Early Intervention in Bipolar Disorder Depends on Early Identification: Strategies for Optimizing Positive Outcomes

Ellen Frank, PhD

Distinguished Professor of Psychiatry, University of Pittsburgh School of Medicine

Allen Doederlein

President, Depression and Bipolar Support Alliance

Funding for this Webinar is provided by the
Substance Abuse and Mental Health Services Administration (SAMHSA)

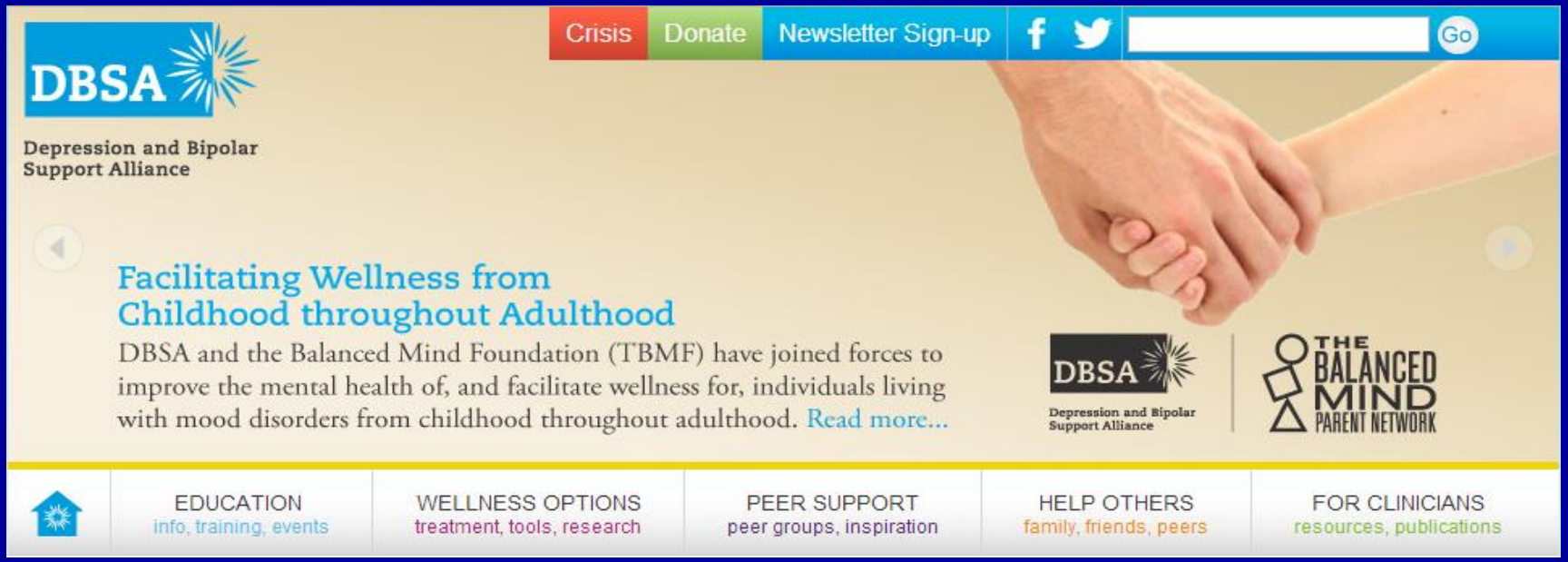
Manic-depressive illness magnifies common human experiences to larger-than-life proportions

- Goodwin and Jamison, 2007

Depression and Bipolar Support Alliance (DBSA)

OUR MISSION: DBSA provides hope, help, support, and education to improve the lives of people who have mood disorders.

DBSA envisions wellness for people who live with depression and bipolar disorder. Because DBSA was created for and is led by individuals living with mood disorders, our vision, mission, and programming are always informed by the personal, lived experience of peers.



Western Psychiatric Institute and Clinic (WPIC)

An internationally–recognized treatment, research and training center for mood disorders.

