BIPOLAR DISORDER AND PSYCHOTHERAPY

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This article gives a very brief overview of bipolar disorder and its psychotherapeutic treatment.

Keywords: bipolar disorder, psychotherapy

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The focus in this article is on bipolar disorder, which means that episodes of hypomania or mania occur, mostly in sequence with episodes of depression.

Symptoms

Mood

Bipolar disorder is a mood disorder. In the two main diagnostic manuals, the International Classification of Diseases (ICD) and the Diagnostic Statistical Manual (DSM), in their current editions it is in the group of affective (mood) disorders. The experience of low and elevated mood is a characteristic feature of bipolar disorder. Previously, it was also called manic-depressive disorder.

Usually, there are also pronounced swings in a patient's activity level. During a manic phase, there is a heightened activity level with racing thoughts and often undirected activity. During a depressed phase, there is a lack of initiative, activity and thinking seems to slow down (at least subjectively).

(Hypo)Mania

Hypomania and mania are phases of elevated mood on a spectrum, with hypomania as the less intense form. During mania an individual behaves or feels abnormally energetic, happy or irritable.[1] The need for sleep is usually reduced during manic phases.[2] Depending on whether the state is one of hypomania or mania, the activities and thoughts can still be goal-directed and useful to the individual in the former or increasingly chaotic and mostly harmful in the latter.

In a full-fledged manic phase, clients describe feeling of "embracing the world" and having the sense that everything is possible in the moment. This often means that the future and the past become subjectively more remote. Often individuals buy expensive goods and services they cannot afford, such as luxury cars (mostly men) or around the world trips, begin 'great' art or business ventures or throw themselves into risky sexual adventures.

Co-Morbidity

Bipolar disorder leads to more pronounced swings in mood and activity, which may be linked the fact that the risk for anxieties and, as a result, substance abuse is higher in bipolar disorders. Clients try to self-regulate with the help of a psychotropic substance, which can then lead to

addiction if the bipolar condition remains untreated. In these cases, it is important to also treat the bipolar condition rather than just the addiction to remove the crucial factor that maintains the addiction.

The Disturbed Timeline

While individuals can still have partial insight in hypomanic states, and as a result often function well on their job for a while, insight and coherent planning for the future collapse in manic states. However, in both states people often lack the insight and self-reflection to enter therapy. Characteristically, even if problems in relationships and in one's finances become apparent, the elevated mood supports the belief that one can solve these problems by oneself. As concern about the future disappears, the sense of having a future often disappears with it.

In the depressed state, the past acquires a greater significance, especially so negative experiences and decisions that turned out disadvantageous to the individual. A positive future ceases to exist.

The present becomes fluid in both cases, and strategies that anchor a patient better in the present can improve both polarities of the condition.

Low Self-Esteem

Problematic is often also a reduced self-esteem which lies below the heightened mood, because the individual knows, at least subconsciously, that life feels more difficult than it should. This makes it difficult to accept help, if it is seen as a confirmation of one's deficits. One may be the tempted to point at the harm from behaviours in the manic or depressed states, such as exorbitant expenditures in the manic phase and social withdrawal in the depressed phase, but this can also decrease the patient's self-esteem and self-confidence, which are required to motivate him or her for therapy. A patient has to belief that change is possible to be motivated for therapy. On the other hand, it is also important to make the patient aware of the consequences if the condition remains untreated.

Developing greater insight in the psychotherapeutic process is how this conundrum can be resolved. It helps the patient to connect with the stable parts of the own person, which increase

self-confidence and self-esteem, and from a better understanding of the underlying dynamics to develop more effective strategies for the manic and depressed phases. This can also increase the compliance for medication, which is often needed in case of bipolar disorder.

Treatment

Psychotherapy and medication are usually used. Often, one or the other is overlooked. However, clinical experience shows again and again that clients with bipolar disorder benefit greatly from the psychopharmacological treatment for the mood swings and the psychotherapeutic treatment to address difficult situations and unresolved issues, which can be both, triggers and consequences of episodes of mania or depression.

Hypomania and Compliance

Unfortunately, many individuals suffering from hypomanic episodes never seek out treatment. They seem to thrive in their jobs and projects they take on. However, the sense of 'high', long work hours, sleepless nights and relationship problems usually take their toll before long. Even places of prior high achievement begin to disintegrate and the individual loses control, throwing him or her into an even depressed state, which usually follows on a hypomanic episode. If it is very severe, there may even be psychosis-like symptoms.

