What is the role of talking therapy in bipolar disorder

- Psychological interventions for bi-polar disorder: recent developments in research, psychological models and implications for treatment. I will cover recent models developed by Warren Mansell in particular and the work of the IAPT SMI services for bipolar. I will focus on interventions aimed at reducing relapse of both depressive and manic episodes, rather than treatment of chronic depression, and will cover individual, group and family interventions.
Bi-polar disorder

- Disorder with huge range of clinical and functional outcomes.

- Consequently present to services across primary and secondary care.

- But time to diagnosis 13 years on average. (RCP and Bipolar UK survey)

- Hasn't been the focus of development of specialists services or early identification pathways outside some small services and more recently IAPT SMI projects.
Development of psychological approaches

- Limitations of pharmacology only: 60% will experience an episode within 2 years.

- Service user voice: for a more psycho-social approach, more talking treatment, and development of self help.

- Growth in psychologically focussed studies:
  - Psychological factors in development and maintenance
  - Trial of interventions.
  - Interest in a continuum model of mania
NICE 14: Bipolar depression: primary and secondary

- Offer adults with bipolar depression:
  
  a high-intensity psychological intervention (cognitive behavioural therapy, interpersonal therapy or behavioural couples therapy) in line with recommendations 1.5.3.1–1.5.3.5 in the NICE clinical guideline on depression.

- Monitor mood carefully for signs of mania or hypomania or deterioration of the depressive symptoms.

- Psychological therapists working with people with bipolar depression should have training in, and experience of, working with people with bipolar disorder.
NICE 14: Bipolar disorder in secondary

Psychological interventions: for people at risk of relapse:

“Offer a structured psychological intervention (individual, group or family), which has been designed for bipolar disorder and has a published evidence-based manual describing how it should be delivered, to prevent relapse or for people who have some persisting symptoms between episodes of mania or bipolar depression.”

• Monitor mood carefully for signs of mania or hypomania or deterioration of the depressive symptoms.

• Psychological therapists working with people with bipolar depression should have training in, and experience of, working with people with bipolar disorder.
NICE 14: Bipolar disorder in secondary

- Offer a family intervention to people with bipolar disorder who are living, or in close contact, with their family in line with recommendation 1.3.7.2 in the NICE clinical guideline on psychosis and schizophrenia.
Psycho social approaches to Bipolar: recent advances:

- Role of life events: in onset (Bebbington et al 1993) and relapse (Johnson et al 2000)
- Significant excess in life events 3 months prior to onset
- Increased sensitivity to life vents as disorder progresses.
- Goal attainment events particularly important for mania
- Role of family conflict in determining outcome (Mikolwitz et al 2005)
Psycho social approaches to Bipolar: recent advances:

- Robust findings that people can detect prodromes (Lam et al 2010).
  - More reliable for mania
  - Mean of 20 days (range of 1-84 days)

- Some evidence that more adaptive coping for manic prodromes is associated with better social functioning and less risk of relapse (Lam et al 2001)

- Rationale for using CBT techniques in remission to reduce time to relapse.
Psycho social approaches to Bipolar: recent advances:

- Developing interest in a continuum model:
  - Udachina and Mansell 2007:
    - Majority of student sample reported history of hypomanic symptoms.
  - Implication for intervention:
    - Use of normal psychological models
    - Look at clinical vs non-clinical populations.
Diathesis stress model based on Lam et al 2010

Stressors such as life events of highly driven behaviour. Disruption to sleep and social routine

Biological vulnerability

Stigma, relationship difficulties, self and illness appraisals

Episode

Poor coping

Prodromal stage
THINKING:
I have a brain disease
“There is no point in doing anything”

BEHAVIOUR:
Avoid people
Give up everyday activities; dwell on problems

FEELINGS:
Low energy
Feel Sad

THINKING:
I can do anything I want
I can overcome all my problems

FEELINGS:
High energy
Feel High

BEHAVIOUR:
More active
Think of new ideas
Do everything faster

Best care by the best people
But:

- Over focusing on EWS can be counterproductive.
- EWS trigger conflicted and highly idiosyncratic appraisals (Mansell)
- Appraisals have highly significant personal meaning: trigger extreme methods of coping.
- Can trigger anxiety lead to disordered efforts at coping
- Following slides based on Mansell 2007 model.
Feelings
Changes in internal state

Thoughts
Appraised as having extreme & CONFLICTED personal meaning

Imagery associated with Previous Experiences

Behaviours
Ascent/Descent behaviours

Triggering event
Event

Low energy
Low mood

I’m safe like this. At least I can’t humiliate myself

Conflicted appraisals

Poor coping

I’m a failure, I will never achieve anything
Event

High energy
High mood

Conflicted appraisals

I can do anything. Sleep is for losers

Disordered coping

Last time I made a fool of myself. People took me to hospital
Ascent behaviours

- Stop medication
- Seek out stimulating and validating company
- Avoid people who challenge
- Ignore feedback from others
- Sleep less
- Exercise
- Look for challenges
- Drink and drugs
- Shopping
Descent behaviours

