Bipolar Disorder – Psychological strategies in primary care.

Dr Stephen Hirneth, Clinical Psychologist

Director, New Ability Health

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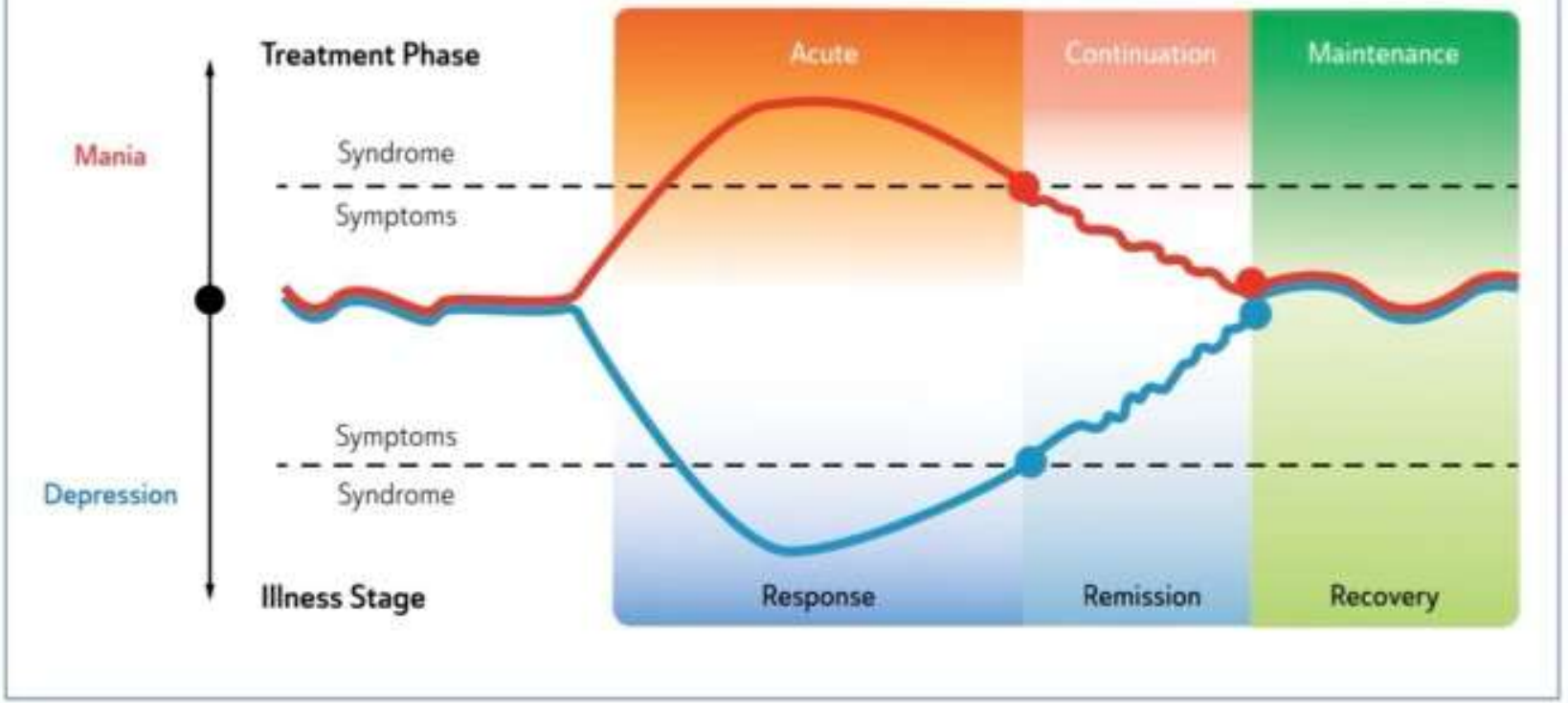
Overview of Presentation

- Collaborative Assessment of bipolar disorder
- CBT and other psychological approaches to treating bipolar disorder
- Questions / Discussion

Collaborative Assessment of bipolar disorder

- Bipolar is often not immediately clear at first
- Presenting picture is usually depression + anxiety
- Intervention is often starting before diagnosis is certain
- Longitudinal + collaborative assessment important
  - Family history
  - Multiple sources
  - Past records
  - Prospective assessment

Figure 5. Mood disorders stages of illness and phases of treatment.



Derived originally from Kupfer (1991) and adapted from Malhi et al. (2009b).

Table 8. Summary of DSM-5 criteria for bipolar disorders.

	BD I	BD II	Cyclothymia
Main Symptom Criteria (Mania)			
Elevated or irritable mood	+	Often irritable	+
Increased activity or energy	Goal-directed	+	+
Increased self-esteem	+	+	+
Decreased need for sleep	+	+	+
Pressured speech	+	+	+
Distractibility	+	+	+
Increased risk taking behaviour (especially for those with comorbid BPD)	+	+	
Main Symptom Criteria for Depressive episodes (Same as MDD)		+	
Severity and duration of episodes			
(Hypo)Mania	Mania	Hypomania**	Sub-threshold Mania
Number of Symptoms	3–4 symptoms	3–4 symptoms	⩽ 3 symptoms
Duration of Episode	> 7 days	4–7 days	< 4 days
Impact on functioning	Disrupts social and occupational functioning or results in hospitalisation	Not severe enough to disrupt functioning or result in hospitalisation	Symptoms of (hypo) mania/depression cause significant distress or impairment in functioning
Depression	Depression	Depression	Sub-threshold Depression
Number of Symptoms	> 5 symptoms	> 5 symptoms	⩽ 5 symptoms
Duration	2 weeks	2 weeks	< 2 weeks
Frequency of episodes	⩾1 manic episode*	>1 hypomanic + ⩾1 depressive episode	Fluctuating subthreshold hypomanic and depressive symptoms for >2 years (>1 year for children/adolescents)

Note: ** Hypomanic episodes are usually less severe and more likely to feature irritable mood than manic episodes. Presence of a manic episode alone is sufficient to meet criteria for BD I. Patients may also have experienced depressive or hypomanic episodes but this is not essential to qualify for a diagnosis of BD I.

Footnote: *The upper and lower cut-offs for BD II are arbitrary. These durations of illness and number of symptoms used to differentiate BD II and cyclothymia lie on a continuum and therefore mood disorders are also conceptualised as a spectrum within which symptoms are dimensional. Malhi and Berk (2014); Malhi and Porter (2014); Ghaemi et al. (2015).*

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Collaborative Assessment of bipolar disorder (cont)

Differential diagnoses:

- Often confused for other diagnoses (+vice versa)
  - Depression
  - Anxiety (racing thoughts)
  - ADHD (impulsivity, hyperactivity) and disruptive impulse control disorders
  - Substance use / abuse
  - Personality disorders

—> Patients may have had a turbulent journey through the health care system

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Table 25. Summary of the relationships of mood disorders and borderline personality disorder.

Clinical data	Major Depressive Disorder (MDD)	Bipolar Disorders (BD)	Borderline Personality Disorder (BPD)	Grade
Affective dysregulation	Mood is depressed with varying severity.	Mood varies between depression, euphoria, or irritability (suggests mixed states).	Mood often contains intense rage, with intermittent anxiety and depression.	EBR I
Age of presentation (typically)	Any age, but particularly early adulthood.	Late adolescence and young adulthood.	Early adolescence.	EBR I
Illness trajectory	Recurrence is common.	Onset: usually prominent affective signs and symptoms. Course: Depressive and mixed episodes become *more common* with advancing age.	Onset: usually behavioural and interpersonal difficulties. Course: intensity of core features *improves* approaching the fourth decade. May then exhibit *improved* capacity to maintain close relationships, and improved affective regulation.	EBR II
Depressive features	Large range of affective features.	Features of melancholia, agitation, mixed affective episodes, all occur commonly. Intense guilt when depressed.	Shame, 'a noxious sense of self' (intense self-loathing and self-denigration). Prominent cognitive, self-defeating core beliefs and projection. MDD may arise comorbidly.	EBR I
Manic features	Nil.	Hypomania is an essential clinical component. Irritable mood/affect is *common* but not always present.	Affective instability is key feature rather than prolonged shifts in mood and affect. Irritability is *ubiquitous*.	EBR I
Impulsivity	Low.	High, but *fluctuates markedly* with periods of mania.	High and *persistent*. Often a trait as well as state phenomenon.	EBR II
Social cognition	Good appreciation of the emotional states of others and meaning for them, when euthymic.	Good appreciation of the emotional states of others and meaning for them when euthymic.	Poor appreciation of the emotional states of others and meaning for them. Often respond to these distorted perceptions negatively (sometimes positively) and may use this to cope with internal emotional pain.	EBR I
Psychosis	May be present.	Present only in BD I.	Psychotic episodes may arise and periods are of brief duration (hours or days), paranoid in content, may include delusions and hallucinations. Occur at times of intense emotional stress. Dissociative phenomena may be misdiagnosed as psychosis.	EBR I
Self/identity	Mostly positive sense of self, except when severely depressed.	Mostly positive sense of self, except when severely depressed. Elevated sense of self importance and potency when hypomanic.	'Noxious sense of self' with self-loathing, sometimes alternating with fragile self-grandiosity.	EBR I
Relationship quality	Relationships often suffer adversely from the disorder.	Relationships often suffer adversely from the disorder.	Relationship difficulties are a primary deficit in this disorder. Interpersonal chaos is common. Intense ambivalence and fear of abandonment are core problems. Improve with age.	EBR I
Family history	Family history of mood disorder is common.	Family history of mood disorder is common.	Family history of mood disorder and/or personality disorder is common.	EBR I
Childhood trauma	Common (physical, neglect and abandonment, sexual).	Common (physical, neglect and abandonment, sexual).	Very common (physical, neglect and abandonment, sexual).	EBR II
Self-harm	Recurrent, deliberate self-harm occur intermittently.	Recurrent, deliberate self-harm occur intermittently.	Recurrent, deliberate self-harm occur frequently.	EBR I

References: (Antoniadis et al., 2012; Bassett, 2012; Coulston et al., 2012; Fletcher et al., 2014; Ghaemi et al., 2014; Malhi et al., 2013c; Renaud et al., 2012; Roepke et al., 2012; Witt et

Journeys through the system…

Survey of those diagnosed with BD:

- 35% had 10+ yr delay in diagnosis following seeking help
- On average it took 10.2 years and 4.2 doctors to obtain a 'correct' diagnosis
- 69% initially 'misdiagnosed' (60% depression 26% anxiety disorder, 18% schizophrenia, 17% Borderline PD) (DMDA, 2001)
- Avg 3.5 'misdiagnoses'

Table 2. Features of bipolar disorders and depressive disorders (based on DSM-5).

