Cognitive Behavioral Treatment of Bipolar Disorder

The original version of these slides was provided by

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Use of this Slide Set

- Presentation information is listed in the notes section below the slide (in PowerPoint normal viewing mode).
- References are also provided in note sections for select subsequent slides

Diagnostic Considerations

- Manic Episode
  - 1 week high, euphoric, or irritable mood plus 3 (4) of the following:
    - exaggerated feelings of importance
    - little need for sleep
    - racing thoughts
    - pressured speech
    - distractibility
    - increased goal directed behavior (agitation)
    - reckless behavior
- Hypomanic Episode
  - 4 days of high, euphoric, or irritable mood plus 3 (4) symptoms (no impairment, psychotic features, need for hosp.)

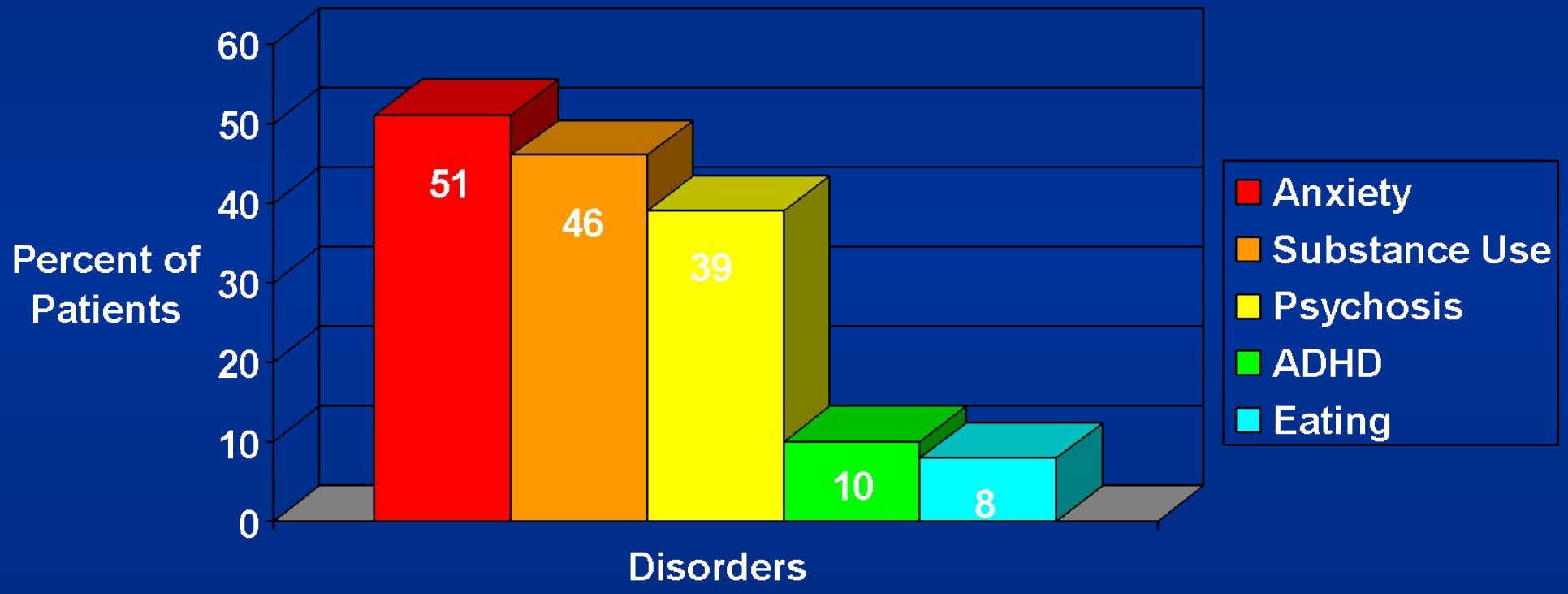
Diagnostic Considerations

- Bipolar I
  - At least one manic or mixed episode
  - May or may not have depressive episode, but most do (71% of sample)
  - 3.5 more likely to have depressive symptoms than manic/hypomanic (Judd et al., 2002)
- Bipolar II
  - At lease one hypomanic episode and one or more depressive episodes
  - 38 times more likely to have depressive symptoms than hypomania (Judd et al., 2003)
- Bipolar I vs II status is only inconsistently predictive of shorter term outcomes (cf., Judd et al., 2003; Miklowitz et al., 2007; Otto et al., 2006).

Characteristics of Patients With Bipolar Disorder

- Prevalence
  - 1-2% of the population
- Age of Onset
  - Late teens to early 20s (earlier age of onset is associated with a worse course; Perlis et al. 2006).
- Sex Ratio
  - Equal, but more rapid cycling among women
- Comorbidity
  - Anxiety, Substance Use, ADHD
- Course
  - 75% relapse 4-5 years, half in 1 year (the proportion of days ill predicts episode frequency the next year; Perlis et al., 2004)

Comorbidity in Bipolar Disorder
(assessed in 1000 patients enrolled in STEP-BD)



Kogan et al., 2004

Diagnostic Issues – Major Depression

- Depression:
  - Youth hospitalized for severe depression (young and severe) – 41% experienced manic/hypomanic episode over next 15 years (Goldberg et al., 2001)
- Depression + Substance Use Disorder
- Depression + Borderline Disorder
- Depression + psychosis (schizoaffective disorder)

Presentation with Psychosis

- Is it mania?
- Schizophrenia?
- Substance Induced?
- Schizoaffective?

