

10. Bipolar Disorder

- 10.1. Definition
- 10.2. Diagnosis
- 10.3. Mania
- 10.4. Hypomania

- Bipolar disorder involves extreme mood swings from episodes of mania to episodes of depression. (Bipolar disorder was formerly known as **Manic-depressive illness**.)
- **During manic phases**, clients are euphoric, grandiose, energetic, and sleepless. They have poor judgment and rapid thoughts, actions, and speech.
- **During depressed phases**, mood, behavior, and thoughts are the same as in people diagnosed with major depression.
- In fact, if a person's first episode of bipolar illness is a depressed phase, he or she might be diagnosed with major depression; a diagnosis of bipolar disorder may not be made until the person experiences a manic episode.
- Bipolar disorder ranks second only to major depression as a cause of worldwide disability. The lifetime risk for bipolar disorder is at least 1.2%, with a risk of completed suicide for 15%.
- Young men early in the course of their illness are at highest risk for suicide, especially those with a history of suicide attempts or alcohol abuse as well as those recently discharged from the hospital.
- Whereas a person with major depression slowly slides into depression that can last for 6 months to 2 years, the person with bipolar disorder cycles between depression and normal behavior (bipolar depressed) or mania and normal behavior (bipolar manic).
- A person with bipolar mixed episodes alternates between major depressive and manic episodes interspersed with periods of normal behavior. Each mood may last for weeks or months before the pattern begins to descend or ascend once again. Figure 1 shows the three categories of bipolar cycles.
- Bipolar disorder occurs almost equally among men and women. It is more common in highly educated people. Because some people with bipolar illness deny their mania, prevalence rates may actually be higher than reported.

*** Onset and Clinical Course**

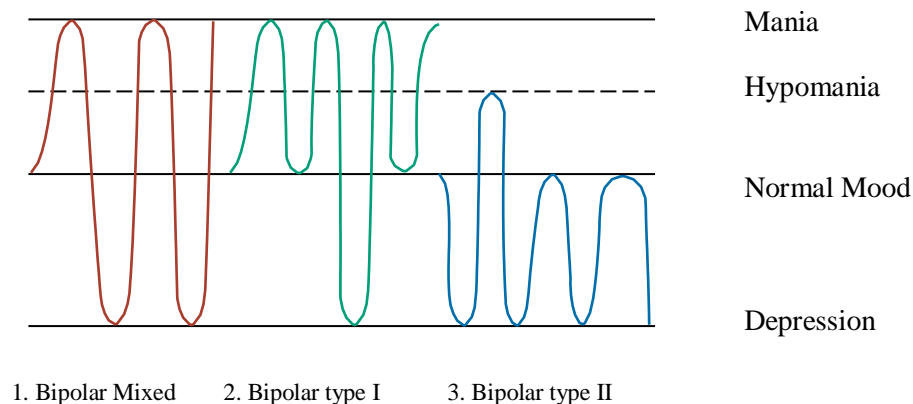
- The mean age for a first manic episode is the early 20s, but some people experience onset in adolescence, whereas others start experiencing symptoms when they are older than 50.
- Manic episodes typically begin suddenly, with rapid escalation of symptoms over a few days, and they last from a few weeks to several months. They tend to be briefer and to end more suddenly than depressive episodes. Adolescents are more likely to have psychotic manifestations.

*** DSM Diagnostic Criteria:**

Typical Symptoms of Mania

- Heightened, grandiose, or agitated mood

- Exaggerated self-esteem
- Sleeplessness
- Pressured speech
- Flight of ideas
- Reduced ability to filter out extraneous stimuli; easily distractible
- Increased number of activities with increased energy
- Multiple, grandiose, high-risk activities, using poor judgment, with severe consequences



1. Bipolar mixed —→ Cycles alternate between periods of mania, normal mood, depression, normal mood, mania, and so forth.
2. Bipolar type I —→ Manic episodes with at least one depressive episode.
3. Bipolar type II —→ Recurrent depressive episodes with at least one hypomanic episode.

