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

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Substance Abuse and Mental Health Services Administration (SAMHSA)
Manic-depressive illness magnifies common human experiences to larger-than-life proportions

- Goodwin and Jamison, 2007
**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.
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
  – decreased need for sleep
  – flight of ideas
  – increased activity
  – excessive engagement in risky activities

• 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
  - decreased need for sleep
  - flight of ideas
  - increased activity
  - excessive engagement in risky activities
- **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.

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.

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)

<table>
<thead>
<tr>
<th></th>
<th>Lifetime Risk of bipolar disorder (%)</th>
<th>Lifetime Risk of unipolar disorder (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monozygotic co-twin</td>
<td>45-75</td>
<td>15-25</td>
</tr>
<tr>
<td>First degree relative</td>
<td>4-9</td>
<td>8-20</td>
</tr>
<tr>
<td>Unrelated</td>
<td>0.5-1.5</td>
<td>5-10</td>
</tr>
</tbody>
</table>

When does bipolar disorder start?

Distribution of Age of First Onset

Age of first episode
Mean=19.8
Median=17.5

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?

![Bar chart showing years to correct diagnosis for different diagnoses.]

- Unipolar MDD: 3.3 years
- All Bipolar Patients: 8.9 years
- Bipolar I Disorder: 5.9 years
- Bipolar II Disorder: 11.6 years
- Bipolar Disorder NOS: 12 years

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

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

- Weeks symptom free: 53%
- Weeks depressed: 32%
- Weeks manic/hypomaniac: 9%
- Weeks cycling/mixed: 6%

n=146
12.8 year follow-up

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
- Anxiety Disorders (62%)
- Substance Use Disorders (36%)
- ADHD (19%)
- Personality Disorders (29%)

1 Merikangas KR et al. *Arch Gen Psychiatry*. 2011;68: 241-251
Common Medical Comorbidities in Bipolar Disorder

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

Bipolar Disorders Affects Multiple Physiologic Systems

**Immunologic**
- Increased levels of pro-inflammatory cytokines

**Cardiovascular/Endocrine**
- Metabolic Dysregulation
- Obesity
- Glucose Intolerance
- Insulin Resistance
- Thyroid Abnormalities

**Neurologic/Brain**
- Mood/Emotion Regulation
- Sleep/Circadian Rhythms
- Cognitive Function

Time to challenge our view of bipolar disorder?

The traditional perspective

A cyclical illness characterised by full-blown manic or depressive episodes interspersed with normal euthymic periods

The modern holistic perspective

A subtle, chronic, progressive multisystem disorder involving both psychiatric and medical comorbidities

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

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

*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
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 Chapters/Support Groups

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Online Support Groups

Can't make it to a DBSA support group in your area? DBSA now offers online DBSA support groups in real-time! These virtual meetings are just like the DBSA support groups offered by our affiliated chapters and provide the same hope, help, and support needed for a lifetime of wellness and recovery.

Click on your state to find a support group in your community

US Search by Zip Code:  Mile: Select  Go
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