide is a significant risk for persons with bipolar disorder. Individuals with bipolar disorder are at higher risk for suicide than persons with any other psychological disorder; 25 to 50% of persons with bipolar disorder attempt suicide at least once (Costa et al., 2015). Persons with bipolar disorder are 60 times more likely to attempt suicide than the general population (Costa et al., 2015). Bipolar disorder plays a role in nearly one quarter of all completed suicides (APA, 2013). While females and younger persons are more likely to attempt suicide, males are more likely to complete suicide and older adults are more likely to choose lethal means. Although the presence of depressive episodes is the major risk factor for suicide in persons with bipolar disorder, a variety of other factors also increase risk. Even when they are not symptomatic, quality of life is significantly impaired for persons with bipolar disorder. The lack of social support and poor coping skills of these persons leave them unable to successfully navigate stressful life events, and they may become overwhelmed with life problems. Having a comorbid chronic health condition or other medical disease increases risk, as does having another severe mental health disorder, especially one that includes delusions or paranoia. An early age of onset of the disorder, as well as symptoms that include depressive episodes, mixed episodes, and rapid cycling, increases risk. Those who experience co-occurring disorders such as substance abuse, anxiety, eating disorders, and personality disorders, particularly borderline personality disorder, are at an increased risk for suicide. Traumas in childhood and a family history of mood disorders and suicide attempts increase risk (Schaffer et al., 2015). In children and adolescents there is an association between suicide attempts and a parental history of depression (Costa et al., 2015)

Substance Misuse

› Bipolar disorders are associated with the highest rates of substance misuse of any mental health disorder (Ladson et al., 2014). Between 48 and 61% of persons with bipolar disorder will have a substance use disorder at some time in their lives (Ladson et al., 2014). There are negative consequences for those with bipolar disorder and concurrent substance use. Persons with bipolar disorder and concurrent substance use are more likely to have an earlier onset of the disorder, an increase in suicide attempts, more completed suicides, more severe depression and mania, more mixed and cycling episodes, poorer physical health, poorer psychosocial functioning, and more nonadherence to treatment

› Distinguishing between symptoms of bipolar disorder and substance use can be difficult. Symptoms such as hyperarousal, weight loss, decreased impulse control, insomnia or decreased need for sleep, and psychotic features characterize both substance use disorders and bipolar I disorder. Intoxication and withdrawal of some drugs, such as methamphetamine

and cocaine, can mimic the symptoms of both manic and depressive episodes. Other drugs such as alcohol, marijuana, and opiates can temporarily mask mood swings. Persons with bipolar disorder who are misidentified as having unipolar depression or other mental health disorders may use substances to self-medicate

- Treatment of bipolar disorder is complicated by the presence of a substance use disorder, and treatment of substance use disorder can be complicated by the presence of a bipolar disorder. The impulsivity and poor judgment associated with mania can cause persons to engage in the use of drugs or alcohol and associated high-risk behaviors when they might not otherwise do so. Persons experiencing a depressive episode may rely on drugs or alcohol to alleviate symptoms. Some psychotropic medications can interact negatively with the use of non-prescribed medications or illegal drugs by exacerbating symptoms, or increasing the risk of overdose. In order for treatment to be effective, both disorders need to be accurately identified and addressed. Because of the complexities of treating clients with co-occurring substance use and bipolar disorders, referral to a program that specializes in treating substance use and mental health disorders concurrently may be indicated

Facts and Figures

Bipolar disorders affect approximately 45 million persons worldwide (GBD 2017 Disease and Injury Incidence and Prevalence Collaborators, 2018). The lifetime prevalence rate of bipolar disorder I is 1.0–1.6% (Marsh, 2022a); the lifetime prevalence of bipolar disorder II is 0.5–1.0% (Marsh, 2022b). For children and adolescents, the incidence rate of bipolar disorder is 1–2% (Birmaher, 2013). No racial differences appear to exist in the prevalence of bipolar disorders. Bipolar I is equally prevalent among males and females, while bipolar II and rapid cycling are more prevalent in females. The average age at onset of bipolar disorder is 25 (Yatham et al., 2018). Bipolar disorder often is misdiagnosed, resulting in a lapse between onset of symptoms and treatment. In 69% of adults in whom bipolar disorder eventually was accurately diagnosed, their condition originally was misdiagnosed; 35% of these adults did not receive an accurate diagnosis for 10 or more years after initially seeking treatment (Ladson et al., 2014). For children and adolescents with early onset of the disorder, the delay in accurate diagnosis is more than 16 years on average (Ladson et al., 2014).

Persons with bipolar disorder are less likely to seek treatment when they are experiencing mania or hypomania and more likely to seek help when they are depressed (NIH, 2020).Even with treatment, approximately 27% of persons with bipolar disorder will have another episode of mania or depression within a year, and 60% will have a relapse within 2 years (Geddes & Miklowitz, 2013).