Figure 1: Graphic depiction of Mood Cycles

Bipolar Disorder is diagnosed when a person's mood cycles between **extremes of mania and depression**.

* **Mania** is a different period during which mood is abnormally and persistently elevated, expansive, or irritable.

- Typically, this period lasts about **1 week** (unless the person is hospitalized and treated sooner).

- At least three of the following symptoms accompany the manic episode: **exaggerated self-esteem or grandiosity**; **decreased need for sleep**; **pressured speech** (unrelenting, rapid, often loud talking without pauses); **flight of ideas** (racing, often unconnected thoughts); **distractibility**; **increased involvement in goal-directed activity or psychomotor agitation**; and **excessive involvement in pleasure-seeking activities with a high potential for painful consequences**.

- Some people also exhibit delusions and hallucinations during a manic episode.

* **Hypomania** is a period of abnormally and persistently elevated, expansive, or irritable mood lasting **4 days** and including **three or four** of the additional symptoms described earlier.

- The difference is that hypomanic episodes **do not impair the person's ability to function** (in fact, he or she may be quite productive), and there are no psychotic features (delusions and hallucinations).

- A mixed episode is diagnosed when the person experiences both mania and depression nearly every day for at least 1 week. These mixed episodes often are called rapid cycling.

- For the purpose of medical diagnosis, bipolar disorders are described as follows:

* **Bipolar I Disorder:** one or more **manic or mixed episodes** usually accompanied by **major depressive episodes**.

* **Bipolar II Disorder:** one or more **major depressive episodes** accompanied by at least one **hypomanic episode**.

- People with bipolar disorder may experience a euthymic or normal mood and affect between extreme episodes, or they may have a depressed mood swing after a manic episode before returning to a euthymic mood. For some, euthymic periods between extremes are quite short. For others, euthymic period lasts months or even years.

Treatment

*** Psychopharmacology**

- Treatment for bipolar disorder involves a lifetime treatment of medications: either an anti-manic agent called **lithium** or **anticonvulsant medications** used as mood stabilizers. ***This is the only psychiatric disorder in which medications can prevent acute cycles of bipolar behaviour.***

- Once thought to help reduce manic behaviour only, lithium and these anticonvulsants also protect against the effects of bipolar depressive cycles.

- If a client in the acute stage of mania or depression exhibits psychosis (disordered thinking as seen with delusions, hallucinations, and illusions), an antipsychotic agent is administered in addition to the bipolar medications. Some clients keep taking both bipolar medications and antipsychotics.

- **Lithium:** Lithium is a salt contained in the human body; it is similar to gold, copper, magnesium, manganese, and other trace elements. Once believed to be helpful for bipolar mania only, investigators quickly realized that lithium also could partially or completely mute the cycling toward bipolar depression. The response rate in acute mania to lithium therapy is 70% to 80%. In addition to treating the range of bipolar behaviours, lithium also can stabilize bipolar disorder by reducing the degree and frequency of cycling or eliminating manic episodes. (Table 5)

Lithium not only competes for salt receptor sites but also affects calcium, potassium, and magnesium ions as well as glucose metabolism. Its mechanism of action is unknown, but it is thought to work in the synapses to hasten destruction of catecholamines (dopamine, norepinephrine), inhibit neurotransmitter release, and decrease the sensitivity of postsynaptic receptors.

