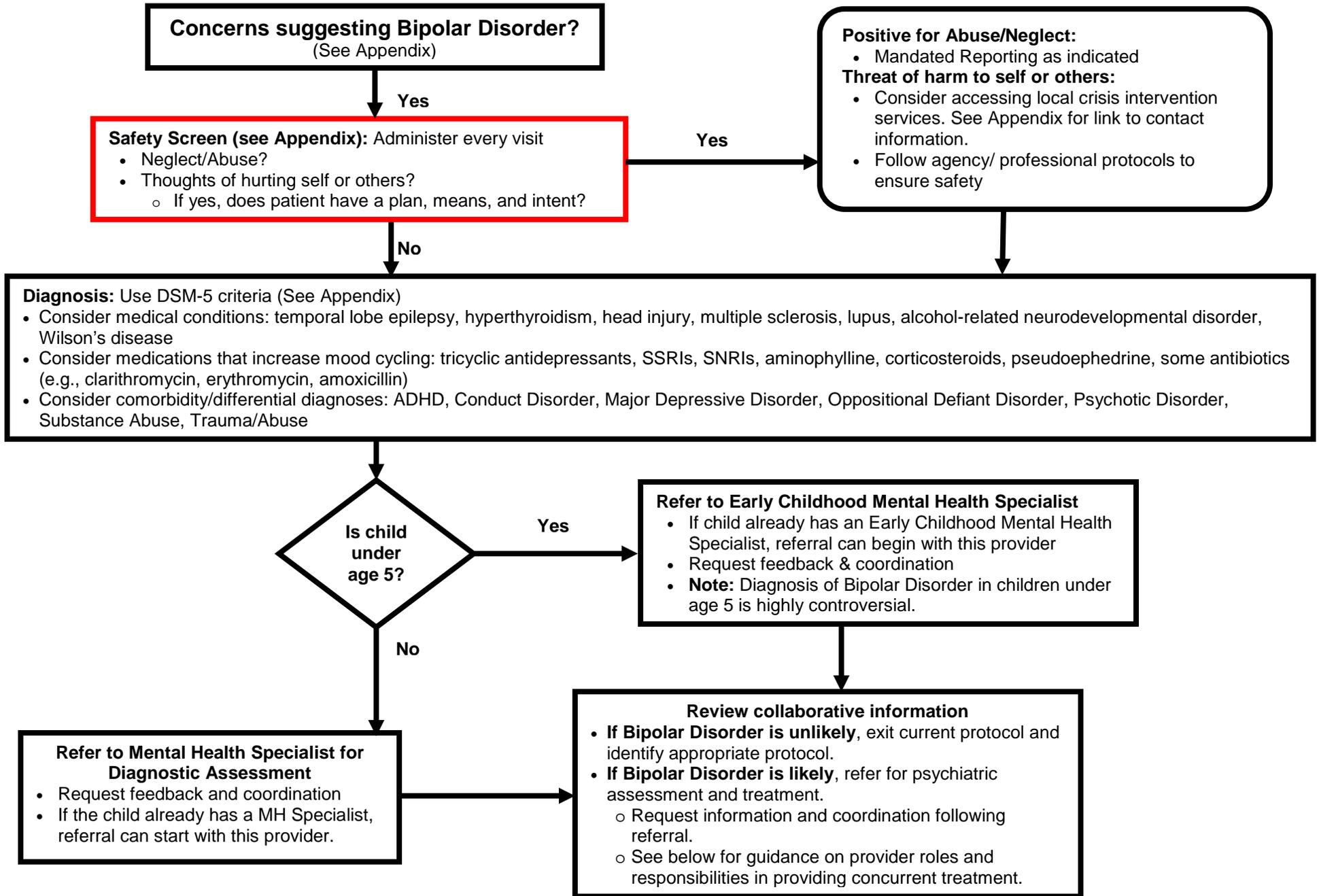


## Bipolar Disorder Assessment & Treatment



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### Primary Care Provider Role in Concurrent Treatment

#### Follow-up appointment:

If safety concerns: 1-3 weeks

- Review collaborative information
- Continue inquiring about mood and behavioral symptoms
- Review safety plan

If therapy referral and no safety concerns: 4-6 weeks

- Review collaborative information
- Continue inquiring about mood and behavioral symptoms

#### Ongoing follow-up appointments once therapy has been established:

Frequency:

- 13-26 weeks until symptoms abate
- Consider comorbidity, safety, and symptom severity in determination of visit frequency

Appointment Content:

