



A quarterly broadcast of things helpful and interesting in local clinical psychology.

Editor's Message

Dear colleague,

The August Newsletter has a focus on Bipolar Mood Disorder. Each quarterly newsletter includes (a) a summary of one or more articles from the psychological literature of interest to GPs, (b) a serialised article on motivational techniques to help patients change their own health behaviours (c) an inspirational quote of the week and (d) an interview with a clinical psychologist.

Have a read and contact us for more information:

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Interview with a Clinical Psychologist

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Q: In addition to Eating Disorders, you have an interest in Mood Disorders. Is it true that bipolar has been over-diagnosed in recent years?

A: It has been well established that Bipolar Disorder has been under-diagnosed for some time, however, there is emerging evidence that it is now being over-diagnosed. One of the reasons for this seems to be the significant overlap of clinical features of Bipolar Disorder with that of other disorders, such as Borderline Personality Disorder (BPD). The 'mood swings' and impulsive behaviours of individuals with BPD (which are due to their difficulties in regulating their emotions) are frequently mistaken for the extreme highs and lows experienced by those with Bipolar. This exemplifies the need for a thorough and specialist assessment, making differential diagnoses and corroborating with others.

Literature Digest: Bipolar Disorder

Diagnosis: Type 1 Bipolar is the more severe variant. It is characterised by recurring depressive episodes and at least one manic episode, where the manic episodes are quite severe and have psychotic features. Type 2 Bipolar Disorder features the same pattern of oscillating between depressive episodes and mania, but the manic episodes are less severe and do not have psychotic features. These 'hypomanic episodes' involve a mood state that is distinctly different from normal, but there is no substantial impairment. It must last four days to reach diagnostic significance.

Indicators of possible Bipolar Disorder include depression that does not respond to standard treatments, alcohol and other substances, irritability, racing thoughts and increased activity. 1% of Australians have bipolar disorder, while 10% have major depression (unipolar). Typical age of onset is late-teens to early 20's.

Pharmacological Treatment: Medication remains the mainstay of management of bipolar disorder. The *prevention* of depressive and manic episodes has been proven with Lithium, anti-epileptics (valproate and lamotrigine) and antipsychotics. The antipsychotics (especially quetiapine and olanzepine) have been shown to be helpful in *responding to an active episode*. Mitchell (2013) provides a helpful guide.

Q: Do clients with bipolar have a good understanding of the role that a clinical psychologist can play in the management of their condition?

A: While this is certainly the case for some clients, it is not for the majority, unfortunately. Clients generally don't realise that in addition to treating their depressive symptoms and any comorbid issues, clinical psychologists can also assist clients in a number of other ways to manage their Bipolar. These include identifying triggers and early warning signs for mood episodes; promoting adherence to medication; managing disclosure of their illness in personal or professional contexts; identifying strategies to minimise the impact of manic symptoms on their life; and rebuilding the life domains that have been impacted by their illness.

Psychosocial Treatments: Clinical psychologists (with training in assessing and treating psychopathology) have a role in managing bipolar disorder, through:

- education about the condition and its management
- increasing adherence to treatment
- treating comorbid drug and alcohol issues
- helping to regulate sleep and activity cycles in the day
- teaching CBT skills to treat depressive episodes (and reduce relapsing with future episodes)
- helping to identify triggers and early warning signs

Helpful Resources:

1. The Mood Disorders Questionnaire (MDQ screening tool) is freely available for doctors on the Basten and Associates website, alongside many other mental health resources for GPs;
2. Various information sheets and mood diaries on the Black Dog Institute website.

References:

1. Castle, D.J., Berk, L., et al. (2009). Psychosocial interventions for bipolar disorder. *Acta Neuropsychiatrica*, 21, 275-284.
2. Geddes JR, Miklowitz DJ. (2013). Treatment of bipolar disorder. *Lancet*; 381:1672-82.
3. Mitchell, PB. (2013). Bipolar disorder. *Australian Family Physician*, Vol 42, 616-619.

Q: What is the most interesting research emerging in the field of bipolar disorder?

