Six of One, Half a Dozen of the Other? Can We Successfully Incorporate Motivational Interviewing Techniques for Weight Loss Problems in Bi-Polar II and Address Associated Impulse Control Difficulties and Mood Problems from A Trans-Diagnostic CBT Approach?

John Roberts

Abstract

Long-term weight loss can be difficult to achieve and weight maintenance even more problematic. If mental health difficulties in the form of Bi-Polar II Disorder (BD II) featuring Binge Eating (BE) and/or sub-threshold BE eating disorders are both co-present and common psychological problems in the management of BD II then when obesity is co-present difficulties for clinicians and patients are compounded. Obesity in BD II is far from a stand-alone difficulty – for instance the cyclothymic, anxious-sensitive, impulse-dyscontrol and binge-eating 'soft spectrum' of BD II has been shown to present with at least 10% of Bi-Polar patients (Perugi and Akiskal, 2002). Thus the treatment of BD II and Obesity can be frequently associated with impulse control difficulties, mood problems as well as most certainly with raised morbidity/mortality rates (Weber et al, 2011). Psychosocial approaches in weight loss treatment and condition management will need to take account of these nuances. It is suggested here that Trans-diagnostic Cognitive behavioural as well as Motivational Approaches are potentially enticing additions to comprehensive weight loss programs and psychosocial interventions for BD II patients. Motivational Interviewing, and in particular Trans-diagnostic CBT (TDCBT) approaches having been demonstrated as an effective method of behaviour change in addictions, chronic disease management, mental health and a range of other difficulties.

Whilst there have been insufficient studies to develop a sufficient evidence base for Motivational Interviewing as a stand-alone intervention for treating co-present psychological problems with Obese and BD II clients, there is robust evidence for incorporating MI approaches into weight loss programmes – especially when there are associated impulse control or mood difficulties - as MI approaches has been demonstrated to increase treatment adherence and motivation. This paper reviews a few theoretical opportunities arising from combining Motivational Approaches with TDCBT interventions for the entities of Obesity, BD II and BE when they are co-present. It concludes by calling for future research into this area.

The author suggests that anecdotally MI techniques (for example rolling with Resistance, Evocation, and the OARs method) might take a place forefront with weight loss for BD II and TDCBT.

BD II is neuro-psychiatric condition typified by mood fluctuations between depression and elevated mood; but not quite reaching the threshold of full blown mania. Instead people with BD II have hypomanic episodes. It would not be unusual for patients to have had at least one manic episode. This lifelong disorder causes severe impairments to functioning as many find themselves managing their conditions for a significant part of their lives. The disorder has severely disruptive impacts on quality of life in terms of relationships, work and other social-emotional criteria. (Compton and Nemeroff, 2000). The National Institute of Clinical Excellence in the UK suggests that BD II merits "clear, individualised social and emotional recovery goals" (NICE 2014) along with concomitant individualised social and emotional recovery goals, crisis plans that highlight imminent fluctuations of mood along both ends of the spectrum, recognition of triggering factors for both mania and depression, relapse and preferred response strategies during relapse planning. In short, BD II can be a crippling burden to manage in its own right: the added burden of Obesity/BE is nothing short of 'double trouble'. As highlighted above, up to 10% of these patients have difficulties with Impulse Control, BE and Weight. Thus psychosocial provisions should include sufficiently sophisticate interventions to improve weight loss programs. The author suggests that incorporating motivational theories of change whilst utilizing TDCBT approaches when implementing weight loss plans is a beguiling area for research.

Motivational Interviewing (MI) was developed initially as a method of assisting people decrease alcohol and drug misuse. It is empirically supported and comprehensively undertaken for a range of health and social care

John Roberts

Abu Dhabi Women's College, UAE

difficulties. It is an intervention for encouraging changes in health behaviour in general and across a variety of settings. MI can be implemented either as a stand-alone intervention or incorporated with other interventions (Rollnick et al, 2002, Dugas and Robichaud 2019).

