University of Southampton

Faculty of Environmental and Life Sciences

School of Psychology

Trauma-Focused Psychological Interventions within Bipolar Disorder: An Examination of Effectiveness and Required Adaptations

by

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Thesis for the degree of Doctor in Clinical Psychology

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Abstract

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There is growing research and clinical interest in the comorbidity between posttraumatic stress disorder (PTSD) and bipolar disorder; however, the significance and effectiveness of trauma-focused psychological interventions for individuals with bipolar disorder remains insufficiently explored. The first chapter of this thesis presents a systematic review that examined the efficacy of trauma-focused psychological therapies in bipolar disorder. A narrative synthesis was conducted across 11 papers. Outcomes suggest reductions in both PTSD symptoms and secondary outcomes following treatment, predominantly for eye movement desensitisation and reprocessing (EMDR) and cognitive behavioural therapy (CBT). Findings emphasise the necessity for further large-scale controlled trials.

The second chapter presents an empirical paper that explored how EMDR can be effectively conducted and adapted for trauma-focused work in individuals with bipolar disorder, using expert consensus generated through a three-round Delphi survey. A total of 71 general, phase-specific and supervisory recommended adaptations were rated as either essential or important. Maintaining client stability during treatment was identified as crucial, and the need for additional guidance for practitioners when adapting trauma-focused EMDR for individuals with bipolar disorder was advocated. These papers make important contributions to the emerging evidence base on the effectiveness of trauma-focused psychological interventions for individuals with bipolar disorder.

Keywords: Bipolar disorder, Delphi survey, Posttraumatic stress disorder, Trauma-focused

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Research Thesis: Declaration of Authorship

Print name: LEEANNE NICHOLLS

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I declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;
2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
3. Where I have consulted the published work of others, this is always clearly attributed;
4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
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6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
7. None of this work has been published before

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Definitions and Abbreviations

ANOVA..... Analysis of variance

BD ..... Bipolar disorder

BLS..... Bilateral stimulation

CAN..... Camberwell assessment of need

CAPS..... Clinician-administered PTSD scale for DSM-IV

CAPS-5 ..... Clinician-administered PTSD scale for DSM-5

CBT ..... Cognitive behavioural therapy

CENTRAL..... Cochrane central register of controlled trials

CINAHL ..... Cumulative index to nursing and allied health literature

CPT ..... Cognitive processing therapy

CT..... Cognitive therapy

DES ..... Dissociative experiences scale

DF..... Degrees of freedom

DSM ..... Diagnostic and statistical manual of mental disorders

EMDR..... Eye movement desensitisation and reprocessing

EPHPP ..... Effective public health practice project quality assessment tool

ERGO II..... Ethics and research governance online

ERRT-B ..... Extended exposure and rescripting therapy for bipolar

GAF ..... Global assessment of functioning

HoNOS ..... Health of the nation outcome scales

IES-R..... Impact of events scale-revised

JBI ..... Joanna Briggs institute quality assessment tool

LSMD ..... Least squares mean difference

MANSA..... Manchester short assessment of quality of life

MDT..... Multidisciplinary team

NET ..... Narrative exposure therapy

PC ..... Positive cognition

PCL-5 ..... PTSD checklist for DSM-5

PCT ..... Present-centred therapy

PE..... Prolonged exposure therapy

PICO..... Population intervention comparison outcomes

PRISMA..... Preferred reporting items for systematic reviews and meta-analyses

PROSPERO ..... International prospective register of systematic reviews

PTSD..... Posttraumatic stress disorder

PTCI ..... Posttraumatic cognitions inventory

RCT ..... Randomised controlled trial

SMI ..... Serious mental illness

SUDS ..... Subjective units of distress scale

ST..... Supportive therapy

TAU ..... Treatment as usual

TF-CBT..... Trauma-focused cognitive behavioural therapy

TFT..... Trauma-focused therapy

VOC..... Validity of cognition

WHO..... World health organisation

Chapter 1: What is the Effectiveness of Trauma-Focused Psychological Therapies in Bipolar Disorder? A Systematic Review

This systematic review has been formatted according to the publishing guidelines of the Journal of Affective Disorders (Appendix A).

Word Count (excluding tables, figures, and references): 8317

1.1 Abstract

Background. Research has demonstrated a robust association between trauma, posttraumatic stress disorder (PTSD), and bipolar disorder. Comorbid PTSD is linked with poorer clinical outcomes, a higher risk of suicidality, and reduced recovery rates. This systematic review evaluates the literature on trauma-focused psychological therapies for individuals with bipolar disorder to determine effects on PTSD symptoms and the impact on secondary domains such as affect, suicidality, and overall functioning.

Methods. A systematic review of PsycINFO, Medline, Central, and CINAHL was conducted, including randomised controlled trials (RCTs), open trials, and case studies. Due to insufficient data for a meta-analysis, a descriptive narrative synthesis was adopted.

Results. The final review comprised of 11 papers that met the inclusion criteria, which included 241 participants diagnosed with bipolar disorder. Overall, the results imply improvements in PTSD symptoms post-treatment, as well as improvements in secondary outcomes. The current evidence also indicates that trauma-focused therapies are well-tolerated and safe for individuals with bipolar disorder.

Conclusions. There is preliminary evidence that trauma-focused psychological therapies, especially eye movement desensitisation and reprocessing (EMDR) and cognitive behavioural therapy (CBT), may be effective in reducing PTSD and trauma-related symptoms for bipolar disorder. However, there are few RCTs that have been conducted in this area. Further research is needed to explore the effectiveness of trauma-focused treatments for individuals experiencing both PTSD and bipolar disorder.

Keywords: Bipolar disorder, Cognitive behavioural therapy, Eye movement desensitisation and reprocessing, Posttraumatic stress disorder, Trauma, Therapies

1.2 Introduction

Bipolar disorder (BD) is a complex mental health condition that poses considerable challenges to healthcare systems worldwide (Moreno-Alcázar et al., 2017). As a mood disorder, BD adversely impacts a person's cognition, energy levels, and day-to-day functioning, and it is distinguished by recurrent depressive and manic (or hypomanic) periods (World Health Organization (WHO), 2024).

There are two primary forms of bipolar disorder. Bipolar I disorder (BD-I) features at least one manic phase with irritable or elevated mood and increased energy lasting a week or more. Symptoms may include a reduced need for sleep and can cause significant impairment or require hospitalisation. Bipolar II disorder (BD-II) is defined by at least one major depressive phase and one or more hypomanic phases, but no full manic phases (American Psychiatric Association, 2013).

The UK Adult Psychiatric Morbidity survey conducted in 2014 showed that 2% of the population met the diagnostic criteria for bipolar disorder, with younger people (16 - 24 years) having a higher prevalence of the disorder (McManus et al., 2016).

Bipolar disorder is correlated with reduced psychosocial functioning and high suicidality risk, and it frequently coincides with conditions such as posttraumatic stress disorder (PTSD) (Katz et al., 2024). Individuals with bipolar disorder are at increased risk of developing PTSD. Estimates of the prevalence of PTSD amongst people with BD range between 16% and 60%, with 16% being approximately twice the lifetime occurrence of PTSD when compared to the general population (Otto et al., 2004; Etain et al., 2008; Bedeschi, 2018).

Individuals with BD experience childhood trauma at a rate 2.6 times higher than that observed in the general population (Palmier-Claus et al., 2016). Exposure to childhood trauma, including experiences of abuse or neglect, during critical neurodevelopmental stages and young adulthood increases the risk of developing bipolar disorder. This risk has

been hypothesised to result from the effect on brain functioning which increases sensitivity to stress and enhances vulnerability to manic and depressive episodes (Quidé et al., 2020).

Adults with bipolar disorder who have experienced traumatic events tend to have more severe psychotic symptoms, a higher frequency of episodes, and greater exposure to psychosocial stressors (Pascual et al., 2020). Quarantini et al. (2010) found that co-occurring PTSD is linked to poorer clinical outcomes in BD, such as increased rapid cycling, more suicide attempts, and a reduced chance of recovery. Kennedy et al. (2002) contend that traumatic experiences occurring during manic or hypomanic episodes are linked to an increased likelihood of triggering PTSD symptoms.

Individuals experiencing both PTSD and bipolar disorder are more likely to receive inaccurate diagnoses and experience challenges in treatment efficacy. Symptoms can overlap between the two conditions, and as a consequence, individuals with BD may not receive the appropriate trauma-informed interventions (Cogan et al., 2021). Symptoms that commonly intersect include feelings of despair, fluctuations in mood, difficulties with concentration, sleep disturbances, irritability, and emotional inhibition (DSM- 5; APA, 2013).

In terms of the potential mechanisms by which PTSD might worsen the course of BD, it has been suggested that PTSD significantly impacts the progression of bipolar disorder. It influences increase emotional instability, which disrupts emotional regulation, intensifies mood fluctuations, and complicates treatment approaches (Otto et al., 2004).

Experiencing both traumatic experiences and bipolar disorder can reduce treatment effectiveness, as trauma-related avoidance can lead to more social isolation, heightened anxiety, and increased severity of depressive symptoms, factors that can intensify affective disturbances (McElroy, 2004). People diagnosed with bipolar disorder and PTSD often experience a lower quality of life, along with more severe manic symptoms. Consequently, it has been argued that treatment plans for individuals with bipolar disorder should incorporate additional trauma-focused psychotherapeutic approaches (Valiente-Gomez et al., 2019).

A large-scale meta-analysis involving 98 studies was performed to evaluate the efficacy of psychotherapeutic interventions for adults suffering with PTSD (Yunitri et al. (2023). They found that the most effective therapies for improving PTSD symptoms were cognitive processing therapy (CPT), eye movement desensitisation and reprocessing (EMDR) (Shapiro, 2001), cognitive therapy (CT), narrative exposure therapy (NET), prolonged exposure (PE), cognitive behavioural therapy (CBT), and present-centred therapy (PCT), thereby demonstrating efficacy in non-comorbid populations.

CBT and EMDR are both recognised as primary, evidence-based therapeutic approaches for supporting individuals experiencing PTSD, as endorsed by the National Institute for Health and Care Excellence (NICE, 2018). NICE supports these trauma-focused therapies due to their strong theoretical foundations, adaptability, and evidenced effectiveness in treating trauma-related issues.

Despite evidence of their effectiveness for PTSD in the wider population, trauma-focused therapies such as EMDR and CBT are frequently underused. Although NICE guidelines are explicit, the provision of psychological therapies for BD in the UK is inadequate (Richardson et al., 2025). Often, clinicians are overcautious about offering these interventions to individuals with BD due to fears that they might exacerbate emotional instability and mood dysregulation, clinician-related barriers that have been equally reported in serious mental illness (SMI) populations (Frueh et al., 2006). As a result of this clinician hesitancy, many individuals with co-occurring PTSD do not receive appropriate treatment.

There is substantial evidence connecting traumatic events to negative outcomes in bipolar disorder, highlighting the need to understand whether existing evidence-based therapy protocols for PTSD are safe and effective for individuals with BD. However, there is a lack of trials investigating the effectiveness of psychological approaches for PTSD within this population (Novo et al., 2014).

To date, there have been no systematic reviews or meta-analyses that have specifically examined the effectiveness of psychological therapies for PTSD symptoms in

individuals with bipolar disorder. However, there have been studies that have explored the efficacy of trauma interventions for various populations. Grubaugh et al. (2021) conducted a meta-analysis to examine the treatment of PTSD in adults with serious mental illness (SMI); the analysis included 14 clinical trials and had 684 participants. The study did include individuals with BD, but the findings were not specific to this subgroup. They found that PE, EMDR and brief treatment had the largest effects on PTSD symptom reduction. They also hypothesised that trauma interventions which had exposure-driven elements may have the largest effectiveness for SMI populations.

Otto et al. (2004) conducted an evaluation of treatment strategies for PTSD in individuals with bipolar disorder; however, their review was limited to pharmacological and cognitive-behavioural treatment options. Oud et al. (2016) performed a systematic review and meta-analysis evaluating psychological interventions for adults with bipolar disorder; however, their review did not focus on trauma-focused interventions.

The main objective of this review is to examine the effectiveness of psychological therapies in treating trauma-related symptoms in individuals with bipolar disorder. The following questions will be addressed: (i) What is the effectiveness of trauma-focused psychological therapies in treating PTSD symptoms in bipolar disorder? (ii) Do trauma-focused psychological therapies lead to improvements in secondary outcomes in bipolar disorder?

1.3 Methods

This systematic review was conducted following the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Page et al., 2021). The review protocol was submitted to PROSPERO, the International Prospective Register of Systematic Reviews, on the 31st of July 2024 (registration number CRD42024555491).

1.3.1 Search Strategy

A systematic review of peer-reviewed literature was conducted through electronic searches of online databases in August 2024. These databases included APA PsycINFO, MEDLINE, the Cochrane Central Register of Controlled Trials (CINAHL) and the Cumulative Index to Nursing and Allied Health Literature (CENTRAL). The reference list of articles retained after full screening was also reviewed.

Grey literature searches were not conducted in this review. While it is recognised that grey literature can be appraised using quality assessment tools (e.g., AACODS; Tyndall, 2010), only studies published in peer-reviewed journals were included to ensure methodological rigor. The exclusion of grey literature may have presented a degree of publication bias, which is acknowledged as a limitation.

Databases were searched using terms related to trauma, psychological therapies, and bipolar disorder. We followed the recommendations of Swan et al. (2017) who advise that when including post-trauma symptom terms within your searches, a broad selection of trauma specific terms should be used, in consideration of the heterogeneous use of terminology in the literature.

Secondary outcomes were intentionally excluded from the primary search terms of this review for several reasons. Primarily, the central focus was on trauma-focused interventions, therefore, the main search terms were tailored to capture studies related to this. Including secondary outcomes would have diluted the focus, and using wider search terms may have increased the risk of including irrelevant studies. Additionally, this approach was consistent with established review practices.

Table 1 outlines the search strategy and the terms that were employed.

Table 1

Search Strategy

Concept	Search Terms
Trauma	"trauma" OR "post trauma" OR "PTSD" OR "post-traumatic stress disorder"
Psychological Therapies	"psychological therap*" OR "psychotherapy*" OR "talking therap*" OR "therap*" OR "trauma therap*" OR "counsel*" OR "CBT" OR "EMDR" OR "Eye Movement Desensitization and Reprocessing" OR "cognitive behavioural therap*" OR "trauma informed" OR “narrative exposure” OR “prolonged exposure”
Bipolar Disorder	"Bipolar" OR "Bipolar Disorder" OR "manic depression" OR "manic depressive disorder" OR "Bipolar Affective Disorder" OR “hypomanic” OR “hypomania” OR “serious mental illness”

1.3.2 Inclusion and Exclusion Criteria

The main domain of interest is bipolar disorder with co-occurring trauma-related symptoms. Primary outcomes included posttraumatic stress symptoms, as measured by self-report measures, clinician-rated measures, or clinical/diagnostic interviews. Secondary outcomes involved various domains, including anxiety and depression, wellbeing, functioning, relapse, quality of life, and suicidality, among others. The PICO framework (population, intervention, comparison, outcome) was used to guide eligibility criteria; Table 2 outlines the inclusion and exclusion criteria applied during the screening of studies.

Bipolar disorder often has its onset during adolescence; therefore, adolescents aged 11-17 were included in the search strategy. This was to ensure a comprehensive review that incorporated early intervention research. However, the available literature was limited, and therefore all included studies focused solely on adult populations.

Case studies were included in this review, considering research on the effectiveness of trauma-focused psychological therapies in bipolar disorder is a relatively under-

researched area, and case studies provide valuable preliminary evidence when exploring new or emerging ideas (Nambiema et al., 2021).

1.3.3 Screening Process

Studies found through electronic searches were uploaded to Endnote, a reference management system and then transferred to Hubmeta, an online platform designed for conducting systematic reviews. Duplicates were deleted, and the titles and abstracts of the papers were screened to determine suitability based on set inclusion criteria. This was followed by a thorough examination of the full texts of the remaining papers. To minimise the risk of bias, a second independent reviewer screened 20% of the selected papers (both abstract and titles and full text). This resulted in a 96.7% agreement, indicating strong inter-rater reliability. Discrepancies were managed through discussions and clarifications of the eligibility criteria.

1.3.4 Data Extraction

The following data were extracted from each of the studies: study characteristics (study design, country of origin, sample size, participant characteristics, inclusion and exclusion criteria, trauma-focused interventions, treatment comparison, and length of treatment) and study findings (assessment tools, primary and secondary outcomes, results, summary of findings, missing data, and information required for study quality assessment). All data extracted was guided by the main research questions regarding treatment effectiveness.

1.3.5 Narrative Synthesis versus Meta-Analysis

After evaluating each of the included studies it was established that a meta-analysis would not be feasible for the following reasons: most of the papers lacked a pre-specified comparison, there were exhibited differences in study designs and populations, there were variations in the interventions tested, and there were missing outcomes in some datasets.

Ioannidis et al. (2008) often cite these factors as reasons for not using a meta-analysis, as they contribute to significant heterogeneity. McKenzie and Brennan (2019) discuss the need to use other synthesis methods when there is high heterogeneity in the data. In consideration of this a descriptive narrative synthesis is chosen for this systematic review (Popay et al., 2006).

Table 2

PICO Framework with Inclusion and Exclusion Criteria

PICO	Definition	Inclusion Criteria	Exclusion Criteria
(P)	Population	Adolescents (ages 11-17) and adults (ages 18+) Diagnosis of bipolar disorder Symptoms or diagnoses of PTSD, and/or other trauma and stress-related disorders, such as acute stress disorder, complex PTSD, or a history of trauma without a full diagnosis	No formal diagnosis of bipolar disorder including cyclothymia Non-clinical samples
(I)	Intervention	Trauma-focused psychological interventions. This might include psychotherapies (group or individual) or psychosocial interventions for people with bipolar disorder and traumatic symptoms (e.g., EMDR, CPT, TF-CBT)	Exclusively based on pharmacology treatment
(C)	Comparison	Comparator/control: no control group, or an active control group consisting of a waiting list, treatment as usual (TAU), or a comparison treatment	–
(O)	Outcomes	Changes in PTSD or trauma-related symptoms, mood symptoms, or overall functioning Standardised quantifiable measures reporting on changes in symptoms of posttraumatic stress disorder/trauma after psychological intervention	Studies without PTSD or trauma-related symptom measurement
Study Design	_	Empirical studies utilising quantitative methods, including any design (e.g., experimental, randomised controlled trial (RCT), non-randomized controlled, uncontrolled, open trial, case studies, observational, mixed methods), and studies focused on quantitative analyses.	Qualitative only studies, abstracts, chapters Non peer-reviewed material

1.3.6 Quality Assessment

The quality of the quantitative studies (including one mixed-methods study) was evaluated using the Effective Public Health Practice Project (EPHPP) Quality Assessment Tool (Thomas et al., 2004). This quality assessment tool has proven validity and it boosts the reliability of systematic reviews by reducing bias and increases transparency throughout the review process (Armijo-Olivo et al., 2012). Thomas et al. (2004) report that the EPHPP tool is appropriate for both non-randomised and randomised studies.

Seven domains make up the EPHPP: (1) selection bias, (2) study design, (3) confounders, (4) blinding, (5) data methods, (6) withdrawals, and (7) analysis. Domains are individually evaluated as weak, moderate, or strong, and a total global rating is assigned (strong = no weak domains, moderate = one weak domain, weak = two or more weak domains) (Thomas et al., 2004). Eight papers were quality assessed using the EPHPP tool; one paper received a strong rating, five received a moderate rating and two received a weak rating (see Table 3).

Three case studies were identified for inclusion in this review, and the risk of bias for these studies was evaluated by the Joanna Briggs Institute (JBI) critical appraisal checklist for case reports (Moola et al., 2017).

The checklist has eight specific criteria, and each criterion is rated as; ‘yes,’ ‘no,’ ‘unclear,’ ‘not applicable.’ The total score is calculated based upon how many criteria scored ‘yes.’ The eight criteria evaluated include a clear description of participant characteristics, a clear timeline of the history, a clear description of the current clinical condition, a clear explanation of the diagnostic tests/assessment methods, a clear description of the intervention, a clear description of the interventional clinical condition, identification and description of the adverse/unanticipated events, and take-away lessons. Two papers reflected low risk of bias and high quality, and one paper identified as low quality (Table 4).

Table 3

EPHPP Quality Assessment Ratings

Author(s) and date	Selection bias	Study design	Confounders	Blinding	Data collection methods	Withdrawals and dropouts	Analysis	Global rating
Hogg et al. (2024)	M	S	M	M	S	W	S	**M**
Katz et al. (2024)	M	M	W	W	S	W	M	**W**
Mauritz et al. (2022)	M	M	W	M	S	S	M	**M**
Miller et al. (2018)	W	M	W	M	S	W	M	**W**
Mueser et al. (2008)	M	S	S	M	S	W	S	**M**
Mueser et al. (2015)	W	S	S	M	S	M	S	**M**
Nishith et al. (2024)	M	M	W	M	S	M	S	**M**
Novo et al. (2014)	M	S	M	M	S	M	S	**S**

Note. Strong = 0 weak ratings; Moderate = 1 weak rating; Weak = 2 or more weak ratings

Table 4

JBI Quality Assessments

Components	Iyadurai et al. (2020)	Moring et al. (2022)	Oh and Kim (2014)
1. Were patient's demographic characteristics clearly described?	Yes	Yes	Yes
2. Was the patient's history clearly described and presented as a timeline?	No	Yes	No
3. Was the current clinical condition of the patient on presentation clearly described?	Yes	Yes	Yes
4. Were diagnostic tests or assessment methods and the results clearly described?	Yes	Yes	No
5. Was the intervention(s) or treatment procedure(s) clearly described?	Yes	Yes	No
6. Was the post-intervention clinical condition clearly described	Yes	Yes	No
7. Were adverse events (harms) or unanticipated events identified and described?	NA	Yes	N/A
8. Does the case report provide takeaway lessons?	Yes	Yes	Yes
Overall Appraisal	**(6) Include**	**(8) Include**	**(3) Include**

Author(s) and date	Comments (Including reasons for inclusion)
Iyadurai et al. (2020)	This case reports meets most of the criteria for the quality assessment tool. Client presentation and characteristics clearly defined, validated measures used to assess symptoms (PTSD – Impact scale), intervention clearly defined and take away message reported, linked to mental imagery task as potential additional tool to evidence-based CBT intervention.
Moring et al. (2022)	This case report appears to meet all criteria, clear timeline, and baseline assessment. Validated measures used to assess symptoms e.g. CAPS and PCL-5. Intervention clearly defined, explained step-by-step. Post intervention measures recorded; outcomes illustrated using a graph. Initial increase in PTSD symptoms identified and discussed. Clear take-away message in relation to use of evidence-based psychological therapies for patients presenting with PTSD and bipolar disorder.
Oh and Kim (2014)	Case study: There were initial difficulties when assessing the quality of this study; being that it is an editorial letter and therefore has many limitations. However the study has relevant findings, validated measures used to assess symptoms e.g. CAPS pre and post measures and it shows the effectiveness of EMDR for PTSD in bipolar disorder.

All quality assessments were completed by the first author, while a second independent reviewer assessed a total of 20% of the papers. This resulted in 100% agreement, demonstrating strong inter-rater reliability. No studies were excluded based on the quality appraisal outcomes.

1.4 Results

1.4.1 Study Selection

A total of 1320 studies were identified and assessed for inclusion. After removal of duplicates and title and abstract screening, 111 studies were analysed for eligibility. Full text exclusions were made for various reasons, the most common being that the population was not of interest, or the study did not include trauma-specific outcomes or measures.

An illustration of the full screening process can be found in the PRISMA flow diagram (Figure 1).

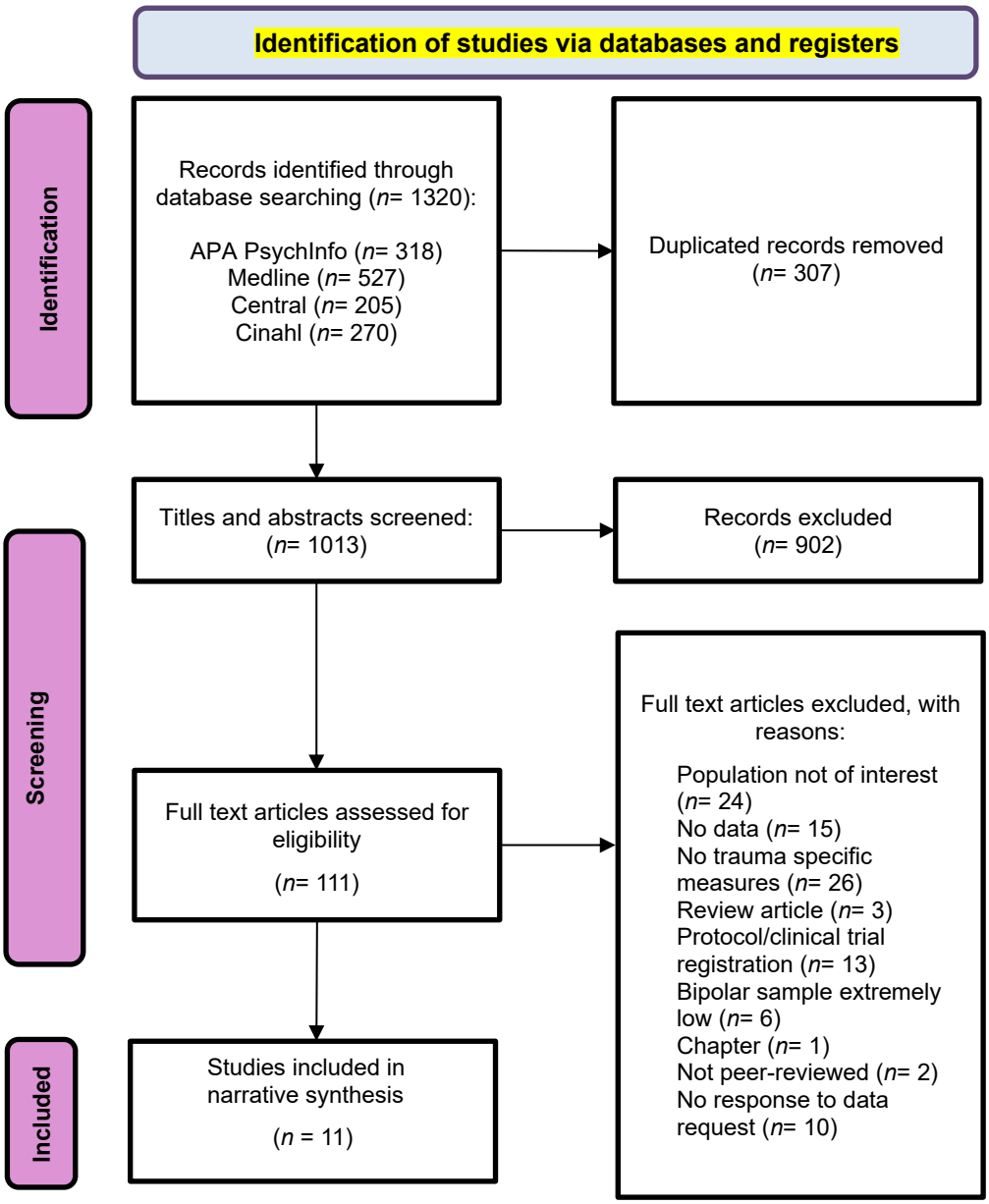
For 18 studies identified, it was implied the sample may have included individuals with BD, but this was not clear. Study authors from these studies were contacted (15 in total) to enquire whether they had specific data that related to the bipolar disorder population. The outcomes of these requests are summarised in Appendix B. Four authors were able to provide relevant outcome data for this systematic review.

1.4.2 Study and Sample Characteristics

A total of 11 papers that met the inclusion criteria were included in this review (Table 5). Out of the studies reviewed, seven focused only on bipolar disorder (Hogg et al., 2024; Katz et al., 2024; Iyadurai et al., 2020; Miller et al., 2018; Moring et al., 2022; Novo et al., 2014; Oh & Kim, 2014), while four looked at serious mental illness (SMI) in general but provided outcomes for the subgroup of participants with BD (Mauritz et al., 2022; Mueser et al., 2008; Mueser et al., 2015; Nishith et al., 2024).

Figure 1

PRISMA Flow Diagram



The research articles were published between 2008 and 2024, and all papers had gone through a peer-review process. The studies were conducted in various countries, including the United States of America (*n* = 6), Spain (*n* = 2), Korea (*n* = 1), Netherlands (*n* = 1) and the United Kingdom (*n* = 1). The studies included samples exclusively from adult populations, predominantly featuring female participants (71%). No eligible studies involving adolescents were identified.

Cultural or ethnic background was reported in 9 out of the 11 studies (82%). The majority of the participants identified as White (56.3%), with other reported ethnicities including African American, Asian, Dutch, and Hispanic. Details on other protected characteristics such as disability, religious beliefs, or gender identity were minimal. Only two studies reported data on sexual orientation, and one study included transgender participants.

The review comprised a total number of 521 participants, among whom 241 were diagnosed with bipolar disorder including, both BD-I and BD-II. Four studies included participants with diagnoses consistent with the SMI population. A majority of the studies excluded participants due to active suicidality (n = 7) and current or untreated substance dependence (n = 6).

The duration of the therapies varied from 3 weeks to 20 weeks, with 12 weeks being the most common duration. Four studies included a comparison condition, such as treatment as usual (TAU) or an alternative intervention and seven studies did not.

The papers included a range of study designs, including three case studies, three randomised controlled trials (RCT), three open-label studies, one mixed-methods convergent study, and one randomised controlled pilot study. Although data collection and analysis methods varied across studies, all recorded both baseline and post-treatment measures of PTSD symptoms.