DBSA and WPIC: A Longstanding Collaboration

Ellen Frank and Allen Doederlein present Tina Goldstein with the DBSA's Klerman Young Investigator Award

The Mood Disorders Cookbook

- Ingredients
  - Major Depressive Episode
  - Manic Episode
  - Hypomanic Episode
- Basic Recipes
  - Major Depressive Disorder
  - Bipolar I Disorder (Manic-depressive Illness)
  - Bipolar II Disorder
- Advanced Recipes
  - Other Specified and Unspecified Bipolar and Related Disorder, Schizoaffective Disorder, Cyclothymia
  - Hyperthymia

Manic episode

- Criterion A: Distinctly elevated (irritable) mood and increased energy/activity
- Criterion B: Three or more of the following:
  - grandiosity
  - more talkative
  - distractibility
  - excessive engagement in risky activities
  - decreased need for sleep
  - flight of ideas
  - increased activity
- May be accompanied by psychotic symptoms
- Marked impairment
- Present for at least 1 week or any duration if hospitalization is needed

Hypomanic Episode

- Criterion A: Distinctly elevated (irritable) mood and increased energy/activity
- Criterion B: Three or more of the following:
  - grandiosity
  - more talkative
  - distractibility
  - excessive engagement in risky activities
  - decreased need for sleep
  - flight of ideas
  - increased activity
- NO psychotic symptoms or hospitalization
- Observable to others
- Involves a change in functioning (may be better), but does NOT cause marked impairment
- Present for at least 4 consecutive days

When I am high, I couldn't worry about money if I tried… So I bought twelve snake bite kits, with a sense of urgency and importance. I bought precious stones, elegant and unnecessary furniture, three watches within an hour of one another (in the Rolex rather than Timex class)….sundry Penguin books because I thought it would be nice if the penguins would form a colony, five Puffin books for a similar reason. …I must have spent $30,000 during my two major manic episodes, and God only knows how much more during my frequent milder manias.

-Kay R. Jamison, *An Unquiet Mind*, 1995

Major Depressive Episode

- Criterion A: Depressed mood or loss of interest – present for at least 2 weeks
- Criterion B: Five or more of the following:
  - Depressed mood
  - Loss of interest
  - Change in weight
  - Poor concentration
  - Insomnia or hypersomnia
  - Psychomotor agitation or retardation
  - Fatigue or low energy
  - Feelings of worthlessness/guilt
  - Suicidal thoughts
- May be accompanied by psychotic symptoms
- Marked impairment in functioning

I had no idea what was happening to me. I would wake up in the morning with a profound sense of dread that I was going to have to somehow make it through another entire day. I would sit for hour after hour in the undergraduate library, unable to muster up enough energy to go to class…When I did go to class it was pointless. Pointless and painful. I understood very little of what was going on, and felt as though only dying would release me from the overwhelming since of inadequacy and blackness that surrounded me.

-Kay R. Jamison, *An Unquiet Mind*, 1995

How common are these disorders?

- Major Depressive Disorder 12.5 %
- Bipolar I 1.0 %
- Bipolar II 1.1%
- Bipolar NOS (now 'Other Specified') 2.4%

