Psychotherapeutic interventions and Bipolar Disorder: Impact of bipolar disorder on individual's families and wider society.

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Abstract

This paper discusses Psychotherapeutic intervention used to treat bipolar disorder. It aims to highlight the importance of psychotherapeutic treatment interventions for individuals with bipolar and the benefits to their families and society. These benefits include improved quality of life, financial status and engagement with psychiatric service, resulting in better medication adherence. In this paper we look at psychotherapeutic interventions both as an adjunct to pharmacology and as an independent treatment of bipolar disorder.

Key words: bipolar, psychotherapeutic, pharmacology, cognitive behaviour therapy, psychoeducation, family therapy, social rhythm therapy.

Introduction

Psychotherapeutic interventions support the symptom management and relapse prevention of bipolar disorder. According to Miklowitz they are recommended as an adjunct to pharmacology (medication) in the treatment of bipolar (1). Mood-stabilising medication is used to aid the stabilizing of all phases of bipolar to manage mood swings effectively and is the main recommended treatment. It is estimated that one third of persons diagnosed with bipolar disorder take less than 30% of their medication and non-adherence to medication is associated with relapse and suicide (2). The aim of psychotherapeutic approaches working with patients diagnosed with bipolar disorder is to: increase medication compliance, reduce relapse episodes and social risks, along with improving overall life experience. This paper is a brief overview, identifying psychotherapeutic approaches that assist in both symptom management and relapse prevention of bipolar disorder.

Bipolar disorder

Bipolar disorder was historically known as manic depression; the current diagnostic criteria are outlined in the clinical descriptions guidelines of ICD -10 (3) under mood disorders. There are varying degrees in severity and frequency of manic and depressive states ICD- 10 (3). Therefore psychiatric diagnosis and classification of bipolar disorder is on the basis of mood episodes DSM-IV (21). Bipolar disorder is defined by 'manic' episodes of abnormally elevated energy levels with increased activity and alternate low mood states associated with depression. Some severe manic states can lead to psychotic episodes and, along with depressive states, can result in suicidal ideation and action with risk of death. Both of these states lead to a disturbance in cognition, mood, behaviour and overall individual functioning. Variations in mood are unique to the different types of bipolar disorder. The main four types include: bipolar 1 which is the most severe. The individual would have one or more manic and depressive episodes. Second, there is bipolar II, where there is at least one depressive episode alternating with a hypomanic state. Third there is cyclothymic disorder, which involves milder mood states than bipolar II, but still consists of both depressive and hypomanic symptoms (episodes) with lesser severity. Finally there is Unspecified bipolar disorder, where the mood states exist outside of the identified diagnostic criteria of the other types mentioned. This disorder can be problematic both for the individual and their family, psychologically and financially.

Impact of bipolar disorder on individuals, their families, friends and wider society

The bipolar disorder diagnosis is proposed to reach a lifetime prevalence of 4% of the population, approximately half divided between Bipolar I and II, with the remaining 2% Bipolar Disorder Not Otherwise Specified (4). The associated risks are high and can be devastating. According to Scott et al., there is a 6% death by suicide rate and 30% - 40% of patients deliberately self-harm (5). A wider study found the suicide rate to total 12.6% which was higher than schizophrenia and depression (5). In addition, there are those who are not yet diagnosed so their associated struggles go unrecorded. An individual experiencing an episode can face interpersonal conflicts, social isolation, cognitive deficits and distortions, affecting the way they are able to relate to themselves and others, in addition to influencing the way in which they perceive and interact with the world. The symptoms also have challenging implications for society generally.

The effect of bipolar disorder for the individual within the context of wider society includes negative effects on: relationships, family, likelihood of criminal activity, social stigma, a range of psychosocial problems and unemployment. In the manic states there can be an increase in abnormally optimistic thinking that can lead to unhelpful behaviours. These thoughts and mood swings can lead to disruptive behaviours, whcih can include over (erratic) spending, promiscuity, violence, excessive multiple tasking and impulsive actions. During the depressive states there can be a tendency for what can be described as a crash in mood. Subsequently, the individual can experience pessimistic thoughts that will be followed by associated behaviours such as: withdrawal from social support networks (isolation), substance misuse, reduced self-care and decreased environmental care. For both states the contemplation and action of suicide can be prevalent. Disruptions to functioning can result in unemployment prior to, during and post hospitalization. It is reported that approximately one third of bipolar patients had impaired work functioning 2 years after hospitization (6). With employment problems, treatment costs and behavior disruptions, there are financial implications to the individual living with the disorder and an economic impact on society as a whole.
These are serious negative consequences, highlighting the importance of effective management of this psychiatric disorder. Even though it is emphasized that pharmacology is the favoured treatment of bipolar symptoms, the integration of other treatments is also recommended in psychiatric practice guidelines (6). Non-adherence to taking medication has been identified as a major factor contributing to relapse and increased overall wider economic cost (2).

