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Research report

Online mindfulness-based intervention for late-stage bipolar disorder: pilot evidence for feasibility and effectiveness

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ABSTRACT

Objectives: People in the late stage of bipolar disorder (BD) experience elevated relapse rates and poorer quality of life (QoL) compared with those in the early stages. Existing psychological interventions also appear less effective in this group. To address this need, we developed a new online mindfulness-based intervention targeting quality of life (QoL) in late stage BD. Here, we report on an open pilot trial of ORBIT (online, recovery-focused, bipolar individual therapy).

Methods: Inclusion criteria were: self-reported primary diagnosis of BD, six or more episodes of BD, under the care of a medical practitioner, access to the internet, proficient in English, 18–65 years of age. Primary outcome was change (baseline – post-treatment) on the Brief QoL.BD (Michalak and Murray, 2010). Secondary outcomes were depression, anxiety, and stress measured on the DASS scales (Lovibond and Lovibond, 1993).

Results: Twenty-six people consented to participate (Age $M=46.6$ years, $SD=12.9$, and 75% female). Ten participants were lost to follow-up (38.5% attrition). Statistically significant improvement in QoL was found for the completers, $t(15)=2.88$, 95% CI:.89–5.98, $p=.011$, (Cohen's $d_z=.72$, partial $\eta^2=.36$), and the intent-to-treat sample $t(25)=2.65$, 95% CI:.47–3.76, (Cohen's $d_z=.52$; partial $\eta^2=.22$). A non-significant trend towards improvement was found on the DASS anxiety scale ($p=.06$) in both completer and intent-to-treat samples, but change on depression and stress did not approach significance.

Limitations: This was an open trial with no comparison group, so measured improvements may not be due to specific elements of the intervention. Structured diagnostic assessments were not conducted, and interpretation of effectiveness was limited by substantial attrition.

Conclusion: Online delivery of mindfulness-based psychological therapy for late stage BD appears feasible and effective, and ORBIT warrants full development. Modifications suggested by the pilot study include increasing the 3 weeks duration of the intervention, adding cautions about the impact of extended meditations, and addition of coaching support/monitoring to optimise engagement.

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1. Introduction

Adding psychotherapy to medication improves outcomes in bipolar disorder (BD), but even with comprehensive treatment, 50–70% of patients relapse within a year (Miklowitz, 2008). Poor outcomes are particularly pronounced amongst people who have experienced numerous episodes ('late stage BD'). The likelihood of relapse within a given time frame may be doubled amongst people who have experienced 10 or more episodes (Berk et al., 2011), and this group exhibits poorer quality of life (QoL) and more impaired functioning (Magalhães et al., 2012). There is also evidence that having experienced more than 12 episodes of BD predicts a *negative* response to

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cognitive behaviour therapy (Scott et al., 2006), suggesting that a new approach to psychological intervention for late stage BD is warranted.

To address this issue, our international team developed a novel adjunctive online psychological intervention designed specifically for late stage BD. ORBIT (online, recovery-focused, bipolar individual therapy) is targeted at improving subjective QoL outcomes, and draws strategies and exercises from mindfulness-based therapies to improve emotion regulation, relationship to self and sleep quality. Therapeutic content includes skills in living in the present moment to improve emotion regulation and sleep, clarifying personal values as a guide to action, and encouraging self-acceptance and self-compassion through avoiding attachment to positive and negative self-evaluations. Here, we report on a pilot investigation of ORBIT, with late stage defined conservatively as six or more BD episodes of any type. We begin by describing the potential for novel treatments targeting late stage BD, and briefly reviewing online delivery of psychological therapies for BD.

1.1. Tailoring therapy to late stage bipolar disorder

There is growing evidence that BD can follow a progressive course, and recognition that treatment response differs with illness stage (Berk et al., 2013; Rosa et al., 2012). Consequently, there are calls to develop stage sensitive psychosocial interventions for BD (Reinares et al., 2014).

Stage-tailoring may be especially relevant for late stage BD. Existing psychotherapies address relapse prevention through early detection and forward planning, but such strategies are less effective for people who have experienced numerous episodes (Scott et al., 2006). Indeed, exhortations to prevent relapse by monitoring triggers may be detrimental to self-esteem in late stage BD where relapse can be unrelated to discernible life events (Kapczinski et al., 2008). In such cases, symptom-focussed models of routine clinical practice may be less effective than approaches that recognise the unavoidability of suffering, emphasise redefinition of life goals, and prioritise QoL or recovery outcomes (Berk et al., 2012). These priorities are consistent with so-called 'third wave' psychotherapies (Hayes et al., 2011), and a priori, we might expect mindfulness-based therapies specifically targeting QoL to be useful in this poorly served population.