- History and family help

An Abundance of Distress and Disability

- Family, job, personal
- Post-episode studies
  - 6 months after: 30% unable to work; only 21% worked at their expected level (Dion et al., 1988)
  - 1.7 years after hospitalization: 42% had steady work performance (Harrow et al., 1990)
- Relatively high rates of suicide in bipolar disorder (predicted prospectively by days depressed and previous attempts; Marangell et al., 2006)

Psychosocial Treatment

Topics

- What is the evidence for the efficacy of psychotherapy for bipolar disorder?
- What are the targets of treatment?
- What are the elements of treatment?

Psychosocial Treatment for Bipolar Disorder

Initial Encouragement:

- Psychosocial Predictors of Bipolar Course
- Incomplete Efficacy of Mood Stabilizers
- Practice Characteristics
  - Majority of bipolar patients are engaged in some sort of psychosocial care

Direct Evidence

- Promising outcomes from well-controlled trials

Role of Psychosocial Factors in Bipolar Disorder

- Psychosocial stressors impact the course of bipolar disorder:
  - Family stress (expressed emotion)[1]
  - Negative life events [2]
  - Cognitive style [3]
  - Sleep disruptions [4]
  - Anxiety comorbidity [5]

[1] Miklowitz et al. (1988)
[2] Johnson & Miller, (1997); Ellicott et al. (1990)
[3] Reilly-Harrington et al., 1999
[4] Malkoff-Schwartz et al. (1998)
[5] Simon et al. (2004); Otto et al. (2006)

Pharmacotherapy for Bipolar Disorder

- Advances in the field, but among patients taking medications:
  - Half relapse first year
  - Three-quarters relapse over several years
  - Continued role impairment between episodes
  - Poor medication adherence

(Gitlin et al., 1995; Keck et al., 1998; O'Connell et al., 1991; Tohen et al., 1990)

Focused Psychosocial Treatments for Bipolar Disorder

- The product of diverse theoretical orientations, but with a high degree of similarity in strategies.
- In particular, randomized trials have shown support for
  - Cognitive Behavioral Therapy (CBT)
  - Interpersonal and Social Rhythm Therapy (IPSRT)
  - Family-Focused Treatment (FFT)

Common Treatment Elements Among CBT, IPSRT, FFT

- Psychoeducation providing a model of the disorder and risk and protective factors (e.g., the role of sleep and lifestyle regularity).
- Communication and problem-solving training aimed at reducing familial, relationship, or external stress.
- Review of strategies for the early detection and intervention with mood episodes (including increased support, pharmacotherapy, more-frequent monitoring).

Some of the Influential, Psychosocial Clinical Trials

- Medication adherence[1]
- Detection of prodromal episodes, early intervention[2]
- Individual CBT for Relapse Prevention[3]
- Individual IPSRT for Relapse Prevention[4]
- Family Interventions for Relapse Prevention[5]
- Group Psychoeducation for Relapse Prevention[6]
- Individual CBT for Episode Treatment [7]
- Intensive CBT, IPSRT, or FFT for Bipolar Depression [8]

1. Cochran (1983)
2. Perry et al. (1999)
3. Lam et al. (2000), Lam et al. (2003); Scott et al. (2001)
4. Frank et al. (1997); Frank et al. (1999)
5. Miklowitz et al. (2003); Rea et al. (2003); Simoneau et al. (1999); also Clarkin et al. (1998)
6. Colom et al. (2003)
7. Scott et al. (2006)
8. Miklowitz et al. 2007

Cognitive-Behavioral Therapy (CBT) for Medication Adherence (Cochran, 1984)

Relapse Prevention

- 6 sessions of adjunctive CBT vs standard clinical care[4]
- At end point and at 6-month follow-up, CBT patients had
  - Greater medication adherence
  - Lower hospitalization rates