- Review collaborative information
- Review symptom presentation
- Continue inquiring about new/additional concerns and safety
- Medications review and monitoring of side effects
- Lab testing or reviewing lab tests from psychiatrist

### Mental Health Specialist Role in Concurrent Treatment

#### Frequency:

- Weekly or bi-weekly at start of treatment
- Decreasing frequency as functioning improves

#### Appointment Content:

- Review symptom presentation
- Continue inquiring about new/additional concerns and safety
- Psychoeducation: refers to the education offered to individuals with a mental health condition and their families to help inform and empower in order to optimize functioning
- Psychotherapy: a general term for treating mental health problems by talking with a mental health provider to learn about the condition, as well as moods, feelings, thoughts, and behaviors

### Psychiatric Specialist Role in Concurrent Treatment

#### Frequency:

- Variable, with decreasing frequency as symptoms abate

#### Appointment Content:

- Review symptom presentation
- Continue inquiring about new/additional concerns and safety
- Medications review and monitoring of side effects
- Lab testing or reviewing lab tests from primary care provider
- Psychoeducation: (see definition under MH specialist role)
- Psychotherapy: (if not being provided by MH specialist; see definition under MH specialist role)

## Bipolar Disorder Assessment & Treatment

### Primary References:

American Academy of Child and Adolescent Psychiatry Official Action (2007) – Practice Parameter for the Assessment and Treatment of Children and Adolescents With Bipolar Disorder.

[http://www.jaacap.com/article/S0890-8567\(09\)61968-7/pdf](http://www.jaacap.com/article/S0890-8567(09)61968-7/pdf)

American Academy of Child and Adolescent Psychiatry Official Action (2009) – Practice Parameter on the Use of Psychotropic Medication in Children and Adolescents. [http://www.jaacap.com/article/S0890-8567\(09\)60156-8/pdf](http://www.jaacap.com/article/S0890-8567(09)60156-8/pdf)

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders (5<sup>th</sup> ed.)*. Washington, DC: Author.

PracticeWise (2015). Evidence-Based Youth Mental Health Services Literature Database.

### Appendix

**Concerns possibly suggesting Bipolar Disorder:** variable moods, short temper, changes in sleep patterns without feeling tired, risky behaviors, impulsivity and concentration problems that are variable within the same setting, rages or extensive temper tantrums, racing thoughts, hypersexuality, suicidal thoughts or behaviors, oversensitivity to environmental stimuli, family history of bipolar disorder

### List of Recommended Screening Tools:

[http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&dDocName=dhs16\\_178591](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&dDocName=dhs16_178591)

### Resources:

American Academy of Child & Adolescent Psychiatry – Bipolar Disorder Resource Center

[https://www.aacap.org/AACAP/Families\\_and\\_Youth/Resource\\_Centers/Bipolar\\_Disorder\\_Resource\\_Center/Home.aspx](https://www.aacap.org/AACAP/Families_and_Youth/Resource_Centers/Bipolar_Disorder_Resource_Center/Home.aspx)

### Safety Screen:

Some questions to assess potential threat of harm to self: Children and adolescents may be asked the following diagnostic questions (Jacobsen et al., 1994).

- “Did you ever feel so upset that you wished you were not alive or wanted to die?”
- “Did you ever do something that you knew was so dangerous that you could get hurt or killed by doing it?”
- “Did you ever hurt yourself or try to hurt yourself?”
- “Did you ever try to kill yourself?”

\*If the threat assessment (i.e., Safety Screen) indicates risk of harm to self or others, educate families on the appropriate care options and safety precautions including removal of firearms from the home and securing all medications, both prescription and over-the-counter.

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**Warning Signs of Suicide:** (Developed by the U.S. Department of Health and Human Services – Substance Abuse and Mental Health Services Administration (SAMHSA; 2011).

These signs may mean someone is at risk for suicide. The risk is greater if a behavior is new or has increased and if it seems related to a painful event, loss, or change.

- Threatening to hurt or kill oneself or talking about wanting to die or kill oneself
- Looking for ways to kill oneself by seeking access to firearms, available pills, or other means
- Talking or writing about death, dying, or suicide when these actions are out of the ordinary for the person
- Feeling hopeless
- Feeling rage or uncontrolled anger or seeking revenge
- Acting recklessly or engaging in risky activities – seemingly without thinking
- Feeling trapped – like there’s no way out
- Increasing alcohol or drug use
- Withdrawing from friends, family, and society
- Feeling anxious, agitated, or unable to sleep or sleeping all the time
- Experiencing dramatic mood changes
- Seeing no reason for living or having no sense of purpose in life

**Minnesota Mental Health Crisis Contact Numbers:** <http://mn.gov/dhs/people-we-serve/people-with-disabilities/health-care/childrens-mental-health/resources/crisis-contacts.jsp>

**Current Evidence-Based Bipolar Disorder Treatments include:** Cognitive Behavior Psychoeducation

**Elements of effective depression treatment include:** activity selection, caregiver coping, cognitive processing, communication skills, maintenance/relapse prevention, problem solving, psychoeducation, and social skills training.

