Overcoming challenges in delivering Integrated Motivational Interviewing and Cognitive-Behavioural Therapy for Bipolar Disorder with Comorbid Alcohol Use: Therapist Perspectives

Short title: Therapist perspectives on MI-CBT

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Abstract

Background: Alcohol misuse is common in bipolar disorder and associated with worse outcomes. A recent study evaluated integrated motivational interviewing and cognitive behavioural therapy for bipolar disorder and alcohol misuse with promising results in terms of the feasibility of delivering the therapy and the acceptability to participants. **Aims:** Here we present the experiences of the therapists and supervisors from the trial to identify the key challenges in working with this client group and how these might be overcome. **Method:** Four therapists and two supervisors participated in a focus group. Topic guides for the group were informed by a summary of challenges and obstacles that each therapist had completed at the end of therapy for each individual client. The audio recording of the focus group was transcribed and data were analysed using thematic analysis. **Results:** We identified five themes: addressing alcohol use versus other problems; impact of bipolar disorder on therapy; importance of avoidance and overcoming it; fine balance in relation to shame and normalising use; and 'talking the talk' versus 'walking the walk'. **Conclusions:** Findings suggest that clients may be willing to explore motivations for using alcohol even if they are not ready to change their drinking and they may want help with a range of mental health problems. Emotional and behavioural avoidance may be a key factor in maintaining alcohol use in this client group and that therapists should be aware of a possible discrepancy between clients' intentions to reduce misuse and their actual behaviour.

Key words: focus group; therapist, alcohol, bipolar, trial, cognitive behavioural therapy, motivational interviewing

Introduction

Alcohol misuse is common in Bipolar Disorder (BD), but Cognitive Behavioural Therapy (CBT) trials focus on individuals who were already motivated to reduce drinking. Jones et al (2019) developed an integrated Motivational Interviewing (MI) and CBT for alcohol misuse and BD to help those who are more ambivalent about change. MI is used to resolve ambivalence and CBT is used to support a substance use reduction and relapse prevention plan.

The feasibility and acceptability of CBT-MI therapy was assessed in a randomised controlled trial (RCT) against treatment as usual in a sample of 44 people with BD and alcohol misuse (Jones et al, 2019). The trial was not powered to assess the effectiveness and found no significant group differences in substance misuse, bipolar symptoms or social functioning. However, mean alcohol use and percentage binge days reduced, and percentage days abstinent increased from baseline in both treatment and control groups. Interviews with participants also indicated that the intervention was well received and enhanced by a collaborative flexible approach.

We describe our experiences as trial therapists and supervisors in delivering the intervention. We highlight the challenges that can present in working with alcohol misuse in the context of BD and describe how these might be overcome.

Method

We used a focus group methodology to collate our experiences and generate ideas. The participants were four trial therapists (two mental health nurses and two clinical psychologists) and two supervisors (clinical psychologists). All participants were Cognitive

and Behavioural Therapists and had received further training in Motivational Interviewing. In order to help structure the focus group we summarised challenges and obstacles in therapy that were recorded in case notes (see Table 1) and developed these into a topic guide. The focus group was facilitated by an experienced non-therapist researcher. It lasted 1 ½ hours and was recorded and transcribed by the facilitator. Data were analysed using thematic analysis (Braun & Clarke, 2013). The process of data analysis was led by the first author, with support from the second author.

Results

Addressing alcohol use versus other problems

Many clients were keen to talk about alcohol including those who were more ambivalent about change. Some clients were, however, more resistant to consider the negative effects of drinking or make changes. As illustrated in the following quote:

Therapist one: '*There was part of you that just wanted to really talk about the alcohol but they [the client] didn't want to go there'.*

Therapists reflected that in these instances it was better to focus on other goals and alcohol use would either come back onto the agenda following other changes in the client's life or because alcohol was so central to other problems they decided to focus on. Equally, therapists reflected that even if they were helping the client to reduce alcohol misuse it was important to pay attention to other areas of the client's life. Many people had used alcohol for many years and reducing drinking would leave a major void in their lives or leave them without alternative coping strategies.

The impact of bipolar disorder on therapy

Therapists felt that in some instances, bipolar symptoms, such as tangential thinking, pressured speech or grandiose ideas impacted on the focus of therapy sessions. In these instances, therapists talked about the need to give the client enough space to speak, whilst constantly re-focusing by drawing the client's attention to 'drift'. As noted by therapist three: *'it was quite difficult really trying to just bring them back I suppose, giving them enough room obviously to speak but kind of constantly refocussing them'.*

Some clients reported that alcohol helped to elevate their mood and enhance feelings of being high and therapists described working with clients to understand the depressionergic effects of alcohol. Despite these unique considerations, on the whole, therapists felt that issues that arose in working with clients with a diagnosis of BD were similar to therapy with other clients.