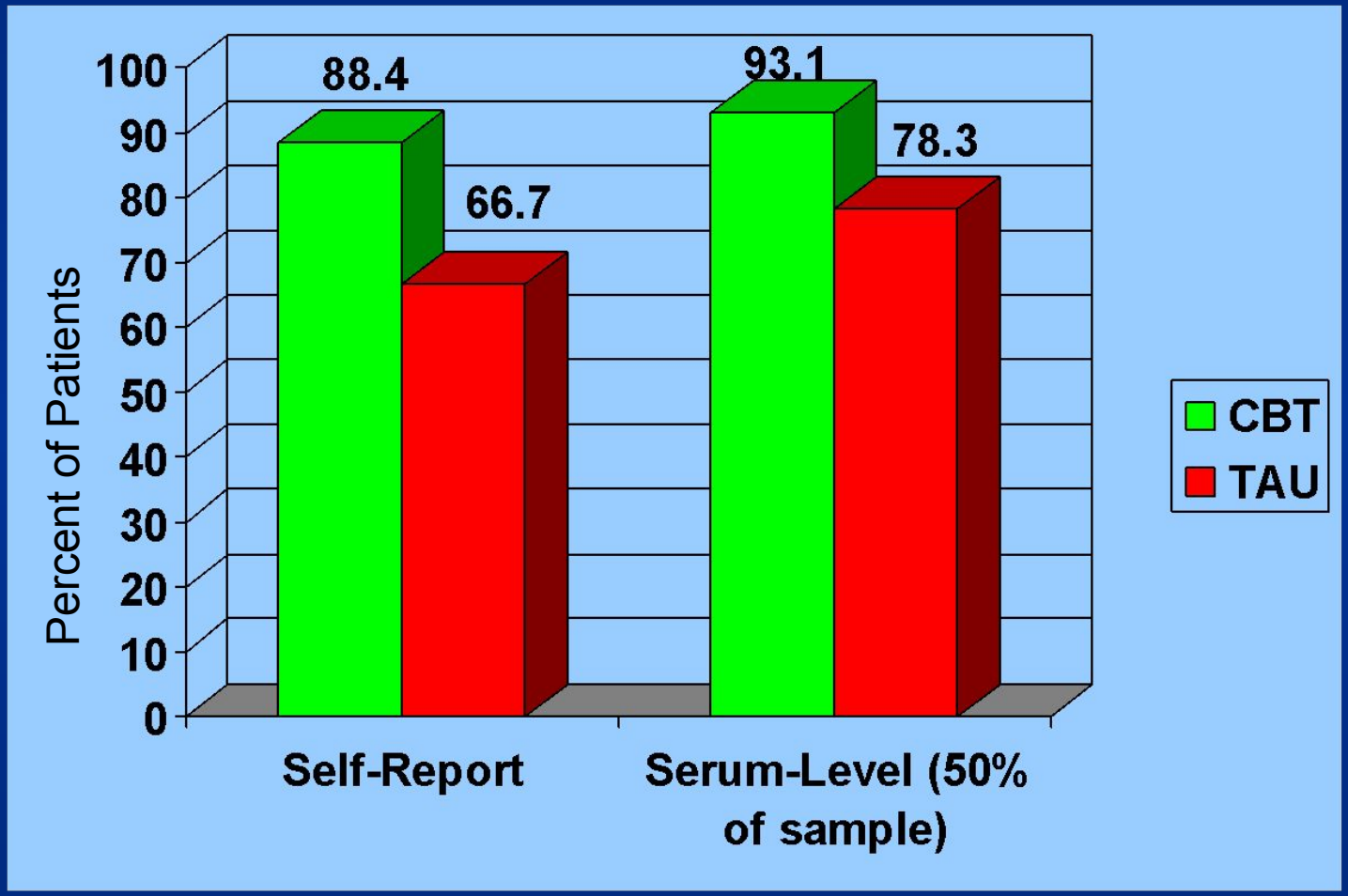
Cochran S. *J Consult Clin Psychol*. 1984;52:873-878.

Lam et al. - An Early CBT Success

- 103 bipolar patients randomized to CBT or TAU
- 12-18 sessions individual CBT
  - Information
  - Monitoring of mood & cognitions (early intervention)
  - Management of sleep and routine
  - Attention to “making up for lost time”
- 8 dropout in each condition