Merikangas KR et al. *Arch Gen Psychiatry.* 2011;68: 241-251

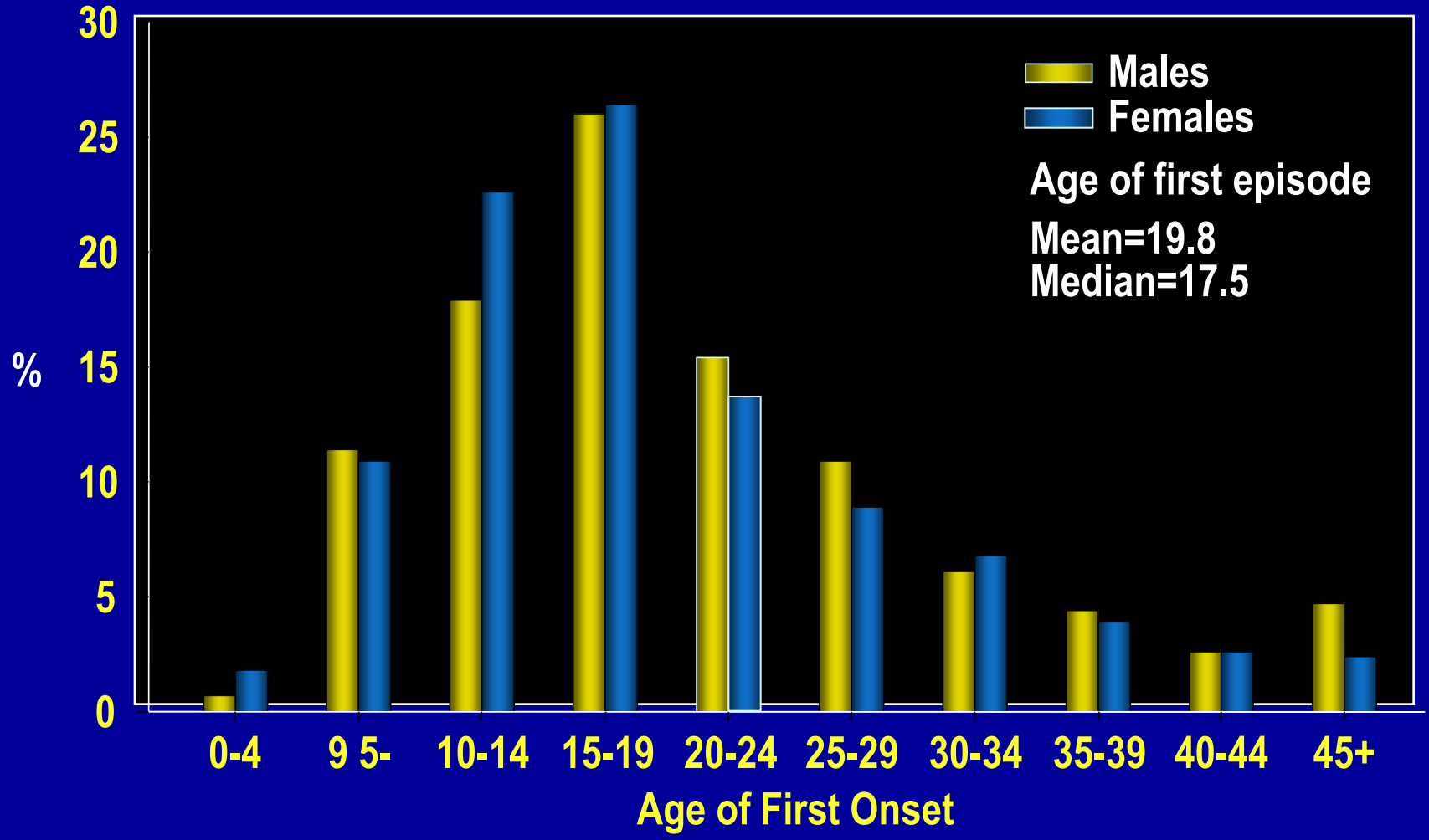
Is there a genetic component to bipolar disorder?

Estimates from studies conducted over the past 30 years that used the modern concept of bipolar disorder (Craddock, 1995)

	Lifetime Risk of bipolar disorder (%)	Lifetime Risk of unipolar disorder (%)
Monozygotic co-twin	45-75	15-25
First degree relative	4-9	8-20
Unrelated	0.5-1.5	5-10

