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Research Paper

Application of Mindfulness Based Cognitive Therapy in Patient with Bipolar Affective Disorder

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ABSTRACT

Background: The origins of bipolar disorder trace back to ancient civilizations, where early medical texts described symptoms resembling manic and depressive episodes. Aim: The present study aims to assess and compare the emotion regulation and quality of life in the in patient with Bipolar Affective Disorder pre and post intervention on the application of Mind Based Cognitive Therapy. **Methods:** This was a quasi-experimental study with pretest-posttest design with control group. The sample consists of a total of 10 patients were diagnosed Bipolar Affective Disorder in remission according to ICD-10 DCR using a purposive sampling selected from the outpatient and inpatients department of the CIIMHANS, Dewada, Rajnandgoan, India. Further these patients divided into two groups as experimental group (5) and control group (5). Tools used WHO Quality of life and Emotion regulation questionnaire. **Results:** Result of the current study revealed that the experiment group of Bipolar Affective Disorder patients improved in different domains of quality of life and emotion regulation after the application of Mindfulness Based Cognitive Therapy treatment and exhibited enhanced quality of life and emotion regulation as compared to control group. **Conclusion:** Mindfulness Based Cognitive Therapy allows patients to have an optimistic attitude on life, accepts difficult events, deal with the present, and adopt suitable behaviours to quality of life with negative thoughts and feelings by enhancing self-cognitions and psychological flexibility of emotion regulation patients with Bipolar Affective Disorder.

Keywords: *Mindfulness Based Cognitive Therapy, bipolar affective disorder patients, quality of life, Emotion regulation*

In ancient Indian texts like the Ayurveda, written around 1500 BCE, descriptions of symptoms now associated with bipolar disorder can be found. These texts refer to a condition called "Unmada," which encompasses various types of mental illnesses, including mood disturbances. In the late 19th century, Emil Kraepelin, a German psychiatrist, played a significant role in categorizing and classifying psychiatric disorders. He distinguished manic depression, which included periods of mania and depression, as a distinct illness. His work laid the foundation for the modern understanding of bipolar disorder. In the early 20th century, Sigmund Freud's psychoanalytic theory shifted the focus from biological factors to psychological and environmental factors in the development of

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mental illnesses. However, the biological aspect of bipolar disorder remained an essential area of study and continued to influence research and treatment approaches.

Over time, the understanding of bipolar disorder evolved, thanks to advancements in psychiatric research and the development of diagnostic criteria. Notable initiatives, such as the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD), further standardized the diagnosis and classification of mental disorders, including bipolar disorder. In India, significant progress in the recognition and treatment of bipolar disorder has taken place in more recent years. Anand Mishra, Thomas Mathai, and Daya Ram in 2018 studied and put together increased mental health awareness, advocacy, and access to mental health services have contributed to improved recognition and management of the disorder. The establishment of psychiatric facilities, training programs, and research initiatives have further enhanced the understanding and treatment of bipolar disorder in the Indian context. Today, bipolar disorder is recognized as a prevalent mental health condition globally, affecting individuals across different cultures and socioeconomic backgrounds. Its impact on individuals, families, and communities has led to continuous efforts to deepen our understanding of the disorder, develop effective treatment modalities, and reduce the stigma associated with mental illnesses. In India, ongoing efforts are being made to increase awareness, provide accessible mental health services, and promote research to further improve the diagnosis and management of bipolar disorder. The integration of traditional healing practices, such as yoga and meditation, with evidence-based approaches is also gaining recognition and contributing to holistic care for individuals living with bipolar disorder.

