Robert P. Reiser
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Advances in Psychotherapy – Evidence-Based Practice

Bipolar Disorder

2nd edition

Bipolar Disorder

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From R. P. Reiser, L. W. Thompson, S. L. Johnson, & T. Suppes: *Bipolar Disorder* (2nd ed.) (ISBN 9781616764104) © 2017 Hogrefe Publishing

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Advances in Psychotherapy – Evidence-Based Practice

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The basic objective of this series is to provide therapists with practical, evidence-based treatment guidance for the most common disorders seen in clinical practice – and to do so in a reader-friendly manner. Each book in the series is both a compact "how-to" reference on a particular disorder for use by professional clinicians in their daily work and an ideal educational resource for students as well as for practice-oriented continuing education.
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Library of Congress Cataloging in Publication information for the print version of this book is available via the Library of Congress Marc Database under the Library of Congress Control Number 2016956063

Library and Archives Canada Cataloguing in Publication
Reiser, Robert P., author
Bipolar disorder / Robert P. Reiser (University of California, San Francisco, CA), Larry W. Thompson (Stanford University, Stanford, CA), Sheri L. Johnson (University of California, Berkeley, CA), Trisha Suppes (Stanford University, Stanford, CA). -- 2nd edition.
(Advances in psychotherapy--evidence-based practice ; v. 1)
Includes bibliographical references.
Issued in print and electronic formats.
ISBN 978-0-88937-410-2 (paperback).--ISBN 978-1-61676-410-4 (pdf).-- ISBN 978-1-61334-410-1 (epub)
1. Manic-depressive illness. I. Thompson, Larry W., author II. Johnson, Sheri L., author III. Suppes, Trisha, author IV. Title. V. Series: Advances in psychotherapy--evidence-based practice ; v. 1

RC516.R45 2016 616.89'5 C2016-906770-X
C2016-906771-8

Cover image based on photo © KatarzynaBialasiewicz – iStock.com

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http://www.hogrefe.com

PUBLISHING OFFICES
USA: Hogrefe Publishing Corporation, 7 Bulfinch Place, Suite 202, Boston, MA 02114
Phone (866) 823-4726, Fax (617) 354-6875; E-mail customerservice@hogrefe.com
EUROPE: Hogrefe Publishing GmbH, Merkelstr. 3, 37085 Göttingen, Germany
Phone +49 551 99950-0, Fax +49 551 99950-111; E-mail publishing@hogrefe.com

SALES & DISTRIBUTION
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30 Amberwood Parkway, Ashland, OH 44805
Phone (800) 228-3749, Fax (419) 281-6883; E-mail customerservice@hogrefe.com
UK: Hogrefe Publishing, c/o Marston Book Services Ltd., 160 Eastern Ave.,
Milton Park, Abingdon, OX14 4SB, UK
Phone +44 1235 465577, Fax +44 1235 465556; E-mail direct.orders@marston.co.uk
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Phone +49 551 99950-0, Fax +49 551 99950-111; E-mail publishing@hogrefe.com

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SWITZERLAND: Hogrefe Publishing, Länggass-Strasse 76, CH-3000 Bern 9

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Format: PDF

ISBN 978-0-88937-410-2 (print) • ISBN 978-1-61676-410-4 (PDF) • ISBN 978-1-61334-410-1 (EPUB)
http://doi.org/10.1027/00410-000

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Preface

In the 10 years since our first edition, interest has continued to grow in the psychosocial treatment of bipolar disorder. A number of new randomized clinical trials have been completed. In the preface of our first edition we noted that, despite the substantial evidence supporting several psychological treatment approaches for bipolar disorder, these treatments were often not used by practitioners. Unfortunately, even with better treatment resources available, a wide gap remains between effective evidence-based treatments and the actual standard of care delivered in the community. The present state of affairs remains consistent with the picture presented in the National Institute of Mental Health (NIMH) white paper on research in mood disorders more than 10 years ago, which summarized that only about 10% of the treatments for depression (a far more common mood disorder) meet the standard guidelines for evidence-based care. This need not be the case. There is a wealth of research and treatment information available, and we aim to make this readily accessible to the individual practitioner. We seek to provide updated practical guidance for an evidence-based treatment of bipolar disorder while trying to avoid an overly narrow or complex approach. We have also attempted to address important problems likely to be encountered with the more challenging patients often seen in treatment settings such as community mental health clinics. We aim to provide the practitioner with an evidence-based, comprehensive, integrated approach to the treatment of bipolar disorder that is practical, easily accessible, and can be readily applied in clinical practice.

Assumptions for Use of this Book

This book presents a psychosocial treatment approach that does not substitute for standard psychiatric care. The treatment program presented here is designed to provide supplemental treatment for individuals who are receiving standard psychiatric care and medication management. Medical treatment should be a requirement of participation in any psychosocial treatment program, and, in most cases, patients with bipolar disorder will need to be on medication. Providing psychotherapy to patients with bipolar disorder without psychiatric care presents a serious risk and is contraindicated in most cases.