	Episodes	Depression		Mania/Hypomania[a]		Possible Psychosis
		Duration	Severity of symptoms	Duration	Severity of symptoms	
BD I	Mania +/– hypomania +/– depression	2 Weeks	Marked Impairment	Mania 7 days most of the day nearly every day or hospitalisation	Marked impairment (Mania only)	Yes
BD II	Hypomania +Depression	2 Weeks	Marked Impairment	Hypomania[b] 4 consecutive days, present most of the day nearly every day.	No marked impairment	In depression but not in hypomania
Cyclothymia[d]	Subthreshold[c] hypomania + subthreshold[c] depression	2 years with no more than two months symptom-free	Clinically significant impairment	2 years with no more than two months symptom-free	Clinically significant impairment	No
MDD[e]	Depression	2 Weeks	Marked Impairment	N/A	N/A	Yes
PDD[d]	Depression	2 Weeks	Clinically significant impairment	N/A	N/A	No
DMDD[f*]	Chronic irritability and temper outbursts	>12 mths with no more than 3 mths symptom-free	≥3 Temper outbursts per week. Present in ≥2 settings	N/A	N/A	No
PMDD[g*]	Depression	Final week before menses to a few days after.	Causes distress or interference with functioning	N/A	N/A	No

Note: For full criteria for manic, hypomanic and depressive episodes, refer to DSM-5 (APA, 2013). Also see: Figures 1 and 2.

References: [a]The main differences between a manic and hypomanic episode in DSM-5 are: (a) duration of symptoms; and (b) presence or absence of increased *goal-directed* activity. In mania, symptoms occur for most of the day, for more days than not, within one week, and/or hospitalisation is required. (However, note that the utility of hospitalisation as an aspect of diagnosis has been questioned recently (Malhi and Berk, 2014). In hypomania, symptoms occur for 4 consecutive days, for most of the day. Both mania and hypomania are characterised by elevated mood, and persistently increased activity. However mania specifies 'increased goal-directed activity', whereas hypomania simply states 'increased activity'.

[b]Hospitalisation or psychotic symptoms automatically warrant a diagnosis of mania rather than hypomania.

[c]Subthreshold refers to a state in which there are several symptoms of hypomania and/or depression but these are insufficient in number and/or severity to meet criteria for either.

Table 7. Features that may distinguish bipolar and unipolar depression.

Features	Bipolar	Unipolar^
Family History	Bipolar disorder (more likely) Alcohol and/or substance use (more likely)	Bipolar disorder (less likely) Alcohol and/or substance use (less likely)
Illness onset	Early onset (approx. 20-25 years)	Later onset (approx. 25-30 years)
Onset/Offset	More often abrupt	More often gradual
Comorbidity	ADHD more often	ADHD less often
Duration of episodes	<6 months	>6 months
Number of Prior Episodes	Multiple prior depressive episodes	Fewer prior episodes
Mood symptoms	Lability of mood/manic symptoms	Depressed mood and low energy
Psychomotor symptoms	Psychomotor retardation	Psychomotor retardation less likely
Sleep disturbances	Hypersomnia and/or increased day time napping	Initial insomnia/reduced sleep
Appetite Changes	Hyperphagia and/or increased weight	Appetite and/or weight loss
Other symptoms	Other 'atypical' depressive symptoms such as hypersomnia, hyperphagia, 'leaden paralysis' Psychotic features and/or pathological guilt	Somatic complaints

Notes: Depressive symptoms common in bipolar disorder are akin to atypical features. A history of hypomania may be easily missed and collateral information from family, health professionals and others is invaluable. If a person presents with this group of depressive features, clinicians should carefully assess for past (hypo)mania. Closely monitor for emergence of such should antidepressant monotherapy be utilised.

^Unipolar depression refers to non-bipolar depression. References: (Angst et al., 2005; Moreno et al., 2012; Perroud et al., 2014).

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Family history

- Strong genetic component
  - 45% relative risk if monozygotic twin affected
  - 9% relative risk if first degree relatives affected
  - 15% concordance for fraternal twins (Kelsoe, 1999)

Mixed states

"I have a violence in me that is hot as death-blood. I can kill myself or – I know it now – even kill another. I could kill a woman, or wound a man. I think I could. I gritted to control my hands, but had a flash of bloody stars in my head as I stared that sassy girl down, and a blood-longing to [rush] at her and tear her to bloody beating bits"

Sylvia Plath, as quoted in Jamison (2000)

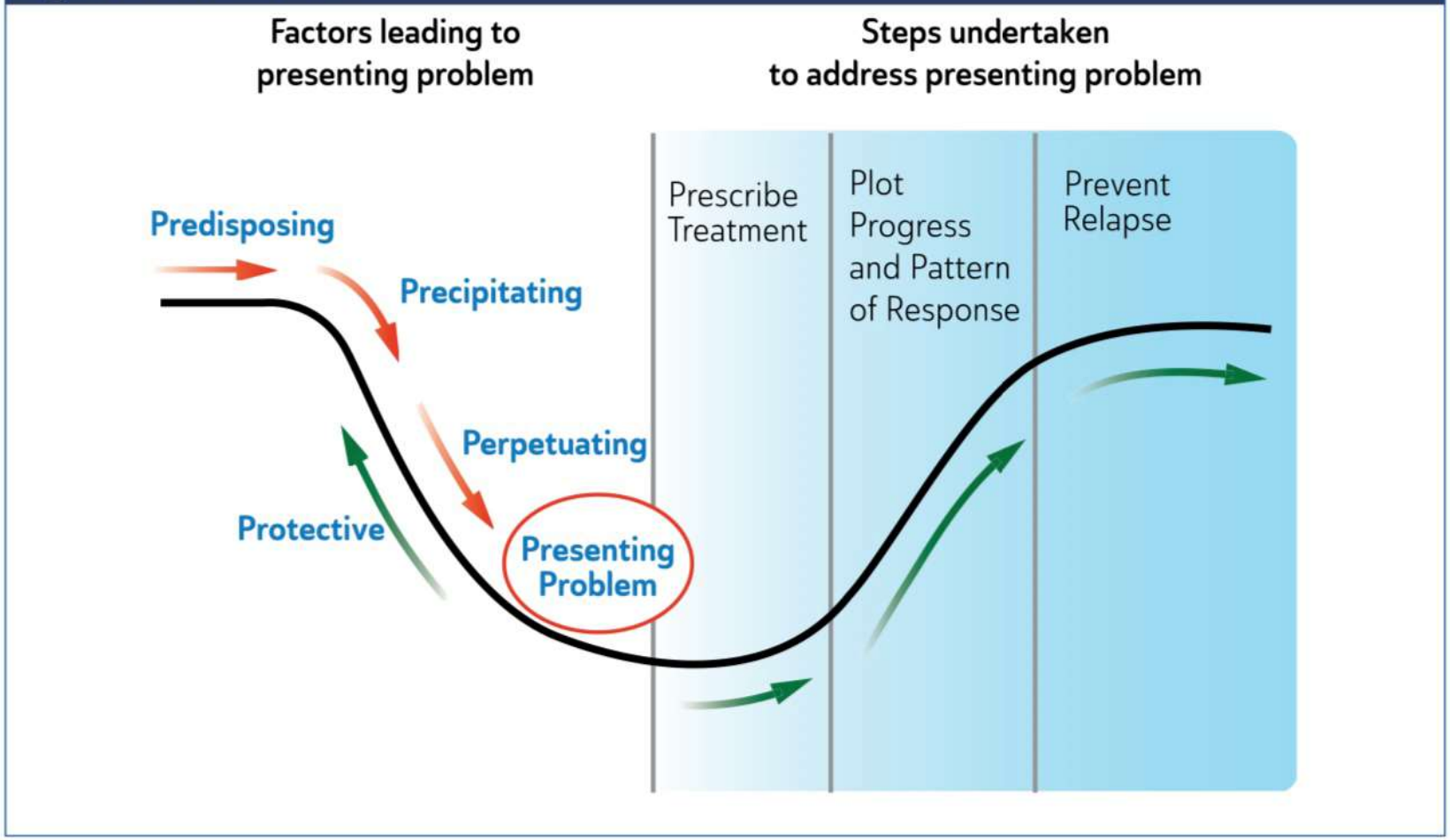
Assessment of BD

- Need a thorough assessment of premorbid functioning and recurring symptoms
- Most people present to primary care services as depressed

—> Usually longitudinal assessment is required.

- Ideally obtain Retrospective (eg life chart) and Prospective (mood chart)

Figure 4. 5P+ Model.



The conventional 5P Model approach to formulation has been expanded by adding three phases of management. This extended model (5P plus; 5P+) adds a longitudinal perspective that builds on the initial formulation and informs management.

