Psychosocial Factors in the Course and Treatment of Bipolar Disorder

Introduction to the Special Section

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ABSTRACT

Bipolar disorder is associated with high rates of relapse and high social and economic costs, even when patients are maintained on proper pharmacotherapy. The background and rationale are offered here for a series of articles that address the role of psychosocial agents in the course of bipolar disorder and psychosocial treatments as adjuncts to pharmacotherapy in the disorder's outpatient maintenance. It is argued that stressful life events and disturbances in social-familial support systems affect the cycling of the disorder against the backdrop of genetic, biological and cognitive vulnerabilities. Current models of psychosocial treatment focus on modifying the effects of social or familial risk factors as an avenue for improving the course of the disorder.

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Bipolar disorder has generally been understood as a biologically based disorder, the treatment of which is limited to pharmacotherapy. The data suggesting that bipolar disorder runs in families (for a review, see Nurnberger & Gershon, 1992) and that drug therapy is effective in controlling the cycling of the disorder (e.g., Keck & McElroy, 1996) are quite convincing. Arguably, the pharmacological treatment guidelines for bipolar disorder (American Psychiatric Association, 1994)—which usually involve lithium, anticonvulsants, and adjunctive agents—are better articulated than for any other psychiatric disorder.

Nonetheless, bipolar disorder is by nature a recurrent illness. Longitudinal studies have suggested that even when patients are protected by state-of-the-art pharmacotherapy, about 40% relapse in 1 year, 60% in 2 years, and 73% over 5 years (e.g., Gitlin et al., 1995). Among patients who do not relapse, at least half suffer from significant residual symptoms of mood disorder (Gitlin et al., 1995; Harrow, Goldberg, Grossman, & Meltzer, 1990). The suicide rate among bipolar patients is about 30 times greater than that of the normal population (e.g., Guze & Robins, 1970).

The disorder also has high economic and social costs. Wyatt and Henter (1995) found that the costs
of bipolar disorder totaled $45 billion in the United States in 1991, well after the mood-stabilizing agents became available. Occupational functioning frequently declines: About one in every three patients cannot work in the 6 months after a manic episode, and only about 20% work at their expected level (Dion, Tohen, Anthony, & Watermaux, 1988). Bipolar disorder is also associated with high rates of separation and divorce and problems in the adjustment of patients' offspring (e.g., Coryell et al., 1993; Hammen, Burge, Burney, & Adrian, 1990).

Because of these unfortunate realities, it is incumbent on psychopathology researchers to identify the risk and protective factors in the course of bipolar disorder. The premise of this special section is that whereas genetic and biological vulnerabilities are undeniably salient in the etiology of bipolar disorder, they cannot fully account for individual differences in the expression of the disorder or in the timing, frequency, severity, or polarity of mood disorder symptoms. As is often argued for schizophrenia, social and environmental factors may evoke or protect against biological, genetic, or cognitive vulnerabilities to bipolar disorder. In parallel, psychosocial treatments, particularly those that reduce the risks associated with individual or contextual risk factors, can be powerful adjuncts to pharmacotherapy in the long-term maintenance of bipolar patients in the community.

**Psychosocial Approaches to Bipolar Disorder**

Suggestions that stressful life events and disturbed family or marital relationships are triggers for episodes of bipolar disorder can be traced to the clinical observations of Kraepelin (1921) and of the ego analysts (e.g., Cohen, Baker, Cohen, Fromm-Reichmann, & Weigert, 1954). Until recently, few studies had systematically evaluated these observations within longitudinal—prospective designs. Miklowitz, Goldstein, Nuechterlein, Snyder, and Mintz (1988) found that bipolar patients who returned following a hospitalization to families who were high in expressed emotion showed negative parent-to-patient verbal behavior during family interactions, or both were highly likely to suffer a relapse during a 9-month community follow-up. Ellicott, Hammen, Gitlin, Brown and Jamison (1990), in a 2-year follow-up of bipolar outpatients, found that patients with high levels of life stress were 4.5 times more likely to have a mood disorder relapse than patients with low levels of life stress. Malkoff-Schwartz et al. (1998) found that bipolar patients with manic episodes were more likely than those with depressive episodes to have experienced, during the 8-week interval before their episode, events that could cause disruptions in daily routines or sleep—wake cycles (social rhythms). Examples of these events included transmeridian air travel and changes in work schedules.

