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The Basics About Bipolar Disorder, Mania & Hypomania

Evidence Based Practices (EBP): Integrated System of Care; Universal Dual Diagnosis Capabilities; Principles of Empathy and Hope; Motivational Interviewing Approach; Stages of Change Model Design; Strength Based; Skill Building; Solution Focused; Neurochemistry Based Disorders of the Brain; Symptom Identification; Symptom Management; EBP Curriculum Topics, i.e. Nutrition, Stress Management, Cognitive Behavioral, and more…

Consistency in the Group Setting

The importance of *consistenc*y in a treatment setting can't be overstated. This is especially true when people are placed in vulnerable situations. *Inconsistency* can, at best, increase uncertainty and insecurity for the person receiving services. At worst, unpredictability can create a sense of helplessness while simultaneously decreasing a person's development of self-reliance. In fact, all human beings benefit from a dependable approach in the treatment of chronic disorders. When a person learns they can rely on consistency, they are less stressed and more relaxed. Consistency in the group setting includes the group structure, psychoeducational material, and the approach.

Each agency or facility will have different requirements – such as group receipts or paperwork – however, consistency can still include a structure similar to the following:

1. Group members pick up: a. Clip Board, b. Paper, and c. Pencil/Pen as they enter the room.
2. Group facilitator picks up the group receipts from each person in the group, and/or the group facilitator passes out the sign-in sheet for the group members to sign.
3. Group facilitator provides a Positive Group Beginning, Consistent Psychoeducational Material, Consistent Approach, and a Positive Group Closure.

Psychoeducational Groups and Crisis Event Processing (when requested)

Notes to Facilitator(s):

1. *The Basics, Second Edition* meets the definitions and goals of Psychoeducational Groups, Skill Building Groups, and Cognitive Behavioral Groups.
2. Group participants who have become accustomed to Interpersonal Processing Groups – as well as staff who have facilitated them – may find it a challenge to now facilitate Psychoeducational Groups.
3. Likewise, facilitators who may have followed a more lecture-style education presentation, may find it challenging to now devote at least 1/3rd of group time to specific topic discussions and interactions.
4. Both types of groups (Interpersonal Processing Groups and Psychoeducational Groups) are extremely important, yet each has different goals and structure.
5. The structure of Psychoeducational Groups, Skill Building Groups, and/or Cognitive-Behavioral Groups in no way means that there will not be *interaction* – far from it. It just means that the interactions, discussions, and exercises will be about the topic(s) of each group.
6. Facilitators *may* – or not – still want to allow time in each group for the group member(s) to discuss a crisis that may have occurred since the last group.
7. We do know, of course, that *every* person in group is typically experiencing many challenges each and every week; however, most of these incidents are often best resolved in ways other than group time where the event does not pertain to every group member.
8. Suggested responses to a challenge, problem, or crisis can also include suggesting the person contact their primary care provider; schedule a 1:1 appointment; reschedule their next 1:1 to an earlier time; or, meet with the facilitator after group to explore options and develop a plan.
9. A facilitator would, of course, not *"grade"* an event as being worthy or not for group time. If a person requests individual time in the group, then that would be accepted as valid and time allotted at the end of the group.
10. Over time, the group begins to understand the differences between a situation, a challenge, a problem, or a crisis and can make decisions to utilize group time or continue with the current psychoeducational topic.

Prepare Professionals

Suggestions for professionals to prepare themselves for group typically includes:

1. Review all content material, appendices, and/or handouts *prior* to group to avoid a lecturing style.
2. Decide beforehand the *key points* to be covered in each group to produce flexibility for group responses, discussions, or questions.
3. Gain an overall understanding of the content so summarizing is possible in order to create an interactive facilitation style.
4. Determine the group structure to achieve the essential balance between education and discussions.
5. Check group room to be sure there are enough clipboards, pencils or pens, and markers or chalk for the board.
6. Make enough copies of any handouts *before* group.
7. Write any group content on the board *prior* to the beginning of group whenever possible.

