Practical Strategies for Working with Clients with Bipolar Disorder

PSYCHOEDUCATION

Psychoeducation can be done in a structured fashion at the initial 5-8 sessions of treatment or can be woven in throughout the treatment. Psychoeducation is different from education in that it's tailored to the individual. There are several components to psychoeducation:

a. **Symptom Review**-Present list of bipolar symptoms to client and family members to help the client understand his/her manifestation of the illness. Elicit from client and family what symptoms they have seen in client. Purpose is to help recognize symptoms/episodes, help client differentiate between self and the illness (if it's the illness, it comes as part of a cluster of symptoms), and increase acceptance of the disorder
b. **Etiology and Course**-explain role of biology and environmental/behavioral influences. Purpose is to address blame/guilt/stigma, provide rationale for comprehensive treatment, identify potential triggering events unique to this person, and help client understand that even if they do everything right, they may still have some symptoms although they can influence how often and how severe.
c. **Risk and Protective Factors**-Review "Risk and Protective Factors" handout (see attached) for purpose of increasing hope that there are things in client's control, engaging family, helping client make informed decisions about actions they might take, and increasing motivation for positive health behaviors.
d. **Review Treatment Options**-Purpose is to increase treatment compliance
e. **Wellness/Relapse Prevention Plan**-Purpose to help client/family understand that bipolar is usually a recurring illness, help them identify early warning signs, promote stabilization and prevent full relapse, minimize negative consequences of relapse should one occur, and decide in advance what steps client would like family to take if they enter into an episode (e.g., While client who is manic may not want family to call clinician, when client is stable and thinking clearly, they may instruct family to ignore their protests and call clinician if they become manic.) Make separate plans for depression, (hypo)mania, and suicide as indicated.

MOOD CHARTING

Mood Charting is a method in which client tracks mood, suicidal ideation, psychotic symptoms, sleep, alcohol and drug use, exercise, menstrual cycle or anything other factor that client or therapist thinks may be related to his/her mood fluctuations. Instead of mood chart, can use Social Rhythm Metric (see E Frank's manual), in which clients track the time and other people involved in the 5 items that correlate most highly with changes in mood. These items are 1) out of bed 2) first contact with another person 3) start work/school/volunteer/family care 4) dinner 5) to bed.

Improving Completion Rates

a. Make sure client understands rationale behind mood charting. Purpose is to identify targets for current session, detect prodromal symptoms, monitor risk and protective factors, measure impact of medication/behavioral changes, and see patterns that only are apparent after weeks/months of tracking. (For sample mood charts go to www.manicdepressive.org/moodchart.html and www.psychiatry24X7.com or create your own).
b. Provide clear instructions about when to fill it out, where to put it, to bring to next session.
c. Anticipate difficulties by asking how important they think it is and how confident they are that they will do it.
d. Start by tracking only a few items.
e. Do one day's worth of data in session before sending it home with the client.
f. If it's overwhelming for client to rate mood, have them start with objective items like sleep or exercise.
g. Stress that for data to be useful it must be accurate. If there's info client doesn't want to share, no data is better than inaccurate data. Tell client that if they miss days, not to go back and try to remember as trying to rate past scores can be affected by current mood. Instead, start with today.
h. If client didn't do it, explore and problem solve obstacles. For example, if client didn't complete it because it's one more thing that reminds them of their bipolar disorder, pair it with something else that client is already doing that reminds them of their disorder, like taking medications.

BEHAVIORAL STRATEGIES

Often initial goal is to prevent them from getting any worse. So if client says homework didn't work, ask them to think about how they think they'd feel if they hadn't done those things. Also ask them to think about how the homework task fit with their values.

Interpreting and Using Mood/Social Rhythm Metric Data

a. Look for items that have the most variability, not day to day correlation.
b. Look for excessive underactivity or overactivity.
c. Search for triggers that disrupt regular schedule and problem solve around them.
d. Figure out with client whether to start with easiest thing to change or thing that will be most impactful.
e. Allow client to experiment with how much change they need to make without it affecting their mood. For example, a client who likes to sleep in on the weekend may agree to sleep only an extra hour on the weekend and track whether that improves mood or whether they need to be more rigid about wake up times.

f. When client anticipates changes (e.g., relatives coming to visit), help them plan so they can adapt. For example, plan your activities in the daytime so you don't get to bed too late.

Opposite of Emotion Action (OEA)

a. Provide client with the following rationale behind Opposite of Emotion Action. All emotions have associated with them urges to do certain actions. While these actions tend to bring short term relief, acting in accord with emotions tends to perpetuate the emotion in the long run. Acting *opposite of emotion* is one of the most powerful ways to shift the emotion. You can take your mood state out of the equation and allow your behavior to be guided by your values.
b. OEAs for mania can be
    i. scheduling down time
    ii. mindful breathing
    iii. limiting social stimulation
    iv. avoiding stimulants (e.g., coffee, cocaine)
    v. sleeping
    vi. delaying making decisions for 72 hours and consulting with 2 people who have client's best interests at heart before making the decision.
c. OEAs for depression can be
    i. Engaging in potentially pleasurable activities
    ii. Activity scheduling (see attachment). Schedule in activities that client intends to do at certain times each day. That way if client wakes up groggy, they don't have to figure out what to do.

References

Basco, R. & Rush, J. (2007) Cognitive-Behavioral Therapy for Bipolar Disorder, 2nd Ed.

Colom, F., Vieta, E. & Scott, J. (2006) Psychoeducation Manual for Bipolar Disorder