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Article 52

Integrating Interpersonal Social Rhythm Therapy and Eye Movement Desensitization Reprocessing in Treatment Planning for Bipolar Disorder

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Abstract

The information presented in this article intends to assist clinicians in developing effective treatment goals for clients with bipolar disorder by integrating interpersonal social rhythm therapy (IPSRT) and eye movement desensitization and reprocessing (EMDR). The information in this paper focuses on aspects of this diagnosis such as research associated with treatment options, advocacy suggestions for this population, and a fictional case study with a treatment plan that integrates IPSRT and EMDR. Due to the complexity of this diagnosis, its resemblance to other disorders, and its frequent comorbidity with other mental disorders, making accurate assessment of a bipolar disorder diagnosis is important in determining effective courses of treatment. In sum, a multifaceted approach may be needed when treating this disorder. Additional research needs to be conducted to determine the usefulness of psychotropic drugs as well as psychotherapies with and without the combination of medication.

Keywords: bipolar disorder, cyclothymic personality, counseling, therapy, bipolar II, treatment

Some people who are clinically diagnosed with bipolar disorder (BPD) experience challenges with attempting to treat it. These challenges include difficulty with medication compliance and suitability and the general lack of counseling offered or even recommended by care providers, often due to misdiagnosis or underdiagnosis, and limited access to appropriate care for this illness (Bhugra & Flick, 2005; Bowden, 2001; President's New Freedom Commission on Mental Health, 2003). Medication management is usually recommended for treatment in conjunction with psychotherapy, but challenges remain with attributing an accurate diagnosis, the potential for rapid cycling induced by inappropriate medications (e.g., antidepressants), and the general ineffectiveness of other medications such as mood stabilizers. Therefore, the question that remains is whether symptoms, duration, and frequency of bipolar disorders can be diminished by the services offered by counselors (Bowden, 2001; National Institute of Mental Health, 2016)? If so, which treatment interventions are most successful, and will psychotropic medications remain a significant part of managing this disorder?

This literature review examines advocacy issues for bipolar disorder, criteria to help distinguish between bipolar disorders and depression, and a fictional case study and treatment plan informed by interpersonal social rhythm therapy (IPSRT) and eye movement desensitization reprocessing (EMDR). Bipolar I disorder (BP-I) is characterized by episodes of mania and depression, whereas bipolar II disorder is comprised of episodes of hypomania (less intense episodes of shorter duration than mania) and oftentimes more severe depression. While the evidence suggests that BP-II is different from BP-I, the literature review conducted by the authors found little difference in treatment interventions, suggesting that more research could be conducted to determine what specific interventions would be most useful for treating either of these disorders (Swartz, Frank, Frankel, Novick, & Houck, 2009; Swartz & Thase, 2011).

Advocacy, Multicultural, Legal, and Ethical Issues for Bipolar Disorder

Bipolar spectrum disorders, among other mental health disorders, are considered when evaluating disability requirements with the federal government in the United States (Social Security Administration, 2016). BPD is characterized by mood swings of depression and mania or hypomania. The National Depressive and Manic-Depressive Association (2001) recommends a better understanding among primary care doctors and the general public in order to assess and treat BPD in a timely manner and to improve quality of life. According to the literature reviewed in this paper, there is a lack of psychosocial interventions for people on the BPD spectrum, and it is often treated only with medication and short visits with psychiatrists (if it is even correctly diagnosed; National Depressive and Manic-Depressive Association, 2001; Swartz et al., 2009; Swartz & Thase, 2011). Rather than referring to other helping professionals or using theories that may not be as useful for this population, mental health professionals, and particularly counselors, could benefit from being acquainted with theories like IPSRT and EMDR, which assist in stabilizing mood and can help prevent the occurrence of mood episodes, (Frank, 2005; Novo et al., 2014). As Frank (2005) indicated, routine is useful for a majority of people, but it is especially helpful to those with BPD because disruptions can contribute to a destabilizing mood that impairs their functioning. Directing clients and their families to certain advocacy organizations, such as The A2A

Alliance (see http://a2aalliance.org/) provides hope by breaking the stigma associated with BPD and other illnesses through showcasing leaders who live full, productive lives. The choice for a client to disclose their illness in a public format like this one is entirely personal, but it may provide encouragement to speak out and receive support for his or her illness. Additional elements of advocacy, such as supporting legislation or writing senators and congressman to support a broadening of mental health services are steps that can be utilized to increase access to mental health services.