Craddock N, Jones I, *The British Journal of Psychiatry* (2001) 178: s128-s133

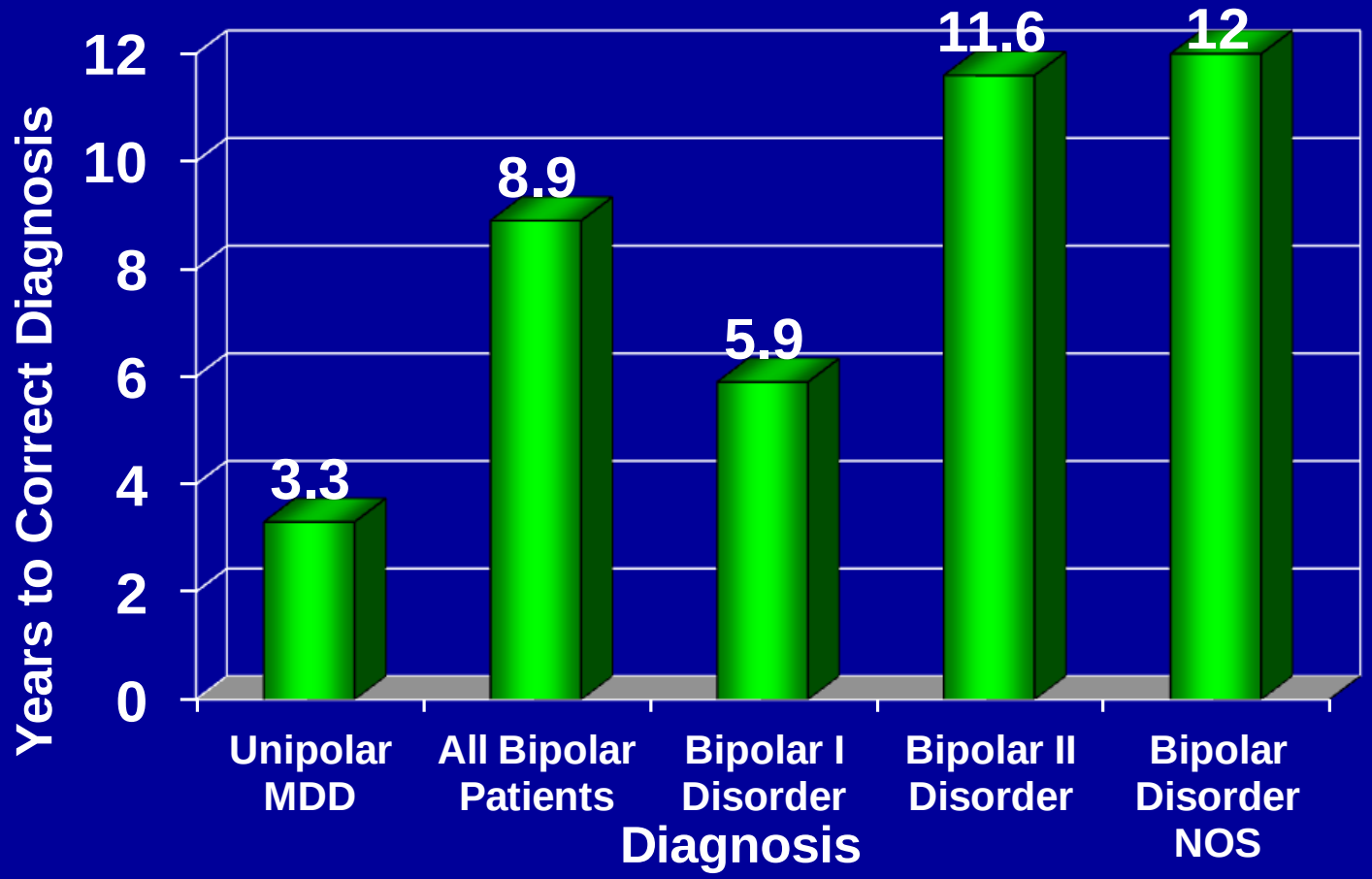
When does bipolar disorder start?



Kupfer DJ et al. *Journal of Clinical Psychiatry* 63:120-125, 2002

KEY QUESTION FOR SERVICE PROVIDERS:

How long does it take to get a correct diagnosis after first seeking professional help?



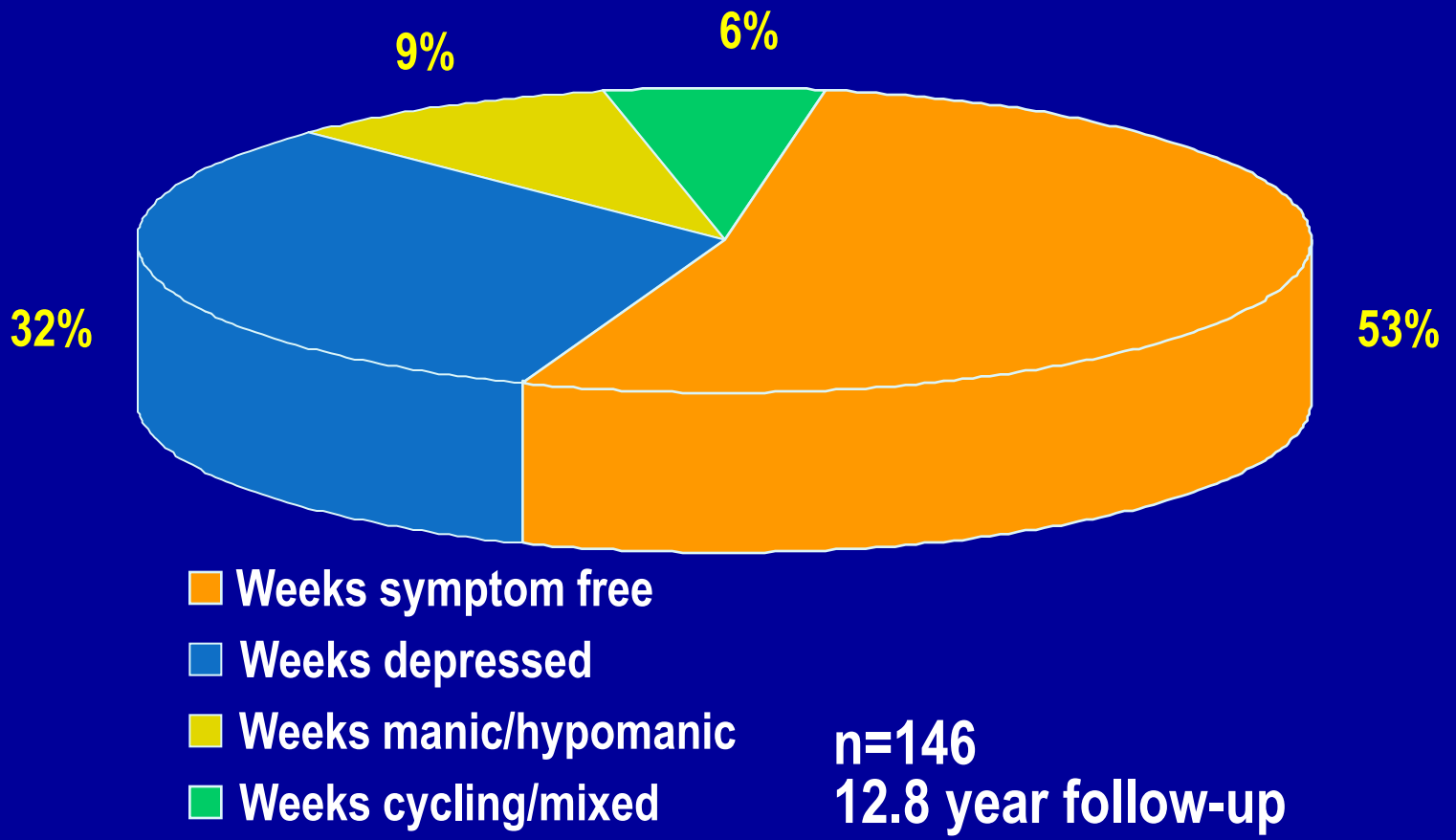
Ghaemi SN, et al. *J Clin Psychiatry* 2000; 61(10):804-808.

