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Counseling Adults Who Have Bipolar Disorders

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DESCRIPTION OF BIPOLAR DISORDERS

The bipolar disorders are characterized by dramatic changes in mood, activity, and/or energy levels that significantly affect one's functioning (NIMH, 2016). Those who have these disorders may display *mixed episodes* in which they demonstrate characteristics of both mania and depression. *Manic* or *hypomanic episodes* (up states that do not meet the criteria for mania) are characterized by periods of elevated mood and high-energy, while *depressive episodes* are characterized by periods of low mood and energy (APA, 2013; NIMH, 2016*)*.

Estimates suggest that in the United States, 2.6% of the adult population has one of the bipolar disorders (NIMH, n.d). An equal number of men and women develop bipolar disorder although, research findings support women have more depressive, mixed episodes, and experience rapid cycling more often than men (American Psychiatric Association [APA], 2013).

Counselors can diagnose bipolar 1, bipolar 11, cyclothymia, and for clients who do not meet the criteria for these more traditional bipolar disorder diagnoses, counselors might designate a diagnosis of *other specified and unspecified related disorders* (NIMH, 2016). *Ultra-rapid cycling* is a possible feature of bipolar disorders which involves multiple mood episodes within one week or even a single day. Rapid cycling is more common in women than men, and it may be caused by an interaction between bipolar disorder and substance abuse, triggered by the use of antidepressants, or associated thyroid disease (White & Preston, 2009). To be diagnosed with the various bipolar disorders, different combinations of symptoms and frequency of symptoms must be present. Additional detail on the symptom patterns associated with the various bipolar disorders can be found in the *DSM-5* (APA, 2013).

Resources:

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

National Institute of Mental Health. (n.d). *Bipolar disorder among adults*. Retrieved from: http://www.nimh.nih.gov/health/statistics/prevalence/bipolar-disorder-among-adults.shtml

National Institute of Mental Health. (2016). *Bipolar disorder*. Retrieved from: http://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml

IDENTIFICATION/ASSESSMENT STRATEGIES

Many disorders are comorbid with a bipolar disorder diagnosis including attention-deficit/hyperactivity disorder (ADHD), substance use disorders, and anxiety disorders. The following section includes several screening measures that may be helpful in identifying bipolar disorders.

Mood Disorder Questionnaire

The Mood Disorder Questionnaire (MDQ; Hirschfeld et al., 2000) is a brief self-report screening measure that is used to help identify individuals who have bipolar disorders. The MDQ has both sensitivity and specificity, and it consists of 13 questions plus items assessing clustering of symptoms and functional impairment. If the patient answers "yes" to seven or more of the 13 items in question 1, and "yes" or "moderate" or "serious" to question 3, this is considered a positive screen, and the possibility of disorders should be examined more closely. The questionnaire takes 5 minutes or less to complete.

A pdf of the MDQ screen is available to view at:

http://www.drdianenguyen.com/images/Bipolar_screen.pdf

Composite International Diagnostic Interview: Bipolar Disorders Screening Scale

The Composite International Diagnostic Interview (CIDI; Kessler et al., 2006) is a structured interview assessment. The CIDI consists of 12 questions including two stem questions, one question related to criterion B symptoms (from the *DSM-5*) screening, and nine questions directly related to criterion B symptoms. The more questions answered in a positive, affirming way the greater the likelihood of a positive diagnosis. The scoring is as follows: nine questions with positive affirmation is very-high risk, 7-8 questions with positive affirmation is high risk, six questions with positive affirmation is moderate risk, five questions with positive affirmation is low risk, and 0-4 questions with affirmation is very low-risk. The interview takes five minutes or less to complete.

A pdf of the CIDI screen is available to view at:

http://www.cqaimh.org/pdf/tool_cidi.pdf

The General Behavior Inventory

The General Behavior Inventory (GBI; Depue et al., 1981) is a self-screened measure designed to assess the severity of the core symptoms of bipolar disorders over the past year. The full 73 item version has demonstrated internal consistency and reliability as well as sensitivity to detecting bipolar disorders. The measure is reported on a 4-point rating scale and is easily administered in a clinical setting.

A pdf of this inventory is available to view at:

https://cls.unc.edu/files/2014/06/GBI_self_English_v1a.pdf

Structured Clinical Interview for *DSM-5*

The Structured Clinical Interview (SCID; Spitzer, Williams, Gibbon, & First, 1992) is a clinical interview first designed to be used as a part of the intake process. Over the years, it has become one of the most common assessment measures used to diagnose bipolar disorders in adults, in particular bipolar 1 disorder (Miller, Johnson, & Eisner, 2009). The SCID is a semi-structured interview that is broken up into different modules to cover different diagnoses; its bipolar module has demonstrated appropriate interrater reliability (Miller et al., 2009).