Emotional regulation is regarded as a core aspect of most forms of psychopathology (Berenbaum, Raghavan, Le, Vernon, & Gomez, 2003; Bradley, 2003; Cicchetti, Ackerman, & Izard, 1995; Cole, Michel, & Teti, 1994; Gross & Mun˜oz, 1995; Keenan, 2000; Kring & Werner, 2004). However, in order to advance the scientific evidence for early identification of risk and prevention of disorder there remains a need for greater precision in defining emotion regulation and specifying the features of emotional development–in terms of both negative and positive emotions– that lead to emotional dysregulation. For example, in what ways does the emotional functioning of an infant who has genetic risk for anxiety disorder develop differently over the course of a lifetime than an infant without that risk? What aspects of emotional development distinguish the emotional functioning of a child without such risk from one who is at risk but does not develop the disorder and another at risk child who does develop the disorder? The broad goal of this special issue of the Journal is to present new and innovative studies that begin to address questions like these, and that push our thinking forward in the area of emotion regulation, risk, and psychopathology.

The quality of life (QOL) defines as “individuals' perception of their position in life in relation to their goals, expectations, standards, and concerns in the context of the culture and value systems in which they live” (WHO, 1995). Several studies have explored and confirmed the association between depression and QOL. Patients who suffer from depression are reported to have lower QOL than the general population (Snyder, 2013; Gigantesco et al., 2019). Although depression severity is correlated with QOL impairment, the changes in QOL are not fully accounted for by changes in depression, (Tang et al., 2019) and QOL changes more slowly than symptoms of depression (Hofmann et al., 2017).

Mindfulness-Based Cognitive Therapy (MBCT) is its positive impact on psychological well-being. Research has consistently shown that Mindfulness-Based Cognitive Therapy (MBCT)

reduces symptoms of depression and anxiety, enhances self-awareness, and improves overall mental health. Individuals who engage in Mindfulness-Based Cognitive Therapy (MBCT) often report reduced stress, greater emotional resilience, and a heightened sense of well-being.

METHODOLOGY

Aim:

The present study aim to assess and compare the emotion regulation and quality of life in the in patient with Bipolar Affective Disorder pre and post intervention on the application of Mind Based Cognitive Therapy.

Objective of the study:

- To assess the efficacy of MBCT on psychological parameter quality of life in patients with remitted Bipolar Affective Disorder.
- To assess the efficacy of MBCT on psychological parameter i.e., emotion regulation in patients with remitted Bipolar Affective Disorder.

Hypothesis of the Study:

1. There will be no significant difference in quality of life patient with remitted bipolar affective disorder in "MBCT with treatment as usual", and "treatment as usual group" in post intervention.
2. There will be no significant difference in emotion regulation of patient with remitted bipolar affective disorder in "MBCT with treatment as usual", and "treatment as usual group" in post intervention.

Venue of the study

This study was conducted from IPD/OPD of Central India Institute of Mental Health and Neuro Sciences (CIIMHANS) Dewada, Rajnandgaon, Chhattisgarh.

Research Design

This study was a hospital based pre and post treatment research design with follow up.

Sample Design

A total number of 10 patients were selected for the comparative study of mind fullness based cognitive therapy on remitted patient of Bipolar Affective Disorder. The sample comprised of 5 Bipolar Affective Disorder in experimental group, and 5 Bipolar Affective Disorder in control group. The patients all fulfilling the exclusion and inclusion criteria was enrolled into the study from the inpatient department of Central India Institute of Mental Health and Neuro Sciences (CIIMHANS) Rajnandgaon (C.G).

Inclusion criteria for bipolar affective disorder in experimental and control condition

- Patient with Diagnosis of Bipolar Affective Disorder in remission according to ICD-10 DCR.
- Belonging to gender male or female
- Age range 18-50 years.
- Educated at least up to 8th grade and who was able to comprehend the instruction.
- Patient who had given written informed consent for study.
- Patient who was cooperative.

Exclusion criteria for bipolar affective disorder in experimental and control condition

- Patient who was not cooperative and unable to comprehend the instruction.
- History suggestive of Mental Retardation, epilepsy, brain injury, any chronic mental condition.
- History of substance abuse.
- Patient with any co-morbid psychiatric illness.
- Patient who was educated below 8th grade.