Assessment of BD (cont)

- Shares symptoms with other diagnoses.
- Need collaborative evidence
- Symptom monitoring
- Look for a family history
- Look at primary and secondary problems

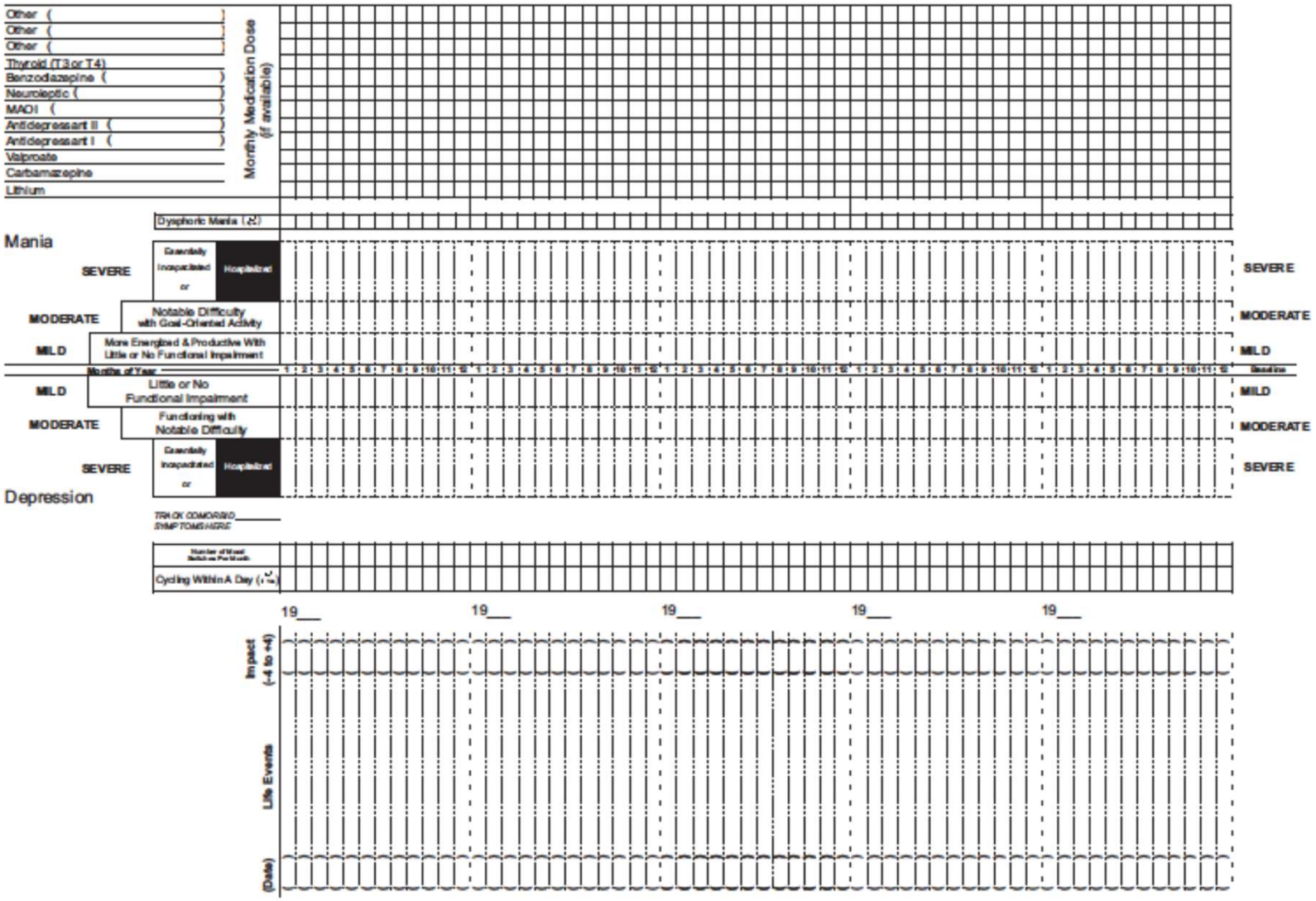
Assessment (cont)

- Personal history / Life events
- Perception of the illness
- Sense of self, dysfunctional beliefs and sense of stigma
- Coping with symptoms
- Current mood state
- Suicidality
- Social functioning
- Support network

NIMH-LCM™ Clinician Ratings (RETROSPECTIVE)

Patient Name _____ **Years 19___ - 19___**

PLEASE PRINT



Life Chart of BD Symptoms (Lam et al., 1999)

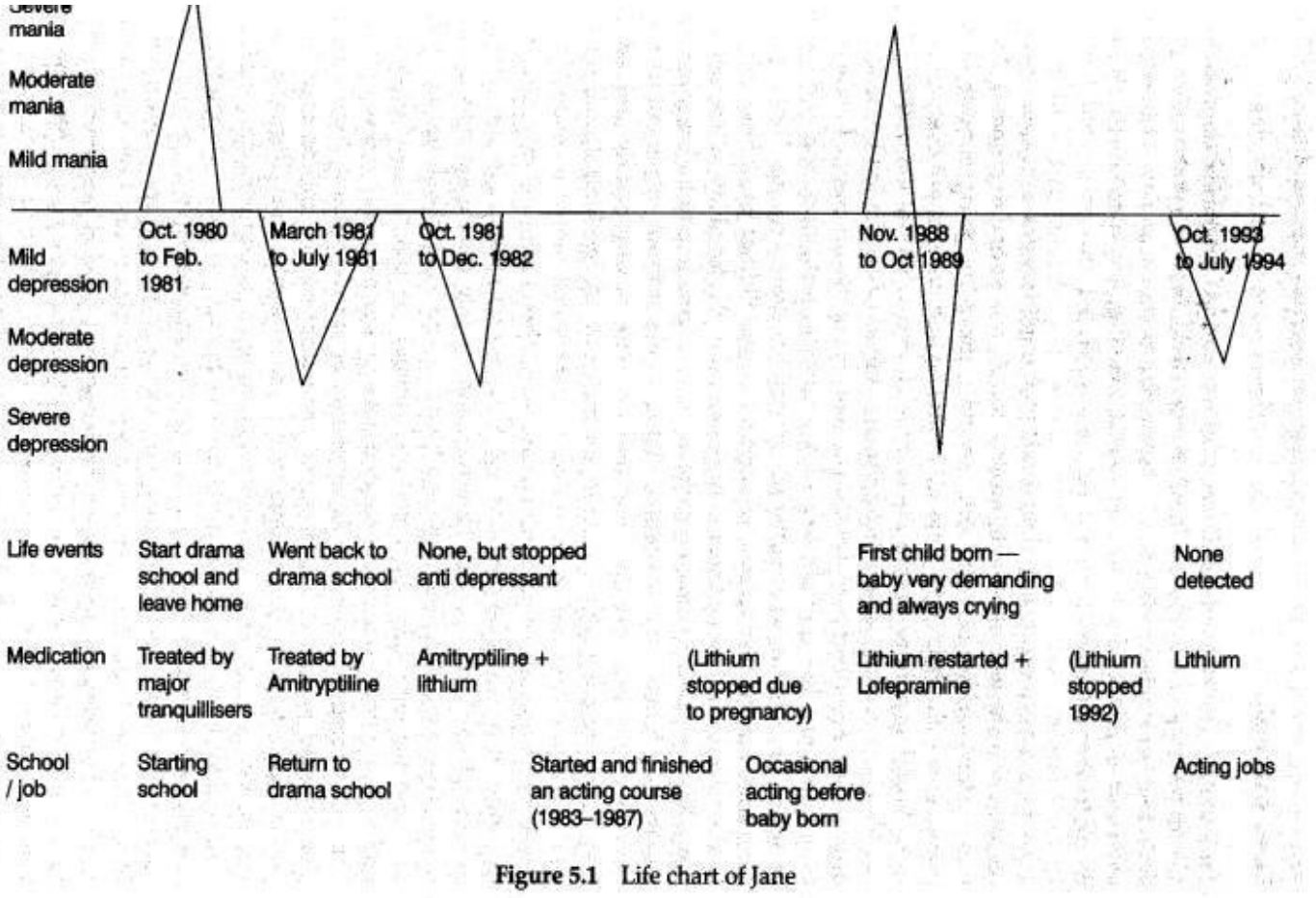
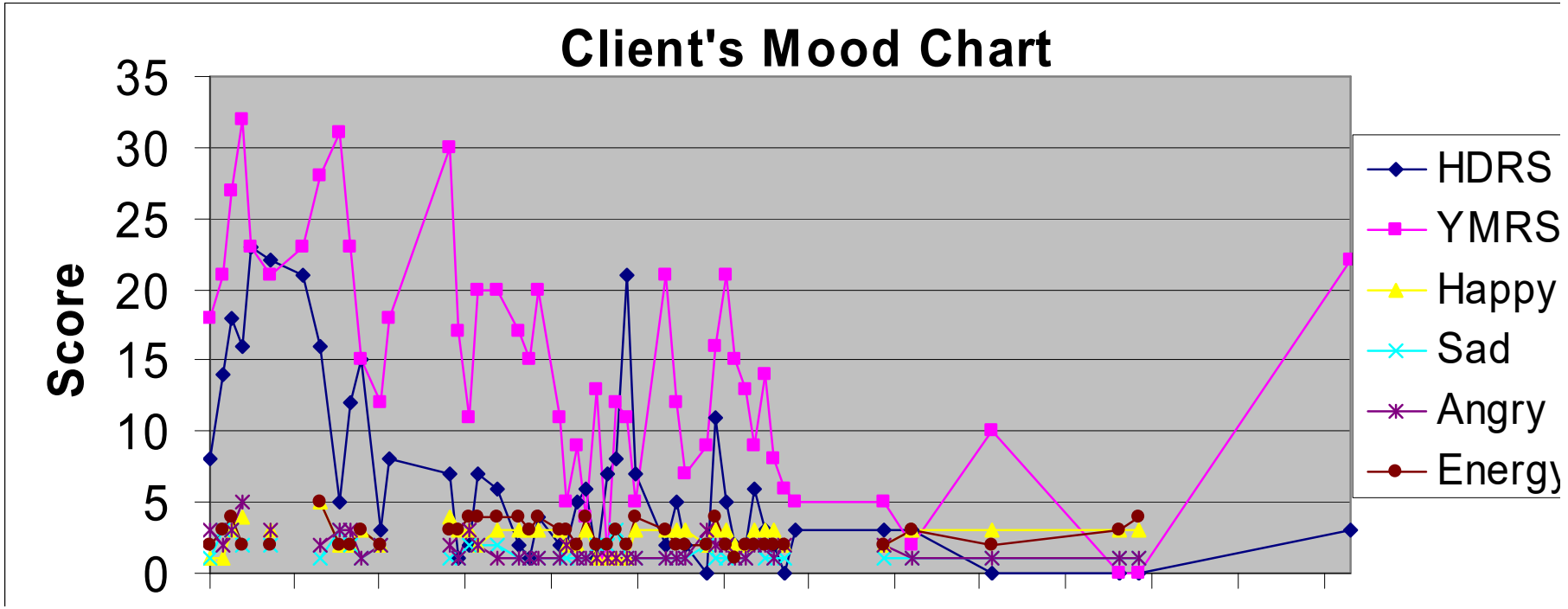