To view more information and/or to purchase the SCID-5 visit:

https://www.appi.org/products/structured-clinical-interview-for-dsm-5-scid-5

INTERVENTION/TREATMENT STRATEGIES

Psychoharmacotherapy

Because the bipolar disorders are caused by a complex set of biological and genetic factors, medication should always be used to treat those who receive the diagnosis. In fact, most people who have bipolar disorder will need to take medication throughout their lives to manage the symptoms of their illness. Medication compliance is an important treatment goal when counseling those who have bipolar disorder. However, many bipolar medications involve short and long term side effects (i.e., weight gain, nausea, sleep and appetite changes; NIMH, 2016) that may cause clients to stop prematurely their medications.

There are strategies that the client and the counselor can use to facilitate medication compliance. For example, counselors may work together with the client to help set up electronic tools for periodic reminders. They may also help the client set up a medication log that can help keep track of the medications, side effects, and other substances that may interfere with the medications.

When prescribing medications, physicians first consider what level of intervention a client needs. These phases include: the acute phase, during which the goal is to control the most severe symptoms of the manic, mixed, or depressive disorder; the stabilization phase, during which the goal is full recovery from the acute phase, and the treatment of residual symptoms and psycho-social impairment; and lastly, the maintenance phase, during which the goal is to prevent recurrences and continue treating residual symptoms (Barlow, 2008).

Mood stabilizers, such as lithium and valproic acid (e.g., Depakote), are the most common medications used to treat those who have bipolar disorders (National Institute of Mental Health [NIMH]; 2016). Lithium is effective in addressing both mania and mixed states and it can significantly decrease the severity and frequency of mood swings (Atkins, 2007; NIMH, 2016). Valproic acid (e.g., Depakote) is an anticonvulsant medication used as a mood stabilizer to treat adults who have "mixed" symptoms of mania and depression and rapid cycling (NIMH, 2016). Lamotrigine (e.g., Lamictal; Atkins, 2007), an anticonvulsant used to treat symptoms of bipolar, is recommended for the prevention of acute mania and depressive episodes associated with bipolar 1, and it is sometimes used in combination with Lithium (VA/DoD, 2010). Other anticonvulsants such as, carbamazepine (e.g., Tegretol) and oxcarbazepine (e.g., Trileptal), are commonly used to treat seizures and neuropathic pain, but can also be used to treat symptoms of bipolar disorder (VA/DoD, 2010).

Antipsychotic medications are also often used to stabilize mood and to treat those who have bipolar disorders. Lurasidone (e.g., Latuda), a newer medication, is used to treat adults who have bipolar disorders and it can be taken alone or with a medication such as lithium or valproic acid (Franklin, Zorowitz, Corse, Widge, & Deckersbach, 2015). Aripiprazole (e.g., Abilify), an antipsychotic, is used to treat adults who have acute manic or mixed episodes associated with bipolar 1 (Barlow, 2008). It can be used by itself or taken with lithium or valproic acid. Cariprazine (e.g., Vraylar) was recently approved by the FDA to treat bipolar 1 disorder in adults. Trials have demonstrated its efficiency in treating acute manic or mixed episodes associated with bipolar 1 (Durgam et al., 2015; McCormack, 2015).

Antidepressants are often used to treat those who have bipolar disorders. However, it can take up to 4-6 weeks for an anti-depressant to have a full effect. As such, physicians often need to try several medications before finding what works best for a patient (Harmer, Goodwin, & Cowen, 2009). Antidepressant medications often used in conjunction with other mood stabilizing medications include SSRIs (selective serotonin reuptake inhibitors; e.g., Zoloft, Prozac) and SNRIs (i.e., selective sero-

tonin and norepinephrine reuptake inhibitors; e.g., Effexor, Wellbutrin; Atkins, 2007; Barlow 2008). It is important to note that antidepressants may lead to worsened rapid cycling and may stimulate hypomanic/manic episodes in adults who have bipolar disorders (Atkins, 2007; Barlow, 2008).

Resources:

For more information:

http://www.bphope.com/blog/when-taking-bipolar-medications-becomes-overwhelming/

http://www.bphope.com/sticking-with-it/

Interpersonal and Social Rhythm Therapy

Interpersonal and social rhythm therapy (IPSRT; Frank, 2005; Hlastala, Kotler, McClellan, & McCauley, 2010) is an evidence-based treatment approach that can help with regulating biological and social rhythms (i.e., sleeping, eating, socializing, and exercise patterns). The goal of this approach is to help clients identify the disruptions that already exist in their daily routine (i.e., sleep) as well as make the connection between daily routine/ rhythm disruptions and mood destabilizations, which can escalate symptoms if not properly managed. IPSRT helps recognize interpersonal conflicts that are disrupting daily routine and making symptoms associated with bipolar worse. This approach emphasizes techniques that can be used to help manage stressful life events, strategies for enhancing and managing social supports and relationships, and it aims to reduce disruptions in social rhythms. The counselor and the client may work together to develop a daily schedule focused on diminishing the conflicts and disruptions caused by the disorder.