Cognitive Behavioural Therapy

Cognitive Behavioural Therapy (CBT) works with the relationship between thoughts, beliefs, feelings and behaviours. Individuals experiencing manic and depressive episodes can have associated distorted perception, thinking and subsequent unhelpful action.
The aim of this therapy is to reframe faulty thinking both to increase awareness (medication compliance) and to support subsequent mood and behavioural responses (7). Miklowitz (1) cites Cochran who examined CBT treatment in a randomized controlled trial, that was reported to be successful in promoting lithium (mood stabilizer) compliance. Subsequently this reduced individual hospitalization and reported mood episodes. Another example of CBT effectiveness can be seen in Lam et al. who found a decrease in relapse rate: 44% for CBT treatment group as opposed to 75% for a routine treatment group (7).

Studies have found CBT to be more effective in managing depressive symptoms than mania. Focusing on these symptoms, techniques such as: challenging unhelpful beliefs and thoughts connected with helplessness or hopelessness, behavioural activation, goal setting and exercise tools are used (8).
Ball (7) found patients attending CBT had lower depression scores and tended to have longer times between depressive episodes and relapse over 18 months; however the benefits of the treatment were reported to diminish over time. This indicated that, even though valuable, this treatment, may have been time limited and therefore subsequent top-up sessions could be recommended. Also, CBT was found to be most effectively delivered in the recovery period rather than in an acute episode. This

study further showed that CBT was most effective in patients that had fewer than 12 previous episodes (7).

There are additional Psychotherapeutic interventions that are also evidentially supported as being useful in managing symptoms.

Individual psychoeducation

Psychoeducation aims to use didactic (directional) teaching about bipolar disorder to facilitate learning about the symptoms, development of relapse prevention plans, and learning the importance of adherence to medication and illness-management strategies (7). Miklowitz (1,11) mentions a randomized study by Perr et al. that looked into the value of this intervention with bipolar patients. This study found 'clear benefits' after 18 months. The likelihood of manic recurrences was 27% of patients in the psychoeducation group relapsed as opposed to 57% of patients in the routine care group. However, there was no time delay in depressive recurrences, unlike the CBT interventions. Even though the value of psychoeducational interventions is recognized, other therapies that specifically target bipolar-related activity have also been reported.

Interpersonal therapy and social rhythm therapy

Interpersonal therapy aims to enable the patient to identify their different emotional states. It focuses on the social situation in which stressors may emerge, with the purpose of identifying the problematic patterns of communications and to propose possible alternatives (4). Two studies revealed greater periods of stability and psychosocial functioning in patients who received interpersonal therapy treatment than those who did not.

Social rhythm therapy derives from interpersonal therapy and two main behavioural observations of bipolar disorder. Bipolar disorder is often associated with poor interpersonal functioning and there are typically sleep disruptions, involving poor sleep and wake cycles. These inconsistencies or instabilities can perpetuate manic episodes (1). The main objective of this therapy is to resolve key interpersonal problems related to: bereavement, role disputes, interpersonal conflicts or deficits. It aims to help stabilize moods and to steady 'social rhythm' that includes irregularities - sleep patterns, exercise and socializing. It does this by monitoring routines, such as keeping track of patterns (disruptive and stabilizing) and the identification and regulating of events that can provoke episodes (1). Miklowitz (1) reported a trial in which acutely ill patients were assigned randomly to pharmacology and weekly interpersonal and social rhythm therapy (IASRT) or pharmacology and weekly clinical management sessions. Also patients, who were in the recovery period, were randomly assigned to interpersonal and social rhythm therapy (IASRT) or clinical management for a two-year maintenance period. Patients who received IASRT during the acute phase had longer intervals of being well in the maintenance phase. IASRT was most effective in delaying recurrences in the maintenance phase and succeeded in stabilizing their social rhythms during the acute phase and for mania. IASRT initiated during the recovery period was no more effective than clinical management in preventing recurrences over two years. Therefore, IASRT presented as being most effective when administered during an acute episode.