Medication

Mood stabilizers, such as lithium and substances from the groups of anticonvulsants and antipsychotics, are often prescribed if the bipolar disorder is at least of moderate strength, and also in a number of milder cases, depending on the impact of the condition on the client's life. As antidepressants can induce manic states in people with a predisposition for bipolar disorder, for the episodes of depression they should be used with care and usually under the protection of a mood stabilizer. For more information, see the author's article on medication for bipolar disorder.

Psychotherapy

On the psychotherapeutic side, the main part is to establish a stable working relationship with the client. This requires meeting the client where he or she is emotionally. As meaningful communication with oneself and the environment is often reduced in manic states, this requires often an extra effort of empathy and alertness for the messages coming from the client. Bipolar

Disorder causes enormous instability in one's emotional world, and this can lead to reduced self-confidence and faith in oneself, and the world in general.

Establishing Continuity in the Timeline

Gradually and carefully bringing in the past and the future as meaningful and stable helps the client better reconnect with the own timeline, which can add stability if the client is open to it. The past on the factual level is unchangeable, the future can be shaped with planning and becoming aware of one's values, needs and wants. In some cases, it might be helpful to first help clients see their entire life as meaningful and not just the moment, while mindfulness for the moment helps prevent from getting carried away by strong emotional oscillations.

In episodes of depression an emphasis on the future rather than the past can be helpful, while trying to establish a more balanced view of the client's past. Bipolar disorder is an up and down, and seeing these movements in the context of a larger picture rather than in the spur of the moment is to many clients extremely helpful.

Communication

Manic, and also hypomanic states make interpersonal communication less effective, and focusing on skills in this area can be helpful in countering some of the consequences, and triggers of bipolar disorder. Feeling 'bad' or 'too good' filters out information that may be of significance to the client. Information associated with positive emotions tends to be filtered out in the 'bad' states, while the reverse is true for information associated with negative emotions. This also reflects on the communication with oneself, leading to a distorted image of oneself. This is what significantly contributes to the suffering, which in the manic phase also comes from overconfident decisions, such as borrowing large sums to start a business because the client believes about her customers that 'if she builds it they will come' in multitudes.

The interaction between therapist and patient can provide valuable feedback to the patient, in part by becoming aware of the communication dynamics, including such concepts as transference and counter-transference. The more insight the patient gathers in the own processes and into the interactions between patient and the environment, the less likely it becomes to get caught in self-defeating cognitions and behaviours in extreme mood conditions.

Acute Psychotherapeutic Intervention

Patients in acute manic episodes are not likely to respond well to intensive psychotherapy because of insufficient insight or rejection of help. [70] Some trials have examined whether psychotherapy enhances remission from acute depression. [71] The STEP-BD study compared up to 30 sessions of family-focused therapy, interpersonal and social rhythm therapy, or cognitive-behavioural therapy (ie, intensive treatment) with a brief psychoeducational therapy (three individual sessions) for 293 patients with acute depression who also received mood stabilisers. Over 1 year, patients in intensive therapy recovered more rapidly (hazard ratio [HR] 1·47, 95% CI 1·08–2·0) and were more likely to be clinically well (1·58, 1·17–2·13) in any study month than those in brief treatment. [45] Effects extended to relationship functioning and life satisfaction. [47] No differences emerged between the three intensive modalities in symptoms or psychosocial functioning over 1 year. Interestingly, patients with depression in STEP-BD who were treated with mood stabilisers and randomly assigned to adjunctive antidepressant treatment did not recover faster than patients who were assigned to adjunctive placebo treatment. [18] Therefore, psychosocial treatment might be a more effective adjunct to mood stabilisers than antidepressants after a bipolar depressive episode.

Psychosocial Intervention

Treatment guidelines increasingly suggest that optimum management of bipolar disorder needs integration of pharmacotherapy with targeted psychotherapy. [15,42] A recent randomised trial in Denmark has shown clinical benefits from this approach. [43] Psychological approaches build on evidence that psychosocial stressors, including excessive family discord or distress, negative life events, or events that disrupt sleep and wake rhythms or accelerate goal attainment are associated with relapses and worsening symptomatic states. [8] The main goals of adjunctive psychotherapy for bipolar disorder include the education of patients, and when possible, caregivers, about strategies for the management of stress, the identification and intervention of early signs of recurrence, and how to keep regular lifestyle (eg, sleep and exercise) habits. [44] Moreover, in view of the high rate of non-adherence to drug treatments (up to 60% after acute episodes [12]), psychosocial treatments emphasise consistency with pharmacotherapy.