Table 5

Characteristics of Included Studies

Study	Study Design	Country	Sample Size (*N*)	Participants Characteristics	Inclusion criteria	Exclusion Criteria	Trauma focused Intervention and characteristics	Comparison (TAU, wait list, No comparison, alternative)	Length of Treatment
Hogg et al., (2024)	Randomised Control Trial	SPAIN	77 EMDR -39 ST - 38	Gender *n* (%): Male: 18 (23.4), Female: 59 (76.6). Mean Age: 46.8 (SD = 8.4) BD Diagnosis *n* (%): BD-I = 56 (72.7) BD-II = 21 (27.3)	(1) age 18–65 (2) from two to six affective episodes in the last year (3) present euthymic or subsyndromal symptoms (4) at least one traumatic event (5) BD diagnosis	(1) active substance abuse or not in recovery (2) previous brain injury and/or neurological condition (3) severe suicidal intent (4) engaged in any form of trauma-specific therapy in the last 2 years (5) intends to engage in any form of additional therapy while enrolled in the study	EMDR therapy for BD, including BD-specific subprotocols for mood stabilization, treatment adherence, and trauma processing	Supportive therapy (ST), offering emotional guidance, attentive listening, and information about BD, excluding trauma processing components	20 weeks (both interventions)
Katz et al., (2024)	Open label trial	United States of America	32	Gender *n* (%): Male: 10 (31.3), Female: 22 (68.8). Mean Age: 34.8 (SD = 12.6) BD Diagnosis *n* (%): BD-I = 29 (90.6) BD-II = 2 (6.3) Missing = 1 (3.1)	Diagnosis of BD and PTSD	(1) mania (2) psychosis (3) unstable medical conditions (4) active intent to die by suicide (5) substance misuse (6) pregnancy (7) previous experience with PE	Prolonged Exposure targeting PTSD symptoms: Content: Psychoeducation, rationale for exposure treatment, repeated in vivo exposures to trauma-relevant stimuli, repeated prolonged imaginal exposures to traumatic memories, verbal processing of exposures	No comparison	10 sessions (90 minutes each) with a six month follow up

Study	Study Design	Country	Sample Size (*N*)	Participants Characteristics	Inclusion criteria	Exclusion Criteria	Trauma focused Intervention and characteristics	Comparison (TAU, wait list, No comparison, alternative)	Length of Treatment
Iyadurai et al., (2020)	Single case (AB) study	United Kingdom	1	Gender: Female BD Diagnosis: BD-II No other characteristics given	Diagnosis of BD with PTSD symptoms	No exclusion	Imagery-focused cognitive therapy incorporating a competing visuospatial task Participant brought an intrusive image to mind and then played Tetris for 10 minutes, with vividness and distress ratings taken pre- and post-task	No comparison	11 weeks (7 x 1 hour sessions) With 3-week pre-intervention phase and a 6-week follow-up
*Mauritz et al., (2022)	Mixed methods convergent *As this is a mixed methods study I only focused on the quantitative data.	Netherlands	23	Gender *n* (%): Male: 4 (17.4), Female: 19 (82.6). Mean Age: 49.9 (SD = 9.81) SMI Diagnosis *n* (%): Schizophrenia Spectrum Disorder = 4 (17.4) BD = 4 (17.4) Major Depressive Disorder = 15 (65.2)	Outpatients with SMI with comorbid PTSD and a history of repeated interpersonal trauma	(1) antisocial personality disorder (2) Dissociative Identity Disorder (3) received TFT within last 12 months	Narrative Exposure Therapy (NET) for PTSD, administered by certified NET Therapists Outpatients received flexible assertive community treatment	No comparison	Minimum of 5 – Maximum 16 Weeks Weekly 90 minute sessions
Miller et al., (2018)	Open label	United States of America	7	Gender *n* (%): Male: 1 (14.3), Female: 4 (57.1) Transgender: 2 (28.6) Mean Age: 36.86 (SD = 14.10)	Diagnosis of BD and a history of experiencing a traumatic event Experiencing at least one nightmare per week for a month period	(1) severe cognitive impairment (2) Psychotic spectrum disorders (3) current or recent mania (4) current or recent suicide attempt or hospitalisation (5) untreated substance misuse	ERRT-B (Extended Exposure and Rescripting Therapy for Bipolar) Content: Sleep strategies, education on traumatic stress symptoms and applied relaxation strategies	No comparison	Five (90 minute sessions) Posttreatment assessments completed at 1 week and 3 months

Study	Study Design	Country	Sample Size (*N*)	Participants Characteristics	Inclusion criteria	Exclusion Criteria	Trauma focused Intervention and characteristics	Comparison (TAU, wait list, No comparison, alternative)	Length of Treatment
Moring et al., (2022)	Case Study	United States of America	1	Female, 50 years old 8 years military experience BD Diagnosis: BD-I	PTSD and BD Historical Experiences: Childhood sexual trauma Military sexual trauma	Not Applicable	Cognitive Processing Therapy (CPT), targeting PTSD and trauma-related cognitions. Content: Psychoeducation on PTSD, identify trauma related thoughts, Socratic dialogue, cognitive restructuring and modifying stuck points	No comparison	12 sessions twice a week over 45 days
*Mueser et al., (2008)	Randomized Controlled Trial	United States of America	108 CBT= 54 14 = BD TAU= 54 11 = BD	Gender *n* (%): **CBT**: Male: 13 (24.0), Mean Age: 45.13 (SD - 9.83) SMI Diagnosis *n* (%): Schizophrenia: 5 (9.3) Schizoaffective Disorder = 5 (9.3) Bipolar Disorder = 14 (25.9) Major Depressive Disorder = 30 (55.6) **TAU**: Male: 10 (18.5), Mean Age: 43.30 (SD = 11.41) Female: 85 (78.7) SMI Diagnosis *n* (%): Schizophrenia: 3 (5.6), Schizoaffective Disorder = 4 (7.4), Bipolar Disorder = 11 (20.4), Major Depressive Disorder = 36 (66.7)	(1) minimum 18 years old (2) current diagnosis of PTSD (3) diagnosis of SMI (BD, major depressive disorder, schizophrenia, or schizoaffective disorder)	(1) current substance dependence (2) suicide attempt or psychiatric hospitalisation within last 3 months	CBT for PTSD content: Structured format, worksheets, homework setting, cognitive restructuring and focus on trauma related beliefs	TAU Content: Participants had continued access to the usual services before commencement of the study. They could also access supportive counselling for trauma-related problems	12 – 16 session programme

Study	Study Design	Country	Sample Size (*N*)	Participants Characteristics	Inclusion criteria	Exclusion Criteria	Trauma focused Intervention and characteristics	Comparison (TAU, wait list, No comparison, alternative)	Length of Treatment
*Mueser et al., (2015)	Randomized Controlled Trial	United States of America	201 CBT = 104 BD = 33 Brief Treatment = 97 BD = 30	Gender *n* (%): **CBT**: Male: 31 (29.8), Female: 73 (70.2). Mean Age: 42.96 (SD – 10.46) SMI Diagnosis *n* (%): Schizophrenia Spectrum only: 26 (25) Major Mood and Borderline Personality Disorder = 23 (22.1) Schizophrenia Spectrum and Borderline Personality Disorder = 6 (5.8) Major Mood Disorder only = 49 (47.1) (inclusive of BD) **Brief**: Male: 32 (33.0), Female: 65 (67.0). Mean Age: 44.52 (SD = 11.60) SMI Diagnosis *n* (%): Schizophrenia Spectrum only: 27 (27.8) Major Mood and Borderline Personality Disorder = 18 (18.6) Schizophrenia Spectrum and Borderline Personality Disorder = 8 (8.2) Major Mood Disorder only = 44 (45.4) (inclusive of BD)	(1) minimum 18 years old (2) current diagnosis of severe PTSD (3) diagnosis of SMI (BD, major depressive disorder, schizophrenia, or schizoaffective disorder) (4) substantial functional impairments in key life activities (over last 3-6 months)	(1) substance dependence within last 3 months (2) suicide attempt or psychiatric hospitalisation within last 3 months	CBT for PTSD Content: 3 sessions on anxiety-focused breathing and PTSD education, and then 9 -13 sessions targeting cognitive restructuring	Brief Treatment Content: Same initial 3 sessions as the CBT treatment	CBT for PTSD: 12-16 weeks Brief: 3 sessions

Study	Study Design	Country	Sample Size (*N*)	Participants Characteristics	Inclusion criteria	Exclusion Criteria	Trauma focused Intervention and characteristics	Comparison (TAU, wait list, No comparison, alternative)	Length of Treatment
*Nishith et al., (2024)	Open label pilot trial	United States of America	49 39 started CPT 13 dropped BD = 9 3 = non-completers	Gender *n* (%): Male: 20 (40.8), Female: 28 (57.1) Transgender: 1 (2.0) Mean Age: 45.33 (SD – 11.65) SMI Diagnosis *n* (%): BD and Psychotic Spectrum Disorder = 17 (43.6) Major Depression Disorder only = 22 (56.4)	(1) current diagnosis of PTSD (2) diagnosis of SMI (BD, Major Depression, Schizophrenia Spectrum Disorder)	(1) organic brain condition (2) current suicidal ideation (3) participation in another trauma treatment	Cognitive Processing Therapy (CPT) Content: Education about trauma, cognitive restructuring, emotional processing of the trauma	No comparison group	12 weeks (1 session per week)
Novo et al., (2014)	Single-Blind randomised controlled pilot study	Spain	20 EMDR: 10 TAU: 10	Gender *n* (%): EMDR Group: Male: 3 (30), Female: 7 (70). Mean Age: 43.90 (SD = 6.87) TAU Group: Male: 5 (50), Female: 5 (50). Mean Age: 44.80 (SD = 6.86)	BD with subsyndromal affective symptoms Constant amounts of mood-stabiliser for a minimum of 3 months Experienced at least three traumatic events over their lifetimes	(1) history of neurological disease (2) substance misuse difficulties (3) suicidality (4) affective episode in the last 3 months (5) previous EMDR therapy (6) score higher than 25 in the DES	EMDR Followed standard protocol of eight phases, selected main targets for reprocessing, utilised bilateral eye movements to aid processing	Treatment as Usual (TAU) which involved standard outpatient care from treating psychiatrists	12 week sessions Follow-up assessment at 24 weeks

Study	Study Design	Country	Sample Size (*N*)	Participants Characteristics	Inclusion criteria	Exclusion Criteria	Trauma focused Intervention and characteristics	Comparison (TAU, wait list, No comparison, alternative)	Length of Treatment
Oh & Kim (2014)	Case Study	Korea	2	25-year-old woman (patient 1) 39-year-old woman (patient 2)	PTSD and BD	Not Applicable	EMDR: the features of EMDR were not mentioned within this study	No comparison	Patient 1 received 10 sessions of EMDR Patient 2 received 9 sessions of EMDR Session Length: 1-1.5 hours per session

Note. BD= Bipolar Disorder; CBT= Cognitive Behavioural Therapy; DES = Dissociative Experiences Scale; EMDR= Eye movement Desensitisation Reprocessing; *N*= number; PE= Prolonged Exposure; PTSD= Post Traumatic Stress Disorder; SMI= Serious Mental Illness, ST= Supportive Therapy, TFT= Trauma Focused Therapy.

*These papers focused on analysing data from the SMI participants as a whole, however the authors did provide pre and post outcomes measures for the BD sample, but no other information was given on BD participant characteristics

1.4.3 Measures of Primary Outcomes

Table 6 provides an overview of the assessment tools used to capture both primary and secondary outcomes, along with a summary of the key findings.

A total of 22 assessment tools were used to measure trauma and PTSD symptoms (Appendix C). The two most frequently used tools were the Clinician-Administered PTSD Scale for DSM-IV (CAPS; Blake et al., 1995) and the PTSD Checklist for DSM-5 (PCL-5; Blevins et al., 2015). Most of the instruments used were self-report assessments, except the CAPS and the Clinician-Administered PTSD Scale for DSM-5 (CAPS-5; Weathers et al., 2018), both of which are administered through a clinician-led interview. All of these instruments demonstrate strong validity and reliability in assessing trauma symptomology.

1.4.4 Measures of Secondary Outcomes

Among the 11 studies, ten primarily examined secondary outcomes, while one study exclusively focused on PTSD outcomes (Oh & Kim, 2014). A total of 20 secondary outcome domains were investigated, with the most common domains being affective symptoms (specifically depression, n = 9, and anxiety, n = 4) and functioning (including general, social, global, psychiatric, physical, and perceived health and mental health, n = 6). A total of 37 instruments were used to capture secondary outcomes.

1.4.5 Overview of Intervention Types

Table 5 gives an overview of the trauma-focused interventions and their characteristics, as well as the comparison interventions, such as treatment as usual (TAU), no comparison, or alternative interventions.

A total of nine psychological interventions were examined within this review; two studies included a TAU comparison, and seven studies did not include any comparative analysis within their study design. The delivery of the trauma interventions varied, but all were conducted in a direct one-to-one format.

A total of three studies included in this current review assessed the effectiveness of EMDR. One study conducted a comparison with supportive therapy (ST) (Hogg et al., 2024); another to TAU (Novo et al., 2014); and the third study did not include a comparison group (Oh & Kim, 2014). Two studies examined the efficacy of cognitive processing therapy (CPT) in isolation, without comparative treatment (Moring et al., 2022; Nishith et al., 2024). Two studies evaluated the effectiveness of CBT, with one comparing it to brief treatment (Mueser et al., 2015) and the other study comparing it to TAU (Mueser et al., 2008).

The four remaining studies did not include control groups. Katz et al. (2024) examined the effectiveness of PE therapy for symptoms of PTSD. Iyadurai et al. (2020) looked at the effectiveness of imagery-focused cognitive therapy that integrated a competing visuospatial task. Mauritz et al. (2022) explored the effectiveness of NET, and Miller et al. (2018) assessed the efficacy of extended exposure and rescripting therapy for bipolar (ERRT-B).

Table 6

Summary of Study Findings

Study	Assessment Tools	Primary Outcomes	Secondary Outcomes	Summary of Findings	Missing Data	Study Limitations
Hogg et al., (2024)	Bipolar Depression Rating Scale (BDRS) Young Mania Rating Scale (YMRS) Trauma: Clinician-Administered PTSD Scale (CAPS) Impact of Events Scale-Revised (IES-R) Dissociative Experiences Scale (DES) Functioning and cognition: Functioning Assessment Short Test (FAST) Screen for Cognitive Impairment in Psychiatry (SCIP-S)	Relapse rates (over 24 months)	Affective symptoms Trauma symptoms General functioning Cognitive impairment	Trauma: Significant reductions in trauma symptoms for both groups from baseline to post-treatment, which was maintained at a 12 month follow-up Relapse rates: No significant differences Depression and Manic Symptoms: EMDR significantly more effective in reducing depressive (large effect size) symptoms and manic symptoms (moderate effect size) than ST at a 12 month follow-up General functioning: EMDR group showed greater improvements in psychosocial functioning compared to ST group at a 12 month follow-up Cognitive impairment (SCIP-S): No significant between-group differences in cognitive impairment	Dropout rate: 24 month follow up = EMDR 76.9%, ST 71.1%. Mixed-effects linear models were used to predict the missing data.	Limitations: Lack of generalisability of results to all BD population High dropout rate Lack of blinding for patients

Study	Assessment Tools	Primary Outcomes	Secondary Outcomes	Summary of Findings	Missing Data	Study Limitations
Katz et al., (2024)	Altman Self-Rated Mania Scale (ASRM) Trauma: PTSD Checklist for DSM-5 (PCL-5) Affective: Quick Inventory of Depressive Symptomatology (QIDS) State-Trait Anxiety Inventory (STAI) Suicidality: Suicide Implicit Association Test (SIAT) Concise Health Risk Tracking Form (CHRT)	Reduction in PTSD symptoms Reduction in suicidality risk	Depression and mania symptoms State and trait Anxiety	Trauma: PE resulted in significant reductions in PTSD symptoms post-treatment, and this was maintained at 6 months, showing sustained symptom reduction Depression: There was significant improvement in depression symptoms from baseline to session 10, but there was a slight rebound in scores at 6 months, but scores remained below pre-treatment scoring Anxiety: There were initial increases in anxiety (state and trait) symptoms at session 5, but symptoms continued to reduce, and this remained stable post-treatment Mania: There were minimal changes in mania scores throughout all assessments Suicidality: There was significant reductions in suicidality ideation from baseline to session 10, but there was a slight rebound in scores at 6 months, but scores remained below pre-treatment scoring	Only 50% of the sample (16/32) completed assessments at a 6-month follow-up	Limitations Significant attrition rate between post-treatment and 6 month follow-up Unable to conduct all fidelity assessments on the PE therapists No control group Limitations of generalisability due to small sample size (*n*=32)
Iyadurai et al., (2020)	Structured Clinical Interview for DSM-IV-TR (SCID) Altman Self-Rated Mania Scale (ASRM) Trauma: Impact of Event Scale (IES-R) Affective: Quick Inventory of Depressive Symptomatology (QIDS) Beck Anxiety Inventory (BAI) Imagery Characteristics: Visual Analogue Scale (VAS) - ratings of imagery realness, vividness and compellingness	Imagery features	Symptoms of PTSD, anxiety, depression, and mania	Trauma: Treatment resulted in statistical reliable reductions in PTSD-related symptoms (reliable change index = -76.01) and distress from intrusive imagery (reliable change index = –29.48) Follow-up (SCID): The patient did not show any PTSD symptoms. The patient reported improved mood stability, and experienced having fewer images with lower distress levels Depression: Baseline – ‘mild’ depression (8.00) and at follow-up was ‘normal’ (5.17). Anxiety: Baseline – ‘minimal’ depression (15.67) and at follow-up (14.33). Mania (ASRM) scores were subclinical.	No missing data reported	Limitations No randomisation No long-term follow up Small sample size Potential selection bias Limited external validity

Study	Assessment Tools	Primary Outcomes	Secondary Outcomes	Summary of Findings	Missing Data	Study Limitations
Mauritz et al., (2022)	Severe Mental Illness (HoNOS) Care Needs (CAN) Quality of Life (MANSA) Global Assessment of Functioning (GAF) Trauma: Post Traumatic Stress Disorder (CAPS-5) Dissociative Experiences Scale (DES) These outcomes were measured at baseline, 1 month post-treatment and 7 months post-treatment	PTSD Dissociation	Severe Mental Illness Care Needs Quality of Life Global Functioning	BD specific outcomes: Trauma: NET treatment resulted in a reduction of PTSD symptoms overtime Dissociation: There was an overall improvement in dissociative symptoms. DES scores reduced substantially post-treatment Quality of Life: There were improvements with participants' perceptions of quality of life, which was maintained at 7 months Global Functioning: Slight improvements from baseline to 1 month post-treatment SMI Severity: Net resulted in a marked reduction in SMI severity post-treatment	No missing data reported	Limitations Small sample size and low representation of male participants Limited causal inferences due to not having a control group Reduced generalisability and selection bias as participants were selected from treatment team's caseload
Miller et al., (2018)	Montgomery–Asberg Depression Rating Scale (MADRS) The Center for Epidemiologic Studies Depression Scale–Revised (CESD-R) PTSD Symptoms: The Life Events Checklist for DSM–5 The Clinician Administered PTSD Scale for DSM–5 (CAPS-5) The Posttraumatic Stress Disorder Checklist (PCL-5) Nightmare and Sleep Symptoms: Trauma-Related Nightmare Survey The Pittsburgh Sleep Quality Index (PSQI) The Insomnia Severity Index (ISI)	Nightmare frequency and severity Sleep symptoms and quality	PTSD symptoms Depression symptoms	Trauma: PTSD symptoms improved substantially with large effect sizes from pre to post-treatment across both self-report and client-rated measures Nightmare Outcomes: Substantial reduction in the frequency of nightmares and significant improvements in the severity of nightmares, with large effect sizes, which was maintained at 3 months Sleep Outcomes: Improvements in both sleep quality (moderate effect size) and insomnia severity (small effect size), that was maintained at 3 months Depression Symptoms: Depression scores showed moderate improvements from pre to post-treatment, across both self-report and client-rated measures	Missing post-treatment scores for CAPS-5	Limitations Short duration of intervention Lack of control group Small sample size

Study	Assessment Tools	Primary Outcomes	Secondary Outcomes	Summary of Findings	Missing Data	Study Limitations
Moring et al., (2022)	The Posttraumatic Stress Disorder Checklist (PCL-5) The Clinician Administered PTSD Scale for DSM–5 (CAPS-5) Beck Depression Inventory-II (BDI-II)	PTSD symptoms Depression symptoms	None reported	Large reductions for both PTSD and depression symptoms for the patient after receiving CPT treatment. At the end of treatment the client did not meet diagnostic criteria for both presentations	Missing session 12 scores for CAPS-5	Limitations Lack of control group makes it difficult to generalise findings
Mueser et al., (2008)	Structured Clinical Interview for DSM-IV (SCID-I) These outcomes were measured at baseline, 3 months post-treatment and 6 months post-treatment Trauma and PTSD: Clinician-Administered PTSD Scale (CAPS) Posttraumatic Cognitions Inventory (PTCI) PTSD Knowledge Test Other symptoms: Short Form-12 Beck Anxiety Inventory (BAI) Beck Depression Inventory (BDI-II) Working Alliance Inventory	PTSD diagnosis PTSD severity	PTSD knowledge Trauma-related cognitions Depression symptoms Anxiety symptoms Psychiatric symptoms Perceived health and mental health functioning Working alliance	BD specific outcomes: Trauma: CBT group had a large decrease in trauma symptoms that was maintained at both 3 and 6 months. TAU group also showed a reduction, but it was smaller compared to the CBT group, and scores increased at 6 months Other symptoms: Depression: Depression symptoms decreased for both interventions post-treatment but only the CBT group had continued improvements that was maintained at 3 and 6 month follow-ups, where the TAU group's depression scores increased over time Anxiety: CBT showed reductions in anxiety symptoms, which was maintained at 6 months. TAU group showed minimal improvements post-treatment	Dropout rate of people who received CBT was 19% There were inconsistencies with data analysis at the set post-treatment assessment timepoints; through dropouts and lost to all follow-up (*n*=11).	Limitations Use of TAU as a control, better to have used more active comparison group Study was completed in a rural area, therefore limited representation of certain minorities Information on medications was not reviewed; these may have accounted for some of the differences between the groups Heterogeneity of participants was not considered

Study	Assessment Tools	Primary Outcomes	Secondary Outcomes	Summary of Findings	Missing Data	Study Limitations
Mueser et al., (2015)	Structured Clinical Interview for DSM-IV (SCID-I) Trauma and PTSD: Clinician-Administered PTSD Scale (CAPS) Posttraumatic Cognitions Inventory (PTCI) PTSD Knowledge Test Other symptoms: Beck Anxiety Inventory (BAI) Beck Depression Inventory (BDI-II) Global Assessment of Functioning (GAF) Brief Quality of Life Interview (QOLI)	PTSD symptom severity	Overall functioning Social functioning PTSD cognitions Depression Anxiety All outcomes were measured at baseline, post-treatment, 6 months post-treatment and then 12 months	BD specific outcomes: (only mean/SD were obtained) Trauma: Both interventions had reductions in trauma-related symptoms and trauma-related cognitions. At a 12 month follow-up brief treatment had slightly lower PTCI scores Other symptoms: Depression: Depression symptoms decreased for both interventions and improvements were maintained at a 12 month follow-up, but brief treatment had lower depression scores at 12 months Anxiety: Both CBT and brief treatment showed reductions in anxiety symptoms, which was maintained at 12 months. Global Functioning: Both interventions showed improvements in general functioning, with both demonstrating stability in functioning scores at 12 months Quality of Life: Both CBT and brief groups showed improvements in quality of life scores, CBT showed larger improvements directly after treatment, and brief treatment had a higher quality of life score at 12 months	CBT 18-22 participants were lost to follow-up Brief 22-29 participants were lost to follow-up Intent-to-treat (ITT) analysis was completed, which helps prevent bias Mixed-effects models were used which is robust to missing values	Limitations Sample size imbalance, could introduce biases Attrition rate is a concern Participants were recruited from clinics for people with SMI and PTSD. Participants assessed as meeting diagnostic criteria. However may not represent larger target population
Nishith et al., (2024)	Assessments were collected at pre and post-treatment only Trauma: The Posttraumatic Stress Disorder Checklist (PCL-5) Depression: Patient Health Questionnaire-9 (PHQ-9) Brief Psychiatric Rating Scale (BPRS) World Health Organisation Disability Assessment Schedule 2.0 (WHODAS 2.0)	PTSD symptoms	General psychiatric and physical functioning Depression	BD specific outcomes: Trauma: For BD participants (*n* = 9) there was a large reduction in trauma symptoms, as evidenced by the average score reduction from moderate severe PTSD levels down to remission after CPT treatment. Depression: PHQ-9: Pre-treatment mean = 16.83 (SD = 5.49), Post-treatment mean = 4.33 (SD = 2.80) There was improvement for both PTSD and depression symptoms	13 participants dropped out, including 3 who had BD, but ITT analysis was completed There was also missing data for certain measures i.e.; sample sizes vary between outcome measures	Limitations Single arm study with small sample size Lack of blinding Lack of control group Limited generalisability (selection procedures and participant characteristics) No long-term follow up

Study	Assessment Tools	Primary Outcomes	Secondary Outcomes	Summary of Findings	Missing Data	Study Limitations
Novo et al., (2014)	Young Mania Rating Scale (YMRS) Hamilton Depression Rating Scale (HDRS) Clinical Global Impression-mania (CGI-m) Clinical Global Impression-depression (CGI-d) Trauma Scales: Impact of Event Scale (IES-R) Clinician Administered PTSD Scale (CAPS)	Depression and mania ratings	Changes in trauma scales Safety aspects of EMDR	Trauma symptoms: The EMDR group showed significant reductions in trauma-related symptoms and trauma impact evaluated by the CAPS, and IES, but trauma impact was marginally sustained at 24 weeks Significant improvements in depressive and mania symptoms for the EMDR group compared to TAU at 12 weeks but these changes were not maintained at 24 weeks	Noted dropouts recorded. EMDR dropout rate was low (0% at 12 weeks and 10% at 24 weeks) Higher dropout rate was observed in the TAU group (30% at 12 weeks and 40% at 23 weeks) but was not statistically significant but could led to potential bias	Limitations Small sample size limits generalisability Lack of comparison to other studies Dropout rates in TAU group
*Oh & Kim (2014)	The Clinician Administered PTSD Scale for DSM–IV (CAPS)	PTSD symptoms	None reported	CAPS Severity Score patient 1: baseline: 52, post-treatment: 7 (complete remission) CAPS Severity Score patient 2: baseline: 67, post-treatment: 18 (significant improvement) EMDR resulted in reductions in PTSD symptoms for both patients who had chronic PTSD. Therapeutic gain was maintained during one-year of follow-up	No information given on missing data. *Author contact but they were unable to provide further information on patients apart from pre and post CAPS scores	Limitations No control group Small sample size Editorial Letter providing limited information on patients' characteristics

Note. CAN= Camberwell Assessment of Need; d = Cohen's d; df= degrees of freedom; EPHPP= Effective Public Health Practice Project Quality Assessment Tool; F-value= is a test statistic (Fisher) used in Analysis of Variance (ANOVA); GAF= Global Assessment of Functioning; HoNOS= Health of the Nation Outcome Scales; JBI= Joanna Briggs Institute Quality Assessment Tool; LSMD= Least Squares Mean Difference; MANSA= Manchester Short Assessment of Quality of Life; PE= Prolonged Exposure; SD= standard deviation; SMI= Serious Mental Illness; TAU= Treatment as Usual

1.4.6 Descriptive Narrative Synthesis of Findings

The following narrative synthesis summarises the outcomes of the 11 studies that examined the efficacy of trauma-focused interventions in individuals with bipolar disorder. A wide range of analytical approaches were used to assess treatment effectiveness, including pre-post comparisons, effect sizes, and group comparisons, among others.

1.4.6.1 Studies Comparing Interventions

Out of the 11 included studies, four had a comparison group as part of their study design.

1.4.6.1.1 EMDR vs Supportive Therapy

In a RCT Hogg et al. (2024) looked at the effectiveness of EMDR in comparison to ST as treatment in trauma-exposed bipolar participants. EMDR therapy (*n* = 39), included bipolar disorder-specific subprotocols for mood stabilisation, treatment adherence, and trauma processing. ST (*n* = 38) provided emotional guidance, attentive listening, and psychoeducation on BD, without trauma processing components. Both therapies lasted 20 weeks. The Impact of Events Scale-Revised (IES-R) scale was used to assess the levels of subjective distress resulting from exposure to traumatic events.

A significant reduction in trauma-related symptoms was observed in both groups from the baseline to post-treatment phase, and this was maintained at 12 months. The analysis indicated that there were no significant between-group differences in trauma-related symptoms at both the 6 and 12 months follow-ups, suggesting that each treatment resulted in similar reductions in trauma symptoms.

1.4.6.1.2 EMDR vs TAU (Treatment as Usual)

Novo et al. (2014) conducted a randomised controlled pilot study that investigated the efficacy of EMDR therapy (*n* = 10) for individuals with subsyndromal bipolar and compared the results to a TAU condition (*n* = 10). EMDR therapy followed the standard eight-phase protocol, which focused on reprocessing of primary targets with bilateral eye movements. The TAU group received standard outpatient care provided by psychiatrists. Participants that

were assigned to the EMDR group engaged in 14 to 18 sessions over a 12-week period (Novo et al., 2014). The researchers used both the IES-R and the CAPS to assess the severity of PTSD symptoms.

EMDR showed statistically significant reductions in trauma-related symptoms and trauma impact in comparison to the TAU group. There was a significant reduction in PTSD symptoms at 12 weeks post-treatment, but this was only partially maintained at 24 weeks. In comparison, TAU treatment showed minimal change.

In order to be eligible for this study, participants were required to have experienced a minimum of three traumatic events (Novo et al., 2014). The researchers evaluated the effects of each event individually (IES 1, IES 2, IES 3). The results indicated that EMDR was associated with significant reductions in trauma-related distress for the first traumatic event, with sustained effects showing at 24 weeks, but its effectiveness was limited for the second event and only showed short-term improvement for the third event. The TAU group did not lead to any meaningful changes across all three events.

1.4.6.1.3 CBT vs TAU

Mueser et al. (2008) conducted an RCT to examine the effectiveness of CBT for PTSD in individuals with SMI, comparing the results to a TAU condition. The CBT intervention (n = 54) consisted of a 12 to 16 week programme designed to address PTSD symptoms through a structured approach. In the TAU condition (n = 54), participants continued with the standard services that they had been receiving and had the option to access supportive counselling.

After corresponding with the main authors, we managed to obtain specific data regarding the bipolar disorder population; however, we were only able to attain descriptive pre- and post-measures; no other statistical tests were provided, thereby limiting interpretability. To evaluate any reduction in PTSD symptom severity, the CAPS outcome measure was used.

For BD participants (*n* = 14), CBT treatment showed notable reductions in PTSD severity immediately after treatment and these improvements were maintained at both 3 and 6 months. In comparison, the TAU group (*n* = 11) showed a reduction, but it was numerically smaller compared to the CBT group, and scores increased at a 6-month follow-up. However, interpretations are made with caution, as significance testing was not possible for the available BD data.

1.4.6.1.4 CBT vs Brief Treatment

Mueser et al. (2015), conducted an RCT to assess the efficacy of CBT compared to brief treatment for PTSD in individuals with SMI. CBT (*n* = 104) was delivered as a 12 to 16 week programme; in contrast, brief treatment (*n* = 97) consisted of only three sessions. The CBT intervention had three sessions that focused on breathing techniques for anxiety along with educational components regarding PTSD. This was followed by an additional 9 to 13 sessions of cognitive restructuring. The brief treatment included the same initial three sessions as the CBT programme. The main author was also able to provide specific data regarding the bipolar disorder population but again only provided pre- and post-scores.

The CAPS was used to review PTSD symptom severity, and the Posttraumatic Cognitions Inventory (PTCI) was used to evaluate trauma-related cognitions.

For BD participants, both the CBT group (*n* = 33) and the brief treatment group (*n* = 30) were associated with reductions in PTSD symptoms and trauma-related cognitions, and these were maintained at 12 months after treatment. At 12 months, the brief treatment group had slightly numerically lower PTCI scores.

The findings from Mueser et al. (2015) suggest that both CBT and brief treatment were associated with improvements in trauma-related negative cognitions and the severity of PTSD symptoms, consistent with changes in mean scores from pre- to post-treatment timepoints.

1.4.6.2 Studies Without a Control Group

1.4.6.2.1 Prolonged Exposure Therapy (PE)

Katz et al. (2024) conducted an open-label study, examining the effectiveness of PE therapy for outpatients with both bipolar disorder and PTSD. The PE therapy (*n* = 32) lasted for a period of five weeks and had a total of 10 sessions. The therapy had various stages, but predominately it aimed at addressing PTSD symptoms through prolonged imaginal exposures to previous traumatic memories. Within this study the PTSD Checklist for DSM-5 (PCL-5) was used to assess the presence and severity of PTSD symptoms.