Psychodynamic Interventions

Even though there are only a few studies identifying the benefits of this type of therapy, due to its unquantifiable nature, there is still an indication of its benefits in supporting individuals with bipolar disorder. When working with patients who have bipolar disorder, this approach aims to: establish a therapeutic relationship which helps patients overcome denial of illness, address relationship issues and manage medication. The clinician's aim is to explore the more traditional themes of psychotherapy and build on the therapeutic alliance. Rothbaum and Astin (6) reported that a group on a combination of lithium and couple psychodynamic therapy had fewer relapses and better social outcomes than two other groups on lithium alone.

Although the approach is adaptable to individuals and groups there are specific therapy models identified to be more effective, with broader interventions.

Systemic Care models

These models are multicomponent programs for the treatment of bipolar disorder that cover a combination of psychosocial interventions. They include those with a psychoeducation character and simple treatment procedures. These interventions include: psychoeducation, encouraging an active role in treatment and permitting the patient easy access to and holistic inclusion with the medical services and team. Lolich et al. (4, 46, 48, 49, 50, 5) found, in controlled studies as stated in the literature review, that there was a significant reduction in severity and frequency of manic episodes and better levels of functionality for patients within the multi-care systems program. The improvements in quality of life and functionality were shown to have a better or longer lasting effect 2 to 3 years after initiation of the intervention; however like the psychoeducational study there was no reduction of depressive symptoms.

Family Therapy

In considering the individual's interaction with their environment, family therapeutic treatments include both the diagnosed individual and their family unit. There are various approaches within this therapy including family psychoeducation and multifamily group psychotherapy. The baseline objectives of this treatment include supporting the individual to regulate their emotions and enhancing interpersonal communication when facing conflict. Also this intervention aims to improve family functioning through psychoeducation and understanding of the nature of the symptoms, disease course and treatment. It aims to develop the skills of the individuals and families and to enable them to acquire knowledge to manage the disorder more effectively. The focus of research studies is on improving communication, problem solving and seeking to prevent or decrease possible conflicts. Family therapy has been most effective when implemented after an acute episode and but can begin in moderate or acute states.

Lolich et al. (4, 9, 31) reported on a study that was carried out in 2003 with 101 patients diagnosed with bipolar disorder. She compared family therapy with family education as an adjunct to medication (pharmacological treatment). The family therapy group had a longer time between episodes, better pharmacological treatment compliance and increased relapse prevention.
There is evidence to suggest that family therapy is identified as an effective adjunct to medication in delaying psychotic reoccurrences in patients with schizophrenia and in relapse prevention of bipolar disorder (1, 16). An example of this is reported by Miklowitz in a small scale trial (N=33) that found acutely ill patients receiving an 11-month psychoeducational marital intervention had better medication adherence and greater improvements in functioning than those receiving pharmacology alone (1, 17).

Miklowitz (1) reports on three trials of family focused therapy (psycho-education, communication enhancement training and problem solving). The first trial focused on medication with family focused therapy or family-based crisis management. Patients in a family-focused therapy had a greater likelihood of survival without disease relapse (52%) unlike those in the crisis management (17%). For those with depressive symptoms there was a stronger benefit than for those with manic symptoms. The effects reported included improved communication. The second trial over a 1-2 year period had two groups of family-focused therapy and pharmacology versus individual therapy and pharmacology. It was found that patients in the family-focused therapy had fewer recurrences (28%) and re-hospitalization (12% rate), compared to individual therapy with a 60% recurrence and re-hospitalization rate. The third trial looked at adolescents who were assigned to family-focused therapy and medication compared with psychoeducation and medication. Those in the family-focused therapy group had quicker recoveries from depressive mood states and spent less time in acute depressive episodes over 2 years.

Multifamily psychoeducation groups

This treatment has the same aims as family therapy but includes multiple families being seen together. The advantage of this treatment is its cost effectiveness along with its suggested clinical effectiveness. Patients from families that were initially high in conflict or low in problem-solving and who family therapy had approximately half as many depressive episodes per year and spent less time in depressive episodes than those who received medication alone. There were no effects of either family intervention on mania symptoms and no differences in the outcomes between patients who received were in single family therapy or in multifamily groups. In summary, this treatment was found to have stronger effects on depression symptoms than manic episodes; there was no difference in outcomes between multifamily psychoeducation groups that worked with more than one family at once and single family therapy. The benefit of the multifamily approach was that it allowed for more cost-effective management of affected individuals and their families (1).

Dialectical behaviour therapy (DBT) and mindfulness cognitive behaviour therapy

In this review, cognitive behavioural therapy, psychoeducation and family focused therapy presented as the approaches with most evidence to indicate usefulness in managing bipolar disorder as an adjunct to pharmacology. There is also some indication that dialectical behavioural therapy (DBT) and one of its components, 'Mindfulness', has benefits but there is currently limited empirical evidence.