The economic costs associated with bipolar disorder were estimated to be $195 billion in the United States in 2018; direct healthcare costs made up 25% of the total(Bessonova et al., 2020).In the United Kingdom, economic costs associated with bipolar disorder were estimated to be £6.43 billion in 2018–2019, of which 68% was attributed to lost productivity and informal care, 31% to healthcare costs, 1% to out-of-pocket expenses, and 0.5% to social care costs (Simon et al., 2021).

Risk Factors

Bipolar disorders are considered to be among the most heritable mental health disorders, and are thought to be due to a combination of genetic predisposition and major stressors (Marsh, 2022a). A family history of bipolar disorder increases the risk for the development of the disorder tenfold in first-degree relatives (Boland et al., 2022). Bipolar disorder and schizophrenia are likely genetically related, as a family history of schizophrenia also increases risk. A stressful event such as a death in the family, divorce, and financial problems may trigger a depressive or manic episode in persons with bipolar disorder. Substance abuse is also a risk factor for bipolar disorder. Medical conditions such as obesity and cardiovascular disease are more common in persons with bipolar disorder than in the general population (Miller et al., 2015). Impulsivity related to manic episodes increases risk for sexually transmitted diseases and substance use.

Signs and Symptoms/Clinical Presentation

Persons with bipolar disorders will experience episodes of mania, hypomania, and/or depression. Those experiencing a manic episode may appear euphoric, impulsive, impatient, agitated, excessively social or talkative, or have a grandiose sense of self-importance or a decreased need for sleep. Persons experiencing a hypomanic episode may experience the symptoms of mania but to a lesser degree. Persons experiencing a depressive episode may have symptoms including lack of interest in normal activities, fatigue, excessive sleep or insomnia, low energy, or slowed mental and physical processes. Rapid cycling between manic, hypomanic, or depressive episodes may take place, in which the person changes mood states several times within a 24-hour period. Mixed states also may occur wherein the person experiences symptoms of mania, hypomania, or depression simultaneously.

Social Work Assessment

› **Client History**

- To determine a differential diagnosis and formulate treatment goals, a thorough biopsychosocial-spiritual assessment should be completed. Emphasis should be placed on the history and duration of symptoms; history of past psychiatric diagnoses and treatment, including medications, and the response to treatments; history of psychiatric hospitalization; and type, frequency, and duration of mood episodes. Personal historical information to include in an assessment are the client's response to stressors and changes in life events, family history of mental health concerns, particularly the presence of bipolar disorders or schizophrenia, and the client's current and past use of prescription and over-the-counter medication, alcohol, and other drugs. A thorough physical examination should take place to rule out medical causes for the symptoms
- All clients with bipolar symptoms should be assessed for safety factors including suicidal risk, self-care, and risk to others
  - Clients should be assessed for suicidal thoughts, intention to act on suicidal thoughts, and whether they have a plan for how to commit suicide and the means to carry out the plan. The presence of psychotic symptoms, especially command hallucinations, or alcohol or other substance misuse can increase risk of suicide. A mental status exam should be conducted, including an assessment of cognitive functioning such as pressured speech, flight of ideas, loss of executive functioning, and delusions or hallucinations. Current stressors and protective factors (e.g., strong social supports) and level of impulsivity should be included. Risk for suicide should be an ongoing part of treatment as mood episodes can remit and reoccur or change polarity during the course of treatment
  - For clients experiencing severe mood episodes, self-care may be compromised. Clients with severe depressive episodes should be assessed for adequate levels of hydration and nutrition and the ability to carry out daily activities of self-care. Clients experiencing severe manic episodes may not sleep for days or may experience delusions or engage in high-risk, impulsive behaviors which may require risk management
  - If the client has children, their ability to safely and adequately care for them may be compromised; if so, steps must be taken to protect the children from further neglect or harm. This may include reporting suspected child maltreatment to the appropriate local authority. If a client who is a parent requires psychiatric hospitalization, the social worker may need to collaborate with the client to find appropriate care for their children while hospitalized
  - The client's risk of harm to others should be assessed. Clients should be assessed for homicidal ideation and, if present, appropriate steps taken to protect the identified victim. Psychosis, substance misuse, impulsivity, and a history of aggression increase homicidal risk
- Assessment is an ongoing process that should be reevaluated as new information regarding the client becomes available, and as the client moves between mood states
- The social environment of the client can have a profound effect on the client's adherence to and response to treatment. The social context of the client should be closely assessed to determine areas of support and vulnerabilities as they relate to treatment
- Accurate information on the client's response to past treatment is key to effective treatment planning, as each person responds differently to medication and to psychosocial stressors
- When working with children or adolescents with bipolar disorders, it is useful to use a family systems framework for assessment using the ecological and strengths perspectives. Noting the positive events and positive attitudes of family members can help them identify their own strengths and resiliencies. In addition, the use of a family genogram with attention to mental health history can alert the social worker and the family to possible family or genetic predisposition to the disorder
- Inclusion of family members in the assessment process is advised unless the client refuses to grant permission or it is otherwise clinically contraindicated. Family members or others familiar with the client often are able to give more accurate information than the client, who may be having active symptoms at the time of assessment and unable to accurately self-report
- Be aware of the cultural attitudes toward mental illness that the family and client many hold
- An observation of functioning and demeanor of the client during the initial interview should be made, with particular attention to possible mood symptoms
- Gather collateral information from family, friends, and other significant relationships regarding the client's functioning in home, work, and social settings, including any recent changes in affect or behavior
- Determine any prior diagnosis of disorders other than bipolar disorder, including substance abuse and unipolar depression
- Assess for alcohol and substance misuse. Such misuse may or may not meet the criteria for diagnosis of substance use disorder, but may nonetheless be significant

