

## Chapter Eight

# Early Intervention & Relapse Prevention Strategies

### Early Recognition and Management of Symptoms

Clients and families must first become highly skilled at identifying early warning signs of a changing or unstable mood and to take action early. Early recognition and management of emergent relapse symptoms and triggers, such as sleep deprivation, stress and substance abuse, can prevent major episodes of Bipolar disorder.

They can then learn to move toward activation when early symptoms of depression occur and toward dampening the high energy of hypomania and mania rather than to fuel its increased energy. Clients and families can develop plans for various stages of intervention depending on the severity of symptoms.

During more stable periods clients can be encouraged to make their wishes known and to teach their family or close friends how to best help them meet their needs during episodes of illness.

A Wellness Recovery Action Plan (WRAP)<sup>1</sup> or a Treatment Contract (See Bipolar Toolbox) can help both clients and family members learn to manage early warning signs and to avoid or deal with triggers as they occur. WRAP planning has been found to be effective when applied by family members for their own needs and is currently being taught to family members as well as to clients.

### Warning Signs and Triggers

#### *Warning signs*

Warning signs can be different for each individual who experiences Bipolar disorder. In some cases, warning signs are the same as the clinical symptoms described to define episodes of depression, hypomania, mania or mixed mood. However, each client may be able to identify specific warning signs that tell him that his mood may be changing.

*Here are some ways individuals describe their warning signs of depression:*

- I quit cooking meals
- I start needing more sleep including naps during the day
- I no longer want to be among people although I normally enjoy social interaction
- I crave chocolate
- I have headaches
- I start having headaches
- I don't care about anybody else
- People bother me

*Here are ways warning signs of mania/hypomania are described:*

- I find myself reading five books at once
- I cannot concentrate
- I find myself talking faster than usual
- I feel irritable
- I need to move around because I have more energy than usual
- I am hungry all the time
- Friends tell me that I'm crabby

The clinician can do a quick check of mood with the client by teaching him to recognize three warning signs of depression and three of mania/hypomania. These can act as a barometer to gauge changes in mood. However, the

real value in warning signs is in their recognition by the client followed by an action step that can be taken in order to help modulate mood. For example, if an early warning sign of depression occurs, the client may want to increase his exercise, make sure he calls a friend to talk for a few minutes, or plan a simple activity to counteract isolating behavior. The WRAP tool further divides warning signs into early warning signs, signs that things are breaking down and warning signs of crisis. In using a WRAP, levels of intervention are planned by clients to manage the various levels of symptoms.

### *Triggers*

“Triggers” are things or events in the environment that can trigger an exacerbation of symptoms. Triggers differ from person to person and at different times in a person’s life. Examples of triggers include:

- Stress
- Disruption in routine
- Family gatherings
- Changes in weather or the amount of sunlight
- Over-stimulation by light or noise
- Certain foods
- Difficulties at work or school
- Interpersonal problems
- Financial concerns

Once clients learn to recognize triggers that cause exacerbations of mood episodes, they can manage them by avoiding them, by planning how to manage triggers that cannot be avoided, or by learning ways to compensate for triggers. For example, loud noises will exacerbate mania in some clients. They may therefore wish to avoid rock concerts or wear earplugs when they

go. Some clients do better when they avoid processed foods or milk products.

Family gatherings may be difficult for many clients, especially around the holidays. They may wish to plan a quiet time with one or two family members instead of attending the family party. Alternatively, perhaps they will choose to attend the party but stay only a short time or take a break by finding a quiet spot or going for a walk. If they know a particular family member inevitably triggers strong emotions, they may choose to limit their conversation with that person or talk with him when another family member is present to help buffer the conversation. The client can find a support person at the event to check in with or ask for assistance.

When faced by an unexpected trigger such as an argument at work, clients can learn compensatory management such as taking deep breaths, talking to a friend or clarifying the issues with problem solving techniques. See Chapters Nine and Eleven for further discussion of stress management and problem solving skills.

Miklowitz<sup>2</sup> recommends a “relapse drill” to use as a dress rehearsal for the client and family members to learn what they need to do when there are signs of a reoccurrence of symptoms. This drill acknowledges that the client is vulnerable to subsequent mood disorder episodes. Although clients can be very resistive to this exercise, particularly if the disorder is of recent onset, resistance can be confronted by relating the exercise to other drills such as a fire drill. It is hoped that the skills learned in a drill will never need to be used, but it is good to have a plan just in case something does happen. Relating this exercise to other practice drills can take the spotlight off the client and make her feel more comfortable with the discussion.

