Tangible Interventions for Treating Clients with Bipolar Disorder

By: Catherine Ness LCPC
Outline

• Conceptualizing Bipolar Disorder (and specifiers)
• Causes of Bipolar Disorder
  • Genetics vs Environment
  • Age of onset
• Diagnostic support
  • Helpful tools in Diagnosing Bipolar Disorder
  • Differentiating from personality disorders, ADHD, substance abuse, schizoaffective
• Psychoeducation (family)
• CBT
Outline continued

• Medications (and compliance issues)
• Social Rhythm and Interpersonal Theory
  • Sleep hygiene
• Social Skill Deficits
  • Interventions for social skills deficits
• Cognitive Deficits
  • Interventions for cognitive deficits
• ECT/TMS/biofeedback
• Putting it Together (order of interventions)
Why Bipolar Disorder Needs Our Attention
(Leboyer, 2010) (World Health Organization)

• Leading cause of suicide for mental health disorders (equal to Major Depressive Disorder)

• Leading cause of premature deaths due to medical complications in mental health disorders

• 6th rated reason for disability in the United States (one of the most expensive disorders to treat)

• Rates of 30-69% misdiagnosis (frequently missing BP2)

• Clients with BP are symptomatic 50% of their lives (experiencing sub-syndromal depression during remitted periods)
Why Bipolar Disorder Needs Our Attention (Miziou, 2015), (Leboyer, 2010)

• During euthymic (resting mood states) clients continue to have increased sensitivity to emotional cues

• Reframing the disorder as “chronic and progressive”

• Current studies focus on symptom remission and not functional recovery
  • In other words, tx stops after mood is more stable, but functional issues remain, which can significantly increase the rate of relapse
Purpose (Leboyer, 2010)

• “[There is a need to] build a combination of psychosocial interventions tailored to the needs of each patient, assess while euthymic, and provided at any given point during the trajectory of their disorder.”

• “To develop personalized health care, and treatment targets [that] should move beyond acute symptoms and prevention of mood episodes to that of cognitive deficits, emotional dysregulation, sleep and circadian problems, as well as reduction of medical risk factors.”
Conceptualizing Bipolar Disorder

- Depression
- Mild Depression
- Sadness
- Euthymia
- Happiness
- Hypomania
- Mania

Emotion
Bipolar Review  (American Psychiatric Association, 2013)

• Bipolar 1 vs Bipolar 2 (combined = 2% of the population)

• Bipolar 1
  • Mood ranges from depressed to manic
  • Only one manic episode is required to diagnose Bipolar 1

• Bipolar 2
  • Mood ranges from depressed to hypomanic

• Cyclothymia
  • Mood ranges from “mild depression” to hypomania
Bipolar Review (Depression) (American Psychiatric Association, 2013)

- 5 or more of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest in pleasure

  - Depressed mood for most of the day, nearly every day, as indicated by either objective report or observations made by other

  - Markedly diminished interest or pleasure in all, or almost all, activities, most of the day, nearly every day

  - Significant weight loss, when not dieting or weight gain, or decrease or increase in appetite nearly every day
Bipolar Review (Depression) (American Psychiatric Association, 2013)

- Insomnia or hypersomnia nearly every day
- Psychomotor agitation or retardation nearly every day
- Fatigue or loss of energy nearly every day
- Feelings of worthlessness or excessive or inappropriate guilt nearly every day
- Diminished ability to think or concentrate, or indecisiveness, nearly every day
- Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, a suicide attempt, or specific plan for committing suicide
Bipolar Review (Mania)  (American Psychiatric Association, 2013)

• A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased goal-oriented activity or energy, lasting at least one week and present most of the day, nearly every day.

• During the period of mood disturbance and increased energy and activity, three or more of the following symptoms are present to a significant degree and represent a noticeable change from usual bx.
Bipolar Review (Mania)  

(American Psychiatric Association, 2013)

- Inflated self-esteem or grandiosity
- Decreased need for sleep
- More talkative than usual or pressure to keep talking
- Flight of ideas or subjective experience that thoughts are racing
- Distractibility as observed or reported
- Increased goal-oriented activity or psychomotor agitation
- Excessive involvement in activities that have high potential for painful consequences
Specifiers (Cycling and Mixed Episodes)
(American Psychiatric Association, 2013) (Miklowitz, 2014),

