Bipolar Disorder

HCBN6102

Knowledge for Nursing Practice 2: Mental Health and Addictions

2024

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Institute of Technology
TE WHARE WĀNANGA O WAIRAKA

Objectives

- Understand what a mood disorder is
- Distinguish between mood disorders
- Recognise potential nursing interventions
- Recognise medication options and side effects/ considerations

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Karakia tīmatanga
(opening prayer)

Manawa mai te mauri nuku
Manawa mai te mauri rangi
Ko te mauri kai au,
He mauri tipua
Ka pakaru mai te pō
Tau mai te mauri
Haumi ē! Hui ē! Taiki ē!

Embrace the life force of the earth
Embrace the life force of the sky
The life force I have gathered is powerful
And shatters all darkness
Come great life force
Join it, gather it, it is done!

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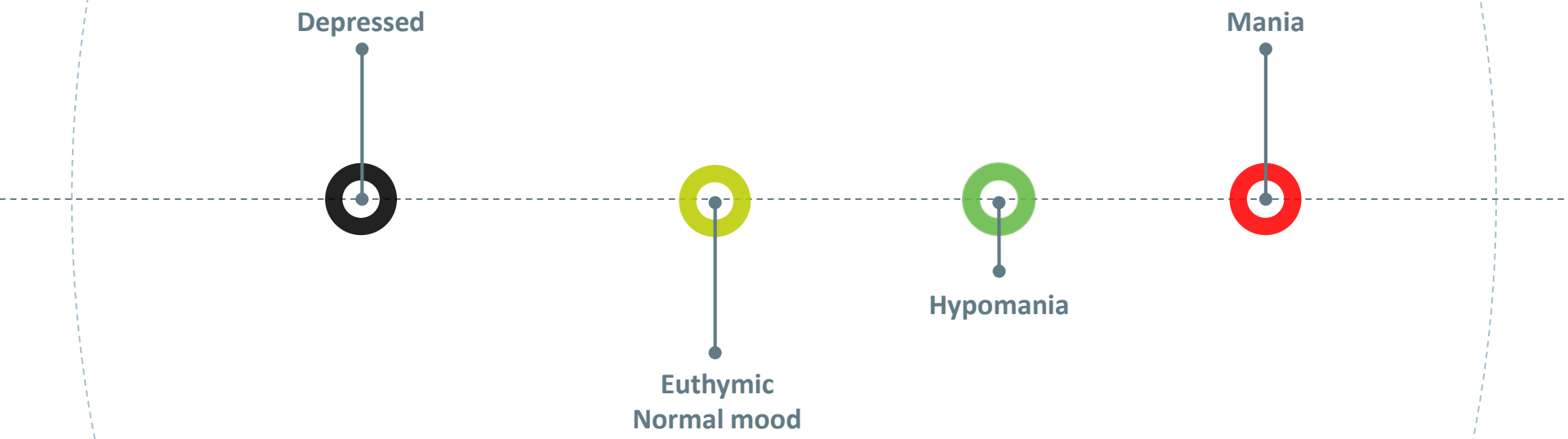
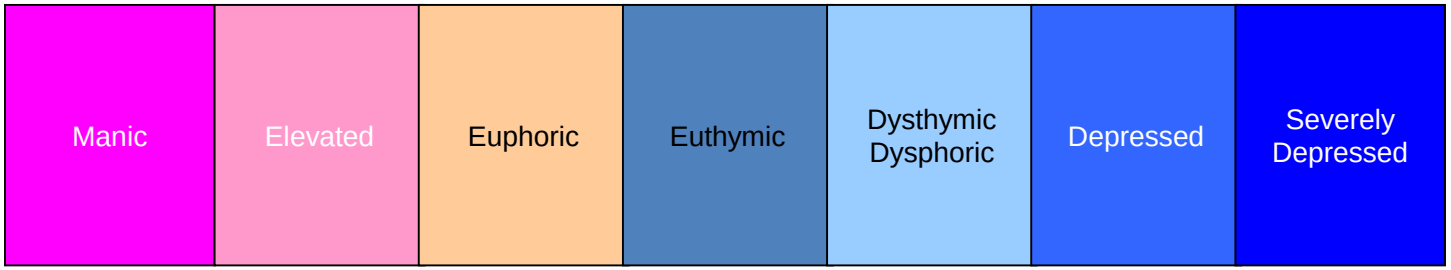
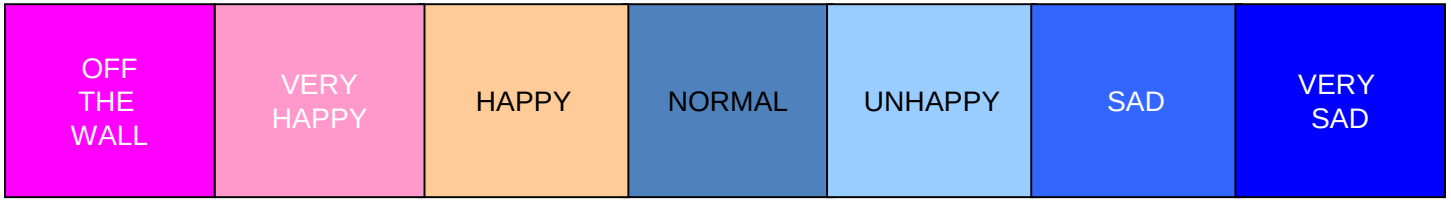
Mood cycles explained