Lam et al., 2003, Arch Gen Psychiatry, 60:145-152

Medication Adherence



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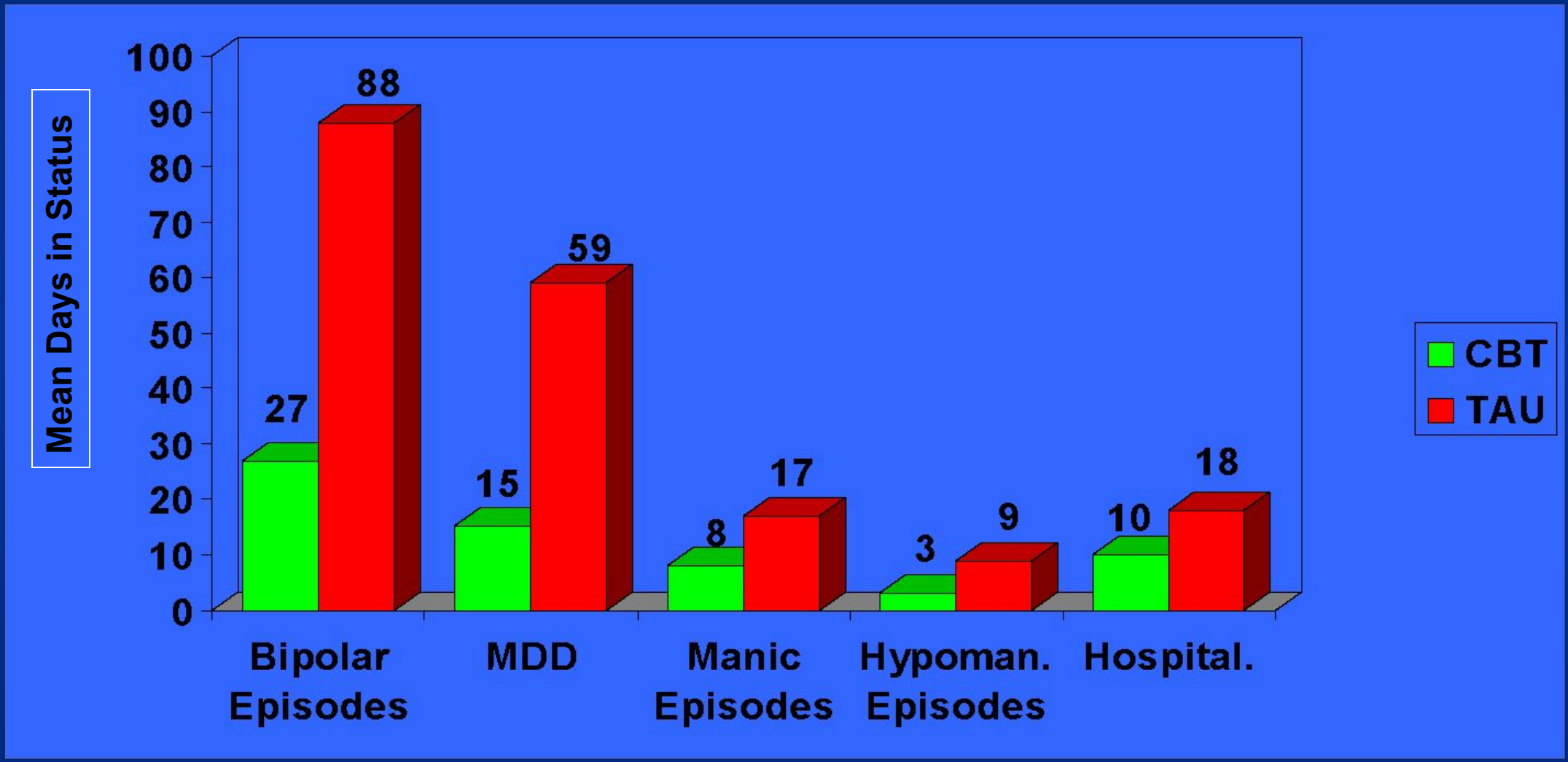
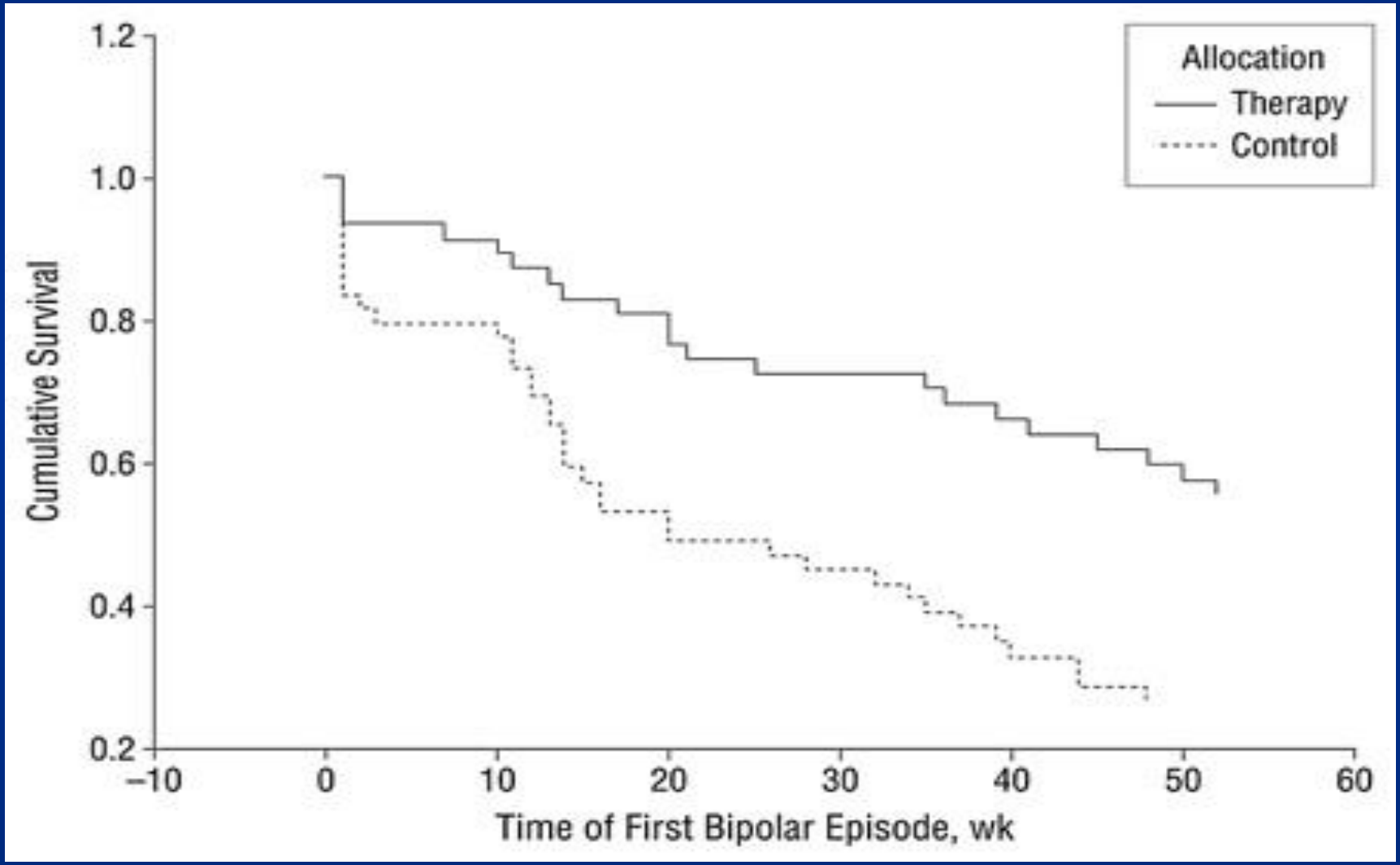
Clinical Outcome (days ill over 1 year)