- **Rapid cycling** 10-35% (non-agreement on stat)
  - Presence of 4 or more mood episodes in the previous 12 months that meet the criteria of a manic, hypomanic, or major depressive episode
  - More common in adolescents or when the disorder has been untreated for a period of time

- **Ultradian cycling** (or ultra rapid cycling)
  - Mood changes within a few hours (may be more indicative of a personality disorder)
  - May also be more common in children (mania is most frequently manifested as tantrums)
Specifiers (Cycling and Mixed Episodes)  

(American Psychiatric Association, 2013), (Miklowitz, 2014),

**Mixed episode**

- Full criteria is met for a manic or hypomanic episode with 3 symptoms of depression **or** full criteria is met for a depressive episode with 3 symptoms of a manic or hypomanic episode
  - Seems to occur more often following rapid cycling of mood
  - Most beneficial to treat it as a manic episode
Causes of Bipolar Disorder

• As with many mental health diagnoses, there is thought to be an environmental and genetic component
  • There is likely a family member that has also been diagnosed with Bipolar Disorder or another significant mood disorder

• Childhood trauma is reported twice as often in those diagnosed with Bipolar Disorder as in the general public
  • The hypothesis is that early trauma lowers the threshold for developing Bipolar Disorder

• Neurological differences are observable
Age of Onset (Bellivier, 2003)

• Research suggests that the age of onset may play a significant role in the how Bipolar Disorder is manifested and overall prognosis

• Three age subcategories are cited in the above research
  • 17.6 years (median)-21.4%-(polygenetic component)
    • Associated with most severe symptoms and poorer prognosis
  • 24.6 years (median)-57.3% (multifactorial model)
  • 39.2 years (median)-21.2% (multifactorial model)

• Keep in mind that most individuals seek tx for unipolar depression first (because manic symptoms tend to occur later and/or are underreported)
Suicide rates

- Statistics vary dramatically (most dependent on whether the study included clients who were already seeking treatment at an inpatient level)
  - Approximately 8% (range of 2-15%) of client’s diagnosed with Bipolar Disorder will commit suicide
  - These are similar levels seen in unipolar depression
  - 25-50% of clients with Bipolar Disorder will attempt suicide
  - 80% of clients with Bipolar Disorder will have suicidal ideation
  - There is no difference between BP1 and BP2 in suicide rates
  - 80% of suicides occur during a depressive state
Suicide Awareness (Miklowitz, 2014)

• Higher probability of suicide:
  • History of past attempts
  • Hopelessness
  • Recent discharge from inpatient hospitalization
  • Agitation or profound anxiety
  • Persistent insomnia

• Psychological predictors
  • Early trauma
  • Stressful life event
  • Social isolation
  • Significant social conflict
Diagnostic Tools  (Miller, 2009)

• If possible, have a family member attend with the client

  • Clients can be poor historians (especially if there has been memory impairment)

  • Potential minimization of symptoms (especially emotional lability/mania)

  • Difficulty remembering childhood

  • Family (parents) may have more knowledge about mental illness in the extended family
Diagnostic Tools  (Miller, 2009) (Goodwin, 2016) (Manning, 2010)

• MDQ (mood disorder questionnaire)

• GBI (general behavioral inventory)

• CIDI 3 (composite international diagnostic interview)

  • These assessment tools help give a “flavor” of Bipolar Disorder, but are not as accurate (more of a screening tool)

  • If a client screen positive for Bipolar Disorder, they should be referred to a professional that can administer the SDIC
Diagnostic Tools (Miller, 2009) (Goodwin, 2016)

- SCID (structured clinical interview)-good reliability and validity
  - Focus on the bipolar module
  - Bipolar 2 is more difficult to diagnose because hypomania does not cause functional impairment (all tools are less sensitive to hypomania)
    - Helpful information to cypher out hypomania (Bipolar 2)
Diagnostic Tools

• Additional areas of focus:
  • Instability in relationships
  • Rejection sensitivity
  • Frequent loss or change in employment
  • Frequent moves
  • Specific family hx of psychosis or bipolar in first degree relative OR a multigenerational hx of mood disorders in general
  • Anti-depressants have not been helpful to mood
Differential Diagnosis (Goodwin, 2016)

• Differential Dx with Bipolar Disorder is challenging!