Tools Used

The following tools were used for data collection:

- Difficulties in emotion Regulation Scale (Hallion,2018)
- The World Health Organization quality of life (WHOQOL-BREF, 1996)

Procedure

The patients who fulfilled all inclusion criteria were selected for the present study. Patients were selected from the inpatient and outpatient department CIIMHANS. Informed consent was obtained. Then patients were randomly allocated to MBCT+TAU and TAU group. Socio- demographic and clinical data sheet was used to collect the information such as age, sex, education, marital status, religion, occupation, family income, type of family, age of onset, duration of illness and family history of mental illness etc. After that baseline assessment was done for both the groups by using Difficulty in Emotion Regulation Scale, Impulsivity Scale**,** Quality of Life Scale, Cognitive Distortion scale, the experimental group was given mindfulness based cognitive therapy. All the subjects were assessed again at the end of the intervention.

Statistical Analysis

The data was entered into the profile scoring sheet initially and thereafter was entered into statistic software (SPSS version 21). The data were analyzed by using SPSS-21. Non parametric test were used as samples were small in the present study. Chi square test was used for categorical variables with a purpose of comparison. Mann Whitney U test was used to compare the variables at post assessment in MBCT+TAU and TAU group. Friedman test was used to compare the variable at three different intervals for both MBCT+TAU and TAU group. Wilcoxon post hoc was used to compare the variables at two different intervals for MBCT+TAU group.

RESULT

Table 1: Comparison of post intervention scores for emotions regulation between (MBCT+TAU) group and treatment as usual TAU group.

Variable	TAU (n = 5) M_{rank}	MBCT + TAU (n = 5) M_{rank}	Mann-Whitney U	*p* value
DERSpostNON	7.80	3.20	1.00	.014*
DERSpostGOL	7.40	3.60	3.00	.045*
DERSpostIMP	8.00	3.00	0.00	.099
DERSpostAWA	7.40	3.60	3.00	.044*
DERSpostSTRG	7.90	3.10	0.50	.011*
DERSpostCAL	7.70	3.30	1.50	.017*

***indicate significance at 0.01 level, *indicates significance at 0.05 level*
NON=Non-Accept, GOL=Goals, IMP=Impulse, AWA=Awareness, STRG=Strategies, CAL=Clarity Post=Post intervention score

The table no. 1 compares the post-intervention scores for emotions regulation between the (MBCT+TAU) (Mindfulness-Based Cognitive Therapy with Treatment as Usual) group and the TAU (Treatment as Usual without intervention) group. The results indicate that the (MBCT+TAU) intervention may have had a statistically significant impact on certain aspects of emotions regulation when compared to the TAU group. These findings suggest that mindfulness-based cognitive therapy, when combined with treatment as usual, may have effectively influenced emotions regulation. The statistically significant differences provide insights into the potential beneficial effects of the intervention on this specific aspect of mental health and well-being. Detailed on sub-scale of DERS are as follows,

On the sub scale of **Non acceptance of emotional response**, there was significant difference of score between (MBCT+TAU) and TAU group in the post intervention phase (Mann Whitney U = 1.000, p = 0.014). In second sub-scale **Difficulty engaging in Goal-directed behavior**, there was significant difference of score between (MBCT+TAU) and TAU group in the post intervention phase (Mann Whitney U = 3.000, p = 0.045). In third sub-scale **Impulse control difficulties**, indicating that there may partially statistically significantly differences for these variables between the two groups (MBCT+TAU) and TAU group in the post intervention phase (Mann Whitney U = 0.000, p = 0.099). In fourth Sub-Scale **Lack of emotional Awareness**, there was significant difference of score between (MBCT+TAU) and TAU group in the post intervention phase (Mann Whitney U = 3.000, p = 0.044). In fifth sub-scale **Limited access to emotion regulation strategies**, there was significant difference of score between (MBCT+TAU) and TAU group in the post intervention phase (Mann Whitney U = 0.500, p = 0.011). In last sub-scale **Lack of emotional clarity**, there was significant difference of score between (MBCT+TAU) and TAU group in the post intervention phase (Mann Whitney U = 1.500, p = 0.017).

