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BIPOLAR DISORDER

DEFINITIONS

Depression - is a common mental disorder, characterized by sadness, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, feelings of tiredness and poor concentration.

Mania – an extended state of intense, wild elation. People experiencing mania feel intense happiness, power, invulnerability, and energy. Believing they will succeed at anything they attempt, they may become involved in wild schemes.

Hypomania – a condition similar to mania but less severe. Hypomanic episodes differ in that they do not cause significant distress or impair one's work, family, or social life in an obvious way while manic episodes do.

Bipolar disorder - a disorder in which a person alternates between periods of euphoric feelings of mania and periods of depression.

Euthymia - is a normal non-depressed, reasonably positive mood.

Cyclothymia - is a condition in which the patient has recurrent hypomanic episodes and subclinical episodes of depression.

Bipolar disorder affects an estimated 2-4 % of the U.S. population and is the sixth leading cause of disability among physical and psychological disorders worldwide. It is associated with heightened risk of financial problems, relationship dysfunction, substance abuse, homelessness, incarceration, and suicide. Bipolar disorder is characterized by a lifelong pattern of pathological mood swings ranging from the energized states which misguided volition and intoxicating euphoria of the manic phases, to the spectrum of depression with compromised energy, volition, and slowed cognition, concentration and physical activity. The swings between highs and lows many occur a few days apart or may alternate over a period of years. In bipolar disorder, periods of depression are usually longer than periods of mania. It is important to understand that bipolar disorder changes lives. Individuals with bipolar disorder generally have trouble with relationships across the lifespan. Disrupted life domains in those with bipolar disorder include self-expression, self-improvement, family relationships, other social relationships, and work relations. Family members and caregivers are reported to be considerably burdened, and their burden is frequently associated with the level of depression in the affected person. Thus, not surprisingly, individuals with bipolar disorder are more likely to be living alone, yet they are also noted be more likely poor, less educated, or unemployed, compared to those with major depression or no affective disorder. These disruptions are observed even when the individuals with bipolar disorder are euthymic at the time of assessment.

CYCLOTHYMIC DISORDER

Cyclothymic disorder is defining as a subtype of bipolar disorder in which people experience a chronic presentation of low-grade depressive and hypomanic symptoms. It is important to say that cyclothymic disorder may take on an increasingly important role as the step between nonclinical levels of mood fluctuation and acute bipolar disorder. Cyclothymia may also be thought as a temperament style, associated with moodiness and irritability. According to investigators cyclomythic temperament may significantly increase risk of developing bipolar I or II. Among the affective temperament styles, cyclothymic temperament is found most often among people who are diagnosed with bipolar spectrum disorder. The idea of temperament as diathesis is similar to the conceptualization of cyclothymic disorder as a prodrome or intermediate stage in the developmental of bipolar I or II. However, Cyclothymia can also be considered a character trait, a personality descriptor without any direct relation to psychopathology.

DIFFERENCES BETWEEN BIPOLAR AND UNIPOLAR DISORDERS

As we know, bipolar disorder is when people sequentially experience periods of mania and depression while unipolar depression is defining as a major depressive episode that occurs without manic phase that occurs in the classic form of bipolar disorder. Bipolar depression differs from unipolar depression in being more characterized by behavioral symptoms such as hypersomnia, lethargy and apathy, in comparison to the pessimistic thoughts and feelings of worthlessness characterising unipolar depression. One study of 920 patients has suggested that bipolar depression is also associated with a poorer quality of life in the areas of general health, social functioning, and the physical and emotional domains of their lives comparison to unipolar patients. Further the recent findings include a study of patients with seasonal, greater psychomotor agitation and greater social withdrawal than unipolar patients. Also it is important to say that bipolar depressed patients were less likely to report loss of appetite than unipolar depressed patients, but a significant minority of bipolar patients reported a co-occurrence of the symptoms of loss of appetite, sleep, disturbance, loss of energy and low interest that were not found to co-occur in the unipolar group.

DIFFERENCES BETWEEN BIPOLAR I AND BIPOLAR II

People in bipolar I disorder suffer full-blown manic episodes (most commonly interspersed with episodes of major depression), and people in bipolar II disorder experience depressive episodes and less severe manic symptoms, classed as hypomanic episodes. Criteria for mania and hypomania have the same symptom profile (apart from psychotic symptoms, that can occur in mania alone) and differ only in the degree of severity. According to comparative studies, bipolar disorder I appears to develop less severe symptoms, but exhibits more of chronic course with more frequent episodes. Moreover, unstable interpersonal relationships and social adjustment and comorbidity of psychiatric illness were more frequently observed in bipolar disorder II than in bipolar disorder I. Also, it is important to say that a higher risk of suicide has also been reported in patients with bipolar disorder II as compared to those with bipolar disorder I. According to investigators, certain personality traits (neuroticism, extraversion, and openness) have been shown to significantly impact on the depressive morbidity component of bipolar I disorder. As those with bipolar II have more depressive illness course than that quantified in bipolar I disorder, examination of associations between personality traits and affective presentation in this group would be of particular interest for future research. Hence, compared to bipolar disorder I, bipolar disorder II seems to be a more complicated condition with regard to clinical course, comorbidity, and familial loading of psychiatric disorders.