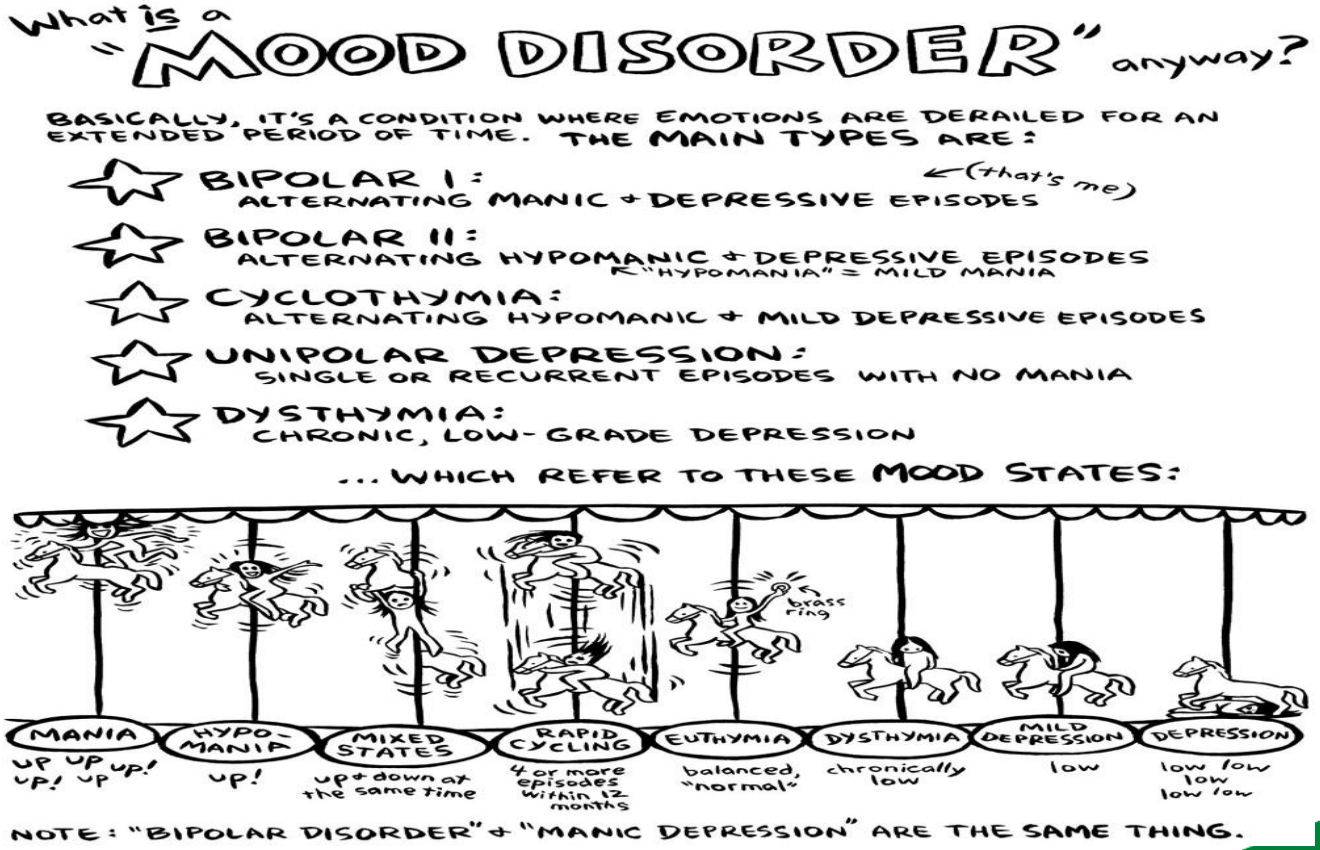
Psychiatric terms

A: Affect/ mood





Quick Guide



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What is a mood disorder?