How common is relapse, once someone is treated?

- 37% relapse in one year, 60% in 2 years, 73% in 5 years *despite pharmacotherapy*
- 90% have multiple recurrences
- Mean number of lifetime episodes = 9
- At least 50% have significant residual symptoms between episodes

Keller MB, et al . *J Nerv Ment Dis*. 1993;181:238-245.; Gitlin MJ, et al. *Am J Psychiatry.* 1995;152(11):1635–1640.; Bauwens F, et al. *Depress Anxiety.* 1998;8(2):50–57. Coryell W, et al. *Am J Psychiatry.* 1993;150(5):720–727. Tohen M, et al. *Am J Psychiatry.* 2000;157(2):220–228. Goldberg JF, et al. *Am J Psychiatry.* 1995;152(3):379–384. Harrow, et al. *Arch Gen Psychiatry*. 1990;47:665-671.

How much of the time are those with bipolar disorder symptom free?



Judd LL, et al. *Arch Gen Psychiatry.* 2002;59(6):530-537.

Goals of Treatment for Bipolar Disorder

- Treat acute mania
- Treat acute depression
- Treat mixed or rapid cycling states
- Improve interpersonal and occupational functioning
- Prevent new mood episodes
  - Maintain stability/ prophylaxis
  - Manage subsyndromal symptom flurries

Common Psychiatric Comorbidities in Bipolar Disorder

- 75% meet criteria for at least one other disorder[1]
- Anxiety Disorders (62%)[1]
- Substance Use Disorders (36%)[1]
- ADHD (19%)[1]
- Personality Disorders (29%)[2]

[1]Merikangas KR et al. *Arch Gen Psychiatry.* 2011;68: 241-251
[2]George et al. *Bipolar Disord*. 2003;5(2):115-22

Common Medical Comorbidities in Bipolar Disorder

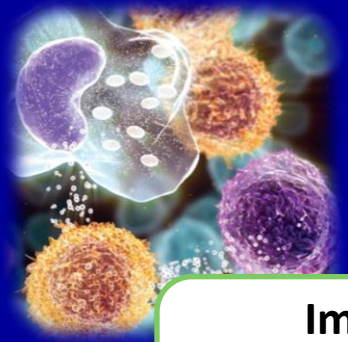
- Obesity
- Diabetes
- Hyperglycemia
- Dyslipidemia
- Thyroid Disease
- Migraine
- Cardiovascular Disease

ADA, APA, AACE, NANSO. *J Clin Psychiatry*. 2004;65:267-272.
Kleiner, et al. *J Clin Psychiatry*. 1999;60(4):249-255.
Johnston AM. *Br J Psychiatry*. 1999;175:336-339.

