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Management Plan

Bipolar disorder (BD) occurs in about 1-4% of the population (Sachs, Huffman, & Stern, 2004). However, many clients are underdiagnosed and untreated. As a result, 15-25% of untreated bipolar clients die from suicide and untreated bipolar female clients experience a decrease in life expectancy of 9 years (Sachs et al., 2004). In addition, the acute episodes are associated with highly risky behaviors that lead to other complications (e.g. substance abuse, violence, suicide, etc.) (Sachs et al., 2004).

Depending on the client's stage of illness, the treatment is varied. Regardless, the general approach is to assess the client's baseline medical and psychological status, eliminate mood-elevating agents, encourage good mood hygiene, and provide mood-stabilizing medications (Sachs et al., 2004). Lithium and divalproex are first line mood stabilizing agents while antipsychotics in conjunction with lithium and divalproex are useful for acute episodes of psychotic mania or severe mania (Sachs et al., 2004).

Although pharmacological management has been the mainstay treatment for BD, recent evidence indicates that pharmacotherapy is not completely effective in treating BD (Gonzalez-Pinto et al., 2004). With recent advances in psychotherapy, many practitioners are now using a combination treatment approach of pharmacology and psychotherapy to manage BD clients (Gonzalez-Pinto et al., 2004). One form of psychotherapy is cognitive behavioral therapy (CBT). CBT has been commonly used and shown to be an effective intervention for treating unipolar depression (Patelis-Siotis, 2001).

Among the different types of psychotherapeutics, the unique characteristics of CBT allow it to be a helpful adjunct treatment of BD. Within CBT management, psychoeducation regarding BD is included. This promotes monitoring and self-regulation of the disorder (Patelis-Siotis, 2001). Studies have shown the effectiveness of CBT in relapse prevention of clients with

unipolar depression which suggests that CBT may be helpful for preventing relapse in BD clients (Patelis-Siotis, 2001). Since BD is always recurrent, relapse prevention needs to be emphasized (Sachs et al., 2004). With reports of over 50% of BD clients being noncompliant with their pharmacology regimen, the use of CBT has been shown to increase compliance with the medication treatment (Patelis-Siotis, 2001). Finally, preliminary studies are showing that the combination of cognitive style and stressful life events are predictors of depressive symptoms in BD (Patelis-Siotis, 2001). Given that cognitive styles are similar between unipolar depression and BD, this also strengthens the usefulness of CBT in managing BD (Patelis-Siotis, 2001).

CBT is based on the Cognitive Model of Emotional Response Model (National Association of Cognitive Behavioral Therapists, 2004). Basically, the model assumes that people's thoughts affect the way they behave and feel and not their situations (National et al., 2004). Therefore, if individuals learn how to control their thoughts, despite their circumstances, they can change their negative thought process to a positive thought pattern (NACBT, 2004). This change in the thought process leads to improved emotions and behavioral patterns.

CBT combines two forms of psychotherapy, cognitive and behavioral therapy. The cognitive therapy identifies faulty spontaneous thought patterns that occur throughout the day that lead to negative emotions and actions (Samson, 2001). By identifying these "automatic" thoughts, the therapist has an idea of the underlying assumptions and beliefs about the client's worldview (Samson, 2001). Thus, by assisting the client in identifying the negative automatic thought patterns, the client is made more aware of his beliefs, encouraged to seek the truth regarding his beliefs and assumptions, and to change his beliefs as needed to achieve a balanced and healthier worldview (Samson, 2001). Various cognitive techniques used are mood

monitoring, collecting and challenging automatic dysfunctional thoughts and assumptions, delaying tactics, and re-framing thoughts as symptoms (Lam, Jones, Hayward, & Bright, 1999).

On the other hand, behavioral therapy focus on promoting or reinforcing positive behaviors (Boyd, 2002). The behaviors facilitate change or ending undesirable behaviors associated with the underlying thought process (Boyd, 2002). Behavioral techniques include activity scheduling, self-control therapy, social skills training, problem solving, thought stopping, graded exposures, and relaxation techniques (Boyd, 2002; Samson, 2001).

