BIPOLAR DISORDER—MANIA

BEHAVIORAL DEFINITIONS

1. Exhibits an abnormally and persistently elevated, expansive, or irritable mood with at least three symptoms of mania (i.e., inflated self-esteem or grandiosity, decreased need for sleep, pressured speech, flight of ideas, distractibility, excessive goal-directed activity or psychomotor agitation, excessive involvement in pleasurable, high-risk behavior).
2. The elevated mood or irritability (mania) causes marked impairment in occupational functioning, social activities, or relationships with others.
3. Demonstrates loquaciousness or pressured speech.
4. Reports flight of ideas or thoughts racing.
5. Verbalizes grandiose ideas and/or persecutory beliefs.
6. Shows evidence of a decreased need for sleep.
7. Reports little or no appetite.
8. Exhibits increased motor activity or agitation.
9. Displays a poor attention span and is easily distracted.
10. Loss of normal inhibition leads to impulsive and excessive pleasure-oriented behavior without regard for painful consequences.
11. Engages in bizarre dress and grooming patterns.
12. Exhibits an expansive mood that can easily turn to impatience and irritable anger if goal-oriented behavior is blocked or confronted.
13. Lacks follow-through in projects, even though energy is very high, since behavior lacks discipline and goal-directedness.

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LONG-TERM GOALS

1. Alleviate manic/hypomanic mood and return to previous level of effective functioning.
2. Normalize energy level and return to usual activities, good judgment, stable mood, more realistic expectations, and goal-directed behavior.
3. Reduce agitation, impulsivity, and pressured speech while achieving sensitivity to the consequences of behavior and having more realistic expectations.
4. Achieve controlled behavior, moderated mood, more deliberative speech and thought process, and a stable daily activity pattern.
5. Develop healthy cognitive patterns and beliefs about self and the world that lead to alleviation and help prevent the relapse of manic/hypomanic episodes.
6. Talk about underlying feelings of low self-esteem or guilt and fears of rejection, dependency, and abandonment.

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SHORT-TERM OBJECTIVES

1. Describe mood state, energy level, amount of control over thoughts, and sleeping pattern. (1, 2)

THERAPEUTIC INTERVENTIONS

1. Encourage the client to share his/her thoughts and feelings; express empathy, and build rapport while assessing primary cognitive, behavioral, interpersonal, or other symptoms of the mood disorder.
2. Assess presence, severity, and impact of past and present mood episodes including mania (i.e., pressured speech, impulsive behavior, euphoric mood, flight of ideas, reduced need for sleep, inflated self-esteem, and high energy) on social, occupational, and interpersonal functioning;

supplement with semi-structured inventory, if desired (e.g., *Young Mania Rating Scale;* the *Clinical Monitoring Form*); readminister as indicated to assess treatment response.

2. Complete psychological testing to assess the nature and impact of mood problems. (3)

3. Arrange for the administration of an objective instrument(s) for evaluating relevant features of the bipolar disorder such as communication patterns with family/significant others, particularly expressed emotion (e.g., *Perceived Criticism Measure*); evaluate the results and process feedback with the client or client and family.

3. Disclose any history of substance use that may contribute to and complicate the treatment of bipolar mania. (4)

4. Arrange for a substance abuse evaluation and refer the client for treatment if the evaluation recommends it (see the Substance Use chapter in this *Planner*).

4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (5, 6, 7, 8)

5. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).

6. Assess the client for evidence of research-based correlated disorders (e.g., oppositional

defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).

7. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.

8. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).

5. Cooperate with a medical/ psychiatric evaluation for medication needs and possible hospitalization to stabilize symptoms. (9, 10)

9. Arrange for or continue hospitalization if the client is judged to be potentially harmful to self or others, unable to care for his/her own basic needs, or symptom severity warrants it.

10. Arrange for a medication evaluation with a psychiatrist to determine appropriate pharmacotherapy (e.g., lithium carbonate, Depakote, Lamictal).

6. Take prescribed medications as directed. (11, 12)

11. Monitor the client for use and effectiveness of psychotropic

medication (e.g., compliance, side effects, and effectiveness).

12. Continually evaluate the client's compliance with the psychotropic medication prescription.

7. Achieve a level of symptom stability that allows for meaningful participation in psychotherapy. (13)

13. Monitor the client's symptom improvement toward stabilization sufficient to allow participation in individual or group psychotherapy.