Bipolar Disorders Affects Multiple Physiologic Systems

Neurologic/Brain

- Mood/Emotion Regulation
- Sleep/Circadian Rhythms
-Cognitive Function



Immunologic

- Increased levels of pro-inflammatory cytokines

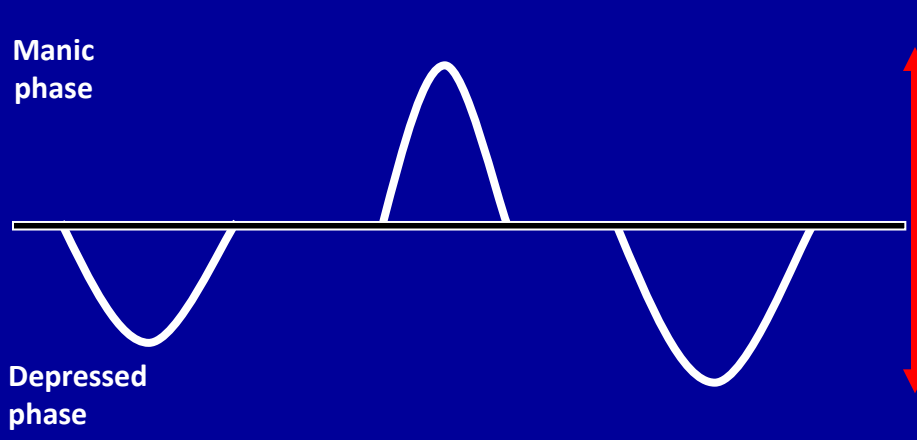
Cardiovascular/Endocrine

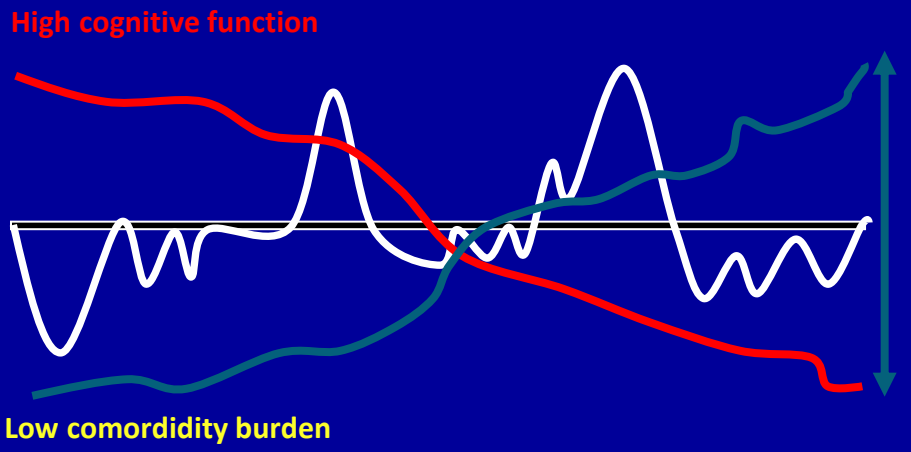
-Metabolic Dysregulation
- Obesity
-Glucose Intolerance
- Insulin Resistance
- Thyroid Abnormalities

Leboyer M & Kupfer DJ. *J Clin Psychiatry* 2010;71(12):1689-1696

Time to challenge our view of bipolar disorder?

The traditional perspective	The modern holistic perspective
A cyclical illness characterised by full-blown manic or depressive episodes interspaced with normal euthymic periods	A subtle, chronic, progressive multisystem disorder involving both psychiatric and medical comorbidities





Leboyer M & Kupfer DJ. *J Clin Psychiatry* 2010;71(12):1689-1696

Medications for Bipolar Disorder

- Mood Stabilizers
  - Lithium
  - Anticonvulsants
    - Valproate (Depakote)
    - Carbemazepine (Tegretol)
    - Lamotrigine (Lamictal)
- Atypical Antipsychotics (SGAs)
    - Olanzapine (Zyprexa)
    - Aripiprazole (Abilify)
    - Ziprasidone (Geodon)
    - Quetiapine (Seroquel)
    - Risperidone (Risperdal)
    - Clozapine (Clozaril)
    - Asenapine (Saphris)
    - Lurasidone (Latuda)

- Adjunctive Medications
  - Antidepressants
    - Selective Serotonin Reuptake Inhibitors
    - Dual Agonist Medications
    - MAOIs
  - Anxiolytics/Sleep Aids
    - Lorazepam (Ativan)
    - Clonazepam (Klonopin)
  - "Typical" Antipsychotics
    - Haloperidol (Haldol)
    - Chlorpromazine (Thorazine)

Unfortunately, polypharmacy is the rule… not the exception….in bipolar disorder. Today, most patients take 3-5 medications.