Table 2: Comparison of post intervention on Quality of life scale between (MBCT+TAU) group and treatment as it is without intervention TAU group.

Variable	TAU (n = 5) Mrank	MBCT + TAU (n = 5) Mrank	Mann-Whitney U	*p* value
WHOQOLpostENV	3.00	8.00	0.00	.009**
WHOQOLpostPHY	3.00	8.00	0.00	.009**
WHOQOLpostPSY	3.40	7.60	2.00	.027*
WHOQOLpostSOC	3.00	8.00	0.00	.006**

***indicates significance at 0.01 level, *indicates significance at 0.05 level*
ENV= Environment, PHY=Physical Health, PSY= Psychological, SOC= Social Relationship. Post=Post intervention score.

The table no. 2 provides information regarding the comparison of post-intervention Quality of Life (QOL) scale scores between the (MBCT+TAU) (Mindfulness-Based Cognitive Therapy with Treatment as Usual) group and the TAU (Treatment as Usual without intervention) group. The results suggest that the (MBCT+TAU) intervention may have had a statistically significant impact on different aspects of Quality of Life, as compared to the TAU group. These statistically significant differences provide insights into the potential effects of the intervention on Quality of Life after treatment. Detailed on sub-scale of DERS are as follows

In domain I **Environment**, there was significant difference of score between (MBCT+TAU) and TAU group in the post intervention phase (Mann Whitney U = 0.000, p = 0.009). In domain II **Physical health,** there was significant difference of score between (MBCT+TAU) and TAU group in the post intervention phase (Mann Whitney U = 0.000, p = 0.009). In domain III **Psychological**, there was significant difference of score between (MBCT+TAU)

and TAU group in the post intervention phase (Mann Whitney U = 2.000, p = 0.027). In domain IV **Social Relationship**, there was significant difference of score between (MBCT+TAU) and TAU group in the post intervention phase (Mann Whitney U = 0.000, p = 0.006).

DISCUSSION OF THE RESULT

The present study attempted to evaluate the effectiveness of MBCT have been associated with more adaptive emotion regulation processes among both clinical and non-clinical populations (Shwart lass & Apache, 2015; Baer et. al., 2006). For example, among healthy young adults, prater levels of the mindfulness skills of observing, describing, acting with awareness, and accepting without judgment were related to fewer emotion regulation difficulties, in present research, shows comparison of factor at follow up within both MBCT+TAU and TAU group. After applying Mann Whitney test, it appeared that at post intervention, the domain non acceptance of emotional response shows significant improvements in the MBCT + TAUgroup (X=23.20, Y=12.20, Z=13.60) compared to the TAU group (X=22.20, Y=16.40, Z=19.60) at post-assessment and follow-up. The Friedman test indicates statistically significant differences within groups over the assessment phases (X>Y, P=0.05; X>Z, P=0.11). For the Difficulty engaging in Goal-directed behavior domain, the MBCT + TAU group exhibits improvements in emotional regulation (X=19.40, Y=14.40, Z=13.00) compared to the TAU group (X=16.80, Y=17.00, Z=17.40). The Friedman test and Wilcoxon signed rank test reveal significant within- group differences for the MBCT + TAU and TAU groups. In the Impulse control difficulties domain, the MBCT + TAUgroup (X=23.40, Y=17.40, Z=16.40) displays enhanced emotional regulation in comparison to the TAU group (X=21.80, Y=23.20, Z=23.20) at both assessment phases, with significant within-group differences. In support to these findings, researchers concluded that, MBCT has been reported to reduce symptoms associated with emotional regulation difficulties in a number of psychological disorders including. major depressive and bipolar disorders (Kumar et al.,2008; Kabat-Zinn, 1990; Segal et al., 2002; Bojic, & Becerra, 2017). In another researches, MBCT in Bipolar Affective Disorder is associated with improvements in cognitive functioning and emotional regulation, reduction in symptoms of anxiety depression and mania symptoms (Rosenzweig et al., 2007; Zinn et al., 1992). Deckersbach and colleagues (2012) used the Emotion Reactivity Scale (ERS: 21-item) a self- report instrument designed to measure emotional sensitivity, intensity, and persistence (Nock et al., 2008). BAD participants who engaged in MBCT reported that they were more aware of internal and external stimuli, were able to respond less judgmentally to their thoughts and feelings and were less reactive to their inner experiences (Deckersbach et al., 2012). It was further noted that there was a linear improvement (from pre-treatment to follow up) in emotional regulation abilities and positive interpersonal relationships, which may suggest that improved abilities to regulate emotions had a positive impact on participants' interpersonal relationships (Deckersbach et al., 2012).