Table 5: Symptoms And Interventions of Lithium Toxicity

Serum Lithium Level	Symptoms of Lithium Toxicity	Interventions
1.5–2 mEq/L	Nausea and vomiting, diarrhoea, reduced coordination, drowsiness, slurred speech, and muscle weakness	Withhold next dose; call physician. Serum lithium levels are ordered and doses of lithium are usually suspended for a few days or the dose is reduced.
2–3 mEq/L	Ataxia, agitation, blurred vision, tinnitus, giddiness, choreoathetoid movements, confusion, muscle fasciculation, hyperreflexia, hypertonic muscles, myoclonic twitches, pruritus, maculopapular rash, movement of limbs, slurred speech, large output of dilute urine, incontinence of bladder or bowel, and vertigo	Withhold future doses, call physician, stat serum lithium level. Gastric lavage may be used to remove oral lithium; IV containing saline and electrolytes used to ensure fluid and electrolyte function and maintain renal function.

3.0 mEq/L and above	Cardiac arrhythmia, hypotension, peripheral vascular collapse, focal or generalized seizures, reduced levels of consciousness from stupor to coma, myoclonic jerks of muscle groups, and spasticity of muscles	All preceding interventions plus lithium ion excretion is augmented with use of aminophylline, mannitol, or urea. Hemodialysis may also be used to remove lithium from the body. Respiratory, circulatory, thyroid, and immune systems are monitored and assisted as needed.
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Lithium's action peaks in 30 minutes to 4 hours for regular forms and in 4 to 6 hours for the slow-release form. It crosses the blood–brain barrier and placenta and is distributed in sweat and breast milk. Lithium use during pregnancy is not recommended because it can lead to first-trimester developmental abnormalities. Onset of action is 5 to 14 days; with this lag period, antipsychotic or antidepressant agents are used carefully in combination with lithium to reduce symptoms in acutely manic or acutely depressed clients. The half-life of lithium is 20 to 27 hours.

*** Anticonvulsant Drugs:** Lithium is effective in about 75% of people with bipolar illness. The rest do not respond or have difficulty taking lithium because of side effects, problems with the treatment regimen, drug interactions, or medical conditions such as renal disease that contraindicate use of lithium. Several anticonvulsants traditionally used to treat seizure disorders have proved helpful in stabilizing the moods of people with bipolar illness. These drugs are categorized as miscellaneous anticonvulsants. Their mechanism of action is largely unknown, but they may raise the brain's threshold for dealing with stimulation; this prevents the person from being bombarded with external and internal stimuli.

1. Carbamazepine (Tegretol), which had been used for grand mal and temporal lobe epilepsy as well as for trigeminal neuralgia, was the first anticonvulsant found to have mood-stabilizing properties, but the threat of agranulocytosis was of great concern. Clients taking carbamazepine need to have drug serum levels checked regularly to monitor for toxicity and to determine whether the drug has reached therapeutic levels, which are generally 4 to 12 µg/ mL. Baseline and periodic laboratory testing must also be done to monitor for suppression of white blood cells.

2. Valproic acid (Depakote), also known as divalproex sodium or sodium valproate, is an anticonvulsant used for simple absence and mixed seizures, migraine prophylaxis, and mania. The mechanism of action is unclear. Therapeutic levels are monitored periodically to remain at 50 to 125 µg/mL, as are baseline and ongoing liver function tests, including serum ammonia levels and platelet and bleeding times.

3. Gabapentin (Neurontin), lamotrigine (Lamictal), and topiramate (Topamax) are other anticonvulsants sometimes used as mood stabilizers, but they are used less frequently than valproic acid. Value ranges for therapeutic levels are not established.

4. Clonazepam (Klonopin) is an anticonvulsant and a benzodiazepine (a schedule IV controlled substance) used in simple absence and minor motor seizures, panic disorder, and bipolar disorder. Physiologic dependence can develop with long-term use. This drug may be used in lithium or other mood stabilizers but is not used alone to manage bipolar disorder. (Table 6)

Table 6: Anticonvulsants used as Mood Stabilizers

Generic (Trade) Name	Side Effects	Nursing Implications
Carbamazepine (Tegretol)	Dizziness, hypotension, ataxia, sedation, blurred vision, leukopenia, and rashes	Assist client to rise slowly from sitting position. Monitor gait and assist as necessary. Report rashes to physician.
Divalproex (Depakote)	Ataxia, drowsiness, weakness, fatigue, menstrual changes, dyspepsia, nausea, vomiting, weight gain, and hair loss	Monitor gait and assist as necessary. Provide rest periods. Give with food. Establish balanced nutrition.