› **Relevant Diagnostic Assessments and Screening Tools**

- Screening should be voluntary, confidential, culturally competent, and nondiscriminatory. Screenings should be conducted using valid and reliable tools, appropriate for the age, language, and culture of the client. Adequately trained professionals must administer screening instruments if the tool requires professional administration or scoring. For minors, parental consent is required. Bipolar screening tools do not determine diagnosis, but can alert health and mental health care professionals to issues that may be present, or may help the clinician distinguish between types of bipolar disorders. Accurate screening for bipolar disorder can lead to faster assessment, diagnosis, and referral to treatment services for those in need. The following screening tools may be useful to screen for bipolar disorder (Hoyle et al., 2015; Ladson et al, 2014)
  - Mood Disorder Questionnaire (MDQ): The MDQ is a 17-question,self-report, yes-or-no response tool that can be completed by the client in 5 minutes
  - Hypomania Checklist–32 (HCL-32): The HCL-32 can help identify hypomania in clients with major depression. The HCL-32 is a self-report screening tool that is composed of 32 statements that describe hypomanic or manic scenarios to which the client answers yes or no. The client can complete the HCL-32in 5–10 minutes
  - Bipolar Spectrum Diagnostic Scale (BSDS): The BSDS is a self-report screening tool that can be completed in 5–10minutes. The tool comprises two sections. The first section consists of a paragraph composed of 19 sentences. After each sentence the client checks a box indicating if the sentence was an accurate description of themselves. The second section asks the client to identify how well the overall scenario in the first section describes them
  - Mood Swings Questionnaire (MSQ): The MSQ has both 46- and 27-question versions. The MSQ is a self-report screening tool
  - Composite International Diagnostic Interview screening tool (CIDI). The CIDI was developed by WHO to identify a variety of mental health disorders. It can be either clinically administered or completed by self-report. The questionnaire includes 12 questions and can be completed in 3 to 5 minutes
  - My Mood Monitor (M-3): The M-3 checklist is a screening tool for a variety of mood and anxiety disorders. It comprises 27 questions that can be answered by self-report. Questions 20–27 focus on bipolar disorder

› **Laboratory and Diagnostic Tests of Interest to the Social Worker**

- Drug or alcohol testing to rule out substances as the cause of symptoms
- Genetic counseling, as risk for the development of the disorder is elevated among first-degree relatives
- Testing for other disorders that may cause changes in mood states to rule out medical causes of symptoms

Social Work Treatment Summary

› 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.

› 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) Global Social Work Statement of Ethical Principles (IFSW, 2018), 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 for clinical practice as they apply to bipolar disorders and practice accordingly (NASW, 2021)

› Creating and maintaining a therapeutic alliance with the client is essential, as it allows the social worker to gain important information about the client and enables the client to develop trust in the social worker and a willingness to participate in the treatment process. The client and, when appropriate, their family, should be included in the treatment planning process as much as possible given the clinical presentation of their symptoms and the severity of their mood state

› There is no cure for bipolar disorders; rather, the goals of treatment are to address acute crises, stabilize mood, and prevent relapse. Because of the biological nature of bipolar disorders, psychopharmacology is considered to be the primary means of treatment. Psychotherapy is usually used in conjunction with psychopharmacology rather than as a stand-alone treatment option. Treatment is generally divided into two phases, acute and maintenance, and varies depending on whether the client is experiencing mania, hypomania, or depression