Figure 5.1 Life chart of Jane

Rating Scales

- Depressive symptoms:
  - Hamilton Rating Scale for depression (HAM-D)
  - Beck Depression Inventory (BDI-II)
- Mania symptoms:
  - Young Mania rating scale (YMRS)
  - Mania rating scale (MRS)

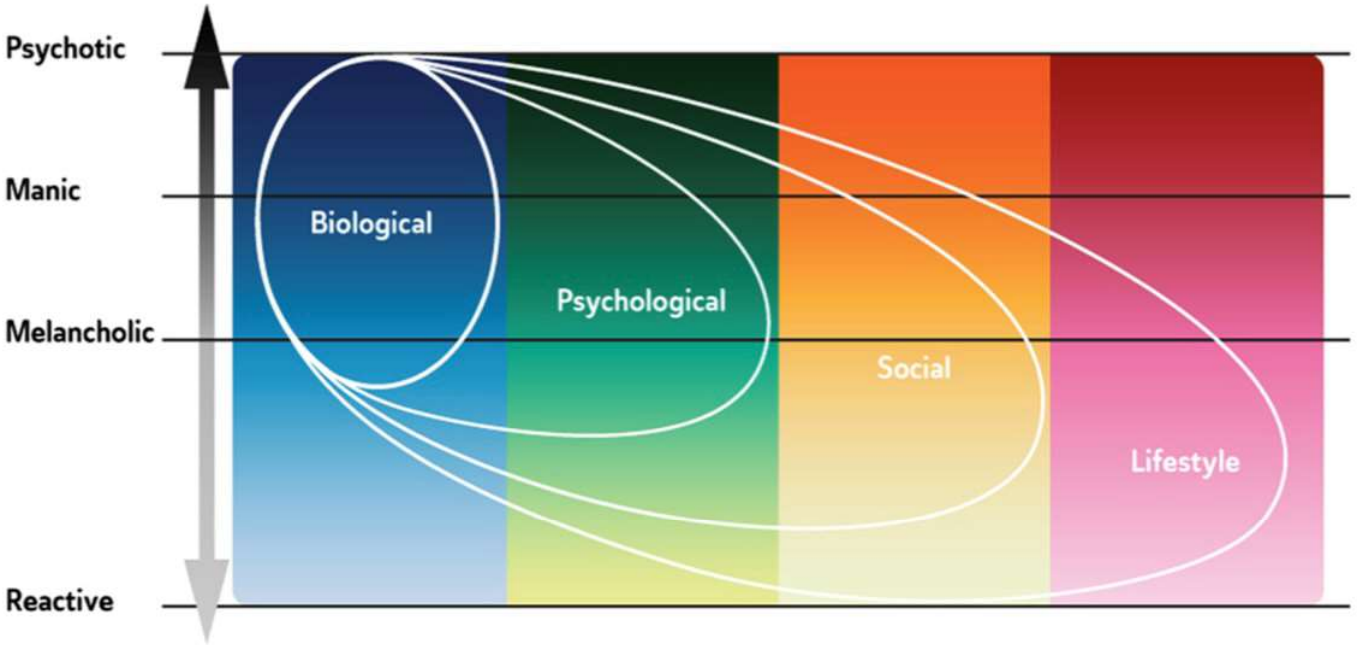
Symptom Ratings Chart



Focused Psychological Strategies

- While biological, BD is also very linked in with lifestyle and circadian rhythms
- —> Significant interventions can be implemented at a primary care level, just like any other illness that's worsened by lifestyle factors.
- Helpful even if assessment is ongoing
- The goals are to help the person:
  - Develop insight
  - Learn about disorder
  - Learn how to manage it

Figure 3. Biopsychosocial & Lifestyle Model (BPSL).



Biological Treatments	Psychological Treatments	Social Treatments	Lifestyle Treatments
· Antidepressants · Antipsychotics · Mood stabilisers · Electroconvulsive therapy · Transcranial magnetic stimulation	· Brief cognitive behavioural therapy · Formal cognitive behavioural therapy · Interpersonal therapy · Mindfulness · Acceptance and commitment therapy · Schema therapy	· Family psychoeducation · Family / friends · Formal support groups · Community groups · Caregivers · Employment · Housing	· Exercise · Diet · Smoking cessation · Alcohol cessation · Ceasing drugs · Managing substance misuse · Sleep

Treatment considerations

- In the acute phase of illness (manic or depressed)
  - Safety and medication are priorities
  - Most helpful role for clinicians is working with family and ensuring access to tertiary services as necessary.
  - Once beginning to recover, may need short sessions
  - In this phase the most important aspect is promoting medication adherence, engagement, family / agency supports.
  - Sufferers may have had BD for a long time before receiving psychological treatment.
  - Have often had traumatic experiences in health care settings.

Table 10. Recommended indications for psychiatric admission.

Category of Indication	Specific Indication
Clinical Presentation	Severe depression with significant disability 1a. Suicidal ideation with seemingly imminent risk 1b. Medical risk (i.e., inadequate fluid intake)^ Mania 2a. Likelihood of escalating manic symptoms/early warning signs of imminent manic episode 2b. Significant impulsivity or reckless disinhibition in context of mania Insight is severely limited to the extent that outpatient treatment is not possible Significant psychotic symptoms
Comorbidities	Medical illness that influences course and treatment of mood disorder Alcohol and other substance misuse (particularly psychostimulants, cannabis, hallucinogens, benzodiazepines)
Psychosocial Variables	Lack of significant social supports (especially recent loss of supports) Stressful home environment
Treatment Variables	Inability to engage in community based care Failure to respond to community based care Initiation of complex treatments (e.g. Electroconvulsive therapy [ECT])

^In such instances, admission to a medical setting may be more appropriate.

Note: Decisions about admission involve weighing a number of the above clinical and psychosocial factors, together with the perspectives of carers and others involved in the community treatment setting.

Theoretical Underpinnings

- Diathesis stress model
  - Stress → biological dysregulation →impairment in cognition/emotion → psychosocial problems → stress and increased symptoms
  - Circadian Rhythm / circadian pacemaker and life events
  - Kindling and Behavioural Sensitisation
  - Conditioned responses to stressful life events

Therapy approaches – CBT and social rhythms / lifestyle managment

- Psychoeducation
- CBT skills to self-monitor, anticipate and manage warning signs
- Measuring and adjusting lifestyle, sleep and routine factors.
- Relapse prevention and managing long-term vulnerabilities

Lam et al.(2003)

"Perfect world" Therapy Structure (Lam et al.)

- 20 sessions
- Stage 1: Treatment structure, therapeutic alliance/education, symptom history, self-monitoring and goal setting.
- Stage 2: CBT techniques, early warning signs and medication compliance.
- Stage 3: Review, self-management, processing / coming to terms with consequences of mental health history.

Stage 1 (sessions 1-5)

- Set structure of therapy (collaboratively)
- Education/therapeutic alliance
- Symptom history
- Self-monitoring
- Goal setting (symptom reduction, medication, functional gains, mood stability, support services.

Daily Mood Swing Graph for Bipolar Disorder

MONTH:	Please use this Daily Mood Graph to chart mood swings and the effects of any triggers and medications prescribed for you.

