
Bipolar Disorder: Causes, Contexts, and Treatments



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Bipolar disorder is a chronic and often devastating illness that may go undiagnosed because of its complex and diverse presentation. Clinicians can provide psychological treatments, in conjunction with pharmacotherapy, that can reduce the frequency, severity, and duration of manic and depressive episodes. Because bipolar disorder is characterized by high degrees of comorbidity and high rates of medical complications, the clinician will frequently need to implement other treatments targeted to comorbid conditions, such as panic, generalized anxiety, substance abuse, and personality disorders. This article introduces the issue of *Journal of Clinical Psychology: In Session* devoted to the treatment of bipolar disorder. We describe the cognitive styles and personal vulnerabilities that pose greater risk for bipolar disorder. Three evidence-based psychological treatments (interpersonal social rhythm therapy, family-focused treatment, and cognitive-behavioral therapy) and current pharmacological treatments are examined and illustrated. Finally, we review the effectiveness and practice implications of a variety of treatments for this severe and underresearched disorder. © 2007 Wiley Periodicals, Inc. *J Clin Psychol: In Session* 63: 417–424, 2007.

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Bipolar disorder afflicts 3 to 5% of the population with detrimental effect on life chances. Individuals with bipolar disorder face a lifetime risk for mood variations, often with devastating—even fatal—consequences. It is the sixth most common cause of disability in the United States (Altman et al., 2006). Lifetime rates for *completed* suicide are 60 times higher than that for the general population, with a much higher rate of completed suicides for each attempt—1:3 versus 1:30 (Baldessarini, Pompili, & Tondo, 2006). Quality of life is often compromised for individuals with bipolar disorder. Lower wages, higher unemployment, work absenteeism, reliance on workmen's compensation, higher rates of divorce, lower levels of educational attainment, higher arrest rates, and hospitalization are often the consequences (Depp, Davis, Mittal, Patterson, & Jeste, 2006; Gardner

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et al., 2006; Glahn, Bearden, Bowden, & Soares, 2006; Michalak, Yatham, Kolesar, & Lam, 2006).

In recent years, there has been increased attention to medical comorbidity, including obesity, that characterizes this problem. In one study, 81% of individuals with bipolar disorder had a current comorbid medical condition (Fenn et al., 2005). Medical conditions found at increased rates include coronary heart disease, hypertension, hyperthyroidism, diabetes, dyslipidemias, and hepatitis. Bipolar individuals also manifest elevated rates of smoking and drug and alcohol abuse. Poorer self-care (e.g., dearth of exercise, less medical care, inactive lifestyles) may contribute to higher obesity rates (Morris & Mohammed, 2005). Increased risk of pulmonary embolism may be a consequence of increased obesity and lifestyle factors in bipolar disorder (Strudsholm, Johannessen, Foldager, & Munk-Jorgensen, 2005). These medical conditions only exacerbate the stress, depression, and struggles of the bipolar illness itself.

The course of bipolar disorder, as the diagnostic label implies, is cyclical and recurring. In the largest multicenter study conducted—the Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD)—1,469 participants with bipolar disorder were followed over a 24-month period. During this period, 48.5% experienced recurrences, with depressive episodes twice as likely to occur as manic episodes (Perlis et al., 2006). Depressive episodes are influenced by seasonal variation, but not markedly so (Friedman et al., 2006).

To more complicate matters, individuals with bipolar seldom present with one mental disorder. A high percent of bipolar patients present with anxiety disorders, personality disorders, and substance abuse (Altindag, Yanik, & Nebioglu, 2006; McIntyre & Keck, 2006). Each of these comorbid disorders contribute to more coping difficulties (McIntyre et al., 2006). However, putative relationships between adolescent attention-deficit disorder and later onset of bipolar disorder appear to be questionable (Jaideep, Janardhan Reddy, & Srinath, 2006). Higher rates (19.4%) of bipolar disorder are found in patients with borderline personality disorder than among patients with other personality disorders (Gunderson et al., 2006), although this does not appear to be related to outcome. Bipolar individuals with comorbid alcohol abuse will have higher rates of rapid cycling, symptom severity, suicidality, aggressivity, and impulsivity (Frye & Salloum, 2006). Bipolar individuals will experience considerably greater problems with employment, economic well-being, and marital stability.