DBT is the recommended treatment for borderline personality disorder but, using similar principles of supporting emotional regulation, it has been applied to bipolar disorder (9). Its aims are to support individuals with bipolar disorder to develop skills to monitor judgments based on thinking and utilizing rational thought rather than the 'emotional mind'. Also, it encourages the identification of self-destructive behaviours and awareness of self and states. DBT also works on the individual's perception of both the social and interpersonal triggers.

The main skills which DBT supports are: interpersonal effectiveness, emotional regulation, distress tolerance and core mindfulness, which will be discussed later in this paper. It utilizes tools such as feeling (emotion) and behavior, identifying the link between thoughts, observations, life charting, mood charting, validation of thoughts, goal setting and progressive relaxation to achieve individual symptom management (9). Van Dijk (9) reported on a study by Goldstein et al. in which DBT was used to treat bipolar disorder with results indicating significant improvements in emotional regulation, depressive symptoms and maladaptive behaviours, including suicide.

The mindfulness component of this approach is outlined by its objectives to support the individual's sense of self, awareness of symptoms, concentration, thought control and attention (9). Mindfulness in this context aims to improve the individual's moment-to-moment awareness of mood and energy levels changes with acceptance and anxiety management.

In a study on mindfulness-based CBT (10), participants showed increased mindfulness, lower residual depressive mood symptoms, less attention difficulties and increased emotional-regulation abilities, improved psychological wellbeing and improved psychosocial functioning. The focus on attention training, the here and now and the present moment could be the factor that challenges the racing thoughts associated with mania and concentration difficulties. The identification and self-acceptance of depressive-related mood states and thoughts may influence the stabilizing of related symptoms.

Bipolar disorder and substance misuse

Bipolar often coexists with substance misuse disorders (11). Weiss et al. created a manual-based group psychotherapy for patients with bipolar and substance dependency. The treatment used was integrated group therapy (IGT). Patients receiving IGT had significantly better outcomes on addiction severity index ($p<.03$), abstinence ($p<.01$) and likelihood of achieving 2 ($< .002$) or 3 ($p<.004$)

consecutive months of abstaining (11). However, not all individuals diagnosed with bipolar would consistently see their substance misuse and other behaviours as a being problems.

Proposed benefits of bipolar II

Fieve describes the perceived benefits of the hypomanic state of bipolar II in individuals valuing the heightened energy states. This includes their lively moods, socializing ability, increased creativity and productivity. He describes many individuals being the 'movers and shakers in society' and categorizes them as bipolar IIB (B for beneficial). However, the cost is the episodes of periodic depression and possible escalation to more severe mania (12).

Conclusion

There is evidence to suggest that psychotherapeutic interventions have significant benefits for bipolar disorder (13). The most evidence is for CBT which targets symptoms, social functioning and risk of relapse, as an adjunct or independent treatment (14). Psychotherapy can be utilized to improve the quality of life of those who have bipolar disorder and others in society directly or indirectly affected by the individual with the disorder. This can have a positive consequence for the patient's social, health and financial circumstances. However, the different approaches discussed present with unique and combined benefits, depending on the needs of the individual, type of diagnosis and subsequent degree of symptoms. Further research and more exploration into psychotherapeutic approaches is required for a more accurate understanding of what is best to treat and in whom. For example, the rates of depression and total time spent in depressive episodes may be as much as 3 times higher than manic episodes (Judd et al. (10)). Therefore, for those cases, a treatment evidenced to be more beneficial at targeting depression would be more suitable. Family therapy can only be effective when the patient, their family, carers and other relevant people are willing to participate.

Research indicates that the cognitive behavioural treatment approach and family therapy may be the most suitable to target depression (depressive episodes), whereas 'social rhythm therapy' has presented as more suitable when a patient presents with symptoms of mania. However, Colom et al. have suggested that the psychoeducation approach combined with CBT techniques seems the most promising, focusing on education, information, treatment compliance and illness management (15). Although there is strong evidence that pharmacology is effective treatment, it may not be enough. For example, in patients with bipolar episodes, recurrence rates are up to 60% in 2 years even when medicated (Gitlen et al.) (10). Adherence to medication can be affected by factors including relationship and social status, educational level, stigma, denial and personal attitudes towards medication. Psychotherapeutic interventions can be utilized to support the potential barriers to effective recovery. Research has indicated the value of psychotherapeutic interventions relating to an improvement in adherence to taking medication and to aid relapse prevention. However, further research is needed to investigate which treatment is suited to individual needs to achieve an improved outcome for this disorder.

