A Sociable Approach to Bipolar Disorder (running head)

Why We Need A More Sociable Approach To Bipolar Disorder And How We Can Make It Happen (title)

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The Covid-19 pandemic has led to widespread restrictions on social contact, which may not seem like the obvious time to encourage health professionals to welcome more family and friends into the healthcare system. However, the pandemic has also highlighted what research evidence has long shown, about the fundamental role that social networks play in the onset and course of bipolar experiences. It has challenged us to think more broadly about the nature and function of social networks and how important it is to sustain these, especially when access to health professionals is compromised.

Decades of research have shown that social relationships play a significant role in outcome across all mental health problems, including bipolar disorder. Social relationships are significantly associated with the development of bipolar symptoms, the occurrence of specific mood episodes, risk of suicide, and the effectiveness of common interventions including medication and psychoeducation. Structured family interventions are clinically and cost effective, leading to better outcomes for family members as well as the person diagnosed with bipolar disorder. However, most people with bipolar disorder are only offered individual treatments (primarily medication and psychoeducation) with limited impacts. Why is this still the case, and what needs to change to make treatment for bipolar disorder more sociable?

Research has identified some specific implementation barriers to delivering family interventions within clinical services such as lack of training, supervision, and allocated time for staff, leading to low levels of staff confidence and commitment [1]. These are practical issues which are important, but which could be easily overcome. The fact that they have not been, forces us to consider more fundamental reasons that may underlie our individualistic approach.

Fundamental reasons for being unsociable- and how they can be overcome

There are several reasons we can consider for limited involvement of social networks in interventions for bipolar disorder, and how they can be addressed.

The first reason is philosophical. The dominant paradigm in mental healthcare is still neurobiological, with far greater funding and credence given to investigating the genetic and biological basis of bipolar experiences, than to understanding the psychological or social factors involved. This is even more so for bipolar disorder than other severe mental health conditions such as psychosis. Within this paradigm, working with social networks will only ever be seen as a “nice to have” addition that may make carers feel better, or increase adherence to medication, but will not fundamentally impact on the “underlying disease”.

The social paradigm offers an alternative perspective that helps us to understand mood episodes as being extremes on a continuum of responses to particular social contexts. It recognises the labelling of these as “bipolar disorder” as being socially determined, and hence varying between groups, and over time and place. Within a social paradigm, the connectedness of people and the quantity and quality of their social networks are seen as fundamental to their mental health [2]. This paradigm highlights many opportunities to improve outcomes for people diagnosed with bipolar disorder: at a societal level to reduce poverty, social inequality, childhood adversity and reduce stigma; and at an individual level to enhance and support their social networks. The neurobiological and psychological dimensions of bipolar disorder are not ignored, but understood within the social context of the person’s life.

There is some evidence underpinning a shift towards a more social paradigm including: (1) meta-analyses demonstrating significantly higher levels of childhood adversity in people diagnosed with bipolar disorder than the general population [3]; and (2) increasing prioritisation of personal recovery outcomes assessing the ability to lead a meaningful life over clinical symptoms in both research studies and clinical services. However, more work is needed to understand how personal recovery outcomes are shaped by the social context of people's lives.

The second reason is societal. The structure and functions of our social networks have changed dramatically over the last decade and how this impacts on our mental health is not yet well understood. Most evidence to support social interventions for bipolar is from family interventions, or group psychoeducation. However, many people draw on support from a far wider range of networks, including friends, work colleagues, and increasingly from relationships formed on social media platforms and within online forums such as offered by Bipolar UK. Online social media has drastically changed what it means to have a "friend", and we do not yet fully understand the impacts of these relationships on bipolar experiences. Social media is widely used by people with mental health conditions and offers access to extended social networks that can be engaged with flexibly, anonymously and asynchronously, making them particularly helpful for people who are depressed or manic. Online peer forums can facilitate connectedness, information seeking, sharing of experiences, and learning new self-management strategies, but come with potential risks of misleading information, rejection, cyberbullying, and excessive social comparison [4]. As healthcare professionals, we need to understand this online world and how it can support recovery. Moderating forums, and active use of social media to tackle misinformation and stigma are increasingly becoming part of our role.

The third reason is methodological. Healthcare services aim to deliver evidence-based interventions for bipolar disorder as recommended by clinical guideline groups such as the UK National Institute for Health and Clinical Excellence (NICE), the Canadian Network for Mood and Anxiety Treatment (CANMAT), and the American Psychiatric Association (APA). These groups conduct rigorous reviews of evidence, prioritising the randomised controlled trial (RCT) as the most robust form of evidence. This prioritisation in turns drives the funding of research that tests the clinical and cost effectiveness of clearly defined, protocolised interventions, including family intervention, and group psychoeducation.

Whilst the benefits of RCTs are well known, this methodology is not well suited to understanding the impacts of adaptations to established practice, which would facilitate flexible engagement with social networks. For example, a key way to overcome the implementation barriers to offering structured family interventions as stand-alone interventions is to take opportunities to adapt existing interventions by involving important social network members at opportune moments. Such involvement might include: discussions about the pros and cons of taking medication; monitoring early signs and supporting coping strategies to prevent relapse; testing out alternative perspectives; facilitating behavioural experiments; or resolving interpersonal conflict. These adaptations are logical, pragmatic and could significantly improve outcomes. However, they need to be applied sensitively, flexibly, and with the person diagnosed with bipolar disorder in control of who, what and when others are involved.

Such approaches are not suited to RCTs (no matter how pragmatic), which prioritise standardisation and ignore heterogeneity in outcomes, leading to either interventions deemed effective but which cannot be delivered, or no longer work, in the myriad of real world contexts that try to adopt them, or null findings. Rather than testing the effectiveness of individual instances of protocolised interventions, we need to test the utility of the underlying theory that working with social networks will improve outcomes, and explore how, why and for whom this is true. This would encourage the use of a broad range of involvement strategies, which are likely to be more suited to the broad range of clinical practices. This approach prioritises the use of iterative mixed-methods case studies, integrating quantitative and qualitative data to identify recurring patterns in what works, for whom, in what contexts [5]. Using this data, we can build and refine generalizable theories about the likely impacts of broadening support for bipolar experiences to more readily involve social networks, which can then be used to help practitioners identify what is likely to work for their clients, in the conditions within which they work

Challenges along the way

There will inevitably be challenges to becoming more sociable. Some people diagnosed with bipolar disorder have very limited social networks, and here the goal may be to support them to establish the kinds of networks that can support their personal recovery journey. Others may not want existing network members involved, or their network members may not want to get involved. Engaging in the family interventions currently recommended is often a huge commitment of time and emotional energy. Broadening the roles that network members can play in supporting recovery, widening participation to include friends and work colleagues, and offering choice in how people can get involved (including using online and remote technologies) are likely to increase engagement but raise additional challenges in maintaining confidentiality and privacy, which must remain paramount.

Conclusion

Covid-19 has reduced access to traditional forms of healthcare support for people with bipolar disorder, increased reliance on broader social networks, and forced us to consider how practice can be adapted to become more robust to future impacts of pandemics. This requires us to recognise and engage with the evolving roles social networks play in personal recovery, and adapt policies and practices to accommodate this. Methodological developments prioritising the testing of the underlying theories of how and why involving social networks might improve outcomes for people with bipolar disorder, rather than protocolised interventions, allows us to embrace the flexibility that this way of working inevitability demands. We have a great opportunity to develop a more sociable approach to supporting people diagnosed with bipolar disorder.

References

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