Updates on Psychological Interventions in Bipolar Disorder

A Review Submitted for Partial Fulfillment
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abbreviation

Bp	Bipolar
BD	Bipolar disorder
CBT	Cognitive-behavioral therapy
CC	Collaborative care
CT	Cognitive therapy
DSM-IV	Diagnostic and statistical manual of mental disorders, 4th ed.
EE	Expressed emotion
FDA	Food and drug administration
FFT	Family focused treatment
GABA	Gamma aminobutyric acid
GAMIAN Advocacy Forum	Global Alliance of Mental Illness Advocacy Networks
HAMD score	Hamilton Rating Scale for Depression

HR-QOL	Health Related Quality of Life
ICM	Intensive Clinical Management
IPSRT	Interpersonal and Social Rhythm Therapy
IPT	Interpersonal Therapy
MDI	Manic Depressive illness
PCSTF	Problem Centered Systems Therapy of the Family
PE	Psychoeducation
RCT	Randomized Control Trials
SRM	Social Rhythm Metric
SSRIs	Serotonin Selective Reuptake Inhibitors
STEP-BD	Systematic Treatment Enhancement Program for Bipolar Disorder
YMRS	Young Mania Rating Scale

List of Figures

List of Tables

Introduction

Introduction

Bipolar disorder, or manic-depressive illness (MDI), is one of the most common, severe, and persistent mental illnesses. Bipolar disorder is characterized by periods of deep, prolonged, and profound depression that alternate with periods of an excessively elevated and/or irritable mood known as mania. The symptoms of mania include a decreased need for sleep, pressured speech, and increased libido, reckless behavior without regard for consequences, grandiosity, and severe thought disturbances, which may or may not include psychosis. Between these highs and lows, patients usually experience periods of higher functionality and can lead a productive life. Bipolar disorder is a serious lifelong struggle and challenge ***(Bowden and Singh, 2003).***

Official estimates put prevalence at between 3 to 4 percent of the population but some researchers believe the real figure is closer to 10 percent if the whole spectrum of bipolar disorder is included ***(Hirschfeld et al., 2003).***

Most people with bipolar disorder, even those with

the most severe forms, can achieve substantial stabilization of their mood swings and related symptoms with proper treatment. Because bipolar disorder is a recurrent illness, long-term preventive treatment is strongly recommended and almost always indicated. A strategy that combines medication and psychosocial treatment is optimal for managing the disorder over time ***(Sachs GS et al., 2000).***

Medications known as mood stabilizers are usually prescribed to help control bipolar disorder. Lithium, the first mood-stabilizing medication approved by the U.S. Food and Drug Administration (FDA) for treatment of mania, is often very effective in controlling mania and preventing the recurrence of both manic and depressive episodes. Anticonvulsant medications such as valproate or carbamazepine also can have mood-stabilizing effects and may be especially useful for difficult to treat bipolar episodes. Atypical antipsychotic medications are being studied as possible treatments for bipolar disorder ***(Keck PE, Jr., et al 2004).***

Historically, individuals with BD were not offered psychologic therapies for three main reasons. First, etiologic models highlighting genetic and biologic factors

in BD have dominated the research agenda and largely dictated that medication was not merely the primary, but the only appropriate treatment. Second, there was a misconception that virtually all patients with BD made a full inter-episode recovery and returned to their premorbid level of functioning. Third, psychoanalysis historically expressed greater ambivalence about the suitability for psychotherapy of individuals with BD than those with other severe mental disorders ***(Scott J, 1995).***

During the last decade, two key aspects have changed. First, there is increasing acceptance of stress-vulnerability models that highlight the interplay between psychologic, social, and biologic factors in the maintenance or frequency of recurrence of episodes of severe mental disorders. Second, evidence has accumulated from randomized, controlled treatment trials regarding the benefits of psychologic therapies as an adjunct to medication in treatment-resistant schizophrenia and in severe and chronic depressive disorders. Although there has been only limited research on the use of similar interventions in BD, there are encouraging reports from research groups exploring the role of manualized therapies in this population ***(Thase et al., 1997).*** Psychological

treatments provide support, education, guidance and strategies to individuals with bipolar disorder and their family members. Psychological treatment complement medical treatments and have been found to help stabilize behaviour and mood, reduce hospitalization and enhance general functioning ***(Huxley NA et al., 2000).***

Psychosocial interventions commonly used for bipolar disorder are cognitive behavioral therapy, psychoeducation, family therapy and a newer technique, interpersonal and social rhythm therapy (Huxley NA et al., 2000) Cognitive behavioral therapy (CBT) helps people with bipolar disorder learn to change inappropriate or negative thought patterns and behaviors associated with the illness. Psychoeducation involves teaching people with bipolar disorder about the illness and its treatment, and how to recognize signs of relapse so that early intervention can be sought before a full-blown illness episode occurs. Psychoeducation also may be helpful for family members. Family therapy uses strategies to reduce the level of distress within the family that may either contribute to or result from the ill person's symptoms. Interpersonal and social rhythm therapy (IPSRT) helps people with bipolar disorder both to improve

interpersonal relationships and to regularize their daily routines. Regular daily routines and sleep schedules may help protect against manic episode ***(Bauer MS et al., 2006).***

Hypothesis and Aim of the work

Although pharmacotherapy is the mainstay of the comprehensive program of medical care for the management of patients with bipolar disorder, there additional benefits of psychological interventions for the patient. Several facets of bipolar disorder can be addressed more effectively by instituting adjunctive psychological interventions. Recent clinical evidence indicates that combining pharmacotherapy with psychological interventions, which are tailored to patients' individual needs, may decrease the risk of relapse, improve patient adherence, and decrease the number and length of hospitalization.

This review article will be done to:-

1- Discuss the rationale for the use of psychologic treatments as an adjunct to usual treatment.

2- Review the randomized, controlled trials of evidence–based psychologic treatment for BD, such as group psychoeducation, individual cognitive therapy, family therapy and interpersonal therapy

Overview of bipolar disorder

Overview of bipolar disorder

Epidemiology

Bipolar disorder is a lifelong illness characterized by unpredictable manic or hypomanic episodes with or without depression and a high mortality rate. Recent epidemiological studies suggest that bipolarity may affect at least 5% of the general population ***(Judd and Akiskal, 2003).***

The lifetime risk of suicide attempts by patients ranges from 25% to 50%, and death from suicide occurs in 10–15% of inadequately treated patients. Bipolar disorder also has a high economic burden because it is one of the leading causes of disability in the world. Onset of the illness usually occurs before the age of 25 years. However, recent studies have shown that treatment for bipolar disorder is not started until up to 10 years after onset ***(Hantouche et al., 2003).***

Course

Bipolar disorder manifests itself in many ways. Less than 5% of patients will experience only one single episode, most others experience repeated recurrences