Evidence-based models of psychotherapy include cognitive-behavioural therapy, family-focused therapy, interpersonal and social rhythm therapy, group psychoeducation, and

systematic care management. Although these models have common objectives, their methods, assumptions, and structure differ substantially. [44, 69]

Memory

There are indications memory might be affected in manic states, which also compromises knowledge one has about oneself. In a manic state, patients engage in activities, such as buying a car they do not need and might even not want in a more 'normal' state. The normal course in life is lost in a manic state, which the individual often later in the depressive episode becomes aware of, leading to pronounced feelings of failure and self-blame.

Both polar mood conditions, the (hypo)manic and the depressed state, affect how memory can be accessed and information retrieved. Making the information easier accessible can help lower extreme conditions and behaviours in manic or depressed states. This can happen in the psychotherapeutic process by having a patient imagine certain situations, develop insight or search for information, that is then easier available in the polar states. While the access to memory is impeded during depression and mania, gaining insight that brings about new perspectives or new ways of thinking about oneself and the world can have a substantial effect even in extreme mood states.

Focusing on the Stable

Bipolar disorder has affected many very creative people, who often became unable to work in acute depressed and, probably to a lesser extent, manic episodes, but their work may have added some stability amidst uncertainty. This underlines the importance of identifying one's fundamental values, interests and aspirations if one suffers from pronounced mood swings, because they remain very stable and help chart a course and make decisions even when the world around seems different. Being able to connect with oneself, in thought and emotion, and get a sense for oneself, one's unchanging values and stable wants, needs and aspirations, adds to a greater sense of stability, also in phases of depression and mania.

Psychotherapy in Practice

Most studies of psychotherapy for bipolar disorder are maintenance trials in which patients receive standard drugs and either an experimental psychosocial intervention or usual care (eg, brief treatment or a supportive treatment of equal frequency and duration). A meta-analysis of eight maintenance psychotherapy trials, which included family, individual, and group treatment trials, yielded effect sizes ranging from an odds ratio (OR) of 0·57 (95% CI 0·39–0·82) for reductions in any type of mood relapse to 1·2 (0·3–2·1) for enhanced social functioning. [72] A second meta-analysis of ten trials showed an overall RR of 0·74 (0·64–0·85) for mood relapse. [73]

Family-focused therapy

Family-focused therapy is based on the frequently replicated association between criticism and hostility in caregivers (so-called expressed emotion) and an increased likelihood of relapse in mood disorders and schizophrenia. [10] Family-focused therapy involves the patient and caregivers (parents or spouse) in up to 21 sessions of psychoeducation, communication skills training, and problem-solving skills training. [74] Two randomised controlled trials including symptomatic patients with bipolar I and II found that, in the 1–2 years after a manic, mixed, or depressive episode, patients with bipolar disorder who received family-focused therapy and pharma co-therapy had 30–35% lower rates of relapse and rehospitalisation and less severe symptoms than did patients in case management [13] or equally intensive individual treatment. [48] Two randomised controlled trials in paediatric populations—one in adolescents (aged 12–18 years) with bipolar disorder [49] and one in children and adolescents (aged 9–17 years) with depression or hypomania with a first degree relative with bipolar disorder [50] —found that children and adolescents who received family-focused therapy and pharmacotherapy recovered more rapidly from depressive episodes (HR 0·37–0·54) than did children and adolescents in brief psychoeducation and pharmacotherapy.

The education of caregivers about bipolar disorder might translate into benefits for patients, even if patients do not attend educational sessions. In one randomised controlled trial, [53] remitted patients whose relatives attended psychoeducation groups had longer intervals before manic and hypomanic episodes than did those whose relatives did not attend groups. In a second trial, [51] patients whose caregivers attended 12–15 family education sessions showed significant decreases in symptoms of depression, especially if caregivers also showed mood improvement. Thus, adjunctive family interventions have the potential to lengthen periods of

stability and alleviate residual symptoms in maintenance care. However, differences in treatment preferences, cultural factors (e.g., willingness to disclose in front of others), and family structure (e.g., parental vs spousal) might affect the willingness of patients or caregivers to participate in family-based treatment.