- Fluctuations in emotions that are manifested by depression, mania or both (or to lesser extent)
- Interferes with individual functioning
- Mood disorders strongly associated with suicide
- Depression is one of the most important risk factors for it

What is Mania?

- Mania (manic syndrome), a state of abnormally elevated arousal, affect, and energy level, or "a state of heightened overall activation with enhanced affective expression together with lability of affect”
- Mania is often conceived as a "mirror image" to depression
- The heightened mood can be either euphoric or irritable; as the mania intensifies, irritability can be more pronounced and result in violence, or anxiety[6].
- Examples: inflated self-esteem, grandiosity, decreased need for sleep (e.g., feels rested after 3 hours of sleep). More talkative than usual, flights of ideas, experience that thoughts are racing, increase psychomotor acceleration, distractibility (too easily drawn to unimportant or irrelevant external stimuli) and excessive involvement in activities

Aetiology

Genetic Factors:

Studies suggest a strong genetic component, with estimates of heritability ranging from 60% to 80%. If one parent has bipolar disorder, there is a 10–25% chance that his or her child will develop the illness.

Neurobiological Factors:

Alterations in the functioning of neurotransmitters like dopamine, serotonin, and norepinephrine are thought to play a role in bipolar disorder.

Stressful Life Events: High levels of stress, trauma, or significant life changes can trigger the onset or recurrence of bipolar episodes.

Substance Abuse: Substance misuse, especially stimulants or drugs that affect mood, can exacerbate symptoms and increase the risk of bipolar disorder.

Biological Rhythms: Dysregulation of circadian rhythms, including sleep disturbances and disruptions in the sleep-wake cycle, is associated with bipolar disorder.

Medication: Use of steroids

Healthify Bipolar Disorder

Prevalence

- First episodes tend to occur in people under 25 years of age.
- The estimated prevalence of bipolar disorder in New Zealand is approximately 1% to 2% of the population.
- Globally, the estimated lifetime prevalence of bipolar disorder ranges from 0.6% to 1.2% of the population.
- In 2019, 40 million people experienced bipolar disorder

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Bipolar Disorders I DSM 5

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For a diagnosis of Bipolar I Disorder”
At **least one manic episode (**a distinct period of abnormally and persistently elevated, expansive, or irritable mood and increased energy or activity that lasts for **at least one week** (or any duration if hospitalization is necessary).
May have **depression**

Must experience 3+ of :

- Inflated self-esteem or grandiosity.
- Decreased need for sleep (feeling rested after very little sleep).
- More talkative than usual or pressure to keep talking.
- Flight of ideas or racing thoughts.
- Distractibility (easily drawn to irrelevant or unimportant stimuli).
- Increased goal-directed activity or psychomotor agitation.
- Excessive involvement in pleasurable activities with a high potential for painful consequences (e.g., reckless behavior, excessive spending, sexual indiscretions)

Bipolar Disorders I DSM 5

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a) The occurrence of the manic episode cannot be better explained by another medical condition, substance use, or medication side effects.

b) The manic episode may be preceded or followed by a major depressive episode, a hypomanic episode, or a depressive episode. These episodes are not required for the diagnosis but often co-occur with the manic episode.

Bipolar Disorders II DSM 5

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- Bipolar II Disorder (**After one or more hypomanic episode and one major depressive episode)**
- A. hypomanic episode is a distinct period of abnormally and persistently elevated, expansive, or irritable mood and increased energy or activity that lasts for at least four consecutive days.
- B. During the hypomanic episode, the individual must experience 3+ of the following symptoms (four if mood is only irritable) and represent a noticeable change from their usual behavior:

- Inflated self-esteem or grandiosity.
- Decreased need for sleep (feeling rested after very little sleep).
- More talkative than usual or pressure to keep talking.
- Flight of ideas or racing thoughts.
- Distractibility (easily drawn to irrelevant or unimportant stimuli).
- Increased goal-directed activity or psychomotor agitation.
- Excessive involvement in pleasurable activities with a high potential for painful consequences (e.g., reckless behavior, excessive spending, sexual indiscretions).

Bipolar Disorders II DSM 5

- C. The occurrence of the hypomanic episode(s) and major depressive episode(s) cannot be better explained by another medical condition, substance use, or medication side effects. The symptoms should not be attributable to another mental disorder.