Since CBT is a specialized intervention, it is also important for advanced nurse practitioners (ANP) to incorporate other counseling interventions prior to using CBT. Stuart and Lieberman (2004) offer helpful general therapeutic guidelines that can be used at any clinical setting. The authors encourage APNs to develop a supportive therapeutic relationship with the client and family, provide options and anticipatory guidance, encourage new behavior, accept the client's reactions to the situation, and to offer early intervention to prevent recurrence (Stuart & Lieberman, 2004). To address the psychological needs of the client in a brief clinical visit, ANPs can apply the acronym BATHE technique as outlined by Stuart and Lieberman (2004). The following is a description and questions for assessing the client's status (Stuart & Lieberman, 2004):

B stands for background.	"What is going on in your life?"
A stands for affect.	"How do you feel about that?" "What's your mood?"
T stands for trouble	"What about the situation troubles you the most?"
H stands for handling	"How are you handling that?"
E stands for empathy	"That must be very difficult for you."

By asking these questions during the visit, they provide APNs with the next appropriate steps of intervention.

Subjective:

V.G. is a 73- year old Caucasian female who was seen for a monthly maintenance exam at the assisted living center in Canton, MI.

CC:

V.G.'s chief complaint was back pain. The pain was located mainly in the lumbar area and radiated to both sides. She rated the pain as "7." The pain was relieved while lying in bed and aggravated when sitting up in her electric wheelchair. V.G. feels a new wheelchair will alleviate her pain. She would like to try a small, manual powered wheelchair, "just like what B.H. has."

Past Medical History:

bipolar disorder, DJD of lumbar spine, gastritis, H. pylori +, GI bleed, HTN, s/p CVA (right hemiparesis), hyperlipidemia, CAD.

Allergies: NKDA

Medications:

Lipitor 20 mg PO QD	Valproic Acid 250mg PO BID
Isosorbide 30mg PO QD	Lisinopril 10 mg PO QD
Metoprolol 50 mg PO QD	Prilosec 20 mg PO QD

Tylenol 500 mg (2 tabs) PO q6hrs PRN

Social History:

V.G. is a widow and has no children. She worked as a bookkeeper. She has a brother and 3 sisters. However, she states her siblings rarely come to visit her. She feels lonely and does

not like living at the assisted living center. V.G. desires to return to her previous living center in Bloomfield where she was able to see a priest and spend time with others who shared her similar beliefs.

According to V.G., a layperson and not a priest lead the Sunday worship service. Therefore, she does not want to share her concerns to someone else other than a priest. Also, V.G. feels there is an "in" group at the facility. Due to this clique, she does not care to join in on any of the activities or outings. Rather, she would work on her crossword puzzles and watch television in her room. She feels the staff is not good to her because she is obese and not part of the "in" group. Also, she feels it is ridiculous not being able to use the phone to make a call without permission from the head nurse.

The APN has been managing her medical condition for the past five years. From APN's reports, V.C. has a loving family, but when observing their interactions, V.C. can be demanding, manipulative, unreasonable, and uncaring. These attitudes can able be seen in her interactions with the staff.

ROS:

No complaints of chest pain, HA, dizziness, weakness, SOB, N/V, chills, fevers. No abdominal pain. Good appetite. Falls asleep but difficulty staying asleep. No numbness or tingling. Requires assistance with all ADLs.

Objective:

V.C. is an 86- year old Caucasian female, seen lying in bed, alert and oriented, pleasant, cooperative. Speech is slurred at times due to s/p CVA residual effect, but understandable. Pt will spell out any words not understood.

HEENT: PERRL, conjunctiva pink, sclera clear, no sinus tenderness, tongue midline, no sores/lesions, no lymphadenopathy.

C/V: S1S2, no murmurs, no bruits, DP intact

Lungs: CTA

Skin: W/D/I, no breakdown

Neuro: no focal deficits, gross sensations intact

MS: UE and LE 5/5 while lying in bed

Psych: Pt. cried several times throughout the history. Mood and affect labile. Brief moments of crying and then smiling.

In order to acquire a clearer picture of V.C.'s bipolar state, the student should have asked direct questions regarding sleep ("This week, how many hours have you actually been sleeping?"), mood condition (Within the past week, how is your mood? More depressed? Periods of excessive anxiousness? Hyperactivity? Irritability? Furthermore, the student should have inquired about suicidal thoughts and ideations, energy level, and done a geriatric depression scale. Questions regarding her desire for manual wheelchair should have been followed up. For her low back pain, the student should have asked if Tylenol or any other medications in the past have relieved her pain.