• 80% of clients with bipolar have a comorbid disorder (Miklowitz, 2014)
  • Most often anxiety

• The following 4 dxs have significant similarities with Bipolar Disorder or can be comorbid with Bipolar Disorder

  • 1 Personality disorders
  • 2. ADHD
  • 3. Substance abuse/dependence
  • 4. Schizoaffective
Differential Diagnosis (Personality Disorders) (Miklowitz, 2014), (Frank, 2005)

- More ultradian cycling

- Mood swings almost always affected by outside triggers

- No family hx of Bipolar Disorder

- No decreased need for sleep or grandiosity

- Impulsive bx can occur during any mood state
Differential Diagnosis (ADHD) (Miklowitz, 2014), (Frank, 2005)

- ADHD is a developmental disorder that begins in childhood

- Impulsivity can occur in any mood state, including euthymic mood state

- Lack of family hx of Bipolar Disorder

- Sleep is impacted less
Differential Diagnosis (Substance Abuse/Dependence) (Miklowitz, 2014), (Goodwin, 2016)

• Obtain a thorough hx to see if symptoms predated the use of substances

• Stimulants such as cocaine and meth, can cause manic-like symptoms
  • Corticosteroids can also cause these types of symptoms
  • Ideally, client should be detoxed off of any drugs that could cause mania prior to diagnoses

• Use of MJ during adolescence is associated with increased rapid cycling and suicide attempts (Asa, 2016)
Differential Diagnosis (Schizoaffective) (Miklowitz, 2014), (Frank, 2005)

- Psychotic symptoms are present in the absence of a mood state
Treatment

• Rapport and Trust
Treatment (psychoeducation)

• The importance of discussing the diagnosis of Bipolar Disorder with your client.

• Managing Bipolar Disorder will require a major investment from your client which will likely include long-term medication and significant behavioral changes. If the client does not accept the diagnosis or identify how it has been/will continue to, impact their life, a sustainable change is unlikely to occur.
  • The problem is especially challenging when client is in a manic/hypomaniac state.
Tx (Medication)-Do not send them to a PCP!

- Below is a non-exhaustive list of commonly prescribed mood stabilizers, with associated pros and cons (of course this will be up to the psychiatrist, but it’s good to have a general feel for medications)

<table>
<thead>
<tr>
<th>Medication</th>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lithium</td>
<td>Effective after 2-3 weeks, more quickly at higher doses (inpatient)</td>
<td>Tremors, polyuria (frequent urination), weight gain, blood draws, cognitive dulling</td>
</tr>
<tr>
<td>Lamictal (Lamotrigine)</td>
<td>No weight gain. Fewest side effects</td>
<td>Rash. Less effective if already in a manic/depressed state</td>
</tr>
<tr>
<td>Risperdal (Risperdone)</td>
<td>Higher doses can tx acute mania well</td>
<td>Weight gain and sedation</td>
</tr>
<tr>
<td>Medication</td>
<td>Description</td>
<td>Side Effects</td>
</tr>
<tr>
<td>------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>---------------------------------------------------</td>
</tr>
<tr>
<td>Depakote (Valproate)</td>
<td>Similar to Lithium, but better tolerated (fewer blood tests needed) can be a stand alone med.</td>
<td>Nausea, sedation, tremor, weight gain, hair loss</td>
</tr>
<tr>
<td>Seroquel (Quetiapine)</td>
<td>Helpful with sleep and if needed increased appetite</td>
<td>Sedation, weight-gain</td>
</tr>
<tr>
<td>Latuda (Lurasidone)</td>
<td></td>
<td>Nausea/vomiting</td>
</tr>
<tr>
<td>Geodon (Ziprasidone)</td>
<td>Little/no weight gain</td>
<td>Can cause sedation or activation (activation with titration)</td>
</tr>
<tr>
<td>Clozaril (Clozapine)</td>
<td>Good for treatment resistant BP</td>
<td>Frequent blood tests</td>
</tr>
<tr>
<td>Vrylar</td>
<td>Newer medication</td>
<td>Possible Tarditive Dyskonesia with long-term use</td>
</tr>
</tbody>
</table>
40-60% of clients with Bipolar Disorder will go off of their medication at some point due to:

1. Wanting to enjoy manic state
2. Prolonged stability means I’m cured!!
3. Side effects
4. Forgetfulness in taking medication
5. Medications don’t seem to be effective or building of tolerance
6. Financial - some medications are expensive or not covered by insurance
Tx (lack of medication compliance)  (Miklowitz, 2014)

- **Financial**-Is there a generic alternative? Have the psychiatrist write a letter to client’s insurance company. Have the client write a letter to the pharmaceutical company.

