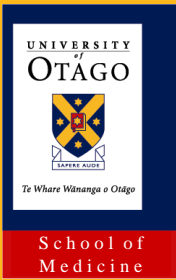


# **“I am me not the Diagnosis” How to Change the Experience of Bipolar Disorder**

**Can Psychotherapy Improve  
Outcomes?**

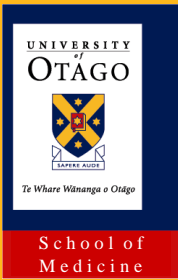
Associate Professor Sue Luty  
Department of Psychological Medicine, University of  
Otago, Christchurch





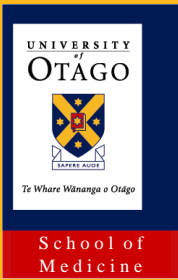
# Acknowledgements

- Assoc Prof Marie Crowe
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- Lynere Wilson
- Robyn Abbott
- Andrea Bartram
- Dr Ben Beaglehole
- Dr Sam Ritz
- Dr Jasna  
Stephanowski
- Dr Duncan Taylor
- Julia Martin



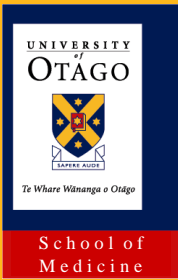
# You are a busy Practice Nurse

- Mr G age 30 comes in for his 6 – monthly lithium levels
- During the appointment you ask him how things are
- ‘Surviving, I suppose, there’s not many options out there for me’
- The receptionist tells you your next patient for immunisation is here and mum is distressed.....



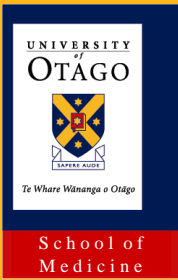
## You are a busy GP

- Your patient who has bipolar disorder, a 32 yr old musician comes in requesting an STI screen
- You notice he appears a bit agitated and you ask how things are?
- ‘I’m more creative now I have stopped my meds, don’t need that diagnosis on my plate - life is busy - don’t tell my wife by the way’



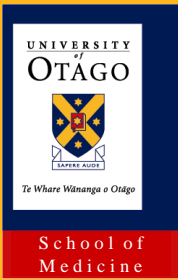
# You are a nurse in the Psych Emergency Team

- A newly diagnosed 22yr old young woman comes in for her follow up appointment in a tearful and highly agitated state
- ‘Look at me now I’ve got bipolar I may as well have F for F\*\*\*\*\*g Failure stamped on my head
- I’m just a bipolar freak’
- You have half an hour only



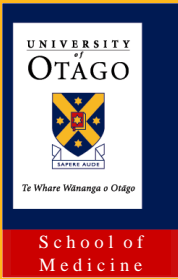
# You are a case manager in a community team

- Your 24yr old patient comes to see you after her 5<sup>th</sup> admission this year following a suicide attempt
- ‘I hate this diagnosis, I hate the medication, my parents don’t understand me or let me do anything, life sucks’
- You have an hour with her



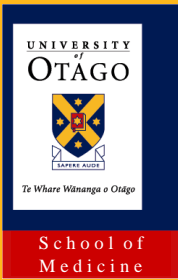
# You are the admitting clinician on a busy psych ward

- Jane age 19 comes in after another suicide attempt
- You pick up her file and read
  - Borderline PD
  - Substance dependence
- She is pacing, dishevelled, and shouting abuse, 'I'm going to leave him he winds me up'
- You have two other patients waiting to be seen



# You are the nurse on night shift on a psych ward

- You take the night meds in to a new 31yr old patient
- She is psychotic, elevated, giggling and asks you why she needs them
- ‘Don’t you tell me I’ve got bipolar disorder I don’t need that! I havent got anything wrong the doctor told me I was cured’
- The ward is busy



# Take

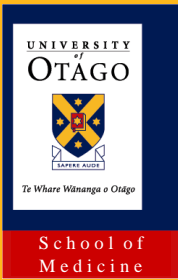
- 2 Cups of Genetic Risk
- Handful of (Mis)Diagnoses
- +/- Bowl of Drug Misuse
- Random Pinches of Life Events
- A drizzle of Social Disruption

## Add

- 10 tablespoons of STIGMA
- 3 teaspoons of self stigma

*Change in Life Trajectory*

- Daily Sensitivity to disturbed sleep

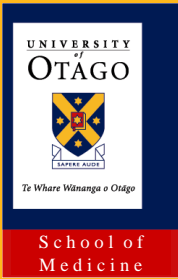


## Complicate all this With

- Service access only when ‘unwell’
- Avoidance of diagnosis/no diagnostic reviews
  - **Sticky labels**
- Medicate till stable then discharge despite side effects
- Minimal psychoeducation/family input/self management strategies

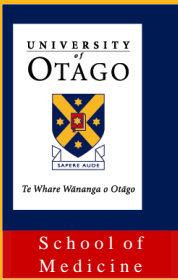
# What do we get?