- Withdraw
- Reduce activities
- Try to rest/ sleep till it's over
- Delay problem solving
- Ruminate over past failures/ criticism
CBT for bipolar disorder

- Formulation based: early signs and coping are idiosyncratic
- For people with experience of highs and lows need to formulate both ascent and descent cognitions and behaviours
- As an adjunct to medication. May include addressing negative beliefs re medication.
- Relapse signature and plan for depressive and manic symptoms.
- Shared with family and care team.
Targets for therapy

- Information
- Lifestyle advice
- Relapse prevention: idiosyncratic early signs, appraisals of mood changes and coping
- Impact of thoughts and behaviour on mood
- Stress management
- Problem solving
- Communication and relationship difficulties.
CBT for bipolar disorder

- Manic episodes influence depressive episodes:
  - Shame and guilt associated with manic behaviours
  - Impact on family and social functioning
  - Impact on occupational functioning
  - Fear of future mania: reduced activity levels and avoidance
  - Sense of self
CBT for bipolar disorder

- Depressive episodes influence coping with manic prodromes:
  - Avoidance of negative feelings
  - Cognitions: I've missed out, I need to do this now. I can’t wait.
  - I have to succeed at this or I'm a failure
  - I've let people down for too long
Groups

- Why groups:
  - Reduces isolation
  - Acceptance and tackling shame
  - Leading in from others
  - Giving to others
  - Hope: seeing others who have dealt with problems
  - Modelling / practising communication of interpersonal problem solving
  - Cost effective - on current evidence.
NELFT group programme WF

- Group 1:
  - Offered to service users in bipolar clinic with > 5 years since diagnosis
  - 8 sessions
  - Psycho-ed.
  - Recognising early signs of mania and depression
  - Coping
  - Medication: delivered by team psychiatrist
  - Employment delivered by ABIT employment lead
  - Individual Relapse/ crisis plan

- Sign posting
Outcomes

- Significant improvement on self report of:
  - understanding of diagnosis and medication
  - Increase awareness of ews
  - Confidence to manage future relapses: greater confidence for depression than for mania)
Bipolar group

- Developed in response to NICE guidelines (2014) to offer a structured intervention to prevent relapse and for people who have persisting symptoms between episodes.
- For people with a diagnosis of Bipolar I for >3 years.
- Experience of full manic episodes and multiple inpatient admissions.
- Clients recruited from Community Recovery Teams, ABIT Bipolar clinic and psychology waiting lists and assessed by facilitators.
Group overview

- 1 – Introductions – exploring our moods.
- 2 – What is Bipolar? Its development and course.
- 3 – Understanding depression.
- 4 – Understanding mania.
- 5 – Identifying and understanding triggers.
- 6 – Early warning signs.
- 7 – Healthy mood states.
- 8 – Developing a mood profile – bringing it all together.
- 9 – Developing an action plan in response to mood changes.
- 10 – Re-cap and finalising your own staying well plan.
Individual CBT for Bi-polar

- Truly individualised
- Clients with other difficulties: childhood abuse/trauma
- Where groups haven't worked
- Poor motivation
- Cognitive difficulties
- Presence of on-going psychotic symptoms: use tailored CBT for psychosis approach.
Family interventions

- Importance of social networks in supporting recovery
- Development Of shared understanding of illness : reduces conflict and stress
- Identification of early signs: relatives may spot what service users miss.
- Social support to adaptive coping.
- Management of crises
- Supportive to relatives
- Impact on caring : may be helpful to carers.
Family work: available models

- F1p: Recommendation based on extensive research in Psychosis that reduces relapse.
- Less research evidence for bi-polar
- Miklowitz: work with adolescents in US

Core components:
- Information giving
- Communication
- Problem solving
Evidence base

- Recent meta-analysis (Oud et al 2016):
  - Evidence that can reduce risk of relapse/ time to relapse
  - Evidence so far of moderate/ poor quality
  - Some better evidence for individual over group CBT
Future directions: Clinical

- Treatment protocols for co morbidity: particularly anxiety
- Roles of peer support
- Treatment for those with history of multiple relapses and significant social and functional impairment: both individual and group less effective
Future directions: service and system

- Implementation of IAPT SMI: do we need specialist pathways/teams?

- Pathway needs to include group, include peer support, family and individual treatment. Delivered by staff with knowledge and expertise.

- Will need to focus on timely and reliable diagnosis across systems in primary and secondary care.

- Work on treatment protocols in EIP.

- Skilling up of current staff as significant new investment unlikely
References:

- The Interpretation of, and Response to, Changes in Internal States; An Integrative Cognitive Model of Mood Swings and Bipolar Disorders. Mansell et al 2007, Behavioural and Cognitive Psychotherapy, 35, 515-539
- Psychological Interventions for adults with Bi-polar disorder: a systematic review and meta-analysis. Oud et al, BJP 2016. 208, 213-222.