SYMPTOMS OF BIPOLAR DISORDER

1. DEPRESSION

Some people with bipolar disorder experience elevated levels of life stress even during asymptomatic periods. High rates of divorce, unemployment, victimization, and stigmatization are well-documented in this population. At a basic level, it is important to clarify that people with bipolar disorder differ in how much depression they experience. It is known that patients with bipolar disorder spend a substantial proportion of time suffering from syndrome or sub-syndrome depressive symptoms. The outcome of a 12-year prospective longitudinal study, in which 146 patients with bipolar I disorder completed weekly mood ratings, reported that depressive symptoms were three times more common than manic or hypomanic symptoms. Major depressive episodes in bipolar disorder are similar to those experienced in unipolar major depression. Patients suffer depressed mood and experience profound loss of interest in activities, coupled with other symptoms such as fatigue, weight loss or gain, difficulty sleeping or staying awake, psychomotor slowing, feelings of worthlessness, excessive guilt and suicidal thoughts or actions. The risk of suicide is greatly elevated during depression episodes. Approximately 17% of patients with bipolar I disorder and 24% of patients with bipolar II disorder attempt suicide during course of their illness. Most suicide attempts and most completed suicides occur in the depressed phase of the illness and patients with bipolar II disorder are at especially high risk. The standardized morality ratio (SMR) for suicide in bipolar disorder is estimates to be 15 for men and 22.4 for women.

2. MANIA AND HYPOMANIA

The longitudinal study of bipolar symptomatology mentioned above reported that patients with bipolar I disorder suffered syndrome or sub-syndrome manic or hypomanic symptoms approximately 9% of the time over 12 years. For patients with bipolar II disorder, approximately 1% of weeks were spent hypomanic. It is known that a history of mania is associated with stronger emphasis on goals, even during euthymic periods. Two studies have found that compared to individuals with no mood disorder, individuals with a history of mania in remission are more likely to endorse items reflecting perfectionism and the need to achieve goals on the dysfunctional attitudes scale. People with bipolar disorder seem to experience greater mood reactivity to environmental circumstances than those without bipolar disorder do. This reactivity may be more pronounced for positive stimuli. When they are manic, people with bipolar disorder remember the positive moments in their life much more readily than the negative moments, and they see themselves much more positively than they do at other times. They show large increases in confidence after initial success or when they are experiencing hypomanic symptoms. On the other hand, there are models focused on 'the manic defense' in which mania was seen as a flight from painful feelings. These models predict that mania will occur after negative life events, as a defensive reaction. Newer cognitive behavioral formulations have propose that people with bipolar disorder might avoid focusing on threatening information. A key of feature of the manic defense model is the idea that people with bipolar disorder have high levels of defensiveness against painful thoughts or experiences. In sum, people with bipolar disorder may not acknowledge negative feelings about the self and may show more defensive behavior after threat.

3. MIXED STATES

In a full-blown mixed episode, criteria are met for a depressive episode and a manic episode nearly every day for at least 1 week. However, a mixture of manic and depressed symptoms may occur without reaching full diagnostic criteria. For example, a patient may have racing thoughts, agitation, overactivity

and flight of ideas but feel worthless, guilty and suicidal. The patients with bipolar I disorder who took part in the 12-year longitudinal study mentioned previously spent an average 6% of weeks in a mixed state. For patients with bipolar II disorder the proportion was just over 2%.

THEORIES

1. BEHAVIORAL ACTIVATION SYSTEM (BAS)

A prominent psychological model of bipolar disorder is the BAS deregulation model, variably also termed the BAS 'sensitivity' model. This model expands on cognitive-behavioral conceptualisations of bipolar disorder, but also attempts to integrate biological vulnerability associated with the condition. Biological vulnerability is hypothesized to result from deregulation of the BAS – a neurobiological motivational system operating via dopaminergic pathways that regulates goal-directed approach to potential reward. Those with bipolar disorder are thought to have a deficit in the serotonergic regulation of such pathways, rendering them more reactive to cues of reward. The BAS is reactive to influence positive affect, energy, and attention – with hypo(mania) reflecting extreme sensitivity of this system. BAS functions include a range of cognitive and affective processes associated with goal-directed behavior.

2. THE COGNITIVE THERAPHY MODEL

Childhood experiences lead to the development of dysfuncional schemas that centre around themes such as the need to be loved or the need to achieve. Disconfirming experiences or life events later in life, for example, in the transition from adolescence to adulthood, may lead to "activation" of the dysfunctional schema in that the person no longer believes that he or she is lovable, or believes that he or she has been a failure throughout life. The activation of the dysfunctional believes causes the production of negative automatic thoughts (e.g. "I am unlovable", "I am failure", etc.), which in turn case the onset of the relevant mood such as the depressed state in the vulnarable individual.