Due to misinterpretation of symptoms and cultural differences between the therapist and client, some research indicates that Hispanic Americans and African Americans with BPD may be more often misdiagnosed with schizophrenia as compared to Caucasians (Bhugra & Flick, 2005). Regardless, the National Depressive and Manic-Depressive Association (2001) found that of 600 bipolar patients surveyed, 69% received a misdiagnosis with an average of 3.5 misdiagnoses overall and on average consulted with four physicians before receiving the proper diagnosis of BPD. Furthermore, language barriers can greatly affect the understanding of presenting symptoms (Bhugra & Flick, 2005). Some cultures do not view depressive or other distressing symptoms as something needing medical or psychiatric treatment, which can affect prognosis as help is not sought or is sought from shamans and other types of healers (Bhugra & Flick, 2005). Cultural competence on the part of the clinician, in addition to accessing interpreters and referrals to robust psychotherapeutic organizations when needed, will be tools the astute clinician will utilize.

The potential for legal issues for BPD clients is present, as impulsive (and sometimes dangerous and/or illegal) behavior and, for some, the tendency to self-medicate with substances might result when BPD is untreated (American Psychiatric Association [APA], 2013). Access to proper and ongoing care is essential for people with BPD, especially when transitioning from inpatient to outpatient care (Bhugra & Flick, 2005). To decrease hospitalization and the heavy burden it places on clients, families, and society as a whole, our society has an ethical responsibility to adequately care for the mentally ill and not punish or prevent them from being employed when their illness, particularly when left untreated, interferes with normal functioning. Greater understanding of BPD as a whole is needed to establish more effective, easily accessible, and affordable treatments for this population. As the A2A Alliance demonstrates, people with BPD can living meaningful, fruitful lives.

BPD is a complicated disorder that is difficult to properly diagnose and requires ongoing treatment. Medication with psychosocial interventions and sometimes psychotherapy alone are possible avenues to pursue when treating this illness (Frank 2005; Swartz et al., 2009). Successful outcomes for clients will depend on many factors, but thorough assessments and understanding of what could work on the part of the clinician will help in tackling this challenging illness.

Distinguishing BP-II from BP-I and Major Depressive Disorder

It is important to distinguish BP-II from BP-I and major depressive disorder (MDD) because treatment options will differ depending on the disorder. Hypomania distinguishes BP-II from MDD, and mania distinguishes BP-I from BP-II (APA, 2013). Hypomania is distinguished from mania by severity and duration; hypomania does not

cause significant impairment in functioning and is without psychosis. The presence of either would qualify as BP-I, with manic episodes being a requirement for the diagnosis of BP-I (APA, 2013). People with BP-II rarely complain of hypomania as they do not view it as disadvantageous (APA, 2013). Depressive episodes are what causes significant impairment for this population, which can lead to impulsive behaviors such as substance abuse and suicide (APA, 2013). To properly distinguish BP-II from a diagnosis of MDD, it is important to talk to people in close proximity to the client to investigate for erratic mood changes that the client may not find problematic or worrisome (APA, 2013).