The present study also attempted to evaluate the effectiveness of MBCT on comparison quality of life, as measured by the World Health Organization Quality of Life (WHO-QOL) scale, with regards to the efficacy of Mindfulness-Based Cognitive Therapy (MBCT) alongside treatment as usual (TAU). People with high mindfulness will have ability to pay attention to the self as what it is without any judgment. Person will accept all the present experiences, focusing on what is happening in the present moment regardless of past and future events, non- judgmental, and embraced conditions that are not can be mastered (Harris, 2009; Mace. 2008: Baer, Smith, & Allen, 2004; Kabat-Zinn, 2004). MBCT had been widely used as an intervention basis. In the Environment domain, the mean rank at the

follow-up assessment (Z) for the MBCT + TAU group notably rises to 3.00, which is significantly higher than the post-assessment mean rank of 2.00 (P=0.046). Conversely, for the TAU group, the mean rank at the follow-up assessment (Z) stabilizes at 2.80, showing no significant difference compared to the post-assessment rank of 1.20 (P=0.029). Within the Physical Health domain, the mean rank at the follow-up assessment (Z) for the MBCT + TAU group increases to 2.20, significantly higher than the post-assessment mean rank of 1.00 (P=0.046). For the TAU group, the mean rank at the follow- up assessment (Z) remains at 1.90, presenting no significant difference compared to the post- assessment rank of 1.90 (P=0.838). In the Psychological domain, the mean rank at the follow- up assessment (Z) for the MBCT + TAU group rises to 2.10, which is significantly higher than the post-assessment mean rank of 1.00 (P=0.066). Similarly, for the TAU group, the mean rank at the follow-up assessment (Z) remains at 1.70, showing no significant difference compared to the post-assessment rank of 2.60 (P=0.223). Moreover, in the Social Relationship domain, the mean rank at the follow-up assessment (Z) for the MBCT + TAU group increases to 2.10, significantly higher than the post-assessment mean rank of 1.00 (P=0.042). Conversely, for the TAU group, the mean rank at the follow-up assessment (Z) stays at 1.70, demonstrating no significant difference compared to the post-assessment rank of 1.90 (P=0.368). Duncan and Bardacke (2010) also developed Mindfulness-Based Childbirth and Parenting Education (MBCP), a preventive intervention based on family to improve the health of pregnant woman and their fetus and also make family relationship better.

CONCLUSION

The mindfulness-based cognitive therapy (MBCT) has a positive impact on emotion regulation, quality of life in patients with bipolar affective disorder. The significant improvements observed in the experimental group following the administration of MBCT demonstrate its potential as an effective intervention for addressing the symptoms and challenges associated with bipolar affective disorder. The study's findings support the utilization of MBCT as a valuable adjunctive therapeutic approach for individuals with bipolar affective disorder, offering the potential for improved outcomes and enhanced quality of life.

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Conflict of Interest

The author(s) declared no conflict of interest.

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