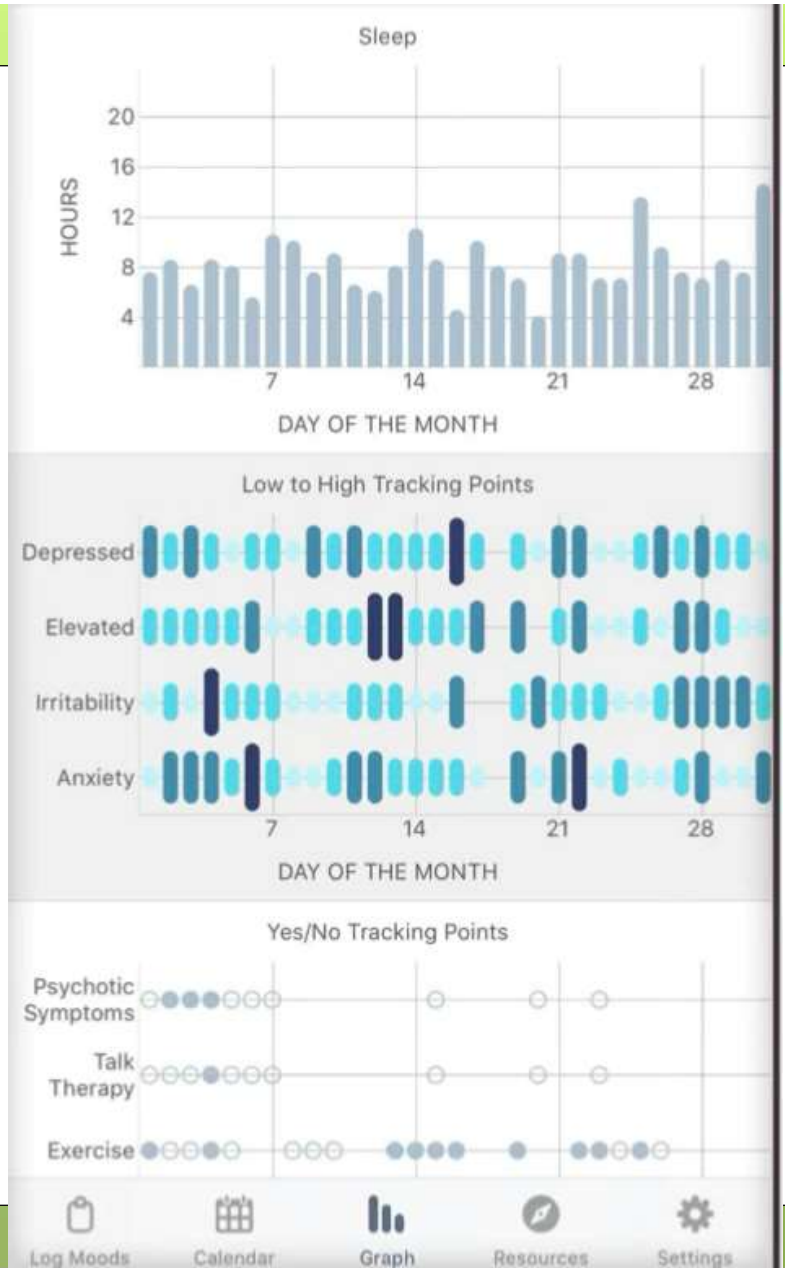
INSTRUCTIONS

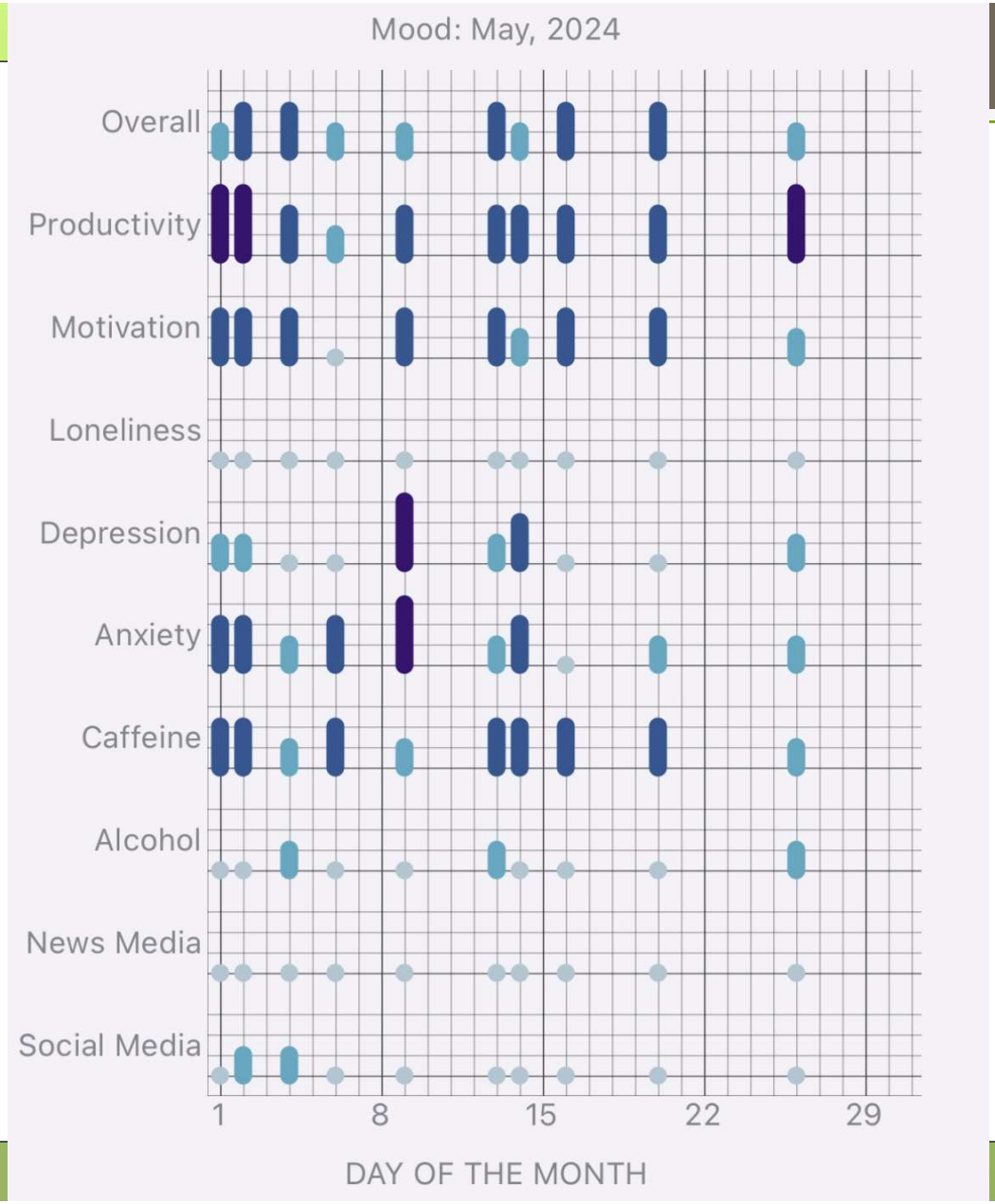
1. Please rate your mood at the end of each day by placing an '**X**' in the appropriate box. If you have experienced both a '**high**' and a '**low**' mood on any given day, please rate both by putting an '**X**' at each level
2. Please write the name of the medications and doses you are taking
3. Next to each medication, please indicate the period of time you took the medication at the same dose by drawing an arrow through the relevant dates. If your dose changes during the course of the charting period, please write the new dose in the relevant box and continue the line.
4. Please also include notes on sleep patterns, any triggers or external events that may impact you and cause a mood change.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Highs 																															
Normal																															
 Depressed																															
Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Medication A																															
B																															
C																															
Example Prozac	20 mg	→																40 mg	→												
Notes on sleep patterns, triggers, events, etc																															

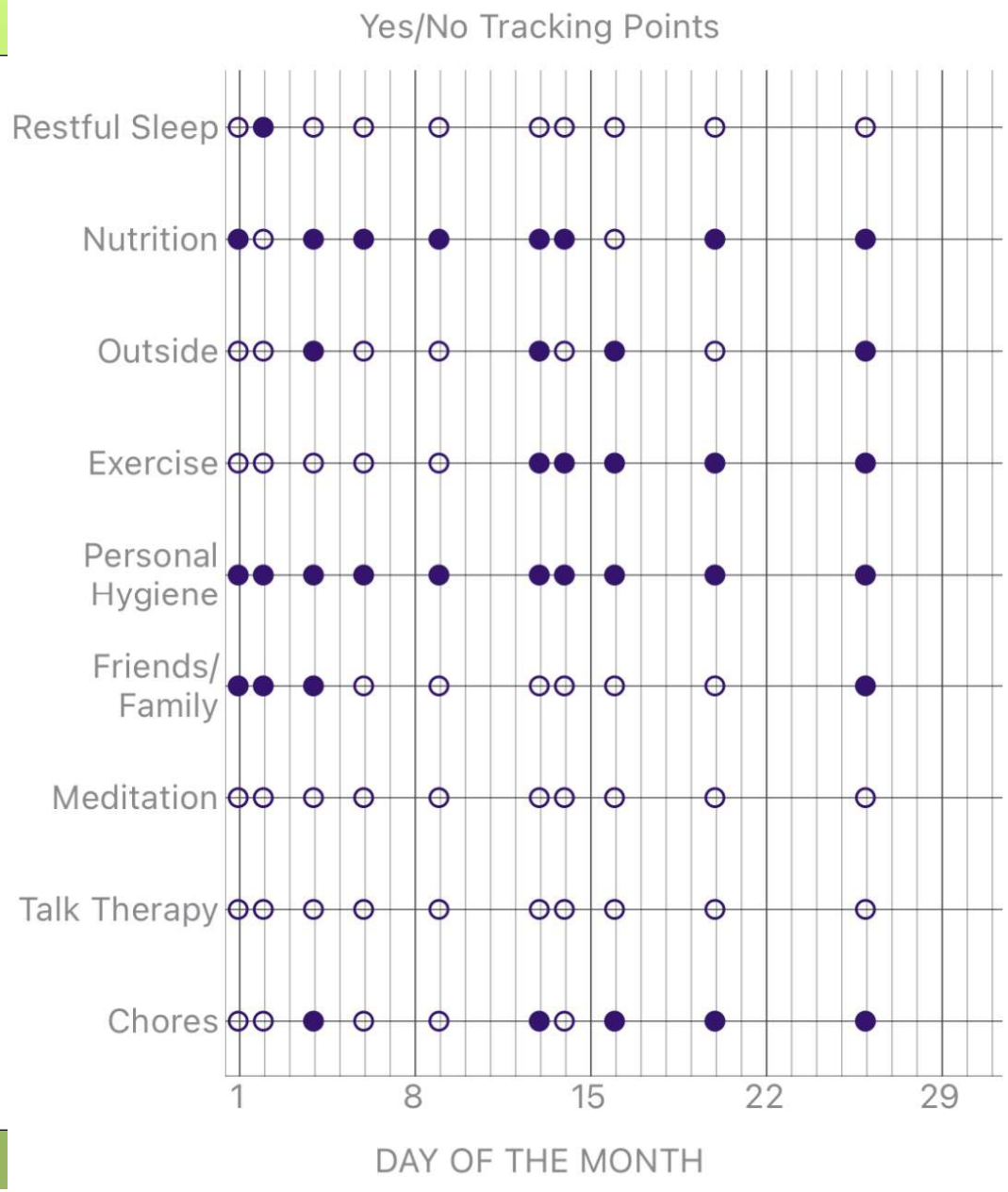
http://www.blackdoginstitute.org.au/clinicians/clinicianaids/index.cfm

eMoods (wellness)





eMoods (wellness)



eMoods (wellness)

Stage 2 (sessions 5-16)

CBT Techniques for:

- Monitoring symptoms
- Averting symptom escalation
- Increasing adherence
- Managing symptoms

My favourite analogies:

- Sailing a boat – steering into the wind
- Driving a car – brakes a bit worn out, sometimes won't start or misfires

Stage 2 (sessions 5-16)

- CBT techniques:
  - Activity schedules
  - Thought monitoring
  - Thought challenging
  - Problem Solving
  - Relaxation and sleep hygiene
  - Stimulus control
- Behavioural experiments
  - Moderating behaviours
  - Precommitment / Delay tactics
- Dysfunctional assumptions
- Early warning signs
- Medication compliance

Lifestyle Assessment Sheet – *FANTASTIC* Checklist

Please circle one response on each line (you may total your score if you wish). Scoring detailed below.