This guide assumes that the reader has some knowledge of treating individuals with more serious mental disorders. As these individuals are often seen in community settings, we discuss adapting treatment strategies to minimize attrition, address motivational issues, and maximize gains for complex multi-disordered patients in diverse, multi-disciplinary, community-based settings. This guide is not intended to substitute for the clinical supervision and requisite training required to treat patients with bipolar disorder, nor is it intended as a substitute for seeking professional medical and psychiatric advice about treatments or medication for each patient.

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Acknowledgments

The first two authors wish to thank The Health Trust, a nonprofit foundation in San Jose, California, that generously supported their work with bipolar disorder for two years. Robert Reiser dedicates this book to honor and keep alive the memory of Tony Masini, a young psychologist who cared for people with serious emotional disorders and was a passionate advocate and spokesperson. All book royalties from the first author will be donated to NAMI. He also wishes to acknowledge the generous contributions of ongoing supervision, assistance, and mentorship of Monica Basco and the initial project support from Ellen Frank. Larry Thompson wishes to acknowledge the value of his wife's ongoing love and support. We are also indebted to our patients and our students who have been our best teachers. Sheri Johnson dedicates this book to her partner, Daniel Rose. Trisha Suppes dedicates this book to her two daughters Rebecca Ann and Kaegan Lee, and to the many wonderful teachers and mentors that have made her journey possible.

Robert P. Reiser
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1

Description

Many people who are diagnosed with bipolar disorder are initially referred for medication treatment, with little consideration of psychosocial treatments. Many therapists worry about their capacity to treat bipolar disorder, as they are keenly aware of potential risks and (correctly) accept that medications are the first line of treatment. Reluctance to treat this disorder has increased therapists' doubts about treating bipolar disorder in private practice settings. When you consider how many facets of life and well-being are influenced by bipolar disorder, though, this would seem to be the perfect disorder to target for psychosocial treatment. Indeed, our own personal experiences suggest that, armed with some humility and some appreciation for the severity of the challenges, along with a well-stocked toolkit, helping people with bipolar disorder gain back a sense of control, promoting understanding of the disorder and its triggers, and considering ways to rebuild life domains damaged by episodes, is an incredibly rewarding endeavor. This book attempts to give the practitioner a firm foundation and background to undertake this work.

Medication plus psychosocial treatment is optimal in many cases

Because accurate diagnosis is a foundation for successful treatment, we begin by considering the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; APA, 2013), with fine-grained attention to differential diagnosis and the implications for clinical practice. Based on growing evidence of partial genetic overlap between schizophrenia and bipolar disorder, "Bipolar and related disorders" is now a separate chapter in the DSM-5. Some additional small changes were made in the criteria set, discussed below and throughout the book, based upon the best available evidence.

1.1 Terminology

Bipolar disorder (BD), previously known as manic depressive illness, is a mood disorder defined by manic symptoms of varying severity. Most people with BD will also experience depressive symptoms. Manic symptoms may involve changes in energy, impulsivity, behavior, and cognition. BD is usually characterized by an episodic course throughout the lifetime, resulting in significant impairment in social, interpersonal, and occupational functioning.

Emil Kraepelin compiled an enduring set of observations regarding the presentation and course of illness for patients with manic-depressive illness (Kraepelin, 1921), and many of the manic symptoms he observed continue to be featured in diagnosis. The DSM-5 (APA, 2013) and the *International Classification of Diseases* of the World Health Organization (Maier &

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Sandmann, 1993) are the major systems in use internationally (see online materials for comparison). In the DSM-5, bipolar disorders (BDs) are grouped into the following mutually exclusive categories depending upon the severity and duration of symptoms during the lifetime.

- **Bipolar I disorder (BD I**) is characterized by at least one manic episode during the lifetime. Manic episodes, in turn, are defined by manic symptoms of sufficient severity to cause marked impairment in social and occupational functioning, to result in a psychiatric hospitalization, or to involve psychosis.
- **Bipolar II disorder (BD II**) is characterized by at least one hypomanic episode, as well as one or more major depressive episodes, during the lifetime. Hypomanic episodes are defined by manic-type symptoms in which symptoms are not long in duration nor as severe to cause marked impairment in social or occupational functioning, to warrant psychiatric hospitalization, or to involve psychosis. Depression episodes may be associated with psychotic symptoms, though this is seen less frequently then in patients with BD I depression.
- **Cyclothymic disorder** is characterized by mood instability over a 2-year period (or one year in children and adolescents) with hypomanic and depressed symptoms that do not meet full criteria for a manic episode or a major depressive episode.
- **Substance/medication-induced bipolar and related disorder** is defined by mood symptoms that have been triggered by use of or withdrawal from substances.
- **Bipolar and related disorder due to another medical condition** is defined by manic type symptoms that appear to be consequent to a medical condition.
- **Other specified bipolar and related disorders** has replaced the *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV-TR* (4th ed.) (DSM-IV-TR; APA, 2000) category of "Not otherwise specified." This category is now used to note four subcategories that do not meet full criteria for one of the above listed disorders: Short-duration hypomanic episodes (2–3 days) and major depressive episodes; hypomanic episodes with insufficient symptom count and major depressive episodes; hypomanic episode without a history of major depression episodes; and short-duration cyclothymia (less than 24 months).
- **Unspecified bipolar and related disorders** is intended for temporary use when insufficient information is available but it appears likely the person has some manic symptom history.