Indeed, bipolar disorder may prove to be the most difficult and serious mental disorder that the clinician may encounter. The clinician treating bipolar patients will quickly recognize a need for proficiency in differential diagnosis, pharmacological treatments, substance abuse, anxiety conditions, personality disorders, marital relationships, child management, suicide risk, anger management, and resistance to treatment. Because of the severity, chronicity, and—sometimes—unpredictability of bipolar disorder, clinicians will learn more from these patients and their families than they will from most other individuals.

Although the challenges are often daunting, the rewards are commensurately satisfying. There is enormous professional satisfaction in making the right diagnosis (after a patient has been seen by other professionals who have rendered incorrect diagnoses), in helping the patient follow pharmacological treatment, in providing effective psychotherapy, and in reducing suicide risk. These patients may often “feel difficult,” but often require the most compassionate and effective care.

The purpose of this issue of the *Journal of Clinical Psychology: In Session* is to assist clinicians in understanding and treating bipolar disorder. For many years in mental health, there was accepted “wisdom” that bipolar disorder was a biological illness that simply required lithium. This “all-or-nothing” view has since been eclipsed by the

development of effective psychological treatments used in conjunction with biological treatments. Three psychological treatments described in this issue have received empirical support for their efficacy: interpersonal social rhythm therapy, family-focused therapy, and cognitive-behavioral therapy. It should be emphasized that each of these treatments encourages the use of medication as part of the complete treatment of the patient.

In this introductory article, I describe several important lessons that clinicians should consider in treating bipolar disorder. In doing so, I also introduce the articles that follow in this issue. These eight essential lessons and the following articles converge in reminding us of the complexity of accurate diagnosis and the centrality of collaboration—often with family members—offering a comprehensive, integrated treatment.

What Should the Clinician Know About Bipolar Disorder?

Eight Essential Lessons

First, the clinician should know the various diagnostic signs for bipolar disorder. Thus, we should recognize not only manic and depressive states but also hypomania and mixed states. The importance of recognizing mixed states (i.e., a combination of depressive and manic features—often agitation and aggression in hypomania or mania) cannot be overstated. Many patients quickly move from a hypomanic to a mixed state, often obscuring the diagnosis of mania and, therefore, bipolar disorder. Hispanic and other minority populations often go underdiagnosed for bipolar disorder, adding to their greater risk for poor outcome; in one recent study, over half of these individuals had concurrently been misdiagnosed as unipolar depression (major depressive disorder; Dilsaver & Akiskal, 2005). Furthermore, few patients voluntarily present to a therapist complaining about manic symptoms such as grandiosity and hypersexuality.

To make matters more difficult, many bipolar patients not only lack insight into their mania but often have poor recollections of their manic episodes. This is why it may often be necessary to consult with family members to obtain a more accurate history. Recent interest in the phenomenology of mania and hypomania, including the development of self-report forms for mania, can help identify symptom patterns (Johnson & Leahy, 2003; Leahy, 1999, 2005; Mansell, 2006). The bipolar spectrum has expanded to include Bipolar I (clear manic episode) and II (hypomanic episode), discussion of Bipolar III (mania triggered by antidepressant medication), cyclothymia (mood shifts which do not qualify for a diagnosis of hypomania), and other manifestations (“not otherwise classified”) that indicate a range of mood dysregulation. Being able to adequately diagnosis hypomania and mania may be the single most important event, prior to medication, in the treatment of bipolar patients.

Second, bipolar disorder has a high genetic determination, which helps the patient medicalize the problem, normalize the use of medication, and reduce the “moralization” of the illness. Although it is important for the patient and the clinician to recognize the strong “biological” contribution of the disorder, the stress-diathesis model also suggests that stress (in the form of interpersonal conflicts and problems, expressed emotion, life events, and paucity of stress-management skills) exacerbates the outcome. A useful analogy is the treatment of diabetes: Although medication is an essential component of treatment, lifestyle also is essential and can reduce the negative effects of the illness.