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Master Guide & Master Tips to Professionals

Note: *The Master Guide* (located at the beginning of Volume I & II) and the *Master Tips to Professionals* (located at the back of Volume I) have many topics to assist in the group process like Master Tip #39: Suggestions For Managing Handouts For Groups (pages Master Tips 64-67). Other tips include:

1. Master Guide: Interactive Style (pages Master Guide 10-11)
2. Master Tip #1: Suggestions for Beginning Group (pages Master Tips 1-4)
3. Master Tip #3: Empathetic Treatment Approach (pages Master Tips 7-9)
4. Master Tip #4: Promoting Hope (page Master Tips 9)
5. Master Tip #5: Maintaining a Consistent, Nonjudgmental, and Positive Attitude (pages Master Tips 10-13)
6. Master Tip #12: Responding to Requests for Copies of Appendices (pages Master Tips 27-29)
7. Master Tip #13: Depth of Psychoeducational Content (pages Master Tips 29-30)
8. Master Tip #14: Group Closure Suggestions (pages Master Tips 30-31)
9. Master Tip #16: Motivational Interviewing (pages Master Tips 31-32)

Present Curriculum/Topic

1. It is extremely important that each group participant leave every group with more Psychoeducation than they came in with – which may also include discussing a "familiar topic" yet with a "present-day" focus. Psychoeducational Groups are designed to provide education about all areas related to the management of Substance Use Disorders and Psychiatric Disorders. Psychoeducational Groups are not Interpersonal Processing Groups – even though interaction and processing the particular *psychoeducational topic(s)* is essential to individualizing the topic(s) or skill(s) presented.
2. It is recommended that a minimum of 1/3rd of group time be devoted to interaction (therapeutic counseling *topic* discussions). This can be accomplished – depending on the individual style of the group facilitator(s) – by any "present education-interact/discuss – present education-interact/discuss" combination while still structuring the group to include the curriculum/topic education to be covered.
3. The presentation of material will, of course, be modified by the facilitator to match the functioning skills of group participants. It is important to note, however, that *The Basics, Second Edition* was written in a conversational language while taking into consideration a wide-range of symptom acuity and severity. Persons with co-occurring psychiatric and substance disorders benefit from learning about their disorders and how to manage them, as do all individuals with any chronic disorder(s). Each group participant will retain what is meaningful to them at the present time.

Group Beginning Suggestions

A positive group beginning (and ending) is extremely important. There are many ways to begin (and end) a group in a positive way. Suggestions to choose from can include:

1. Reading the Thought For The Day from a meditation book. (Note: Meditation books that also contain an index at the end of the book – such as *Easy Does It* – are helpful in choosing a specific reading that matches the topic(s) presented in group like Self-Esteem.), or
2. Reading an inspirational or humorous curriculum handout from *The Basics, Second Edition*, or
3. Practicing a deep breathing or a stretching exercise, *or*
4. Sharing of one thing that each person is grateful for today, *or*
5. Sharing of one positive thing that he/she did that contributed to their recovery in the past few days, or
6. Reading an AA Slogan with a brief explanation or AA/NA/Dual Recovery inspirational reading.

* Recommended Beginning: Breathing Exercise (located on page Master Tips 3)

Practice Curriculum/Topic

Practicing subject material is the best way participants can internalize and personalize the curriculum content. Practice includes the group interactions, worksheets, exercises, handouts, and content discussions.

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The Basics About Bipolar Disorder, Mania & Hypomania
Volume I; Subject Two; Pages: Appendix II-12 – II-13; Subject 2-14 – 2-19