› Address acute crises and stabilize mood

- For clients who are experiencing active manic, hypomanic, or depressive episodes, the goal of treatment is to return the client to the optimal level of psychosocial functioning. This phase of treatment also requires the monitoring and management of high-riskbehaviors such as suicidal ideation, aggression, and extreme impulsivity that are features of manic or depressive episodes in order to ensure client safety and the safety of others. All clients should be assessed for suicidal ideation, including current or past suicidal ideations, plans, or attempts, access to the means of suicide and

the potential lethality of the means, the presence of psychotic symptoms, particularly command hallucinations, and the presence of alcohol or other substance use. The safety of the client is paramount, and may require voluntary or involuntary hospitalization. While most suicidal ideation takes place during a depressive episode, clients experiencing manic episodes may also be in an acute crisis. Clients with ideations of violence toward others and those displaying extremely bad judgment or extremely impulsive behavior that is potentially risky to the client or those around them may also require hospitalization. If the client is maintained in treatment on an outpatient basis, ongoing monitoring should take place. Family members may be of assistance in helping to maintain client safety during active manic episodes by limiting the client's access to vehicles, cell phones, bank accounts, or credit cards that may be misused during this time

- Psychopharmacology is usually the primary treatment approach, with lithium, anticonvulsants,and/or antipsychotic medication being used to treat manic episodes, and mood stabilizers, atypical antipsychotics, and anticonvulsants recommended to treat depressive episodes. Antidepressants should be used with caution because they may trigger a switch from depression to mania and increase the risk for mixed states; when used, they may be combined with a mood stabilizer (Boland et al., 2022)
- Psychotherapy alone should not be used during this phase of treatment unless the client has refused all other forms of treatment and involuntary treatment is not indicated. If used alone, the focus of psychotherapy should be to address resistance to medication or should be crisis-oriented. Electroconvulsive therapy (ECT) has been found to be highly effective in managing mood episodes that have been resistant to other forms of treatment, or if the episode includes psychotic features (Grande et al., 2015)

› Relapse prevention and long-term maintenance treatment

- The chronic nature of bipolar disorders requires ongoing relapse prevention and long-term maintenance. Relapse prevention will usually include pharmacotherapy, psychotherapy, and lifestyle adjustments all designed to maintain the client's optimal level of psychosocial functioning
- Medication for long-term treatment of bipolar disorder often depends in part on whether mania, depression, or both need to be prevented. Mood stabilizers are generally better tolerated, but the antipsychotic aripiprazole may be preferable if mania is predominant whereas the anticonvulsant lamotrigine may be preferable if depression is predominant (Malhi et al., 2020) Lithium has been determined to be the best medication for long-term treatment of bipolar disorder (Geddes & Miklowitz, 2013)
- Psychological treatments may focus on client and family education about early signs of relapse, maintaining regular schedules of sleep and wake cycles, and the importance of medication adherence. Underlying dynamics that may contribute to clients' stress such as marital discord and family dynamics may also be addressed

› Psychotherapy

- Evidence-based approaches that have been found to be effective for promoting treatment adherence, coping skills, and relapse prevention include psychoeducation, family-focused therapy, cognitive-behavioral therapy, and interpersonal and social rhythm therapy (Malhi et al., 2020; Miklowitz et al., 2021)
  - Psychoeducation concerning bipolar disorders, treatment, and maintenance should be provided to clients, as well as their family and friends when appropriate. Group psychoeducation can help the client develop an awareness of symptoms and signs of relapse, help with adherence to psychopharmacology, and promote regular sleep cycles. Group psychoeducation has been found to improve self-efficacy and the internal locus of health control in clients with bipolar disorders (Grabski et al., 2016)
  - Family-focused therapy consists of up to 21 sessions with both the client and their or parents and includes psychoeducation, communication skills training, and problem-solving skills training. The central goal of family-focused therapy is improving family relationships, including decreasing criticism and hostility of family members toward the client,in order to reduce relapse. Family-focused therapy has been found to be particularly useful with adolescents and children with bipolar disorder. It may be effective in reducing relapse even without the client's participation, as family members are educated about the disorder and learn to change their negative reactions toward the client (Geddes & Miklowitz, 2013)
  - Cognitive behavioral therapy is a goal-directed model that focuses on examining the relationships between the individual's thoughts, feelings, and behaviors with the goal of assisting them to modify their patterns of thinking and improve coping. Cognitive behavioral therapy for bipolar disorders typically consists of 20 individual sessions. It is a recommended treatment for acute bipolar depression and for maintenance (Yatham et al., 2018)
  - Interpersonal and social rhythm therapy emphasizes the impact of biological and social rhythms on mood symptoms. Treatment generally consists of 24 individual sessions. Clients are encouraged to maintain regular schedules and regular sleep cycles and learn techniques to managestress. While interpersonal and social rhythm therapy has not been found to help speed time to stabilization, it has been found to reduce the frequency of episodes and improve mood symptoms (Haynes et al., 2016)