8. Verbalize an understanding of the causes for, symptoms of, and treatment of manic, hypomanic, and/or mixed episodes. (14, 15, 16)

14. Provide psychoeducation to the client and family, using all modalities necessary, including reviewing the signs, symptoms, and phasic relapsing nature of the client's manic mood episodes; destigmatize and normalize (see *Psychoeducation Manual for Bipolar Disorder* by Colom and Vieta).

15. Teach the client a stress diathesis model of bipolar disorder that emphasizes the strong role of a biological predisposition to mood episodes that is vulnerable to stresses that are manageable and the need for medication compliance.

16. Provide the client with a rationale for treatment involving ongoing medication and psychosocial treatment to recognize, manage, and reduce biological and psychological vulnerabilities that could precipitate relapse.

9. Verbalize acceptance of the need to take psychotropic medication and commit to prescription compliance with blood level monitoring. (17, 18)

17. Educate the client about the importance of medication compliance; teach him/her the risk for relapse when medication is discontinued, and work toward a commitment to prescription adherence.

18. Assess factors (e.g., thoughts, feelings, stressors) that have precipitated the client's prescription noncompliance; develop a plan for recognizing and addressing them (or assign "Why I Dislike Taking My Medication" in the *Adult Psychotherapy Homework Planner* by Jongsma). EBT

EBT 10. Attend group psychoeducational sessions designed to inform members of the nature, causes, and treatment of bipolar disorder. (19, 20)

19. Conduct or refer client to a group psychoeducation program that teaches clients the psychological, biological, and social influences in development of BPD, its biological and psychological treatment (see *Structured Group Psychotherapy for Bipolar Disorder* by Bauer and McBride; *Psychoeducation Manual for Bipolar Disorder* by Colom and Vieta). EBT

20. Teach the group members illness management skills (e.g., early warning signs, common triggers, coping strategies), problem-solving focused on life goals, and a personal care plan that emphasizes a regular sleep routine, the need to comply with medication, and ways to minimize relapse through stress regulation. EBT

EBT 11. Identify and replace thoughts and behaviors that trigger manic or depressive symptoms. (21, 22, 23)

21. Use cognitive therapy techniques to explore and educate the client's about cognitive biases that trigger his/her elevated or depressive mood (see *Cognitive Therapy for Bipolar Disorder* by Lam et al.). EBT

22. Assign the client a homework exercise in which he/she identifies self-talk reflective of mania, biases

in the self-talk, alternatives (or assign "Journal and Replace Self-Defeating Thoughts" in the *Adult Psychotherapy Homework Planner* by Jongsma); review and reinforce success, providing corrective feedback toward improvement. EBT

23. Teach the client cognitive behavioral coping and relapse prevention skills including delaying impulsive actions, structured scheduling of daily activities, keeping a regular sleep routine, avoiding unrealistic goal striving, using relaxation procedures, identifying and avoiding episode triggers such as stimulant drug use, alcohol consumption, breaking sleep routine, or exposing self to high stress (see *Cognitive Therapy for Bipolar Disorder* by Lam et al.). EBT

12. Client and family members verbalize an understanding of bipolar disorder, factors that influence it, and the role of medication and therapy. (24, 25)

24. Conduct Family-Focused Treatment with the client and significant others beginning with psychoeducation emphasizing the biological nature of bipolar disorder, the need for medication and medication adherence, risk factors for relapse such as personal and interpersonal triggers, and the importance of effective communication, problem-solving, and early episode intervention (see *Bipolar Disorder* by Miklowitz and Goldstein).

25. Assess and educate the client and family about the role of aversive communication (e.g., high expressed emotion) in family distress and risk for the client's relapse.

13. Family members implement skills that help manage the client's bipolar disorder and improve the quality of life of the family and its members. (26, 27, 28, 29)

26. Use cognitive-behavioral techniques (education, modeling, role-playing, corrective feedback, and positive reinforcement) to teach family members communication skills, including offering positive feedback, active listening, making positive requests of others for behavior change, and giving constructive feedback in an honest and respectful manner.

27. Assist the client and family in identifying conflicts that can be addressed with problem-solving techniques.

28. Use cognitive-behavioral techniques (education, modeling, role-playing, corrective feedback, and positive reinforcement) to teach the client and family problem-solving skills, including defining the problem constructively and specifically, brainstorming solution options, evaluating the pros and cons of each option, choosing an option and implementing a plan, evaluating the results, and adjusting the plan.

29. Assign the client and family homework exercises to use and record use of newly learned communication and problem-solving skills (or assign "Plan Before Acting" or "Problem-Solving: An Alternative to Impulsive Action" in the *Adult Psychotherapy Homework Planner* by Jongsma); process results in session toward effective use; problem-solve obstacles.