Based on a 2-Hour group: Two 50 minute segments	Time-Frame
Group Beginning	**20 Minutes Total**
Positive group beginning (suggestions are located on the previous page).	5 Minutes
1. Brief Group Introductions: (Note: The *interactions* in a psychoeducational group are discussions about the *topics*, not interpersonal processing or case management questions which do not apply to the entire group.) a. Ask the group members to tell the group their name. b. Welcome any group members who are new to this group or phase. 2. Crisis Processing (when requested and optional): a. Ask the group if anyone has experienced a crisis since their last group, and if they need/want additional time in this group to discuss it, i.e. what happened, how they managed the crisis, and/or explore options and develop a plan. b. Let the person(s) know that you will allow time at the end of this group for them to share their experience and receive support from their fellow group members.	10 Minutes ↓
Summarize Introduction of the Group Topic and Why It's Important (page Subject 2-14): There are four major types of mood disorders. Major Depression | Dysthymia | Bipolar Disorder | Cyclothymia Today we will focus on Bipolar Disorder, Mania, and Hypomania. "*Knowledge is power, and this knowledge became one of the ways I restored sanity to my life* (Judy N., 1992, p.1)." "Bi" means *two* and "polar" refers to opposite ends or *poles*. Because this condition involves emotions of two alternating extremes, it's called Bipolar Disorder. It is also sometimes called Manic Depressive Disorder. It involves symptoms that are experienced as "highs" or elevated moods called mania and alternating "lows" called depression. The various mood states in Bipolar Disorder can be thought of as falling somewhere on a continuous range (Grubb, Chalem, Bot, Ashby & Moulton, 1997): "1" is severe depression — "5" is average — "10" is severe mania Major Depression → Dysthmic Disorder (milder but chronic depression) → Average Mood → Hypomania (milder form of Manic Episode) → Manic Episode	5 Minutes ↓

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Skill Building Exercise and Discussion - Suggestions for topic discussion:	Time-Frame
To the Facilitator(s): 1. It is recommended that any group content for this particular group be written on the board prior to the beginning of group – whenever possible. 2. This group is never intended to diagnosis a Bipolar Disorder. It *is* intended to provide enough information for participants to decide if they relate to these symptoms of a Mood Disorder and if they would like/need to explore this further with their therapist, counselor, case manager, etc. 3. In the cases where a person says these symptoms of depression or mania are a part of the common emotional swings caused by the nervous system healing in the early recovery process of Substance Disorders, a facilitator can let the person(s) know: a. If something does change, like symptoms of depression (persistant depressed mood, feelings of worthlessness, or any other symptoms) becoming more acute, or symptoms of mania, (unusually elevated mood, exaggerated feelings of unrest, or any other symptoms) becoming more acute, *or* b. If symptoms of depression or mania do not lessen with abstinence or harm reduction – the person is then encouraged to bring this up with their primary counselor for further discussion. 4. For the individual(s) who may see a strong identification with a Bipolar Disorder or has a history of depressive or manic symptoms or has a diagnosis of a Bipolar Disorder – it would be recommended that he/she follow-up right away with their primary service provider for evaluation and/or specific treatment planning. 5. You *may* or *may not* decide to cover the information in the group that is found in the next section (depending on your specific group) about the symptoms of Bipolar Disorders. However, these points are *important* and you may want to interject them as you go or in the sequence below. **To the Group:** When talking about symptoms of any Psychiatric Disorder like Bipolar Disorders, there are a few things to keep in mind: 1. A specific set of criteria must be met in order to diagnose a Psychiatric Disorder. 2. When any of us read about mental health disorders we experience common responses. We often look at the symptoms and say: “Oh my, I have *that one* and *that one* and *that one* too! I must have a psychiatric disorder.” That is very typical among us human beings. 3. Remember to have a specific illness – a person would have to have specific *symptoms*, a specific *number* of symptoms, for a specific *amount of time*, and the symptoms have to be *severe enough* to cause *significant distress* in important areas of the person’s functioning. 4. Also the diagnosis of a Bipolar Disorder must rule out or eliminate other causes for the symptoms. This would include Substance Use Disorders. In other words when symptoms of mood disorders are caused by substance abuse or substance dependence, a diagnosis would be made of “Substance-Induced Mood Disorder.” In that situation, the symptoms of depression or mania would lessen or clear with continued recovery for Substance Use Disorders. 5. However, whether symptoms of depression or mania are substance-induced or not, it is still very important to address *any* symptoms that are persistent, or *any* symptoms that don’t clear with recovery, or *any* symptoms you may have experienced for a long time, or *any* symptoms that are causing you distress at the present time. 6. Self-awareness is a skill to develop and education about symptoms is critical to that process. 7. We want you to be aware of any symptoms you may be experiencing now or may or experience in the *future*. We – your treatment team – want to be sure we are working *with* you in symptom management and treatment planning to meet your individual needs. 8. In other words, symptoms of a Mood Disorder are treated *as if* they *won’t* clear with time.	30 Minutes