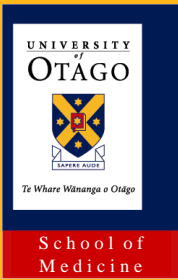
# We Know Enough About Bipolar Disorder

- Recurrent, Chronic
- Average time from symptom onset to diagnosis is 10 years
- Common to be given other diagnoses first
- For many females onset is **postpartum**
- Non adherence is common (upwards of 50% don't take their medication or take it infrequently or wrongly)
- Clinicians forget the psychosocial issues /don't have time



## In addition

- Many patients remain ill-informed about their illness
- Never assume someone has full knowledge of the disorder
  - Family prejudice/lack of knowledge/myths add to this
  - Plus stigma from society
- Adjustment to and acceptance of illness are more often than not THE key issues

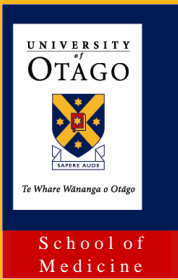


# Stigma, Fear, Misinformation, Mismanagement

- Health care practitioners and families biased against individuals Bipolar Disorder
  - E.g 45% advised to not get pregnant!\*
- >75% experience stigma from families and others
- >25% experience self stigma

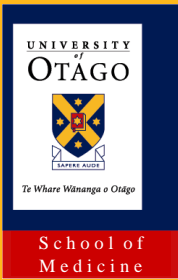
e.g. Daksha Emshon UK

\* Bouffard S et al. Presented at the American Psychiatric Association Meeting, 2001.



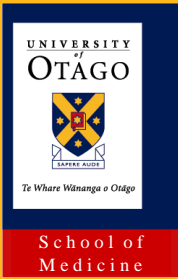
## Other Relevant Facts

- Patients are symptomatically ill 47.3% of time over mean 12.8 years' follow-up.
- Depressive symptoms predominate
- Subsyndromal symptoms - 3x > major depressive and manic episodes



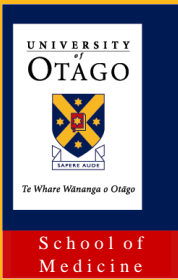
## Facts

- Those hospitalised spend more likely to spend ~ 20% of lifetime in episodes from onset of disorder
- 50% of episodes last 2 – 7 months (median 3 months).



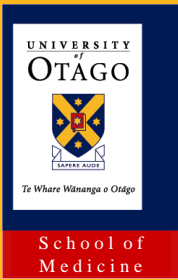
# Functioning

- 40% maintain pre-morbid level of functioning
- 25%-35% partial impairment
- 25%-35% have profound functional deficit



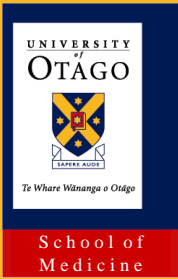
# Health Service Utilisation

- High burden
  - ED, inpatient, respite
- 30% mental health services
- 14% primary care
  - cf general population of 4 and 6%
- Healthcare utilisation costs 4x > than those without bipolar disorder
  - Intangible costs very high



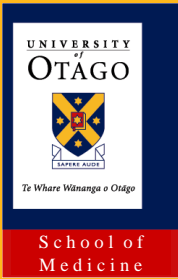
# Local Data - Chch

- Length of stay
  - Acute inpatient 33 days (range 0-654 days)
  - Outpatient community teams 426 days (range 0-5479 days)
  - 26% of acute inpatient admissions
  - 80% of BD admissions are readmits
    - 52% within 18/12
    - + 10% to primary care