Angst et al. (2003), in the BRIDGE study of 5,635 patients experiencing major depressive episodes in 18 countries, identified additional criteria that may help distinguish BP-I, BP-II, and MDD from each other. For instance, specific criteria distinguishing the bipolar disorders from MDD include onset of bipolarity before the age of 30, the occurrence of at least two or more episodes in a lifetime, and the presence of mania/hypomania among first-degree relatives (Angst et al., 2003). Family history of mania/hypomania and number of episodes were higher among BP-I patients (Angst et al., 2003). A further clarifier for BP-II, in comparison to BP-I and MDD, included hypomanic episodes lasting only 1–3 days (instead of the requisite 4 days) and differences in comorbidity patterns (Angst et al., 2003). Those with BP-II showed higher rates of all anxiety disorders in comparison to those with BP-I (save for social phobia), specifically, obsessive compulsive disorder, generalized anxiety disorder, panic disorder, and anxiety disorder (Angst et al., 2003). In comparison to MDD, both bipolar disorder groups possessed more comorbidity with borderline personality disorder and ADHD (other non-anxiety disorders, such as substance use did not differ much between the two groups of bipolar patients; Angst et al., 2003). According to the *DSM-5* (APA, 2013), substance use disorder occurs in 37% of people with BP-II, 75% will have an anxiety disorder, and 60% have at least three co-occurring mental disorders. However, while suicide attempts were higher in those with BP-I, comorbidity with anxiety disorders in BPD patients contributed to an increased risk of suicide attempts (Angst et al., 2003; Simon et al., 2004). Indeed, the high rate of anxiety disorders in those with BPD suggests that anxiety interventions ought to be included when treating people suffering from BPD. Anxiety contributed to less well periods, including less likelihood of recovering from a depressive episode, a greater probability of relapse from an acute episode, and "poorer role functioning and quality of life" (Otto et al., 2006; Simon et al., 2004 p. 1). Furthermore, antidepressants as a stand-alone medication for people with BPD is generally not efficacious and, it is therefore important for clinicians to accurately differentiate BPD from MDD to ensure better care (Hirschfeld, 2014). This information is useful when patients complain of depression as it is wise to always screen for BPD in addition to depression due to a similar presentation, which has implications for the planning of treatment (National Depressive and Manic-Depressive Association, 2001).

Contributing Factors to Diagnosis of BPD

The research informs clinicians that a strong genetic component to BPD, and the term "chemical imbalance" was likely first associated with it (Frank, 2005). Yet, the onset of individual episodes appears to be linked with environmental factors, which suggests the use of psychosocial strategies to help treat BPD (Frank, 2005). While the

lifetime prevalence rate for bipolar spectrum disorders is 4.5%, the prevalence of unipolar depression is 16.2%; the actual prevalence rate may be inaccurate as both sets of clients will usually present during a depressive episode. (Hirschfeld, 2014).

Much debate in the research exists as to whether antidepressants may do more harm than good for BPD patients by triggering rapid cycling, a hypomanic or manic episode, and producing overall disruption (Hirschfeld, 2014). Some research reports that selective serotonin reuptake inhibitors (SSRIs) generally have little to no effect and are not as harmful as once believed (Hirschfeld, 2014). Yet, in another study, antidepressants were responsible for an almost three-fold increase in depressive episodes and a 168% increase in overall mood episodes for people with BP-II (El-mallakh et al., 2015). Therefore, another distinguishing characteristic among bipolar disorders is a history of treatment-resistant depression (Hirschfeld, 2014). Other factors to consider when determining a BPD diagnosis are previous suicide attempts, psychiatric hospitalizations, a family history of BPD, mixed features present with depression, seasonal depression (winter), an earlier age of depression onset (22 vs. 26 in unipolar), signs of the bipolarity prior to 19 years of age, increased appetite, weight gain, and hypersomnia (Goodwin & Jamison, 2007, as cited in Hirschfeld, 2014).