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Psychoeducation Part I: Topics & Focus	Pages & Location	Presentation Suggestions	Time-Frame
The Basics About Bipolar Disorder	Appendix II-12	Summarize one paragraph.	continued ↓
Prevalence of Bipolar Disorder (#1 in table)	Appendix II-12	State the information in this section of the table.	
Risk Factors (#3 in table)	Appendix II-12	Discuss information in table.	
Causes of Bipolar Disorder (#4 in table)	Appendix II-12 – II-13	Briefly summarize the following information	
1 Biochemistry; 2 Genetics/ Heredity; 3 Social/ Environmental			
Types of Bipolar Disorder	Subject 2-14 – 2-15	Summarize brief paragraphs.	
Bipolar I Disorder			
Bipolar II Disorder			
Episodes of Bipolar Disorder			
Depressive Episode Defined			
Symptoms of Depressive Episode in Bipolar Disorder (Note: This table of symptoms of Bipolar Disorder Depressed Episode is located on Subject 2-11.)	Subject 2-15	Summarize paragraph and give brief list of symptoms shown below: (Note: The expanded version of the symptoms of Bipolar Disorder Depressive Episode can be found on Appendix II-10 – II-11.)	

Physical Symptoms	Cognitive/Thinking, Emotional, and Behavioral Symptoms	Spiritual Emptiness
1. Significant Changes in Appetite or Weight 2. Sleep Problems 3. Fatigue 4. Psychomotor Agitation of Retardation (muscle activity related to mental processes)	1. Cognitive Problems 2. Persistent Depressed Mood 3. Feelings of Worthlessness or Excessive Inappropriate Guilt 4. Functioning Impairment	1. Loss of Capacity for Pleasure and Joy 2. Recurrent Thoughts of Death (not just fear of dying)

Skill Building Exercise and Discussion - Suggestions for topic discussion:

To the Group:

1. Do you relate to any of the symptoms of depression?
2. In what way?
3. How do you manage these symptoms or cope with depression?

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Psychoeducation Part II: Topics & Focus	Pages & Location	Presentation Suggestions	Time-Frame
Manic Episode Defined	Subject 2-15	1. Summarize one paragraph. 2. Explain two types of Mania: Euphoric (elevated or high mood) and Dysphoric (exaggerated feelings of unrest, such as agitation, rage, discomfort, etc.) shown in the table below:	continued
Symptoms of Manic Episode	Subject 2-16	Discuss briefly the symptoms of a Manic Episode shown in the table below: (Note: The expanded version of the symptoms of Bipolar Disorder Manic Episode can be found on Appendix II-15 – II-16.)	

1	Euphoric	2	Dysphoric

Physical, Cognitive/Thinking and Emotional Symptoms	Behavioral Symptoms
1. Sleep Disturbances 2. Inflated Self-Esteem 3. Flight of Ideas 4. Easily Distracted 5. Distinct Periods of Irregular Mood	1. Pressured Speech 2. Increase in Goal Directed Activity 3. Excessive Involvement in Pleasurable Activities with High Potential for Painful Consequences 4. Functioning Impairment

Break	10 Minutes

Psychoeducation Part II: Topics & Focus	Pages & Location	Presentation Suggestions	Time-Frame with Crisis Processing	Time-Frame without Crisis Processing
Hypomanic Episode Defined	Subject 2-17	Summarize one paragraph.	10 Minutes	15 Minutes
Symptoms of Hypomanic Episode	Subject 2-18	Discuss briefly the symptoms of a Hypomanic Episode:		
Cyclothymic Disorder Defined	Subject 2-18	Summarize one paragraph.		