Bipolar mood states (episodes) can be triggered by activating events. Episode trigger factors include life events, economic pressures (socioeconomic status), high-pressured work environments, diet and lifestyle. As well as providing the appropriate treatment to suit the symptoms, factors such as triggers and therapeutic management of them need to be considered. Further exploration is required to establish what treatments would be most effective in relation to these factors. Other triggers include family difficulties, social relationship breakdowns, communication difficulties and bereavement; these can all be destabilizing factors that contribute to triggering or to maintaining an episode. Targeting the individual's ability to manage and cope with these life events and situations are areas in which psychotherapeutic interventions are proven to be successful.
As individuals in the media (celebrities) work to reduce the social stigma of bipolar disorder by making their diagnosis public, open discussion or talking therapies may increase acceptance in a wider social context for the individual patient with this diagnosis. Psychotherapeutic models need to be developed, researched and should be based on clear therapeutic advantages for reducing bipolar symptoms and improving effectiveness of treatment.

GP Comment

What have I learned from this paper?

Psychotherapeutic interventions for bipolar disorder have to been shown to be effective in the management of patients with bipolar disorder. It seems that CBT has the most evidence and its impact is not only in symptoms but also in social functioning and quality of life. Patients who benefit the most from psychotherapy are the ones suffering more depressive episodes than manic ones. As family physicians we have the possibility to explore the family as a potential alliance to help in the therapeutic process.

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References

1. Milklowitz DJ. Adjunctive Psychotherapy for Bipolar Disorder. Am J Psychiatry.
2. Sajatovic M, Daviies M, Hrouda DR. Enhancement of Treatment Adherance Among Patients with Bipolar Disorder. Psychiatric services 2004;doi: 10.1176/appi.ps.55.3.264.
3. The ICD-10 Clasification of mental and Behavioural Disorders; Clinical descriptions and diagnostic guidelines. World Health Organisation. Geneva 2002:110-131.
4. Lolich M, Vazquez GH, Alvarez LM, Tamayo JM. Psychosocial interventions in Bipolar Disorder: A review. Actas Esp Psiquiatra 2012;40 (2):84-92.
5. Scott J, Anderson IM, Haddad PM. Bipolar disorder. BMJ 2013;Volume 346:27-32.
6. Rothbaum BO,Astin MC. Intergration of Pharmacology and Psychotherapy for Bipolar Disorder. J Clin Psychiatry 2000;61 (suppl 9):68-75.
7. Fieve RR. Bipolar II: Enhance Highs, Boost Creativity, Escape Cycles (book on order)
8. Windy Dryden Dealing with Emotional Problems; Using Rational-Emotive Cognitive Behaviour Therapy. A Practitioner's Guide. Routledge 2012:22-87.
9. DBT ref
10. Mindfulness based CBT
11. Weiss RD et al. Group Therapy for Patients With Bipolar Disorder and Substance Dependence; Results of a Pilot Study. J Clin Psychiatry 2000 May;61:5.
12. Fieve RR. Bipolar II. Enhance Your Highs, Boost Your Creativity, and Escape the Cycles of Recurrent Depression. The Essential Guide to Recognize and Treat the mood Swings of This Increasingly Common Disorder. Rodale; 2006.
13. Scott J. Psychotherapy for Bipolar disorder. University Department of Psychiatry. Royal Victoria Infirmatory. Newcastle upon tyne.
14. Jones, S. Psychotherapy of bipolar disorder: A review. Journal of Affective Disorders 2004;Vol 80 (2-3):101-114.
15. Colom F et al. What is the role of Psychotherapy in the Treatment of Bipolar Disorder? Psychother Psychosom 1998;67:3-9.
16. Mace C. Mindfulness and Mental Health: Therapy, Therory and Science. Routledge. Taylor and Francis Group. London and New York; 2008.
17. Jones E, Asen E. Systemic Couple Therapy and Depression; Systemic Thinking And Practice Series, Edited by David Campbell and Ros Draper; Karnac; 2002.
18. Dryden W. Dealing with Emotional Problems; Using Rational–Emotive Cognitive Behaviour Therapy. A Practitioner's Guide. Routledge; 2012.
19. ICD-10
20. Secondly there is Hypomania, where a lesser elevated mood state is present without hallucinations or delusions but increased social activity and talkatively.
21. DSM-IV