Studies have concluded that sleep is *vital* in regulating bipolar disorder and irregular sleep routines can have a negative impact on those who have bipolar disorder, even between mood episodes (Ng et al., 2016). Disturbed sleep, or a lack of sleep even when not experiencing mood symptoms, has been correlated with irregular social rhythms (Ng et al., 2016). For those who have bipolar disorders, a lack of sleep can increase insomnia, therefore triggering a mood episode. In addition, disturbed sleep can incite depressive episodes (Ng et al., 2016). Counselors can have clients monitor the number of hours they sleep so that they can recognize patterns, shifts in sleep patterns, and how these relate to their mood and energy states. A regular, consistent sleep-wake schedule is *essential* in preventing and triggering symptoms of bipolar disorder.

Resources:

A downloadable pdf of a sleep log can be found at:

http://yoursleep.aasmnet.org/pdf/sleepdiary.pdf

For more information:

http://www.bphope.com/blog/five-tips-for-better-sleep/

http://www.bphope.com/hope-harmony-headlines-bipolar-sleep-problems-and-solutions/

http://www.bphope.com/poor-sleep-predicts-mood-recurrence-in-remitted-bipolar-2/

http://www.huffingtonpost.com/wendy-k-williamson/sleep-the-other-half-of-bipolar-medication_b_7985708.html?ir=Healthy%20Living?

http://www.bphope.com/sleep-irregularities-impact-more-than-just-mood/

Cognitive Behavioral Therapy

When combined with psychopharmacological intervention, cognitive behavioral therapy (CBT) is an evidence-based approach for treating bipolar disorders. CBT involves identifying distorted thoughts and helping clients to learn how to control, manage, and change these thoughts (Driessen & Hollon, 2010). CBT is founded on the assumption that mood, thinking, and behavior all influence each other. Therefore, in treating adults who have bipolar disorders, the first step is to determine the problem such as identifying the rapid - distorted thoughts and behaviors and the emotions associated with them. CBT also focuses on communication, problem-solving skills, and teaching clients the skills required to cope with symptoms and the disruption of routines (i.e., sleep, diet, social interactions) that trigger bipolar episodes. Instability of circadian rhythms and impairment of the motivational/reward system in the brain (i.e., goal attainment) are important factors that are affected by bipolar disorder. Furthermore, applying self-regulation skills, promoting a routine and schedule, and challenging thoughts and behaviors can help reduce symptoms.

Studies have demonstrated that CBT reduces the frequency of bipolar episodes, enhances social functioning, and stabilizes mood (Driessen & Hollon, 2010; Lam et al., 2003). Studies have also demonstrated that combining CBT with medication can reduce the risk of bipolar relapse and result in fewer manic episodes as compared to medication alone (Lam et al., 2003; Salcedo et al., 2016; Watkins, 2003).

Mindfulness-based cognitive therapy (MBCT; Segal, Williams, & Teasdale, 2002) was recently adapted for the treatment of bipolar disorder and shows promise as an effective intervention. This mindfulness-based approach was designed to prevent relapse in patients who have recurring major depressive episodes (Segal et al., 2002). MBCT combines the use of traditional CBT techniques (i.e., thought and feeling connection) and mindfulness practice (i.e., meditation, self-observation) to help clients become more aware of their thoughts and feelings through focusing their attention and being present. Research examining the effectiveness of MBCT has demonstrated decreases in relapse of depression by 43% and decreases in anxiety over time (Miklowitz et al., 2009; Stange et al., 2011; Williams et al., 2014).

Resources:

More information on MBCT can be found at: http://mbct.com/

http://mbct.com/wp-content/uploads/Mindful-Future-of-Therapy-08_2016.pdf

Family-Focused Therapy

Family-focused therapy (FFT; Miklowitz & Goldstein, 1997) is an evidence based family therapy approach that involves the client and family members developing skills related to family communication and problem solving, as well as diminishing family conflict. Social support plays an important role in managing bipolar disorder, and thus a strong family structure is crucial. Family structure helps promote stable, consistent routines (i.e., sleep schedule, eating habits, medication management; Reinares, Bonnin, Hidalgo-Mazzei, Moreno-Sanchez, & Vieta, 2016). FFT involves providing psychoeducation to both the client and family about illness-management strategies, relapse prevention, and adherence to pharmacotherapy. It also involves enhancing the family's knowledge about the symptoms of bipolar disorder and how to handle these symptoms (Miklowitz, 2006).

FFT applies a biopsychosocial framework to encourage balance within the social and family environment (Miklowitz & Goldstein, 1997). The term *expressed emotion* is used to describe hostile

and critical attitudes that the family members may have towards each other (Reinares et al., 2016). Counselors work with the client and family members to help facilitate an awareness of *expressed emotion* and adaptive strategies that can be used to best facilitate family communication. Treatment typically consists of 21 sessions over the course of 9 months (Miklowitz et al., 2004). Studies have demonstrated a decrease in depressive symptoms and *expressed emotion* among families, as well as an increase in positive communication between family members when FFT is applied (Rivas-Vazquez, Johnson, Rey, & Blais, 2002). FFT has been shown to improve the clients' level of social adjustment and perceptions of relationship functioning (Rivas-Vazquez et al., 2002).

Resources:

http://gracepointwellness.org/4-bipolar-disorder/article/11221-bipolar-disorder-treatment-family-focused-therapy-and-interpersonal-social-rhythm-therapy

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