PE was associated with large within-group effect sizes for significant reductions in PTSD symptoms from pre- to post-treatment, and this was maintained at 6 months, showing potential sustained symptom reduction. However, interpretation of efficacy should be treated with caution in consideration that this was a small, open-label study without a control group.

1.4.6.2.2 Imagery Focused Cognitive Therapy

Iyadurai et al. (2020) conducted a single case study targeting intrusive imagery using an alternative cognitive approach in CBT with a patient diagnosed with bipolar disorder and PTSD symptoms. This involved cognitive therapy that centred on imagery, where the patient was asked to recall an intrusive image and then play the video game Tetris for 10 minutes. Vividness and distress ratings were taken before and after the task. The Structured Clinical Interview for DSM-IV-TR (SCID) diagnostic tool and the IES-R were used to assess levels of subjective distress resulting from exposure to traumatic events.

Imagery-focused cognitive therapy resulted in statistically reliable reductions in PTSD-related symptoms and distress from intrusive imagery. At follow-up, the patient showed no symptoms of PTSD, as measured by the SCID, indicating remission. While the results are promising, they must be approached with caution, as this is a single-case design with no control group, and therefore the results may not be generalisable to a wider population.

1.4.6.2.3 Narrative Exposure Therapy (NET)

Mauritz et al. (2022), conducted a study that investigated the efficacy of NET in individuals with SMI and co-occurring PTSD. NET (*n* = 23) was administered to target PTSD symptoms specifically and was delivered by certified NET therapists. In addition, outpatients were provided with flexible assertive community treatment alongside the NET intervention. The duration of NET ranged from 5 weeks to a maximum of 16 weeks.

Through correspondence with the main authors, we were able to obtain specific data relating to the bipolar disorder population; however, again, we were only able to attain descriptive pre- and post-mean scores. The trauma-focused outcomes used were the Post Traumatic Stress Disorder (CAPS-5), which measures PTSD severity, and the Dissociative Experiences Scale (DES) which measures dissociative symptoms.

For BD participants (*n* = 4), NET treatment showed gradual reductions in PTSD symptom severity scores over time, and DES scores reduced substantially from treatment to a 7-month follow-up. This suggests that NET may be associated with reductions in PTSD and dissociation symptoms, but the study lacked a control group and had a small sample size.

1.4.6.2.4 Extended Exposure and Rescripting Therapy for Bipolar (ERRT-B)

Miller et al. (2018) conducted an open-label pilot study to examine the effectiveness of a five-session manualised version of ERRT-B. ERRT-B (*n* = 7) included techniques for improving sleep, education on traumatic stress symptoms and relaxation strategies. Post-treatment evaluations were completed at 1 week and 3 months, using the PCL-5 and the CAPS-5 trauma assessment tools.

PTSD symptoms improved substantially with large effect sizes from pre- to post-treatment across both self-report and client-rated measures. However, no statistical significance testing was reported. Interpretations of findings need to be approached with care due to the study's small sample size and lack of a control group.

1.4.6.2.5 Cognitive Processing Therapy (CPT)

Moring et al. (2022) conducted a case study examining the efficacy of CPT for a patient with co-occurring PTSD and bipolar disorder. CPT was administered to specifically target PTSD and trauma-related cognitions. The therapy involved psychoeducational components on PTSD, assisted individuals in identifying trauma-related thoughts, and cognitive restructuring. A total of 12 sessions were provided, occurring twice a week over a 45-day period. The PCL-5 and the CAPS-5 trauma measures were administered to assess outcomes.

After CPT treatment, there was a large reduction in PTSD symptoms from treatment to a 3-month follow-up. Moring et al. (2022) also highlighted that the patient no longer met the diagnostic criteria for PTSD, signifying their recovery. However, the study is a single-case design without a control group.

1.4.6.2.6 Cognitive Processing Therapy (CPT)

Nishith et al. (2024) carried out an open-label pilot trial to assess the efficacy of CPT for PTSD in individuals with SMI. CPT (*n* = 39) lasted for 12 weeks and included education on trauma, cognitive restructuring, and involved the emotional processing of traumatic experiences. The PCL-5 was used to assess the severity and presence of PTSD symptoms. The main authors of the study were able to provide specific data regarding the bipolar disorder population, but we only were able to get pre- and post-measures and no other statistical outcomes were provided.

For BD participants (*n* = 9) there was a large reduction in trauma symptoms, as evidenced by the average score reduction from moderate severe PTSD levels down to remission after CPT treatment. CPT therefore may be associated with a reduction in PTSD symptoms among individuals with bipolar disorder; however, further considerations are needed when interpreting these results, for example, open-label design, lack of a control group and a small sample size.

1.4.6.2.7 EMDR

Oh and Kim (2014) carried out a case study to explore the effectiveness of EMDR in treating PTSD among two individuals with a diagnosis of bipolar disorder who received 9 or 10 sessions of EMDR. As the findings were published in an editorial letter, certain study characteristics were missing, and details regarding the EMDR therapy were not included. The CAPS trauma outcome measure was used to assess the severity of PTSD symptoms.

For the first individual, the CAPS severity score decreased from 52 at baseline to 7 following treatment, indicating a total remission of PTSD symptoms. For the second individual, the CAPS decreased from 67 at baseline to 18 after treatment. EMDR was associated with marked reductions in PTSD symptoms for both participants who were diagnosed with chronic PTSD prior to treatment, and therapeutic gains were maintained over the course of a one-year follow-up period. In consideration of the case study design and limited details, results should be treated with caution when inferring effectiveness levels.

1.4.6.3 Group Comparisons of Effectiveness

There are many differences in the analytical methods adopted within these studies, which makes the evaluation of findings challenging. Interpretation of efficacy is dependent on PTSD symptom reduction, study design, methodological quality, sample size, sustainability of the effects and limitations.

Important points are that many studies had small sample sizes, which makes the estimates of the treatment effect imprecise (Miller et al., 2018; Moring et al., 2022). Several studies did not include a control group (Iyadurai et al., 2020; Katz et al., 2024) making it difficult to draw conclusions about the treatment's efficacy compared to other treatments or TAU. Additionally, because of limitations in obtaining specific BD data, many studies only had descriptive data (pre and post measures), (Mauritz et al., 2022; Mueser et al., 2008; Mueser et al., 2015) therefore, we were unable to determine the significance of these findings. Finally, Nishith et al. (2024) did not provide follow-up data within their analysis, which is important for evaluating therapeutic outcomes over time.

Most interventions showed reductions in trauma symptoms, but the interventions with the most promising evidence base for treating PTSD in individuals with bipolar disorder appeared to be EMDR and CBT.

EMDR demonstrated significant PTSD reductions across two studies with a control group. Novo et al. (2014) indicated that EMDR had an advantage over TAU, and Hogg et al. (2024) showed that EMDR had similarities with ST treatment outcomes. Sample sizes did vary, but study designs were relatively strong (RCTs). All studies demonstrated sustained improvements, and Oh and Kim's (2014) case study also showed continued reductions at a 1-year follow-up. The EPHPP quality assessments also reflected the positive reliability for both RCTs; Novo et al. (2014) received a high-quality rating suggesting a low risk of bias, and Hogg et al. (2024) received a moderate rating which indicated acceptable methodological quality.

CBT showed stable reductions in PTSD symptoms across two controlled studies (RCTs) and improvements were maintained at the follow-up assessments (3 to 12 months), indicating some association with the sustainability of treatment effects. BD sample sizes were moderate in comparison to some of the other studies (Mueser et al., 2008; Mueser et al. 2015), and EPHPP quality ratings for both studies were placed at moderate.

Both PE (Katz et al., 2024) and CPT (Nishith et al., 2024; Moring et al., 2022) also demonstrated promising outcomes. PE was associated with large effect sizes in PTSD reduction, and this benefit was maintained at 6 months, but limitations are related to the open-label study design and the high dropout rates. CPT also indicated substantial reductions in PTSD symptoms, with Moring et al. (2014) reporting that the patient in their study no longer met the diagnostic criteria for PTSD. However, limitations exist in interpreting the findings related to both study design and generalisability.

1.4.6.4 Secondary Outcomes – Comparison Across Studies

The secondary outcomes identified in the studies are summarised in Table 6.

1.4.6.4.1 Depression

A total of nine studies evaluated depression outcomes. Each intervention was associated with a reduction in depression levels following treatment, with the most promising evidence base for EMDR, PE and CBT. Hogg et al. (2024) showed that EMDR resulted in statistically significant reductions in depressive symptoms in comparison to ST at a 12-month follow-up with a large effect size. Novo et al. (2014) indicated that EMDR showed significant improvements in depression levels versus TAU at 12 weeks after baseline, however this improvement was not sustained at 24 weeks.

PE (Katz et al., 2024) was associated with reductions in depressive symptoms with a large effect size from baseline to post-treatment, with a slight rebound in scores at 6 months. This implies a movement from moderate depression as measured by the Quick Inventory of Depressive Symptomatology (QIDS) at baseline, to mild depression at 6 months. However, due to the open-label design and no comparator treatment, there are limitations to the study's findings.

CBT was associated with efficacy at reducing depressive symptoms (across both RCTs). Mueser et al. (2008) reported that depression symptoms decreased for both interventions post-treatment, but only the CBT group had continued improvements that were maintained at both 3 and 6-month follow-ups, in comparison the TAU group's depression scores increased over time. For Mueser et al. (2015) depression symptoms decreased for both interventions, and improvements were maintained at a 12-month follow-up, however brief treatment had slightly lower depression scores at 12 months. Again, limitations are present in both studies due to a lack of inferential statistics for the BD data.

1.4.6.4.2 Anxiety

A total of four studies evaluated anxiety outcomes. Each intervention was associated with a reduction in anxiety levels after treatment, with CBT having the strongest impact on anxiety. In the study conducted by Mueser et al. (2008), the CBT group showed a steady decease in anxiety scores over 6 months, according to the Beck Anxiety Inventory (BAI), in comparison, the TAU group saw minimal improvements in anxiety. Mueser et al. (2015)

found that both CBT and brief treatment showed reductions in the BAI outcomes which were sustained at 12 months post-treatment. However, we cannot determine if these results have statistical significance due to a lack of inferential testing, but the study's strengths lie in the sample sizes and the RCT design.

1.4.6.4.3 Mania

Four studies evaluated mania outcomes as part of their study design. The trauma intervention that was associated with the most promising result in reducing mania symptoms was EMDR (Hogg et al., 2024; Novo et al., 2014). Hogg et al. (2024) showed significant reductions in mania at 12 months with a moderate effect size and was superior to ST in comparison. Novo et al. (2014) reported significant reductions in hypomanic symptoms from baseline to post-treatment, while the TAU group only observed minimal improvements.

For PE (Katz et al., 2024) the mania scores remained stable as measured by the Altman Self-Rated Mania Scale (ASRM), this was seen as positive in terms of PE not inducing (hypo)mania during treatment, and the mania scores for imagery cognitive-focused therapy (Iyadurai et al., 2020) remained at a subclinical level.

1.4.6.4.4 Reduction in Suicidality Risk

Katz et al. (2024) was the only study to examine the risk of suicidality. The findings indicated that PE therapy was associated with significant reductions in suicidality risk immediately post-treatment, with a slight rebound at the 6-month follow-up assessment. Findings suggest the PE may reduce suicidality; however, limitations need to be accounted for, including the open-label design with no control group, alongside high rates of dropouts at the 6-month assessment.

1.4.6.4.5 Relapse Rates Over 24 Months

Hogg et al. (2024) assessed the rates of relapse in their study and found that 35.1% of participants experienced a recurrence of a mood episode, and 15.6% had a relapse that required hospitalisation. There were no significant differences between EMDR and ST in preventing these relapses.

1.4.6.4.6 Functioning

A total of three studies assessed functioning outcomes as part of their analysis. The treatments that were associated with the most promising results were EMDR (Hogg et al., 2024) and CBT (Mueser et al., 2015). At the 12-month follow-up, EMDR was indicated to have significantly greater improvements in improving psychosocial functioning compared to ST, with a moderate effect size (Hogg et al., 2024). In Mueser et al. (2015), both CBT and brief treatment were associated with improvements in global functioning from baseline to 12 months.

1.4.6.4.7 Quality of Life

Two studies evaluated quality of life outcomes within their study design. In their RCT, Mueser et al.'s (2015) results implied that both interventions of CBT and brief treatment resulted in improvements in quality of life outcomes, with brief treatment showing more gains at 12 months. In Mauritz et al. (2022), NET was associated with improvements in participants' perceived quality of life, as indicated by a 5-point increase on the Manchester Short Assessment of Quality of Life (MANSA), from baseline to 7 months. However, these findings are based on a small sample size of four participants; there is also the absence of a control group, and it adopts a mixed-methods convergent design, which lacks power in terms of causal inference.

1.4.6.4.8 SMI Severity

Mauritz et al. (2022) was the only study that examined the severity of SMI as measured by the Health of the Nation Outcome Scales (HoNOS). After NET treatment there were reported slight improvements in SMI severity from baseline to 1 month post-treatment, but this was not sustained, with scores increasing at 7 months. Additionally, there were minimal changes in need severity, and findings are based on a low BD sample (n = 4).

1.4.6.4.9 Nightmare Frequency and Severity

Miller et al. (2018) assessed the effectiveness of ERRT-B on the frequency and severity of nightmares and sleep symptoms and overall sleep quality. ERRT-B was

associated with observed sizable reductions in both nightmare frequency and severity, with large effect sizes. Findings are associated with the support of ERRT-B as a promising intervention in the reduction of nightmare frequency and severity; however, conclusions are limited by the open-label design, lack of a control group and small sample size.

1.4.6.4.10 Sleep Symptoms and Quality

Mixed findings were observed on sleep measures as captured by the Pittsburgh Sleep Quality Index (PSQI) and the Insomnia Severity Index (ISI) after ERRT-B treatment (Miller et al., 2018). There were moderate effect sizes for improvements in sleep quality at post-treatment and at a 3-month follow-up assessment. However, only small effect sizes were observed for improvements in insomnia severity. Again, findings are to be treated with caution.

1.5 Discussion

This review combined findings from 11 studies that examined how effective psychological therapies are in reducing posttraumatic stress symptoms in people diagnosed with bipolar disorder.

1.5.1 Summary of Findings

Study outcomes have emphasised the positive impact that trauma-focused psychological interventions can have in reducing PTSD and trauma-related symptoms. There were varying levels of reported efficacy among the therapeutic approaches but EMDR and CBT presented with the most favourable outcomes. In consideration of the noted limitations that affected interpretability, findings are to be treated with caution.

EMDR showed sizable reductions in trauma symptoms, both in the short term (Novo et al., 2014) and with lasting effects, especially among individuals with long-standing PTSD (Oh & Kim, 2014). However, additional RCTs are needed to investigate its potential for trauma reduction in bipolar disorder. CBT also yielded observed reductions in PTSD symptoms across two controlled studies (Mueser et al., 2008; Mueser et al., 2015) with some levels of sustainability at follow-up timepoints.

However, conclusions regarding the interpretability of the findings are made with reservation. It is important to clarify that no treatment modality had consistent support from multiple RCTs involving participants with BD, and the variability in study quality requires careful reflection. Case studies assessed by the JBI tool were mostly placed as high quality but had limitations due to their study design. Most RCTs received a moderate EPHPP quality rating, indicating some potential risk of bias, with only one study rated as strong. This necessitates caution in the interpretation of CBT and EMDR's effectiveness, highlighting the need for more controlled trials to draw more reliable and convincing conclusions. Nevertheless, the evidence base appears marginally stronger for EMDR and CBT.

Both PE and CPT also showed preliminary evidence as beneficial trauma interventions for individuals with bipolar disorder. PE therapy was associated with significant reductions in PTSD symptoms, and the findings suggest that the intervention may offer long-lasting advantages (Katz et al., 2024). These outcomes corroborate with earlier research that also supports the efficacy of PE in achieving significant reductions in PTSD (Booysen & Kagee, 2021).

CPT (Moring et al., 2022; Nishith et al., 2024) appeared to lead to notable reductions in PTSD symptoms in two different studies, and the reduction in symptoms was maintained over several months. The findings corroborate earlier research that showed positive outcomes through the use of a modified CPT protocol (Galovski et al., 2012).

Imagery-focused cognitive therapy was associated with large reductions in trauma-related distress, with one patient reportedly achieving complete remission of PTSD symptoms (Iyadurai et al., 2020). The intervention was distinct in that it incorporated the visuospatial computer game 'Tetris' to address disturbing mental imagery. This affiliates with existing models of imagery and reinforces the gains of such methods for reducing psychological symptoms (Hales et al., 2018). This intervention could provide a more innovative approach for individuals experiencing both PTSD and bipolar disorder, particularly those who do not benefit from conventional therapeutic approaches.

Brief treatment, ST and NET also displayed some positive outcomes. In their study, Mauritz et al. (2022) explored the impact of NET on dissociative symptoms and showed encouraging outcomes with reductions following treatment. These findings suggest that this intervention may be beneficial for individuals experiencing co-occurring dissociative symptoms, which have been shown to be significantly correlated with PTSD (van der Hart et al., 2008).

ERRT-B demonstrated encouraging outcomes, with prominent reductions in PTSD symptoms with large effect sizes (Miller et al., 2018). To validate the generalisability of the study's findings, however, more research is needed, given that it was a pilot study and had a restricted sample size.

Examining secondary outcomes in this review was important, as it shows the wider benefits of trauma-focused therapies for individuals with bipolar disorder. There were varying levels of improvement in secondary outcomes. EMDR was associated with some levels of efficacy in alleviating depression and mania, whilst also improving psychosocial functioning (Hogg et al., 2024). CBT emerged as the most effective psychological therapy for reducing anxiety and showed substantial improvements in quality of life outcomes (Mueser et al., 2015). Since, co-morbid PTSD in individuals with bipolar disorder has been linked to more severe symptoms of depression and anxiety, this finding is particularly important (Russell et al., 2024). Katz et al. (2024) outcomes suggest that PE treatment has the potential to lower the risk of suicidality among individuals with bipolar disorder, a population where the presence of PTSD is associated with a heightened risk of suicide (Cerimele et al., 2017).

The psychological therapies examined in this review were found to be well-accepted and safe for individuals with bipolar disorder. Katz et al. (2024) found that PE therapy was both feasible and safe for individuals with co-occurring PTSD and bipolar disorder. Hogg et al. (2024) showed that trauma-focused EMDR was safe and well-tolerated for people with trauma-related symptoms and BD. But due to the lack of comparability to other interventions these findings are somewhat limited.

The findings of this review demonstrate how trauma-informed psychological therapies can have a beneficial effect on a range of secondary outcomes for individuals with bipolar disorder.

1.5.2 Strengths and Limitations

To our knowledge, this is the first systematic review to examine the efficacy of a full range of trauma-focused psychological therapies for individuals with bipolar disorder. Due to heterogeneity of the studies, a meta-analysis was not completed, however, outcomes suggest varying levels of potential effectiveness for each therapy reviewed and that these interventions are feasible and beneficial for this population.

Strengths of this review are reflected in the adoption of a thorough search strategy that ensured the inclusion of a broad range of studies, with different research designs, whilst consistently focusing on trauma-focused therapies. Stringent inclusion and exclusion criteria were also applied to emphasise high quality research.

This review presents limitations. The majority of the studies included samples that lacked sufficient representation of the wider population. Information on protected characteristics was limited, and there was no evidence that the interventions had been culturally adapted, which emphasises the need for more culturally sensitive and inclusive approaches. Griner and Amith (2006) stress that there is a growing demand to improve access to high-quality mental health care for racially and ethnically disadvantaged populations.

Furthermore, seven studies lacked a control group, some studies showed inconsistencies in their follow-up data, attributed to high dropout rates or incomplete data and there were variations in the statistical methods used across the studies' analyses. Limitations also include the inclusion of only 11 studies and the small number of participants diagnosed with bipolar disorder.

1.5.3 Implications and Future Research

Potential benefits of these trauma-focused psychological therapies has been shown, including less severity of PTSD symptoms, better functioning, decreased dissociation, and reduced affective symptoms.

Given the complexity that is present in the bipolar disorder condition and the diverse treatment experiences, the suitability of trauma-focused therapies needs further evaluation. Individuals experience bipolar disorder in different ways, which suggests that a more personalised approach would be supportive, with a treatment that incorporates each person's unique symptom profile.

Despite clinician apprehensions about mood dysregulation in BD, trauma-focused therapies have been shown to be safe and promising for the treatment of PTSD in individuals with this condition. Clearer guidelines and enhanced training could improve access to appropriate trauma-focused care and help reduce clinician hesitancy.

Additional large-scale RCTs that include more diverse populations would strengthen the applicability of the findings. They could explore direct comparisons between different trauma-focused therapies to determine the levels of effectiveness and include the evaluation of treatment effects across different bipolar disorder subgroups.

Many of the studies in this review had established exclusion criteria, including untreated substance dependency and active suicidality, this reflects the difficulties faced by many individuals with bipolar disorder in accessing treatment, especially for those who are dealing with difficult circumstances or who are experiencing severe episodes. Therefore, the findings may be restricted to demonstrate only efficacy levels for individuals experiencing a more stable phase of their condition. Additional research that examines the effectiveness of treatments in relation to chronicity of bipolar disorder would be supportive.

1.5.4 Conclusion

The findings of this review present encouraging outcomes that demonstrate the value of trauma-focused therapies as treatments for individuals experiencing both trauma-related

symptoms and bipolar disorder. To improve the acceptability and efficacy of these interventions, further research is needed. Future studies should assess long-term outcomes and explore strategies that will improve the quality of life for individuals navigating these co-occurring conditions.

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Chapter 2: How is EMDR Best Conducted and Adapted for Trauma-Focused Work Within Bipolar Disorder? A Delphi Study

This empirical paper has been written and formatted according to the publishing guidelines of the Journal of Affective Disorders (Appendix A).

Word Count (excluding tables, figures, and references): 5166

2.1 Abstract

Background: Individuals with bipolar disorder are at increased risk of exposure to traumatic events and developing posttraumatic stress disorder (PTSD). Eye movement desensitisation and reprocessing (EMDR) may be effective in treating trauma-related symptoms in bipolar disorder; however, there is limited guidance on whether adaptations are needed for this clinical group. This study aimed to develop consensus from practitioners on adaptations that may enhance the accessibility and effectiveness of trauma-focused EMDR for individuals with bipolar disorder.

Methods: A three-round Delphi study was conducted to establish consensus on 'essential or important' EMDR adaptations. An international sample of EMDR practitioners participated, 34 in Round 1, 22 in Round 2, and 20 in Round 3. Initial thematic analysis of Round 1 responses generated consensus statements for the Round 2 survey.

Results: Barriers to EMDR access included client-related attributes, such as mood symptoms and safety concerns, as well as systemic influences, including limited guidance on treating trauma in individuals with bipolar disorder. A total of 131 adaptations were identified; of these, 71 adaptations reached consensus as rated as important or essential by at least 80% of participants. These included general adaptations, such as the importance of mood stability and preparation, and phase-specific adaptations, including an emphasis on emotional safety.

Conclusions: Study outcomes indicate the importance of ensuring client stability during EMDR treatment, considering the potential fluctuations in affective symptoms. They also emphasise the need for further guidance and training for practitioners in adapting trauma-focused EMDR for individuals with bipolar disorder.

Keywords: Bipolar disorder, Delphi survey, Eye movement desensitisation and reprocessing, Posttraumatic stress disorder, Trauma-focused therapy

2.2 Introduction

Bipolar disorder is a chronic, recurrent mental health condition that affects 2% of the adult population (Aniserowicz et al., 2022). It is defined by periods of stability interspersed with alternating episodes of depression and mania (Quide et al., 2020). Manic episodes involve elevated mood states, such as euphoria, racing thoughts, reduced sleep, irritability, and impulsive behaviours. Depressive episodes include loss of interest, fatigue, hopelessness, difficulty concentrating, and suicidality (World Health Organisation (WHO), 2022).

Bipolar disorder can be a debilitating condition, which negatively affects psychosocial functioning, quality of sleep, and cognitive abilities. It is one of the ten leading causes of disability worldwide (Grande et al., 2016). Relapse and recurrence rates in bipolar disorder are high (Maj, 2000). There are concerns that the disorder is associated with a reduced life expectancy and an increased risk of premature fatality, particularly among younger males, for whom suicide is the prominent cause of death (Chan et al., 2022).

Bipolar disorder is viewed as a complicated, heterogeneous condition, often accompanied by comorbid conditions, which negatively impact both the short-term treatment responses and long-term progression of the disorder (McIntyre et al., 2004). The most common mental health challenges that co-occur with bipolar disorder are posttraumatic stress disorder (PTSD), substance use, and behavioural and anxiety disorders (Spoorthy et al., 2019). The presence of these conditions leads to poorer outcomes and a lower quality of life (Maina et al., 2011). Bipolar disorder impairs social functioning, resulting in disrupted interpersonal relationships, reduced social interactions, and increased feelings of isolation (Bauwens et al., 1998).

2.2.1 Bipolar Disorder and PTSD

PTSD develops when someone experiences or witnesses an event where there is a perceived threat to life or physical well-being and safety. These experiences result in feelings of terror, fear, or helplessness (American Psychiatric Association (APA), 2013). PTSD is

characterised by avoidance, negative changes in mood and thought processes, intrusive and repetitive symptoms; and hyperarousal (APA, 2013).

As many as 60% of individuals with a diagnosis of bipolar disorder have experienced traumatic events (Bedeschi, 2018). The comorbidity of PTSD has been reported in 16 to 39% of individuals with bipolar disorder (Otto et al., 2004); however, prevalence rates are difficult to estimate precisely due to diagnostic overshadowing and the lack of validated tools. Other studies have indicated that this comorbidity rate may surpass 50%, influenced by multiple factors, such as increased exposure to traumatic events through childhood abuse and neglect, higher rates of risk-taking behaviours and involuntary hospitalisations (Katz et al., 2020). Additionally, traumatic experiences may act as an underlying cause in the development of both PTSD and bipolar disorder (Russell et al., 2024).

Many studies have led to the hypothesis of a causal link between childhood trauma and bipolar disorder (Misiak et al., 2018). Bortolato et al. (2017) argue that experiencing childhood adversities is one of the most substantial risk factors for the development of the disorder. Palmier-Claus et al. (2016) showed that individuals with bipolar disorder are 2.6 times more likely to encounter childhood adversity when compared to a non-clinical control group with no premorbid diagnoses.

Agnew-Blais and Danese (2016) found that trauma in individuals with bipolar disorder (without a formal PTSD diagnosis) was associated with more severe symptoms and a higher frequency of manic episodes. Goodman et al. (2001) highlight the significance of dealing with adverse events in bipolar disorder, as comorbid PTSD is associated with more depressive and (hypo)manic symptoms in comparison to individuals without PTSD.

Conversely, symptoms displayed during manic episodes can lead individuals to engage in risk-taking behaviours, which increases the possibility of experiencing more traumatic events and heightens the risk of further developing PTSD (Otto et al., 2004).

2.2.2 Evidence-Based Psychological Interventions for PTSD

The National Institute for Health and Care Excellence (NICE) recommends both cognitive behavioural therapy (CBT) and eye movement desensitisation and reprocessing (EMDR) as first-line, evidenced-based psychotherapies for the treatment of PTSD in children and adults (NICE, 2018). A previous meta-analysis, which consisted of 90 trials and a total of 6560 participants, demonstrated that both trauma-focused CBT (TF-CBT) and EMDR were the most effective treatments for improving remission rates and symptom reduction in adults with PTSD (Mavranezouli et al., 2020).

However, the effectiveness of CBT in targeting trauma in individuals with bipolar disorder is unclear. Concerns have been raised about sustaining mood stability during CBT trauma-focused treatment, with the recognition of the need for additional safeguards that support mood-regulation skills within treatment (Otto et al., 2004).

EMDR is an integrative therapeutic approach that is piloted by the adaptive information processing model (AIP). The AIP model proposes that adverse events trigger upsetting memories that lead to current struggles. These memories are inadequately processed and are stored in the brain in a disorganised way (Perlini et al., 2020). Dual attention bilateral stimulation (BLMs) is then used to desensitise distress and process these memories, resulting in memory reconsolidation (Laliotis et al., 2021). The EMDR standard protocol consists of eight phases (see Appendix D), with each session lasting between 60 to 90 minutes. The duration of treatment varies depending on the nature of symptoms being treated.

2.2.3 EMDR and Bipolar Disorder

In consideration of the high rates of comorbid PTSD and the detrimental consequences of this comorbidity, bipolar disorder presents as a strong candidate for EMDR treatment (Perlini et al., 2020; Quarantini et al., 2010).

EMDR is a psychotherapy that can be adapted to support idiosyncratic presentations. It could be particularly supportive for individuals with bipolar disorder, as it targets negative

symptoms, improves emotional regulation, and reduces trauma symptoms related to past events, while also processing current environmental stressors (Shapiro, 2001). Although still limited, emerging evidence suggests that EMDR can be a safe treatment for bipolar disorder, addressing both trauma symptoms and affective subsyndromal symptoms (Novo et al., 2014).

Amann et al. (2015) have argued that EMDR acts as a psychotherapeutic mood stabiliser strengthening positive resources through bilateral stimulation. As a result, it may be highly beneficial for individuals with bipolar disorder who struggle with severe mood dysregulation and require additional stabilisation in order to engage in trauma-focused treatment. However, further research is required to examine the potential of EMDR as a mood-stabilising intervention for individuals living with bipolar disorder (Valiente-Gomez et al., 2019).

Currently, only three studies have examined the effectiveness of EMDR on trauma symptoms in bipolar disorder (Appendix E). This includes a case study by Oh and Kim (2014), where two people with bipolar disorder and comorbid PTSD received 9 and 10 weekly sessions of Shapiro's (1989) standard EMDR protocol. After treatment both individuals experienced remission, which was maintained at a 1-year follow-up. The second study is a randomised controlled pilot study by Novo et al. (2014), that compared EMDR with treatment as usual (TAU). In the EMDR group, 10 participants with subsyndromal affective symptoms received 14 to 18 sessions of the standard protocol and displayed positive improvements in hypomania, depression, and trauma-related symptoms, in comparison to the TAU group.

Hogg et al. (2024) conducted a randomised controlled trial to investigate the effectiveness of EMDR versus supportive therapy as an adjunctive treatment for individuals with bipolar disorder and comorbid trauma. EMDR treatment lasted for 20 weeks and included the EMDR bipolar protocol (Amann et al., 2015), which consisted of five supplementary bipolar disorder-specific subprotocols for mood stabilisation, treatment adherence, illness awareness, detection of prodromal symptoms and de-idealisation of

manic symptoms (Hogg et al., 2024). The results showed a reduction in trauma-related symptoms in both groups. The EMDR protocol for bipolar did offer evidence advocating the tolerability and safety of trauma-focused EMDR in individuals with bipolar disorder (Hogg et al., 2024). However, the trial did not clearly show a benefit of EMDR over supportive therapy, which raises questions about the effectiveness of the bipolar disorder-specific protocol and if its inclusion dilutes the core aspects of EMDR and reduces its impact on trauma-related symptoms.

It could also be argued that the bipolar disorder-specific protocol is unnecessary, and treatment should adhere to NICE-recommended evidence-based approaches, like Shapiro's EMDR standard eight-phase protocol, while incorporating practitioner-recommended bipolar disorder-specific adaptations.