Physical Symptoms	Cognitive/Thinking, Emotional, and Behavioral Symptoms	Emotional Symptoms	Behavioral Symptoms
1. Sleep Disturbances 2. Speech Disturbances	Distorted Perceptions and Thinking Patterns	Mood Disturbances	Behavioral Disturbances

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Psychoeducation Part II: Topics & Focus (continued)	Pages & Location	Presentation Suggestions	Time-Frame with Crisis Processing	Time-Frame without Crisis Processing
Symptoms of Cyclothymic Disorder	Subject 2-18	Discuss briefly the symptoms of a Cyclothymic Disorder:	continued	continued

Physical Symptoms	Emotional Symptoms	Behavioral Symptoms
Sleep Disturbance	Mood Disturbances	1. Short and Irregular Cycles of Behavior 2. Functioning Impairment

Skill Building Exercise and Discussion - Suggestions for topic discussion:

To the Group:

1. Are there any symptoms of Mania, Hypomania or Cyclothymic Disorder that you relate to personally?
2. For example, have you experienced times of great restlessness that did not appear related to substance abuse? *or*
3. Times of being euphoric or excessively elated mood that were not related to substance use? *or*
4. Times of depression not related to substance abuse or withdrawal?
5. How do you manage these moods or cope with these mood disturbances?

Psychoeducation Part II: Topics & Focus (continued)	Pages & Location	Presentation Suggestions	Time-Frame with Crisis Processing	Time-Frame without Crisis Processing
Reluctance to Seek Treatment or Not Wanting Help	Subject 2-19	Summarize two paragraphs.	20 Minutes	25 Minutes
Treatment of Bipolar Disorder	Subject 2-19 – 2-20	1. Summarize two paragraphs. 2. Discuss the ten treatment recommendations for Bipolar Disorder shown in table below using the text.		

1	Education	5	Reasonable Activity Level	8	Balanced Lifestyle
2	Mood Stability	6	Stress Reduction	9	Restoration of Social Function
3	Medication	7	Harm Reduction or Goal of Abstinence	10	Follow-Up
4	Family & Social Support				

Skill Building Exercise and Discussion - Suggestions for topic discussion:

To the Group:

1. All chronic illnesses have similar treatment recommendations.
2. For instance, developing healthy nutritional habits is recommended for individuals in recovery of a Bipolar Disorder and is also recommended for substance disorders, anxiety, and even heart disease.
3. Stress reduction is recommended in the recovery for *every chronic disorder* as well.
4. Whether you personally have a Mood Disorder or not – as we look closer at the treatment of a Bipolar Disorder – ask yourself how you're doing in each of these areas that *do* apply to your personal recovery plan.
5. What areas of recovery do you relate to?

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Skill Building Exercise and Discussion - Suggestions for topic discussion:	Time-Frame with Crisis Processing	Time-Frame without Crisis Processing
To Group: (continued) 6. For example, Stress reduction? In what way? *or* Balanced lifestyle? In what way? *or* Strengthening or developing a suppport network? In what way? *or* Others? 7. What area(s) have you made progress in or experienced success? How did you accomplish that? 8. What area(s) will you work to improve in the future? 9. Where will you start first?	Continued	Continued
Crisis Processing	**Time-Frame**	
1. Ask the group member(s) to tell the group what happened. 2. Explore options and/or develop an immediate plan for coping. 3. Allow the group to offer support.	10 Minutes	
"Paper Work"	**Time-Frame**	
Group participants fill out Group Notes.	5 Minutes	
Group Closure	**Time-Frame**	
1. Read or ask a group participant to read an inspirational reading of your choice, *or* 2. Ask each group participant what they will do this week to protect their recovery, *or* 3. Ask each group member what they will practice this week from the areas of treatment for Bipolar Disorder – as it relates to either a Bipolar Disorder or to their specific recovery plan of another disorder, *or* 4. Read a daily meditation for the day or an inspirational message of your choice.	5 Minutes	