### DSM-5 Bipolar Disorder Criteria:

#### Bipolar I Disorder

- A. Criteria have been met for at least one manic episode (Criteria A-D under “Manic Episode” below).
- B. The occurrence of the manic and major depressive episode(s) is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.

#### Bipolar II Disorder

- A. Criteria have been met for at least one hypomanic episode (Criteria A-F under “Hypomanic Episode” below) and at least one major depressive episode (Criteria A-C under “Major Depressive Episode” below).
- B. There has never been a manic episode.

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- C. The occurrence of the hypomanic episode(s) and major depressive episode(s) is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.
- D. The symptoms of depression or the unpredictability caused by frequent alternation between periods of depression and hypomania causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

For a diagnosis of Bipolar I Disorder, it is necessary to meet the following criteria for a manic episode. The manic episode may have been preceded by and may be followed by hypomanic or major depressive episodes.

### Manic Episode

- A) A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased goal-directed activity or energy, lasting at least 1 week and present most of the day, nearly every day (or any duration if hospitalization is necessary).
- B) During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms (four if the mood is only irritable) are present to a significant degree and represent a noticeable change from usual behavior:
  1. Inflated self-esteem or grandiosity.
  2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep).
  3. More talkative than usual or pressure to keep talking.
  4. Flights of ideas or subjective experience that thoughts are racing.
  5. Distractability (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.
  6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (i.e., purposeless non-goal-directed activity).
  7. Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).
- C) The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalization to prevent harm to self or other, or there are psychotic features.
- D) The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment) or to another medical condition.

**Note:** A full manic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a manic episode and, therefore, a Bipolar I Disorder.

**Note:** Criteria A-D constitute a manic episode. At least one lifetime manic episode is required for the diagnosis of Bipolar I Disorder.

### Hypomanic Episode

- A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least 4 consecutive days and present most of the day, nearly every day.

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- B. During the period of mood disturbance and increased energy and activity, three (or more) of the following symptoms (four if the mood is only irritable) have persisted, represent a noticeable change from usual behavior, and have been present to a significant degree:
1. Inflated self-esteem or grandiosity.
  2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep).
  3. More talkative than usual or pressure to keep talking.
  4. Flight of ideas or subjective experience that thoughts are racing.
  5. Distractability (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.
  6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation.
  7. Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).
- C. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the individual when not symptomatic.
- D. The disturbance in mood and the change in functioning are observable by others.
- E. The episode is not severe enough to cause marked impairment in social or occupational functioning or to necessitate hospitalization. If there are psychotic features, the episode is, by definition, manic.
- F. The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment).
- Note:** A full hypomanic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a hypomanic episode diagnosis. However, caution is indicated so that one or two symptoms (particularly increased irritability, edginess, or agitation following antidepressant use) are not taken as sufficient for diagnosis of a hypomanic episode, nor necessarily indicator of a bipolar diathesis.

**Note:** Criteria A-F constitute a hypomanic episode. Hypomanic episodes are common in bipolar I disorder but are not required for the diagnosis of Bipolar I Disorder.

### Major Depressive Episode

- A. Five (or more) of the following symptoms have been present during the same 2-week period and present a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.
- Note:** Do not include symptoms that are clearly attributable to another medical condition.
1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, or hopeless) or observation made by others (e.g., appears tearful). (**Note:** In children and adolescents, can be irritable mood.)

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2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
  3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (**Note:** In children, consider failure to make expected weight gain.)
  4. Insomnia or hypersomnia nearly every day.
  5. Psychomotor agitation or retardation nearly every day (observable by other; not merely subjective feelings of restlessness or being slowed down).
  6. Fatigue or loss of energy nearly every day.
  7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
  8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
  9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.
- B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- C. The episode is not attributable to the physiological effects of a substance or another medical condition.

**Note:** Criteria A-C constitute a major depressive episode. Major depressive episodes are common in bipolar I disorder but are not required for the diagnosis of bipolar I disorder.

**Note:** Responses to a significant loss (e.g., bereavement, financial ruin, losses from natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss.