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Bipolar Disorder & Substance Use Treatment in Adults: A Tool for Recovery

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BIPOLAR DISORDER & SUBSTANCE USE TREATMENT IN ADULTS: A TOOL FOR RECOVERY

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ABSTRACT

Bipolar Disorder is an affective disorder characterized by moderate to extreme lability in emotional states where individuals experience symptoms of mania, hypomania, mixed mood and/or depression. Individuals may be diagnosed with bipolar I disorder, which is hallmarked by extreme mood lability between mood states of mania and depression. Alternatively, bipolar II disorder is distinguished by fluctuating hypomanic and depressive episodes (DSM-V, 2014). Cyclothymia is defined by shifting mood states that are less severe than bipolar I or II. According to the National Alliance on Mental Illness (NAMI, 2017), 2.8% of adults in the United States are diagnosed with a type of bipolar disorder, which equals nearly seven million individuals. Additionally, NAMI (2021) estimates that in 2020, 6.7% of adults, or 17 million people, in the United States have concurrent substance use and mental illness diagnoses.

Individuals who have been diagnosed with bipolar disorder often attempt to stabilize their emotional states by self-medicating with substances (Canham et al., 2018). In most cases, clients with dual diagnoses struggle to recover from their mental health symptoms and substance use histories. As such, the aim of this paper is to add a therapeutic tool to the literature that assists in the management of both mood and substance use concurrently. This paper details a method in which clinicians aid their clients through a collaborative approach to holistic recovery by increasing insight and positive coping, decreasing substance use, and improving mood stability. The Positive Coping Recovery Narrative tool utilizes a numerical scale to track various mood states. Additionally, it includes columns that record symptoms of each mood state, various substances typically used in each state, and necessary supports, coping skills, and self-care to promote rehabilitation. This tool is helpful for mood management for individuals with serious mental illnesses and substance use histories.

Literature Review

Bipolar Disorder is an affective disorder characterized by varying degrees of mood lability and is considered a serious mental illness (NAMI, 2017, para 2). In the United States, 2.8% of individuals are diagnosed with bipolar disorder, which equals nearly seven million people (NAMI, 2017, para 2). Additionally, in 2020, 6.7% or 17 million, of individuals in the United States were diagnosed with a co-occurring substance use disorder and another serious mental health disorder (NAMI, 2021, para 4). Serious mental illnesses (SMI) include disorders of psychosis, mood, personality, trauma, or eating disorders (Evans et al., 2016, para 1). Bipolar disorder and substance use disorders are often co-morbid, or co-occurring. Additionally, there is evidence that individuals who are diagnosed with bipolar disorder are more likely to abuse substances (Nery & Soars, 2011; Alloy et al., 2009). Genetic vulnerabilities, neurocognitive differences, and stressful experiences are all noted as possible etiologies for both bipolar disorder and substance use disorder. (Miklowitz, 2019, p. 93) Stressful experiences or substantial changes in life have been linked to the emergence of mood episodes. This model is often called the stress-diathesis model (Miklowitz, 2014, p. 93). Ultimately, understanding the connection between bipolar disorder and concurrent substance use disorders is pertinent when considering and identifying treatment options for individuals diagnosed with comorbid mood disorders and substance use disorder.

There is substantial evidence that substance use disorders directly negatively influence the symptoms of bipolar disorder. Negative symptoms of bipolar include hyperarousal, irritation, difficulty focusing, lack of sleep, etc. Substances can heighten or exacerbate these symptoms of bipolar disorder leading to aversive consequences such as suicide attempts or dying by suicide (Salloum & Brown, 2017). Comorbid bipolar disorder and substance use disorders cause more

functional impairment than having a singular diagnosis of either substance use or bipolar disorders (Sheidow, McCart, Zajac, & Davis, 2012). Due to the detrimental effects of untreated comorbid bipolar disorder and substance use disorder, there is a great need for a therapeutic tool for clinicians to utilize when integrating treatment for both diagnoses.

To diagnose bipolar disorder, symptoms cannot be explained by a substance or medical factor and other diagnoses such as schizophrenia or psychotic-based diagnoses must be ruled out (DSM-IV, 2014). In addition, there much be a significant marked difference in the individual's functioning and interpersonal relationships. According to the Diagnostic Statistical Manual of Mental Disorders- Fifth Edition (DSM-V, 2014), the most widely utilized diagnostic manual for all mental health diagnoses or concerns, bipolar disorder has three major distinctions: bipolar I, bipolar II, and cyclothymia.

Bipolar Disorder

To be diagnosed with bipolar I disorder there must be the presence of a manic episode. Manic episodes are typically characterized by persistently elevated or irritable mood that is markedly abnormal from the individual's usual mood state. Criteria for a manic episode includes elevated mood that often results in goal-oriented thoughts and behaviors, thoughts of grandiosity, less of a need/desire for sleep, being more talkative or social, racing thoughts, and/or feeling easily distracted (DSM-V, 2014, p. 124). Three of the above symptoms must be present for at least one week to be considered a manic episode (DSM-V, 2014, p. 124). Individuals in a manic episode may also participate in risky activities, such as "purchasing items that are unnecessary or un-needed, driving recklessly, dangerous business endeavors, or risky sexual behavior" that may have dire consequences (DSM-V, 2014, p. 129). The DSM-V (2014) identifies grandiose thoughts, higher sense of importance of self, and unrealistic ambitions or goals as common

symptoms of manic episodes (p. 129) This is widely supported by research conducted by Johnson, Carver, & Gotlib (2012). Manic episodes may also induce an episode of psychosis, which could include delusions of grandiosity such as believing an individual is a God. During an acute episode of psychosis, auditory and/or visual hallucinations will be present (DSM-V, 2014, p. 152). There are no known accurate predictors of a manic episode, but life events that cause a disruption in sleep or a propensity towards goal-attainment might spur manic episodes for individuals. However, the evidence for this is weak (Johnson et al., 2008). While bipolar I disorder only requires the presence of a manic episode, a hypomanic episode may follow but is not required.

In bipolar I disorder, manic episodes must be followed by a hypomanic or depressive episode within two weeks of the elevated mood state. A major depressive episode diagnosis contains the following symptoms: lack of interest or pleasure in nearly, if not all activities, either weight gain or loss, sleep disturbance, loss of energy, feelings of worthlessness or hopelessness, and/or thoughts of death or suicide. While a depressive episode often follows a manic episode, it is not required for an official diagnosis of bipolar I disorder—only the presence of a manic episode is required (DSM-V, 2014, p. 125)

Bipolar II disorder is similar to bipolar I with the difference being the absence of a fully diagnosable manic episode in bipolar II disorder. Instead, there is a presence of a hypomanic episode. Hypomanic episodes are characterized by the following: higher than normal self-esteem or personal grandiosity, decreased need for sleep, experiencing themselves as highly talkative, racing thoughts, being easily distractable, increased interest in goal-oriented activities, and involvement with activities that may have dire consequences. Three or more of these symptoms must be present for at least four days in consecutive order (DSM-V, 2014, p. 133-134). In bipolar

II disorder, a major depressive disorder must be present two weeks directly following the hypomanic episode.

Essentially, the primary differences between bipolar I disorder and bipolar II disorder are the severity and duration of hypo/manic episodes. Someone who experiences a manic episode experiences more severe symptoms for a longer timeframe than an individual who experiences a hypomanic episode (DSM-V, 2014, p. 125-134). Fewer symptoms are required for a diagnosis of a hypomanic episode than a manic episode. Finally, a depressive episode following an episode of hypo/mania is necessary only to diagnose bipolar II disorder (DSM-V, 2014, p. 125-134).

Finally, cyclothymia requires a two-year period when an individual experiences symptoms which are similar to that of hypomania and depressive episodes but do not meet the full criteria for diagnosis of either. These combined symptoms must be present for at least half of the two-year requirement for this diagnosis (DSM-IV, 2014). Diagnosing bipolar disorder can be difficult because it is often based off the subjective report of symptoms experienced and can often be clarified with long-term observation (Goldberg, 2019). In addition, the thresholds between mania, hypomania, and baseline can often be difficult to distinguish between, which increases the difficulty in accurately diagnosing the appropriate from of bipolar disorder. Finally, it can be greatly difficult to accurately identify a clear bipolar diagnosis without prior documentation, trauma history, length of time since first mood episode, or substance use interactions (Goldberg, 2019).

National Alliance on Mental Illness (2017) reported there are no significant differences in the frequency of bipolar diagnoses regarding age or gender. However, bipolar disorder typically emerges between young adulthood and adulthood and does present differently in males and females. For example, women typically experience initial symptoms of bipolar disorder slightly

later in life, experience more depressive episodes, and rapid cycling more than men (Miklowitz, 2019).

One of the most common treatments for bipolar disorder, often in conjunction with therapy, is mood-stabilizing medication. Lithium Carbonate is commonly utilized, which, if not closely monitored, can have detrimental consequences to an individual's health (Miklowitz, 2019). If Lithium Carbonate is not properly monitored individuals are at risk for "lithium toxicity" where there is excess lithium in the blood and creatine levels change, causing difficulty in kidney function and can even be lethal (Miklowitz, 2019, p. 131-133). Therefore, consistent monitoring ensures patients are within a therapeutic dose (Miklowitz, 2019, p. 133). Additional side effects include difficulties in memory, weight gain, and feeling mentally sluggish. For these reasons, many people are weary of lithium (Miklowitz, 2019, p. 133). It can be difficult for individuals to continue taking their prescribed medications when experiencing these side effects. Additionally, many of the symptoms of hypo/mania are temporarily enjoyable and some individuals miss these feelings when they are on psychotropic medications. While there are many challenges to medication adherence, it is of the upmost importance in stabilization and long-term maintenance for individuals diagnosed with bipolar disorder.

Another one of the most common types of medications are anticonvulsants. Anticonvulsant medications such as Depakote, Lamictal, Tegretol, Trileptal, and Topamax are a few of the most effective (Miklowitz, 2019, p 134-138). Anticonvulsants can be prescribed alongside other medications to assist in other mental health symptoms such as anxiety which also have their own side effects (Miklowitz, 2019, p. 138). This can be a helpful alternative for individuals who are weary of utilizing lithium carbonate despite have many of the same side effects.

In conjunction to medication, it is highly recommended that individuals track their moods and habits. Miklowitz (2019) created a daily mood chart which includes sections to track mood, sleep, medications taken, frequency of talk therapy, and levels of anxiety/irritability (p.190). This daily mood chart should be completed daily in order to present a comprehensive picture. The proposed tool in this paper is similar to that of Miklowitz (2019). However, the new tool proposed is not created to be utilized as a daily mood tracker. The proposed tool contains a personal narrative of symptoms and behaviors for individuals to reference to identity mood states, positive coping skills, and substances used throughout a mood spectrum. Once an individual is diagnosed with a form of bipolar disorder, they may benefit from charting their moods daily to understand their symptoms and triggers.

Substance Use Disorder

As mentioned, substance use disorders are quite common in the United States. For the purposes of the proposed therapeutic tool, there are no specifications in the type of substance used. The ten classes identified in the Diagnostic Statistic Manual- 5th Edition (2014) are: alcohol, caffeine, cannabis, hallucinogens, inhalants, opioids, sedatives, hypnotics, anxiolytics, stimulants, tobacco, or other unknown substances (p.483). Substance use disorders are comprised of a conglomerate of cognitive, behavioral, and physiological changes for an individual, yet the individual continues to engage in use. There is often a significant change in physiology, specifically within the brain, that has lasting affects even after someone has undergone detoxification and is no longer consuming the substance. As a result, behavioral changes experienced during the time of chronic substance use may persist (DSM-V,2014, p. 483).

There are four domains in which an individual must have impairment or difficulty in to be diagnosed with a substance use disorder. These domains are impaired control, social

impairment, risky substance use, and pharmacological effects such as tolerance and withdrawal. The impaired control domain centrals around an individual's difficulty or inability to discontinue or slow their use, utilizing more of a substance over a longer period of time, and spending a substantial amount of time obtaining, using, or recovering from the effects of the substance (DSM-V, 2014, p.483). Craving the substance is a physiological, behavioral, and cognitive challenge that also falls under the domain of impaired control. Functional impairment in substance use disorders is illustrated by failing to fulfill responsibilities to work/school, family, social connections, and continuance of use even after the impairments are present. The act of giving up hobbies, friends, occupational duties because of substance use is also a significant aspect of social impairment (DSM-V, 2014, p. 483).

According to the DSM-V (2014) risky use is the third domain, which encompasses utilizing substances in situations that are hazardous physically or psychologically—for example, substance use undeterred by the knowledge of a recurrent problem such as a physical ailment or psychological problem (p.483). The physical ailment or psychological/emotional problem are likely to be made worse by the substance and the inability to abstain from the substance is key to the risky use.

Finally, the pharmacological criteria of tolerance and withdrawal are two of the most notable and dangerous symptoms of a substance use disorder (DSM-V, 2014, p.484). Tolerance is hallmarked by a physiological change that requires increased amounts of the substance to be consumed in order to reach the desired level of effect. Simply stated, the individual needs more of the substance to reach the same level of intoxication they once were able to with a smaller dose of the substance. Alternatively, withdrawal is often found in individuals who have heavily consumed substances for a long amount of time. These individuals experience a change in their

blood tissue concentration due to the prolonged substance use and experience physical symptoms without continued use of the substance (DSM-V, 2014, p.484). When individuals experience withdrawal, they often use the substance again to alleviate the symptoms. Withdrawal appears differently for each class of substance and can vary across individuals, but can cause severe physical, emotional, cognitive, and social distress. In some cases, withdrawal can be dangerous and even lethal. Individuals with a history of dangerous withdrawal should highly consider undergoing a medical detox. The presence of tolerance and withdrawal is not necessary for a diagnosis of a substance use disorder; however, it can provide information on the severity of the disorder for clinicians. Ultimately, only two of the previously mentioned symptoms must be present within a twelve-month period to be classified as a substance use disorder (DSM-V, 2014, p.484).

In substance use disorders, there are specifications of mild, moderate, or severe. The difference between these specifiers is in the number of symptoms present. For a diagnosis of a mild substance use disorder, the individual must experience two to three symptoms. Moderate substance use disorders require four to five symptoms and severe includes six or more symptoms (DSM-V, 2014, p. 484). The severity of a substance use disorder can change over time with other specifiers included such as “early remission or sustained remission” at any time (DSM-V-2014, p. 484).

Canham et al., (2018) conducted a qualitative study on personal narratives of individuals diagnosed with comorbid bipolar and substance use disorders. Various themes were identified by the participants in this study as reasons for substance use in conjunction with bipolar disorder. The most notable themes included self-medication and living in a culture of substance use (Canham et al., 2018). Many individuals struggle to quickly find the right psychotropic

medication regimen to treat bipolar disorder and may find themselves choosing substances to cope or regulate their mood instead. Individuals who live in a culture of use, or a culture where using substances is the norm, face a unique challenge where non-use of substances would be more ostracizing than the use of substances. As a result, individuals in this culture might not consciously or intentionally utilize substances to manage symptoms of bipolar disorder but are engaged in substance misuse regardless (Canham et al., 2018).

Comorbid Bipolar Disorder and Substance Use Disorder

Substance use and bipolar disorders often emerge during young adulthood. Additionally, substance use rates are higher among young adults who are diagnosed with a serious mental illness, such as bipolar disorder (Armstrong & Costello, 2002). Since both disorders emerge within the same time frame, individuals with comorbid substance use and bipolar disorders often struggle with the developmental tasks that are associated with transitioning into adulthood (Vida et. al, 2009). Difficulty managing transitionary tasks of adulthood can cause problems for individuals later in life, which would already be exacerbated by both diagnoses. Often, substances become a primary way to medicate undiagnosed bipolar disorder or cope with the stress related to these transitionary tasks.

Treatment Options

While there is a great need for more clinics specialized in treating comorbid bipolar disorder and substance use disorders, there is a low number of these treatment options or facilities in most communities (Salloum & Brown, 2017). Salloum & Brown (2017) indicate that an integrated treatment option for these disorders appears to be more successful than treating each disorder individually. One widely utilized treatment method is medication, which may have

the capacity to treat both disorders. However, evidence-based psychotherapy treatment for each individual disorder could be just as effective (Cerullo & Strakowski, 2017).

There are commonly utilized treatment modalities for bipolar and substance use disorders in both inpatient and outpatient settings. Both settings have been found to be effective, however, there is often difficulty in treating this population due to a lack of consistency in treatment and frequent cycles of mood lability (Gold et al., 2018). In addition, psychopharmacological interactions, difficulty attending therapy, identifying/treating the proper phase of treatment for each disorder, and managing relapses or acute mood stabilization are barriers to consistency in treatment (Salloum & Brown, 2017). When an individual does engage in treatment, there are two key aspects to nearly all therapeutic modalities: treatment for acute stabilization as well as a maintenance phase (Salloum & Brown, 2017).

Individual psychotherapies in either outpatient or inpatient settings vary on their focuses and efficacy for these comorbid disorders. Cognitive Behavioral Therapy (CBT) is one of the most widely used treatment modalities for the treatment of bipolar disorder and substance disorder. As an evidence-based treatment model, it has proven to be effective for each disorder when treated separately (Gold et al., 2018). While this is useful, an integrative treatment model may prove to be more effective. Schmitz et al., (2002) conducted a randomized study investigating the difference between success in patients who received CBT and medication management versus only medication management for individuals with comorbid substance use disorder and bipolar disorder. They identified that a combined approach of CBT and medication management increased knowledge of mood management and compliance with medications (Schmitz et al., 2002). The researchers did not identify significant changes in substance use, however were able to record differences with mood management and medication adherence

(Schmitz et al., 2002). Early Recovery Adherence Therapy (ERAT) is an individual therapy that is solely focused on acute stabilization after acute episodes or relapses (Salloum & Brown, 2017). This treatment is useful at the acute phase of treatment but fails to address more maintenance therapy and growth.

Group therapies are widely utilized for many reasons; one being that the social component of group therapy can be pivotal in personal recovery. Integrated Relapse-Prevention Group Therapy (IGT) is a common group treatment for these disorders (Weiss, Najavits, & Greenfield, 1999). This modality focuses on identifying and planning for triggers, relationships/supportive contacts, and high-risk situations for relapse. Clients check in on their medication adherence and current symptoms of bipolar disorder. These meetings are typically sixty minutes long and meet around twenty times. This treatment was useful for the substance use aspect of treatment, but there was less of a change for clients regarding improved skills in mood management (Weiss, Najavits, & Greenfield, 1999). Therefore, this treatment is lacking in effectively treating both bipolar disorder and substance use disorder.

Dialectical Behavioral Therapy (DBT) is often used for the treatment of serious mental illness, including bipolar disorder (Linehan, 2015). Dr. Marsha Linehan (2015) created DBT for the treatment of borderline personality disorder or high suicidality. This treatment focuses on distress tolerance, emotion regulation, and effective communication. These are all useful positive coping skills for those diagnosed with bipolar disorder (Cavicchioli et al., 2021). Misdiagnoses of borderline personality disorder versus bipolar disorder are common, thus enhancing the utility of DBT while gathering additional information for diagnostic clarification.

In a study completed by Biseul et al., (2017), a new protocol named “HABIT” was created by combining Integrated Relapse Prevention Group Therapy (IGT) and various

mindfulness-based techniques. “HABIT”, which stands for “Helping individuals with Addictions and Bipolar Disorder with Integrated cognitive behavioral and mindfulness-based relapse prevention therapy” was successful in remediating symptoms of depression but not mania (Biseul et al., 2017, p. 889). This indicates that there may be a significant social component to the treatment that assisted in the remediation of depressive symptoms. While this study has a small sample size, the remediation of depressive symptoms was notable. This adds to previous evidence that the social aspect of treatment is a well-validated indicator of personal recovery and learning to live with bipolar and substance use disorders (Jones et al., 2013)

The Wellness Recovery Action Plan (WRAP) created by Dr. Mary Copeland (2011) is a treatment modality that addresses both substance use and other severe mental illnesses. This therapy helps individuals learn to manage their mental illness(es) on their own, with the assistance of social supports. The WRAP tool is typically provided either in small groups that meet for eight to ten full sessions or on an individual basis (Cook et al., 2012). The WRAP approach requires individuals to create a personalized plan for their own health and wellness, much like the Positive Coping Recovery Narrative Tool proposed in this paper. There is a focus on “reestablishing, maintaining, and then enhancing an individual’s wellness” (Petros & Solomon, 2020, p. 133). The social support innately provided by the group modality has been found to be a significant indicator of personal growth and engagement. Overall, the WRAP as an intervention has definite usefulness regarding identifying strengths, personal engagement, personalization, effective coping, crisis plans and social support.

The Positive Coping Recovery Narrative Tool

In recent years, there has been a call for increasingly positive language around recovering from mental health conditions (SAMSA, 2010, p. 4-7). The goal of the recovery-oriented

treatment movement is to use and implement strategies that are more person-centered and recovery-oriented. Central tenets of this movement include the following: “Recovery emerges from hope; recovery is person-driven; recovery occurs via many pathways; recovery in holistic; recovery is supported by peers and allies; recovery is supported through relationship and social networks; recovery is culturally-based and influenced; recovery involved individual, family, and community strengths and responsibilities; recovery is based on respect (SAMSA, 2010, p. 4-7). These tenets of the recovery-oriented movement fuel this tool and the way in which it is utilized.

The Positive Coping Recovery Narrative Tool utilizes three customizable categories for clients to personalize for their individual experiences and mood states. The first category is titled “Personal Narrative”. This personal narrative provides an opportunity to dictate a subjective description of idiographic and individualized experiences in various mood states including behaviors, thoughts, and emotions. This can be useful to complete with partners, family members, or significant social supports as they may provide additional helpful information. As previously noted, social support is a substantial indicator of personal recovery. Therefore, including social supports in the creation of this tool can provide unique insights and collaborative support. Promoting collaboration also assists in facilitating culturally-based solutions, respect, community support, and an overall person-driven approach to treatment. Each of these values align with the tenets of recovery-oriented treatments (SAMSA, 2010).

The second category is titled “Substance(s)” and is dedicated to identifying which substances are used at various points of an individual’s mood state as it fluctuates. In the study completed by Canham et al., (2018) self-identified themes, or risk factors, of substance use and bipolar disorder were illuminated such as: “self-medication, access to alcohol, early social exposure/use as a facilitator, living in a culture of substance use, and lack of alternative activities

(p.814)". This study provided insight into the intertwined symptomology of bipolar disorder and substance use disorder which creates a chronic pattern of use. This chronic pattern of use in direct connection to bipolar disorder mood lability is emphasized in this section of the proposed tool. As individuals explore which substance(s) they use at points of their mood lability, they may notice patterns of chronic or acute use that illuminate a pattern of self-medicating. The theme of self-medication highlights an individual's attempt to personally stabilize their mood when they have either found prescribed medications to be ineffective, when they have stopped medications, or when they have not had access to psychiatry services (Canham et al., 2018). As discussed, illicit substances are often used as a short-term tool to ease mental health symptoms and must be addressed in conjunction with bipolar disorder symptoms to promote holistic recovery. However, many individuals find that self-medicating does not alleviate symptoms in the long-term, but rather exacerbates the negative symptoms of bipolar disorder such as mania, depression, or suicidal thoughts (Salloum & Brown, 2017).

The final category is titled "Positive Coping". This may include topics such as social supports/connections, personal hygiene, and safety (including crisis center information and locations for potential hospitalization). Dunne, Perich, & Meade (2019) identified important changes in engagement with social connections depending on mood state. For example, during hypo/mania and depressive episodes individuals connect less with their friends/family or they may become hyper social. During various phases of mood states, social connections can be more or less important to individuals. When hypo/manic an elevated sense of confidence may lead to less importance placed on social connections whereas in a depressive state, social connections may be perceived as less vital (Dunne, Perich, & Meade, 2019). However, social connection is pertinent regardless of mood state and is an integral part in any recovery plan.

Collaboration is pivotal to creating a successful coping and safety plan as part of this segment of the tool. An individual may indicate who they would like to call or be notified during various mood states. Care coordination can be part of this section as the client should indicate which hospital they would like to go to, which provider to call at various times, and other important phone numbers or addresses, if desired. For supportive others, individuals are encouraged to place names of family members or friends who can provide support, as well as a backup individual(s). Self-help or peer support groups can be noted in this section so that individuals are reminded to call or connect with their sponsor or peer support specialist. Contact information for loved ones, medical providers, and therapists should also be included in this section so everyone on the plan has access to who to contact in times of crisis. Personal hygiene can vary greatly because of labile mood states and substance use. Therefore, it is important to discuss with individuals how they will maintain their personal hygiene and safety during times of distress.

Safety can be a significant concern for substance use, manic, and depressive states. In manic and depressive mood states active suicidal ideation with plans and intent can be present, therefore safety planning and providing crisis resources is key. Impaired judgement, agitation, sleep deprivation, and decreased functioning can exacerbate safety concerns and make it difficult for individuals to problem-solve in the moment. Therefore, it is crucial to ensure that these individuals remain safe or have resources to become safe. Due to the various safety concerns, it is important to discuss with individuals where their nearest Emergency Department and/or Crisis Walk-In Center are located and where they can receive supplies such as Narcan in case of overdose. It is recommended to include these contacts as part of safety planning for the future. Communicating with supportive others, psychiatrists, or therapists can also be indicated in this

section to ensure that all supportive parties of the client are briefed and aware of their current mood state and/or level of use.

The hallmark of this tool is collaboration and communication with individuals who would like to engage in the process of completing it. Collaboration is useful not only for gaining information that a clinician would otherwise not have, but it can be useful for motivational interviewing in discussing explicitly how clients can prioritize their mental wellness and safety during various mood states rather than remaining ambivalent (Buckner, 2021, p. 115). It is highly encouraged to utilize supportive others throughout the process of creating this tool to assist in accountability and overall support as the individual works towards holistic mental health and wellness.

Dr. David Miklowitz (2019) created a tool to manage bipolar disorder similar to the Positive Coping Recovery Narrative Tool. His tool includes various mood sates, differentiated between “depressed, without significant impairment, and elevated” (p. 190). Individuals are asked to write how many hours of sleep they obtained, how irritable they feel, and how much anxiety they are experiencing. Finally, it includes a note section and location to note which medications are taken and if the individual has attended psychotherapy or not. This tool is intended to be utilized each day as a mood tracker and allows for individuals to directly indicate what they are experiencing each day (Miklowitz, 2019, p. 190).

The tool created by Miklowitz has thematic similarities to the Positive Coping Recovery Narrative Tool but has a different approach to monitoring symptoms. The primary differences between the tool created by Miklowitz and the Positive Coping Recovery Narrative Tool is that the new tool is not intended to be filled out each day to track moods. The proposed tool utilizes a personal narrative of each mood state that includes many of the same components such as

medications taken, differentiation between mood states, substance use and general structure of the tool. However, the Positive Coping Recovery Narrative Tool allows for individuals to use their personal language and broaden the categories or symptoms, coping skills, and treatment options to what fits for their life. Another striking difference is the collaboration necessary for the new tool's creation. Finally, the intent of the tool is not to be a daily tracker solely for the individual but rather for the patient to use themselves and share with others to assist in tracking moods episodes, utilizing coping skills, and understanding their substance use.

Helpful Tips for Utilizing the Positive Coping Recovery Narrative Tool:

1. Collaboration in completing this tool is advisable once an individual is relatively stable and clean/sober. Checking for symptoms of withdrawal or other acute symptoms is pertinent. It an individual appears to be in active withdrawal, this tool should not be utilized, and the individual should be directed to the appropriate level of care.
2. Psychoeducation on bipolar disorder, various mood states, substance use, positive coping skills and common symptoms can be useful.
3. Utilize the individual's words as much as possible.
4. Start either at a manic state or a depressive state and work towards baseline mood.
5. If there are any acute safety issues, always assess for safety and include safety planning contacts as part of the tool.
    a. The Columbia Suicide Severity Risk Scale (C-SSRS) is a well validated, free, and printable safety assessment tool (Posner et al., 2010).

   b. Safety planning, including removing access to hazardous items, should be considered upon assessment. Stanley & Brown (2011) created a free printable safety plan for clinicians to utilize.

6. It can be useful to provide individuals with mood wheels, symptom descriptions (such as: void, sad, empty, excited, talkative, etc) to assist in creating a cohesive narrative.
7. If the individual has safe, supportive, and trusted friends, community members and/or family who would be willing to assist in creating the tool this would be advised.
8. Encourage the client to have multiple copies of the tool around areas they frequent. Supportive others and members of the care team may also be provided a copy of the tool to assist in monitoring moods and encouraging positive coping skills.
9. Clinicians should use a culturally competent approach to assess and address cultural components such as racial identification, ethnic identification, sexual orientation, military status, spirituality, etc (American Psychological Association, 2018)
   a. More information and education on the importance of this concept can be found on the American Psychological Association's statement on multicultural competency for clinicians released in 2018.
10. Clinicians should also provide support as individuals identify supports through religious groups and/or spiritually based groups if applicable to the individual.

Table 1: Positive Coping Recovery Narrative Tool – Blank

Scale Number and Mood	Personal Narrative	Substance(s) Used	Positive Coping
1 Manic			Social Supports/Connections: Personal Hygiene: Safety:

2 Hypomanic- Manic			Social Supports/Connections: Personal Hygiene: Safety:
3 Hypomanic			Social Supports/Connections: Personal Hygiene: Safety:
4 Elevated			Social Supports/Connections: Personal Hygiene: Safety:
5 Neutral			Social Supports/Connections: Personal Hygiene: Safety:
6 Neutral			Social Supports/Connections: Personal Hygiene: Safety:
7 Below Baseline			Social Supports: Personal Hygiene: Safety:
8 Depressed			Social Supports/Connections: Personal Hygiene: Safety:
9 Moderately Depressed			Social Supports/Connections: Personal Hygiene:

			Safety: Hospitalization:
10 Severely Depressed			Social Supports/Connections: Personal Hygiene: Safety: Hospitalization:

Case Example

**Some identifying information has been removed or altered to protect the confidentiality of the individual.*

Dave is a twenty-five-year-old, Black, gay, single, cisgender male. Dave grew up in Denver, Colorado and was raised by a middle-class family. He remains consistently close with his sister, parents, and a few friends within his LGBTQIA+++ community. Dave's family and a few friends comprised his sober supportive others. He was diagnosed with Bipolar Disorder I at the age of 18 and has engaged in the utilization of cocaine, alcohol, and heroin consistently since that time. Dave presented at a residential treatment facility for the treatment of his substance use after being placed on an involuntary commitment hold by the state, which was initiated by his mother and sister.

In treatment, Dave discussed his fear of high-risk relapse situations in his social circle, as many of his friends were still utilizing substances. For example, Dave expressed the importance of his community and the regular gatherings in night clubs where many individuals in his social circle would use, offer, and share illicit substances. While Dave recognized that these situations

would be high-risk, he identified that the lack of this social connection would be detrimental to his mental health and substance use.