The relapse drill can be used as the family’s first attempt to problem solve together in the

therapeutic environment. The exercise puts the client and family members in the situation of considering what specific steps each will take in order to facilitate appropriate treatment for the client if symptoms of an episode reoccur. They begin by identifying prodromal symptoms, and then each member of the family suggests roles or actions each might take when these symptoms appear. As in other problem solving interventions, pros and cons are not considered until all the ideas have been shared. Only after all possible solutions have been suggested, the family evaluates which interventions might be most helpful. Then client and family choose which combination of actions they will use for future responses to symptoms.

The relapse drill examines what specific symptoms the client and family members have identified at different stages of the mood disorder, beginning with the most benign symptoms and preceding with symptoms requiring crisis intervention. Interventions are addressed at the appropriate level of symptomatology and include how the client wishes to be treated by family members when certain symptoms arise. For example, there may be plans for little or no family action other than discussing mild symptoms that might not be recognized by the client. Some clients appreciate a hug or someone to walk with them when they are feeling mild symptoms of depression.

If symptoms become extreme or dangerous, plans could include which hospital will be used if the client needs inpatient care, who will have legal responsibility if the client becomes incompetent to make decisions, and what forms of treatment she prefers in an emergency situation. When symptoms of mania arise, it can be helpful to decrease family activities and stimulation within the home environment.

The fire drill gives the client a chance to convey these individual needs with the family before symptoms arise or get out of hand. The client is encouraged to take a lead role in her care whenever possible. For example, if the client has a history of psychosis during a mood episode, a contract can be developed in which she identifies who should take charge in the event that she becomes unable to make appropriate decisions about care.

The relapse drill can augment an understanding that mood disorder symptoms are the result of an illness and are not willfully produced by the client. Helping the client and family consider options and decide on action plans enables the clinician to reinforce a hopeful attitude regarding the future course of the illness. Reviewing each participant's role or action and praising the entire family for participating in a difficult process conclude the exercise.

## Children and Adolescents

- Modifications to relapse prevention in children are made to address the lack of formal operational thinking in children and many adolescents. Children will have more difficulty than adults in recognizing patterns of cause/effect relationships.
- Children most often cannot generalize new information to different settings. The therapist must direct this process—what are some triggers at home? Are there triggers kind of like that at school? When my friends tell me I'm behaving like a jerk, are they just creeps or are they telling me something about my warning signs of relapse?
- Child must be helped to practice new skill in different settings. Therapists can begin this process. But it is also important for family and educators to assist the child as well.

- Children with bipolar disorder have shown worse performance on numerous IQ tests, including measures of attention, verbal/nonverbal memory, and executive function, than control groups.<sup>3</sup>
- Determine child or adolescent and parents' beliefs and schema about warning signs and triggers. A distorted belief might be that there is no connection between behavior and outcome. For example, the family might not see a connection between the child staying up extra late and problems with agitation in school the next day.
- Validate the belief.
- Connect belief to behavior. Adolescent must grapple with changing belief, which is the goal of CBT—to change belief. For example the adolescent may believe that staying up later and later at night is cool and not a warning sign of impending mania or hypomania.
- Explore with child the internal cues to recognize warning signs as such. Children may not have the language or ability to separate “bad day” from “stress over a school test.”

## Implications for Parents

- After observing the child and parents and gathering history the therapist should develop a list of triggers and review first with the child or adolescent then with parents, to get corroboration, agreement and to ask if there are other triggers. In asking children first, you can assess for his/her level of insight regarding their thoughts, feelings, behaviors, or reactions to the event. It is often helpful for parents and diagnostic for the clinician to hear how children respond to these questions versus being “set up”

by their parents. Parents can then make additional comments and/or correct their children.

- Must ascertain if parents have distorted or skewed perceptions and beliefs about child's behavior.
- Help parents discriminate between behaviors that are related to Bipolar Disorder and those that are “attitude” issues over which the child has more control. Validate parent's feelings about how difficult this task may be.
- Help parents with struggle to maintain structure and prompt child to practice skills.
- Help parents understand that the nature of the disease is such that even if the child can demonstrate a skill or ability once or twice, it is likely that they will forget or not use it every time, and constant prompting throughout adolescence and early adulthood may be necessary.
- Help parents develop a reward system for children when they do practice skills.
- Help parents develop a way of talking with children about how children can handle their behaviors and emotions differently in situations where their reactions were inappropriate. Increase parent's ability to help their children problem solve.

## References

1. Copeland ME.: *Wellness Recovery Action Plan*. Peach Press, West Dummerston, VT, 2000.
2. Miklowitz DJ: *The Bipolar Disorder Survival Guide*. The Guilford Press, New York, 2002.
3. Bates M, Voelbel G, Pandina G, Hendren R: “Memory and Executive Function Impaired in Children with Bipolar Disorder.” *Poster presentation, NIMH Collaborative Pediatric Bipolar Disorder Conference*, Massachusetts General Hospital, Boston, 2003.