Treatment Options

A good portion of the information presented in this selected research was dedicated to correctly diagnosing BP-II because treatment will differ for this population. If suspicion of a bipolar spectrum disorder is present, the Mood Disorder Questionnaire (MDQ) is a valid and reliable instrument for ruling out bipolar disorder (9 out of 10 times) and correctly screening for it (captures approximately three quarters of people with it; Hirschfeld, 2014). The MDQ is the most widely used instrument internationally and takes only 5 minutes to complete (Hirschfeld, 2014). Assuming that the client presents with BPD, the criteria cited earlier will help determine if the client is experiencing BP-I or BP-II. While some treatment options exclude the use of medication, depending on the level of functioning and disturbance the client is facing, referral to a psychiatrist is warranted to help determine the best course of action (Frank, 2005). Antidepressants must be approached with caution, but medication that has proven to be moderately efficacious for the treatment of BP-II depression compared to placebo includes quetiapine (an antipsychotic) as a monotherapy drug and lamotrigine (an anticonvulsant) as an adjunctive drug (Swartz & Thase, 2011).

Although BPD is greatly understudied, a review of the literature suggests a few treatments stand out as potentially useful in reducing depression and mania and improving overall life satisfaction, regardless of BPD type: interpersonal and social rhythm therapy (IPSRT), eye movement desensitization reprocessing (EMDR), and family therapy (Miklowitz et al., 2007; Novo et al., 2014; Swartz et al., 2009). IPSRT involves psychoeducation on the disorder, including explanations of treatment options and possible side effects; social rhythm therapy, which promotes the idea that routine and regulation in one's life promotes stabilization of mood; and, lastly, bolstering a client's relationships by helping clients recognize the interpersonal challenges related to their mood and find more functional methods for dealing these (Swartz et al., 2009). EMDR is a therapy intervention designed by Francine Shapiro (2001) and is noted for its relief of

trauma and trauma-like symptoms. It is believed that insufficient processing of distressing experiences creates pathological symptoms and once satisfactorily processed, the memories are stored more adaptively, allowing for better functioning in the present (Shapiro, 2001).

The Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD) study of 3,153 bipolar patients found significant comorbidity with post-traumatic stress disorder (PTSD; about 20% vs. 8% among the general population; Hernandez et al., 2013). Even without meeting full criteria for PTSD, people with BPD were likely to have a history of trauma that contributed to the onset of symptoms, like hypomania and depression, as well as an increase in rapid cycling, substance use, and attempted suicide (Novo et al., 2014). The study by Novo et al. (2014) presented a significant reduction in mania and depression among the participants suffering with BPD and improved mood stabilization when given EMDR as compared to a treatment as usual group. Lastly, including at least one family member in sessions to help understand the illness, its effects, and behavioral strategies, facilitated BPD clients with life satisfaction and functioning (Miklowitz et al., 2007).

The following is a fictionalized case study to illustrate the application of IPSRT and EMDR in the planning of treatment for a client with bipolar disorder. Though the case does not involve a real clinical circumstance, it does provide insight for utilizing this integrated approach that is responsive to the elements of mood and the need for potential reprocessing as it relates to past trauma.

Case Study

A 22-year-old African-American male named Matthias was referred to his college counseling center at the recommendation of a professor. He was studying medical office management at a technical community college. He had missed several class sessions and was in jeopardy of failing. When asked why he did not attend class, he reported feeling overwhelmed with trying to take classes and work at the same time, and he found it hard to come to class, often oversleeping. He reported some concerns, such as financial difficulties, he was experiencing with his live-in girlfriend, and feared the consequences of failing out of school, such as the possibility of ruining his future career opportunities if he cannot graduate. Matthias indicated recent feelings of irritability and restlessness, with difficulty adhering to regular sleep-wake times, exercise, or eating. He was enjoying working as an office assistant at a dental practice, although at times he would have difficulty focusing, yet at other times he was able to accomplish more than his colleagues. Due to more variety in his day, he indicated being able to function better at work than at school.

Matthias claimed to no longer have a religious affiliation, and he lived with his girlfriend, reporting a few other close friendships. He and his girlfriend had been living together for over a year and both worked minimum-wage to slightly above minimum-wage jobs. Matthias possessed a youthful presence, although he acted and dressed slightly immature for his age: Noticeable was his adolescent (or smaller) clothes for his fuller frame, which did not fit well. He was neat and clean, talked rapidly, jumped quickly from one topic to another, suggesting a jumbled cognitive process, and spoke of

his many troubles without pause. He did not appear to be experiencing any current or past hallucinations or delusions and denied any substance use other than caffeine.