- D. The hypomanic episode(s) and major depressive episode(s) are associated with a noticeable change in functioning but do not typically cause severe impairment in social or occupational functioning. Bipolar I Disorder, which involves full-blown manic episodes, Bipolar II Disorder involves hypomanic episodes, which are less intense.

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Schizophrenia

- Patients with schizophrenia have been observed to demonstrate mania-like symptoms including over-activity and goal-directed behaviour among people with the non-paranoid subtype of schizoaffective disorder (undifferentiated and disorganized).[12]
- BD subjects exhibit increases in the amount of locomotor activity when compared to SCZ patients.
- Consequently, differential diagnosis between BD and Schizoaffective disorder is difficult due to "overlapping boundaries with regard to symptomatology" (Lindenmayer et al., 1995).

Cyclothymia

- Cyclothymia can be described as mild chronic bipolar affective disorder and is characterised by numerous episodes of mild elation and mild depressive symptoms that are not sufficiently severe or prolonged to meet the criteria for bipolar depression or recurrent depressive disorder.
- Cyclothymia usually develops in early adult life and is more common in the relatives of bipolar disorder patients. 15–50% of cases progresses to bipolar affective disorder
- Cyclothymia causes mood changes – from feeling low to emotional highs. It has many similarities to bipolar disorder. But high risk of developing bipolar disorder.
- Men and women of any age can get cyclothymia, but it's more common in women.

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Assessment Tools

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Bipolar Disorder Self Assessment Tool

Young Mania Rating Scale

Mental State Examination in Bipolar

- **Appearance:** Colourful clothing, unusual combinations of clothing, too much make-up
- **Behaviour :** Hyperactive, entertaining, flirtatious, hypervigilant, assertive, aggressive
- **Speech:** Pressured speech, neologisms, clang associations
- **Mood/affect** : Euphoric, irritable, labile
- **Thought:** Optimistic, self-confident, grandiose, pressure of thought, flight of ideas, loosening of associations, circumstantiality, tangentiality, mood-congruent delusions or less commonly mood-incongruent delusions
- **Perception:** Hallucinations
- **Cognition:** Poor concentration but intact memory and abstract thinking
- **Insight:** Very poor insight

>Ray Jauny

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Pharmacological Treatment

- Lamotrogine
- Mood stabilisers (Lithium)
- Anticonvulsants (Sodium valproate)
- Antipsychotic IMI

Lamotrogine Associated Rash

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Pharmacological Treatment

Treatment for depression with antidepressants alone can have serious consequences for patients with bipolar disorder

- If an antidepressant is prescribed to a patient with bipolar disorder it is usually in combination with a mood stabiliser, e.g. lithium to reduce the risk of a swing to mania (Page 13 Bpac NZ)

- A study of over 3000 patients with bipolar disorder treated with antidepressant monotherapy shows and increased risk of mood cycling compared to treatment with antidpressant and mood stabiliser combined

The Risk of Switch to Mania in Patients With Bipolar Disorder During Treatment With an Antidepressant Alone and in Combination With a Mood Stabilizer

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Non Pharmacological Treatment

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Psychoeducation: Identify symptoms and triggers, and the importance of medication adherence.

Family Focused Therapy: involves family members in the treatment process, helping them understand bipolar disorder and learn how to support their loved one effectively.

Wellness Recovery Action Plan (WRAP):

WRAP is a self-help program that empowers individuals to develop their own personalized plan for managing bipolar symptoms and maintaining wellness.

Peer Support Groups:

Peer support groups, led by trained facilitators who have lived experience with bipolar disorder, provide a safe space for individuals to share their experiences, coping strategies, and support one another.

Physical Activity and Exercise:

Regular exercise can have a positive impact on mood and overall well-being. It can help reduce depressive symptoms and improve sleep patterns.

Non Pharmacological Treatment

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Sleep Hygiene:

Maintaining a regular sleep schedule and practicing good sleep hygiene is crucial for individuals with bipolar disorder, as sleep disturbances can trigger mood episodes.

Psychotherapeutic Apps and Online Resources:

Some digital tools and online resources offer evidence-based self-help strategies and mood tracking for individuals with bipolar disorder.

Daily Mood Swing Diary

Mood Tracker App

Additional Information

Bpac NZ Bipolar Disorder Best Practice Guidelines

Alila Mood Disorder Video

Karakia mutunga
(closing prayer)

Ka wehe atu tātou,

I raro I te rangimārie,

Te harikoa, me te manawanui

Haumi ē! Hui ē! Taiki ē!

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