A: The role of sleep and circadian rhythms as an underlying and maintaining factor in Bipolar Disorder is incredibly interesting and has clinical implications. The reduced need for sleep during a manic episode, coupled with the insomnia and/or hypersomnia associated with depressive episodes, have long been documented. Recent research has been examining altered rhythms in body temperature and melatonin, as well as assessing sleep latency, efficiency, and continuity. These findings can be used to develop self-management strategies to reduce the occurrence and severity of depressive, manic and hypomanic symptoms. This hands a sense of self-control and hope back to clients.



“Success is walking from failure to failure with no loss of enthusiasm.”

– Winston Churchill

“You may have to fight a battle more than once to win it.”

– Margaret Thatcher

Basten & Associates

Basten and Associates is a practice of clinical psychologists devoted to enhancing mental health in our community.

We have been providing psychological treatments since 1998 and have three locations in Sydney – Sydney CBD, Chatswood and Westmead.

We are passionate about making a special contribution to mental health and emotional wellbeing. We differ from other practices in several ways:

1. We are all clinical psychologists with post-graduate clinical training.
2. We have enough specialists for different conditions, so you will find the right psychologist to work with your patients.
3. Our clinicians are committed to staying up to date with research into the causes and treatments of common conditions.
4. We only use treatments that have a known basis of evidence showing them to be effective and then adapt and tailor these treatments to each individual after a thorough assessment.

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Series on Motivating Patients

Motivating patients to change behaviour:

Focus on medication adherence.

Predictors of poor adherence in medical patients are often quite simple (even predictable). They include:

- Inconvenience of the medication regimen (Allen et al., 2000) and unpleasant side-effects.
- Poor memory: inaccuracy about details, forgetting at the right time; misplacing the medication
- Lack of confidence in medication-taking ability (Allen et al., 2000)
- Avoiding negative emotions about their health condition (Sherbourne et al., 1992)
- Not believing or realising the importance of treatment
- Being influenced by close others who take a non-medical view to their illness

In mental health conditions, such as bipolar all these factors apply. In addition, sometimes the illness itself and its first degree comorbid conditions affect adherence further such as (a) Comorbid drug and alcohol abuse; (b) Neurobiology (e.g. depression, Parkinsons, vascular dementia, age-related dementia...); (c) uncaring apathy, as in depression; or (d) uncaring disinhibition, as seen in mania or substance use.

Intervening to Promote Adherence

1. Assess and normalise imperfect degrees of adherence

The first step is not to assume perfect compliance and so one should assess the degree of adherence to treatment advice. The doctor can assume imperfect compliance without sounding accusing, if you normalise and validate with statements like these... “most people forget the medications at times. How often do you find this happens in your week?” or “most of my patients have understandable reasons why they hesitate taking some medications – what concerns do you have?”. “If we worked backwards

day by day, did you take your medication yesterday”.

2. Problem-solve concerns and negatives

This simple step can improve compliance by 30%. At the time of prescribing, invest time in asking the patient what their concerns are about the treatment (e.g. side-effects, financial cost, stigma). Then try to address the concerns that they raise and collaboratively

3. Tip the balance of motivation with information

Write out information to enhance and protect memory (most people forget some of what the GP said within a day). Discuss their likely outcomes if they do or if they do not do the recommended treatments. If precise adherence is needed, be clear about this and ask if you may share the information with someone else.

4. Enlist help.

Work out what the local pharmacist can do with dosing boxes and the like. Ask who their ally at home could be and how they can use them as a ‘reminder service’. Use smart phone alerts and apps.

5. Monitoring and follow-up

Suggest that the patient uses a monitoring form – some would prefer a mobile app while others will prefer a written form. **A blank self-monitoring form for medications is available in the GP Resources section of our website.** For high risk patients (those with poor memory, or with a poor track record, or where compliance is medically crucial), offer a follow-up appointment in a week to check on progress and problem-solve as required.

Next article in November

Motivating patients across the age spectrum – from uncaring adolescents to dependent elderly.

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