Richardson and Amann (2024) propose that trauma-focused approaches for individuals with bipolar disorder should include adaptations to treatment plans that consider current mood states through mood monitoring, stabilisation strategies, a review of hypo(manic) symptoms, a focus on relapse prevention, and the development of self-efficacy. Whilst these suggestions are helpful, a clear gap remains in the evidence base, and no study has systematically collected expert opinions to generate a comprehensive set of both general and phase-specific recommendations.

2.2.4 Study Objectives

The comorbidity of PTSD and bipolar disorder is high, and there is limited guidance on the use of EMDR in the treatment of traumatic stress in bipolar disorder, making the development of treatment guidelines a priority. Establishing a consensus among expert EMDR practitioners could enhance treatment accessibility, improve treatment compliance, reduce the risk of relapse, and provide recommendations that can be used in future trials (Taylor et al., 2020).

This study aimed to establish a consensus among EMDR practitioners on two key areas: (1) adaptations to EMDR that are important when treating trauma in individuals with

bipolar disorder, to improve treatment accessibility and effectiveness, and (2) recommendations for EMDR supervision for practitioners working with this population.

2.3 Methods

2.3.1 Design

This study adopted Delphi survey methodology, an iterative process that is advantageous when collecting perceptions and generating consensus from a group of experts about under-researched topics through repeated surveys (Diamond et al., 2014). Each survey asks participants to rate the extent to which they endorse a list of created statements. If consensus is not agreed, these items are re-rated in the next round of the survey (Langlands et al., 2008).

We established expert consensus through three rounds of online surveys, with the aim of reducing participant burden and encouraging active involvement (Spain & Happe, 2020). Delphi surveys are efficient and constructed to support anonymity, as combined responses are circulated with participants. Conducted online, they have the potential for a wider sampling frame (Spain et al., 2023).

This study and the approach followed the methods of previously completed studies that incorporated Delphi designs (Langlands et al., 2008), some of which explored adaptations to psychological therapies, including EMDR, for particular clinical populations (Fisher et al., 2023; Spain et al., 2023).

2.3.2 Ethical Approval

Ethical approval was granted by the University of Southampton Research Ethics Committee (UREC; ERGO 91294.A1, Appendix F).

Participants were fully informed about all aspects of the study through a participant information sheet, which included full details about the study process, confidentiality, data collection, signposting, and information about the dissemination of the findings (Appendix G). Participants gave their informed consent, which was obtained through the online survey platform Qualtrics, and a full debrief was provided (Appendix H).

2.3.3 Participants

2.3.3.1 Inclusion criteria

Participants were included if they were: (1) EMDR practitioners currently working in any setting, with any population, and based in any country; (2) any experience (limited through to advanced ability) of using EMDR with trauma and/or PTSD; (3) experiences of working with individuals with bipolar disorder using any therapeutic intervention; (4) proficient in English. We collected basic demographic information about professional roles, clinical settings, and experiences of trauma and bipolar disorder cases. Due to the nature of the study aims, other personal characteristics (e.g. gender, age) were not collected.

2.3.3.2 Recruitment

We recruited participants using convenience sampling methods. Recruitment was conducted through snowballing, forums, social media, clinical academic networks such as EMDR Association UK, EMDR Europe, regional associations, and the International Society for Bipolar Disorders Psychological Therapies Task Force. An advertising poster for the study was developed to facilitate the recruitment process (Appendix I). After round 1, no further participants were accepted into the study, so only those who participated in the first round were invited to take part in subsequent rounds.

2.3.4 Survey Development

The Delphi methodology and survey development process were conducted with guidance from several researchers and supervisors with complementary expertise in research methods and experience.

2.3.4.1 Usability Testing/Community Involvement

Initial piloting of the survey was conducted through patient and public involvement (PPI). Four EMDR practitioners and one expert with lived experience (with a diagnosis of bipolar disorder and had engaged in EMDR therapy for trauma-related difficulties) provided informal feedback on the study's scope and aims, the survey content and potential barriers to

trauma-focused therapies. PPI involvement helped shape the first survey through reflections on ethical considerations, ensuring feasibility and engagement, and refining the survey focus.

2.3.4.2 Round 1 Survey

The first survey (Appendix J) contained three sections: (1) demographic Information (e.g., profession, work setting, experience of providing EMDR therapy, supporting clients with bipolar and trauma and training); (2) proposed barriers affecting EMDR accessibility and efficacy, along with general and phase-specific adaptations used to overcome those barriers; (3) considerations for EMDR supervision with trauma-focused approaches in bipolar disorder.

2.3.4.3 Round 2 Survey

The round 2 survey included 131 statements from the thematic analysis of the round 1 survey (Appendix K). These statements consisted of: (1) 30 general adaptations; (2) 82 phase-specific adaptations; and (3) 19 considerations for clinical supervision.

2.3.4.4 Round 3 Survey

A total of 27 statements were re-rated in the round 3 survey (Appendix L): (1) six regarding general adaptations, (2) 18 that were phase-specific, and (3) three concerning clinical supervision.

2.3.4.5 Measurement Scale

In accordance with established guidelines for Delphi surveys, general and phase-specific statements in the round 2 and 3 surveys, were subject to ratings on a 5-point Likert scale (Langlands et al., 2008). Supervision statements were subject to a newly developed Likert scale from Fisher et al. (2023) as this aligned more effectively with the statements. Both rating scales are outlined in Table 7.

2.3.6 Procedure

The study was conducted between July 2024 and December 2024, which is a recommended optimal period for full data collection within the Delphi methodology (Iqbal &

Pipon-Young, 2009). Surveys were retrieved through Qualtrics and constructed in a consistent style, starting with demographic questions, followed by more specialised qualitative questions (round 1) and quantitative statements (round 2 and 3). Each round also provided free text options (Fisher et al., 2023).

Table 7

Survey Statement Measurement Scales

Adaptations to EMDR	Considerations for supervision
1. Essential	1. This is essential for all
2. Important	2. This is important
3. Don't know/depends	3. This could be useful, depending on the client group
4. Unimportant	4. This is not important
5. Should not be included	5. This is actively unhelpful

Note. EMDR= eye movement desensitisation and reprocessing

2.3.8 Data Analysis

Data analysis was conducted using a mixed-methods approach. We summarised the demographic characteristics of participants using descriptive statistics.

2.3.8.1 Thematic Analysis (Statement Generation)

Thematic analysis (Braun & Clarke, 2021) was conducted on the participants' free text comments from round 1, to establish statements for the round 2 survey.

A step-by-step reflexive thematic analysis approach was employed, utilising both inductive and deductive processes, and was conducted using NVivo software. Data was coded and clustered into themes. (1) general adaptations to EMDR, (2) phase-specific adaptations, and (3) considerations for clinical supervision. Sub-themes were identified within each main theme. These themes are depicted in a thematic map in Figure 2. Additionally, we created a map for coding that incorporated reflections to support the process of thematic analysis (Appendix M).

Independent reviews of the participants' responses were completed by two members of the research team, who then agreed on assigned codes and overarching main theme names.

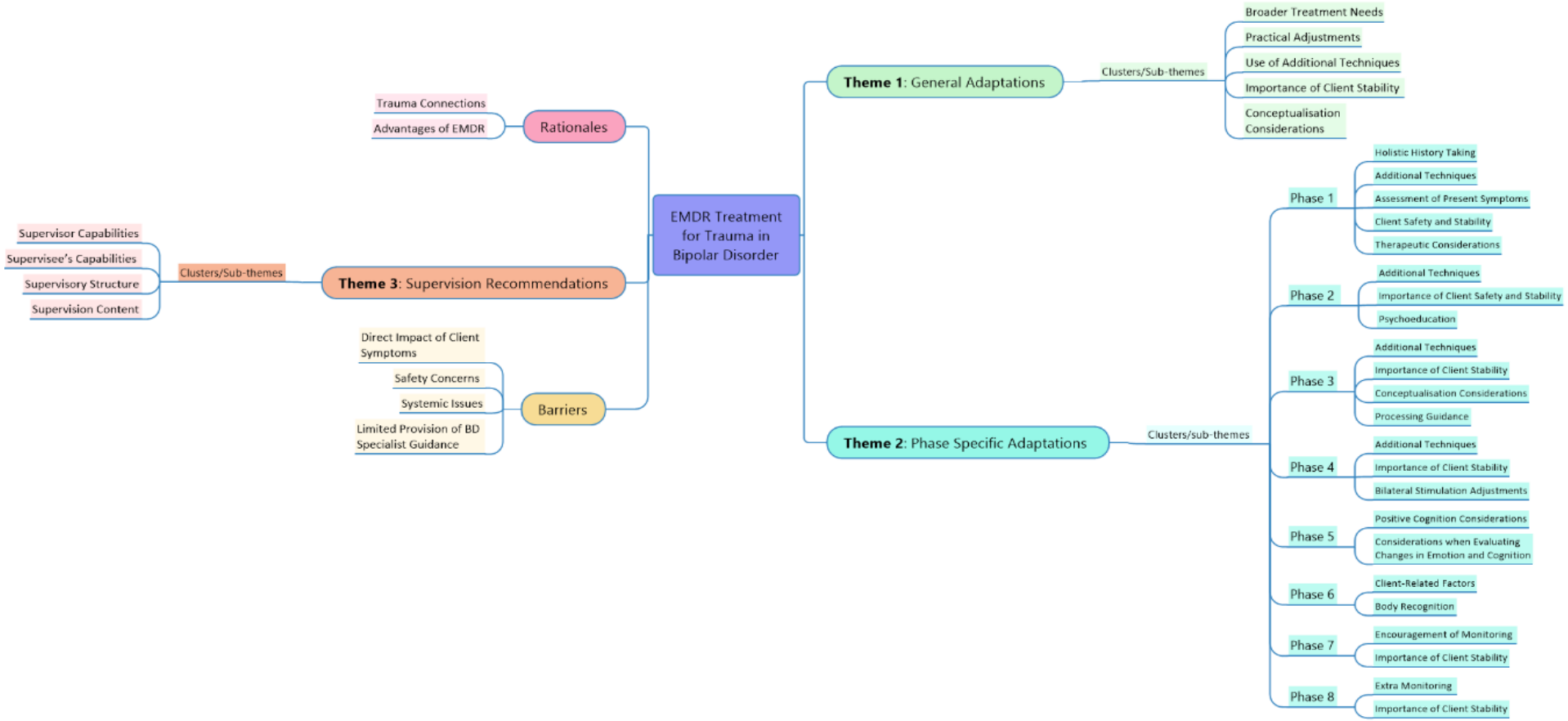
This study was shaped by a pragmatic epistemological approach (Feilzer, 2020), drawing on interpretivist principles through Braun and Clarke's (2021) reflexive thematic analysis. The aim was to develop a practical, consensus-based understanding by combining participant opinions and structured response scales, through the integration of both qualitative and quantitative methodologies.

Reflexivity was a fundamental part of the thematic analysis to enable transparency and self-awareness of positionality and subjectivity. This perspective was maintained through written reflections that captured key decisions and interpretations during data coding and theme development, consistent with the reflexive approach to thematic analysis (Braun & Clarke, 2021).

2.3.8.2 Quantitative Analysis

For rounds 2 and 3, we calculated the percentage of participants who rated each statement in the same way to attain group consensus. Langlands et al. (2008) provided the guidelines used to determine the criteria for determining consensus: (1) statements rated as essential or important on the Likert scales by approximately 80% or more, were classified as fundamental components of EMDR; (2) statements rated as essential or important with 60 to 79% of respondents agreeing were re-assessed in round 3; and (3) statements with less than 60% agreement were excluded.

Figure 2 *Thematic Map*



2.4 Results

2.4.1 Participant Demographics

Thirty-four participants completed the round 1 survey (Table 8). They reported a range of professional backgrounds and worked across various healthcare settings.

Participants had between less than one and 15+ years of EMDR experience, with a mean of 7.11 years (SD = 4.82). The majority of participants were accredited EMDR practitioners (47%), and 38% of participants had between 5 and 9 years of EMDR experience. Nearly half of the participants (44%) had worked therapeutically with 10 or more individuals with bipolar disorder; additionally, 67.6% (*n* = 23) had used EMDR with an individual with bipolar disorder before, and 64.7% (*n* = 22) had used EMDR to treat trauma in bipolar disorder. Regarding training, 41.2% (*n* = 14) had received training in trauma work for bipolar disorder, while only 5.9% (*n* = 2) had received training on EMDR trauma-focused treatment with bipolar disorder specifically.

2.4.2 Round 1

Rationales for utilising EMDR in treating trauma in individuals with bipolar disorder (Appendix N).

Participants identified two main rationales:

(1) *Trauma connections*: Participants' responses emphasised that trauma can be an underlying cause of bipolar disorder and may contribute to the development of this condition, and treating trauma could help a person develop more effective strategies for managing triggers and help stabilise mood fluctuations.

(2) *Advantages of EMDR*: Many benefits of EMDR treatment were acknowledged, including it being an evidenced-based intervention for trauma. Research supports its effectiveness and the EMDR protocol can be adapted to meet the individual's needs and specific presentation. Practitioners also reported positive experiences when using EMDR for trauma with this population.

Table 8

Participant Demographics

	Round 1 (*n*= 34)	Round 2 (*n*= 22)	Round 3 (*n*= 20)
Profession:			
Psychologist (clinical, health, counsellor)	15 (44.1%)	11 (50%)	11 (55%)
Psychiatrist	4 (11.8%)	2 (9.1%)	1 (5%)
Psychotherapist (systemic, trauma, cognitive behavioural, psychosexual)	9 (26.5%)	7 (31.8%)	8 (40%)
Counsellor	3 (8.8%)	1 (4.5%)	-
Nurse	2 (5.9%)	1 (4.5%)	-
Social Worker	1 (2.9%)	-	-
Population worked with:			
Children and Adolescents	6 (17.6%)	1 (4.6%)	1 (5%)
Adolescents and Adults	1 (2.9%)	5 (22.7%)	4 (20%)
Adults	27 (79.4%)	16 (72.7%)	15 (75%)
EMDR Training:			
Not yet finished basic training	2 (5.9%)	-	-
Basic adult training	16 (47.1%)	7 (31.8%)	6 (30%)
Both basic adult and child training	1 (2.9%)	1 (4.6%)	1 (5%)
Accredited EMDR Practitioner	9 (26.5%)	8 (36.4%)	6 (30%)
Accredited EMDR Consultant	6 (17.6%)	6 (27.3%)	7 (35%)
Years of experience providing EMDR:			
Less than a year	2 (5.9%)	-	-
1-4	10 (29.4%)	6 (27.3%)	5 (25%)
5-9	13 (38.2%)	8 (36.4%)	8 (40%)
10-14	6 (17.6%)	5 (22.7%)	5 (25%)
15-20	3 (8.8%)	3 (13.6%)	2 (10%)
Number of cases treating someone with bipolar disorder using any therapy:			
1-2	6 (17.6%)		
3-5	8 (23.5%)		
6-10	5 (14.7%)		
10+	15 (44.1%)		
Number of cases treating trauma with someone with bipolar disorder:			
0	7 (20.6%)		
1-2	6 (17.6%)		
3-5	5 (14.7%)		
6-10	6 (17.6%)		
10+	10 (29.4%)		
Number of cases using EMDR with someone with bipolar disorder:			
0	11 (32.4%)	4 (18.2%)	4 (20%)
1-2	6 (17.6%)	4 (18.2%)	4 (20%)
3-5	10 (29.4%)	7 (31.8%)	7 (35%)
6-10	2 (5.9%)	4 (18.2%)	2 (10%)
10+	5 (14.7%)	3 (13.6%)	3 (15%)

	Round 1 (*n*= 34)	Round 2 (*n*= 22)	Round 3 (*n*= 20)
Number of cases using EMDR to treat trauma with someone with bipolar disorder:			
0	12 (35.3%)	6 (27.3%)	5 (25%)
1-2	4 (11.8%)	4 (18.2%)	4 (20%)
3-5	12 (35.3%)	7 (31.8%)	7 (35%)
6-10	3 (8.8%)	2 (9.1%)	2 (10%)
10+	3 (8.8%)	3 (13.6%)	2 (10%)

Note. *n*= number; EMDR= eye movement desensitisation and reprocessing

Barriers to the efficacy and accessibility of EMDR treatment for trauma in individuals with bipolar disorder (Appendix N).

The analysis revealed that the reported barriers could be grouped into four main categories:

(1) *Client attributes*: The direct impact of client symptoms, such as inconsistency in attending therapy, mood fluctuations, and levels of dissociation, can hinder processing and impair cognition, which reduces capacity for reprocessing. Additionally, the presence of manic and depressive symptoms can reduce treatment efficacy.

(2) *Safety concerns*: Apprehensions about the potential negative consequences of EMDR, such as the possibility that trauma therapy might trigger a manic, depressive, or psychotic episode, which could worsen the client's disorder and heighten risk and safety concerns during treatment.

(3) *Systemic issues*: Inflexible care pathways, including barriers existing within a service's care structure and restrictions on access to therapy due to a bipolar disorder diagnosis.

(4) *Limited provision of bipolar disorder specialist guidance*: Emphasis on the biomedical model and pharmaceutical treatment, which restricts access to psychological therapy, alongside a lack of evidence and guidance to determine the efficacy of EMDR treatment for this population.

EMDR adaptations for trauma-focused treatment in bipolar disorder: Participants reported various adaptations that could be used to overcome these barriers, which were

integrated through thematic analysis for the statements in the round 2 survey (Table 9 and 10).

2.4.3 Round 2

Twenty-two participants took part in round 2 (64.7% retention rate). A total of 131 statements were included in the survey, and 71 statements were rated as aspects of EMDR that at least 80% of practitioners considered as essential or important (Table 9). Furthermore, a minimum of 80% of respondents identified 15 factors of EMDR supervision as essential or important (Table 10).

Of the original 131 recommended adaptations, 24 items were excluded at this stage for not reaching a consensus of 60%. Additionally, 27 statements lacked clarity in placement, as 60 to 79% of participants rated them as essential or important or don’t know/depends.

The round 3 survey re-rated these statements to achieve a comprehensive consensus (Langlands et al., 2008). These statements are indicated with an asterisk in Tables 9 and 10, and in Appendix O.

Table 9

Aspects of EMDR that ≥80% of Practitioners Place as 'Essential or Important'

	% of participants agreeing items 1–2
General Adaptations to EMDR	
Follow usual trauma work considerations, (window of tolerance)	96
Review if this is an appropriate time for treatment (e.g., not at a time of extreme mood/mania)	100
Give reminders of ability to say or signal stop	87
Offer thorough psychoeducation about EMDR protocol	100
Check that the person's mood is stable enough to continue with therapy	91
Increase responsiveness to any signs of mood relapse	91
Reinforce client stability before processing	91
Develop strategies to manage variations in client's mood	91
Build strength through resourcing	96
Develop a clear safety plan with the client in case of relapse	91
Make sure the client has a network of support around them	91
Create awareness about dissociation to help with stability	100
Develop a relapse plan for bipolar symptoms	82
Empower the client to report any difficulties with symptoms that they may experience during therapy	100
Develop thorough assessment and preparation phases before processing	91
Develop a robust, collaborative formulation of the trauma memory networks underlying the client's experiences of going high and feeling low	87
** Use a combination of psychological therapies to help mood variations	90
Phase 1: Client History/Treatment Planning	
Thorough history taking of client and their presentation, including links to historic and present trauma	91
Capture a detailed biographical timeline that encompasses all client history	86
Attention to periods of stability and instability in client history	100
Understand the links between bipolar history with trauma history	95
Identify the trauma memory networks underlying going high and feeling low	87
Assess client's view on relationship between trauma and bipolar symptoms	96
Develop clarity on what symptoms are being treated	91
Identify signs of an acute episode (relapse signature)	96
Review links between trauma and psychotic symptoms	87
Complete an in-depth risk assessment	91
Review what support networks they have available	96
Review impact of medication (past and current)	91
Review client's safety and establish relapse plan	91
Assess if the client is stable enough to proceed with therapy	100
Clarify that client has coping strategies in place to help with mood variations	96
Clearer focus on expectations	91
**Ensure client can access an image that provokes calmness	90
** Offer psychoeducation on bipolar disorder	90
Phase 2: Preparation Stage	
Incorporate emotional regulation and distress tolerance skills	82
Encourage client to monitor their moods	96
Have more awareness of relapse indicators	95
Develop more somatic resources for increasing the window of tolerance.	82

	% of participants agreeing items 1–2
Complete thorough resourcing by using attachment informed figures and client's own abilities to resource.	86
Develop clear safety plan that highlights relapse indicators	86
Include safe place protocol	95
Establish trust between therapist and client	100
Use standard protocol stability tools (container, calm place).	91
Discuss with client the consequences of potential reprocessing	100
** Install protective, compassionate, wise figures/ (attachment focused EMDR)	80
Phase 3: Assessment Phase	
Develop a clear formulation that considers the client's elated and low mood patterns	95
Identify aspects that may trigger abreactions.	82
Have strategies in place to deal with abreactions	95
Offer a clear explanation of case conceptualisation beforehand	91
Look for similar themes in traumatic events	100
Identifying realistic cognitions (negative and positive) and deeper beliefs	95
Ensure the client can feel the disturbance in their body.	82
** Have additional resources in place	80
Phase 4: Desensitisation	
Making sure that the client is able to engage within this phase before proceeding	95
Complete regular check-in's	100
Clarify client preference around BLS	100
Phase 5: Installation	
Make sure positive cognition is realistic and not overly grandiose	96
Encourage a PC that welcomes neutral acceptance	91
Be flexible in the approach to reduction of SUDs ratings, as you may not get them down to zero	82
Phase 6: Body Scan	
When clients need to pay attention to their bodies, find a way that makes them more comfortable.	91
Evaluate the impact of any hallucinatory experiences if they are present.	96
Develop clearer ways to recognise change within a client's body	91
Make sure body scan is linked to target not general sensitivity	91
Phase 7: Closure	
Closely monitor client's wellbeing in between sessions	86
Encourage client to make contact if they experience heightened symptoms that make them feel unsafe	86
Normalise any disturbance if it should occur	91
Phase 8: Re-evaluation	
Complete regular check-ins for client's wellbeing	100
Increase the client's awareness of potential relapse warning signs	95
Have additional time for grounding at end of the session	82
Have agreed measurement tools to monitor the client's mood levels	81

Note. **Item was re-rated in round 3, EMDR= eye movement desensitisation and reprocessing, BLS= bilateral stimulation, SUDS= subjective units of distress scale, PC= positive cognition

Table 10

Aspects of EMDR Supervision Considered 'Essential or Important' by ≥80% of Practitioners

	% of participants agreeing items 1–2
Supervisor should have knowledge and understanding of bipolar disorder	95
Supervisor should have knowledge of what specific adaptations of EMDR to use when working with dissociation	86
Supervisee understands bipolar psychiatric treatment	91
Supervisee has good engagement skills	100
Supervisee has an understanding of bipolar	95
There should be time to review the skills that are needed by the supervisee when working with trauma and bipolar	91
There needs to be regular updates on client progress (mood and trauma symptoms)	82
Spend time reflecting on client formulation, which accounts for the complexity of both bipolar disorder and trauma	95
Focus on client safety throughout	95
Spend time discussing the aspects of the 'reprocessing' of traumatic events	82
Focus on supervising client stability throughout treatment	95
Spent time discussing skillful ways to stop or pause treatment if therapy is causing adverse reactions	91
Move away from the medical model and medicalised language in supervision	100
There should be time to reflect on recent research and developments in clinical practice for bipolar and dissociation	82
**There should be time to review supervisee's competence to work with bipolar disorder	90

Note. ** statements were re-rated in round 3.

2.4.4 Round 3

A total of 20 participants took part in the round 3 survey (58.8% retention rate from round 1). Of the 27 statements that were re-rated, six reached consensus with over 80% rating them as essential or important, while 21 statements did not reach consensus and were excluded. Appendix O provides an overview of all the statements that did not reach consensus or were excluded throughout the analysis.

In the round 3 survey, an additional question was included asking participants to indicate why they had selected 'don't know/depends'. The aim was to gain a better understanding of the decision-making process and the reasons behind these ratings (Table 11).

Table 11

Reasons for Selecting the Option 'Don't Know/Depends'.

Reasons	Number of responses
Depends on the individual and their presentation	18
Depends on the needs of the client	18
Confidence in modifying EMDR protocols	9
Lack of training in specific techniques	7
Less awareness of the research evidence base for bipolar disorder treatment	6
Amount of experience working with bipolar disorder presentations	4
Concerns about risk	4
Service restrictions	4
Preference for particular protocols	3

Note. EMDR= eye movement desensitisation and reprocessing

2.4.5 Summary of Results

Collectively, 71 statements related to EMDR adaptations in the treatment of trauma in bipolar disorder were rated as essential or important (17 general and 54 phrase-specific), along with 15 recommendations for supervision (a total of 86 statements). Forty-five statements did not attain a consensus of 80% or more, and there were 14 statements that were rated 'should not be included' in consideration of adaptations (both general and phase-specific) (Appendix P). No statements were rated 'this is actively unhelpful' within the supervision considerations.

2.5 Discussion

This present study aimed to gather practitioners' perspectives on the barriers to accessibility and effectiveness of trauma-focused EMDR for individuals with bipolar disorder, while establishing consensus on key adaptations for optimising treatment for this population and considerations for clinical supervision.

Findings identified four prominent barriers that can affect access to and the effectiveness of trauma-focused EMDR. These barriers include client-related factors,

systemic influences, safety concerns and an acknowledgement of limited guidance. The latter is reflected in the fact that 94.1% of practitioners in this study had not received any EMDR training for treating trauma in individuals with bipolar disorder.

Concerns about increased risk, mania, and worsening the client's condition were all suggested client-related barriers regarding the potential impact of trauma-focused treatment for this population. These concerns suggest that practitioners may have reservations about offering EMDR to this group, which could limit access to therapy (Perlini et al., 2020).

Frueh et al. (2006) explored clinicians' perspectives on trauma-focused treatments for individuals with Serious Mental Illness (SMI). They found several clinician-related barriers, including apprehension about directly addressing trauma with this population and a lack of confidence in their own abilities. Client-related barriers included concerns that clients might become distressed, suicidal, or require psychiatric hospitalisation.

Barriers of misdiagnosis or failure to diagnose exist for bipolar disorder and comorbid PTSD. Many of the presenting symptoms overlap, and individuals may not be receiving the appropriate trauma-informed interventions, which necessitates the need for trauma-informed psychological assessments to enhance the effectiveness of appropriate treatment pathways (Cogan et al., 2021).

Bipolar disorder is a heterogeneous condition, which emerged as a recurring theme throughout our analysis of participants' responses, highlighting the importance of tailoring treatment to each individual.

Consensus among participants indicated that general adaptations focused on the importance of reinforcement of client stability (e.g. through safety and relapse plans, developing strategies to help with mood variations, increasing responsiveness and transparency in symptom acknowledgement, among others), as well as conceptualisation considerations to aid treatment planning. These adaptations are not surprising given the identified characteristics of mood instability associated with a diagnosis of bipolar disorder (Wright et al., 2021).

Participants offered suggestions to make EMDR more effective and accessible for the bipolar population while still adhering to the main function of each phase, and more adaptations were suggested for the initial treatment planning, preparation, and assessment phases (phases 1 to 3), reasons may be linked to the acknowledgement of establishing stability, identifying risk factors and safety planning early in the therapy process, and the need for extended preparation.

Adaptations to the initial phase of history-taking included capturing a detailed biographical timeline that encompasses all client history, with attention to both stable and unstable periods, completion of a thorough assessment of present symptoms, and a focus on client safety and stability.

Recommendations for the preparation phase (phase 2) focused on using additional techniques, which included mood monitoring, emotional regulation, and distress tolerance skills; and highlighted the importance of offering psychoeducation on processing. Additionally, numerous suggestions were made to ensure the safety and stability of the client. Strategies for these purposes included using standard protocol stability tools (e.g., container, safe place) and incorporating somatic and attachment-informed compassionate resourcing

During the assessment phase (phase 3), participants agreed with the continuation of ensuring client stability, particularly with the management of abreactions, and reinforcing and persisting in the building of conceptualisation and processing guidance.

Within the desensitisation phase (phase 4), suggestions were focused on assessing the client's readiness for processing and their preference for bilateral stimulation.

For the installation phase (phase 5), participants recommended positive cognition considerations, such as making sure that they are realistic and not overly grandiose, as well as being flexible with SUDs rating reductions.

The body scan (phase 6) adaptations were targeted at body recognition factors, such as checking that the body scan is linked to the target and not general sensitivity, and the importance of evaluating the impact of any hallucinatory experiences (if present).

The adaptations in the latter phases (closure and re-evaluation) primarily targeted client stability and additional mood monitoring.

The participants' suggestions to include mood monitoring could be based on the recognition that individuals with bipolar disorder need to build their own foundation of autonomy and control in their treatment plans (Miklowitz, 2006).

These consensus findings suggest that trauma-focused EMDR for individuals with bipolar disorder should be empathic, flexible, and responsive to client safety and mood fluctuations. Participants also recommend using a comprehensive formulation to guide decisions about which adaptations to incorporate.

There was strong consensus on the considerations pertaining to supervision, including supervisor capabilities (supervisors should have knowledge and understanding of bipolar disorder) and supervisee capabilities (the supervisee understands bipolar and bipolar psychiatric treatment). Additionally, it was acknowledged that increasing understanding and awareness of comorbid bipolar disorder and trauma presentations enhances clinical skills and increases confidence when working with this population. Other supervisory considerations offered were about supervision content, like the need for regular updates on client progress (mood and trauma symptoms), spending time reflecting on client formulation, and focusing on supervising client stability. Supervision has an important role in ensuring practitioners are equipped to manage the complexities of the disorder alongside comorbid trauma in EMDR treatment.

Although there has been some recognition of the need to develop EMDR protocols specifically for bipolar disorder (Amann et al., 2015), consensus was not reached in this study regarding the suggestion to 'use specific EMDR protocols or subprotocols for bipolar disorder', with only 32% endorsing this concept.

Reasons behind this might be attributed to the limited trials on the effectiveness of the protocol (Hogg et al., 2024) and practitioners being unaware that such protocols exist. Furthermore, practitioners might have confidence in Shapiro's (2002) standard EMDR protocol, believing it to be sufficient for this population, and clinical experience has shown they can make necessary adaptations idiosyncratically, resulting in successful treatment.

2.5.1 Limitations

This study has several limitations. The sample size was relatively small (n = 34), and the number of participants decreased across rounds. Therefore, the generalisability of our findings to a larger population of EMDR practitioners may be limited. We also did not conduct subgroup analyses due to sample size restrictions.

All participants had clinical experience of working with individuals with bipolar disorder; however, several reported limited or no experience using EMDR with this population, which may have impacted the findings. Practitioners with more experience might have provided more detailed and specific recommendations.

Finally, we adopted the same rating scales as other Delphi studies (Langlands et al., 2008), including one rating that combined 'don't know' and 'it depends'. By combining two different types of uncertainty statements into one rating, this could be problematic and therefore misleading (Spain & Happé, 2020).

2.5.2 Research Implications

More consensus-based research is needed. This could involve larger Delphi studies with a greater sample of EMDR practitioners. Findings could help provide practitioner training and guidance on the use of EMDR in trauma-focused treatment in bipolar disorder presentations. In addition, further RCT studies comparing the bipolar-specific protocol versus the standardised protocol could help determine which adaptations, if any, are associated with improved outcomes. Future research should also focus on evaluating the impact of proposed adaptations by gaining a clearer insight into how individuals with bipolar disorder perceive and respond to these adaptations.