In the intake interview, Matthias reported an extremely erratic sleep schedule, but claimed to function well on only a few hours of sleep a night. There were times when he felt so overwhelmed that he would sleep the entire day. When asked about his relationship with his girlfriend, he indicated that they argued sometimes about the way Matthias spends money, and he said that he is not allowed to buy things without his girlfriend's permission. The client reported being in close communication with his family but that he was closer to his dad than his mom because his mom has "awful mood swings," that make their relationship hard on him. He was the only living child as he had a younger brother who died in a car wreck they were both in when they were teenagers. Matthias said that experience was challenging for the entire family, and they went to his family church for support in dealing with the tragedy. He indicated often being sad when remembering his brother and became tearful in the session when discussing it. Matthias tried to complete suicide the summer after his brother's death, but he did not take enough pills to do it, although he was hospitalized for about a week after the incident for care and observation. He was given antidepressants, which did not work, but going back to school helped. That was his only suicide attempt and hospitalization.

After high school, Matthias began to work at the dental office and became interested in office administration. He reported enjoying the work itself and his colleagues, but since enrolling in school this last year, life has felt more difficult to manage, and he agreed that his performance in school was suffering. Matthias possessed a desire to do well in school and appreciated his professor's concern to help him instead of failing him, but he felt unsure about continuing his education.

Diagnosis

At the outset, Matthias appeared to meet diagnostic criteria for a bipolar spectrum disorder, most likely BP-II as he did not meet full criteria for mania due to the absence of psychotic features and the fact that the manic-like symptoms were not causing significant impairment in life-functioning (APA, 2013). Additional signs pointing toward a BP-II diagnosis included a first-degree relative (i.e., his mother) possibly having an undiagnosed mood disorder, weight gain, periods of inappropriate spending, and previous hospitalization and trauma. The client possessed some understanding that his behavior was of concern to those in his life at an academic and interpersonal level, at least in regard to class attendance and excessive spending. He was also aware that his sleep and attention patterns were maladaptive, but failed to see the ongoing pattern of how the debilitating depressive episodes began or that his energized behavior might have been an indication of hypomania. The client's mood episodes increased since he started work and school. This indicates that changes in routine were particularly disturbing and that his current coping responses were not sufficient to handle his disorder and may, in fact, be worsening their duration and frequency of his mood episodes. The client was not suicidal, although a brief assessment would be warranted due to his previous attempt. The traumatic event of losing his brother suggested that his unresolved grief may be contributing to the inception of mood episodes as well.

IPSRT and EMDR-Informed Case Conceptualization

The counselor's session with Matthias revealed that he was struggling with maintaining stability in various areas of his life due to interpersonal stressors, as demonstrated by his relationships with close significant others, the work-student-life balance, and the lack of a social rhythm for his life due to irregular daily routines. The goals of IPSRT for Matthias were three-fold. First, psychoeducation was a priority as Matthias was unaware of his illness and, therefore, how to properly manage it. The issue of medication and medication adherence would need to be discussed with him as psychoeducation about the illness and treatment options would help Matthias make informed and committed decisions for himself about how to prevent new episodes and/or extend his well periods (Frank, 2005). Second, Matthias' decision to become a student in addition to working was a role and routine change that was difficult for him to navigate. This change inevitably exerted stress on his relationships with his girlfriend and family, in conjunction with the independent stressors of previous trauma (i.e. the loss of his sibling), erratic behaviors (i.e., uninhibited spending), and mood changes. Third, Matthias' irregular schedule contributed to his instability and stress. IPSRT for Matthias would address the need for, and compliance with, a more predictable and routine schedule with sleeping, eating, exercise, study time, and other commitments.