Gabapentin (Neurontin)	Dizziness, hypotension, ataxia, coordination, sedation, headache, fatigue, nystagmus, nausea, and vomiting	Assist client to rise slowly from sitting position. Provide rest periods. Give with food.
Lamotrigine (Lamictal)	Dizziness, hypotension, ataxia, coordination, sedation, headache, weakness, fatigue, menstrual changes, sore throat, flu-like symptoms, blurred or double vision, nausea, vomiting, and rashes	Assist client to rise slowly from sitting position. Monitor gait and assist as necessary. Provide rest periods. Monitor physical health. Give with food. Report rashes to physician.
Topiramate (Topamax)	Dizziness, hypotension, anxiety, ataxia, incoordination, confusion, sedation, slurred speech, tremor, weakness, blurred or double vision, anorexia, nausea, and vomiting	Assist client to rise slowly from sitting position. Monitor gait and assist as necessary. Orient client. Protect client from potential injury. Give with food.
Oxcarbazepine (Trileptal)	Dizziness, fatigue, ataxia, confusion, nausea, vomiting, anorexia, headache, tremor, confusion, and rashes	Assist client to rise slowly from sitting position. Monitor gait and assist as necessary. Give with food. Orient client and protect from injury. Report rashes to physician.

Psychotherapy

Psychotherapy can be useful in the mildly depressive or normal portion of the bipolar cycle. It is not useful during acute manic stages because the person's attention span is brief and he or she can gain little insight during times of accelerated psychomotor activity. Psychotherapy combined with medication can reduce the risk for suicide and injury, provide support to the client and family, and help the client to accept the diagnosis and treatment plan.

*** Nursing Interventions for Mania**

- Provide for client's physical safety and those around.
- Set limits on client's behaviour when needed.
- Remind the client to respect distances between self and others.
- Use short, simple sentences to communicate.
- Clarify the meaning of client's communication.
- Frequently provide finger foods that are high in calories and protein.
- Promote rest and sleep.
- Protect the client's dignity when inappropriate behaviour occurs.
- Channel client's need for movement into socially acceptable motor activities.

*** Client Family Education for Mania**

- Teach about bipolar illness and ways to manage the disorder.
- Teach about medication management, including the need for periodic blood work and management of side effects.
- For clients taking lithium, teach about the need for adequate salt and fluid intake.
- Teach the client and family about signs of toxicity and the need to seek medical attention immediately.
- Educate the client and family about risk-taking behaviour and how to avoid it.
- Teach about behavioural signs of relapse and how to seek treatment in early stages.

❖ Nursing Intervention for Bipolar Disorder

1- During Manic phase

- Decrease environmental stimuli, to promote relaxation and enable to sleep
- Monitor drug level, especially lithium
- Ensure safe environment to protect the client

- Define and explain acceptable behaviours and then set limits
- If a mood swing to depression, implement suicide precaution for client
- Channel the client's energy in one direction and pace activities, to decrease client's energy expenditure, prevent overstimulation and have soothing effect

2- During Depressive phase

- Assess the risk of suicide and formulate a safety contract with client
- Assess the level and intensity of client's depression to obtain baseline information
- Ensure a safe environment to client to protect from self-inflicted harm
- Encourage the client to identify current problems and stressors, so that can begin with therapeutic treatment
- Select activities that ensure success and accomplishment to increase self esteem
- Spend time with the client, even if he's too depressed to talk, in order to enhance therapeutic relationship
- Help the client to modify negative expectations and think more positively
- Promote opportunities for increased involvement in activities through a structured and daily program
- Observe the client for medication compliance and adverse effect

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