2.5.3 Conclusion

This study is the first to examine barriers, adaptations, and supervision needs for trauma-focused EMDR in individuals with bipolar disorder. It emphasises how the distinctive features of bipolar disorder (namely, heterogeneity of symptoms, mood instability, and the risk of triggering depressive or manic episodes) can influence EMDR's accessibility and effectiveness. Findings show that systemic inequalities, such as inflexible care pathways and lack of specialised training on bipolar disorder, present distinct challenges for this population and that additional training and skill development are needed in this area.

Consensus on treatment adaptations emphasises the importance of a flexible protocol centred on mood stabilisation and safety. Outcomes indicate that trauma-focused EMDR requires a responsive and adaptable approach, representing a novel and meaningful contribution to trauma-informed care for individuals with bipolar disorder.

Participants acknowledge the benefits of EMDR in treating trauma in individuals with bipolar disorder and agreed that, due to the disorder's heterogeneity, there are times when adapting certain elements of the standardised EMDR protocol is necessary. Being knowledgeable about bipolar disorder presentations and receiving bipolar-specific clinical supervision are also imperative for the intervention's effectiveness.

This study offers practical clinical guidance relevant to co-occurring bipolar disorder and PTSD and highlights both the needs and obstacles faced by individuals with this mental health condition.

In summary, the evidence base for the effectiveness and value of EMDR for trauma-focused work in bipolar disorder needs further development.

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Chapter 3: Bridging Trauma and Stability: The Role of Trauma-Focused Psychological Therapies in Bipolar Disorder

Word Count (excluding references): 2012

3.1 Introduction

The main objective of this chapter is to act as both a conclusion and a conceptual bridge between the first two chapters, bringing together the context, rationales, and reflections that underlie the research presented. My thesis goals was to explore the effectiveness of trauma-focused psychological therapies in bipolar disorder (BD) presentations, identify the specific adaptations necessary when implementing EMDR, and find ways to improve treatment efficacy through the generation of evidence and expert consensus.

In my systematic review, I sought to consolidate evidence from studies that investigated trauma-focused therapies in individuals with bipolar disorder, with the goal of providing a clearer understanding of treatment outcomes. I conducted a descriptive narrative synthesis to determine the levels of effectiveness and found preliminary evidence that trauma-focused psychological therapies, especially eye movement desensitisation and reprocessing (EMDR) (Hogg et al., 2024; Nova et al., 2014; Oh & Kim, 2014) and cognitive behavioural therapy (CBT) (Mueser et al., 2008; Mueser et al., 2015), may be effective in reducing PTSD and trauma-related symptoms for bipolar disorder and in improving secondary outcomes; however, the included studies had many limitations that affect the overall interpretability of the findings.

For my empirical research, I explored how EMDR can be most effectively conducted and adapted for trauma-focused work within bipolar disorder, using the Delphi survey methodology. Study outcomes indicate the importance of maintaining client stability prior to and during EMDR treatment in light of the fluctuations in affective symptoms that can occur in BD and the need for further guidance and training for practitioners in adapting trauma-focused EMDR for individuals with bipolar disorder.

3.2 The Significance of Trauma-focused Therapies in Bipolar Disorder

“Bipolar disorder is a mental health condition that affects a person’s mood, energy, activity, and thought, and is characterised by manic (or hypomanic) and depressive episodes” (World Health Organization (WHO), 2024, para. 1).

Otto et al. (2004) report that PTSD is present in 16 to 39% of individuals with bipolar disorder, with 16% approximately twice the lifetime prevalence of PTSD in the general population. Etain et al. (2008) propose that PTSD comorbidity rates may exceed 50%, and other studies indicate that up to 60% of individuals with bipolar disorder have a history of traumatic events, which is linked to higher relapse rates (Bedeschi, 2018).

Comorbid PTSD is associated with reduced clinical outcomes in BD, such as more suicide attempts, intensified rapid cycling, and a reduced chance of recovery (Quarantini et al., 2010).

To date, bipolar disorder treatment has been prevalent with pharmacological approaches, and advancements in psychological therapies have not yet led to full recovery for some individuals with bipolar disorder, and they continue to endure persistent mood episodes within their presentations (Paykel et al., 2006).

There are several factors that have been identified as reasons why trauma-focused treatments for individuals with bipolar disorder have not been extensively studied. There are complexities within the comorbid presentations, where mood instability in bipolar disorder presentations confuses the ability to isolate the impact of trauma-focused therapies. The diverse treatment needs of this population make it difficult to develop effective treatment protocols, and therapies may need to be adapted to account for emotional instability that is common within BD, and suggested adaptations require further investigation (Otto et al., 2004).

In the UK access to psychological therapies is reportedly unreliable (Richardson et al., 2025). Bipolar UK states that only 69% of individuals with BD had been offered therapy in a National Health Service (NHS) setting, with 29% being told they couldn’t have access (Goodwin et al., 2022).

Trauma-focused therapies are rarely employed for individuals with BD, mainly due to potential barriers including client-related factors and safety concerns. In our empirical study, EMDR practitioners identified barriers that were related to their concerns about increasing a

client's risk and triggering mood instability. These reservations could limit access to trauma therapy for this population (Perlini et al., 2020).

In consideration of these challenges in getting therapy, it has motivated the reasoning for the two studies, with recognition of the need for a stronger evidence base to determine ways to improve the acceptability and efficacy of trauma-focused care for individuals with BD.

3.3 Integrating Findings Across Studies and Wider Literature

Both the review and the empirical study complement each other in that they address specific gaps in the literature for trauma-focused approaches in BD.

To date, there has been no other systematic review that has examined the effectiveness of psychological therapies for PTSD symptoms in individuals with bipolar disorder. This review synthesised data from 11 peer-reviewed papers and found supporting evidence of the value and impact of the included trauma-focused interventions (such as EMDR, CBT, PE, CPT, among others) for individuals with BD. In addition, the therapies examined in this review were found to be well-accepted, feasible, and safe for individuals with bipolar disorder and comorbid PTSD (Katz et al., 2024; Hogg et al., 2024), providing evidence that detracts from the previously noted reservations.

The Delphi study provided insight through the generation of a consensus from EMDR experts on 71 recommendations for both general and phase-specific adaptations for EMDR trauma-focused treatment in BD, something that has not been conducted before. Adaptations focused on thorough history taking while paying attention to periods of mood instability, providing emotional regulation and psychoeducation in the preparation phases, prioritising client stability across all phases, the importance of processing that must be flexible to meet the idiosyncratic presentation of the client, and post-processing monitoring.

Across both studies, EMDR has demonstrated its potential efficacy as a psychotherapy that can help individuals with bipolar disorder to improve their quality of life

through improvements with PTSD reduction and reduced affective symptoms such as depression, anxiety, and mania (Hogg et al., 2024; Novo et al., 2014).

There are emerging hypotheses of EMDR's capabilities beyond trauma processing. Researchers have argued that EMDR may act as a mood stabiliser by strengthening positive resources, such as internal coping mechanisms and self-regulation through bilateral stimulation (Amann et al., 2015), which in turn can be very supportive for individuals with bipolar disorder who need extra stabilisation within their trauma-focused treatments.

EMDR has been reported to improve neurobiological mechanisms. In their case study, Landin-Romero et al. (2013) acknowledge the potential benefits of EMDR treatment for a traumatised bipolar disorder patient, which resulted in improvements in brain functioning, by helping restore the functioning of the default mode network and, as a consequence, reduce negative symptoms of PTSD. Bedeschi (2018) hypothesised that EMDR is able to access neuronal networks, which in turn control and stabilise mood states, which would be very supportive for individuals with BD.

However, Landin-Romero et al. (2013) do recognise that while many studies have tried to provide models or theories towards the explanations of the mechanisms of action in EMDR (psychological; psychophysiological; neurobiological), EMDR is a complex psychotherapy, and so far, no consensus has been reached.

3.4 Reflections and Motivations

There are both professional and personal motivations for conducting these research projects. Why trauma and why bipolar disorder? I have personal family connections in Northern Ireland and have witnessed many family members who have been immersed in transgenerational trauma and have experienced the negative impact this has had on their mental health. Specifically, I have two cousins, one from the Catholic province and one from the Protestant province in Belfast, and both have been given a diagnosis of bipolar disorder, and I have seen them struggle with obtaining appropriate treatments and the lack of trauma-informed care. These personal reflections made me connect the potential complex causal

interaction between childhood maltreatment, environmental factors, and the development of a stress-sensitive illness like bipolar disorder (Levandowski & Grassi-Oliveira, 2018).

Individuals with bipolar disorder often experience early childhood adversities and negative life events (Johnson et al., 2008). Research has shown that childhood trauma is consistently linked to an earlier onset and greater severity of bipolar disorder, and it may increase the likelihood of developing BD.

Conducting research that focused on expanding the knowledge base for trauma-informed psychological approaches in bipolar disorder would, therefore, be highly beneficial.

As an EMDR practitioner and having successfully applied Shapiro's (2001) standard EMDR protocol with over 50 clients, I have developed an appreciation for the effectiveness of EMDR as a trauma intervention.

My interest in Delphi survey methodologies was sparked by my involvement in a previous Delphi study (Fisher et al., 2023), which sought consensus from EMDR therapists on adaptations to improve the acceptability and efficacy of EMDR when working with autistic individuals. I recognised the many benefits of this approach, specifically that you could broaden the evidence on how to optimise under-researched treatment areas by establishing a consensus about what constitutes best practice, which can be built upon with future research and potentially lead towards consolidation as treatment guidelines (Hsu & Sandford, 2007).

Conducting research across both a systematic review and an empirical study at times has been challenging, but overall I feel that I have learnt and developed skills pertaining to time management and rigour, abilities in completing comprehensive literature searches, critical appraisal, and narrative synthesis. The empirical study has taught me about data collection, ethical considerations, the importance of participant involvement and given me an appreciation of mixed-method approaches.

3.5 Future Directions and Dissemination

The findings from these two studies offer insight into the importance of trauma-focused interventions for bipolar disorder. It informs evidence-based practice, supports a more holistic, individualised approach for individuals with comorbid PTSD and BD and highlights that trauma-focused treatments for the BD population are under-researched.

The results show that we need more large-scale RCTs that examine the effectiveness of trauma-focused psychological therapies for individuals with bipolar disorder, with the main aim of developing high-quality trauma-focused treatment pathways. More robust controlled trials will provide more reliable conclusions (Swan et al., 2017). In addition, more consensus-based research is required to determine the recommended adaptations when using trauma-focused EMDR in BD, and there needs to be clearer treatment guidelines to increase the acceptability and treatment efficacy.

Maintaining ongoing stability for individuals with bipolar disorder is essential to preventing reoccurrence; therefore it would be beneficial to investigate the therapy's long-term effects on relapse prevention. Psychotherapy can help individuals to develop strategies to better manage the difficulties associated with the condition and improve their overall quality of life (Lam et al., 2000). Future studies that examine the effectiveness of treatments in relation to chronicity would also be supportive for the bipolar disorder population.

I have written two research papers for this thesis, with the intention of being published in a peer-reviewed journal. Both papers have been written and formatted according to the publishing guidelines of the Journal of Affective Disorders. This journal is interdisciplinary and aims to publish articles that are focused on an array of affective disorders, including mania, depression, anxiety, and bipolar disorder, among many others. Papers are included that focus on any aspect of affective disorders, ranging from neuroimaging to intervention and treatment trials, which makes it an appropriate journal to seek publication for my studies. Additionally, the majority of my included references have been published in this journal, showing that my research is relevant to the interests of the journal and that I am familiar with the journal's previous publications.

For my empirical paper I have asked the EMDR UK Association to present my research as a poster at their annual conference in March 2026, my abstract has already been submitted. I have also been asked by a board member from the association if I could disseminate my empirical study's findings in a continuing professional development (CPD) presentation for the child and adolescent committee next year. My systematic review research has recently been reviewed by the British Association for Behavioural and Cognitive Psychotherapies (BABCP) National Conference Programme Advisory Group and the European Association for Behavioural and Cognitive Therapies (EABCT) Scientific Committee, and it has been accepted for a poster presentation at the 55th EABCT congress in September.

I am hopeful that my thesis findings will be built upon and inspire future research, with the overall aim of developing a model of care that is more trauma responsive for individuals with bipolar disorder and encapsulates stabilisation-focused treatments.

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Appendix A Journal of Affective Disorders: Publishing Guidelines

Which can be found at:
https://www.sciencedirect.com/journal/journal-of-affective-disorders/publish/guide-for-authors

The Journal primarily publishes:

Full-Length Research Papers
(up to 5000 words, excluding references and up to 6 tables/figures)

Review Articles and Meta-analyses
(up to 8000 words, excluding references and up to 10 tables/figures)

Writing and formatting – APA Format

Some guidelines:

Lay out text in a single-column format.

Remove any strikethrough and underlined text from your manuscript, unless it has scientific significance related to your article.

Title page
You are required to include the following details in the title page information:

Article title. Article titles should be concise and informative. Please avoid abbreviations and formulae, where possible, unless they are established and widely understood, e.g., DNA).

Abstract

You are required to provide a concise and factual abstract which does not exceed 250 words. The abstract should briefly state the purpose of your research, principal results, and major conclusions. Some guidelines:

Abstracts must be able to stand alone as abstracts are often presented separately from the article.

Avoid references. If any are essential to include, ensure that you cite the author(s) and year(s).

Avoid non-standard or uncommon abbreviations. If any are essential to include, ensure they are defined within your abstract at first mention.

Keywords

You are required to provide 1 to 7 keywords for indexing purposes. Keywords should be written in English. Please try to avoid keywords consisting of multiple words (using "and" or "of").

Tables

Tables must be submitted as editable text, not as images. Some guidelines:

Place tables next to the relevant text or on a separate page(s) at the end of your article.

Cite all tables in the manuscript text.

Number tables consecutively according to their appearance in the text.

Please provide captions along with the tables.

Place any table notes below the table body.

Avoid vertical rules and shading within table cells.

Figures, images, and artwork

Figures, images, artwork, diagrams, and other graphical media must be supplied as separate files along with the manuscript. We recommend that you read our detailed artwork and media instructions. Some excerpts:

When submitting artwork:

Cite all images in the manuscript text.

Number images according to the sequence they appear within your article.

Submit each image as a separate file using a logical naming convention for your files (for example, Figure_1, Figure_2 etc.).

Please provide captions for all figures, images, and artwork.

Text graphics may be embedded in the text at the appropriate position. If you are working with LaTeX, text graphics may also be embedded in the file.

Figure captions

All images must have a caption. A caption should consist of a brief title (not displayed on the figure itself) and a description of the image. We advise you to keep the amount of text in any image to a minimum, though any symbols and abbreviations used should be explained.

Appendices
We ask you to use the following format for appendices:

Identify individual appendices within your article using the format: A, B, etc.

Give separate numbering to formulae and equations within appendices using formats such as Eq. (A.1), Eq. (A.2), etc. and in subsequent appendices, Eq. (B.1), Eq. (B. 2) etc. In a similar way, give separate numbering to tables and figures using formats such as Table A.1, Fig. A.1, etc.

References
References within text
Any references cited within your article should also be present in your reference list and vice versa. Some guidelines:

References cited in your abstract must be given in full.

We recommend that you do not include unpublished results and personal communications in your reference list, though you may mention them in the text of your article.

Any unpublished results and personal communications included in your reference list must follow the standard reference style of the journal. In substitution of the publication date add "unpublished results" or "personal communication."

References cited as "in press" imply that the item has been accepted for publication.

Linking to cited sources will increase the discoverability of your research.

Reference style

All citations in the text should refer to:

Single author: the author's name (without initials unless there is ambiguity) and the year of publication.

Two authors: both authors' names and the year of publication.

Three or more authors: first author's name followed by 'et al.' and the year of publication.

Citations can be made directly (or parenthetically). Groups of references can be listed either first alphabetically, then chronologically, or vice versa. Examples: "as demonstrated (Allan, 2020a, 2020b; Allan and Jones, 2019)" or "as demonstrated (Jones, 2019; Allan, 2020). Kramer et al. (2023) have recently shown".

The list of references should be arranged alphabetically and then chronologically if necessary. More than one reference from the same author(s) in the same year must be identified by the letters 'a', 'b', 'c', etc., placed after the year of publication.

Abbreviate journal names according to the List of Title Word Abbreviations (LTWA).

Appendix B Table B.1

Summary of Author Responses to Requests for Bipolar Disorder Data

Authors	Study	Population	Outcome
Clarke et al., 2022	A randomised multiple baseline case series of a novel imagery rescripting protocol for intrusive trauma memories in people with psychosis	Psychosis	No BD sample
Every-Palmer et al., 2024	Eye movement desensitisation and reprocessing (EMDR) therapy compared to usual treatment for posttraumatic stress disorder in adults with psychosis in forensic settings: Randomized controlled trial	Psychosis	Request for payment to run separate analyses on BD population, therefore declined
Fortney et al., 2021	Comparison of tele-integrated care and tele-referral care for treating complex psychiatric disorders in primary care, a pragmatic randomized comparative effectiveness trial	Complex Psychiatric Disorders	Author responded, but we were unable to access data from American depository
Frueh et al., 2009	Exposure-based cognitive-behavioral treatment of PTSD in adults with schizophrenia or schizoaffective disorder: A pilot study	Schizophrenia or Schizoaffective Disorder	No BD sample
Grubaugh et al., 2016	Open trial of exposure therapy for PTSD among patients with SMI	SMI	Requests made to inquire if there were BD related data, no responses received
Lu et al., 2009	Cognitive behavioural treatment of PTSD in severe mental illness: Pilot study replication in an ethnically diverse population	SMI	Requests made to inquire if there were BD related data, no responses received

Authors	Study	Population	Outcome
Mauritz et al., 2022	Investigating the efficacy and experiences with narrative exposure therapy in severe mentally ill patients with comorbid post-traumatic stress disorder receiving flexible assertive community treatment: A mixed methods study	SMI	Data obtained for patients with BD
Mueser et al., 2007	The trauma recovery group: A cognitive-behavioral program for post-traumatic stress disorder in persons with severe mental illness.	SMI	Data was not obtained
Mueser et al., 2008	A randomized controlled trial of cognitive–behavioral treatment for posttraumatic stress disorder in severe mental illness	SMI	Data obtained for patients with BD
Mueser et al., 2015.	Evaluation of cognitive restructuring for post-traumatic stress disorder in people with severe mental illness	SMI	Data obtained for patients with BD
Nishith et al., 2015	A brief intervention for posttraumatic stress disorder in persons with a serious mental illness	SMI	Requests made to inquire if there were BD related data, no responses received
Nishith et al., 2024	Effectiveness of cognitive processing therapy for PTSD in SMI	SMI	Data obtained for patients with BD
Oh and Kim, 2014	Eye movement desensitisation and reprocessing for posttraumatic stress disorder in bipolar disorder	PTSD and BD	Requests for additional data were made, but authors could only provide pre/post PTSD measures
Rosenberg et al., 2004	Cognitive-behavioral treatment of PTSD in severe mental illness: Results of a pilot study	SMI	Requests made to inquire if there were BD related data, no responses received

Authors	Study	Population	Outcome
Sacks et al., 2017	A pilot study of the trauma recovery group for veterans with post-traumatic stress disorder and co-occurring serious mental illness	PTSD - Veterans	Requests made to inquire if there were BD related data, no responses received
Valiente-Gomez et al., 2020	A multicenter phase II RCT to compare the effectiveness of EMDR versus TAU in patients with first episode psychosis and psychological trauma: A protocol design	Psychosis	Request to see if study had been conducted, no response
van den Berg et al., 2015	Prolonged exposure vs eye movement desensitization and reprocessing vs waiting list for posttraumatic stress disorder in patients with a psychotic disorder: A randomized clinical trial	Psychotic Disorder	Requests made to inquire if there were BD related data, no responses received
Varkovitzky et al., 2018	Effectiveness of the unified protocol for transdiagnostic treatment of emotional disorders among veterans with posttraumatic stress disorder: A pilot study	PTSD, Veterans, Emotional Disorders	Requests made to inquire if there were BD related data, no responses received

Note. SMI= serious mental illness

Appendix C Table B.1

PTSD Measures

No of Studies	PTSD Outcome Measure	Author	Overview
5	Clinician-Administered PTSD Scale for DSM-IV (CAPS)	Blake et al. (1995)	Diagnostic test to determine current or lifetime PTSD diagnosis
3	Impact of Events Scale-Revised (IES-R)	Weiss (2007)	Assesses trauma symptoms (intrusions, avoidance, hyperarousal) experienced over the last week
2	Dissociative Experiences Scale (DES)	Dubester & Braun (1995)	Measures the presence of dissociative symptoms
4	PTSD Checklist for DSM-5 (PCL-5)	Blevins et al. (2015)	Self-report measure that assesses the severity and presence of PTSD symptoms
3	Clinician-Administered PTSD Scale for DSM-5 (CAPS-5)	Weathers et al. (2018)	To determine existence of PTSD according to the DSM-5
1	The Life Events Checklist for DSM–5	Weather et al. (2013)	Self-report measure that screens for 17 potential traumatic events
2	Posttraumatic Cognitions Inventory (PTCI)	Foa et al. (1999)	Self-report measure that evaluates trauma-related cognitions
2	PTSD Knowledge Test	Pratt et al. (2005)	Checks understanding of PTSD

Note. DSM-IV = Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition; DSM-5 = Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition

Appendix D Table D.1

Eight Phases of EMDR

Phases	Content
Phase 1: History Taking	The first few sessions focus on gathering information about a client's history, assessing readiness for EMDR and identifying targets for treatment. Maladaptive beliefs are also detected.
Phase 2: Preparation	The second phase looks at preparation for processing. The testing of appropriate BLMs, psychoeducation on theory, and checking the client has enough resources for stabilisation (completion of safe place visualisation exercises).
Phase 3: Assessment	An image of the target memory is captured along with associated negative and positive cognitions, affect and body sensation are also identified.
Phase 4: Desensitisation	The client focuses on the target memory whilst following BLMs. New adaptive and resourceful information and insight is reinforced with further sets of BLMs. This discontinues when there is no reported disturbance linked to the memory as measured by subjective units of disturbance rating scale (SUDs).
Phase 5: Installation	This involves the client 'holding together' the target image and the positive cognition with BLMs, with the aim to strengthen and install the positive cognition.
Phase 6: Body Scan	Clients are asked to notice any physical responses when they think of the target image with the positive cognition, this is to identify if any residual somatic distress is present. BLMs are used to process these sensations if any are indicated.
Phase 7: Closure	This ends the session, helping the client return to a calm state in the present moment.
Phase 8: Re-evaluation	The last phase involves re-evaluation of the effects of the previous processing; to determine if treatment gains have been maintained (Shapiro & Maxfield, 2002).

Note. BLM= bilateral stimulation

Appendix E Table E.1

Overview of the Three EMDR Studies that Examined Effectiveness of Trauma-focused Approaches in Bipolar Disorder

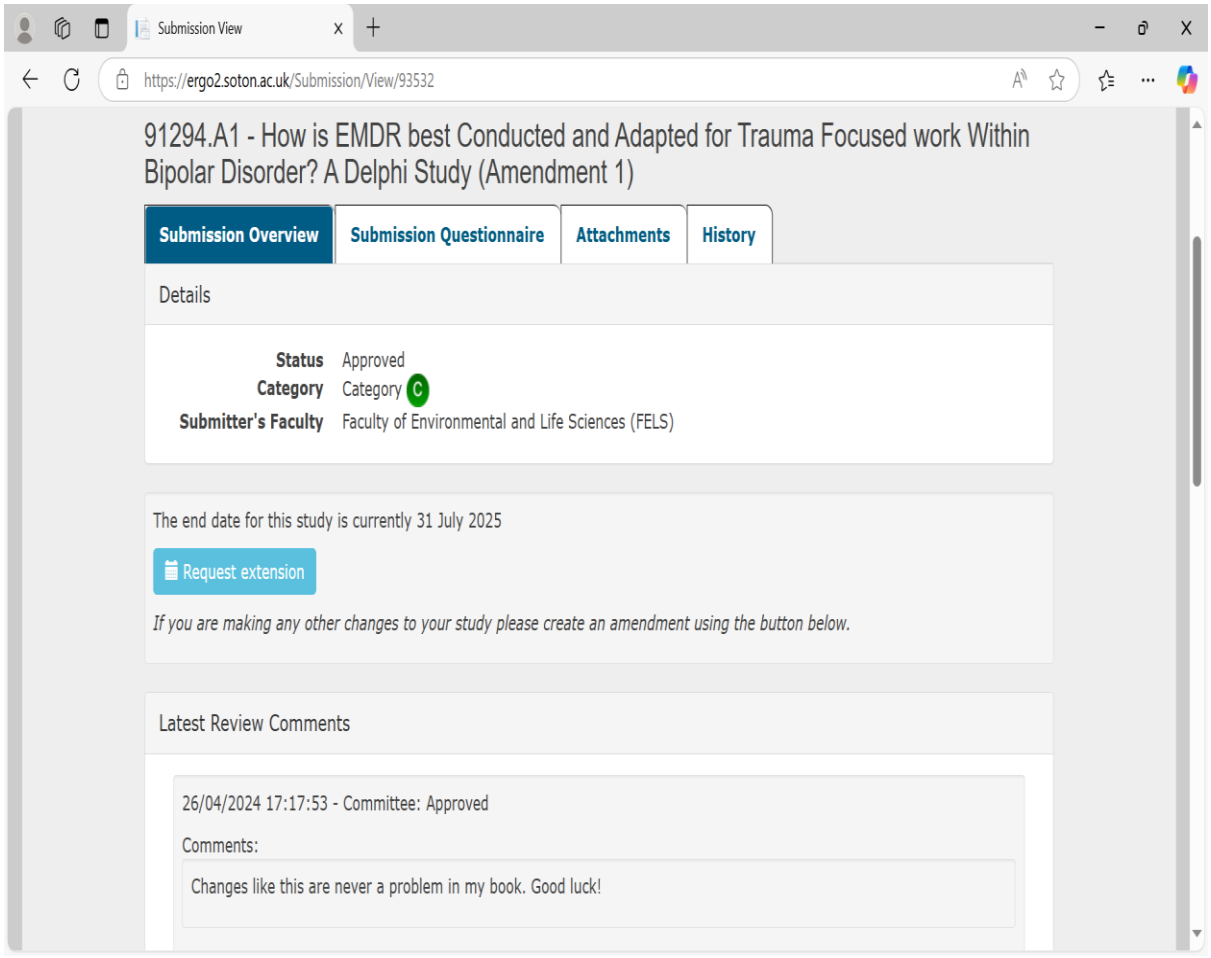
Study	Study Design	Sample Size (*N*)	Participants Characteristics	Inclusion criteria	Exclusion Criteria	Trauma-focused Intervention and Characteristics	Comparison (TAU, wait list, no comparison, alternative)	Length of Treatment	Strengths and Limitations
Hogg et al., (2024)	Randomised Control Trial	77 EMDR - 39 ST - 38	Gender *n* (%): Male: 18 (23.4), Female: 59 (76.6). Mean Age: 46.8 (SD = 8.4) BD Diagnosis *n* (%): BD-I = 56 (72.7) BD-II = 21 (27.3)	(1) age 18 to 65 (2) from two to six affective episodes in the last year (3) present euthymic or subsyndromal symptoms (4) at least one traumatic event (5) BD diagnosis	(1) active substance abuse or not in recovery (2) previous brain injury and/or neurological condition (3) severe suicidal intent (4) engaged in any form of trauma-specific therapy in the last 2 years (5) intends to engage in any form of additional therapy while enrolled in the study	EMDR therapy for BD, including BD-specific subprotocols for mood stabilization, treatment adherence, and trauma processing	Supportive Therapy (ST), offering emotional guidance, attentive listening, and information about BD, excluding trauma processing components	20 weeks both Interventions	Strengths: RCT Vigorous statistical methods Limitations: Lack of generalisability of results to all BD population Lack of blinding for patients

Study	Study Design	Sample Size (*N*)	Participants Characteristics	Inclusion criteria	Exclusion Criteria	Trauma-focused Intervention and Characteristics	Comparison (TAU, wait list, no comparison, alternative)	Length of Treatment	Strengths and Limitations
Novo et al., (2014)	Single-blind randomised controlled pilot study	20 EMDR: 10 TAU: 10	Gender *n* (%): EMDR Group: Male: 3 (30), Female: 7 (70). Mean Age: 43.90 (SD = 6.87) TAU Group: Male: 5 (50), Female: 5 (50). Mean Age: 44.80 (SD = 6.86)	BD with subsyndromal affective symptoms Constant amounts of mood-stabiliser for a minimum of 3 months Experienced at least three traumatic events over their lifetimes	(1) history of neurological disease (2) substance misuse difficulties (3) suicidality (4) affective episode in the last 3 months (5) previous EMDR therapy (6) Score higher than 25 in the DES	EMDR Followed standard protocol of eight phases, selected main targets for reprocessing, utilised bilateral eye movements to aid processing	Treatment as Usual (TAU) which involved standard outpatient care from treating psychiatrists	12 week sessions Follow-up assessment at 24 weeks	Strengths: RCT Intervention was administered by trained EMDR therapists to ensure high level of fidelity Transparency within reporting methods Limitations Small sample size Lack of comparison to other studies Dropout rates in TAU group

Study	Study Design	Sample Size (*N*)	Participants Characteristics	Inclusion criteria	Exclusion Criteria	Trauma-focused Intervention and Characteristics	Comparison (TAU, wait list, no comparison, alternative)	Length of Treatment	Strengths and Limitations
Oh & Kim (2014)	Case Study	2	25-year-old woman (patient 1) 39-year-old woman (patient 2)	PTSD and BD	Not Applicable	EMDR: the features of EMDR were not mentioned within this study	No comparison	Patient 1 received 10 sessions of EMDR Patient 2 received 9 sessions of EMDR Session Length: 1-1.5 hours per session	Strengths Effective EMDR for treatment of chronic PTSD in patients with BD Limitations No control group Small sample size

Note. BD= bipolar disorder; EMDR= eye movement desensitisation reprocessing; *N*= number; PTSD= posttraumatic stress disorder; ST= supportive therapy

Appendix F Ethical Approval



Appendix G Participant Information Sheet

Study Title: How is EMDR best Conducted and Adapted for Trauma-focused work Within Bipolar Disorder? A Delphi Study

Researcher: Leeanne Nicholls, Dr Thomas Richardson, and Prof. Kim Wright
ERGO number: 91294
Version: 3
Date: 26/04/24

University email(s): l.nicholls@soton.ac.uk
t.h.richardson@soton.ac.uk
k.a.wright@exeter.ac.uk

You are being invited to take part in the above research study. To help you decide whether you would like to take part or not, it is important that you understand why the research is being done and what it will involve.

Please read the information below carefully and ask questions if anything is not clear or you would like more information before you decide to take part in this research. You may like to discuss it with others, but it is up to you to decide whether or not to take part. If you are happy to participate, you will need to add your initials to the boxes below to show your consent.

What is the research about?

I am a Trainee Clinical Psychologist who is completing their doctoral thesis at the University of Southampton. I have a passionate interest in Eye Movement Desensitisation and Reprocessing (EMDR), having previously used this psychotherapy with individuals successfully for the treatment of trauma.

There is emerging evidence that EMDR is a helpful and safe treatment for trauma in bipolar disorder, but there is a clear necessity for further guidance for EMDR practitioners on how to approach the treatment of trauma in bipolar disorder presentations.

The aim of this research is to explore how EMDR as an evidenced based psychotherapy is best conducted and adapted for trauma focused work in a population of individuals who are diagnosed with bipolar disorder.