› Psychopharmacology

- While prescribing medication is outside the scope of practice for social workers, a basic understanding of the types of medications and their side effects is important to understand: social workers likely will be working in conjunction with psychiatrists or other medical professionals when treating persons with bipolar disorder and will play a role in supporting medication management and compliance. Many medications used to treat bipolar disorders have significant side effects that negatively impact the client's daily life and may result in reluctance to comply with prescribed treatment. Social workers play a role in providing psychoeducation about medications, encouraging compliance, and acting as a liaison between the client and the treating physician when side effects occur
- Anticonvulsants, antipsychotics, and antidepressants are the primary medications used to manage bipolar symptoms and are collectively referred to as mood stabilizers when used to treat manic, hypomanic, and depressive symptoms associated with bipolar disorder. Most of these medications, with the exception of lithium, are used for the treatment of bipolar disorder as an extension of their use for other disorders (e.g., anticonvulsants being used for the treatment of mania as an extension of their use for seizures). While drug combinations will vary, most medications will be used in conjunction with either lithium or valproate. The choice of medication used should take into account the client's primary mood state (e.g., manic, hypomanic, euthymic/stable mood), as treatments will vary according to the symptoms present. Other factors to consider include medical or psychiatric comorbidities, the client's past history of medication use, compliance, side effects, and response to treatments (Grande et al., 2016). Past or current suicidal ideation should be considered, as some medications are lethal if taken in large quantities
- The benefits of medication must be weighed against the presence of or risk for extrapyramidal symptoms (EPS) and other side effects. EPS are side effects that arise from the use of antipsychotic medication. EPS can include tremors, dystonia, restlessness, slurred speech, sedation, sexual dysfunction, tachycardia, and weight gain. The most common EPS is akathisia, which usually occurs early in treatment and is characterized by an inability to sit or stand still and a subjective need to be in constant motion. This may be accompanied by feelings of terror, suicidality, or anxiety. It is important to educate clients and their family members that what they are experiencing is a side effect. Clients with akathisia should be referred back to their treating psychiatrist for an adjustment to their medication regimen
- Acute dystonia is an EPS that usually occurs in persons who have been on antipsychotic medication for many years and in younger clients. It is characterized by bizarre muscle spasms in the neck, head, and tongue. The use of antiparkinson medication can be helpful in alleviating symptoms. All clients with signs of acute dystonia should be referred to their treating psychiatrist
- One of the most serious potential EPS is tardive dyskinesia (TD). TD is involuntary movements of the face (e.g., grimacing), tongue (e.g., tongue thrusting), jaw (e.g., repetitive chewing), or extremities (e.g., finger movements). Early identification of TD is important as TD can become permanent and may worsen even after suspension of the associated medication. Stopping the medication soon after the emergence of TD may cause the symptoms to reverse, so immediate referral back to the treating psychiatrist is imperative
- Medication nonadherence is a significant barrier to successful treatment. Reasons for nonadherence are complex. Clients may be unaware of or in denial about the severity of the illness or may experience stigma related to taking a daily psychotropic medication. Many persons with bipolar disorders have co-occurring substance use disorders that interfere with adherence to a prescribed medication regimen. Clients with bipolar disorders may experience environmental barriers such as lack of access to healthcare services and inability to pay for the medications because of poverty, unemployment, or insurance issues. Many medications have severe and debilitating side effects that discourage adherence. A multidisciplinary team approach is recommended to encourage medication adherence. A team approach allows for the opportunity to not only address clinical issues but to provide assistance in navigating the healthcare system and overcoming environmental obstacles to compliance. Social workers play a key role in providing care coordination, assisting clients in communicating with the treatment team, helping them overcome environmental barriers, and obtaining supportive services
- Below is a list of commonly used medications, including both their generic and (in parentheses) brand names used in the United States, along with a description of their uses and side effects
  - Lithium
    - Lithium has been used for the treatment of bipolar disorder for over 50 years with consistent evidence of long-term efficacy. Lithium is also known to reduce suicidal ideation by up to 50% (Geddes & Miklowitz, 2013). However, its use is not without risk. Lithium has a limited therapeutic range and its use must be closely monitored to ensure both efficacy and safety. Serious side effects can occur if there is a toxic buildup of lithium in the blood, including arrhythmia, low blood pressure, weight gain, cognitive problems (e.g., impaired memory, poor concentration), tremors, sedation, poor coordination, and gastrointestinal distress. Some evidence suggests that long-term use may lead to thyroid, parathyroid, and renal problems (Bobo, 2017). Accidental or intentional overdose with lithium is possible, which should be a consideration for clients with suicidal ideation