- **“I’m Cured”**-If you cannot convince the client to stay on medication have them agree to keep a mood/thought journal while on medication and once they stop medication.

- **Enjoying the mania/loss of creativity**-Empathize (there may be a true loss of creativity). Again, have the client keep a journal that describes their mood following a manic episode or possible consequences to job/relationships/money/etc., when manic.
Tx (lack of medication compliance) (Miklowitz, 2014)

- **Forgetfulness** - Invest in alarms, pills boxes, or have a family member help remind the client.
- **Side Effects** - See if there is alternative medication. If weight gain is the issue, increase commitment to healthy eating and exercise. Do the pros still outweigh the cons?
- **Medications don’t work** - Keep a journal of mood states before, during and after trying a particular medication to see if there is some level of improvement. See if there is a sister medication to cycle back and forth on if tolerance becomes an issue.
Tx (Family psychoeducation) (Miklowitz, 2000)

• 7 sessions of psychoeducation
  • Increased understanding of disease
  • Signs and triggers for mood changes
  • Understanding the importance of medication compliance

• 7-10 sessions of communication
  • Active listening
  • Role playing

• 4-5 sessions of problem-solving
  • How does the family dynamic trigger symptoms? Are there better options?
Pros and Cons of Psychoed/family

• Pros:
  • Support group is built into treatment
  • Ability to improve family communication and conflict resolution

• Cons:
  • Family may be the source of trauma
  • Client may have paranoid ideation around the family
  • Client can feel less in control of tx
  • Difficult to have family attend every session (scheduling)
TX (CBT)

• Have the client chart their mood

  • Paper and pencil or an online app can be used
    • Wellness: Mood Meds and Health, eMoods Bipolar Mood Tracker

  • Check in with their mood at least 3x daily or make a specific note if client identifies a significant change in mood

  • Look for specific triggers that are associated with a mood swing

  • Note if there is a specific time of day where mood/energy is consistently higher or lower
### TX (CBT) (Basco, 2015)

- Assist client in identifying personal mood states *(The Bipolar Workbook-Dr. Monica Ramirez Basco)*

<table>
<thead>
<tr>
<th>Category</th>
<th>Manic/hypomanic</th>
<th>Depressed</th>
<th>“normal” euthymic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mood</td>
<td>Irritable/hyper</td>
<td>Sad</td>
<td>content</td>
</tr>
<tr>
<td>Sleep</td>
<td>Sleeping 2-4 hours a night and feel energetic</td>
<td>Sleeping 10 hours a night and still exhausted</td>
<td>Sleeping 6-8 hour and feel a little tired</td>
</tr>
<tr>
<td>Attitude towards self</td>
<td>“I am the only one with a brain”</td>
<td>“I’m worthless”</td>
<td>“I feel pretty accomplished”</td>
</tr>
<tr>
<td>Social confidence</td>
<td>“Everyone loves me”</td>
<td>“Everyone hates me”</td>
<td>I get along with most people and have a few close friends</td>
</tr>
</tbody>
</table>
• Identifying prodromal symptoms and triggers
  • Common triggers for mood swings include:
    • Change in sleep habits
    • Major life changes (loss of job or relationship)
    • Use of substances
  • Common prodromal symptoms can include:
    • Problems with sleep
    • Increased agitation/irritability
    • Difficulty focusing
  • Although there can be common triggers/prodromal symptoms, it is most effective when clients can identify symptoms and triggers specific to themselves.
• Create an action plan

  • When the client/therapist/family identifies that a mood swing may be coming, there needs to be a plan of action to prevent/lessen the swing

For example:

  • When I notice I am feeling more irritable, I need to . . .
    • Prioritize sleep/spend a day with friends/increase exercise, etc.

  • When I notice I am having trouble focusing, I need to . . .
    • Take more breaks at work/increase self-care, etc.
Tx (CBT)

• Although interventions are much more effective and easier to implement prior to the client entering a manic or depressed state, this is not always possible.