Cognitive-behavioural therapy

Cognitive-behavioural therapy presumes that recurrences of mood disorder are determined by pessimistic thinking in response to life events and core dysfunctional beliefs about the self, the world, and the future. [75] Cognitive-behavioural therapy to treat depression has been adapted for patients with bipolar disorder with recognition that manic episodes are often associated with excessively optimistic thinking. [56] One randomised controlled trial [43] reported that patients who received 12–14 sessions of cognitive-behavioural therapy were less likely to have depressive episodes and had better social functioning than patients in routine care for 30 months. However, an effectiveness trial (n=252) comparing cognitive-behavioural therapy with treatment as usual in five UK community care centres found no advantage for cognitive-behavioural therapy over 18 months, except among patients with fewer than 12 previous episodes. [58]

A Canadian trial compared six group psychoeducation sessions with 20 sessions of individual cognitive-behavioural therapy, both with pharmacotherapy, in 204 patients in full or partial remission. [60] No differences were recorded over 72 weeks in symptom burden or recurrence. Group psychoeducation was estimated to cost US$180 per patient, whereas cognitive-behavioural therapy was estimated to cost $1200 per patient. In summary, the evidence for adjunctive cognitive-behavioural therapy for relapse prevention is inconclusive.

Interpersonal and social rhythm therapy

Substantial evidence exists that mood instability in bipolar disorder is related to changes in circadian rhythms. [5] The relation between sleep and mood disturbances seem to be bidirectional. Polymorphisms in CLOCK genes are related to circadian mood fluctuations and recurrences in bipolar disorder.91 In one promising animal model,92 mice with mutations in CLOCK genes behaved in ways that resembled manic behaviour in people (e.g., increases in activity and decreased sleep); these behaviours were reversed upon treatment with lithium.

Interpersonal and social rhythm therapy, an adaptation of the interpersonal psychotherapy for depression, uses a problem-solving approach to interpersonal problems by encouraging

patients to maintain and regulate daily routines and sleep and wake rhythms. [6] In a large (n=175) randomised clinical trial, 21 acutely manic, mixed, or depressed patients with bipolar I disorder were assigned to weekly interpersonal and social rhythm therapy or to equally intensive clinical management, both with pharmacotherapy. After acute stabilisation, random assignment was done again (interpersonal and social rhythm therapy vs clinical management) and treatment continued for a 2-year maintenance phase. No differences in time-to-recovery between the groups during acute stabilisation were recorded. However, patients who received interpersonal and social rhythm therapy in the acute phase had longer times to recurrence and better vocational functioning in the maintenance phase than did patients who received clinical management during the acute phase. Moreover, the effects of interpersonal and social rhythm therapy in the delay of recurrences were most pronounced in patients who had been able to stabilise their daily or nightly routines during acute treatment. [6] Thus, to help patients to stabilise their sleep and wake rhythms after an acute episode might have downstream effects on the prevention of future mood instability.

Group psychoeducation

In view of the many patients who could benefit from psychoeducation, group approaches following a predesigned curriculum have been proposed. The Barcelona approach [63] emphasises awareness of illness, treatment adherence, early detection of recurrences, and sleep and wake regularity. In a trial of patients with bipolar disorder types I and II in the euthymic phase of illness, patients were randomly assigned to pharmacotherapy and 21 sessions of structured group psychoeducation or 21 sessions of an unstructured support group. After 5 years, patients who had received the structured groups had fewer relapses and were ill for less time than those who had been in the unstructured groups. [14, 63] Moreover, over 5 years, the reduction in days in hospital translated into a cost savings of approximately €5000 per patient in psychoeducation. [78]

Functional remediation

Functional remediation treatment emphasises patients' cognitive functioning through exercises for memory, attention, problem solving, reasoning, and organisation. In a ten-site randomised clinical trial in Spain, [64] 268 euthymic patients who had moderate to severe psychosocial impairment were assigned to 21 weekly group sessions of functional remediation, 21 sessions of standard group psychoeducation, or treatment as usual. Patients in functional remediation showed greater changes in occupational and social functioning than did those treated as usual,

but differed only slightly from patients in the standard psychoeducation groups. No differential effects of functional remediation were recorded for neurocognitive or clinical change variables.

Systematic care management

Two research groups have examined collaborative care programmes that combine protocol-driven pharmacotherapy, group psychoeducation, and intensive patient monitoring by a nurse care manager. Importantly, these studies were done in managed health-care cooperatives in the USA and included large patient samples with systematic follow-up. In trials at a group health cooperative (n=441) [67] and in 11 Veterans Administration sites (n=306), [68] patients were randomly assigned to systematic care or usual care. Although neither study showed reductions in relapses, patients in systematic care had fewer weeks in manic episodes than did those in usual care. In the Veterans Administration study, patients in collaborative care also had improved social functioning and quality of life over 2 years. Cost-effectiveness analyses suggested that the care programmes saved money despite their greater intensity of follow-up. [67, 68]

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