	ITEM	2 points	1 point	0 points	Your score
Family	Communication with others is open, honest and clear	Almost Always	Sometimes	Hardly Ever	
Friends	I give and receive affection	Almost Always	Sometimes	Hardly Ever	
	I get the emotional support that I need	Almost Always	Sometimes	Hardly Ever	
Activity	Active exercise – 30 minutes eg. Running, cycling, fast walking	Almost Always	Sometimes	Hardly Ever	
	Relaxation and enjoyment of leisure time	Almost Always	Sometimes	Hardly Ever	
Nutrition	Balanced meals	Almost Always	Sometimes	Hardly Ever	
	Breakfast daily	Almost Always	Sometimes	Hardly Ever	
	Excess sugar, salt, animal fats, or junk foods	Minimal Use	Sometimes	Frequently	
	Ideal weight	Within 4kg	Within 8kg	Not Within 8kg	
Tobacco	Tobacco in the past year	None	Occasional Use	Daily Use	
Toxics	Abuse of drugs: Prescribed and unprescribed	Seldom or Never	Sometimes	Frequently	
	Coffee, tea, cola	Under 3 per Day	3 – 6 per Day	6 or More	
Alcohol	Average intake per day	Less Than 2	2 Drinks	More Than 2	
	Alcohol and driving	Never Drink and Drive	Only Rarely	Fairly Often	
Sleep	7-9 hours sleep per night	Almost Always	Sometimes	Hardly Ever	
Seatbelt	Frequency of seatbelt use	Always	Most of the Time	Sometimes	
Stress	Major stressful events in past year	None	1 - 2	3 or More	
Type of Personality	Sense of time urgency; impatience	Hardly Ever	Sometimes	Almost Always	
	Competitive and aggressive	Hardly Ever	Sometimes	Almost Always	
	Feelings of anger and hostility	Hardly Ever	Sometimes	Almost Always	
Insight	Positive thinker	Almost Always	Sometimes	Hardly Ever	
	Anxiety, worry	Hardly Ever	Sometimes	Almost Always	
	Depression	Hardly Ever	Sometimes	Almost Always	
Career	Satisfied in job or role	Almost Always	Sometimes	Hardly Ever	
	Good relationships with those around	Almost Always	Sometimes	Hardly Ever	
				Total (out of 50)	

Scoring: ***42-50 = You're in control / 35-41 = Good / 30-34 = Fair / < 29 = You need to take more control over your lifestyle behaviours.***

From 'Lifestyle assessment: Development and use of the FANTASTIC checklist', by Wilson DMC, Ciliska D Can. Fam Physician, 1984, 30: 1527-32, with modification to the tobacco question by K Wilhelm.

Patient handout: Lifestyle Assessment Sheet, FANTASTIC Checklist (Jan 2007) http://www.blackdoginstitute.org.au

Activity schedules

- Sheets provided for monitoring of activities and routine for each 24hr period.
- The rationale is given for
  - Identifying natural variations in mood
  - Checking for changes in sleep patterns
  - Noting type and range of tasks.
- These help to work out what behaviours to schedule in or reduce and what sleep hygiene techniques are needed.

Weekly Activity Schedule

Use the schedule below to plan your activities for the coming week. Make sure you balance fun and pleasurable activities with your daily responsibilities and duties.

	Mon	Tues	Wed	Thur	Fri	Sat	Sun
8 to 9am							
9 to 10							
10 to 11							
11 to 12pm							
12 to 1							
1 to 2							
2 to 3							
3 to 4							
4 to 5							
5 to 6							
6 to 7							
7 to 8							
8 to 10							
10 to 12 am							

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Behavioural Activation Worksheet
FUN & ACHIEVEMENT

One simple way of combating depression is to prescribe some fun for yourself. By engaging in some simple, pleasant activities, you can actually improve your mood and your energy level. Try it and see!

You may also want to engage in some simple tasks or responsibilities that you have neglected for some time. Often, accomplishing tasks can improve your motivation and give you a sense of achievement. Start with tasks that are simple and achievable. BUT remember that it is important to BALANCE both responsibilities and pleasurable activities. Try not to go overboard on one and leave out the other.

Use the following rating scale to rate your depression, pleasant feelings, and sense of achievement BEFORE and AFTER the activity.

0	1	2	3	4	5	6	7	8
Absolutely None	Minimal	Slight	Mild	Moderate	Much	Higher	Very High	Extreme

Activity & Date:		Depression	Pleasure	Achievement
	Before:			
	After:			
Activity & Date:				
	Before:			
	After:			
Activity & Date:				
	Before:			
	After:			
Activity & Date:				
	Before:			
	After:			

What did you notice about yourself?

Thought monitoring

- Just like normal CBT
  - + overly positive automatic thoughts can be associated with mania.
  - The client is encouraged to have a more objective view of their thoughts.
  - A though recording sheet is given with the therapist looking for patterns of thinking associated with mood changes.
  - Or could do 'chain analysis' – "what happened before that?"

Thought Diary [1]

A Activating Event

This may include an actual event or situation, a thought, mental picture or physical trigger.

B Beliefs

1. List all self-statements that link A to C. Ask yourself: "What was I thinking?" "What was I saying to myself?" "What was going through my head at the time?"
2. Find the most distressing (hot) thought and mark it with an asterisk (*).
3. Rate how much you believe this thought between 0 to 100.

C Consequences

1. Write down words describing how you feel.
2. Mark the one that is most associated with the activating event using an asterisk (*).
3. Rate the intensity of this feeling between 0 to 100.

4. Jot down any physical sensations you experienced or actions carried out.

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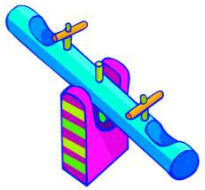
Thought Challenging:

- Re-framing thoughts as symptoms of depression or mania
- Have to go slowly especially when challenging overly positive expectations. Nobody likes to have their bubble burst.
- Try to incorporate ideas from the manic side to combat depressive thoughts and vice versa.
- Idea of thought 'innoculation', practicing ways to respond to unrealistic thoughts.

The "Balance" Sheet

When I am feeling euphoric, I often think:	An Alternative, Balanced View
	
	Ask yourself: • What evidence do I have that my thoughts are true? • What facts or details might I have ignored or overlooked? • What other explanations could there possibly be? • Are there other ways of viewing the situation? • What is a balanced view of this situation?

Behavioural Experiments

- Graded task assignment
- Sitting / listening targets when mood is elevating
- ‘Safe thrills’

Weekly Goals Record

Name: _____ Signature: _____

TASKS TO BE COMPLETED	How often?	Monday Date:	Tuesday Date:	Wednesday Date:	Thursday Date:	Friday Date:	Saturday Date:	Sunday Date:	Done? Y/N	Impact? 0-4
Reading		☐	☐	☐	☐	☐	☐	☐		
Calming Technique		☐	☐	☐	☐	☐	☐	☐		
Thought Diaries		☐	☐	☐	☐	☐	☐	☐		
Pleasant Events		☐	☐	☐	☐	☐	☐	☐		
		☐	☐	☐	☐	☐	☐	☐		
Exposure tasks		☐	☐	☐	☐	☐	☐	☐		
		☐	☐	☐	☐	☐	☐	☐		
Other behavioural goals		☐	☐	☐	☐	☐	☐	☐		
		☐	☐	☐	☐	☐	☐	☐		

Centre for Clinical Interventions

Impact Ratings: 0 = Definitely did not find task useful 1 = Not very useful 2 = Not sure if it was useful 3 = Quite useful 4 = Very useful

Week of _____

Activity	Actual Time							
	Target Time	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
 Out of bed								
 First contact (in person or by phone) with another person								
 Start school or main activity of the day								
 Physical exercise								
 Have dinner								
 Homework								
 Other activity: _____ _____								
 Go to bed								
Rate your mood *(-5 to +5)*								

Figure 3. Social Rhythm Metric (adolescent version).

Hlasta and Frank (2006)

Precommitment strategies

- Recognising / circumventing temptations
  - Having part of salary withheld for bills / rent etc
  - Do daily mood check – if 3 or more manic symptoms then leave credit cards at home
  - Keep credit card in the freezer
  - Wait 48 hours and have 2 nights of good sleep before any shopping trips
  - Don't spend more than $200 without talking with partner, lower transaction limit
  - Check with at least 2 friends before making important life decisions

Stimulus control

- Stimulus control
  - Identify stimuli associated with relapses
  - eg alcohol, caffeine drugs, sexual promiscuity, financial access, work stress, physical context, level of stimulation.
  - Working on proactively managing these stimuli.

- **Common Risk Factors For A Low Mood**
- Taking drugs
- Drinking alcohol
- Stress
- Being physically unwell
- Not taking your medication
- Not Enough stimulation
- Certain thinking styles

- **Risk Factors For a High Mood**
- Lack of sleep
- Taking drugs
- Drinking alcohol
- Periods
- Stress
- Not taking medication
- Too much stimulation
- Too much caffeine
- Success / positive outcomes

What Are My Specific Risk Factors For Mood Changes?

You are the real expert on yourself and your moods.

List those things you have found to make you have a low or high mood in the past.

- **Low Mood**
- 1.
- 2.

- **High Mood**
- 1.
- 2.

How To Plan Ahead and Prevent These Risk Factors:

Being able to think about a situation when we are not actually in the middle of it can give us more time to think through a really good plan.

Here are some common risky situations that can lead to a mood change, try and work out how to manage it.

- **Risk Factor**
- ***Your friends at a party want you join with them in taking drugs or drinking alcohol.***
- ***You have too many things on at the moment and you are feeling stressed out.***
- ***You are feeling physically sick.***

- **What To Do**
  - .

Delaying Tactic

*Do I need to do this now?

*What will happen if I leave it until tomorrow?

*Will this still be a good idea in 2 weeks time?

*What happened last time I rushed my decision?

*What can I do In the meantime while waiting?