Mindfulness has two defining features – developing an awareness of present experience and a non-judgemental and accepting stance towards this experience (Kabat-Zinn, 2003). This would seem a useful skill for managing the emotion regulation challenges of BD, and there is evidence that mindfulness practices are common amongst people with BD. More than 50% of patients with BD report using meditation and spiritual practices naturalistically (Kilbourne et al., 2007), and more than half of 2,685 respondents to a public website (curetogether.com) report trying mindfulness meditation, rating it as effective as psychotherapy for BD. Furthermore, high functioning people with BD report that mindfulness and reflective practices are valuable wellbeing strategies (Russell and Browne, 2005; Suto et al., 2010).

Clinical trials in BD populations have shown Mindfulness-Based Cognitive Therapy (MBCT) to reduce symptoms of anxiety, mania, depression, and suicidal ideation and improve emotion regulation, psychological well-being, positive affect, psychosocial and cognitive function (Deckersbach et al., 2012; Howells et al., 2013; Miklowitz et al., 2009; Williams et al., 2008b). While no published studies have investigated mindfulness specifically for late stage BD, Acceptance and Commitment Therapy (ACT) has been shown effective in related severe and chronic mental illness populations (Bach et al., 2012; Clarke et al., 2012; Farhall et al., 2013). Indeed, the ACT premise that suffering is an unavoidable part of life (Hayes et al., 1999) has the potential to reassure and empower a population whose disorder has proven difficult to manage (Berk et al., 2012).

1.2. Online therapy for bipolar disorder

Worldwide, less than half of those with BD receive mental health treatment (Merikangas et al., 2011; Schaffer et al., 2006). Online delivery can overcome many barriers to access, including cost, perceived need for treatment and trust in professionals (Leitan et al., 2014). Web-based mental health programs have demonstrated immediate and long term benefits for a range of mental disorders (Griffiths et al., 2010) while being highly cost-effective (McCrone et al., 2004). Our previous work shows that online therapies are acceptable to people with BD (Krusche et al., 2013; Lauder et al., 2013; Todd et al., 2012).

Although the benefits of online treatments are yet to be disseminated widely to people with BD, a number of interventions have initial research support (Barnes et al., 2007; Lauder et al., 2014; Proudfoot et al., 2007; Proudfoot et al., 2012; Smith et al., 2011; Todd et al., 2014). Existing research therefore underlines the potential of online dissemination of BD treatments, but interventions tested to date have been variants of traditional face-to-face psychosocial treatments, and none have accounted for stage of disorder.

1.3. ORBIT and the present study

ORBIT is a low-intensity, brief intervention drawing on three recent conclusions in the psychosocial literature: mindfulness-based interventions are beneficial for serious mental illness (Khoury et al., 2013), treatments for BD can and should be tailored to illness stage (Berk et al., 2013), and the web has unrealised potential to economically deliver treatments for BD (Leitan et al., 2014). The intervention focuses on QoL outcomes, and are intended to augment rather than replace symptom management approaches. The aim of the present study was to assess the feasibility, potential effectiveness, and any negative effects of ORBIT in an open pilot trial.

2. Materials and methods

2.1. Inclusion criteria

To maximise generalisability, inclusion criteria were broad, including self-reported primary diagnosis of BD, receiving care from a medical practitioner, access to the internet, proficient in English, and 18–65 years of age. Finally, being in late stage BD was an inclusion criterion, operationalised as self-report of six or more BD episodes (depressive, manic, hypomanic or mixed).

2.2. Sample

Twenty-six people (Age $M=46.6$ years, $SD=12.9$) completed written informed consent procedures. Twelve of 16 (75%) with valid gender data were female (gender was not gathered for 10 participants due to technical error). Modal employment and marital status were 25.0% and 37.5%, respectively. Ten participants were lost to follow-up (38.5% attrition), with complete pre- and post-intervention data obtained from $n=16$.

2.3. Measures

Self-report measures were completed at baseline and immediately on completion of the four modules (post-test). The primary outcome variable was baseline to post-test change in subjective QoL, measured on the 12-item brief Quality of Life in Bipolar Disorder scale (QoL.BD), an instrument with sound psychometric properties (Michalak and Murray, 2010). Satisfaction with functioning is rated on a 5-point Likert scale, with higher scores representing greater satisfaction. Secondary outcomes were depression, anxiety and stress measured on the widely used Depression Anxiety and Stress Scales (DASS, Lovibond and

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