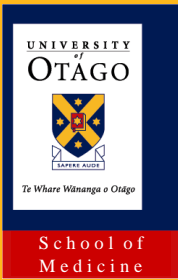
# Current Model of Healthcare in NZ

- Fails to take into account the chronic recurrent nature of bipolar disorder
- Patients discharged from services when 'well'
  - Does not optimally focus on self management strategies
  - This is a prime opportunity to utilise psychosocial intervention



# A Longer Psychosocial Intervention

- Can reduce Hospitalisation by impact on symptoms
  - Most costly aspect
  - Outpatient Rx half cost of inpatient
- Plus improve functioning longer term by maintaining well being – keep patients mindful of their illness



# Psychosocial issues are strongly linked with relapse and recurrence despite **the medication**

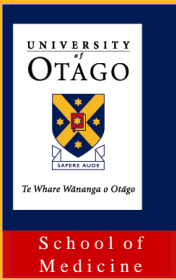
- Family stress (Expressed Emotion)<sup>1</sup>
- Negative life events <sup>2</sup>
- Cognitive style <sup>3</sup>
- Sleep disruptions <sup>4</sup>

1 Miklowitz et al, 1988

2 Johnson & Miller, 1997; Ellicott et al, 1990

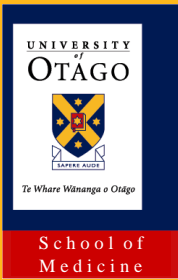
3 Reilly-Harrington et al, 1999

4 Malkoff-Schwartz et al, 1998



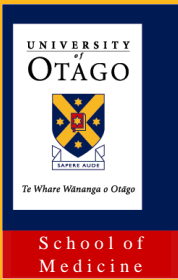
## Treatment for Bipolar Disorder should target....

- Onset/acceptance
- Illness education
- Adherence/Manage meds
- Sub threshold highs
- Sub threshold lows
- Acute episodes of mania and depression
- Prevent further episodes of above
- Stress management
- High EE if present
- Disrupted activity (sleep etc)
- All the other issues!
  - E.g. comorbidity, family impact, illicit drug use etc



## Specific interventions cover many of these

- Psychoeducation (PE)
- Cognitive Behavior Therapy (CBT)
- **Interpersonal and Social Rhythm Therapy (IPSRT)**
- Family, Family Focused (FFT), Couples Therapy, Group Therapy



## IPSRT

- Stressful life events affect the illness by affecting mood AND disrupting routines and social rhythms
- Disruption in social rhythms disrupts circadian cycles (sleep wake etc)
- Disrupted circadian disrupts mood
- IPSRT encourages pts to recognize the impact of interpersonal events on social and circadian rhythms

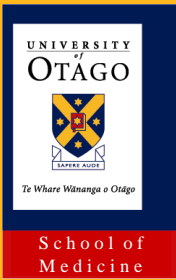
Frank et al, *Biological Psychiatry*, 1997; 41(12):1165-1173

Frank E et al, *Biological Psychiatry*, 2000;15;48(6):593-604

# IPSRT

- Two published trials
  - *Increased stability of social rhythms*
  - *More effect on depression*
  - *Shorter time to recovery from depression*
  - *No effect on manic relapse*

Frank et al



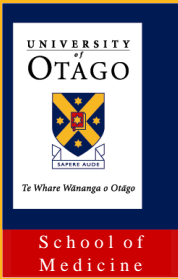
# Systematic Treatment Enhancement Program (STEP – BD)

- Cognitive-Behavioral Therapy (CBT)
- Family-Focused Treatment (FFT)
- Interpersonal and Social Rhythm Therapy (IPSRT)

Psychotherapy

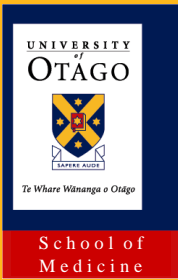
vs. Collaborative Care

- **Depressed, 30 sessions over 9 months**
  - Plus placebo or Ads
- *Recovery 64.4% (Psychotherapy) vs 51.5% (CC)*
- *No difference across all three therapies in time to recovery and time remaining well, over 12 months\**



# IPSRT

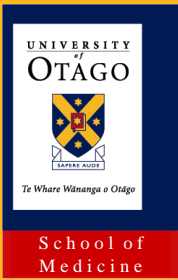
- Two completed trials Christchurch
  - Randomised trial N=100 good outcomes
  - Feasibility study within services