Interpersonal Social Rhythm Therapy (IPSRT) - Ellen Frank

- Derived from IPT for depression
- First therapy developed specifically for BD.
- Aims to regulate social rhythms & sleep-wake cycles & to work on interpersonal issues.
- Model includes
  - Stressful life events
  - Interpersonal problems
  - Circadian pacemaker

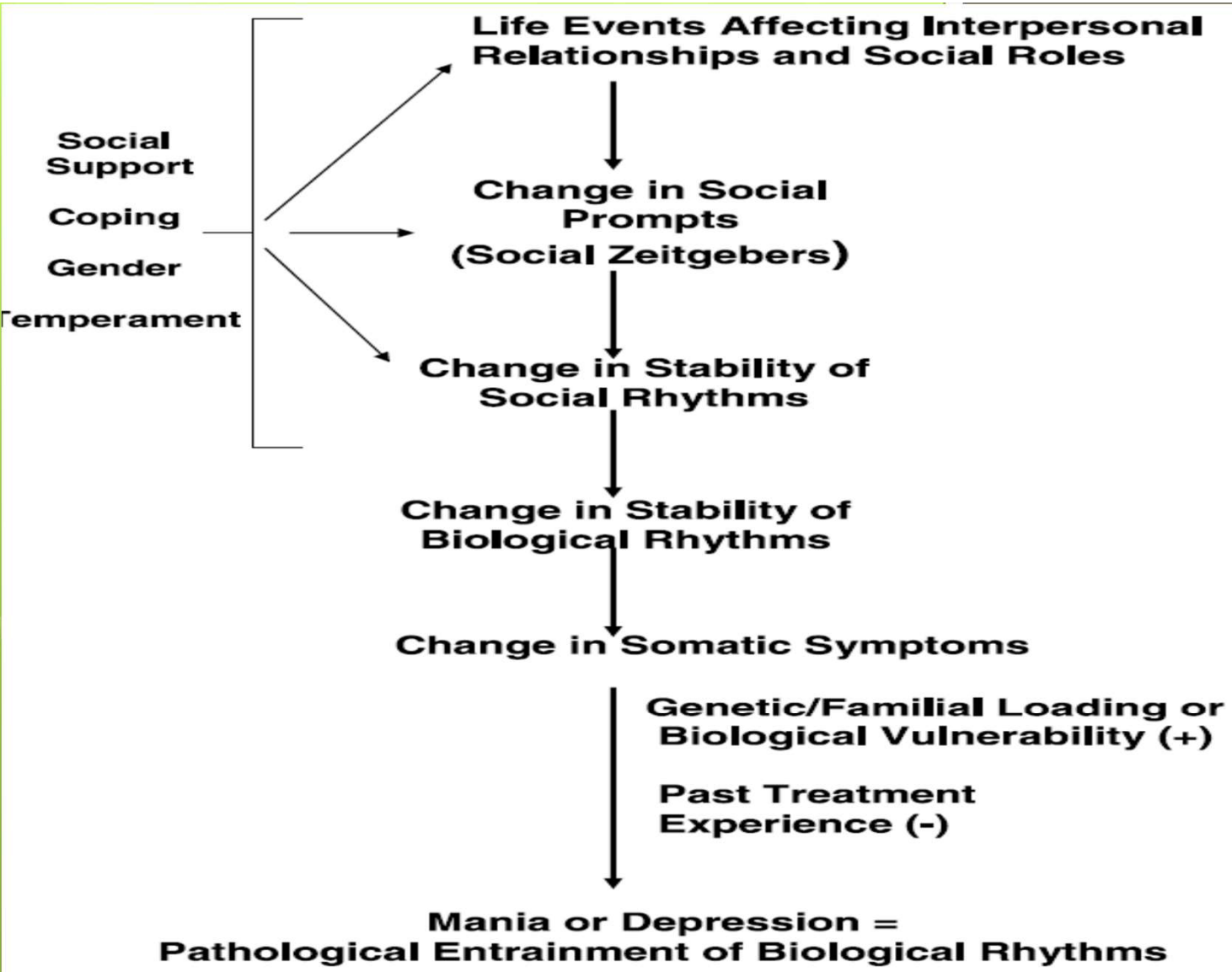


Figure 1. Schema for social zeitgeber theory.

Aspects of IPSRT

1. Monitoring and changing social rhythms
2. Identifying interpersonal problems
   - Grief
   - Role disputes
   - Role transitions
   - Interpersonal deficits

IPSRT

3 stages of IPSRT:

1. Assessment
   - Interpersonal inventory
   - Introduce Social Rhythm Metric
   - Psychoeducation
   - Negotiating interpersonal problems
2. Developing strategies
   1. Social rhythms
   2. Manage affective symptoms
   3. Resolve identified interpersonal problems
3. Working towards termination & identifying future stressors

Date (week of): _____

Directions:

- Write the **ideal** target time you would **like** to do these daily activities.
- Record the **time** you actually did the activity each day
- Record the **people** involved in the activity: 0 = Alone; 1 = Others present; 2 = Others actively involved; 3 = Others very stimulating

		Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday	
Activity	Target Time	Time	People	Time	People	Time	People	Time	People	Time	People	Time	People	Time	People
Out of bed															
First contact with other person															
Start work/school/ volunteer/family care															
Dinner															
To bed															
Rate MOOD each day from -5 to +5 -5 = very depressed +5 = very elated															

Figure 2. Social Rhythm Metric-II—Five-Item Version (SRM II-5).

Hlasta and Frank (2006)

Stage 3 (sessions 16-20):

- Review of previously learnt strategies
  - Clearly identifying warning signs / states for various stages of illness and strategies for each.
- Self-management
  - Sleep, routine, diet, exercise
  - Social networks and repairing damage
  - Not ‘making up for lost time’

Stage 3 (cont)

- Consequences of mental health history
  - Longer term process of addressing
  - Stigma
  - Guilt
  - Loss
  - Anger
  - Avoidance
  - Overall self concept and defining self vs illness

Wellbeing Plan for Bipolar Disorder

NAME: ..... Date: .....

TREATING HEALTH PROFESSIONALS: .....

.....

Lifestyle actions to stay well:

.....

.....

My personal triggers and actions I will take to avoid them:

.....

.....

Relapse signature - early warning signs:

Depression: .....

.....

Highs: .....

.....

Actions I agree to take if I develop the above signs:

.....

.....

.....

Person (people) I agree can take action if they observe the above signs:

.....

.....

Actions I agree they may take:

.....

.....

If due to illness, I refuse to take action as agreed, I acknowledge that the person (people) named above may take the following actions:

.....

.....

.....

Signed: .....

Ass. & Management tools for GPs: Wellbeing Plan for Bipolar Disorder (August 2007) http://www.blackdoginstitute.org.au

A Plan of Action

My most significant early warning signs are:

Early Warning Signs of Mania	*Early Warning Signs of Depression*

My plan of action for relapse prevention:

What I would do to prevent a full-blown mania episode	**What I would do to prevent a full-blown *depressive* episode**
What I would ask my friends or family to do for me	**What I would ask my friends or family to do for me**
What I would ask my friends or family to say to me	**What I would ask my friends or family to say to me**

“My Stay-Well Plan”

*Early Warning Signs for A High (what to do):

*Early Warning Signs for a Low (what to do):

*I Accept Feedback From:

*Who Will Do What:

*Extra Medications:

*How I Want My Treatment to Go:

Organising the Ideas List

List of Ideas, Projects &/Or Actions

Evaluating New Ideas, Projects or Actions

For each idea or possible project, or action, ask yourself: What are the costs & benefits of this trying out this idea (or embarking on this project)? What resources do I need? What are the steps I must take to carry out this idea/project successfully?

Idea or Project: _____

COSTS	BENEFITS
RESOURCES	**SPECIFIC STEPS**

Managing long-term illness

- 'Veteran' patients are a difficult to treat subgroup, requiring
- –Cognitive rehabilitation
- –Problem solving
- –Emphasis in non-verbal memory
- –Social care
- –Family support and support for the family

Colom et al. (2009)

Tips for Psychological Strategies

- Best to be conducted when client is euthymic.
- Safety / medication is the main issue when the client is acutely unwell.
- Involve family/significant others.
- Common elements of therapy for BD:
  - Psychoeducation
  - Lifestyle regularity
  - Adherence to medication regime
  - Early recognition & management of symptoms of relapse.

Advice from Clients

"The single biggest helpful thing is comprehensive and reliable information specifically about *how to live with it*. There's plenty of info online about DSM definitions of what it is, but very hard to find anything else. People diagnosed with diabetes or cancer leave a health appointment with pamphlets and resources… BP gets nothing. It took me almost a year of independent and unguided research to find reputable up to date info and start to understand a lot of it, including how problematic the DSM criteria can be."

Client recommended resources

- “Discord community: "r/bipolar2", welcomes anyone with a mood disorder, or family members and carers. Extremely well managed by volunteers with lived experience, and a very safe and supportive space. https://discord.gg/rbipolar2

- “They also have a Reddit sub r/bipolar2 which is similarly well managed but I'm not a huge fan. It can be a flood of negative / depressed posts unfortunately. In contrast the discord server has plenty of areas for wholesome connection and positivity, as well as support.