• Similar to strategies used to prevent a mood swing, client needs to identify personal coping skills that are effective for each mood state:
  • ie, challenging negative/irrational thoughts, decreasing or increasing stimulation (depending on mood state), avoiding social isolation, talking to support system, medication changes, etc.
Pros and Cons of CBT

• Pros:
  • Parallel tx with many higher level care programs
  • Easier to conceptualize and tangible homework assignments
  • Effective when clients have had fewer episodes and in a euthymic state

• Cons:
  • Least evidence based of discussed theories/techniques for Bipolar Disorder
  • Minimal focus on circadian rhythms
  • Neglects hx of client and how life has shifted due to Bipolar Disorder
  • Little efficacy for clients in severe moods states or clients with many episodes
Tx for psychosis/severe mania  (Rakofsky, 2014)

1. Assess for safety. If you do not believe the client can be safe, he or she needs to be hospitalized.

2. If psychotic symptoms are beginning to emerge or client’s mania is increasing (i.e. mild paranoia, not sleeping) immediate communication with psychiatrist for medication management is most effective in stopping the emergence of psychosis. (sedative/mood stabilizers/anti-psychotics)
   - Ask about medication compliance, use of illegal drugs, (are antidepressants being used?)
   - Make sure there is communication with family/support system

3. As symptoms escalate, it is helpful to see the client as much as possible. Despite the onset of psychosis, most clients can still appreciate that you are concerned. In addition, it allows you to monitor the severity of the situation and move the client to a higher level of care if needed.
Tx (Interpersonal and Social Rhythm Theory-IPSRT) (Frank, 2005)

• Focused on regulating circadian and social rhythms, which research has demonstrated affect mood in people with Bipolar Disorder
  • In other words, managing biologics and social interactions

• Determine pre and post level of functioning after a stressful life event/transition
  • Did the social role change? Did sleep or overall self-care change?
  • Helpful to use a time line
  • Grieving the “old self”
Tx (Interpersonal and Social Rhythm Theory-IPSRT)

• **Focus on sleep hygiene**
  • Go to bed the same time every night and get up the same time every morning
  • Avoid electronics before bed
  • Create a soothing bedtime routine
    • i.e. reading, bath, yoga, etc.
  • Invest in “amber glasses” and wear them 1-2 hours before bed
  • Invest in a “dawn stimulator” alarm clock
Tx (Interpersonal and Social Rhythm Theory-IPSRT)

• Be vigilant in monitoring stressful events and or changes in social roles (Frank 2005)

• Have clients tract their mood looking at, time of day, their role during the day, if they are alone or with others, and types of engagement (physical, emotional, cognitive) to establish patterns that affect mood
  • Keeping the following chart for several weeks can help identify individual patterns
    • Please refer to the chart at the back of the Powerpoint presentation

• Establish an effective and manageable routine
Pros and Cons of IPSRT

• Pros
  • Best outcome rates in decreasing mood extremes
  • Focuses on current and past functioning

• Cons
  • Indicates tx should last 27 sessions
  • Does not focus on rapport and assumes client is motivated for tx
  • More complex life changes that may be difficult to maintain
Exercise and Nutrition (Thompson, 2015)

• There is a positive correlation between exercise and decreased severity of depression/depressive episodes
• There is no evidence that exercise has a positive, neutral or negative effect for people experiencing mania
  • Therefore, personal hx about the effects of mania and exercise may be the deciding factor in using exercise when mood is elevated
• Exercise and nutrition are most beneficial to those struggling with Bipolar Disorder as a way to manage weight/health concerns that could eventually lead to medical complications (and more potential triggers for mood instability)
  • Much higher rate of co-morbid medical conditions in those with Bipolar than in the general public
Social Skill Deficits (Francy, 2018)

• Research demonstrates a deficit in social skills in persons diagnosed with Bipolar 1

• Persons with Bipolar 1 and parent(s) that struggle with a mood disorder show higher levels of social difficulties

• Deficit in social skills may result from genetics, poor modeling of social skills, poor self-esteem, lack of experience socializing in a euthymic state (socialization previously state-dependent)

• Consequently, there is a need to teach social skills when deficits are apparent
Managing Social Skills Deficits

• Model a healthy and genuine relationship in session

• Identify client’s expectations in various relationships

• Analyze previous relationships
  • What was modeled for them growing up?
  • What relationships do they feel secure in and why?
  • Are there certain personality traits in others that are triggering?
Managing Social Skills Deficits

• Process the idea of empathy
  • Are there alternative reasons a person said something to you
  • Other people can make mistakes or act out of emotion too

• Role play
  • ie . . Your boss giving you critical feedback
  • ie . . Your friend not agreeing with something you feel passionate about
  • ie . . . A family member indicates they are concerned about your behavior/thoughts
Cognitive Deficits (Goldberg et al. 2008), (Douglas et al. 2015)

• Even when persons with Bipolar Disorder are in a euthymic state, cognitive dysfunction is evident