– Valproate/Valproic Acid (Depakote)
  - While used as a mood stabilizer for bipolar disorder, valproate is technically an anticonvulsant, used for the treatment of seizure disorders such as epilepsy. Valproate has fewer side effects than lithium and is less lethal if taken in large quantities. Accidental overdoses are uncommon, making it a safer alternative to lithium for some clients. Common side effects include gastrointestinal distress, tremors, and sedation; however, these side effects often resolve with continued use
– Carbamazepine (Tegretol, Atretol)
  - Carbamazepine is an anticonvulsant. Some evidence suggests that carbamazepine may be as effective for the treatment of bipolar disorders as lithium; however, side effects are common and taking carbamazepine may increase the risk of suicidal thoughts and behaviors (NAMI, 2013). Because of this, it is usually used in clients who have not responded well to either lithium or valproate. The most common side effects are double vision, blurred vision, fatigue, nausea, mild rash, decreased blood cell count, and lack of muscle coordination. These side effects often dissipate over time with continued use. Overdose may be fatal after ingesting amounts as low as 6 g. Signs of toxicity include tachycardia, hypotension, impaired consciousness, and convulsions
– Lamotrigine (Lamictal)
  - Lamotrigine is an anticonvulsant that iswell tolerated and effective for treating bipolar depressionin the acute and maintenance phases; it is not recommended for treating mania. Lamotrigine can cause non-serious skin rashes in approximately 10% of individuals and potentially life-threatening skin rashes in 0.3% - 1%; gradual titration can reduce the risk of serious skin rashes (Yatham et al., 2018). If the client develops blistering, hives, or skin rash, they should be referred to their prescribing physician immediately
– Olanzapine (Zyprexa, Zydis)
  - Olanzapine is an antipsychotic medication that is used to treat acute manic symptoms in persons with bipolar disorder. Olanzapine can cause high blood pressure, weight gain, dizziness, muscle spasms, and EPS effects such as involuntary movements, slurred speech, and tardive dyskinesia. If symptoms of tardive dyskinesia are observed in the client, they should be referred to their prescribing physician immediately as these symptoms can become permanent. Symptoms of overdose include drowsiness, confusion, slurred speech, increased heart rate, fainting, uncontrolled muscle movements, and agitation or aggression
– Risperidone (Risperdal)
  - Risperidone is an antipsychotic medication that is used to treat symptoms of mania in bipolar disorder. It is often used for short-term treatment of acute manic symptoms. Side effects include constipation, nausea, dizziness, drowsiness, anxiety, and EPS. As with other antipsychotics, if signs of tardive dyskinesia are evident the client should be referred to their treating physician immediately. Signs of overdose include drowsiness, increased heart rate, fainting, lightheadedness, and involuntary muscle movements
– Aripiprazole (Abilify)
  - Aripiprazole is an antipsychotic used to treat manic symptoms of bipolar disorder. Common side effects include drowsiness, dizziness, salivation, urinary incontinence, weight gain, nausea, and constipation. As with other antipsychotics, symptoms of tardive dyskinesia should result in an immediate reassessment of medication by the client's treating physician
– Clozapine (Clozaril)
  - Clozapine is an antipsychotic medication primarily used to treat schizophrenia or suicidal behavior in persons with schizophrenia. In persons with bipolar disorder it is used to treat manic episodes. Clozapine can cause a reduction in the body's ability to make white blood cells, and thus requires weekly blood draws to monitor this side effect. Other side effects include weight gain, sedation, diabetes, constipation, inflammation of the heart (myocarditis), tremors or rigid muscles, and tardive dyskinesia
– Quetiapine (Seroquel)
  - Quetiapine is a relatively new antipsychotic that has fewer side effects than other antipsychotic medication. Quetiapine may be used for longer-term,maintenance treatment of bipolar disorders, often in conjunction with lithium. Common side effects include dizziness, increased appetite and associated weight gain, dry mouth, and gastrointestinal distress. Despite a lower risk of side effects, overdose is possible and can result in death; symptoms of tardive dyskinesia are possible and should be monitored
– Antidepressants
  - Most practice guidelines recommend that antidepressants should not be used for persons with bipolar disorders unless necessary in cases of severe depression that does not respond to mood stabilizers or antipsychotics(Liu et al., 2017)

- Despite their prevalence of use, evidence for the effectiveness of antidepressants in the treatment of bipolar disorder is mixed. It is therefore recommended that antidepressants never be used in isolation for clients with bipolar disorders, but that they be combined with mood stabilizers (Grande et al., 2016)
  - SSRIs are the class of drugs usually used to treat depression. SSRIs include fluoxetine, sertraline, paroxetine, fluvoxamine, citalopram, and escitalopram. Side effects of SSRIs include gastrointestinal upset, weight gain, and sexual dysfunction. SSRIs can cause migraine or tension headaches to become worse. While the risk of extrapyramidal side effects is low, SSRIs are associated with akathisia, dystonia, parkinsonism, and tardive dyskinesia
  - Monoamine oxidase inhibitors (MAOIs) are used to treat depressive episodes that are severe or that have not responded to other, safer pharmacotherapies. MAOIs include phenelzine, tranylcypromine, isocarboxazid, and selegiline. MAOIs, when combined with certain other drugs or foods, can result in a hypertensive crisis that can be fatal. This reaction may include severe nausea and/or headaches, heart palpitations, and confusion, and may lead to stroke or death. Foods to avoid when taking an MAOI include aged cheeses and meats and fermented products such as beer, red wine, or overripe foods
  - There can be a potentially lethal interaction between SSRIs and MAOIs, so discontinuation of one drug should be followed by a 2-week waiting period before the introduction of another