Roles of Pharmacotherapy and Psychotherapy in Management of Bipolar Disorder

- Medications
  - Stabilize the biological instability of mood, energy, sleep, etc.
- Psychotherapy
  - Help patients to live with the illness
  - Modulate psychosocial risk factors
  - Aid in stabilizing the biological instability of mood, energy, sleep, etc.

I cannot imagine leading a normal life without both taking lithium and having had the benefits of psychotherapy…ineffably, psychotherapy heals. It makes some sense of the confusion, reigns in the terrifying thoughts and feelings, returns some control and hope and possibility of learning from it all…It is where I have believed – or have learned to believe – that I might someday be able to contend with all of this."

Kay Jamison, Ph.D., *An Unquiet Mind*, 1995

Effect Sizes for Evidence-based Psychosocial Treatments for Bipolar Disorder

Psychotherapy	Outcome/Endpoint	Effect Size	NNT
Psychoeduction (Perry et al., 1999)	Manic Relapse	.30	4
Psychoeducation (Perry et al., 1999)	Depressive Relapse	.16	-
Psychoeducation (Colom et al., 2003)	Relapse during treatment phase	.22	5
Psychoeducation (Colom et al., 2003)	Relapse during 2 year follow up phase	.32	4
Case Management (Simon et al., 2005)	Number of weeks without manic symptoms	.14	-
Cognitive Therapy (Lam et al.)	Relapse/Recurrence over 1 year	.32	4
Cognitive Therapy (Scott et al., 2001)	Relapse/Recurrence over 18 months	.45	3
Family Focused Therapy (Miklowitz et al., 2003)	Relapse/Recurrence over 2 years	.17	6
Interpersonal and Social Rhythm Therapy (Frank et al., 2005)	Relapse/Recurrence over 2 years	.57*	4*

*For those with <4 comorbid diagnoses.

Adapted from Swartz et al., 2006.

Interpersonal and Social Rhythm Therapy (IPSRT): Goals

- Use behavioral techniques to stabilize daily routines and sleep/wake cycles
- Use IPT techniques to ameliorate interpersonal problems related to grief, role transitions, role disputes, interpersonal deficits
- Gain insight into the tri-directional relationship among mood symptoms, social rhythms and interpersonal events
- Thereby, reduce the frequency of episode recurrence

Frank E, *Treating Bipolar Disorder: A Clinician's Guide to Interpersonal and Social Rhythm Therapy*, Guilford Press, 2005

Peer Support and Recovery from Bipolar Disorder - I

- Use of Personal Experience
  Peer support and peer specialists complement and increase effectiveness of traditional mental health service models (SAMSHA, 2012).

- Use of Example
  When provided with a peer role model, individuals show significant gains in expanding social networks and reducing isolation (Chinman, 2001), increasing physical activity, and promoting health-enhancing behaviors (Cook, 2009, Druss, 2010).

Peer Support and Recovery from Bipolar Disorder - II

- Use of Natural Supports

  Peer support group members experience significant decrease in family stress, improvement in interpersonal relationships, and increase in identified support persons (Thompson, Norman, 2008).

- Ownership of Recovery

  Individuals with access to peer support show greater gains in confidence and self-advocacy (Cook, 2009), knowledge and management of illness (Lucksted et al., 2009), and medication adherence and problem-solving (Druss, 2010), when compared to individuals receiving traditional services only.