The importance of avoidance and overcoming it

Therapists talked about how many clients avoided emotions and how alcohol facilitated this avoidance. As therapist one pointed out: *'a lot of my caseload, it was all about emotional avoidance. I mean I guess that is why people use substances a lot of the time'.* Therapists discussed reviewing the pros and cons of avoidance with clients. In addition, it was helpful to identify and address negative appraisals that clients had in relation to emotions, such as believing that they would end up back in hospital if their mood dipped. Therapists talked about helping clients to formulate the role of alcohol in maintaining avoidance and problems, for example, people used alcohol as a way of coping with distress and then developed positive expectancies about substances helping them to deal with negative emotions and an

intolerance of negative affect. The depressionergic effects of alcohol then set up a vicious cycle. Relatedly, therapists talked about helping clients to challenge the belief that they cannot manage their moods without alcohol or other substances; a belief that may have been reinforced by mental health services dominated by a medical model.

A fine balance

Shame

When reflecting on the issue of shame and related negative feelings clients may have in relation to drinking behaviour, therapists discussed the fine balance between increasing client awareness of negative unwanted outcomes in order to motivate a change, but not making them feel bad enough to adversely affect motivation and confidence in change. It was noted that clients often drink to avoid feelings of shame so evoking shame may provoke further drinking in a vicious cycle.

Supervisor one: *'don't close the shame down but at the same time not leave them feeling so dreadful that they need another drink'.*

Therapists talked about de-shaming in terms of showing empathy in relation to the reasons for the client's drinking and affirming clients for looking at the reasons for drinking, but then helping them explore the often unintended negative consequences of their behaviours.

Overcoming normalising

A related issue that required a fine balance was the use of normalisation strategies. Whilst normalising information could be used to destigmatise clients' difficulties, often clients

normalised their drinking in order to reduce their concerns and often excessive drinking was 'normal' within the client's social network. Therapist two talked about clients equating alcohol problems with being an 'alcoholic' and physical dependency on alcohol.

Therapist two: *'I remember people saying things like, you know I am not really an alcoholic, so because I am not an alcoholic I don't need to do abstinence'.*

In these instances, as highlighted by therapist one, it was helpful to provide information about psychological dependency, whilst being mindful of evoking feelings of failure and stigma.

'Talking the talk' versus 'walking the walk'

Therapists reflected that on the whole clients were well motivated to attend sessions, easily grasped formulations in relation to factors driving alcohol misuse and its consequences for them and in some cases readily expressed clear change talk. However, despite this seemingly positive engagement, therapists felt that clients often experienced difficulties in making changes in their alcohol use, often deferring making changes until other life events had occurred. Therapists talked about how it was important not to be 'fooled' by clients' level of engagement and falsely assume that clients are more ready to make changes than they actually are.

Therapists highlighted the importance of formulating why clients might be expressing a desire to change, yet not making changes and for many clients this related to feelings of shame in relation to their drinking behaviour. Therapists reflected that clients were not always honest about how much they were drinking or their ambivalence in reducing drinking due to previous experiences of being negatively judged by others and by health care professionals in particular.

Therapist three: *'I think there was the need to say I have not been drinking because it's chastised. Yes and it would be difficult then to be open about it because I was associated with the service and the system'.*

Therapists also talked about how they handled feeling stuck with clients. They reflected on the spirit of MI and how ultimately it is about helping clients to assess the pros and cons of behaviour change in relation to their values and enhancing self-efficacy. Therefore it aims to help clients make the decisions for themselves and for some people this might be continuing to drink high levels of alcohol at that point in time.

Discussion

The finding that clients were willing to talk about making changes in relation to their alcohol misuse even if they were not ready to make changes to their use, suggests that clinicians should not hold back from bringing up the topic. However, the MI literature suggests that approaches which highlight the dangers of drinking are likely to be met with resistance (Miller & Rollnick, 2012). The spirit of MI encourages an open dialogue about the pros and cons of alcohol misuse and exploring how current behaviour sits with clients' goals and values (Miller & Rollnick, 2012).

Bipolar symptoms were important to consider in therapy and as highlighted by therapists it is common to use substances including alcohol to manage or enhance elevated mood or to cope with feelings of low mood (Bolton et al., 2009). The role of both emotional and behavioural avoidance in maintaining alcohol misuse is also consistent with previous research (Brotchie et al., 2006) and can prevent individuals from learning to tolerate distress or learn alternative

ways of coping. Not surprisingly a key focus of therapy was therefore breaking these vicious cycles and encouraging clients to face up to difficult situations without drinking.

The fourth theme highlighted that in encouraging changes in alcohol use, therapists often found themselves managing a fine balance between eliciting enough negative emotion in clients to motivate change, but not making them feel so bad about themselves to lead them to turn to drink as a coping mechanism.

The final theme reflected the difficulty that some clients experience with change despite seeming to be engaged in therapy sessions. Therapists highlighted the importance of formulating these discrepancies in order to move clients on but also sharing this sense of 'stuckness' with clients and in the spirit of MI giving the responsibility for change back to the client.

Limitations and strengths

There are differences between therapy trials and routine practice, in terms of the therapists' access to specialist training and supervision, but also in terms of the self-selecting client group. Our use of a focus group to generate ideas and collate our thinking may also be criticized for preventing individuals from being open about their personal struggles. Despite the limitations, as trial therapists and supervisors, we spent a significant amount of time working with the client group and thinking how to resolve blocks in therapy. The perspectives presented here, thus provide a useful source of information about therapeutic processes influencing outcomes which may also translate to clinical practice.

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