Lam et al., 2003, Arch Gen Psychiatry, 60:145-152

Survival Analysis

(N = 103)



Lam et al., 2003, Arch Gen Psychiatry, 60:145-152

Family-Focused Treatment

Elements

- Psychoeducation about bipolar disorder
- Communication-enhancement training
- Problem-solving training[1]

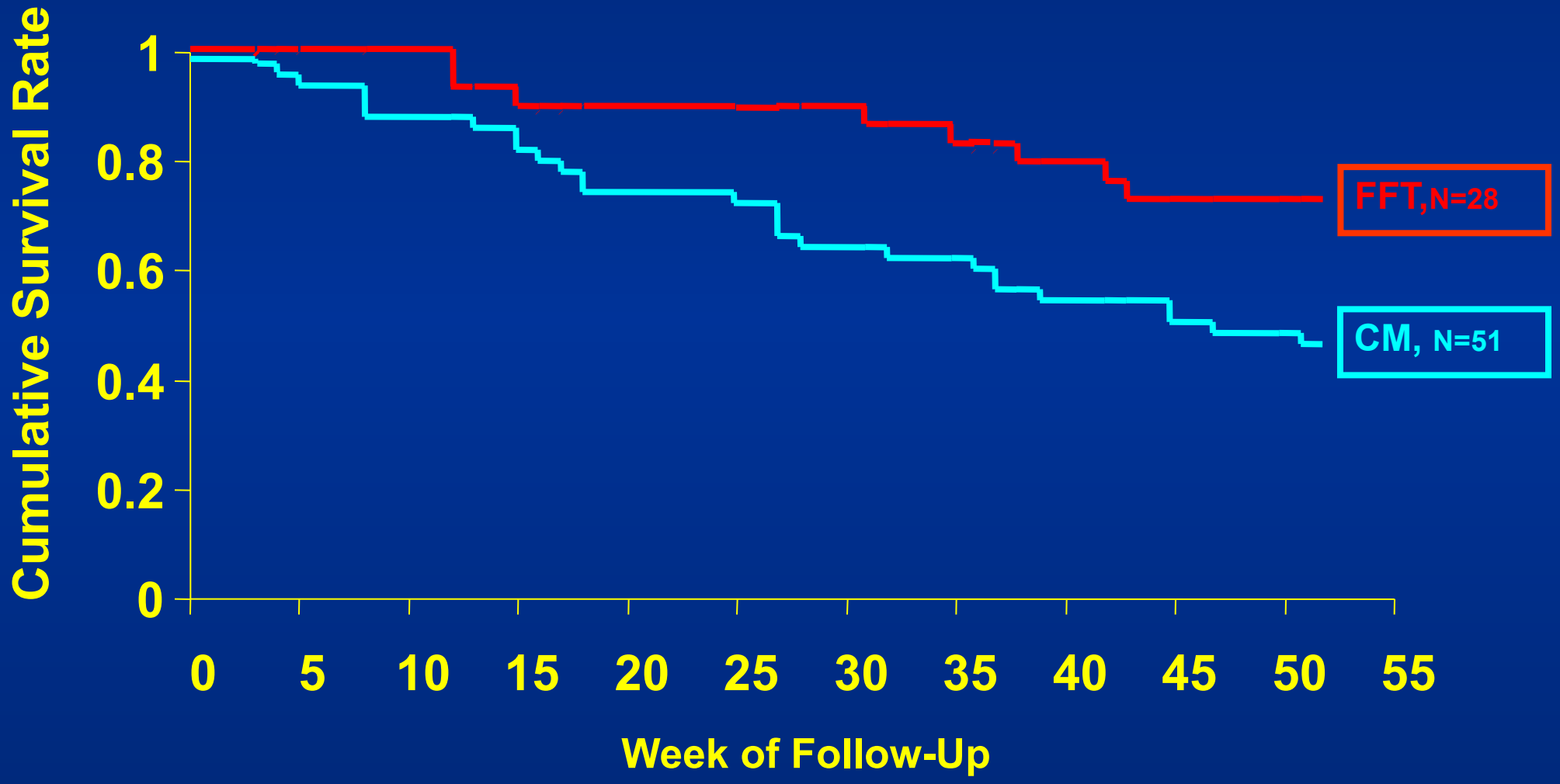
Outcome

- Adjunctive FFT appears to effect[1]
  - Depressive symptoms
  - Manic symptoms
  - Rehospitalization times

Miklowitz DJ, et al. *Arch Gen Psychiatry.* 1988;45:225-231.