The literature on psychosocial interventions as adjuncts to pharmacotherapy for bipolar disorder has developed in concert with this basic risk research, but few results have been published (for a review, see Craighead, Miklowitz, Vajk, & Frank, 1998). Most of the existing models of psychosocial treatment are family focused and psychoeducational (e.g., Clarkin, Carpenter, Hull, Wilner, & Glick, 1998; Miklowitz & Goldstein, 1997) or attempt to engender, on an individual basis, strategies for minimizing the impact of social-rhythm—disrupting life events (Frank et al., 1994).

**Overview of the Special Section**

Our intent in this special section is to acquaint readers with (a) the various theoretical and empirical approaches to understanding the prognostic roles of psychosocial variables in bipolar disorder and (b) models of psychosocial intervention that follow from these theoretical approaches. Readers will note that the study of psychosocial variables in bipolar disorder presents methodological challenges not present in the study of most other disorders. These include the bidirectional nature of the symptomatology and the frequent switching of mood states. Central design features of these studies
include careful diagnoses, reliable evaluation of symptomatic states, evaluations of the impact of pharmacotherapy regimes on patients' outcomes, and the use of detailed psychosocial treatment manuals.

Two of the articles (Johnson, Winett, Meyer, Greenhouse, & Miller, 1999; Reilly-Harrington, Alloy, Fresco, & Whitehouse, 1999) deal with the prospective relationships between life stressors and bipolar symptoms and potential moderators of these relationships. Johnson et al. report that higher social support is associated with more rapid recovery from a bipolar episode. In contrast, stressful life events are independently associated with longer recovery intervals but do not interact with social support in predicting time to recovery. An important feature of this study is the distinction between depressive and manic symptoms: Over a 6-month follow-up, life events and social support predicted changes in levels of the former but not of the latter.

Reilly-Harrington et al. (1999) proceed with a hypothesis derived from the unipolar depression literature: that life events have a more powerful effect on bipolar symptoms when cognitive predispositional factors are present. They found that bipolar individuals' attributional styles for negative events (internal, global, and stable), dysfunctional attitudes, and negative self-referent information processing interacted with stressful life events to increase the severity of both manic and depressive symptoms over a 1-month interval. Thus, cognitive vulnerability—stress models appear applicable to persons with bipolar disorder.

The other two articles (Frank et al., 1999; Simoneau, Miklowitz, Richards, Saleem, & George, 1999) discuss the role of psychosocial interventions in conjunction with pharmacotherapy. With their treatment model, interpersonal and social rhythm therapy, Frank et al. attempted to stabilize patients' social routines and sleep—wake cycles so that their mood states became less vulnerable to disruptive life events. They found that patients who remained in the same form of psychosocial treatment (interpersonal therapy or intensive clinical management) across an acute and a preventive phase of treatment had lower rates of recurrence over a 1-year follow-up than those whose treatments changed when moving from one phase of treatment to the next. When these results are taken together with the earlier findings of Malkoff-Schwartz et al. (1998), it appears that consistency of routines, including the routine of the patient's adjunctive psychosocial treatment, is a protective factor in the course of this disorder.

Simoneau et al. (1999) examined a family-focused treatment (FFT) that is similar in structure to the psychoeducational models applied to schizophrenia (for a review, see Goldstein & Miklowitz, 1995). FFT was originally designed to reduce the risks associated with high levels of expressed emotion and negative family interactional patterns. It is notable that Simoneau et al. found that family psychoeducation has a greater impact on variables measuring positive family communication. Families of patients who completed the 9-month FFT treatment had higher levels of positive interactional behavior at 1 year than families of patients who received individual crisis management, even after controlling for pretreatment levels of positive interactional behavior.

It is our hope that this special section will acquaint readers with current research on the roles of life stress, cognitive vulnerability, interpersonal relationships, and psychosocial treatment in the longitudinal course of bipolar disorder. People suffering from the disorder have long been aware of the importance of social and environmental influences, perhaps even more so than the clinicians treating them. As articulately stated by Jamison (1995) in An Unquiet Mind, her moving autobiography of her own experiences with bipolar disorder,

My temperament, moods, and illness clearly, and deeply, affected the relationships I had with others and the fabric of my work. But my moods were themselves powerfully shaped by the same relationships and work. The challenge was in learning to understand the complexity of this mutual beholdenness ... it was the task and gift of psychotherapy. (p. 88)

References