• The 3 areas most greatly affected are:
  • 1. Attention
    • “The ability to selectively and flexibly process some information in the environment at the expense of other information”
  • 2. Verbal learning and memory
  • 3. Executive Functioning
    • A “broad term that refers to a collection of higher-level cognitive processes, including planning, working memory, strategy development, inhibitory control and cognitive flexibility.”
Cognitive Deficits

• Cognitive deficits are made worse by:
  
  • The use of illegal substances
  
  • Side effects of certain medications that cause “cognitive dulling”
  
  • Co-morbid anxiety
  
  • Increased number of hospitalizations and personal/family history of psychosis
  
  • Being in a mood state (especially mania)
Presentation and Tx of Cognitive Deficits (Goldberg, 2008)

1. Impaired memory (inability to learn from past experiences)
   • Intervention - journal about experiences in the moment

2. Impaired sustained attention
   • Build redundancies in daily routines
   • In session, summarize client’s thoughts and bring them back on topic
     • Summarize main points and write down, or have client write down, what was discussed and homework for the week
3. Disinhibition and impulse control
   • “Delay and distract before making a decision”
   • Substitute healthier obsessive bxs
     • i.e. working out, reading, etc,
   • Relaxation/meditation
   • Go over mood intensity chart and have client agree not to make any major decisions if mood is a +/- 4 or more

4. Impaired insight
   • Have clients write down insights/limitations/core values while in a euthymic state
Presentation and Tx of Cognitive Deficits (Goldberg, 2008)

5. Impaired capacity for empathy
   • Role-play to see how behaviors affects others

6. Executive Functioning
   • Wait 24 hours before making a decision
   • Write down a specific plan of action
   • Try scaled-back versions of goal-oriented bx
Presentation and Tx of Cognitive Deficits (Veeh, 2017)

Cognitive remediation:
- “After specific objective cognitive deficits have been identified while a client is in a euthymic state, exercise (usually computer generated) are preformed by clients in an effort to target areas of deficiency.”
- Research has demonstrated significant improvement for Schizophrenia and TBI
- Initial results for Bipolar demonstrates
  1. Improved executive functioning
  2. Working memory
  3. Problem-solving and divided attention
Next Level Treatment

• Biofeedback

• TMS (not yet approved by insurance for treating Bipolar Disorder)

• ECT (Lots of side effects)
Putting it all together (an integrative approach)

• Flexibility in approach (ie lithium doesn’t work for everyone, neither does one theoretical approach)
  • The idea of integration comes out of the limitations of each theoretical model

• Research across theoretical models indicates the need for an individualized tx plan for best outcomes
Mood Stabilization
- Assess safety/hospitalization
- Medication management
- Family/support system involvement
- Meet frequently to monitor

Action Plan
- If I feel/think this . . . . .
  I agree to . . .
- Medication management
- Sleep regulation
- Coping skills
- Family support system involvement

Severe Relapse

Mild Relapse

Differential Dx
- Hypomania, Mild Depression, Euthymia (-3 to +3)
- Presenting problem
- Complete hx
- Include family (if possible)

PsychoEd
- Discussion of Dx/mood pendulum
- Medication management

CBT/IPSRT
- ID personal mood states
- Chart mood
- ID triggers
- Develop coping skills
- Routine
- Action plan

Family sessions
- (handout)
- PsychoEd for family
- How to support
- Communication skills
- Conflict resolution

Introspection
- Timeline
- Grieving of “old self”
- Goal setting

Deficits/Skills
- ID cognitive and social deficits
- Skill building to improve cognitive and social deficits
In Session and Homework Activities

• Create a Timeline
  • Focus on major life transitions/noticeable changes in mood/relationships

• Journaling
  • Thought patterns in all mood states
    • ie how does perception change with moods?
  • Journaling as a tool to assist with memory
  • Journaling on and off medication (if needed)

• Practice role-playing challenging conversations in and out of session
  • Practice communication skills with loved ones
  • Focus on mirroring back empathy and acknowledging different viewpoint
In Session and Homework Activities

• Mood tracking
  • Have client complete the IPSRT mood tracker for 2-4 weeks
    • Assist client in identifying patterns
    • Establish a new routine based on personal observations from mood tracking

• Identify Individual triggers for mood changes

• Identify prodromal symptoms

• Create an action plan
  • Coping skills/interventions for when mood begins to shift
  • Coping skills/interventions if mood is no longer manageable
References


References


References