People with chronic conditions make day to day decisions about self-managing their conditions. The reality of living with a chronic condition and taking self-management decisions has important implications - as a range of condition specific issues are invoked. These decisions can range from disease complications in the future to healthcare cost burdens for provider systems and toward deferment of longer term benefits in exchange for more immediate gratification. In the management of a chronic condition the relationship between healthcare provider and patient also becomes significant. Thus modern healthcare-patient relationships have increasingly moved toward collaborative models of care provision – as the consultative approach has been found to be disempowering to healthcare consumers. Today, more motivational approaches are utilised.

Trans diagnostic (TD) theories (Norton, 2012, 2017) for treating psychiatric problems have found traction in their application towards a range of DSM-5 diagnoses. A number of well-established TD treatments have been developed for individual formats (e.g., The Unified Protocol; Barlow et al., 2011). TD treatments have also found a home in the treatment of eating disorders (for example, Fairburn 2009) The TD approach is also adjunctive to psychopharmacological treatment-as-usual (TAU) for BD II. These TD treatments were initially developed to address important common features that underlie DSM-V difficulties. Research findings from neuroscience, physiological studies, behavioural studies, and genetics demonstrate that people across the Bi-Polar Spectrum have susceptibilities in affective lability and impulse control in comparison to other healthier populations. BD II patients often experience their emotional states as being aversive, uncontrollable and quite unpredictable. These cognitive and affective experiences are accompanied by cognitive and behavioural maladaptive strategies that 'accidently' negatively reinforce a person's attempts to control, occasionally surrender to, avoid or regulate their cognitive-emotional and behavioural experiences. TDCBT protocols aim to identify and address such entities in cognitive-affective processing and target maladaptive behaviours for change.

Thus potential for these two common treatments in combination when engaging with Obesity and Binge Eating in BD II seems seductive. However, limited research has been conducted into this area rendering suggestions any further than a call for that research inappropriate.

Anecdotally the author of this paper notes that the majority of his adult patients have responded positively to menus of choices, OARS strategies and have found useful TD formulations and techniques. The author suggests that further trialled and protocolled research into effects and techniques may shed some light into this very debilitating combination of problems.

References

1. Barlow, D. H., Farchione, T. J., Bullis, J. R., Gallagher, M. W., Murray-Latin, H., and Cassiello-Robbins, C. (2017). The Unified Protocol for Trans Diagnostic Treatment of Emotional Disorders compared with diagnosis-specific protocols for Anxiety disorders: a randomised clinical trial. *JAMA Psychiatry, 74, 875-884.*

2. Compton, M. T., & Nemeroff, C. B. (2000). The treatment of bipolar depression. *The Journal of Clinical Psychiatry, 61*(Suppl9), 57–67

3. Dugas, M., Koerner, N., and Robichaud, M. (2019) *Cognitive and Behavioural Treatment for Generalised Anxiety Disorder* (2nd edit) Routledge, New York
4. Fairburn, C., Cooper, Z., Doll, H., O'Connor, M., Bohn, K., Hawker, D., Wales, J., and Palmer, R. (2009) Trans diagnostic Cognitive Behavioural Therapy for Patients with Eating Disorders: A Two site trial with 60 week follow up. *Am Jnl of Psychiatry* https://doi.org/10.1176/appi.ajp.2008.08040608
5. Norton, P. J. (2017). Trans diagnostic approaches to the understanding and treatment of anxiety and related disorders. *Journal of Anxiety Disorders, 46, 1-3.*
6. Norton, P. J. (2012). *Group Cognitive-Behavioral Therapy of Anxiety: A trans diagnostic treatment manual.* New York, NY: Guilford Press.
7. Perugi, G., & Akiskal, H. S. (2002). The soft bipolar spectrum redefined: Focus on the cyclothymic, anxious-sensitive, impulse-dyscontrol, and binge-eating connection in bipolar II and related conditions. *Psychiatric Clinics of North America, 25*(4), 713–737

8. Rollnick, S., Mason, P., and Butler, C. (2002). *Health behaviour change: a Guide for Practitioners.* London. Churchill-Livingstone.
9. Weber, M., Warren, L., and Fiedorowjcz, J. (2011) Cardiovascular Morbidity Mortality and Morbidity in Bi-Polar Disorder. *Ann Clin Psychiatry 23(1) 40-47*

John Roberts

Abu Dhabi Women's College, UAE