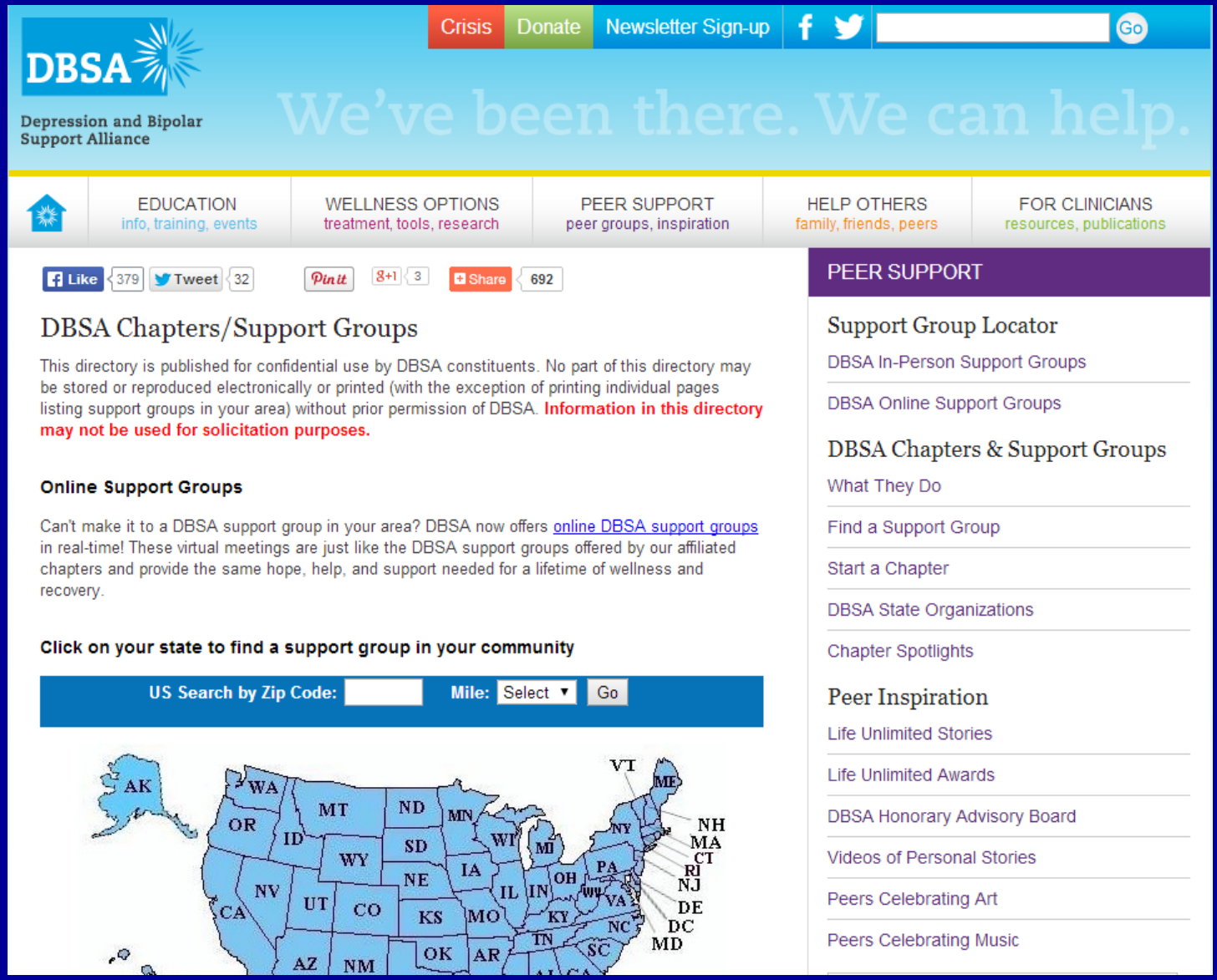
Peer Support and Recovery from Bipolar Disorder - III

- Use of Mutual Benefit
  Peer specialists report personal gains from helping others, including greater interpersonal competence, social approval, professional growth, and self-management (Salzer, Liptzin-Shear, 2002).

- Experience with mental health system
  Peers are often more proficient with benefit acquisition and provide rapport to keep others engaged (Lupfer, 2012).

DBSA Support Group Finder

www.dbsalliance.org/findsupport



What's on the Horizon

- Online training for clinicians in psychosocial interventions
- Internet–based psychosocial interventions, both supported and unsupported
- Smartphone-based self-monitoring and clinician feedback systems
- Ability to personalize interventions depending on where an individual is on his or her illness journey
- An IPSRT-based intervention for young people at risk for bipolar disorder

Conclusions: Bipolar Disorder

- Common, early onset, biological basis
- Highly variable, chronic course
- Depressive episodes and symptoms predominate
- Diagnosis often missed, leading to many years of unnecessary suffering
- High comorbidity, both medical and psychiatric
- Challenging to treat effectively
- Most patients seem to benefit from a combination of psychopharmacologic and psychosocial approaches to treatment

For those who would like to learn more about the basics of IPSRT

Free on-line training and downloadable materials for patients and therapists are available at:

www.ipsrt.org

IPSRT
Interpersonal and Social Rhythm Therapy