14. Develop a "relapse drill" in which roles, responsibilities, and a course of action is agreed upon

30. Help the client and family draw up a "relapse drill" detailing roles and responsibilities

in the event that signs of relapse emerge. (30)

(e.g., who will call a meeting of the family to problem-solve potential relapse; who will call the client's physician, schedule a serum level to be taken, or contact emergency services, if needed); problem-solve obstacles and work toward a commitment to adherence with the plan.

15. Maintain a pattern of regular rhythm to daily activities. (31, 32, 33, 34)

31. Conduct Interpersonal and Social Rhythm Therapy beginning with the assessment of the client's daily activities using an interview and the Social Rhythm Metric (see *Treating Bipolar Disorder* by Frank).

32. Assist the client in establishing a more routine pattern of daily activities such as sleeping, eating, solitary and social activities, and exercise; use and review a form to schedule, assess, and modify these activities so that they occur in a predictable rhythm every day.

33. Teach the client about the importance of good sleep hygiene (or assign "Sleep Pattern Record" in the *Adult Psychotherapy Homework Planner* by Jongsma); assess and intervene accordingly (see the Sleep Disturbance chapter in this *Planner*).

34. Engage the client in a balanced schedule of "behavioral activation" by scheduling rewarding activities while not over-stimulating (see "Identify and Schedule Pleasant Activities" in the *Adult Psychotherapy Homework Planner* by Jongsma); use activity and mood monitoring

to facilitate an optimal balance of activity; reinforce success.

16. Discuss and resolve troubling personal and interpersonal issues. (35, 36, 37)

17. Participate in periodic "maintenance" sessions. (38)

18. Increase understanding of bipolar illness by reading a book on the disorder. (39)

35. Conduct the interpersonal component of Interpersonal and Social Rhythm Therapy beginning with the assessment of the client's current and past significant relationships; assess for themes related to grief, interpersonal role disputes, interpersonal role transitions, and interpersonal skills deficits.

36. Use interpersonal therapy techniques to explore and resolve issues surrounding grief, role disputes, role transitions, and social skills deficits; provide support and strategies for resolving identified interpersonal issues.

37. Establish a "rescue protocol" with the client and significant others to identify and manage clinical deterioration; include medication use, sleep pattern restoration, maintaining a daily routine, and conflict-free social support.

38. Hold periodic "maintenance" sessions within the first few months after therapy to facilitate the client's positive changes; problem-solve obstacles to improvement.

39. Ask the client to read a book on bipolar disorder to reinforce psychoeducation done in session (e.g., *The Bipolar Disorder Survival Guide* by Miklowitz; *Bipolar 101: A Practical Guide to Identifying Triggers, Managing Medications, Coping with Symptoms, and More* by White

and Preston); review and process concepts learned through the reading.

19. Differentiate between real and imagined losses, rejections, and abandonments. (40, 41, 42)

40. Pledge to be there consistently to help, listen to, and support the client.

41. Explore the client's fears of abandonment by sources of love and nurturance.

42. Help the client differentiate between real and imagined, actual and exaggerated losses.

20. Verbalize grief, fear, and anger regarding real or imagined losses in life. (43, 44)

43. Probe real or perceived losses in the client's life.

44. Review ways for the client to replace the losses and put them in perspective.

21. Acknowledge the low self-esteem and fear of rejection that underlie the braggadocio. (45, 46)

45. Probe the causes for the client's low self-esteem and abandonment fears in the family-of-origin history.

46. Confront the client's grandiosity and demandingness gradually but firmly; emphasize his/her good qualities (or assign "What Are My Good Qualities?" or "Acknowledging My Strengths" in the *Adult Psychotherapy Homework Planner* by Jongsma).

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	296.xx	Bipolar I Disorder
	296.89	Bipolar II Disorder
	301.13	Cyclothymic Disorder
	295.70	Schizoaffective Disorder
	296.80	Bipolar Disorder NOS
	310.1	Personality Change Due to Axis III Disorder
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Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
296.xx	F31.1x	Bipolar I Disorder, Manic
296.89	F31.81	Bipolar II Disorder
301.13	F34.0	Cyclothymic Disorder
295.70	F25.0	Schizoaffective Disorder, Bipolar Type
296.80	F31.9	Unspecified Bipolar and Related Disorder
310.1	F07.0	Personality Change Due to Another Medical Condition

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

EB indicates that the Objective/Intervention is consistent with those found in evidence-based treatments.