In addition to IPSRT, EMDR is suggested to help Matthias learn from his negative past experiences, desensitize himself to present, distressing situations, and incorporate adaptive templates for future actions (Shapiro, 2001). A possible target for EMDR would be his sibling's death and anything else he and the clinician identified as sources of stress that may have led to maladaptive beliefs and behaviors.

The overt symptoms of BPD could be stabilized with Matthias utilizing the protocol designed by Shapiro (2001). Matthias may have unrecalled or hidden dysfunctional memories other than the loss of his sibling that inadvertently affected his quality of life and mood stabilization. It is important for the clinician to assess for other areas of distress (Shapiro, 2001). Since EMDR is a self-healing process, it is suspected that Matthias would gain a sense of self-empowerment and future autonomy to respond appropriately to future challenges (Shapiro, 2001).

With immediate care and management, Matthias' prognosis for accomplishing his goals of graduating, sustaining his relationship with his girlfriend, and getting a better job in the future was moderate. Positive outcomes are hard to determine due to the complexity of this lifetime illness, the possibility of a BP-I diagnosis at some point, and other factors like medication adherence or the experience of a new trauma. However, due to the early discovery of BP-II, Matthias may fare well for developing a thorough understanding of the nature of his illness and the best ways to manage it over the course of his life. Treatment will necessarily be ongoing throughout his life but could decrease over time, depending on his progress. Weekly counseling will be necessary for the first few months with the possibility of tapering to biweekly or monthly sessions. Other factors contributing to a better prognosis include his positive performance at work, at least one supportive parent, a supportive girlfriend, and a nurturing academic environment. Establishing routine, forging better interpersonal relationships, and finding medication that is effective could help his resilience against this illness, particularly if his access to quality health care will be less than optimal after he finishes school. Most

importantly, Matthias appears receptive to counseling and medication in order for him to live a more functioning life.

Treatment Plan

The client's goals were to successfully continue in his education so that he could receive his degree and pursue his chosen field of work and maintain a stable, happy relationship with his girlfriend. Initially, the clinician needed to collaborate with the school psychiatrist to determine if Matthias was a good candidate for IPSRT (Frank, 2005). If this determination is made, the long-term goal of preventing another episode and prolonging the time between episodes will aid the client in keeping the stability needed to finish school, work on his interpersonal relationship, and become gainfully employed (Frank, 2005). Because episodes of BPD may be triggered by medication noncompliance, interpersonal challenges as a result of life stressors and changes, and disturbances to life routines, the treatment of IPSRT will address each of these areas (Frank, 2005). Lastly, if sufficient trust between the clinician and client has been established and the client has stabilized significantly, EMDR can be employed to treat the client's past trauma and any associated negative cognitions tied to the event or other events within his life (Novo et al., 2014). Due to the fact that trauma is highly co-morbid with this population and appears to be so with Matthias, EMDR will likely enhance the effectiveness of IPSRT by resolving his maladaptive beliefs and supporting new, healthier behaviors. The following is a brief treatment plan associated with Matthias' experience to further establish the manner in which IPSRT and EMDR can be integrated to address his situation.

Initial Goal: Screen for bipolar spectrum disorders and suicidality to develop an appropriate treatment plan.

Short-Term Goals:

1. Assess for suicidality and develop a safety plan if needed. Establish the therapeutic relationship, especially if client is in crisis, and utilize crisis counseling skills (Frank, 2005).
2. Administer the MDQ and discuss results with the client.
3. Depending on MDQ results, consult with the staff psychiatrist and refer client to the psychiatrist.
4. Develop a joint medication (if needed) and counseling plan in conjunction with the staff psychiatrist. A subset of BP-II clients do well with psychotherapy alone (Frank, 2005).

Long-Term Goal 1: Provide psychoeducation around the illness to develop motivation for medication adherence (if needed) and commitment to counseling (Frank, 2005).

Short-Term Goals:

1. Begin psychoeducation portion of IPSRT: What is BPD? Discuss symptoms, stability of illness throughout lifetime, treatment options, including medication information, and an overview of IPSRT counseling interventions (Frank, 2005).