## What if?..

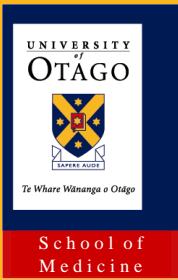
Provide patients with psychological patient-centred strategies and pharmacological management when would normally be discharged to community

Compare this with usual general practice care



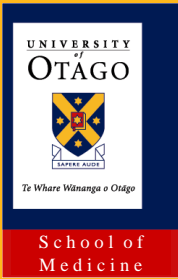
# Potential Impact

- lower relapse at 18/12
  - because of better self-management than patients randomised to general practice.
- more cost-effective than usual care over the 18/12 month intervention



# Recruitment

- Discharge from all mental health services TO GP
  - Electronic database triggers notification to team
- Approached – info
- Consent\*
- Randomised

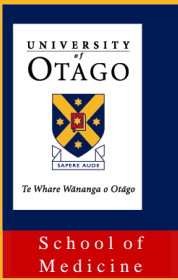


## Intervention

- IPSRT
  - Individually tailored but based on original manual

## Control Group

- Usual Care from GP

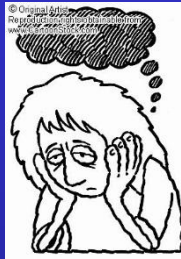


# Outcomes

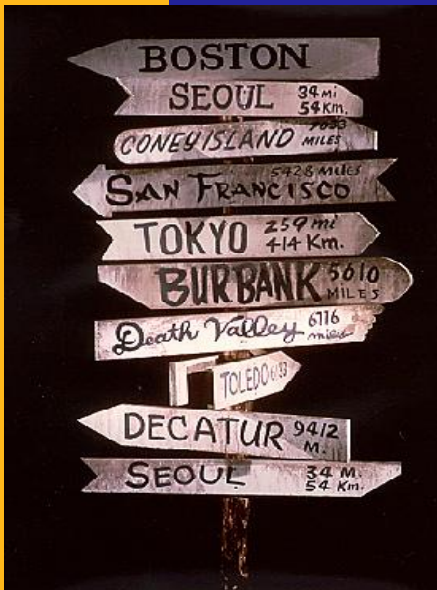
- LIFE – measures episodes, time to episode
- Cost Analysis
  - Electronic database
- Functioning
- Qualitative interview both groups
  - Plus qualitative analyses of sessions

# Can we change our Typical Trajectory

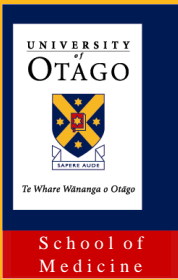
- From



to

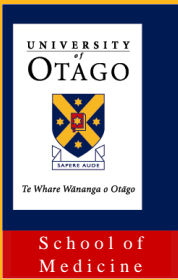


~~Numerous  
exciting  
choices~~



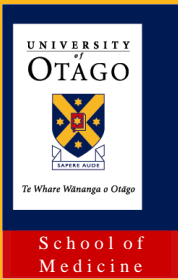
## Back to Our 6 Patients

- Consider what happened when they presented
- Consider impact of an earlier intervention
  - Particularly if offered when discharged at index episode



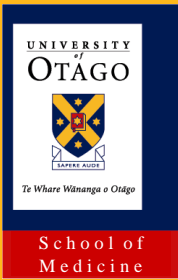
# You are a busy Practice Nurse

- The lithium check



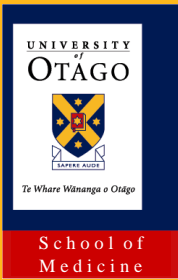
- Get him to come back and spend more time
- Address subthreshold issues
- Psychotherapy for relationship and life stressors + enhance routines

**The diagnosis doesn't have to take over your life you can function better**



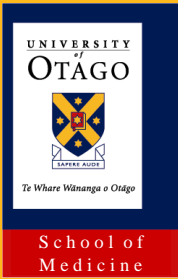
# You are a busy GP

- The I've stopped meds



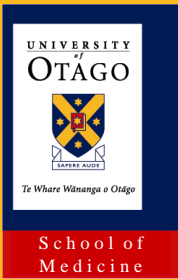
- Bring back
- Talk about diagnostics/model
- Address functioning/relationships
- Stabilise social rhythms
- Reinstate and moderate meds