Moreover, the genetic contribution suggests complications in differential diagnosis. For example, genome scans suggest that bipolar disorder shares commonality with schizophrenia (with which it is sometimes confused), and further research will need to specify the nature and extent of these similarities (Farmer, Elkin, & McGuffin, 2007). Perhaps because of this similarity, antipsychotic medications are often useful for bipolar disorder.

Third, the clinician should realize that psychological therapy involves recognizing and treating the specific episode while laying the groundwork for maintenance treatment over the long term. Bipolar patients often present to the therapist either in a severe depressive episode or during or after a serious manic episode has led to relational, occupational, or legal problems. Treatment of the bipolar patient requires the recognition that hospitalization may, in some cases, be an essential protective and stabilizing intervention that can allow more aggressive pharmacological treatment, withdrawal from prescribed or recreational drugs, reduction of risk of aggressive or self-injurious behavior, and more complete evaluation; however, hospitalization is often not required, and most bipolar patients can be effectively treated as outpatients.

Fourth, pharmacological treatment is typically essential for bipolar disorder. As Goldberg (this issue) illustrates in his article "What Psychotherapists Should Know About Pharmacotherapies for Bipolar Disorder," a range of effective pharmacological treatments are now available, each with its potential side-effect profile. Although the first line of treatment generally entails lithium, anticonvulsants, and atypical antipsychotics, some patients also may benefit from thyroid augmentation, clozapine, calcium channel blockers, and electroconvulsive therapy (ECT; Gitlin, 2006). Some female patients may benefit from hormonal treatments for mania or hypomania; specifically, tamoxifen and medroxyprogesterone acetate (Kulkarni et al., 2006). Continuing ECT as maintenance (C-ECT) has shown some promise for alleviating the recurrence of episodes (see Sienaert & Peuskens, 2006).

Few pharmacological treatments will alleviate the cyclical nature of this mood disorder, so the clinician and patient will need to collaborate to assure both compliance with medication and vigilance over mood fluctuations that will emerge despite medication compliance. Antidepressant medication may be used during depressive episodes, but this also adds to the risk of increased cycling of the illness and, therefore, greater likelihood of future depressive (and manic) episodes (see Goldberg, this issue). Indeed, some evidence indicates that for a subset of bipolar disorders, antidepressants may increase the risk of suicide, possibly in the form of an agitated manic conversion—although some data contradict this claim (Bauer, Wisniewski, et al., 2006). Lithium continues to be the most effective agent in decreasing suicidal risk (McElroy, Kotwal, Kaneria, & Keck, 2006). Patients who are on lithium and show poor compliance are 5.2 times more likely to attempt suicide than patients who are lithium compliant (Gonzalez-Pinto et al., 2006).

Many bipolar patients have been treated for unipolar depression in the past with antidepressant medication, a regimen that some have claimed is likely to cycle them into more frequent and severe manic episodes; however, a recent naturalistic study has indicated that there is no increased switching into mania with the use of antidepressants (primarily SSRIs) (Bauer, Rasgon, et al., 2006). Nonetheless, this issue continues to provoke controversy. The cyclical nature of bipolar disorder and its lifelong chronic vulnerability are often difficult for some patients to accept. This is a serious challenge for treatment since not accepting the diagnosis and its chronicity will lead to poor treatment compliance.

Fifth, each of the psychological treatments described in this issue recognizes a psychoeducational (PE) component in treatment. Of course, this requires helping the patient understand what bipolar disorder is—and what it is not (e.g., unipolar depression, schizophrenia). Recognition of the prodromal signs of a manic or depressive episode is a vital component in each of the three psychological treatments described in this issue. Of particular value is the importance of sleep, often predictive of the onset of mania (see Bauer, Grof, et al., 2006). In fact, sleep disturbance is even common during euthymic phases, with 70% of these individuals reporting significant sleep dysregulation (Harvey, Schmidt, Scarnà, Semler, & Goodwin, 2005).