Through the generation of practitioner perspectives, the current study seeks to explore and expand this knowledge in order to produce a consensus that will guide approaches to trauma work in bipolar disorder.

I aim to get consensus about; barriers that affect EMDR accessibility and efficacy for the treatment of trauma within bipolar disorder, the necessary adaptations that are employed in order to address these barriers and the recommendations that need to be adopted in clinical supervision when using EMDR to treat trauma in bipolar disorder presentations.

Why have I been asked to participate?

You have been asked to participate in this study because you have been identified as meeting the requirements of participation. The requirements are as follows:

- Internationally based EMDR practitioners, who are currently working in any setting.
- You have experience (limited through to advanced proficiency) of using the therapeutic approach of EMDR with trauma and/or PTSD.

- You have experiences of working with the bipolar disorder presentation in any therapeutic modality.
- You are able to read, speak, and comprehend English and will have access to an online device.

This research aims to have at least 100 participants.

What will happen to me if I take part?

Prior to completion of the survey

If you decide that you would like to take part in the research, after you have read this information sheet you will be directed to a consent form where you will be asked to read statements and then add your initials in corresponding boxes.

You will be then asked to provide your email address, this is only for purposes that you can be invited to complete another two online 40 minute surveys within the next 5 months, this will allow the generation of a consensus from the participant's responses. Round one of the survey responses are used to develop the statements of the next survey and so on. Your email address will be stored separately away from your other responses and deleted at the end of the study.

Survey

The survey comprises of different sections looking at: general demographic information, like core profession, work setting, training, and experience of EMDR and supporting clients with bipolar and trauma, rationales for using EMDR, perceived barriers of accessibility and efficacy, adaptations employed in therapy and recommendations for clinical practitioners within supervision when approaching treatment for trauma in bipolar disorder presentations.

On completion of the survey the debrief statement will be shown, including all links to the resources and support services.

Are there any benefits in my taking part?

If you decide to take part in this study, you will not receive any benefits, but your participation will contribute to the expansion of knowledge in this area of research.

It is anticipated that this research through the generation of practitioner's perspectives will form an overall consensus about what constitutes as effective practice in approaches to trauma work in bipolar disorder presentations.

It is hoped that this will lead to further research where findings can be consolidated towards further guidelines for the use and recommended relevant adaptations of the current standard EMDR protocol towards the effective treatment of trauma in individuals with a diagnosis of bipolar disorder.

Are there any risks involved?

There are no direct risks in taking part in this study. However, if taking part in this study has caused you discomfort or distress, you can contact the following organisations for support:

- NHS mental health services (for those in the UK)
- NHS 111 phone service for advice and support (for those in the UK)
- Mental health services - NHS www.nhs.uk Find information, advice, and local services on the NHS website.

- Samaritans (UK and Ireland) www.samaritans.org Available 24 hours a day to provide confidential emotional support for people who are experiencing feelings of distress, despair, or suicidal thoughts.
- 116 123 (free to call from within the UK and Ireland), 24 hours a day
- Bipolar UK https://www.bipolaruk.org/, Email: info@bipolaruk.org
- Mind (UK only) Lines are open Monday to Friday 9am to 6pm (except bank holidays). www.mind.org.uk Email: info@mind.org.uk InfoLine: 0300 123 3393 to call, or text 86463 Mind offers advice, support, and information to people experiencing a mental health difficulty and their family and friends. Mind also has a network of local associations in England and Wales to which people can turn for help and assistance.
- Outside of the UK, you can find information on local mental health support on the following websites:
- https://unitedgmh.org/mental-health-support

What data will be collected?

All data will be collected online and will consist of your responses to questionnaire items.

The online survey tool Qualtrics will be used to collect the data. Your answers will be exported from this software to password-protected files stored on University of Southampton servers. A participant ID will be assigned to you, ensuring that your data remains anonymous during analysis.
Your email address, which is needed for future participation purposes only, will be kept separately in a password protected file away from the information you provide in the survey. Only I will have access to this file.

As per University of Southampton regulations, research data will be kept on the University's networked storage. When being transferred or stored, data will be password- and encryption-protected. It will not be locally stored; instead, it will only be maintained on the university's networks. The GDPR law will be followed when storing and using data.

The research data will be archived in a discipline-specific data repository upon project completion. Following the completion of the study, data will be retained for ten years before being securely destroyed in compliance with our research data management policy.

Will my participation be confidential?

Your participation and the information we collect about you during the course of the research will be kept strictly confidential.

Only members of the research team and responsible members of the University of Southampton may be given access to data about you for monitoring purposes and/or to carry out an audit of the study to ensure that the research is complying with applicable regulations. Individuals from regulatory authorities (people who check that we are conducting the study correctly) may require access to your data. All of these people have a duty to keep your information, as a research participant, strictly confidential.

Your survey responses are securely transferred to a database program that has been authorized by the university. The data will be stored in a password-protected file that only my two supervisors and I can access after it has been uploaded to the database.

Do I have to take part?

No, it is entirely up to you to by completing the consent form after this information sheet.

What happens if I change my mind?

You have the right to change your mind and withdraw at any time without giving a reason and without your participant rights being affected. You can withdraw at any time during the survey up
until you have completed it. You can also decide not to take part in follow-up time points. It is not feasible to remove your participation once the survey has been completed, as the email address you provide is kept apart from the other information you provide.

If you withdraw from the study, we will keep the information about you that we have already obtained for the purposes of achieving the objectives of the study only.

What will happen to the results of the research?

Your personal details will remain strictly confidential. Research findings made available in any reports or publications will not include information that can directly identify you without your specific consent.

As part of the researcher's Doctorate in Clinical Psychology training, the research will be written up in a report and presented at a conference and to a panel of examiners. I also aim to publish this research in a relevant academic journal.

Where can I get more information?

If you have any inquiries regarding this study or about possible participation, please contact:

Leeanne Nicholls (Trainee Clinical Psychologist) - l.nicholls@soton.ac.uk

What happens if there is a problem?

If you have a concern about any aspect of this study, you should speak to me the researcher, Leeanne Nicholls (l.nicholls@soton.ac.uk) and I will do my best to answer your questions.

If you remain unhappy or have a complaint about any aspect of this study, please contact the University of Southampton Head of Research Ethics and Clinical Governance (023 8059 5058, rgoinfo@soton.ac.uk).

Data Protection Privacy Notice

Please find the University's Data Privacy Notice here:
https://www.southampton.ac.uk/about/governance/policies/privacy-policy.page

The University of Southampton conducts research to the highest standards of research integrity. As a publicly funded organisation, the University has to ensure that it is in the public interest when we use personally identifiable information about people who have agreed to take part in research. This means that when you agree to take part in a research study, we will use information about you in the ways needed, and for the purposes specified, to conduct and complete the research project. Under data protection law, 'Personal data' means any information that relates to and is capable of identifying a living individual. The University's data protection policy governing the use of personal data by the University can be found on its website
(https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page).

This Participant Information Sheet tells you what data will be collected for this project and whether this includes any personal data. Please ask the research team if you have any questions or are unclear what data is being collected about you.

Our privacy notice for research participants provides more information on how the University of Southampton collects and uses your personal data when you take part in one of our

research projects and can be found at http://www.southampton.ac.uk/assets/sharepoint/intranet/ls/Public/Research%20and%20Integrity%20Privacy%20Notice/Privacy%20Notice%20for%20Research%20Participants.pdf

Any personal data we collect in this study will be used only for the purposes of carrying out our research and will be handled according to the University's policies in line with data protection law. If any personal data is used from which you can be identified directly, it will not be disclosed to anyone else without your consent unless the University of Southampton is required by law to disclose it.

Data protection law requires us to have a valid legal reason ('lawful basis') to process and use your Personal data. The lawful basis for processing personal information in this research study is for the performance of a task carried out in the public interest. Personal data collected for research will not be used for any other purpose.

For the purposes of data protection law, the University of Southampton is the 'Data Controller' for this study, which means that we are responsible for looking after your information and using it properly. The University of Southampton will keep identifiable information about you for 10 years after the study has finished after which time any link between you and your information will be removed.

To safeguard your rights, we will use the minimum personal data necessary to achieve our research study objectives. Your data protection rights – such as to access, change, or transfer such information - may be limited, however, in order for the research output to be reliable and accurate. The University will not do anything with your personal data that you would not reasonably expect.

If you have any questions about how your personal data is used, or wish to exercise any of your rights, please consult the University's data protection webpage (https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page) where you can make a request using our online form. If you need further assistance, please contact the University's Data Protection Officer (data.protection@soton.ac.uk).

Thank you for taking the time to read this information sheet and considering whether you would like to take part in this research project.

Appendix H Debrief Statement

Study Title: How is EMDR best Conducted and Adapted for Trauma-focused work Within Bipolar Disorder? A Delphi Study

Ethics/ERGO number: 91294

Researcher(s): Leeanne Nicholls, Dr Thomas Richardson, Prof. Kim Wright

University email(s): l.nicholls@soton.ac.uk
t.h.richardson@soton.ac.uk
k.a.wright@exeter.ac.uk

Version and date: Version1, 23/02/24

Thank you for taking part in our research project. Your contribution is very valuable and greatly appreciated.

Purpose of the study

The aim of this research was to explore how Eye Movement Desensitisation and Reprocessing (EMDR) as a psychotherapy is best conducted and adapted for trauma focused work in a population of individuals who are diagnosed with bipolar disorder. The research aims to broaden this knowledge through the generation of practitioner's perspectives in order to form an overall consensus about what constitutes as effective practice. The research aims to get consensus about; barriers that affect EMDR accessibility and efficacy for the treatment of trauma, the necessary adaptations that are employed in order to address these barriers and recommendations that need to be adopted in clinical supervision.

Your data will contribute to further understanding of the recommended adaptations of the current standard EMDR protocol towards the effective treatment of trauma in bipolar disorder presentations.

Confidentiality
Results of this study will not include your name or any other identifiable characteristics.

Study results
If you would like to receive a copy of the final report when it is completed, please let us know by using the contact details provided on this form.

Further support
If taking part in this study has caused you discomfort or distress, you can contact the following organisations for support:

Information and support for bipolar disorder:

Bipolar UK: www.bipolaruk.org/
CrestBD: www.crestbd.ca
DBSA (US): www.dbsalliance.org

For support with mental health:

Mind (UK only):
Website: www.mind.org.uk
InfoLine: 0300 123 3393
Email: info@mind.org.uk

Open Monday-Friday (except for bank holidays) 9am – 6pm.

Infoline provides information and referrals about mental health issues, including options for treatment, advocacy services, and local resources for help.

Samaritans:
Website: www.samaritans.org
Telephone: 116 123 (free to call from UK & Ireland)
Email: jo@samaritans.org

The helpline is open 24 hours, 7 days a week. Samaritans by email may take several days to respond. The Samaritans can be called if you are in crisis. The website also has details of a self-help app here:
Self-Help | Samaritans

Shout:
Website: https://giveusashout.org/
Text: 85258

You can access support through text message services, and this is provided by the charity give us a shout. They are similar to the Samaritans but provide the service through text.

*If you are **OUTSIDE THE UK:***

Please visit: https://unitedgmh.org/mental-health-support
for a list of international helpline numbers.

Alternatively, please contact your local health facilities.

Further reading
If you would like to learn more about this area of research, you can refer to the following resources:

Reference:

Hogg, B., Radua, J., Gardoki-Souto, I., Fontana-McNally, M., Lupo, W., Reinares, M., Jiménez, E., Madre, M., Blanco-Presas, L., Cortizo, R., Massó-Rodriguez, A., Castaño, J., Argila, I., Castro-Rodriguez, J. I., Comes, M., Macias, C., Sánchez-González, R., Mur-Mila, E., Novo, P., ... & Amann, B. L. (2024). EMDR therapy vs. supportive therapy as adjunctive treatment in trauma-exposed bipolar patients: A

randomised controlled trial. *Spanish Journal of Psychiatry and Mental Health, 17*(4), 203-214.

Link to article:

https://doi.org/10.1016/j.sjpmh.2023.11.005

Reference:

Valiente-Gómez, A., Moreno-Alcázar, A., Gardoki-Souto, I., Masferrer, C., Porta, S., Royuela, O., Hogg, B., Walter, L., & Amann, B. L. (2019). Theoretical background and clinical aspects of the use of EMDR in patients with bipolar disorder. *Journal of EMDR Practice and Research, 13*(4), 307-312.

Link to article:

https://connect.springerpub.com/content/sgremdr/13/4/307.full.pdf

Further information

If you have any concerns or questions about this study, please contact Leeanne Nicholls at l.nicholls@soton.ac.uk who will do their best to help.

If you remain unhappy or would like to make a formal complaint, please contact the Head of Research Integrity and Governance, University of Southampton, by emailing: rgoinfo@soton.ac.uk, or calling: + 44 2380 595058. Please quote the Ethics/ERGO number which can be found at the top of this form. Please note that if you participated in an anonymous survey, by making a complaint, you might be no longer anonymous.

Thank you again for your participation in this research.

Appendix I Participant Recruitment Poster

For more information contact:
Trainee Clinical Psychologist,
Leeanne Nicholls
l.nicholls@soton.ac.uk

Research Opportunity

Participants Needed

How is EMDR best conducted and adapted for trauma focused work within Bipolar Disorder? A Delphi study

University of Southampton

Supervisors: Dr Thomas Richardson and Prof. Kim Wright
t.h.richardson@soton.ac.uk
Date: 07/05/24
Version: 2
Ethics number: 91294

Why is this research being carried out?

Research has highlighted the clinical necessity to attend to traumatic events in bipolar disorder.

At present there is limited guidance offered for EMDR practitioners to how they should approach the treatment of trauma in bipolar disorder.

This study aims to produce a consensus generated from practitioner's perspectives that will inform and guide clinical practice for trauma work in bipolar disorder.

Who can take part?

To be eligible to take part you must be:

- Internationally based EMDR practitioners, who are currently working in any setting.
- Any experience (limited through to advanced proficiency) of using EMDR with trauma.
- Experiences of working with individuals with bipolar disorder using any therapeutic approach.
- Have access to an online device and be proficient in reading and understanding English.

Who is undertaking the study?

Leeanne Nicholls, a Trainee Clinical Psychologist at the University of Southampton as part of her doctoral training.

Leeanne has successfully treated trauma in individuals using EMDR, which has sparked an interest in this psychotherapy.

What is involved?

- Taking part in an online survey.
- The survey consists of 3 different rounds, administered over a 5 month period.
- Each round should take no longer than 40 minutes to complete.

I want to get involved, what do I do next?

If you are interested in being part of this study, please scan the QR code for more details.

Thank you.

Appendix J Online Round 1 Survey Layout

Section 1: General Demographics:

- What is your core profession?

  (free text box)

- What is your work setting, and what population do you work with?

  (free text box)

- What is your level of EMDR training?

  Not yet finished basic training ☐

  Basic adult training ☐

  Basic children's training ☐

  Accredited EMDR Practitioner ☐

  Accredited EMDR Consultant ☐

  Accredited EMDR training facilitator/trainer ☐

- How many years of experience do you have in providing EMDR?

  ☐

- How much experience do you have of treating someone with bipolar disorder (using any therapeutic approach)?

  1-2 cases ☐ 3-5 cases ☐ 6-10 cases ☐ 10+ cases ☐

- How much experience do you have of treating **trauma** with someone with bipolar disorder (using any therapeutic approach)?

  0 cases ☐ 1-2 cases ☐ 3-5 cases ☐ 6-10 cases ☐ 10+ cases ☐

- How much experience do you have of using EMDR with someone with bipolar disorder?

  0 cases ☐ 1-2 cases ☐ 3-5 cases ☐ 6 -10 cases ☐ 10+ cases ☐

- How much experience do you have of using EMDR to treat **trauma** with someone with bipolar disorder?

  0 cases ☐ 1-2 cases ☐ 3-5 cases ☐ 6 -10 cases ☐ 10+ cases ☐

- Have you had any training for treating trauma with someone with bipolar disorder (using any therapeutic approach)?

  No ☐ Yes ☐

- Have you had any EMDR specific training for treating trauma with someone with bipolar disorder?

  No ☐ Yes ☐

- Have you been involved in research on EMDR and bipolar disorder?

  No ☐ Yes ☐

Section 2: Perceived Barriers and Adaptations:

- What are the rationales for using EMDR for the treatment of trauma with someone with bipolar disorder?

  (free text box)

  Please answer the following questions with what you have identified or employed in your provision of EMDR and/or what you think is necessary

- What are the barriers that affect EMDR **accessibility** for the treatment of trauma for individuals with bipolar disorder?

  (free text box)

- What are the barriers that affect EMDR **efficacy** for the treatment of trauma for individuals with bipolar disorder?

  (free text box)

- What would be the necessary *'general'* adaptations that are employed in EMDR therapy when treating trauma with someone with bipolar disorder in order to address these barriers?

  (free text box)

- What would be the necessary *'phase specific'* adaptations that are employed in EMDR therapy when treating trauma with someone with bipolar disorder in order to address these barriers?

(You do not have to put answers in all the phase specific boxes but please indicate which phase(s) you feel needs to be adapted).

Phase 1: Client History/Treatment Planning *(free text box)*

Phase 2: Preparation Stage *(free text box)*

Phase 3: Assessment Phase *(free text box)*

Phase 4: Desensitisation *(free text box)*

Phase 5: Installation *(free text box)*

Phase 6: Body Scan *(free text box)*

Phase 7: Closure *(free text box)*

Phase 8: Re-evaluation *(free text box)*

Other: *(free text box)*

Section 3: Considerations for Supervision:

- What additional considerations need to be adopted for both supervisees/supervisors in clinical supervision provision when using EMDR to treat trauma in bipolar disorder presentations?

(free text box)

Appendix K Online Round 2 Survey Layout

Summary Overview

How is EMDR best Conducted and Adapted for Trauma Focused work Within Bipolar Disorder? A Delphi Study

Researchers: Leeanne Nicholls, Dr Thomas Richardson, and Prof. Kim Wright

University email: l.nicholls@soton.ac.uk

We value your participation in the survey's initial round. The first round of the survey looked at recommended adaptations and barriers for using EMDR in trauma-focused work with individuals with bipolar disorder. Please find attached the download for the round 1 summary.

(round one summary here)

From the round 2 survey we want to develop a consensus from practitioners' perspectives about how important the adaptations are for improving EMDR treatment for trauma work in bipolar disorder. This survey should take approximately **20 - 30 minutes** to complete.

There are some initial demographic questions, followed by a second section which consists of a list of both general (during the course of EMDR therapy) adaptations and phase specific adaptations. Using the following scale, you will be asked to rate how important you believe these adaptations are for EMDR trauma work with individuals who have bipolar disorder:

1. Essential
2. Important
3. Don't know/depends
4. Unimportant
5. Should not be included

EMDR supervision considerations and adaptations will be the focus of the survey's third section. Using the following scale, you will be asked to rate how important you believe these supervision considerations and adaptations are for EMDR trauma work with individuals who have bipolar disorder:

1. This is essential for all
2. This is important
3. This could be useful, depending on the client group
4. This isn't important
5. This is actively unhelpful

You can finish the survey over the course of 72 hours at different times because your responses will be automatically saved. Kindly complete all the survey sections until you reach the final statement, which signifies the completion of the survey.

Please contact the main researcher Leeanne Nicholls on the included email address if you have any further questions or comments.

Consent statement

Please provide your email address so that we can contact you to ask you to participate in the final round of the Delphi survey. Thank you.

- Email free text box

<u>Section 1:</u> General Demographics:

This section asks repeated questions from round 1, about core profession, work setting, the client population that you work with and experiences of using EMDR with clients with bipolar disorder.

- What is your core profession?

(free text box)

- What is your work setting?

(free text box)

- What population do you work with and what is the age range?

(free text box)

- What is your level of EMDR training?

Not yet finished basic training ☐

Basic adult training ☐

Basic children's training ☐

Accredited EMDR Practitioner ☐

Accredited EMDR Consultant ☐

Accredited EMDR training facilitator/trainer ☐

- How much experience do you have of using EMDR with someone with bipolar disorder?

  0 cases ☐ 1-2 cases ☐ 3-5 cases ☐ 6 -10 cases ☐ 10+ cases ☐

- How much experience do you have of using EMDR to treat **trauma** with someone with bipolar disorder?

  0 cases ☐ 1-2 cases ☐ 3-5 cases ☐ 6 -10 cases ☐ 10+ cases ☐

- If you have offered EMDR to individuals with a diagnosis of bipolar disorder, what have your experiences been like?

  (free text box)

<u>Section 2</u>: General Adaptations

The first part of the second section focuses on general adaptations (during the course of EMDR therapy).

Please indicate below the **degree** to which you consider the following **general adaptations** as <u>important</u> when using EMDR to treat trauma in individuals with bipolar disorder.

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Consultations with psychiatrist to monitor bipolar symptoms	◯	◯	◯	◯	◯
MDT Involvement (Team Approach)	◯	◯	◯	◯	◯
Treat Comorbidities (drug abuse)	◯	◯	◯	◯	◯
Infrastructure in service to facilitate acute treatment.	◯	◯	◯	◯	◯
Review if inpatient treatment is needed for the client	◯	◯	◯	◯	◯
Have gaps in the treatment plan	◯	◯	◯	◯	◯

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Have Reminders of Appointments	○	○	○	○	○
Follow usual trauma work considerations - Window of tolerance	○	○	○	○	○
Review if this is appropriate time for treatment (e.g. not at a time of extreme mood/mania)	○	○	○	○	○
Give reminders of ability to say or signal STOP	○	○	○	○	○
Offer thorough psychoeducation about EMDR protocol	○	○	○	○	○
Use Flash Technique first if SUDs ratings are high	○	○	○	○	○
Use Specific EMDR protocol/Subprotocols for Bipolar Disorder	○	○	○	○	○

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Focus on processing current traumatic/stressful events first (Inverted Protocol)	○	○	○	○	○
Use Attachment Focused EMDR approaches (SAFE) (Kennard)	○	○	○	○	○
Use a combination of Psychological Therapies to help mood variations	○	○	○	○	○
Incorporating therapy that focuses on parts work and ego states.	○	○	○	○	○
Use a bipolar scale with clients, and routinely discuss mood on the scale	○	○	○	○	○
Check that the person's mood is stable enough to continue with therapy	○	○	○	○	○

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Increase responsiveness to any signs of mood relapse	○	○	○	○	○

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Reinforce client stability before processing	○	○	○	○	○

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Develop strategies to manage variations in client's mood	○	○	○	○	○

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Build strength through resourcing	○	○	○	○	○

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Develop a clear safety plan with the client in case of relapse.	○	○	○	○	○

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Make sure the client has a network of support around them	○	○	○	○	○

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Create awareness about dissociation to help with stability	○	○	○	○	○

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Develop a Relapse Plan for Bipolar Symptoms	○	○	○	○	○

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Empower the client to report any difficulties with symptoms that they may experience during therapy	○	○	○	○	○

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Develop thorough assessment and preparation phases before processing	○	○	○	○	○

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Develop a robust, collaborative formulation of the trauma memory networks underlying the client's experiences of going high and feeling low.	○	○	○	○	○

This second part of this section focuses on what **phase specific** adaptations.

Phase 1: Client History/Treatment Planning

Please indicate below the **degree** to which you consider the following **phase 1 adaptations** as important when using EMDR to treat trauma in individuals with bipolar disorder.

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Thorough history taking of client and their presentation, including links to historic and present trauma	○	○	○	○	○

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Capture a detailed Biographical Timeline detailed that encompasses all client history	○	○	○	○	○

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Attention to periods of stability and instability in client history.	○	○	○	○	○

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Understand the links between bipolar history with trauma history.	○	○	○	○	○

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Identify the trauma memory networks underlying going high and feeling low.	○	○	○	○	○

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Use of back of the head scale measure of dissociation (Jim Knipe).	○	○	○	○	○

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Use Jim Knipe's Loving Eyes if they are critical towards themselves or emotionally avoidant.	○	○	○	○	○
Assess client's view on relationship between trauma and bipolar symptoms	○	○	○	○	○
Develop clarity on what symptoms are being treated.	○	○	○	○	○
Identify Signs of Acute Episode (relapse signature)	○	○	○	○	○
More focus on present symptoms rather than core trauma	○	○	○	○	○
Review links between trauma and psychotic symptoms	○	○	○	○	○
Complete an In depth risk assessment	○	○	○	○	○

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Review what support networks they have available	○	○	○	○	○
Review impact of medication (past and current)	○	○	○	○	○
Review client's safety and establish relapse plan	○	○	○	○	○
Assess if client is stable enough to proceed with therapy	○	○	○	○	○
Ensure client can access an image that provokes calmness	○	○	○	○	○
Clarify that client has coping strategies in place to help with mood variations	○	○	○	○	○
Clearer focus on expectations	○	○	○	○	○

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Have a Prolonged Engagement Phase	◯	◯	◯	◯	◯

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Offer psychoeducation on bipolar disorder	◯	◯	◯	◯	◯

Please provide any additional comments or adaptations that you believe are relevant for the history taking phase

(free text box)

Phase 2: Preparation Stage

Please indicate below the **degree** to which you consider the following **phase 2 adaptations** as important when using EMDR to treat trauma in individuals with bipolar disorder.

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Incorporate therapy that focuses on parts work and ego states.	◯	◯	◯	◯	◯

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Practice techniques to change behaviours and thought patterns that contribute to mood variations.	◯	◯	◯	◯	◯

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Using CBT approaches to enhance treatment outcome and support mood management	◯	◯	◯	◯	◯

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Incorporate emotional regulation and distress tolerance skills	○	○	○	○	○

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Create subprotocols in case of adherence Difficulties	○	○	○	○	○

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Encourage client to monitor their moods	○	○	○	○	○

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Have more awareness of relapse indicators	○	○	○	○	○

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Develop more somatic resources for increasing window of tolerance.	○	○	○	○	○

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Complete thorough resourcing by using attachment informed figures and clients own abilities to resource.	○	○	○	○	○

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Spend more time on increasing a client's stability	○	○	○	○	○

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Develop clear safety plan that highlights relapse indicators	○	○	○	○	○
Use a phased Approach to Grounding	○	○	○	○	○
Spend more time on installation of positive material	○	○	○	○	○
Install protective, compassionate, wise figures/ (attachment focused EMDR).	○	○	○	○	○
Include safe place protocol	○	○	○	○	○
Gather information from others (family, support networks, health professionals, psychiatry)	○	○	○	○	○
Establish trust between therapist and client	○	○	○	○	○

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Use standard protocol stability tools (container, calm place).	◯	◯	◯	◯	◯

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Simplify Explanations	◯	◯	◯	◯	◯

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Reassure client that treatment is unlikely to trigger episode	◯	◯	◯	◯	◯

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Discuss with client consequences of potential reprocessing	◯	◯	◯	◯	◯

Please provide any additional comments or adaptations that you believe are relevant for the preparation phase

(free text box)

Phase 3: Assessment Phase

Please indicate below the **degree** to which you consider the following **phase 3 adaptations** as important when using EMDR to treat trauma in individuals with bipolar disorder.

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Use CIPOS (Constant Installation and Present Orientation to Safety) Technique (Knipe)	◯	◯	◯	◯	◯

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Develop a clear formulation that considers the client's elated and low mood patterns	◯	◯	◯	◯	◯
Identify aspects that may trigger abreactions.	◯	◯	◯	◯	◯
Have strategies in place to deal with abreactions	◯	◯	◯	◯	◯
Have additional resources in place	◯	◯	◯	◯	◯
Trial EMDR processing with a small SUDs level event beforehand.	◯	◯	◯	◯	◯
Offer a clear explanation of case conceptualisation beforehand	◯	◯	◯	◯	◯
Look for Similar Themes in Traumatic Events	◯	◯	◯	◯	◯

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Identifying realistic cognitions (negative and positive) and deeper beliefs	◯	◯	◯	◯	◯

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Ensure the client can feel the disturbance in their body.	◯	◯	◯	◯	◯

Please provide any additional comments or adaptations that you believe are relevant for the Assessment phase

(free text box)

Phase 4: Desensitisation

Please indicate below the **degree** to which you consider the following **phase 4 adaptations** as important when using EMDR to treat trauma in individuals with bipolar disorder.

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Use 'Flash' First (Manfield) as way to ways to reduce intensity of target	◯	◯	◯	◯	◯

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Adapt Interweaves	◯	◯	◯	◯	◯

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Adapt Suds ratings to suit the client	◯	◯	◯	◯	◯

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Slower desensitisation to aid stability	◯	◯	◯	◯	◯

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Complete mood monitoring Alongside Processing	○	○	○	○	○
Make sure to decrease triggering the stress response in a client	○	○	○	○	○
Making sure that the client is able to engage within this phase before proceeding	○	○	○	○	○
Complete regular check-in's	○	○	○	○	○
Stick to agreed treatment plan set during initial phases	○	○	○	○	○
Clarify client preference around BLS	○	○	○	○	○
Slow down BLS	○	○	○	○	○
Shorter and Faster Sets of BLS	○	○	○	○	○

Please provide any additional comments or adaptations that you believe are relevant for the Desensitisation phase

(free text box)

Phase 5: Installation

Please indicate below the **degree** to which you consider the following **phase 5 adaptations** as important when using EMDR to treat trauma in individuals with bipolar disorder.

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Make sure Positive Cognition is Realistic and not overly grandiose	○	○	○	○	○
Encourage a PC that welcomes neutral acceptance	○	○	○	○	○
Adapt VOC Ratings to suit the client	○	○	○	○	○
Be flexible in the approach to reduction of SUDs ratings, as you may not get them down to 0	○	○	○	○	○

Please provide any additional comments or adaptations that you believe are relevant for the Installation phase

(free text box)

Phase 6: Body Scan

Please indicate below the **degree** to which you consider the following **phase 6 adaptations** as important when using EMDR to treat trauma in individuals with bipolar disorder.

	Essential	Important	don't know/ depends	Unimportant	Should not be included
When clients need to pay attention to their bodies, find a way that makes them more comfortable.	○	○	○	○	○

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Evaluate the impact of any hallucinatory experiences if they are present.	○	○	○	○	○

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Develop clearer ways to recognise change within a client's body	○	○	○	○	○

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Make sure body scan is linked to target not general sensitivity	○	○	○	○	○

Please provide any additional comments or adaptations that you believe are relevant for the Body Scan phase

(free text box)

Phase 7: Closure

Please indicate below the **degree** to which you consider the following **phase 7 adaptations** as important when using EMDR to treat trauma in individuals with bipolar disorder.

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Closely monitor client's wellbeing in between sessions	○	○	○	○	○

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Encourage client to keep a journal	○	○	○	○	○

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Encourage client to make contact if they experience heightened symptoms that make them feel unsafe.	○	○	○	○	○

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Ensure that there is a "blueprint" for ongoing recovery.	○	○	○	○	○

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Normalise any disturbance if it should occur	○	○	○	○	○

Please provide any additional comments or adaptations that you believe are relevant for the Closure phase

(free text box)

Phase 8: Re-evaluation

Please indicate below the **degree** to which you consider the following **phase 8 adaptations** as important when using EMDR to treat trauma in individuals with bipolar disorder.

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Complete regular check in's for client's wellbeing.	○	○	○	○	○

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Increase the client's awareness of potential relapse warning signs	○	○	○	○	○

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Have additional time for grounding at end of the session	○	○	○	○	○

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Have agreed measurement tools to monitor the client's mood levels	○	○	○	○	○

Please provide any additional comments or adaptations that you believe are relevant for the Re-evaluation phase

(free text box)

Section 3: Supervision

Please indicate below the **degree** to which you consider the following **considerations** as important for Supervision (both supervisors and supervisees) when using EMDR to treat trauma in individuals with bipolar disorder.