Dave completed the Positive Coping Recovery Narrative Tool during a forty-five-minute individual session with his individual therapist. The tool was utilized collaboratively halfway through his four-week residential treatment stay. His next step-down treatment was intended to be a sober living environment where he would no longer be under the direct supervision of mental health providers or psychiatrists. Dave's tool can be found below:

Table 2: Positive Coping Recovery Narrative Tool - Case Example

Scale Number and Mood	Personal Narrative	Substance(s) Used	Positive Coping
1 Manic	*"Staying up for days, feeling super social and talkative- I am the life of the party, not showering for days, lack of appetite, reckless behavior, not as careful using safe needles, often engaging in reckless sexual activities"*	*"Mostly heroin and alcohol when I get this manic. I would do anything to try to feel level again. I'm not safe at all. Honestly, I don't remember much from this time."*	Social Supports/Connections: *Call Sister* *Call Parents* **request parents or sister inform work and other responsibilities of hospital stay.* Personal Hygiene: *Shower twice weekly* *Go home each night* *Practice safe sex and use habits such as utilizing condoms or sterilized/clean needles* Safety: **request parents or sister to inform psychiatrist and/or therapist of hospitalization.* *Remove firearms from home* *Remove access to lethal suicidal means* Hospitalization: *Swedish Medical Center Emergency*

			Department 501 E Hampden Ave, Englewood, CO 80113 *Take and/or bring prescribed medications* *Obtain Narcan*
2 Hypomanic-Manic	*"I typically stop shaving my face around this time but still feeling really confident. When I go to the club to drink, I struggle to feel any effects of the alcohol but its okay because I can stay up all night anyways"*	"*I usually start drinking a lot more during this time. I take a lot more edibles sometimes too"*	Social Supports/Connections: *Call parents* *Call Sister* *Inform sponsor or peer-support about mental health and recovery* *Continue going to work* Personal Hygiene: *Come home each night* *Eat 1-2 meals per day* *Practice safe sex and use habits* *Shower twice weekly* Safety: *Call Psychiatrist and/or therapist* *Take prescribed medications* *Monitor thoughts of suicide and risky behavior* *Remove firearms from home* *Remove access to lethal suicidal means* Consider Hospitalization: *Swedish Medical Center Emergency Department 501 E Hampden Ave, Englewood, CO 80113* *Obtain Narcan*
3 Hypomanic	*"Feeling really good* *Not sleeping as much, agreeing to too many projects, I start to feel more irritated with the people around me. This is usually when I am feeling good in my sobriety and tend to slip up socially."*	*"When I have relapsed in the past, it has definitely been during this time frame. I feel over-*	Social Supports/Connections: *Call sister* *Call parents* *Go to work* Personal Hygiene: *Shower three times weekly* *Eat 2-3 meals per day*

		confident in my recovery"	Safety: *Continue to meet with psychiatrist and/or therapist* *Monitor thoughts of suicide and risky behavior* *Remove firearms from home* *Remove access to lethal suicidal means*
4 Slightly Elevated	*Feeling a bit higher than normal, I usually just think that I am having a good day that day. Who knows, maybe it is just a good day.*	Maintenance Substances: Cigarettes, Marijuana	Social Supports/Connections: *Continue going to AA/NA/CMA Meetings or Other Peer-Support groups* *Go to work* *Dinner with friends* Personal Hygiene: *Shower 3-4 times weekly* *Regularly take prescribed medication* *Eat 2-3 meals per day* Safety: *Continue meeting with psychiatrist and/or therapist* *Monitor any thoughts of suicide and/or risky behavior* *Call Sponsor when experiencing triggers or cravings*
5 Neutral	Neutral *Living life as normal, taking regular medications, sleeping, working, eating, etc.*	Maintenance Substances: Cigarettes, Marijuana, etc.	Social Supports/Connections: *Continue going to AA/NA/CMA Meetings or Other Peer-Support groups* *Go to work* *Dinner with friends* Personal Hygiene: *Shower 3-4 times weekly* *Regularly take prescribed medication* *Eat 2-3 meals per day*

			Safety: *Continue meeting with psychiatrist and/or therapist* *Monitor any thoughts of suicide and/or risky behavior* *Call Sponsor when experiencing triggers or cravings*
6 Neutral	*"Completing daily tasks, going to work, seeing friends, feeling pretty good, like I can manage everything on my plate."*	Maintenance Substances: Cigarettes, Marijuana, etc.	Social Supports/Connections: *Continue going to AA/NA/CMA Meetings or Other Peer-Support groups* *Go to work* *Dinner with friends* Personal Hygiene: *Shower 3-4 times weekly* *Regularly take prescribed medication* *Eat 2-3 meals per day* Safety: *Continue meeting with psychiatrist and/or therapist* *Monitor any thoughts of suicide and/or risky behavior* *Call Sponsor when experiencing triggers or cravings*
7 Below Baseline	*"I start to feel a little down, maybe a little insecure with my friends or partners. I know that I definitely start to sleep and eat more as I feel more and more sad"*	*"I try really hard to stay clean, but I know that one drink can help me feel more confident, more myself"*	Social Supports: *Call sister* *Call friends* *Attend an AA/NA/CMA or other Peer-Support group* *Continue going to work* Personal Hygiene: *Eat 2-3 meals a day* *Workout 4 times weekly* *Shower every 2 days* Safety: *Call Psychiatrist* *Continue taking medication*