› Electroconvulsive therapy

• Electroconvulsive therapy (ECT), conducted under general anesthesia, involves sending small electrical currents through the brain, causing a seizure. Six to 12 sessions, 2to 5 days apart, usually are given. ECT has been used successfully to treat mania, bipolar depression, and mixed states (Malhi et al., 2020). In a meta-analysis of 19 articles, investigators found that the response rate to ECT among individuals with bipolar disorder in a depressive episode was 77.1% and the remission rate was 52.3%; individuals with bipolar depression responded faster to ECT treatment and had higher response rates compared with individuals with major depressive disorder (Bahji et al., 2019). A great deal of stigma and controversy continues to exist over the use of ECT, despite the fact that the treatment used today is generally safe. While the amount of electrical stimulation used has decreased significantly since the treatment was introduced in the 1930s, side effects may still occur, including temporary confusion, headaches, nausea, muscle soreness, tachycardia, and permanent memory loss. ECT may be considered if the client has been nonresponsive to other forms of treatment, or for those with psychotic symptoms. ECT is usually used in conjunction with psychotropic medication

Problem	Goal	Intervention
Client is experiencing a manic or hypomanic episode	Stabilize mood, return client to optimal level of psychosocial functioning	Assess risk factors including high-risk behaviors, impulsivity, aggression, and suicidal ideation. Take necessary steps to ensure safety, which may include referral to an inpatient psychiatric facility. Refer to a psychiatrist or other medical professional for psychopharmacological treatment. Monitor side effects of prescribed medications and communicate with treating medical professional if concerns arise. Provide appropriate treatment interventions. Provide support to family members and caregivers

Client is experiencing a depressive episode	Stabilize mood, return client to optimal level of psychosocial functioning	Assess risk factors, including suicidal ideation and lack of self-care. Take necessary steps to ensure safety, which may include referral to an inpatient psychiatric facility. Refer to a psychiatrist or other medical professional for psychopharmacological treatment. Monitor side effects of prescribed medications and communicate with treating medical professional if concerns arise. Provide appropriate therapeutic treatment. Provide support to family members and caregivers
Client is suicidal	Establish safety	Safety planning: Assess to determine whether the client has a plan for how to commit suicide and a means to carry out the plan. If client is in immediate danger of harming themselves, take the necessary steps to initiate an evaluation for psychiatric hospitalization per agency/facility protocol; if client's suicidal ideation is nonspecific and/or client does not have a plan or a means to carry out the plan, provide psychotherapy if qualified or refer client to a qualified mental health professional. Refer client for pharmacological assessment and intervention. Continue to assess client on a regular basis for changes in suicidal status
Client has a bipolar disorder and a substance use disorder	Stabilization of mental health disorder and substance use disorder	Assess treatment priority and treat (or refer for treatment for) predominant disorder first, or treat concurrently if both are unstable. Referral for medical evaluation for detoxification, if necessary, and to a treatment program that specializes in treating both substance use and mental health disorders concurrently
Client is asymptomatic following a manic, hypomanic, or depressive episode	Maintain current level of functioning, reduce risk of relapse	Encourage continuation of medication support as prescribed by treating medical professional. Begin psychosocial interventions, which may include individual, family, or group therapy and psychoeducation for client and their caregivers. Help the client identify lifestyle adjustments that can be made to help support stabilization of mood

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 (National Association of Social Workers, British Association of Social Workers, etc.), and practice accordingly
› Each jurisdiction (e.g., nation, state, province) has its own standards, procedures, and laws for involuntary hospitalization and reporting of suicidal ideation, homicidal ideation, and child maltreatment. Many social workers and healthcare professionals are bound by the "duty to warn," which requires that they inform the proper authorities if a person is found to be a danger to themselves or others. Clinicians should be aware of the policies and procedures laid out in their jurisdiction and practice accordingly
› Social workers should be knowledgeable about limits to confidentiality in the jurisdiction within which they practice

