USING GROUP WORK TO PREVENT RELAPSE IN BIPOLAR DISORDER

ABSTRACT


This article outlines the principles and ideas behind a group intervention aimed at managing bipolar disorder. This is a summary: the full paper and reference list can be accessed at nursingtimes.net.

The development of a groupwork approach for bipolar disorder grew out of an awareness that there were no services available to meet the needs of this group.

The benefits of working collaboratively with service users has been well demonstrated. We approached a local service user, Jan Hall, following discussion with her CPN, who had suggested she might be interested. Once Jan had agreed to participate and the process had been explained to her, she was also involved in planning before the first group session.

Key workers identified service users who might want to attend the group. The only condition for attending was a primary diagnosis of schizoaffective disorder or bipolar disorder.

The other three facilitators, in addition to Jan, were mental health nurses. The model for the future is likely to be two mental health professionals plus a service user. Our experience of running this group suggests that a single facilitator would be inadequate. A group could be run by mental health workers from any professional background.

At the end of each session the four facilitators met to review and debrief for an hour. Jan was offered access to an independent clinical supervisor (a clinical psychologist), which she declined.

One of the other significant features of the group was the use of flipcharts to capture discussion. This was particularly useful during sessions based on recognising the early warning signs of illness and coping strategies. Permission was sought from group members to use the suggestions they came up with to build a ‘database’ of coping techniques, which make up a significant part of the package we produced. Working in this way also generated an atmosphere of genuine collaboration within the group.

DELIVERING THE INTERVENTION

During the first few weeks the group went through a ‘slow/open’ format – allowing service users to dip in and out of the group process over a number of weeks. This made it necessary to repeat information and revisit key concepts at each meeting, which was welcomed by the other group members and fits in with the suggestion that people with serious mental illness can have difficulty processing information.

Recent research also suggests that full functional recovery in bipolar disorder is unlikely (Baker, 2001), therefore any group education programme needs to take this information into account.

We were also careful to avoid introducing potentially painful topics, such as depression, too early in the group process. Mania was introduced first because experience suggested that talking and thinking about depression were often difficult and that the subject should only be broached when members had established confidence in themselves and trust in the group process. We also tried to warn people if a painful topic was coming up and we never began talking about something new in the last 30 minutes of the group, so that there was time to resolve issues within the 90 minutes allocated. Where it was deemed necessary, clients were followed up individually.

Over the first six to eight weeks, five people became regular attendees, one person chose to drop out, one person was hospitalised (becoming too ill to continue attending) and three clients saw the group through to the end. These three consistent attendees were all women and had all had significant periods of illness, lasting around 20–30 years. All three had been diagnosed with bipolar disorder following...
the births of their first children, although at least two identified hormonal change in puberty as the first time they could clearly identify what they now believe to be the onset of symptoms.

All the attenders were women. The literature suggests that women are often more readily diagnosed with affective disorders than men. It may also reflect a traditional readiness on the part of women to engage with the idea of talking about their emotions. We would recommend that there are both male and female facilitators.

A pharmacist with specialist knowledge of mental health led two sessions on medication. This gave group members the opportunity to obtain feedback about the medication they were taking.

**Group dynamics**

On reflection, we realised there was a change in the way the intervention was delivered as the group became more cohesive. Earlier sessions were largely facilitator-led and focused on the explanation and categorisation of symptoms and experience, while in the latter stages there was more of a group dynamic that tended to concentrate on comprehension of the experience of members.

As the members became more comfortable with sharing their experiences, there was little need to structure the group sessions very closely. Instead, topics such as loss were introduced and group members’ experiences were elicited and then discussed.

The sessions reflect this structure and for future groups we intend to close the group to new members after session 8. This was the point at which it seemed the structure and dynamic of the group moved decisively away from being didactic and facilitator-led towards a more personally focused group. This was also reflected in the level of self-disclosure that took place, both by group facilitators and group attenders, and it was felt that at this stage in the group process it would have been counterproductive to introduce new members to the group.

**Mixed affective states**

As we worked through the group process, it became clear that we had paid little attention to dealing with mixed affective states. There is almost no published literature on working psychologically with this aspect of bipolar disorder, so we attempted to work on this within the group on a ‘here and now’ basis.

Working within the group, flipcharts were used to brainstorm ideas for coping with mixed states, and they are included as part of the coping strategies generated by the group. A number of the group members have also modified their own action planning charts to include mixed signs as a separate mood state to plan for, alongside highs and lows.

**Relatives and carers**

The group also included an evening session for relatives and carers. This was organised at the request of group members and their relatives. Recent literature has emphasised the importance of including relatives and carers as part of any management package for the treatment of bipolar disorder (Hill et al, 1998).

**PLANS FOR THE FUTURE**

Future groups may have a greater emphasis on dual diagnosis issues (alcohol and substance misuse). Previous studies suggest that as many as 60% of people with a bipolar disorder diagnosis also have problems with alcohol and substance misuse. In future we may invite outside speakers with local expertise in dual diagnosis issues or signpost group members to relevant organisations.

We would also like to catch people as early as possible in the pathway of their disorder, although a group approach may be harder to implement for people in the earlier stages of their illness.

As facilitators we believe that overall this process has enormous value and could easily be adopted and run in both statutory and non-statutory mental health settings. It is hoped that the next phase of development of the group will be to promote the delivery of relapse prevention for bipolar disorder on a county-wide basis.

**REFERENCES**


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**BACKGROUND**

- There has been growing interest in the psychological management of bipolar disorder, building on the work of pioneers such as Newman (Newman and Beck, 1992).

- Targeted group intervention for bipolar disorder has been shown to prevent and ameliorate both manic and depressive swings in mood (Colom et al, 2003).

- There is a lack of a systematic approach for the management of bipolar disorder across mental health services. Local implementation of services could address this shortfall (Morris et al, 2002).