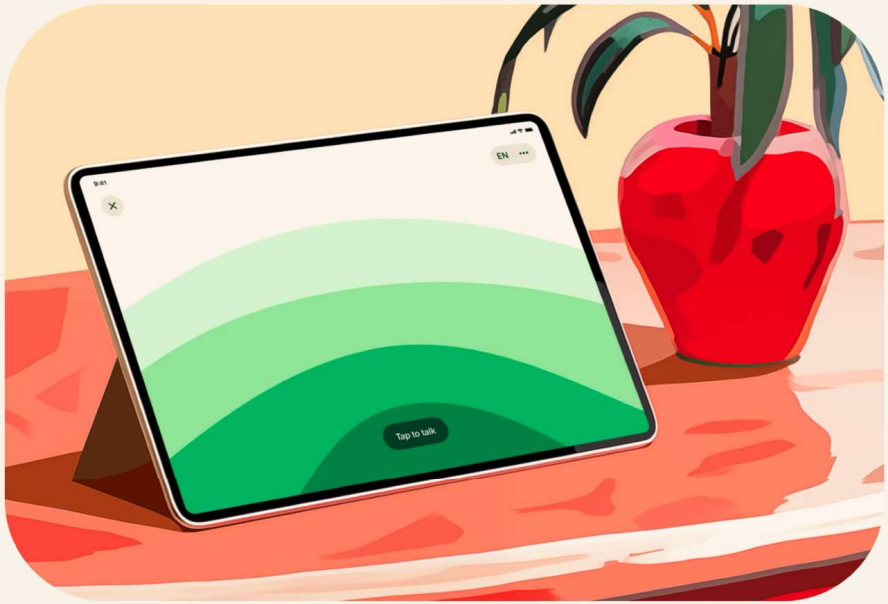
Client resources (cont)

- Web: WA health has a solid collection of self help stuff https://www.cci.health.wa.gov.au/Resources/Looking-After-Yourself/Bipolar
- https://psycheducation.org/home-page/
- YouTube: Polar Warriors is a channel by a person with lived experience of BP including mania, and shares some great stories and advice about caring for yourself and finding stability.
- “DBT skills can also be helpful, as can local services info like knowing about the Safe Haven in town.”
- Bipolar Disorder Survival Guide - Miklowitz

Client resources (cont)

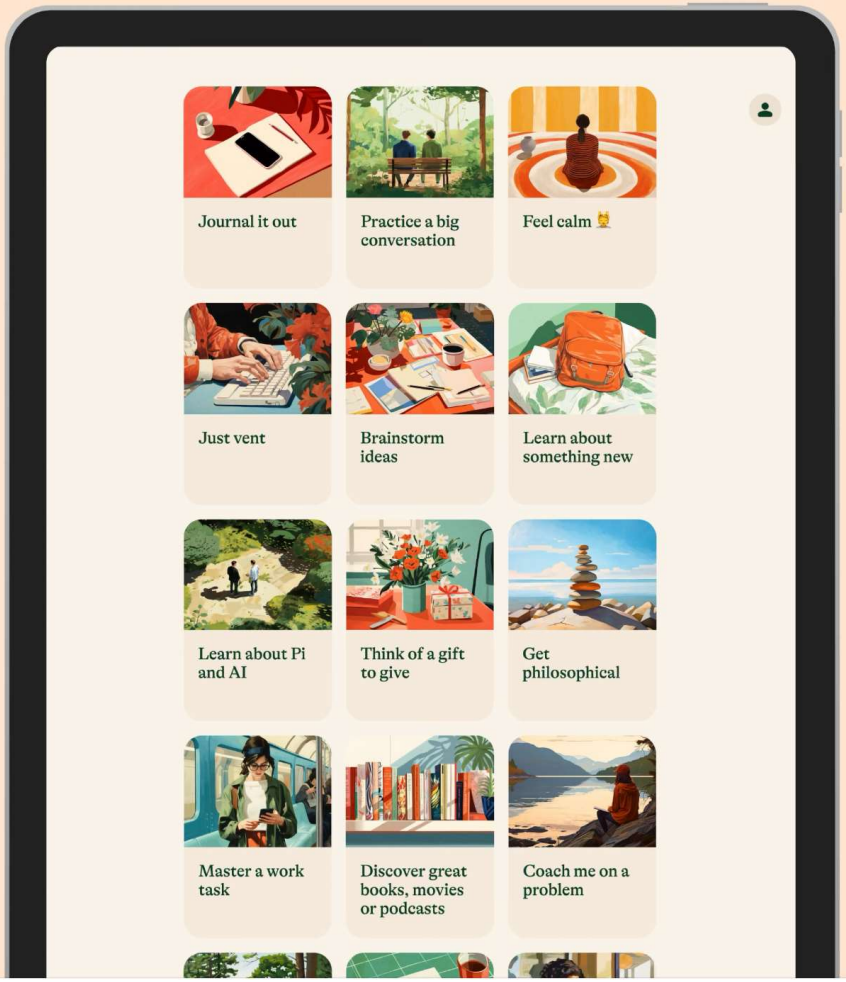
- Mood tracking apps – eg eMoods, daylio
- AI apps – PI
- General wellbeing apps such as Calm
- Sleep tracking apps / devices – eg sleep watch (apple), Garmin watch

I'm Pi, your *personal* AI



Pi

Here to help *you*...



Useful Resources/Events

- Websites:
  - National Institute of Mental Health http://www.nimh.nih.gov
- Conferences/Societies
  - International Society of Bipolar Disorders
  - Australasian Society of Bipolar Disorders
- Journals
  - Bipolar Disorders

This way up – Mood and anxiety

- Treatment programs normally cost AUD $59 when used as 'self-help', but can be accessed by patients for free when prescribed by a health professional. You will need to create an account to prescribe the programs and monitor your clients' progress. Not bipolar specific.
- To view the available programs and learn how to prescribe a program so your patient can access online treatment for free, please visit www.thiswayup.org.au/clinician-hub

The Black Dog Institute

- www.blackdoginstitute.org.au
- Online resources and information
- On-line BD education treatment focuses on:
  - Diagnosing
  - Causes
  - Medication
  - Psychological treatment
  - Staying Well Plans
  - Carer's issues

Science. Compassion. Action

Multidisciplinary Program

Managing Bipolar Disorder

Audience

Multi-disciplinary;
Counsellors;
GP Registrars;
GPs;
Psychologists,
Social Workers.

Duration & Format

9-hours
Face to face
(plus morning tea, lunch, and afternoon tea)

Topics

Topic 1
Assessment & Diagnosis
Topic 2
Pharmacological Management
Topic 3
Recovery & Wellness
Topic 4
Diagnostic Dilemmas

Description

The diagnosis and management of bipolar disorder presents many challenges to primary care clinicians. Our six hour highly interactive program explores the key issues and difficulties in the detection and treatment of bipolar disorder, equipping the clinician with the knowledge and skills required to deliver an integrated pharmacological and psychological approach best suited to the needs of people living with bipolar disorder.

Learning Outcomes

- Identify the key features of bipolar disorder.
- Assess patients presenting with depression for possible underlying bipolar disorder.
- Undertake a risk assessment for patients with bipolar disorder.
- List common co-morbid conditions that accompany bipolar disorder.
- Outline the pharmacological management of bipolardisorder.
- Delineate the role of psycho-education and psychological strategies in achieving and maintaining well-being in patients with bipolar disorder.

Accreditation

- 8 CPD hours incl. 5 hrs Education Activity & 3 hrs Reviewing Performance (RACGP & ACRRM)
- FPS CPD (GPMHSC)

RACGP CPD — Educational Activities 5 hours; Measuring Outcomes 00 hours; Reviewing Performance 3 hours

gpmhsc FPS CPD 2023-25 triennium

ACRRM CPD ACCREDITED ACTIVITY 2023-2025

To learn more, contact us via this **form**
or at education@blackdog.org.au

Black Dog Institute

- My practice: New Ability Health
  - Allied health practice based in Hamilton
  - Offering Psychology, Physiotherapy, Dietetics and OT
  - Clients across the lifespan and with wide range of presenting issues
  - Appointments available immediately!
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- Phone: 02 4926 9813
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New Ability Health

References

Ball, J. R., Mitchell, P. B., Corry, J. C., Skillecorn, A., & Malhi, G. S. (2006). A randomized controlled trial of cognitive therapy for bipolar disorder: Focus on long-term change. Journal of Clinical Psychiatry, 67, 277–286.

Colom F. Vieta E. Sanchez-Moreno J. Palomino-Otiniano R. Reinares M. Goikolea JM. Benabarre A., & Martinez-Aran A. (2009. Group psychoeducation for stabilised bipolar disorders: 5-year outcome of a randomised clinical trial. British Journal of Psychiatry. 194(3):260-5.

Cochran, S. D. (1984). Preventing medical noncompliance in the outpatient treatment of bipolar affective disorders. Journal of Consulting and Clinical Psychology, 52, 873–878.

Hlasta, SF & Frank, E (2006). Adapting interpersonal and social rhythm therapy to the developmental needs of adolescents with bipolar disorder. Development and Psychopathology, 18, 1267-1288.

Jamison, KR (2000). Night Falls fast: Understanding suicide. London: Macmillan.

Joyce, P.R., & Mitchell, P.B. (2004). Mood disorders: Recognition and treatment. Sydney: UNSW Press.

Lam, D.H., Jones, S.H., Hayward, P., & Bright, J.A. (2003). Cognitive therapy for bipolar disorder: A therapist's guide to concepts, methods and practice. Brisbane: Wiley.

Lam, DH et al (2003) A Randomised controlled study of cognitive therapy for relapse prevention for bipolar affective disorder: Outcome of the first year. Arch Gen Psych, 60, 145.

Lam, DH et al (2005). Relapse Prevention in Patients With Bipolar Disorder: Cognitive Therapy Outcome After 2 Years. Am J Psychiatry 162(2), 324–329.

References (cont)

Miklowitz, M et al (2007) Psychosocial Treatments for Bipolar Depression: A 1-Year Randomized Trial From the Systematic Treatment Enhancement Program. Arch Gen Psych 64(4), 419–426

Miklowitz, D., Simoneau, T., George et al. (2000). Family focused treatment of bipolar disorder: 1 year effects of a psychoeducational program in conjunction with psychotherapy. Biological Psychiatry, 48, 582-92.

Miklowitz, D.J. (2002). The bipolar disorder survival guide: What you and your family need to know. New York: The Guilford Press.

Miklowitz, D.J., & Goldstein, M.J. (1997). Bipolar disorder: A family-focused treatment approach. New York: The Guilford Press.

References (cont)

Saddock, B.J., & Saddock, V.A. (2004). Kaplan & Sadock's concise textbook of clinical psychiatry (2nd Ed.). Sydney: Lippincott Williams & Wilkins.

Scott, J., Paykel, E., Morriss, R. et al. (2006). Cognitive-behavioural therapy for severe and recurrent bipolar disorders. British Journal of Psychiatry, 188, 313-320.

Scott J & Colom F (2005). Psychosocial treatments for bipolar disorders. Psychiatr Clin N Am, 28, 371-384.

Torrey Fuller, E., & Knable, M.B. (2002). Surviving manic depression: A manual on bipolar disorder for parents, families and providers. New York: Basic Books.

Questions and Discussion