

Chapter Six

Treatment Planning

Given the broad array of psychosocial interventions with evidence of usefulness in managing Bipolar Disorder, the task of treatment planning can be daunting for both the consumer and clinician.

BHI has designed an adult psycho-education program (Bipolar Education and Skills Training) that delivers the entire menu of evidence-based information in 32 sessions.

But for the individual consumer a customized version of the guidelines, based on his or her goals, will be more realistic. This chapter offers strategies for prioritizing treatment options, a treatment planning menu to assist with treatment choices and sample treatment goals.

Prioritizing Treatment Goals

The following questions may be of help:

1. Are the consumer and family currently safe?
2. Where is the family on their diagnostic journey?
3. Are the consumer and/or family vested in treatment?
4. Does the consumer have a psychiatrist? How do the parents of a youth consumer feel about medications?
5. Are symptoms currently acute, or is the consumer euthymic?
6. What is working and what is not working for this consumer and family in managing this disorder?

7. What has the consumer and family done in the past that has helped and can be built on?

Prioritize interventions based on:

- Vestment in treatment—assess family in grief cycle related to acceptance of diagnosis, stages of change. Ask consumer or family what one thing they would change if they could
- Safety—build a safety plan
- Reduction of acute symptoms:
 1. Vest parents and consumers to restore hope, review evidence of efficacy of interventions. What do the consumer and family know about Bipolar disorder? What are the education deficits?
 2. Check medication status—is the consumer on medication? Does the consumer need a medication referral? Does he or she have a psychiatrist? Do they need help in getting one? Does the consumer feel the meds are helpful?
- Building relapse prevention skills: Does the consumer or family know what triggers mood events? Are they aware of the warning signs of impending trouble?
- Gaining additional skills to build self-monitoring, self-regulation of mood and recovery. What other factors contribute to stress and subsequent relapse for the consumer? Negative thinking? High EE? Interpersonal stress? Communication and problem solving deficits? Feelings of isolation and stigma?

Treatment Planning Menu

- Referral to psychiatry and Bipolar specialist
- Identifying areas in which skill development is needed

- Assessing parental empowerment, vesting consumer and family in treatment
- Education about the diagnosis and diagnostic journey for children
- Education about medication
- Relapse prevention skills and planning
- Daily rhythm stabilization
- Addressing cognitive distortions
- Interpersonal skills building
- Stress and change management
- Communication skill building
- Problem solving skill building
- Facilitating of peer and community support

Delivery modalities can include the following:

- Individual psychotherapy and education
- Group psycho education
- Skills learning groups
- Family counseling

Examples of Goals and Objectives in the Treatment of Bipolar Disorder

Treatment goals should:

- Be age appropriate
- Use language understandable to the consumer and family
- Be written in behavioral terms—measurable achievement
- Be written in positive terms—what the consumer wants, not what he wants to get away from
- Incorporate what is already working for the consumer and family

Examples of Treatment Goals

The following examples of goals relate to each of the menu items, but will need modification to address the age and needs of the consumer.

Diagnosis education:

- Consumer will become an expert in Bipolar disorder as evidenced by successfully completing the Test your Knowledge of Bipolar Disorder Questionnaire.

Addressing medication education:

- Consumer will identify any barriers to receiving the maximum benefit from medications and develop strategies to overcome those barriers.

Addressing relapse prevention:

- Consumer (and family) will identify at least five warning signs of an impending episode of depression, hypomania or mania.
- Consumer (and family) will develop strategies to intervene when warning signs are apparent.
- Consumer (and family) will identify at least five triggers that can exacerbate symptoms.
- Consumer (and family) will develop strategies to recognize, avoid or deal with triggering events.

Addressing the need to stabilize daily rhythms:

- Consumer will recognize stable and unstable patterns in her daily routine.
- Consumer will identify one daily routine to stabilize and perform that routine at the same time each day give or take 45 minutes.

Addressing the management of stress and change:

- Consumer will learn and practice stress management techniques to successfully manage stress and change.

Addressing interpersonal stresses:

- Consumer will strengthen interpersonal relationships through identifying areas of interpersonal stress and using new tools to effectively manage that stress.

Addressing cognitive errors and beliefs:

- Consumer will develop a repertoire of thinking skills to identify and combat negative thoughts.

Addressing peer and community support:

- Client will enhance her support system.

A Note about Strengths-Based Planning

In strengths-based planning, the clinician seeks evidence of specific ways in which the individual has managed with or in spite of his or her limitations to meet the challenges of everyday life. The clinician maintains a curious stance about past successes, however small. Noticing and amplifying small positive efforts made by the client can instill hope. For example, the youth who manages to get out of bed and make it to school just two days last week still applied some level of authentic will or resourcefulness that should be explored and amplified.

Strengths-based planning recognizes the individuality and giftedness of the client and her family and seeks to build on these strengths. For example, a bipolar spectrum disorder may be contributing to marital discord in a long-

term relationship. Within a pathologically oriented model, the relationship can be viewed as dysfunctional. From a strengths-based model, however, the strengths of the marriage that resulted in a long-term relationship would be emphasized and the focus of treatment would be to shore up the strengths while providing tools to effectively deal with the impact that the illness has had upon the family.

The clinician must engage the consumers assuming that she or he would like to participate in decision making and to continue to have control over his own life. The client becomes a partner in his healthcare and he is encouraged to plan and manage the events of both his therapy and his life. Periods of decreased ability to function are seen as temporarily needing intervention, but the sickness role is not imposed as a life-long pattern that has to be adhered to with disregard for the dignity and individuality of a person.¹

According to the Surgeon General's Report, "All services for those with a mental disorder should be consumer-oriented and focused on promoting recovery. That is, the goal of services must not be limited to symptom reduction but should strive for restoration of a meaningful and productive life."²

Language: "A Bipolar" or "a Person with Bipolar Disorder"?

The language we use to describe individuals frequently focuses on pathology to the extent that individuals become the diagnosis they have been given, being referred to as "Bipolars" or "Bipolar" patients. Individuals who are diagnosed with cancer do not become "cancers" following their diagnosis, but a person who has been known as a husband and father, an accountant, an outstanding softball pitcher in

the local men's league and an artist can become "a Bipolar" overnight in his clinician's, family's and community's language. Sadly, he can also become "a Bipolar" in his own language. The power of language is far-reaching and often fear and helplessness replace hope as individuals lose the lives they enjoyed prior to the diagnosis of Bipolar disorder.

References

1. McDiarmid D, Ridgeway P, Davidson L, Bayes J: *Pathways to Recovery: A strengths recovery self-help workbook*. University of Kansas, 2002.
2. U.S. Department of Health and Human Services. Mental Health: "A Report of the Surgeon General." Rockville, MD: *U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health*, p. 455, 1999.