			Call therapist
8 Depressed	*"The more sad I get, the more I stay at home by myself in bed. I don't like to call anyone, I feel like such a burden. So I guess all I do is eat and use. But then I feel worse because I am using and I know that everyone would be so disappointed in me. I don't really shower or take my meds… What's the point?"*	*"I don't go out much. I think I usually drink or use cocaine at this point"*	Social Supports/Connections: *Call sister* *Call one friend every day* Personal Hygiene: *Eat at least two meals a day* *Walk around the house* *Spend 5 minutes outside* *Shower every 2 days* Safety: *Call Psychiatrist and/or therapist* *Continue taking medication* *Obtain Narcan for emergencies* *Use fentanyl strips to test drugs before use*
9 Moderately Depressed	*"I literally don't want to do anything but lay in bed and use, all day. I think about death a lot, I know I get risky with my use during this time. My friends might call, but I never answer. I just want to be left alone"*	*"I don't even want to go out to get my heroin, but it's the only thing that helps me feel better"*	Social Supports/Connections: *Call sister* Personal Hygiene: *Shower once a week* *Walk around the house once a day* *Eat at least one meal each day* Safety: *Call psychiatrist and/or therapist* *Obtain Narcan for emergencies* *Continue taking mediation* *Remove firearms from home* *Remove access to lethal suicidal means* Hospitalization: *(Swedish Medical Center Emergency Department 501 E Hampden Ave, Englewood, CO 80113)* *Obtain Narcan for emergencies*
10 Severely Depressed	*Same as above, just more severe depression or suicidal ideation*	*"Like I said, I use a lot. I use heroin to make me feel*	Social Support/Connections: *Notify sister and parents* *Notify sponsor or peer-support*

	"Same as what I just said. It's just super bad, really dark. My thoughts are usually always thinking about death. I sometimes think I would scare myself if I weren't so numb. I use a lot… Not sure if its to keep me numb or make me feel"	*better, but sometimes I also try to use a ton of cocaine to try to get back to a more stable state. When that doesn't help, I can feel really hopeless. I think about how much I would need to use to end my life"*	Safety: *Call Psychiatrist and/or therapist* *Immediate Hospitalization* *Remove firearms from home* *Remove access to lethal suicidal means* Hospitalization: *(Swedish Medical Center Emergency Department 501 E Hampden Ave, Englewood, CO 80113)* *Residential Treatment* *Obtain Narcan for emergencies*

Discussion

The proposed tool can be useful in a variety of settings to help individuals self-manage their recovery from these comorbid disorders. Through engagement with the tool, on an individual basis or with social supports, individuals can customize their treatment and safety planning for their mental well-being and to work towards recovery. Uniquely, this tool provides individuals with one comprehensive plan that holds information needed to manage co-morbid bipolar disorder and substance use disorder. This assists in recovery from both disorders, as it simplifies the process of identifying coping skills, resources, and individuals involved in care. Finally, this tool is created with the intent for clients to include information and input on their own cultural identities or spiritual/religious practices.

Through collaboration, individuals can track their moods and develop a greater awareness of various symptoms of a mood episode prior to experiencing an acute mood episode. Similarly, when utilizing this tool, individuals can develop a greater awareness around substance use cravings, triggers, and symptoms in an effort to reduce overall use. This tool can be used in combination with other mental health self-management tools such as the mood chart created by

Dr. Miklowitz (2019). As a tool intended to be integrative it can be used in combination with other tools to best promote their personal health and wellness.

Limitations

One substantial limitation of this tool is that if a client is unable or unwilling to participate in filling out the tool, it would be difficult to utilize the tool at all. Since collaboration is necessary for creating the personal narrative, substances used, and positive coping skills for the individualization, the tool's usefulness would greatly decrease if an individual is unable or unwilling to engage with the tool. In cases like this, it would be useful to direct clients to a more structured tool such as the mood chart created by Dr. Miklowitz (2019).

This tool is also inherently biased towards individuals who experience symptoms of bipolar I disorder rather than bipolar II disorder or cyclothymia due to the scale presented. The numerical scale presented in this tool includes a wider range of mood states (1-10), which may fit best for individuals who experience manic episodes. For those who are diagnosed with bipolar disorder II or cyclothymia, it is recommended to alter the numerical scale. Discussing with the client on which range of numbers fits their experience strengthens the usefulness of the tool while also building rapport.

Future Research

In the future, this tool would greatly benefit from research exploring its efficacy with a variety of clinical populations and settings. The Positive Coping Recovery Narrative Tool has not yet been researched for efficacy in various treatment settings or modalities. Previous research completed on similar interventions, such as the WRAP, can be minimally extrapolated and applied to this tool. However, it has been utilized in treatment with various individuals and has been useful in identifying patterns of substance use, clarifying mood states, and identifying

resources and coping skills personalized to the individual. An initial study on the efficacy of the tool in general would be essential to the progression and validity of the tool. After the initial research study, possible expansions may include social support versus without social support, specific substances, and efficacy with cyclothymia. Finally, if research supports this tool as an effective intervention, this tool can be converting into a phone application.

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