Diagnoses:

Medical Diagnoses: Low back pain secondary to DJD of lumbar spine, bipolar disorder

Nursing Diagnoses: Altered thought patterns, Individual ineffective coping, altered family bonding

Plan:

From the client's perspective, her main concern was her low back pain associated with her electric wheelchair. However, from the clinician's view, the main concern was the predromal symptoms of depression and dysfunctional thoughts associated with her BD. According to the APN, V.C. has had an extensive history of low back pain due to her DJD. Tylenol has already been ordered, but has not been administered. With significant history of GI bleed, gastritis, H. pylori, and creatinine of 1.5, the Tylenol PRN order will be maintained. However, the staff will be educated and the question printed on the medication record sheet to ask the question, do you have any pain?

The consequences of her cerebrovascular attack left V.C. with right side hemiparesis. Despite receiving PT/OT over the past five years at the facility, she has not been able to maintain full function and mobility. Her inability to propel a wheelchair and to use other assistive devices qualified V.C. to receive the electric wheelchair. In addition, V.C. in the past was frequently noncompliant with PT. Regardless, since it has been a long time since she received PT, a PT referral will be given for evaluation for a manual wheelchair as well as to increase function and mobility. After the PT evaluation and therapy, the APN will have documented evidence to provide V.C. whether or not she can use a manual wheelchair.

To assess V.C.'s psychosocial issues, the BATHE technique was first attempted. By just asking the first question of what is going on in her life? V.C. openly communicated her struggles with pain, loneliness, and frustrations about the assisted living center. During this time, the student was able to identify dysfunctional thoughts such as, "There is an in group in this place. I've been to the different places and I'm not part of the in group." "My family does not care about me, they just want my money." "The people who work here don't like me because I'm too big."

She has been sad and lonely at the assisted living center. In conjunction with her resentment for her electric wheelchair and dislike for activities and staff, she is more hesitant to sit up and interact with others. When asked how she is handling her frustrations, she replied, "I just do my word puzzles and watch T.V." The student used nonverbal communications (eg. holding her hand, nodding, affirming) and active listening to facilitate the therapeutic conversation. After the BATHE intervention and research on BD, the student was able to identify the next steps of intervention.

Although specialized CBT therapists generally perform CBT, advanced nurse practitioners can readily apply some of the general principles of CBT in their management of individuals with BD in a clinical setting. For instance, mood and activity monitoring by using a 24- hour chart can be applied as a brief intervention. Mood monitoring is particularly useful for clients who have experienced frequent relapses (Lam et al., 1999). Their increased feelings of tiredness, sadness, and feeling 'fed up' of normal everyday occurrences are indicated as precursors to a depressive episode (Lam et al., 1999). In V.C.'s situation, she is developing increased feelings of frustrations living at the center and experiencing more sadness.

The client is given and provided a rationale and instructions in filling out a weekly 24-hour mood and activity monitoring chart (see Appendix A). This chart has been modified from Lam et.al. (1999) version to better fit the need's of V.C. For instance, instead of hourly monitoring, 2-hour interval will be used, meal schedules will be pre-recorded, and the print is enlarged. The mood rating will be based on –10 to +10 with –5 and +5 set at normal mood range. The mood and activity monitoring chart will help the clinician identify the fluctuations in V.C.'s mood in correlation with her activities. Furthermore, it will teach the client normal mood fluctuations associated with certain activities. Although this is an intensive assignment, V.C.'s

cognition is capable of filling out forms. This may also aid in decreasing altered thoughts about herself and others throughout the day and increase feelings of productivity.

To decrease V.C.'s low back pain, CBT can also be applied. In a pilot study done by Carrington Reid et.al. (2003), a 10 week individual CBT sessions showed that CBT was a feasible treatment option and possibly efficacious in decreasing pain levels in cognitively intact elderly adults with chronic low back pain. In this preliminary study, the CBT method used were psychoeducation, relaxation techniques (diaphragmatic breathing, visual imagery, progressive muscle relaxation), cognitive restructuring (eg. replacing maladaptive thoughts with adaptive thoughts), anger and sleep management (Carrington Reid, Otis, Barry, & Kerns, 2003).

From these techniques, diaphragmatic breathing and cognitive restructuring can be used to decrease V.C.'s chronic low back pain. Abdominal breathing is a simple adaptive breathing exercise that can be taught quickly. The APN instructs the client to place one hand on her abdomen. As the client inhales, she is told to relax her shoulders and inhale slowly. She should slightly feel her hand rise on her abdomen. As she exhales, the client is instructed to breathe out slowly through her mouth or her nose. The client is encouraged during the exhalation to completely allow her body to let go and imagine a her arms and legs going loose and limp (Bourne, 1997).