Ellen Frank's (2005) interpersonal social rhythm therapy (IPSRT) has received empirical support in reducing severity and frequency of recurrent episodes. This approach combines a recognition of the "illness" component of bipolar disorder with training in regularizing disruptive sleep patterns (which lead to more cycling) and daily routines. IPSRT targets interpersonal precipitants, sources of stress, and the impacts of bipolar disorder on relationships of all kinds.

Sixth, psychotherapists and psychopharmacologists need to work collaboratively in addressing the specific problems of the *current* episode. Thus, the patient presenting with an agitated and aggressive manic episode may be helped in acute treatment with antipsychotic medications, which may be tapered off once the episode has subsided or which may be combined with atypical antipsychotics, lithium, or anti-epileptic (anticonvulsant) medications. Acute phase treatment is an essential part of ongoing treatment since many manic episodes may result in a depressive episode or a depressive episode may emerge on its own. The clinician should realize that no treatment, medication or otherwise, is a panacea and that episodes may emerge or "break through." This does not mean that treatment is ineffective. The patient should be informed that mood variation, including breakthrough episodes, can emerge and that this requires collaboration among patient, family, psychotherapist, and psychopharmacologist to catch a phase early and to intervene effectively. Medication compliance is increased by more expectations by the patient of positive outcome and with a stronger therapeutic alliance with the prescribing doctor (Gaudiano & Miller, 2006). Each of the psychological treatments described here provides additional support to patients for the importance of medication.

Seventh, although there is a strong genetic component to bipolar disorder, there is considerable evidence that life events, coping skills, and family environment contribute to the expression of manic and depressive disorders. Bipolar disorder is not only exacerbated by negative life events (e.g., loss of job or relationship) but also may cause these life events. Individuals who are prone to global and negative cognitive styles and who lack the skills to regulate emotion, solve daily problems, or resolve conflicts are more likely to have recurrent episodes and to require hospitalization (Johnson, 2005). Family context and conflict emerge as particularly problematic. Miklowitz and colleagues (in press; Miklowitz et al., 2003) found that high expressed (negative) emotion contributes significant greater risk. These expressed emotion vulnerabilities are addressed in the current issue by both Morris and Miklowitz.

Eighth, bipolar disorder can be understood within a cognitive model (Leahy & Beck, 1988; Newman, Leahy, Beck, Reilly-Harrington, & Gyulai, 2002). Specific patterns of manic overoptimism and energizing, goal-oriented thinking may exacerbate manic episodes and increase risky behavior. These cognitive proclivities for mania and for depression within the bipolar spectrum are described by Johnson and Tran (this issue) as well as by others (Johnson & Fingerhut, 2004; Lam, Wright, & Smith, 2004; Mansell, Morrison, Reid, Lowens, & Tai, 2007). In the present issue, Mansell provides an integrative cognitive-behavioral treatment for bipolar disorder that incorporates our recognition of many of these cognitive vulnerabilities.

In Closing

Over a century ago, when Emil Kraepelin (1921) described the life histories and future course of "manic-depressive" disorder, clinicians were limited to taking detailed case histories and hoping that eventually effective treatments would be found. Kraepelin's descriptions are certainly worth reading today, if only to get a sense of the astute sensitivity and acute awareness of the entire person that was the focus of psychiatry at that

time. But the only treatments available in his time were simply palliative, supportive, and ultimately ineffective therapy. Bipolar disorder then was a case of a diagnosis in search of an effective treatment.

Today, we are facing more optimistic options for a number of reasons. First, with the delineation of subtypes of bipolar disorder and the distinctions among hypomanic, manic, and mixed states, the clinician has a much greater likelihood of correctly identifying a patient with bipolar disorder. Second, earlier detection, especially during adolescence, provides potential bipolar patients with a greater chance that future episodes can be avoided or, at least, lessened in their impact. Third, the proliferation of new mood-stabilizing drugs such as lithium, anticonvulsants, antipsychotics, and mood-specific treatments that augment them provide greater hope to patients. In addition, electrical stimulation treatments such as ECT, VNS, and TCM can offer relief to refractory or severe depressive episodes when waiting for medication to take effect seems either risky or ineffective. Finally, the leading psychological treatments for bipolar disorder described by the authors in this issue offer promising new treatments for a group of individuals who, not many years ago, had no hope of effective help.

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