1-Year Survival Rates Among Bipolar Patients in Family-Focused Treatment versus Case Management

Miklowitz DJ, et al. *Arch Gen Psychiatry.* 1988;45:225-231.



Wilcoxon Test, χ^2 (1) = 4.4, p = .035

Six Objectives of FFT

Help the patient and her or his relatives to:

- Understand the nature of bipolar disroder and cyclic mood disturbances.
- Accept the concept of vulnerability to future episodes
- Accept a crucial role for mood-stabilizing medication for symptom control
- Distinguishing between personality and bipolar disorder
- Recognize and develop coping skills for managing the stressful life events that trigger recurrences of bipolar disorder
- Reestablishing role and interpersonal functioning after a mood episode

Interpersonal and Social Rhythm Therapy

- Educate patient about bipolar disorder
- Identify current interpersonal problem areas (e.g., grief, disputes, role transitions, interpersonal deficits)
- Initiate social rhythm metric

Frank et al. *Biological Psychiatry* 1997 1165-1173

Group Psychoeducation vs. Standard Care

- 21 Weeks of Randomized Treatment, 2-year follow-up
- 120 outpatients in remission for 6 months
- Standard Care
  - Treatment algorithms
  - Monthly sessions
  - Serum levels of medications assessed
- Group Treatment 21 90-minute sessions
- Outcome
  - Recurrences at endpoint: 38% in group vs. 60% in SC
  - Recurrences at 2 years: 67% in group vs. 92% in SC

Colom F, et al. *Arch Gen Psychiatry.* 2003;60:402-407.

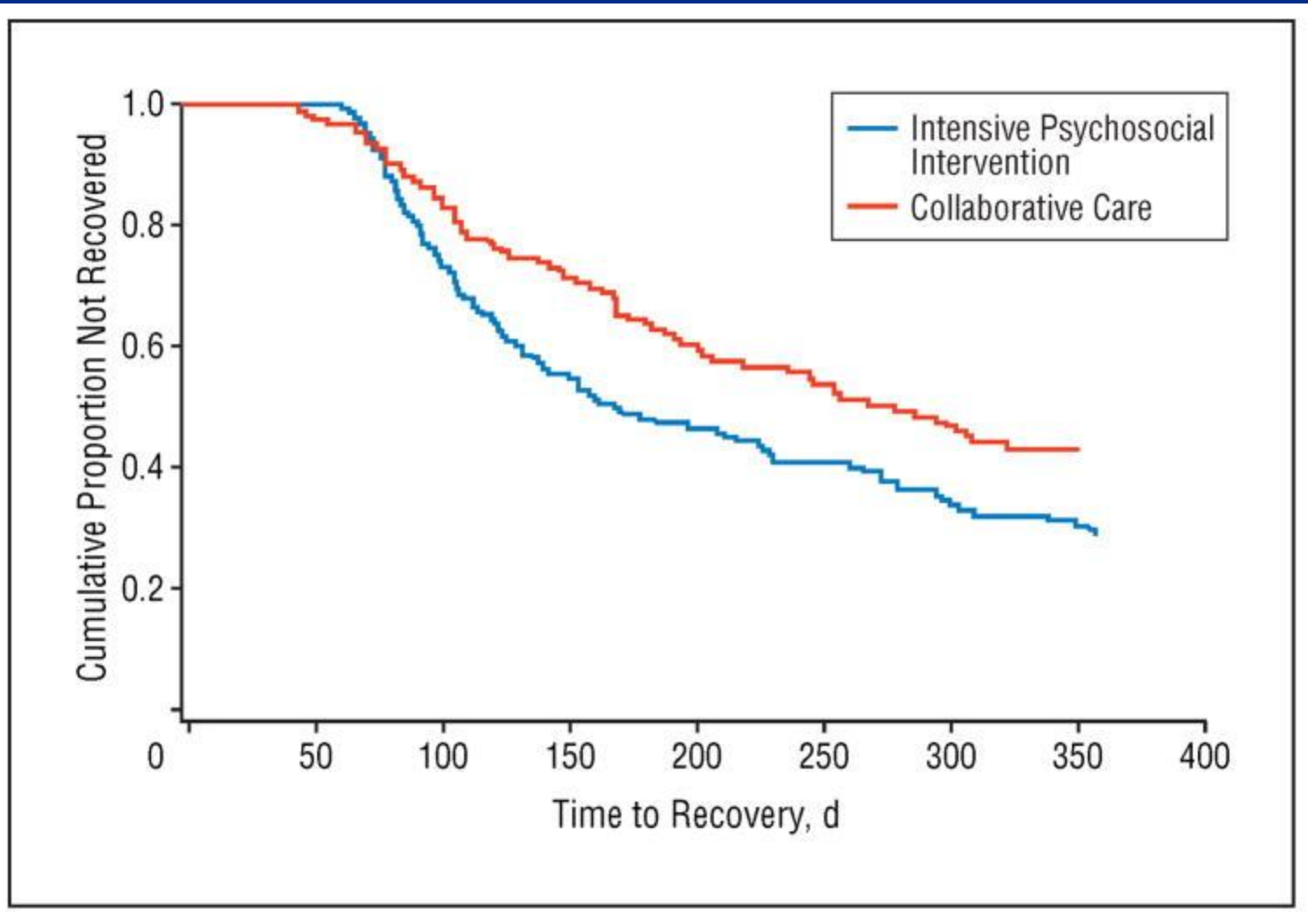
Psychoeducation?