3. THE INTERPERSONAL AND SOCIAL RHYTHM THERAPY

The interpersonal and social rhythm therapy approach to bipolar disorder combines the Interpersonal Psychotherapy approach by Weissman, Klerman for the treatment of unipolar depression, together with a circadian rhythm model developed by the ITP group at the University of Pittsburg. The IPT approach to depression was originally developed as a control intervention in a pharmacotherapy trial for unipolar depression. IPT works with three phases in therapy. The first phase focuses on assessment and formulation. In addition to history and diagnostic interviewing, IPT includes the so-called Interpersonal Inventory which is an interview assessment of the social network and social support of the client. The second phase of therapy selects one of four focus areas on which to base the intervention: Interpersonal Role Disputes (for example: marital conflict, problems at work); Role Transitions (for example: the transition from adolescence to adulthood, retirement); Grief (the loss of a significant other); Interpersonal Deficits problems in establishing and maintaining relationships. The third and final phase of the therapy is the Termination phase in which the therapist works to establish therapeutic gains and to deal with the issues arising from the ending of therapy. The second main feature of IPSRT is its focus on social circadian rhythms. The Social Rhythm Metric is completed as part of the assessment. The SRM seeks to identify specific triggers that are likely to disrupt normal social rhythms for the individual, to monitor mood, and to monitor social interactions. The plan then is to regularize social rhythms, especially under circumstances of vulnerability for the individual, or when certain prodromes or early warning signs of a manic or depressive episode are identified.

TREATMENTS

The established psychological treatments for bipolar disorder as an adjunct to medication are cognitive behavior therapy (CBT), behavioral family therapy, interpersonal and social rhythm therapy (IPSRT) and psychoeducation. In terms of formal, the treatments are each highly structured and based on a coherent stress-vulnerability model. They provide the patient with a personalized overview of their problems and clear rationale for the intervention, they encourage the independent use skills and knowledge learned and they promote the patient's sense of self-efficacy. In terms of continent, they each cover at least four key domains: psychoeducations about bipolar disorder; stabilization of lifestyle and daily routines, medication adherence and relapse prevention. Stabilisation of routines is a particular focus given the evidence that disruption in routine and sleep are key factors preceding mania. Recent reviews of psychological treatment for bipolar disorder conclude that they lead to sicnificantly fewer relapses when compared to medication and standard psychiatric treatment alone.

COGNITIVE BEHAVIOURAL THERAPIES

A key component addressed in CBT for bipolar depression is the way that the patients deal with the serious losses that experience as a consequence of their bipolar disorder. According to Lam, the cognitions of people with bipolar disorder are likely to centre around themes of loss in realation to the illness, dwelling on feelings of apathy and indecision, ruminating on poor levels of goal attainment (e.g. "I can't do it"; "I am no longer able to") and making unfavourable comparisons with others. In CBT, the negative automatic thoughts are addressed using thought diaries. In particular, the patient is encouraged to see the benefits of pleasurable behaviours that do not ilvolve large increases in activity and are not directed at achieving highly challenging goals. Having a bath or listening to relaxing music are examples. These adaptations have two functions: first, to encourage activities that may raise the risk of hypomania, and second to provide evidence against the dysfunctonial belief that they must become greatly activated and highly successful in order to overcome their depression. A regular routine of behaviour is also encouraged rather than merely the increase in levels of activity. Importantly, there is evidence that the prodromes of depression are harder to predict than the prodromes of mania. CBT for bipolar disorder also focuses on the consequences of bipolar disorder for the patient's sense of self. Stigmatisation is a real issue that impacts their social and occupational functioning. Further, patients may experience guilt and shame concerning behaviours during pats manic episodes and they may have real losses to grieve owing to the damaging consequences of their illness to work, family and friendship. Other patients may experience intense feelings of helplessness, disillusionment and hopelessness associated with depression following their repeated relapses and failed treatments. There is evidence from mixed sample of patients with schizophrenia and bipolar disorder that negative appraisals of the consequences of the disorder (e.g. low levels of perceive control of the illness, stigmatization and social containment) were closely correlated with current symptoms of depression.

OTHER EVIDENCE-BASED PSYCHOLOGICAL TREATMENTS

Several groups have developed programmes of psychoeducation which is usually delivered in a group discussion format led by a clinical and covers the key areas of medication adherence, stabilization of routines and relapse prevention. A randomized controlled trial compared 21 sessions of group psychoeducation with a non-structured group therapy in euthymic patients.

The family focused treatment (FFT) developed by Godlstein and Miklowitz is the most widely research family intervention. It focuses on improving family communication, problem-solving and coping strategies, and involves psychoeducation and relapse prevention. Over a 1- year period, the treatment group were less likely to experience a depressive relapse and showed less depressive symptoms. The effects were partially mediated by increases in patients' positive nonverbal interactions during treatment.

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