Using family therapy for bipolar disorder

The article "When bipolar treatment fails" (Current Psychiatry, January 2008, p. 38-46) states that 70% of patients with rapid cycling bipolar disorder have subclinical hypothyroidism, which leads me to wonder how many patients diagnosed as rapid cycling actually suffer from a medical problem that could cause dangerous complications if untreated. Psychiatrists need to rule out organic causes of affective instability.

As noted by the authors, psychotherapy could address the patient's as well as the family's emotional issues. Studies have established family therapy's efficacy in reducing expressed emotions in the families of patients with schizophrenia, but there are no studies showing the same effect in bipolar affective disorder. Because high expressed emotions play a role in relapse of bipolar affective disorder, using family therapy to reduce these emotions could decrease relapse rates. Educating patients to recognize the early warning signs of a relapse and encouraging them to seek help could reduce the risk of relapse.

Clinicians also should address social issues such as housing, relationships, and employment, including working hours and workplace stress. The authors make it clear that using a biopsychosocial approach to managing bipolar affective disorder will help treat rapid cycling, which in turn will help reduce the relapse rate.

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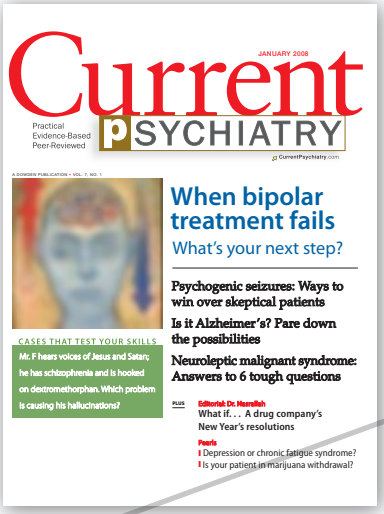

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Psychiatrists' resolutions?

Thank you for Dr. Henry Nasrallah's articulate fantasy list of "What if...A drug company's New Year's resolutions" (From the Editor, Current Psychiatry, January 2008, p. 19-20). Every one of Dr. Nasrallah's "resolutions" hits a bull's eye. These comments remind me of on-target interpretations during a psychotherapy session that result in feelings of empathic understanding and relief.

The pharmaceutical companies' marketing departments should understand how much harm they have caused the medical profession and taxpayers. The very nature of marketing is to market, just as the duty of a lawyer is to represent and defend a client. The consequences of marketing—other than to direct attention and increase sales of a product—are not important to the companies.

Recent articles in the press have discussed the deficiencies and insidiousness of pharmaceutical studies and misrepresentation of these studies to physicians. The truth is that marketers tell us what we want to hear.

If psychiatrists could fulfill our fantasies of providing proper care to our patients:

- We would be left alone to give the best and most clinically effective treatments to our patients.
- There would be no interference or outright sabotage of our efforts by insurance companies and HMOs ("We value your telephone call; please wait for the next available representative").
- We would not be second-guessed by patient quality care agents, insurance agents with no training, Medicaid care managers, lawyers (in and out of the treatment room), delayed or "non-approved" payments, retroactive denials of treatment authorizations, and demands for repayments.
- Psychiatrists' autonomy, training, and judgment would be respected, and fully informed patients would follow our recommendations.
- We would have time with our patients and money for appropriate testing and hospital stays.
- We would not come home tired, drained, and disappointed.
- Patient care would not be ruled by an adversarial relationship with nonpatient, self-interested agencies.

It is unclear whether this scenario ever existed. Our mentors and older clinicians have spoken of "the good old days," no matter when they practiced. It is all fantasy, but it is nice to have fantasies.

What remains important is to maintain our autonomy and not abdicate our responsibility to our patients simply because it is easier to do so.

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To comment on articles in this issue or other topics, send letters in care of Erica Vonderheid, Current Psychiatry, 110 Summit Avenue, Montvale, NJ 07645, erica.vonderheid@dowdenhealth.com or visit CurrentPsychiatry.com and click on the "Contact Us" link.