	This is Essential For All	This is important	This could be useful depending on the client group	This isn't important	This is actively unhelpful
Supervisor should have knowledge and understanding of bipolar disorder	○	○	○	○	○

	This is Essential For All	This is important	This could be useful depending on the client group	This isn't important	This is actively unhelpful
Supervisor should have knowledge of what specific adaptations of EMDR to use when working with dissociation.	○	○	○	○	○

	This is Essential For All	This is important	This could be useful depending on the client group	This isn't important	This is actively unhelpful
Supervisee understands bipolar psychiatric treatment	○	○	○	○	○

	This is Essential For All	This is important	This could be useful depending on the client group	This isn't important	This is actively unhelpful
Supervisee has good engagement skills	○	○	○	○	○

	This is Essential For All	This is important	This could be useful depending on the client group	This isn't important	This is actively unhelpful
Supervisee has an understanding of bipolar.	○	○	○	○	○

	This is Essential For All	This is important	This could be useful depending on the client group	This isn't important	This is actively unhelpful
There should be time to review the skills that are needed by the supervisee when working with trauma and bipolar.	○	○	○	○	○

	This is Essential For All	This is important	This could be useful depending on the client group	This isn't important	This is actively unhelpful
There should be time to review supervisee's competence to work with bipolar	○	○	○	○	○

	This is Essential For All	This is important	This could be useful depending on the client group	This isn't important	This is actively unhelpful
Supervision will need to be more regular	○	○	○	○	○

	This is Essential For All	This is important	This could be useful depending on the client group	This isn't important	This is actively unhelpful
There should be psychiatry involvement.	○	○	○	○	○

	This is Essential For All	This is important	This could be useful depending on the client group	This isn't important	This is actively unhelpful
There needs to be regular updates on client progress (mood and trauma symptoms)	○	○	○	○	○

	This is Essential For All	This is important	This could be useful depending on the client group	This isn't important	This is actively unhelpful
Spend time reflecting on client formulation, which accounts for the complexity of both bipolar disorder and trauma	○	○	○	○	○

	This is Essential For All	This is important	This could be useful depending on the client group	This isn't important	This is actively unhelpful
Focus on client safety throughout	○	○	○	○	○

	This is Essential For All	This is important	This could be useful depending on the client group	This isn't important	This is actively unhelpful
Spend time discussing the aspects of the 'reprocessing' of traumatic events	○	○	○	○	○

	This is Essential For All	This is important	This could be useful depending on the client group	This isn't important	This is actively unhelpful
Focus on supervising client stability throughout treatment	○	○	○	○	○

	This is Essential For All	This is important	This could be useful depending on the client group	This isn't important	This is actively unhelpful
Spent time discussing skilful ways to stop or pause treatment if therapy is causing adverse reactions	○	○	○	○	○

	This is Essential For All	This is important	This could be useful depending on the client group	This isn't important	This is actively unhelpful
Spent time determining whether the bipolar presentation is compensating for any unmet needs of the client	○	○	○	○	○

	This is Essential For All	This is important	This could be useful depending on the client group	This isn't important	This is actively unhelpful
Move away from the medical model and medicalised language in supervision.	○	○	○	○	○

	This is Essential For All	This is important	This could be useful depending on the client group	This isn't important	This is actively unhelpful
Incorporate an attachment focus and reflect in supervision	○	○	○	○	○

	This is Essential For All	This is important	This could be useful depending on the client group	This isn't important	This is actively unhelpful
There should be time to reflect on recent research and developments in clinical practice for bipolar and dissociation.	○	○	○	○	○

Please provide any additional comments or adaptations that you believe are relevant for <u>supervision</u>

(free text box)

Please provide any additional comments or further suggested adaptations that you feel is important for EMDR treatment for trauma work in bipolar disorder.

(free text box)

Thank you for completing this survey. Your contribution is very valuable and greatly appreciated.

Appendix L Online Round 3 Survey Layout

Summary Overview

How is EMDR best Conducted and Adapted for Trauma Focused work Within Bipolar Disorder? A Delphi Study

Researchers: Leeanne Nicholls, Dr Thomas Richardson, and Prof. Kim Wright

University email: l.nicholls@soton.ac.uk

We value your participation in the survey's second round.

The second round of the survey aimed to establish consensus on the relevance of specific adaptations (based on Round 1 responses) to enhance EMDR practice for trauma treatment in individuals with bipolar disorder. Please find attached the download for the round 2 summary.

(round two summary here)

The Round 3 survey is divided into four parts: (1) demographics, (2) re-ratings of 24 items from Round 2 (EMDR adaptations), (3) three questions related to EMDR supervision, and (4) an exploration of the factors that contributed to selecting "don't know/it depends".

This survey should take approximately **10 minutes** to complete.

You can finish the survey over the course of 72 hours at different times because your responses will be automatically saved.

Kindly complete all the survey sections until you reach the final statement, which signifies the completion of the survey.

Please contact the main researcher Leeanne Nicholls on the included email address if you have any further questions or comments.

Consent statement

Please provide your email address so that we can send you the final study summary. Thank you.

- Email free text box

Section 1: General Demographics:

This section asks repeated questions from rounds 1 and 2, about core profession, work setting, the client population that you work with.

- What is your core profession?

  (free text box)

- What is your work setting?

  (free text box)

- What population do you work with and what is the age range?

  (free text box)

- What is your level of EMDR training?

  Not yet finished basic training ☐

  Basic adult training ☐

  Basic children's training ☐

  Accredited EMDR Practitioner ☐

  Accredited EMDR Consultant ☐

  Accredited EMDR training facilitator/trainer ☐

- How much experience do you have of using EMDR with someone with bipolar disorder?

  0 cases ☐ 1-2 cases ☐ 3-5 cases ☐ 6 -10 cases ☐ 10+ cases ☐

- How much experience do you have of using EMDR to treat **trauma** with someone with bipolar disorder?

  0 cases ☐ 1-2 cases ☐ 3-5 cases ☐ 6 -10 cases ☐ 10+ cases ☐

<u>Section 2</u>: General Adaptations

The first part of the second section focuses on general adaptations (during the course of EMDR therapy). These items were **previously** rated in Round 2, and we are asking you to **re-rate** them now to help establish consensus.

Please indicate below the **degree** to which you consider the following **general adaptations** as <u>important</u> when using EMDR to treat trauma in individuals with bipolar disorder.

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Treat Comorbidities (drug abuse)	◯	◯	◯	◯	◯

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Infrastructure in service to facilitate acute treatment.	◯	◯	◯	◯	◯
Review if inpatient treatment is needed for the client	◯	◯	◯	◯	◯
Use Attachment Focused EMDR approaches (SAFE) (Kennard)	◯	◯	◯	◯	◯
Use a combination of Psychological Therapies to help mood variations	◯	◯	◯	◯	◯
Use a bipolar scale with clients, and routinely discuss mood on the scale	◯	◯	◯	◯	◯

This second part of this section focuses on what **phase specific** adaptations.

Phase 1: Client History/Treatment Planning

Please indicate below the **degree** to which you consider the following **phase 1 adaptations** as important when using EMDR to treat trauma in individuals with bipolar disorder.

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Use of back of the head scale measure of dissociation (Jim Knipe).	○	○	○	○	○
Use Jim Knipe's Loving Eyes if they are critical towards themselves or emotionally avoidant.	○	○	○	○	○
Ensure client can access an image that provokes calmness	○	○	○	○	○
Offer psychoeducation on bipolar disorder	○	○	○	○	○

<u>Phase 2</u>: Preparation Stage

Please indicate below the **degree** to which you consider the following **phase 2 adaptations** as <u>important</u> when using EMDR to treat trauma in individuals with bipolar disorder.

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Practice techniques to change behaviours and thought patterns that contribute to mood variations.	○	○	○	○	○
Spend more time on increasing a client's stability	○	○	○	○	○

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Use a phased Approach to Grounding	○	○	○	○	○

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Install protective, compassionate, wise figures/ (attachment focused EMDR).	○	○	○	○	○

Phase 3: Assessment Phase

Please indicate below the **degree** to which you consider the following **phase 3 adaptations** as important when using EMDR to treat trauma in individuals with bipolar disorder.

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Have additional resources in place	○	○	○	○	○

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Trial EMDR processing with a small SUDs level event beforehand.	○	○	○	○	○

Phase 4: Desensitisation

Please indicate below the **degree** to which you consider the following **phase 4 adaptations** as important when using EMDR to treat trauma in individuals with bipolar disorder.

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Use 'Flash' First (Manfield) to reduce intensity of target	○	○	○	○	○

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Adapt Interweaves	○	○	○	○	○

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Adapt Suds ratings to suit the client	◯	◯	◯	◯	◯

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Complete mood monitoring Alongside Processing	◯	◯	◯	◯	◯

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Make sure to decrease triggering the stress response in a client	◯	◯	◯	◯	◯

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Stick to agreed treatment plan set during initial phases	◯	◯	◯	◯	◯

Phase 5: Installation

Please indicate below the **degree** to which you consider the following **phase 5 adaptations** as important when using EMDR to treat trauma in individuals with bipolar disorder.

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Adapt VOC Ratings to suit the client	◯	◯	◯	◯	◯

Phase 7: Closure

Please indicate below the **degree** to which you consider the following **phase 7 adaptations** as important when using EMDR to treat trauma in individuals with bipolar disorder.

	Essential	Important	don't know/ depends	Unimportant	Should not be included
Encourage client to keep a journal	◯	◯	◯	◯	◯

<u>Section 3</u>: Supervision

Please indicate below the **degree** to which you consider the following **considerations** as important for <u>Supervision</u> (both supervisors and supervisees) when using EMDR to treat trauma in individuals with bipolar disorder.

	This is Essential For All	This is important	This could be useful depending on the client group	This isn't important	This is actively unhelpful
There should be time to review supervisee's competence to work with bipolar	◯	◯	◯	◯	◯

	This is Essential For All	This is important	This could be useful depending on the client group	This isn't important	This is actively unhelpful
Spent time determining whether the bipolar presentation is compensating for any unmet needs of the client	◯	◯	◯	◯	◯

	This is Essential For All	This is important	This could be useful depending on the client group	This isn't important	This is actively unhelpful
Incorporate an attachment focus and reflect in supervision	◯	◯	◯	◯	◯

Section 4:

We would like to gain a deeper understanding of the reasons behind your choice of **'don't know/it depends'** in your responses in Round 2 and/or 3. This will help us further explore the factors that influence clinical decision-making.

Please select all the relevant boxes that apply.

◯ It depends on the individual and their presentation

◯ Amount of experience working with bipolar disorder presentations

◯ Confidence in modifying EMDR protocols

- ◯ Lack of training in specific techniques
- ◯ Service restrictions
- ◯ Preference for particular protocols
- ◯ Depends on the needs of the client
- ◯ Concerns about risk
- ◯ Less awareness of the research evidence base for bipolar disorder treatment

Other – (free text box)

Please provide any additional comments that you feel is important for EMDR treatment for trauma work in bipolar disorder.

(free text box)

Thank you for completing this survey. Your contribution is very valuable and greatly appreciated.

Appendix M Map for Coding

Reflections: How do these themes link together; what are their relationships?

Thirty-four EMDR practitioners with varied experiences of using EMDR with individuals diagnosed with bipolar disorder (BD) completed the online survey. They gave clear rationales for EMDR's effectiveness with this population and identified barriers that affected the accessibility and efficacy of trauma treatment.

Free-text responses were analysed in NVivo using a reflexive thematic analytical approach with a combination of both deductive and inductive processes. The data was coded and clustered accordingly into three main themes: general adaptations to EMDR, EMDR phase-specific adaptations, and considerations for clinical supervision.

These practitioners reported similar clinical experiences with EMDR provision when treating trauma in individuals with bipolar disorder. Many noted general adaptations associated with systemic factors, practical adjustments, the importance of reinforcing client stability throughout treatment and the use of additional techniques.

There were overlaps in participants' responses regarding specific adaptations across the phases of EMDR. This relationship was likely to have developed as the EMDR protocol is highly phase-driven. Patterns emerged within the codes that specifically focused on the importance of prioritising client safety when processing traumatic memories.

This automatically led to responses related to supervision and the capabilities of both the supervisor and the supervisee, and the need to have specific training and guidance when working with individuals with bipolar disorder. Supervision structure and content were also identified as vital components when using this trauma-informed therapeutic approach.

M.1 Theme 1:

General Adaptations to EMDR

Cluster 1: Broader Treatment Needs

- Consultation With Psychiatrist
- MDT Approaches
- Treat Comorbidities
- Infrastructure in Service
- Consideration of Inpatient Treatment

Cluster 2: Practical Adjustments

- Allowing Gaps in Treatment
- Spacing Out Processing Sessions
- Having Reminders of Appointments
- Follow Usual Considerations
- Consideration of Therapy Timing
- Reminders of STOP Signal
- Thorough Psychoeducation

Cluster 3: Use of Additional Techniques

- Use of Flash Technique First if Suds Ratings Are High
- Use of Specific EMDR Protocol For BD
- Use Inverted Protocol
- Use of Attachment Focused EMDR
- Utilising Combination of Psychological Therapies To Help Mood Variation
- Inner Parts Work
- Use of Bipolar Scale

Cluster 4: Importance of Client Stability

- Check That the Person s Stable Enough
- Being More Responsive
- Reinforce Client Stability
- Develop Strategies to Manage Mood Variation
- Building Strength Through Resourcing
- Clear Safety Plan
- Support Systems in Place
- Create Awareness of Dissociation
- Relapse Plan For Bipolar Symptoms

Cluster 5: Conceptualisation Considerations

- More Thorough Assessment and Preparation
- Develop a Robust, Collaborative Formulation

M.2 Theme 2:

Phase-Specific Adaptations to EMDR

Phase Specific – 1 - Client History/Treatment Planning:

Cluster 1: Holistic History Taking

Thorough History Taking

Detailed Biographical Timeline

Attention to Periods of Stability and Instability in Client History.

Understanding Links Between Bipolar History With Trauma History.

Identify the Trauma Memory Networks Underlying Going High and Feeling Low.

Cluster 2: Additional Techniques

Use of Back of the Head Scale

Consider Jim Knipe's 'Loving Eyes' - Links to Self-Criticism

Cluster 3: Assessment of Present Symptoms

Assess Client's View on Both Trauma and Bipolar Symptoms

Develop Clarity on What Symptoms Are Being Treated.

Identify Signs of Acute Episode

More Focus on Present Symptoms

Consider Links Between Trauma And Psychosis

Cluster 4: Client Safety and Stability

In-Depth Risk Assessment

Review Support Systems

Review Impact Of Medication

Safety and Relapse Planning

Ensure They Have a Calm Place

Review Mood Stability

Ensure They Have a Suitable Calm Place

Review Coping Strategies For Mood Variation

Cluster 5: Therapeutic Considerations

Clearer Focus on Expectations

Prolonged Engagement Phase

Focus on Psychoeducation of BD

(Phase Specific – 2 – Preparation Stage):

Cluster 1: Additional Techniques

Parts Work

Practice CBT Techniques to Change Behaviours and Thought Patterns for Mood Variation.

Inclusion of CBT Approaches

Emotional Regulation and Distress Tolerance Skills

Create Subprotocols in Case of Adherence Difficulties

Encourage Mood Monitoring

Cluster 2: Importance of Client Safety and Stability

More Awareness of Relapse Indicators

More Somatic Resources

Thorough Resourcing

Increase Stability

Develop Safety and Relapse Plan

Consider Phased Approach to Grounding

Increase Installation Work

Develop Compassionate Resources

Safe Place Protocol

Use of Container

Include Support of Psychiatrist

Adjust Medication

Establishing Trust Between Therapist and Patient

Using Established and Appropriate Tools

Cluster 3: Psychoeducation
Simplify Explanations
Reassure Client That Treatment is Unlikely to Trigger Episode
Discuss With Client Consequences of Potential Reprocessing

Phase Specific – 3 – Assessment Phase:

Cluster 1: Additional Techniques
Use of CIPOS (Constant Installation and Present Orientation to Safety)
Use of Formulation to Incorporate Mood Variation

Cluster 2: Importance of Client Stability
Identifying Aspects That may Trigger Abreaction
Having Strategies in Place to Deal With Abreactions
Additional Resources
Go Through Some Trial Runs of EMDR with Small SUDS Event

Cluster 3: Conceptualisation Considerations
Clear Explanation of Case Conceptualisation
Look for Similar Themes in Traumatic Events

Cluster 4: Processing Guidance
Establishing Realistic Negative and Positive Cognitions
Ensure They Can Feel the Disturbance in Their Body.

Phase Specific – 4 – Desensitisation:

Cluster 1: Additional Techniques
Use of Flash First
Adapt Interweaves
Adaptation of SUDs Ratings

Cluster 2: Importance of Client Stability
Slower Desensitisation to Aid Stability
Mood Monitoring Alongside Processing
Decrease Triggering of Stress Response
Ensure That This is the Right Time to Process
Regular Check-In's
Sticking to Identified Treatment Plan.

Cluster 3: Bilateral Stimulation Adjustments
Clarify Preference Around BLS
Slow Down BLS
Shorter And Faster Sets Of BLS

Phase Specific – 5 – Installation:

Cluster 1: Positive Cognition Considerations
Ensure Positive Cognition is Realistic
Encourage a PC that Welcomes Neutral Acceptance

Cluster 2: Considerations when Evaluating Changes in Emotion and Cognition
VOC Ratings should Be Adapted to Suit the Client
Flexibility with Getting SUDs Rating Down to 0

Phase Specific – 6 – Body Scan:

Cluster 1: Client-Related Factors
Making This Part of The Protocol More Comfortable
Consider Impact of Hallucinatory Experiences

Cluster 2: Body Recognition
Clearer Ways of Recognising Change With the Body
Body Scan Linked to Target

Phase Specific – 7 – Closure:

Cluster 1: Encouragement of Monitoring
Close Monitoring in Between Sessions
Encourage Client to Keep a Journal
Allowing Open Contact

Cluster 2: Importance of Client Stability
Importance of Relapse Focus
Normalise Disturbance

Phase Specific – 8– Re-evaluation:

Cluster 1: Extra Monitoring
Check In's
Having Re-Evaluation Time Dedicated in Each Session
Having Agreed Measurement Tools

Cluster 2: Importance of Client Stability
Ability to Recognise a Relapse, Manic or Depressive Episode
Additional Time For Grounding at End of Session

M.3 Theme 3:

Recommendations for EMDR Clinical Supervision

Cluster 1: Supervisor Capabilities

Having a Supervisor Who is Familiar With BD Presentations

Supervisor Who Has Knowledge of Adaptations of EMDR

Cluster 2: Supervisee's Capabilities

Understanding of Bipolar Psychiatric Treatment

Good Engagement Skills

Understanding of Bipolar Disorder

Cluster 3: Supervisory Structure

Needs to be More Regular

Psychiatrist Involvement

Cluster 4: Supervision Content

Regular Reflection on Client's Mood State

Use of Formulation to Review Complexities of BD

Making Sure There is the Focus on Patient Safety Throughout

Encouragement of the Reprocessing of Traumatic Events

Importance of Supervising Client Stability

Reviewing Skills Needed to Work With Trauma and BD

Considerations of Supervisee's Competence

Considerations of How to Pause Processing

Consider the Unmet Needs of the Client

Move Away From the Medical Model

Incorporating Attachment Focus

Review Evidence Base and Keep Up to Date on BD Knowledge

Flexibility With Treatment Plan

Approach Treatment at Slower Pace

Appendix N Coding Manuals

Coding Manual – Rationales

Table with examples of identified codes with survey response examples.

Definition:

This theme is looking at what are the rationales for using EMDR for the treatment of trauma in individuals with bipolar disorder?

Cluster 1: Trauma Connections – Definition: Trauma is linked with bipolar disorder presentations in many ways and there is a high percentage of this population who have experienced trauma.

Code Label	Definition	Illustrative Quotes
Links between trauma and bipolar disorder	Trauma is aetiological for bipolar disorder and can contribute to the development of this diagnosis.	*"Bipolar as a disorder can increase risk taking and thus a vulnerability to traumatic experiences, being sectioned is often a traumatic experience too."* *"Trauma underlines many different psychological difficulties and those with bipolar are very likely to have experienced trauma either prior to onset of symptoms or during the course of their illness."*
Treating trauma helps with mood disturbance	Mood disturbance with bipolar is normally linked to trauma experiences and treating this can lead to better outcomes.	*"Decreasing ups and downs, by desensitising traumatic events and making the adult self-stronger"* *"Treating trauma could help a person develop better ways of managing their triggers and help stabilise some mood disturbance."*

Cluster 2: Advantages of EMDR – Definition: Benefits of EMDR treatment with bipolar disorder population.

Code Label	Definition	Illustrative Quotes
EMDR has evidence base	EMDR is a known treatment of choice for treating trauma and studies have shown its efficacy.	*"EMDR and CBT are the most commonly recommended trauma interventions and have a good evidence base."* *"EMDR is an evidence-based intervention for trauma so if that is their primary presenting problem and EMDR is suitable then that would be a rationale."*
EMDR can be adapted	EMDR protocol can be adapted to meet the individual's needs and presentation.	*"Experience has shown adaptations to the delivery of EMDR are also very effective."* *"I am trained in SAFE EMDR (Somatic and Attachment Focused EMDR) and lean heavily into present symptoms/behaviours being helpful at some point for attachment and safety."*
Positive clinical experience of using EMDR for trauma	Therapist's positive experiences when utilising EMDR for trauma with this population.	*"It could yield some really positive results."* *"My bipolar client had experienced trauma after sexual trauma and had not benefited from CBT."* *"My clinical experience has been hugely positive"*

Coding Manual – Barriers

Table with examples of identified codes with survey response examples.

Definition:

This theme is looking at what barriers affect EMDR accessibility and efficacy for the treatment of trauma for individuals with bipolar disorder?

Cluster 1: Direct Impact of Client Symptoms – Definition: Reviewing the impact of the client's bipolar symptoms and how they impact on their wellbeing, engagement in therapy, alongside co-morbidity within this presentation.

Code Label	Definition	Illustrative Quotes
Client's inconsistency in attending therapy	Client not attending therapy on a regular basis	*"Acute episodes of illness that may restrict engagement in the process."* *"Bipolar disorder can make it very hard for someone to prioritize treatment."*
Client's mood fluctuations can interfere with therapy	The client's mood swings may cause therapy to be interrupted.	*"Client's mood fluctuations can interfere with therapy"* *"Also, some periods of mania impact clients ability to engage in processing effectively due to feelings of euphoria and flight of ideas."*
Dissociation levels	Client's levels of dissociation can impact on ability to attend or impact processing	*"Potentially higher degrees of dissociation"*
Cognitive impairment (less capacity for reprocessing)	Reprocessing ability is reduced due to cognitive impairment.	*"Acute affective episodes = Cognitive impairment (less capacity for reprocessing)"*
The presence of manic and depressive symptoms	The existence of symptoms of depression and mania can be a barrier for treatment	*"Periods of elated or low mood could reduce efficacy."* *"Depending on what is presented manic or low in mood can mask trauma symptoms"*

Cluster 2: Safety Concerns – Definition: Concerns for client safety within treatment, especially processing traumatic memories

Code Label	Definition	Illustrative Quotes
Concerns about negative consequences of EMDR	Concerns that EMDR will make the client worse	*"I wonder whether clinicians and /or clients might worry that EMDR might trigger a manic or depressive episode."* *"Clinician concern that offering EMDR will make psychotic symptoms or mental state worse"*
Concerns about client's safety	Worries over risk and safety of the client within treatment	*"Risk /safety concerns especially if recent admissions and with medication sometimes e.g., if benzodiazepines or high dose anxiolytics"*

Cluster 3: Systemic Issues – Definition: Issues that relate to entire systems around a client

Code Label	Definition	Illustrative Quotes
Inflexible Pathways	Barriers existing within a service's rigidity in their care pathways	*"Inflexible pathways (e.g., that someone cannot step off and step back on therapy, if they have a relapse)."* *"Clinical pathways and research to support the approach."*
Having bipolar label and as a consequence being treated negatively	Restrictions placed on access to therapy by having a bipolar label	*"Bipolar presentations tend to fall under the general heading of mental health (ill health) and may not be listened to properly."*

Cluster 4: Limited Provision of BD Specialist Guidance – Definition: Restricted provision of services, knowledge, adapted approaches for this population when treating trauma

Code Label	Definition	Illustrative Quotes
Emphasis on biomedical model and pharmaceutical treatment	Recommended treatments for bipolar disorder often focus on medications and this restricts access to psychological therapy	*"Medical focus may mean that they are not referred appropriately."* *"The illness model: clients are told their difficulties are an illness and they require meds. This story can shut down exploration of adverse life events that are related to their difficulties."*
Lack of research and evidence base	Lack of evidence base and guidance to determine EMDR efficacy for the BD population	*"It is not in the NICE guidelines and therefore is not deemed appropriate treatment."* *"Lack of studies with this client group to establish efficacy."*

Coding Manual – Theme 1 'General Adaptations'

Table with examples of identified codes with survey response examples.

Definition:

This theme is looking at what would be the necessary 'general' adaptations that are employed in EMDR therapy when treating trauma with someone with bipolar disorder?

Cluster 1: Broader Treatment Needs – Definition: Consideration of wider treatment needs that should be in place when working with bipolar disorder presentations

Code Label	Definition	Illustrative Quotes
Consultation with Psychiatrist	Communication with the psychiatrist to monitor bipolar symptoms.	*"Good working relationship with psychiatrist to assure mood stabilisation adequate."* *"Work with the client and psychiatry around dose of meds."*
MDT Involvement	Importance of multi-disciplinary care and joined up services	*"Ensure to work as an MDT"* *"More options for consultation and bespoke supervision."* *"A team approach was used."*
Treat Comorbidities	The need to treat comorbidity within Bipolar presentations alongside offering EMDR treatment	*"To treat comorbidities such as drug abuse"*
Infrastructure in service	Importance of having infrastructure in services that support clients with Bipolar, to build team efficacy.	*"Infrastructure in service to facilitate acute treatment if necessary."*
Review if inpatient treatment is needed for the client	Consideration of inpatient treatment	*"Possibly inpatient treatment"*

Cluster 2: Practical Adjustments – Definition: Practical considerations in clinical therapy provision

Code Label	Definition	Illustrative Quotes
Have gaps in the Treatment Plan	The need to have flexibility in the treatment plan	*"Also allowing gaps in treatment if acute illness appears and it is inappropriate to continue."*
Have reminders of appointments	Send out appointment reminders to the client	*"Having reminders for appointments should also help."*
Follow usual trauma work considerations	Follow standard EMDR protocol considerations	*"All the usual considerations. Window of tolerance, resourcing, crisis plans, stabilisation skills, frequency / duration of sessions."*

Be mindful if appropriate time for treatment	Be mindful if appropriate time for treatment and amount of time each session takes dependent on individual needs of client.	*"Consideration of timing e.g., if manic and how their bipolar is being managed."* *"And be very mindful of getting the timing right (e.g., not at a time of extreme mood/mania if possible)"* *"More time, longer or shorter sessions"*
Reminders of STOP Signal	Important to remind client that they can stop the session at any time using STOP signal	*"Reminders of ability to say or signal STOP"*
Thorough Psychoeducation	Offer education to the client about EMDR protocol and importance of stabilisation	*"And well psychoeducation"* *"Psychoeducation to understand bipolar disorder and identify signs of relapse before starting with EMDR"* *"Psychoeducation on trauma and trauma stabilisation skills before starting with EMDR"* *"Stabilisation psychoeducation adapted to bipolar."* *"Initial psychoeducation about bipolar disorder"*

Cluster 3: Additional Techniques – Definition: Use of extra techniques to enhance effects of the EMDR standard protocol

Code Label	Definition	Illustrative Quotes
Use Flash technique first if SUDs ratings are high	If distress levels are high connected to trauma event, useful to use the 'Flash' technique first	*"If the client's SUDS levels are high, it would be advisable to use an adaptation like the FLASH technique, which engages the client in a conversation about something pleasant and asking them to tap themselves with intermittent blinking."* *"Adapted processing phases e.g., utilising EMDR or flash etc."*
Use specific EMDR protocol/subprotocols for Bipolar Disorder	To use the EMDR specific protocol for Bipolar Disorder	*"The use of specific EMDR protocol for bipolar disorder."* *"To use the subprotocols for bipolar disorder"* *"Creating a protocol for EMDR with Bipolar"*
Use Inverted Protocol	To focus on processing current traumas rather than past events first	*"Often the inverted protocol is needed as bipolar patients often have current traumatic/stressful events which needs first attention."*
Use of attachment focused EMDR	Use of Attachment Focused EMDR approaches (Kennard)	*"I am trained in SAFE EMDR (Somatic and Attachment Focused EMDR) and lean heavily into present symptoms/behaviours being helpful at some point for attachment and safety."* *"Therefore, I am inclined to look at any present BP symptoms through this same lens."*

Use a combination of psychological therapies to help mood variation	Include both CBT and EMDR approaches, integrative approaches can be helpful.	*"Include using EMDR techniques such as safe space alongside CBT techniques and compassion focused techniques to support stabilisation of mood."* *"Options for integrative approaches."*
Inner parts work	Incorporating therapy that focuses on parts work and ego states.	*"Work inner parts"* *"Create awareness of inner parts with the aim of an internal secure attachment (adult part watches hurt inner child)"* *"I have found that a gentle blend of parts work has been helpful. Noticing the excitable/manic part and the sad/depressed part of self as often alternating and then working to create a stable 'self' that can be a part of the AIP process. A bit like a parent communicating with a child."* *"Also inviting the client to notice what the goal and unmet needs of each of these parts have been very helpful for accessing stability during processing."*
Use of a Bipolar Scale	Importance of monitoring through use of the bipolar scale	*"I share the bipolar scale with clients, and we routinely discuss mood on the scale and whether able to do EMDR that session."*

Cluster 4: Importance of Client Stability – Definition: Making sure that the client is stable enough to go through processing

Code Label	Definition	Illustrative Quotes
Check that the person's mood is stable enough	Checking the client is stable enough to proceed with therapy	*"Clarify the person is 'well enough' / not too symptomatic to do EMDR at that time"* *"Only if and when the patient is stable and willing to undergo EMDR assessment"*
Increase responsiveness to any signs of mood relapse	Being able to respond quicker and react within a therapy session	*"Responsiveness."* *"Watching out for manic relapse"*
Reinforce client stability, particularly before processing	Focus on client stability before processing	*More clinical stability* *To increase stability: include safe place protocol, 4 elements (E: Shapiro), our mood stabilizer subprotocol* *To have a good stabilization phase* *And work to stabilisation before beginning reprocessing stage.* *And processes that help to maintain the patient in a calm state*
Develop strategies to manage variations in mood	Importance of development of strategies to help with mood variation	*"I think it's important for the person to have strategies to manage variation in mood prior to starting the reprocessing phase"* *"And compassion focused techniques to support stabilisation of mood."*

Build strength through resourcing	The process of recognising and creating coping mechanisms to help people manage difficult emotions.	*"Check-ins re mood using resources to support mood"* *"Resourcing prior to installation if current baselines hypomania"*
Clear safety plan	Development of a safety plan with the client in case of relapse.	*"Client to feel safe and well engaged before commencing work."* *"Clear safety plan in place to support potential relapse."*
Support systems in place	Making sure the client has a network of support around them if needed	*"Support systems in place."*
Create awareness of dissociation	Educate about levels of dissociation that may occur with processing	*"Create awareness about dissociation to help with stability"*
Relapse plan for bipolar symptoms	Creation of a clear relapse plan to guide the client through any relapse difficulties	*"Attention to relapse prevention plan for bipolar symptoms."*
Empower the person to feel able to report any difficulties with psychotic symptoms during therapy	Encourage the client to report any difficulties with symptoms that they may experience	*"Empower the person to feel able to say how they feel / if they are experiencing psychotic symptoms before, during or after sessions"*

Cluster 5: Conceptualisation Considerations – Definition: Importance of a thorough formulation to guide treatment

Code Label	Definition	Illustrative Quotes
More thorough assessment and preparation	Importance of development of thorough assessment and preparation phases before processing	*"Assessment and preparation for suitability and dealing with what may arise."*
Develop a robust, collaborative formulation of the trauma memory networks	Develop a strong formulation that is viewed and agreed by the client in consideration of trauma memory networks	*"Develop a robust, collaborative formulation of the trauma memory networks underlying the client's experiences of going high and feeling low."*

Coding Manual – Theme 2 'Phase 1 Adaptations'

Table with examples of identified codes with survey response examples.