- Psychoeducation
  - What is bipolar illness
  - Symptoms
  - Treatments
  - Serum levels
- Early detection of episodes
- Risk reduction - substance use
- Lifestyle regularity
- Stress management
- Problem solving

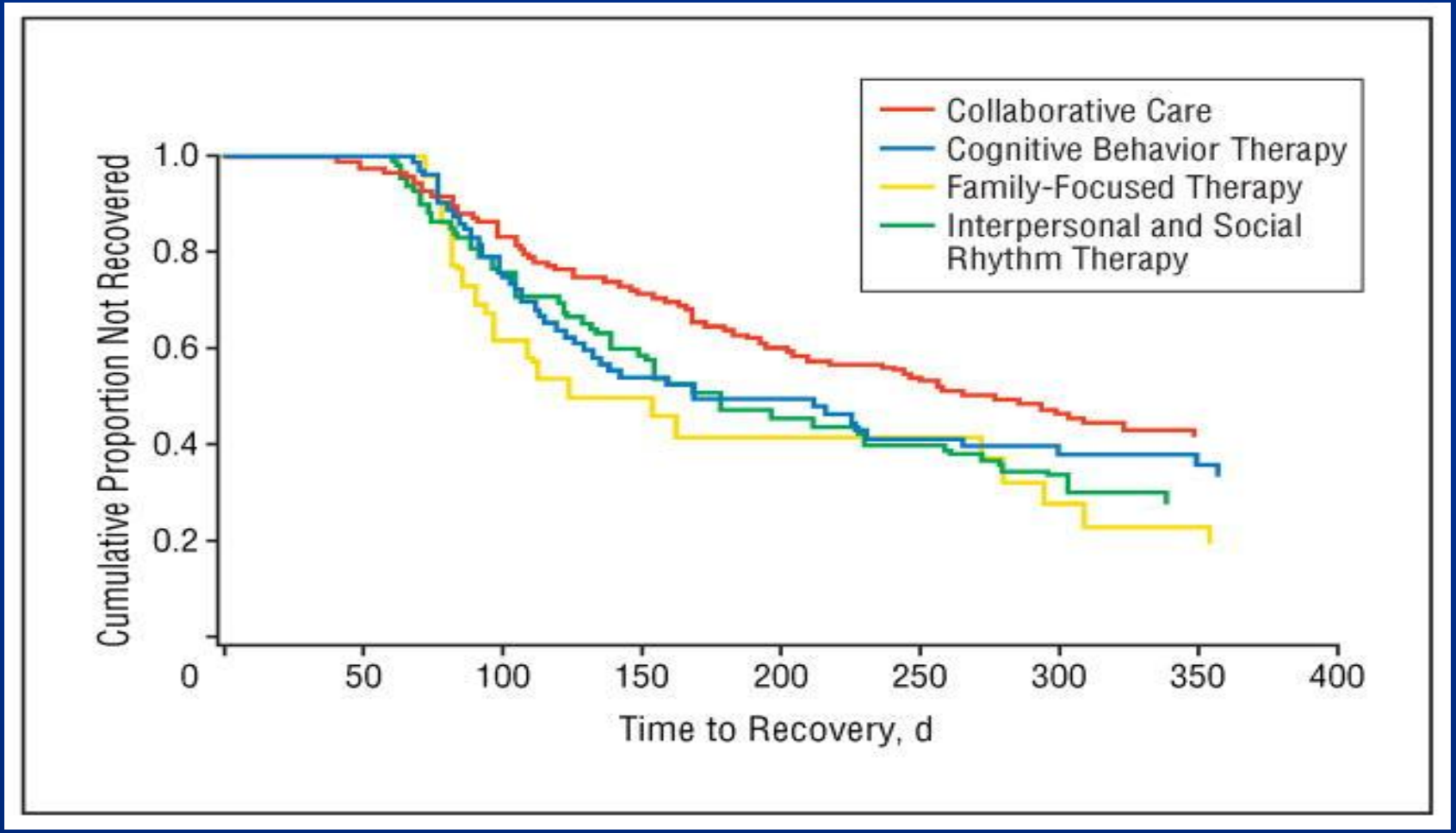
Colom F, et al. *Arch Gen Psychiatry.* 2003;60:402-407.