**You can still be a musician, a husband, a father despite your bipolar disorder**



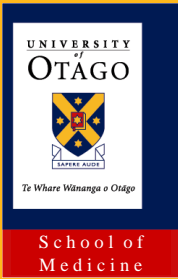
# You are a nurse in the Psych Emergency Team

- The F\*\*\*\*\*g Failure



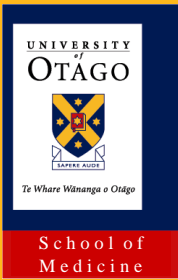
- Bring back
- Educate her and parents
- Adjust to loss of healthy self

**Move forward alongside the illness not AS the illness**



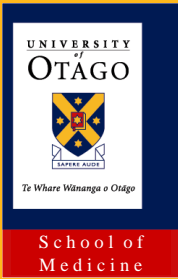
# You are a case manager in a community team

- The 'I hate this diagnosis'



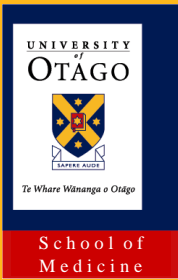
- Bring back
- Work through disputes with others and on self stigma

**Don't fear the diagnostics take chances and make informed choices**



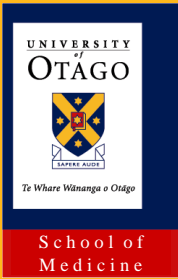
# You are the admitting clinician on a busy psych ward

- The labels
  - Borderline PD
  - Substance dependence



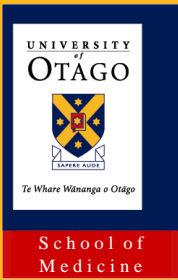
- Review diagnostics
- Drop the labels see beyond the chaos
- Establish diagnosis and adjust to this
- Work on many disputes

**Your illness can be managed better without losing your sense of identity**



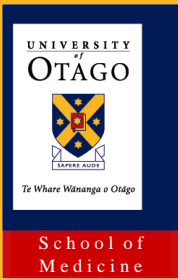
# You are the nurse on night shift on a psych ward

- The 'I'm cured'



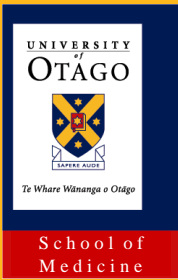
- Engage in therapy
- Education
- Work on disputes with family and adjustment to living with illness plus loss of healthy self
- Promote stable routines

**You will learn to live with the illness but it will not change who you are**



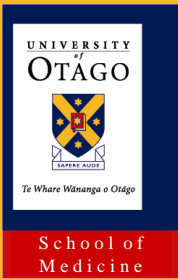
# Balance for Services

- Access to training – cost benefit
- Allowing for autonomy vs being overly paternalistic
- ALL patients are learning and making mistakes – not catastrophising
- Normal fluctuation of mood vs abnormal



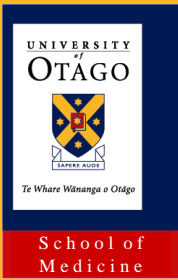
## For Patients

- Do they like it?
  - Patients like, welcome, benefit from psychotherapy as adjunct to medication
- Will they stay coming?
  - Attrition rates across all three STEP BD psychotherapies similar (35.6%)



## The Way Forward Clinically

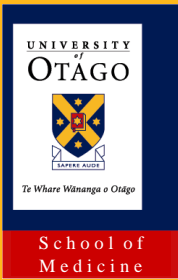
- Disseminate more widely to mental health clinicians + Improve diagnostic awareness
- Promote access to services at all levels of illness not just high risk times
  - The time of discharge from a service is just the beginning
- We don't need to sell to the consumers!!
- Help Individuals become themselves and not a diagnosis



# Promote Psychotherapy

## Patients

- Adhere to regimes/accept diagnosis
- Are more willing to accept medication/diagnosis
- Learn strategies other than medication to control mood



**Psychotherapy also allows us to be less judgemental and more supportive of our patients' decisions**

**“Hold onto that delusion. Most people call them plans.”**

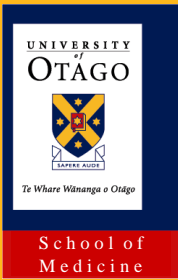
**“Psychiatry has no label for delusions of grandeur that come to pass.”**

**R.R. Fieve MD.**

# So we CAN Improve Outcomes

Be Ourselves  
not the  
diagnosis





Thank You