2. Invite client's girlfriend and father in for a joint session to understand baseline behavior of client when functioning normally and to increase support and understanding of illness (Miklowitz, 2007).
3. Explore feelings around having the illness (Frank, 2005).
4. Process grief of the "lost healthy self" however the clinician chooses to do so, such as using creative arts therapy or journaling (Frank, 2005, p. 43).

Long-Term Goal 2: Reduce interpersonal stress (Frank, 2005).

Short-Term Goals:

1. Client will select one or two problems in interpersonal life that he wants to work on (e.g., relationship with girlfriend, parents, professors etc.; Frank, 2005).
2. Client and clinician will develop coping strategies to aid in reducing stress with social roles and transitions (mindfulness activities, creative outlets, rituals, etc.).
3. Client and clinician will practice and role-play pro-social behaviors and asserting oneself, including the use of "I" statements, asking for a "time-out" with friends or girlfriend if client experiences warning signs of a mood switch, and requesting special accommodations at school if warranted, while proper legal documentation for the disorder is pursued if the client so desires.

Long-Term Goal 3: Establish and maintain a set routine and schedule to stabilize social rhythms (Frank, 2005).

Short-Term Goals:

1. Provide psychoeducation on sleep hygiene, eating habits, exercise, the use of stimulants, potential stimulating situations (e.g., crowded places, class presentations, etc.), and how to cope with unavoidable or unplanned changes in routine (Frank, 2005).
2. Develop a working list of areas with the client that he may need to modify or develop a routine for, such as sleeping and waking hours, and give him a written plan to begin following. Re-visit plan and change as needed.
3. Develop a working list of environmental factors and situations that may cause stress and heightened stimulation such that social-seeking or social-avoiding behaviors occur. Identify strategies with client to modulate his involvement with them to avoid the frequency and intensity of stimulation (Frank, 2005). Re-visit plan and change as needed.

Long-Term Goal 4: Help process past or current traumas to reduce bipolar symptoms generally and the reoccurrence of new episodes (Novo et al., 2014).

Short-Term Goals:

1. After relationship between client and clinician is established and strategies to combat life stressors are in place, with client's permission, discuss using EMDR as treatment for client's previous trauma.
2. Provide psychoeducation on EMDR and possible side-effects.
3. Provide appropriate grounding and stabilization skills prior to EMDR processing.
4. With client's permission, perform EMDR for as long as clinically appropriate (Novo et al., 2014). Re-visit grounding and stabilization as necessary.

Long-Term Goal 5: Termination of treatment.

1. Begin discussing reduction in sessions and/or possible termination.
2. Plan for 3–4 month check-ups if possible (Frank, 2005).
3. If not possible or not desired to continue the relationship, begin planning for termination over the span of a few months (Frank, 2005).

Long-Term Goal 6: Address advocacy issues with client in regard to illness.

Short-Term Goals:

1. Provide information on campus resources to help manage client's illness, including a learning assistance center to provide disability accommodations if needed, Student Health Services for access to doctors, psychiatrist, medication management, and a list of off-campus referrals for when student is away from school or decides to seek care outside of school.
2. Provide client with advocacy information, such as Web sites like The A2A Alliance, to help client in dealing with stigma and finding empowerment.
3. If in line with clinician's capabilities or university policy, consider inviting family or partner in for sessions with client to help in providing psychoeducation on BPD and ways significant others can contribute to each other's health and wellness.

Conclusion

In sum, the difficulty in diagnosing BPD presents a challenge to clinicians in order to successfully treat this concern. Because BPD resembles other types of diagnoses as it shares qualities of depression and mania, treatment planning must necessarily be comprehensive and uniquely tailored to address all of these issues. We offered evidence for advocacy and diagnostic issues with bipolar disorders followed by a fictional case study and treatment plan using IPSRT and EMDR as its foundation to give clinicians a potential map for addressing this concern. Clinicians interested in implementing IPSRT or EMDR, but particularly EMDR, should seek appropriate, certified, professional training before using with clients.

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