CBT, IPSRT, FFT vs. Collab Care for Bipolar Depression

Miklowitz et al., 2007, Archives Gen Psychiatry



No Significant Differences Among the Intensives: CBT, IPSRT, FFT



Given this Evidence...
...What are Some Targets for Psychotherapy?

- Medication adherence
- Early detection and intervention
- Stress and lifestyle management
- Treatment of bipolar depression
- Treatment of comorbid conditions

Medication Non-Adherence in Mood Disorder

- 98 patients taking mood stabilizers (80% bipolar)
- 50% non-adherence rate last year
- 30% non-adherence last month (≤70% adherent)
- Predictors of non-adherence:
  - denial of severity of illness
  - previous non-adherence
  - greater illness duration

(Scott & Pope, 2002, J Clin Psychiatry, 63:384-390)

Relapse Prevention

- Patient as cotherapist
- Treatment contract
- Training in early detection
- Use of treatment team

Individualized Treatment Contract

- Why contract?
- Formulate a plan for the future
- How I know I am depressed
  - Plan during depression
- I am manic when…
  - Plan during mania (include who initiates the plan)
- Other modules
  - Substance abuse, Bulimia, Gambling, Budget, etc

Mood Charting

- Enables early and accurate identification of changes in mood
- Allows for early intervention prior to severe episodes
- Tracks medication doses and adherence to psychological treatment
- Tracks hours slept and sleep/wake times
- Notes daily psychosocial stressors that may serve as triggers for relapse

Strategies for Hypomania

- Explore medical solutions
  (e.g., dosage or medication changes)
- Counteract impulsivity
  - Give car keys or credit card to someone to hold
  - “Make rules” about staying out late or giving out phone number
  - Avoid alcohol and substance use
- Minimize stimulation
  - Avoid confrontational situations

Newman et al. *Bipolar disorder: A Cognitive Therapy Approach*. 2001

Cognitive-Behavioral Therapy for Bipolar Depression/Relapse Prevention

Structure of Sessions

- Review of symptoms, progress, and problems
- Construction of the agenda
- Discussion, problem solving, rehearsal
- Consolidation of new information/strategies
- Assignment of home practice
- Troubleshooting of homework (including signposts of adaptive change)

Cognitive Restructuring and Skill Acquisition

Restructuring

- Education (role and nature of thoughts)
- Self-monitoring of thoughts
- Identification of errors
- Substitution of useful thoughts
- Core beliefs and strategies

Skill acquisition

- Assertiveness
- Communication skills
- Problem solving

Cognitive Restructuring

- Examine the evidence for the thought
- Generate alternative explanations
- De-catastrophize
- Debunk “shoulds”
- Find the logical error
- Test out its helpfulness

Questions Used to Formulate Rational Response

- What is the evidence that the automatic thought is true? Not true?
- Is there an alternative explanation?
- What is the worst that could happen? Would I live through it?
- What's the best that could happen?
- What's the most realistic outcome?

Questions Used to Formulate Rational Response (Cont'd)

- What is the effect of my believing the automatic thought?
- What is the cognitive error?
- If a friend was in this situation and had this thought, what would I tell him/her?

Respecting Hot Emotions

- Interventions are in relation to, not in spite of, the patient's current mood.
- Train emotional regulation skills
- Gain access to mood-state dependent cognitions

Activity Assignments: Bipolar Disorder

- Management of sleep
- Management of over/under activity
- Management of destructive activities (substance use)
- Resetting goals given limitations due to the disorder

Activity Assignments - 1

- Independent Intervention or used in conjunction with cognitive restructuring
- Help ensure that therapy is not over-focused on thinking rather than doing
- Often requires a problem-solving analysis to understand patterns of over- and under-activity relative to the patient's values

Activity Assignments - 2

- Monitor current Activities
- For change:
  - Start small (where the patient is)
  - Be specific
  - Rehearse elements in session
  - Define outcome objectively
  - Troubleshoot problems and signposts
  - Review cognitions (expectations, concerns)

Activity Assignments - 3

- Review performance relative to objective criteria (and the degree of mood disturbance)
- Assess the patient's cognitive and emotional response to the assignment
- Discuss further applications

Well-Being Therapy Phase

- In this phase, therapeutic effort and monitoring is devoted to increasing periods of well being rather than reducing pathology.
- It provides a way to consolidate gains around positive outcomes
- An excellent strategy for fading out treatment

End of Treatment

- Patient has skills to act as his or her own therapist
- Patient focuses on well-being
- Therapist contact fades

Cognitive-Behavioral Therapy for Comorbid Disorders

- Anxiety disorders
- Substance use disorders
- Eating disorders

New Directions in CBT for Bipolar Disorder Promoting Emotional Tolerance

- Getting better with the rollercoaster of emotions
- Learn to apply emotional acceptance plus problem solving in the context of strong emotions (anxiety, sadness, euphoria)
- Initial evidence for mindfulness training in bipolar disorder – improvements in mood and cognitive symptoms
    - (Deckersbach et al., 2012, CNS Neurosci Ther).