Specifiers, which have changed significantly in DSM-5, are used to denote important elements about the presentation or course of illness**.** Most specifiers are used for BD I and BD II illnesses, with some applicable to the other bipolar diagnoses**.** Current specifiers include:

- With anxious distress (new to DSM-5)
- With mixed features (new to DSM-5, applies to manic/hypomanic or depressive episodes)
- With rapid cycling
- With melancholic features

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- With atypical features
- With psychotic features, which can be mood-congruent or mood-incongruent
- With catatonia
- With peripartum onset, which now includes peripartum as well as post-partum within 4 weeks of delivery
- With seasonal pattern (applies to depressive, hypomanic, and manic symptoms now)
- Further course specifiers:
- In partial remission or full remission
- Mild, moderate, or severe severity

The specifiers have significantly changed in DSM-5 compared to DSM-IV-TR. The new mixed features specifier is an important change in DSM-5. In an improvement over DSM-IV-TR, symptoms like irritability, distractibility, and agitation that are common to mania and depression, are not used in the mixed feature specifier criteria. Mixed states are important to detect, as they are related to the higher likelihood of suicidal behavior. Increased energy during depressive periods could also foster impulsive behaviors.

The new mixed features specifier, an important change in DSM-5

1.2 Definition

Table 1 presents the criteria for a **manic episode** or a **hypomanic episode** as described in the DSM-5. Increased activity or energy was added as a cardinal symptom in DSM-5, in part because this may be more reliably reported than mood states.

BD II criteria require the presence of at least one episode of major depression. Table 2 presents the criteria for a DSM-5 diagnosis of a **major depressive episode**. Although the diagnosis of BD I does not require the presence of an episode of major depression, the majority of people who experience manic episodes will experience at least one or more episodes of depression during their lifetime. Depressive and manic episodes can and do co-occur, and the mixed feature specifier is used when at least three symptoms of the opposite pole are present (see Table 3).

Over time, the DSM has given increasing attention to bipolar spectrum disorders. Cyclothymic disorder was introduced in DSM-III, and BD II was introduced in DSM-IV. As with BD I, both are considered long-term conditions. Accurate detection of bipolar spectrum disorders may require observing fluctuations over time. BD II is not just a subthreshold or a “light” version of BD I. This condition is stable over time, and involves significant depressive episodes, levels of functional impairment, and suicidality that are similar to those observed in BD I (Merikangas et al., 2011). As we will discuss, there is relatively little evidence concerning treatments for BD II.

BD II not a “light” version of BD I

As with other forms of BD, cyclothymic disorder is tied to poor outcomes. Youth with cyclothymic disorder have been found to have lower quality of life and fewer days of good quality of life than youth with serious medical illnesses (Freeman et al., 2009). Findings of two studies suggest that cognitive

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behavioral treatment has promise for improving prognosis and quality of life (Van Meter & Youngstrom, 2012).

Table 1
DSM-5 Criteria for Manic and Hypomanic Episodes (Adapted from APA, 2013)

A. Abnormally and persistently elevated, expansive, or irritable mood and increased activity or energy
B. During this period, three or more (four if mood is only irritable) of the following changes from usual behavior are present to a significant degree and persistent:
   1. Increased self-esteem
   2. Little need for sleep (e.g., feels rested after 3 hours of sleep)
   3. More talkative than usual or pressure to keep talking
   4. Flight of ideas or subjective experience of racing thoughts
   5. Distractibility (attention overly drawn to irrelevant stimuli)
   6. Increased goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
   7. Excessive involvement in activities with potential painful consequences (e.g., reckless spending, sexual indiscretions, or unwise investments)
C. The episode is not caused by the direct effects of a substance (e.g., drug of abuse, an antidepressant medication, or other treatment) or medical condition (e.g., hyperthyroidism), unless symptoms persist after the effects of the somatic agent are no longer present
D. Symptoms are present most of the day, nearly every day

For a Manic Episode
Symptoms are present ≥ 1 week (or less if hospitalization is needed)
The symptoms cause marked occupational or social impairment, require hospitalization, or include psychotic features

For a Hypomanic Episode
Symptoms are present for ≥ 4 consecutive days
Unequivocal change in functioning, but not marked impairment or need for hospitalization
Psychotic symptoms are not present

Table 2
DSM-5 Criteria for a Major Depressive Episode (Adapted from APA, 2013)

A. Depressed mood or loss of interest or pleasure in almost all activities.
B. At least four of the following are present during the period of depressed mood or low interest:
   1. Significant weight loss or gain
   2. Sleeping too much or too little
   3. Psychomotor agitation or retardation that is observable by others
   4. Fatigue or low energy
   5. Worthlessness or excessive guilt
   6. Difficulty concentrating, making decisions, or thinking clearly
   7. Recurrent thoughts of death or suicide, or a suicide plan or attempt
C. Significant distress or impairment
D. Not due to a substance or medical condition
E. Symptoms are present nearly every day, most of the day, over a two week period

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