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CIRCADIAN RHYTHMS, MULTILEVEL MODELS OF EMOTION AND BIPOLAR DISORDER—AN INITIAL STEP TOWARDS INTEGRATION?

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ABSTRACT. *This paper sets out possible links between disruption of circadian rhythms in bipolar disorder and the affective symptom, which are experienced in this disorder. Evidence is drawn from Healy and Williams' [Psychiatr. Dev. 1 (1989) 49.] review of circadian function in manic depression, along with later reports, which indicate a role for disrupted circadian rhythms in both depressed and manic phases of manic depression (bipolar disorder). This is integrated within a version of the multilevel model of emotion proposed by Power and Dalgleish [Cognition and emotion: from order to disorder. Hove: Psychology Press (1997); Behav. Cognit. Psychother. 27 (1999) 129.]. The aim of this process is to propose a possible psychological mechanism by which the disruption of circadian rhythms might result in the observed clinical symptoms of bipolar disorder. The integration of these approaches leads to a number of specific testable hypotheses that are relevant to future research into the psychological treatment and understanding of bipolar disorder.* © *2001 Elsevier Science Ltd.*

KEY WORDS. Bipolar disorder, Circadian rhythms, Cognitive therapy, Models of emotion

INTRODUCTION

BIPOLAR DISORDER IS relatively common, affecting around 1–1.5% of the population (Bebbington & Ramana, 1995; Weissman, Leaf, Tischler, et al., 1988). Kraepelin (1921) distinguished manic depressive psychosis from dementia praecox primarily by

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the more benign course of the former. However, evidence in relation to people diagnosed as manic depressive is that it is an illness characterised by repeated episodes (Tohen, Waternaux, & Tsuang, 1990; Zis, Grof, Webster, & Goodwin, 1980), increasing frequency of relapse (Goodwin & Jamison, 1990), and high risk of attempted and completed suicide (Chen & Dilsaver, 1996). In addition, far from being well in between psychiatric episodes up to 50% of people with this disorder continue to experience significant, but subsyndromal, levels of symptoms causing substantial distress and disruption (Gitttler, Swendsen, Heller, & Hammen, 1995; Keller et al., 1992).

Traditionally, pharmacotherapy has been the main form of treatment for bipolar disorder, with initial reports in the 1950s and 1960s indicating that lithium was extremely effective as a prophylactic treatment. However, more recent studies reviewed by Solomon, Keitner, Miller, Shea, and Keller (1995) indicate a relapse rate of 50% within 2 years in patients treated with lithium. The report of the National Institute of Mental Health Workshop on Treatment of Bipolar disorders (Prien & Potter, 1990) indicates that 20–40% of manic depressive patients do not respond to lithium prophylaxis due either to side effects or lack of clinical response. Although other drugs are used in prophylaxis (carbamazepine, sodium valproate), research evidence is currently tentative and that which does exist does not indicate they perform any better than lithium (Solomon et al., 1995). Therefore, whilst there is clear evidence of an important role for pharmacotherapy, it is insufficient on its own for many patients. This led Prien and Potter (1990) to call for the development of effective psychotherapeutic interventions to supplement the pharmacological approach.

There is increasing interest in developing psychological treatments for bipolar disorder at present. The few available reports to date indicate that there are some grounds for optimism that cognitive behavioural interventions may have merit in the treatment of this disorder (Cochran, 1984; Lam et al., 2000; Zaretsky, Segal, & Gemar, 1999). However, if the early promise of this type of approach is to be fulfilled, it is important that efforts are made to develop models that might help further our understanding of the cognitive, emotional, and biological processes which occur within bipolar illness.

CIRCADIAN RHYTHMS IN BIPOLAR DISORDER

Bipolar disorder is generally seen as being caused by a complex interaction between biochemical, psychological, physiological, and genetic factors. Although, as Scott (1995) has noted, there has been a historical emphasis on the genetic/biological aspects of bipolar disorder, there is also evidence that psychosocial stressors are associated with risk of onset of manic and depressed episodes (e.g. Bebbington et al., 1993; Ramana & Bebbington, 1995). Recently, there has been much work undertaken into the circadian functioning of people with affective disorders (Feldman-Naim, Turner, & Leibenluft, 1997; Healy & Waterhouse, 1995; Healy & Williams, 1989; Piletz, DeMet, Gwirtsman, & Halaris, 1994; Tsujimoto, Yamada, Shimoda, Hanada, & Takahashi, 1990). In terms of bipolar disorder, it has been suggested that situations that serve to disrupt circadian functioning are associated with elevated risk of relapse. Psychological interventions, which have begun to be employed with people with bipolar disorder, both cognitive behaviour therapy (CBT; Lam et al., 2000) and interpersonal psychotherapy (Frank et al., 1997), indicate the importance of structure and routine in improving clinical state. This has led to basic diathesis-stress

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