Available Services and Resources

› The National Institute of Mental Health provides an overview of bipolar symptoms, diagnosis, risk factors, and treatments: https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml
› The National Institute of Mental Health also offers educational information specifically about children and adolescents with bipolar disorders:https://www.nimh.nih.gov/health/publications/bipolar-disorder-in-children-and-teens/index.shtml
› The National Alliance on Mental Illness (NAMI) provides information, support, and discussion groups for persons with bipolar disorders and their families:https://www.nami.org/Learn-More/Mental-Health-Conditions/Bipolar-Disorder/Overview
› The American Psychological Association provides articles about bipolar disorders: http://www.apa.org/topics/bipolar/
› The United States Department of Health and Human Services provides information specifically about bipolar disorder in women through the Office on Women's Health: https://www.womenshealth.gov/mental-health/mental-health-conditions/bipolar-disorder-manic-depressive-illness
› National Suicide Prevention Lifeline: 1-800-273-8255, provides free confidential emotional support to persons in emotional distress or suicidal crisis: https://suicidepreventionlifeline.org/
› The Substance Abuse and Mental Health Services Administration provides information for persons seeking treatment for substance use and mental health issues: https://findtreatment.samhsa.gov/
› Depression and Bipolar Support Alliance provides information and resources for clinicians and for clients with bipolar disorder:https://www.dbsalliance.org/

Food for Thought

› In a 2016 study, researchers found that 90% of survey respondents with bipolar disorders reported having at least one comorbid chronic health condition and over 50% reported three or more health conditions. While the presence of comorbid chronic health conditions was associated with the use of mental health services, it was not associated with the use of general healthcare providers. Researchers concluded that collaboration between general health and mental health providers could aid in successful service provision for persons with bipolar disorders and chronic health conditions (Lee & Matejkowski, 2016)

Red Flags

› U.S. FDA reviewed a meta-analysis of 372 randomized clinical trials of antidepressant medications to determine the association between antidepressants and increased suicidal ideation. The analysis showed that there was no clinically significant increased risk for suicidal ideation across age groups but that there was a slight increase in risk for persons ages 18 to 24. This finding led the FDA to issue black-boxed warnings for antidepressants regarding the need for increased monitoring for emerging suicidal ideation among persons being treated with these medications (APA, 2013). Drugs with black-boxed warnings are required to have information about the significant health risks of taking the drug on the label or in package inserts, and the text of the warning must be formatted with a box around it for emphasis
› Pharmacological management of bipolar disorders becomes more complicated during pregnancy; potential impacts of medication on fetal development and childhood outcomes, the impact of pregnancy and postpartum on drug metabolism,and the relative risks of not treating bipolar disorders during pregnancy have to be weighed when making treatment decisions(. Carbamazepine and valproate involve special considerations for women who may become pregnant as both carry a risk of teratogenicity(Goodwin et al., 2016; McAllister-Williams et al., 2017)
› Complex polypharmacy (i.e, treatment involving 4 or more psychotropic medications) is common in patients with bipolardisorders. In one study, researchers found that 21% of inpatients with bipolar disorders received complex

polypharmacy, with the proportion greatest in patients treated for bipolar depression and lowest among patients treated for bipolar mania(Golden et al., 2017)
› Persons with bipolar disorder are at increased risk for suicide. The lifetime prevalence of suicide attempts in persons with bipolar disorder has been estimated to be 34% (Dong et al., 2020), with 6%–7% dying by suicide (Yatham et al., 2018). Suicide risk should be assessed on a regular basis (Yatham et al., 2018)

Discharge Planning

› Clients should not be discharged from services if suicidal ideation or other high-risk behavior is present unless they have been connected to a higher or more appropriate level of care, such as admission to an inpatient psychiatric hospital
› Ensure that clients are aware of confidentiality restrictions related to harm to self or others
› Educate clients and their family members on the signs and symptoms of bipolar disorder, and provide them with community resources should symptoms return or worsen
› Help clients develop informal social supports by encouraging attendance at self-help groups and engagement in social activities
› Educate clients and family members on the need to continue with psychopharmacological therapies even after symptoms have remitted and psychotherapeutic interventions have ended
› If psychopharmacology is discontinued by the treating physician, clients should continue to be monitored periodically over the course of several months for the recurrence of symptoms
› Clients who are receiving psychotherapy should be informed of the plan to end treatment well in advance of the termination and should be included in the planning of the termination process
› Interventions designed to reduce dependence on the social worker or dependence on psychotherapy to manage symptoms should be included as part of treatment well before termination begins in order to help the client build a sense of self-efficacy
› Provide referral when indicated and link client to services
› Provide written information as indicated. Patient information sheets are available from the International Society for Bipolar Disorders, https://www.isbd.org/patients

DSM-5 Codes

› 296.41 – Bipolar Disorder, Mild
› 296.42 – Bipolar Disorder, Moderate
› 296.43- Bipolar Disorder, Severe
› 296.44 – Bipolar Disorder, with psychotic features
› 296.45 – Bipolar Disorder, in partial remission
› 296.46 – Bipolar Disorder, in full remission
› 296.40 – Bipolar Disorder, Unspecified

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