A cognitive restructuring technique tailored for V.C.'s altered thought processes is thought stopping. V.C.'s statements such as, "The staff doesn't like me because I'm fat," "My family just want my money." "You can't do anything in this place!" are negative thought patterns. Thought stopping is recognizing these negative comments, taking a deep breath, and saying, "Stop it!" (Bourne, 1997). Then, replacing these negative thoughts with calming, positive, and supportive statements such as, "The staff does care. They help me to eat, to dress,

etc." "I can do something. I can read, write, talk, etc." To further challenge cognitive distortions, Bourne (1997) recommends for clients to write down negative thoughts or statements.

Thought stopping and abdominal breathing are methods that can be easily thought and practiced by the individual. Another way to help V.C. see the illogical reasoning of the "in" group at the center and that the staff is only good to the "in" group, is to use Socratic questions to challenge and refute these cognitive distortions (Bourne, 1997). The APN can ask, "What is the evidence behind your judgment about the "in" group?" "Why do you feel there is an "in" group?" "Why do you feel the staff treats the "in" group better?" "Are you going solely by your feelings?"

All the activities listed previously cannot be done in one meeting especially considering V.C.'s advanced age. Therefore, the following list is a summarized plan and the order of implementation for the interventions listed above.

Current Action Plan:

Next meeting in one week:

1. Take the Modified (Cooper) Yesavage Geriatric Depression Scale
2. Teach abdominal breathing
3. Homework assignment: 24-hour Mood and Activity Monitoring Worksheet

Second meeting one week after the first meeting:

1. Go over Mood and Activity Worksheet
2. Inquire if abdominal breathing is decreasing her low back pain
3. Teach thought stopping

4. Incorporate use of Socratic questions

Third meeting after 4 weeks for the monthly maintenance exam

Retake the Cooper Yesavage Geriatric Depression Scale

Expected Outcomes

After the first meeting:

- Client will be able to demonstrate and explain rationale for abdominal breathing.
- Client will have completed the 24-hour worksheet

After the second meeting:

- Client will be able to recognize and verbalize her negative thoughts.
- Client will write down her negative thoughts and the counteractive statements.

Overall Outcomes:

- Client will be able to decrease her pain severity score to less than 5 after using deep breathing and CBT techniques.
- Client will achieve a Cooper Yesavage Geriatric Depression score of less than 5.

Bourne, E. J. (1997). *The Anxiety & Phobia Workbook* (Revised 2nd ed.). Oakland: New Harbinger Publications, Inc.

Boyd, M. A. (2002). Psychiatric Nursing Interventions Overview. In M. A. Boyd (Ed.), *Psychiatric Nursing Contemporary Practice* (2nd ed., pp. 258-275). Philadelphia: Lippincott.

Carrington Reid, M., Otis, J., Barry, L. C., & Kerns, R. D. (2003). Cognitive-Behavioral Therapy for Chronic Low Back Pain in Older Persons: A Preliminary Study. *Pain Medicine, 4*(3), 223-230.

Gonzalez-Pinto, A., Gonzalez, C., Enjuto, S., Fernandez de Corres, B., Lopez, P., Palomo, J., et al. (2004). Psychoeducation and cognitive-behavioral therapy in bipolar disorder: an update. *Acta Psychiatr Scand, 109*(2), 83-90.

Lam, D. H., Jones, S. H., Hayward, P., & Bright, J. A. (1999). *Cognitive Therapy for Bipolar Disorder A Therapist's Guide to Concepts, Methods and Practice*. New York: John Wiley & Sons, LTD.

National, Association, of, Cognitive, Behavioral, & Therapists. (2004). *What is CBT?* Retrieved June 1st, 2004, from http://www.nacbt.org/whatiscbt.htm

Patelis-Siotis, I. (2001). Cognitive-behavioral therapy: applications for the management of bipolar disorder. *Bipolar Disord, 3*(1), 1-10.

Sachs, G. S., Huffman, J. C., & Stern, T. A. (2004). The Patient with Elevated, Expansive, or Irritable Mood. In T. A. Stern, J. B. Herman & P. L. Slavin (Eds.), *Massachusetts General Hospital Guide to Primary Care Psychiatry* (2nd ed., pp. 181-196). Chicago: McGraw-Hill.

Samson, J. A. (2001). Cognitive Behavioral Therapy. In J. L. Jacobson & A. Jacobson (Eds.), *Psychiatric Secrets* (2nd ed., pp. 210-214): Hanely and Belfus.

Stuart, M. R., & Lieberman, J. A. (2004). *The Fifteen Minute Hour Practical Therapeutic Interventions in Primary Care* (3rd ed.). Philadelphia: Saunders.