Definition:

This theme is looking at what would be the necessary 'phase-specific' adaptations that are employed in EMDR therapy when treating trauma with someone with bipolar disorder in order to address these barriers?

Phase 1: Client History/Treatment Planning

Cluster 1: Holistic History Taking: – Definition: Development of an all-inclusive detailed history taking of client background

Code Label	Definition	Illustrative Quotes
Thorough history taking	Good, detailed history taking of client and their presentation.	*"May have to gather history from a carer, medical notes, family member."* *"Taking more of a history."* *"Links to historic and present trauma to episode triggers needs identifying."* *"Good history taking around mood disorder (what this is like for them/ their personal experiences)"* *"More clear mental health history."*
Detailed Biographical Timeline	Capturing a detailed timeline that encompasses all client history	*"A detailed biographical line beyond typical traumatic events includes further possible adverse events such as involuntary admissions and medication, physical restraint, consequences of manic episodes"* *"Timelines I believe have a reasonable evidence base in bipolar disorder, so I would pay attention to this aspect."*
Attention to periods of stability and instability in client history.	Pay attention to periods of both stability and instability in client's history	*"Attention to periods of stability/ instability in client history."*
Understanding links between bipolar history with trauma history.	Highlights importance of noticing links and patterns within client's history taking	*"Understanding links between bipolar history with trauma history."*
Identify the trauma memory networks underlying going high and feeling low.	Capture memory networks linked to mood variation	*"Identify the trauma memory networks underlying going high and feeling low."*

Cluster 2: Additional Techniques – Definition: Use of extra techniques to enhance effects of the EMDR standard protocol during phase 1

Code Label	Definition	Illustrative Quotes
Use of back of the head scale	Extra scale to measure the level of client's dissociation	*"Discussion of dissociation/ back of the head scale."*
Use Jim Knipe's 'Loving Eyes' - links to self-criticism	Technique to help a client visualise the adult part of themselves looking at the child-like part that holds the trauma	*"Consider Jim Knipe's Loving Eyes if they are critical towards themselves or emotionally avoidant."*

Cluster 3: Assessment of Present Symptoms – Definition: Importance to assess client's current symptoms

Code Label	Definition	Illustrative Quotes
Assess client's view on relationship between trauma and bipolar symptoms	Capture client's view of their bipolar and trauma symptomology	*"How do they view "trauma" symptoms and "bipolar symptoms", are they separate or similar"?* *"Are these experiences very separate or intertwined for them"?*
Develop clarity on what symptoms are being treated.	Check in what symptoms that the client wants support with	*"Develop clarity about what symptoms are being treated"*
Identify signs of acute episode	Clarify what are the signs of a relapse	*"Signs of acute episode (relapse signature) need identifying."*
More focus on present symptoms rather than core trauma	For client's with BD presentations – there is the need to focus more on present symptoms	*"More focus on present symptoms from an attachment lens."* *"How are the present symptoms something that was once necessary for safety/connection/empowerment"?* *"Links to historic and present trauma to episode triggers need identifying."* *"Present target rather than core trauma"?*
Consider links between trauma and psychosis	Review the links between trauma and a client's potential psychotic symptoms	*"Consider links between trauma and psychotic symptoms"*

Cluster 4: Importance of Client Stability and Safety – Definition: Importance of focusing on keeping a client safe and stable during treatment

Code Label	Definition	Illustrative Quotes
In-depth risk assessment	Include a thorough risk assessment at this phase	*"In depth risk assessment and management"* *"How to keep self-safe when mood very elevated/ depressed."*
Review support systems	Review of what support networks they have available	*"Do they have plans/ support systems in place"?* *"Do they have a wider support team (mental health) - contact with them as well as GP?"*
Review impact of medication	Assess what medication a client takes and how it impacts them	*"Impact of medication (past and current) both positive and negative experiences."* *"Meds"*
Safety and relapse planning	Review client's safety and establish relapse plan	*"Safety and relapse planning"* *"Risk safety Client"*
Review mood stability	Assess if the client is stable enough to proceed	*"How stable is their mood?"* *"Are they in the right place to start EMDR (readiness/ stability) or is further preparation needed."*
Ensure they have a suitable calm place	Ensure clients can access an image that provokes a calm place	*"Ensure they have a calm place they can use, and a resourcing exercise."*
Review coping strategies for mood variation	Establish client has coping strategies in place to help with mood variation	*"Understanding how client currently manages variation in mood and how frequently changes occur"* *"How would they manage a deterioration/ change in mood? Can they usually recognise this?"*

Cluster 5: Therapeutic Considerations – Definition: Considerations for the content of therapy

Code Label	Definition	Illustrative Quotes
Clearer focus on expectations	Set out clarification of client expectations within this phase	*"Simpler/appropriate explanations of how things work and what to expect."* *"What are their hopes/ expectations for therapy?"*
Prolonged engagement phase	A longer engagement phase here may be useful	*"Getting to really know the person and fluctuations in symptoms - prolonged engagement phase"* *"Allowing plenty of time to allow therapeutic rapport and trust to develop."*
Focus on psychoeducation of bipolar	Spending time focusing on psychoeducation on having a bipolar presentation	*"Honouring the Bipolar presentation as something that was once necessary for survival while also exploring what needs it no longer meets."*

Coding Manual – Theme 2 'Phase 2 Adaptations'

Table with examples of identified codes with survey response examples.

Definition:

This theme is looking at what would be the necessary 'phase-specific' adaptations that are employed in EMDR therapy when treating trauma with someone with bipolar disorder in order to address these barriers?

Phase 2: Preparation Stage

Cluster 1: Additional Techniques – Definition: Use of extra techniques to enhance effects of the EMDR standard protocol during phase 2

Code Label	Definition	Illustrative Quotes
Parts work (IFS 8 c's of self)	Incorporating therapy that focuses on parts work and ego states.	*"Introduction of present self (sometimes blending with IFS 8 C's of the self) to create a part of self that is most neutral and observational".*
Practice techniques to change behaviours and thought patterns for mood variation.	Using techniques to help alter variations in mood levels	*"During the preparation phase include practicing recognising the patterns and changing behaviours/thought patterns that contribute/ maintain the variation in mood."*
Inclusion of CBT approaches	Using CBT approaches to enhance treatment outcome and support mood management	*"Possibly include CBT to support mood management and stabilise mood if this is currently problematic or to provide further support if mental state were to deteriorate."*
Emotional regulation and distress tolerance skills	Focus on ways to regulate emotions	*"Emotional regulation and distress tolerance skills"*
Create subprotocols in case of adherence difficulties	Create subprotocols alongside standard protocol	*"We created further four subprotocols in case of adherence problems, not being aware of prodromal symptoms, lack of insight or idealization of manic symptoms."*
Encourage mood monitoring	Encourage client to monitor their moods	*"Encourage client to monitor mood to be able to more readily pinpoint when mood is elevating/ dipping"* *"Can they usually effectively monitor and manage changes in their mood?"*

Cluster 2: Importance of Client Stability and Safety – Definition: Importance of focusing on keeping a client safe and stable during treatment

Code Label	Definition	Illustrative Quotes
More awareness of relapse indicators	Increasing awareness of potential relapse triggers	*"More awareness of relapse indicators* *Can they recognise early warning signs etc."*

Code Label	Definition	Illustrative Quotes
More somatic resources	Increasing body awareness through the positive use of somatic resources	*"More somatic resources for increasing the window of tolerance."*
Thorough resourcing	Focus on more resourcing by identifying client's own abilities to resource and calm the nervous system.	*"Thorough resourcing by using attachment informed figures and clients own abilities to resource."* *"Resource teams"*
Increase stability	Spend more time on increasing a client's stability	*"To increase stability: include safe place protocol, 4 elements (E: Shapiro), our mood stabilizer subprotocol".* *"Good stabilization before starting the reprocessing."* *"Extra stabilising and resourcing"* *"Adapted or longer stabilisation if necessary"*
Develop safety and relapse plan	Develop clear safety plan that highlights relapse indicators	*"Develop safety and relapse plan that is coordinated with other services and consistent with what they offer"* *"Know some of their red flags for episodes if they are not medicated or stable."*
Consider phased approach to grounding	Consider a slower approach to grounding within this phase	*"Consider phased approach to grounding"*
Increase Installation work	Spend more time on installation of positive material	*"Ensuring to do lots of installation work"*
Develop compassion resources	Focus on development of compassionate resources for client	*"Compassion resources during periods of low mood"* *"Installation of protective, compassionate, wise figures/ attachment focused EMDR."*
Safe place protocol	Make sure that the client has a safe place to access.	*"Include safe place protocol"* *"Using EMDR techniques to manage mood e.g., safe space at the first signs of mood becoming elated."*
Gather information from others (family, support networks, health professionals, psychiatry)	Importance of obtaining information from wider support networks	*"Include a psychiatrist and a family member, if possible"* *"Gathering additional information from others (e.g., health professionals, partners, parents)"*
Establishing trust between therapist and client	Establish trust between client and therapist	*"Establishing trust between therapist and patient"* *"Allowing plenty of time to allow therapeutic rapport and trust to develop."*
Using established and appropriate tools	Use of standard protocol stability tools	*"Using appropriate tools such as safe/calm space/place, containers, and measurement tools."*

Cluster 3: Psychoeducation – Definition: Content of therapy that focuses on educating a client over specific details of their presentation and difficulties

Code Label	Definition	Illustrative Quotes
Simplify explanations	Use of simplified terminology with client	*"Reinforcing simple/appropriate explanations of how things work and what to expect."*
Reassure client that treatment is unlikely to trigger episode	Importance of showing reassurance	*"Reassurance that treatment is unlikely to trigger an episode as trauma already impactful and treatment leads to quick gains."*
Discussing with client consequences of potential reprocessing	In terms of preparation, fully make client aware of the potential impact of processing	*"Include in preparation that the reprocessing of trauma may be a trigger so that people can make an informed choice about when to proceed with treatment."* *"Education and information on EMDR"*

Coding Manual – Theme 2 'Phase 3 Adaptations'

Table with examples of identified codes with survey response examples.

Definition:

This theme is looking at what would be the necessary 'phase-specific' adaptations that are employed in EMDR therapy when treating trauma with someone with bipolar disorder in order to address these barriers?

Phase 3: Assessment Phase

Cluster 1: Additional Techniques – Definition: Use of extra techniques to enhance effects of the EMDR standard protocol during phase 3

Code Label	Definition	Illustrative Quotes
Use of CIPOS (Constant Installation and Present Orientation to Safety)	Consideration of using the CIPOS technique	*"Would do CIPOS"*
Use of formulation to incorporate mood variation	Development of a clear formulation that takes into consideration client's mood patterns	*"During the assessment phase including formulation of elated and low mood patterns to help the person understand contributing and maintaining factors for these (if they don't already understand it)."* *"Formulation of low and elated mood patterns"* *"To be aware that episodes of high/ low mood in the past may have been traumatic or had a significant impact on their life and be relevant to any timelines."*

Cluster 2: Importance of Client Stability – Definition: Importance of focusing on keeping a client stable during treatment

Code Label	Definition	Illustrative Quotes
Identifying aspects that may trigger abreaction	Make sure to identify potential triggers for an intense reaction in processing	*"Identifying aspects that may trigger abreaction and agreeing strategies to deal with them"* *"Identify targets on impactful symptoms or episode triggers."*
Having strategies in place to deal with abreactions	Have developed strategies in place to manage potential abreactions	*"Identifying aspects that may trigger abreaction and agreeing strategies to deal with them"*
Additional resources	Have additional resources in place when working with Bipolar	*"Additional resources in place"*
Go through some trial runs of EMDR with small SUDs event	Trial the EMDR processing with client with a small SUDs level event beforehand.	*"And has undergone some trial runs of the EMDR technique e.g., for safe place and SUD3-4 recent life event".*

Cluster 3: Conceptualisation Considerations – Definition: Importance of a thorough formulation to guide treatment

Code Label	Definition	Illustrative Quotes
Clear explanation of case conceptualisation	Importance of establishing a clear formulation beforehand	*"Clear explanation of case conceptualisation beforehand"*
Look for similar themes in traumatic events	Look for similar cluster of themes to aid formulation	*"What are the aims of EMDR? one off event or more complex? Either way, is there similar themes in these events?"*

Cluster 4: Processing Guidance – Definition: Guidance on Processing within EMDR

Code Label	Definition	Illustrative Quotes
Identifying realistic cognitions (negative and positive) and deeper beliefs	Establish realistic cognitions with the client during this phase	*"Really making sure both the negative cognition and positive cognition are realistic (i.e., grounded in reality)."* *"Be flexible re-identification of negative and positive cognition"* *"Identify the underlying "I am...." negative cognition, ensuring this is about the self."* *"Be wary of "I am" statements around control of emotions, as no human is ever in control of their emotions, and about vulnerability, as we are all vulnerable."* *"EMDR cannot make someone be in control and invulnerable."*
Ensure they can feel the disturbance in their body.	Ensure client can feel distress levels somatically	*"Ensure they can feel the disturbance in their body."*

Coding Manual – Theme 2 'Phase 4 Adaptations'

Table with examples of identified codes with survey response examples.

Definition:

This theme is looking at what would be the necessary 'phase-specific' adaptations that are employed in EMDR therapy when treating trauma with someone with bipolar disorder in order to address these barriers?

Phase 4: Desensitisation

Cluster 1: Additional Techniques – Definition: Use of extra techniques to enhance effects of the EMDR standard protocol during phase 4

Code Label	Definition	Illustrative Quotes
Use of Flash first	Suggested use of the Flash protocol before EMDR full processing	*"Use of flash technique first"* *"Using methods to reduce SUDS before processing if necessary. I use Flash or EMDR 2.0"* *"Flash? Other ways to reduce intensity of target, if necessary, e.g., EMDR"*
Adapt interweaves	Use of adapted Interweaves (to help with stuck processing)	*Adapt interweaves*
Adaptation of SUDs ratings	Adapting SUDs (rating of emotional disturbance) ratings to accommodate for client that you are working with	*"SUD ratings may be adapted to suit the patient"*

Cluster 2: Importance of Client Stability – Definition: Importance of focusing on keeping a client stable during treatment

Code Label	Definition	Illustrative Quotes
Slower desensitisation to aid stability	Slower processing throughout phase 4.	*"Slower desensitisation to aid stability* *Be aware that many sessions may be needed; reprocessing may be slow going."*
Mood monitoring alongside processing	Importance of close monitoring within this processing phase	*"To be aware of changes in presentation."* *"Is processing triggering changes in mood? And plans to manage this."* *"With monitoring of the level of emotional affect (not necessarily SUDs)"*
Decrease triggering stress response	Decrease or counter the stress response in a client	*"Decrease triggering of stress response believed to be a trigger for manic episodes"*

Code Label	Definition	Illustrative Quotes
Ensure that this is the right time to process	Making sure that the client is able to engage within this phase before proceeding	*"Ensuring the moment was right for this and the person was able to focus."*
Regular check-in's	Monitor the wellbeing of client	*"Check-ins re mood using resources to support mood"*
Sticking to identified treatment plan.	Adherence to agreed treatment plan set during initial phases	*"Putting into practice the identified treatment plan."*

Cluster 3: Bilateral Stimulation Adjustments – Definition: Bilateral stimulation adjustments within EMDR processing

Code Label	Definition	Illustrative Quotes
Clarify preference around BLS	Clarify what type of BLS the client prefers to help with processing	*"Clarifying preferences around BLS, (e.g., depending on types of psychotic symptoms)"*
Slow down BLS	Be careful that BLS is not too fast, if so may need to slow down	*"As usual in the standard protocol but watch out as sometimes too fast EM is not tolerated well by bipolar clients and induces more hypomanic symptoms."* *"In that case slow down velocity or change to tapping."*
Shorter and faster sets of BLS	Client due to manic behaviours will need shorter sets of BLS to aid processing	*"Sometimes shorter and faster sets are helpful when client is experiencing more manic behaviours."*

Coding Manual – Theme 2 'Phase 5 Adaptations'

Table with examples of identified codes with survey response examples.

Definition:

This theme is looking at what would be the necessary 'phase-specific' adaptations that are employed in EMDR therapy when treating trauma with someone with bipolar disorder in order to address these barriers?

Phase 5: Installation

Cluster 1: Positive Cognition Considerations – Definition: Things to consider when choosing appropriate positive cognition to install

Code Label	Definition	Illustrative Quotes
Ensure positive cognition is realistic	Make sure positive cognition selected is meaningful and not ambitious	*"Again, ensuring the positive cognition being installed in realistic and not overly grandiose."*
Encourage a PC that welcomes neutral acceptance	Encourage positive cognitions for client that welcomes neutral acceptance	*"A PC that welcomes neutral acceptance (so avoiding PCs of "I am amazing" or "I can do anything" which may occur in more manic phases."*

Cluster 2: Identifying Change in Emotion and Cognition – Definition: Things to consider when evaluating reported changes in measurements of emotions and cognitions

Code Label	Definition	Illustrative Quotes
VOC ratings should be adapted to suit the client	Validity of cognition ratings should be adapted to suit the client	*"VOC ratings may be adapted to suit the patient"*
Flexibility with getting SUDs rating down to 0	Be mindful that you may not get the SUDs ratings down to 0 when working with this population	*"Flexibility with getting suds rating down to 0 / or for cognitions to be completely true - this may not be the most appropriate goal unless other symptoms treated"*

Coding Manual – Theme 2 'Phase 6 Adaptations'

Table with examples of identified codes with survey response examples..

Definition:

This theme is looking at what would be the necessary 'phase-specific' adaptations that are employed in EMDR therapy when treating trauma with someone with bipolar disorder in order to address these barriers?

Phase 6: Body Scan

Cluster 1: Client-Related Factors – Definition: Considerations concerning client experiences

Code Label	Definition	Illustrative Quotes
When clients need to pay attention to their bodies, find a method that makes them more comfortable.	Adapting this phase so that it is more comfortable for the client to experience	*"Sometimes my clients with bipolar found tuning into their bodies challenging so finding a way to make it more comfortable."*
If present assess the impact of any hallucinatory experiences	Consider if the client has hallucinatory experiences	*"Consider impact of hallucinatory experiences"*

Cluster 2: Body Recognition – Definition: Creating body awareness

Code Label	Definition	Illustrative Quotes
Clearer ways of recognising change with the body	Develop clearer ways to recognise changes within a client's body	*"How to recognise change and how the target(s) may now be named/recognised"* *"Can be very helpful to get a sense of how levels of affect are experienced somatically and work on those areas."*
Make sure body scan is linked to target	Make sure body scan is linked to target not general sensitivity	*"Linked to target not general sensitivity"*

Coding Manual – Theme 2 'Phase 7 Adaptations'

Table with examples of identified codes with survey response examples.

Definition:

This theme is looking at what would be the necessary 'phase-specific' adaptations that are employed in EMDR therapy when treating trauma with someone with bipolar disorder in order to address these barriers?

Phase 7: Closure

Cluster 1: Extra Monitoring – Definition: Importance of increased monitoring of client

Code Label	Definition	Illustrative Quotes
Close monitoring in between sessions	Encourage close monitoring of client's wellbeing	*"What to note at the end of each session and how to monitor in between sessions and report progress /or otherwise."* *"I offer in between session contact."*
Encourage client to keep a journal	Encourage client to keep a well-being journal to track progress	*"Encouraging keeping journal."*
Encourage client to make contact with yourself or primary care, if they experience heightened symptoms that make them feel unsafe.	Allow open contact between therapist and client to ensure that they have someone to talk to if they feel unsafe	*"Contacting me or primary care if experiencing heightened symptoms that feel unsafe."*

Cluster 2: Importance of Client Stability – Definition: Importance of focusing on keeping a client stable during treatment

Code Label	Definition	Illustrative Quotes
Importance of relapse focus	Ensure that there is a plan for relapse	*"But be clear about when they may need out to reach out due to indicators of relapse into a manic/depressive state."* *"Assuring relapse signature is known and to encourage engagement with usual team if occur."* *"Ensuring that this is a planned process with a "blueprint" for ongoing recovery."*
Normalise Disturbance	Making client aware that further disturbance may occur, but this can be normal	*"Make sure to normalise some disturbance if it should occur"*

Coding Manual – Theme 2 'Phase 8 Adaptations'

Table with examples of identified codes with survey response examples.

Definition:

This theme is looking at what would be the necessary 'phase-specific' adaptations that are employed in EMDR therapy when treating trauma with someone with bipolar disorder in order to address these barriers?

Phase 8: Re-evaluation

Cluster 1: Extra Monitoring – Definition: Importance of increased monitoring of client

Code Label	Definition	Illustrative Quotes
Regular check in's.	Importance of more check's in on client's wellbeing	*"Check in around any mood fluctuations as well as intrusions."* *"Consider check in between sessions"* *"Short session at the beginning of each session to collect information about patients progress or difficulties encountered in between sessions."*

Cluster 2: Importance of Client Stability – Definition: Importance of focusing on keeping a client stable during treatment

Code Label	Definition	Illustrative Quotes
Increase a client's ability to recognise potential relapse warning signs	Create awareness of potential relapses for client	*"Need to be able to recognise relapses into manic or depressive episodes"*
Additional time for grounding at end of session	Making space for grounding at end of the session	*"Additional time for grounding at end of session"*
Having agreed measurement tools	Have measurement tools that have been agreed upon to record the mood ratings of the client	*"Use of agreed measurement tools"*

Coding Manual – Theme 3 'Supervision'

Table with examples of identified codes with survey response examples.

Definition:

This theme is looking at what are the additional recommendations and considerations that need to be adopted in clinical supervision provision, when using EMDR to treat trauma in bipolar disorder presentations?

Cluster 1: Supervisor Capabilities – Definition: Qualities, knowledge, abilities, and aptitudes of a supervisor.

Code Label	Definition	Illustrative Quotes
Supervisor should have knowledge and understanding of bipolar disorder	The importance of being supported by a supervisor who is familiar with bipolar presentations	*"Knowledge and understanding of bipolar disorder"* *"Supervisor needs to be familiar with bipolar disorder and has hopefully used EMDR with this population."* *"Making sure supervisors and supervisees understand bipolar as a condition."*
Supervisor should have knowledge of what specific adaptations of EMDR to use when working with dissociation.	Having a supervisor who has knowledge of adaptations to the standard protocol of EMDR with dissociation.	*"Supervisor - Knowledge of EMDR adaptations and dissociation with clinical experience to guide dissociation knowledge."*

Cluster 2: Supervisee Capabilities – Definition: Definition: Qualities, knowledge, abilities, and aptitudes of a supervisee.

Code Label	Definition	Illustrative Quotes
Understanding of bipolar psychiatric treatment	A supervisee having a knowledge of the psychiatric treatment for Bipolar, i.e., types of medication	*"Supervisee - Assure some working understanding of bipolar psychiatric treatment."* *"Understand what medications do what and why."*
Good engagement skills	A supervisee having good communication skills within therapy	*"Good engagement skills in treatment."*
Understanding of bipolar	A supervisee having good comprehension of bipolar disorder.	*"Understanding of bipolar and the service context."* *"Making sure supervisors and supervisees understand bipolar as a condition."*
Review skills needed to work with trauma and bipolar	Look at the specific skills set that is needed by a supervisee when treating trauma with client's with bipolar.	*"Consider skills to work with bipolar and trauma"*

Code Label	Definition	Illustrative Quotes
Consideration of Supervisee's Competence	Consider if the supervisee is competent and has the skills to work with this population	*"Also thinking about whether it is within the supervisees competence"*

Cluster 3: Supervisory Structure – Definition: Structure of supervision

Code Label	Definition	Illustrative Quotes
More regular supervision	Supervision sessions will need to be more regular to support the supervisee's clinical practice	*"Supervision will need to be more regular"*
Psychiatrist Involvement	Importance of consultation/guidance of psychiatric treatment for bipolar.	*"The psychiatrist should be in the boat and agree on the trauma-focused intervention, also in case of relapse."* *"Considering impact of medications which can be somewhat straight jacketing."*

Cluster 4: Supervision Content – Definition: What content needs to be discussed and covered within supervision setup.

Code Label	Definition	Illustrative Quotes
There needs to be regular updates on client progress	Monitoring of client progress within therapy	*"Regular reflection on the mood state as well as the progress with direct trauma symptoms."*
Use of formulation to take into consideration the complexities of trauma and bipolar	Importance of forming conceptualisation and developing a formulaic picture to take into consideration of BD complexities	*"Formulation of the complexity of patients with trauma and bipolar and how this affects history taking and target selection."* *"Develop a fully trauma-informed formulation, rather than some aspects of a person's experiences being understood as trauma-related distress and some as illness."*
There should be time to focus on client safety throughout	Review client safety throughout treatment	*"Patient Safety - triggers and interventions, safety factors relevant to each patient."*
Encourage discussions of the reprocessing of traumatic events	Support conversations about reprocessing of trauma events	*"Encourage discussions about the reprocessing of traumatic events"*
Importance of supervising client stability	Making sure client stability is reviewed during phase 2 of the protocol in supervision	*"Supervise stability of the client (phase 2)"*

Code Label	Definition	Illustrative Quotes
Considerations of how to pause/stop processing	If therapy is causing adverse reactions, knowing how to stop or pause treatment	*"How to skilfully stop/pause processing (or indeed therapy) if it is causing de-stabilisation and increasing risk to self and others."*
Consider the unmet needs of the client	Identify if the presentation is compensating for any needs that are unmet or unidentified for the client	*"What is the unmet need/needs of the client that the bipolar presentation compensates for?"*
Move away from the medical model	Making sure that supervision does not have the focus of a medical model.	*"Move away from the medical model and medicalised language in supervision"*
Incorporating attachment focus and reflect in supervision	To consider utilising a modified strategy that incorporates attachment theory concepts into conventional EMDR	*"Honestly, an attachment focus feels essential for this work, reflect in supervision."*
Review evidence base and keep up to date on dissociation knowledge	Keep up to date with recent reviews and knowledge of Dissociation	*"Using recent reviews, research and clinical experience to guide, bipolar and dissociation knowledge"*

Appendix O Table O.1

Statements That Did Not Reach Consensus

	% of participants agreeing with items 1-2
General Adaptations to EMDR	
Consultations with psychiatrist to monitor bipolar symptoms	59
MDT involvement (team approach)	59
Have gaps in the treatment plan	32
Have reminders of appointments	55
Use Flash technique first if SUDs ratings are high	50
Use specific EMDR protocol/subprotocols for bipolar disorder	32
Focus on processing current traumatic/stressful events first (Inverted Protocol)	28
Incorporate therapy that focuses on parts work and ego states	37
**Treat comorbidities (drug abuse)	70
** Infrastructure in service to facilitate acute treatment	55
**Review if inpatient treatment is needed for the client	75
** Use attachment focused EMDR approaches (SAFE) (Kennard)	55
** Use a bipolar scale with clients, and routinely discuss mood on the scale	60
Phase 1: Client History/Treatment Planning	
More focus on present symptoms rather than core trauma	36
Have a prolonged engagement phase	50
**Use of back of the head scale measure of dissociation (Jim Knipe)	55
**Use Jim Knipe's 'loving eyes' if they are critical towards themselves or emotionally avoidant.	70
Phase 2: Preparation Stage	
Incorporate therapy that focuses on parts work and ego states	37
Using CBT approaches to enhance treatment outcome and support mood management	46
Create subprotocols in case of adherence difficulties	41
Spend more time on installation of positive material	59
Gather information from others (family, support networks, health professionals, psychiatry)	59
Simplify explanations	59
Reassure client that treatment is unlikely to trigger episode	59
** Practice techniques to change behaviours and thought patterns that contribute to mood variations	70
** Spend more time on increasing a client's stability	75
** Use a phased approach to grounding	65
Phase 3: Assessment Phase	
Use CIPOS (Constant Installation and Present Orientation to Safety) Technique (Knipe)	45
**Trial EMDR processing with a small SUDs level event beforehand.	50
Phase 4: Desensitisation	
Slower desensitisation to aid stability	55
Slow down BLS	32
Shorter and faster sets of BLS	37
**Use 'Flash' first (Manfield) to reduce intensity of target	30
** Adapt interweaves	60
**Adapt SUDs ratings to suit the client	50

	% of participants agreeing with items 1-2
** Complete mood monitoring alongside processing	70
**Make sure to decrease triggering the stress response in a client	50
** Stick to agreed treatment plan set during initial phases	35
Phase 5: Installation	
**Adapt VOC ratings to suit the client	50
Phase 7: Closure	
Ensure that there is a "blueprint" for ongoing recovery.	59
**Encourage client to keep a journal	45
Elements of EMDR Clinical Supervision	
Supervision will need to be more regular	50
There should be psychiatry involvement.	50
**Spend time determining whether the bipolar presentation is compensating for any unmet needs	75
** Incorporate an attachment focus and reflect in supervision	60

Note. MDT= multidisciplinary team, SUDs= subjective units of distress scale, EMDR= eye movement desensitisation and reprocessing, CBT= cognitive behavioural therapy, BLS= bilateral stimulation, VOC= validity of cognition
**These items were re-rated in round 3.

Appendix P Table P.1

General and Phase-Specific EMDR Adaptations Rated as 'Should not be Included'

	% of participants agreeing with item 5	% of participants agreeing with items 1–2
General Adaptations to EMDR		
*Have gaps in the treatment plan	14	32
*Use specific EMDR protocol/subprotocols for bipolar disorder	5	32
Phase 2: Preparation Stage		
*Practice techniques to change behaviours and thought patterns that contribute to mood variations	4	70
*Using CBT approaches to enhance treatment outcome and support mood management	4	46
*Create subprotocols in case of adherence difficulties	4	59
*Simplify explanations	4	59
*Reassure client that treatment is unlikely to trigger episode	14	59
Phase 4: Desensitisation		
*Adapt SUDs ratings to suit the client	9	50
*Slower desensitisation to aid stability	4	55
*Complete mood monitoring alongside processing	4	70
*Slow down BLS	9	32
Phase 5: Installation		
*Adapt VOC ratings to suit the client	4	50

Note. EMDR= eye movement desensitisation and reprocessing, CBT= cognitive behavioural therapy, VOC= validity of cognition, BLS= bilateral stimulation
* did not meet consensus