

Psychological interventions in bipolar disorder: From wishful thinking to an evidence-based approach

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Objective: We aimed to examine the historical and current relevance of psychosocial approaches to bipolar illness by conducting a systematic review of prospective studies assessing the effectiveness of psychological interventions for bipolar disorder.

Method: A systematic literature search was conducted using EMBASE, MedLine and PsychLIT and reference sections of papers were scrutinized for further relevant reports. Only four trials met the criteria of a prospective study and achieved the necessary methodological standards.

Results: The studies showed benefits for patients in terms of relapse prevention and the reduction of hospitalization rates. Psychoeducation (delivered in groups or as part of a family intervention) and cognitive behavioural therapy were also found to be effective prophylactic treatments for bipolar disorder in medicated patients. Other interventions do not appear to be supported by sufficient evidence.

Conclusion: Psychological approaches, and particularly psychoeducation and cognitive-behavioural therapies, are evidence-based prophylactic therapies for bipolar patients receiving pharmacotherapy. They should be used as adjuncts to medication where possible in the prevention of bipolar disorder.

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Key words: psychotherapy, bipolar disorder, psychoeducation, adherence, relapse prevention, evidence-based medicine

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Introduction

Before the era of pharmacological therapies, psychosocial and psychoanalytic approaches were the mainstay treatments for bipolar disorder. This was a time when 'wishful thinking' supported such interventions, which aimed to achieve, perhaps somewhat optimistically, a cure for the disease by enhancing insight and overcoming early trauma. However, in the middle of the last century the sudden emergence of efficacious pharmacological treatments coupled with disappointment about 'psychological cure' precipitated despair amongst psychotherapists as to their role and the value of their treatment in the management of bipolar disorders. As a consequence psychoanalytic approaches rapidly lost favour. However, now in the new millennium the

situation is once again changing as it has become apparent that pharmacological approaches alone are also often insufficient to achieve a cure. In the acute phase of bipolar disorder drugs are essential however, they usually require augmentation with psychosocial strategies in order to maintain remission and achieve full recovery: a fact that is brought into sharp relief by the realization that, despite adequate pharmacological management, bipolar patients experience subsyndromal symptoms for almost half their lives (1).

Both pharmacological treatments and psychological interventions coincide in their primary goal, namely that of avoiding recurrences and improving clinical outcome. The two approaches are in fact complementary and share many goals despite having different specificity for treatment

pathways. Common goals include prophylaxis of recurrences, avoidance of drug use, treatment of anxiety and insomnia, coping with functional impairment and prevention of suicide; however, the stabilization of acute episodes and treatment of associated symptoms such as psychosis remains the exclusive realm of drug treatment (2). Psychoeducational goals include helping patients to adjust and come to terms with having a chronic illness, an aspect with which patients with concomitant personality disorders often have more difficulty. Enhancing treatment compliance is another principal psychoeducational goal and is arguably the most important component of every treatment regimen. Another key goal is to provide information and emotional support to patients and their families. The latter often complain about the lack of involvement and information about both the condition and the prescribed drug treatments (3). In practice, it is important to identify prodromal symptoms early and to help patients to cope with the psychosocial consequences of past and future episodes. For example, a patient may be treated successfully to the point of remission but because of ongoing unemployment could be unable to afford the medication or psychological therapy necessary for maintenance of well-being. Other targets for psychosocial interventions include the improvement of interepisodic functioning, coping with social impairment, and generally enhancing quality of life.

Aim of the study

To examine the historical and current relevance of psychosocial approaches to bipolar illness by conducting a systematic review of prospective studies assessing the effectiveness of psychological interventions for bipolar disorder.

Material and methods

A systematic literature search was conducted using EMBASE, MedLine and PsychLIT and reference sections of papers were scrutinized for further relevant reports. The key words were 'bipolar disorder', 'psychotherapy', 'psychoeducation', 'cognitive-behavioural therapy', 'interpersonal therapy', 'psychoanalysis', and 'family therapy'. Only four trials met the criteria of a prospective study and achieved the necessary methodological standards, including: (a) appropriate sample size; (b) valid and reliable outcome measures; (c) accurate description of the procedures for replicability; and (d) control group.

Results

Prophylaxis of bipolar disorder using psychological interventions

The beginning of the 21st century has been a crucial period for evidence-based psychological interventions in bipolar disorders, beginning with the publication in 1999 of the first well-designed randomized controlled study involving psychological strategies for preventing relapses (4). In this study, 69 bipolar patients who had experienced a relapse within the previous 12 months were randomized to receive either routine care alone or routine care plus 7–12 individual treatment sessions geared to teaching them to identify early symptoms of relapse and to seek prompt treatment from their healthcare providers. The additional treatment sessions were associated with a significant increase in time to first manic relapse (25th percentile, 65 weeks vs. 17 weeks; $P = 0.008$) as well as a 30% decrease in the number of manic episodes over 18 months ($P = 0.013$). However, the time to first depressive relapse and number of depressive relapses were unaffected, although overall social functioning and employment over 18 months were significantly improved with additional treatment sessions. This study demonstrated that teaching patients to recognize the early symptoms of manic relapse yielded important clinical gains.

Another key study in the field, published by Lam and colleagues (5) showed the usefulness of bipolar-tailored cognitive therapy in the prevention of relapse. It is interesting to note that an acute-phase intervention such as cognitive-behaviour therapy can be successfully applied in the context of an educational prophylactic approach when transposed and adapted to bipolar disorders.

There is also evidence for the utility of a focus on the families of bipolar patients. Miklowitz et al. (6) carried out a 9-month treatment study involving 101 bipolar patients who were stabilized on maintenance drug therapy and were randomized to receive either 21 sessions of manual-based family focused psychoeducational treatment ($n = 31$) or two family education sessions and follow-up crisis management ($n = 70$). After 1 year of follow-up patients assigned to the longer psychosocial treatment arm had fewer relapses, longer times to relapse, and significantly lower non-adherence rates than patients assigned to the shorter intervention. At 2-year follow-up (7), the results were sustained and even improved, as shown by the fact that mood symptoms improved amongst the patients receiving family-focused therapy. The authors judged that these differences could not be explained by differences in medication regimens

between the two groups. Interestingly, the efficacy of family-focused therapy seems to have greater persistence, mainly on time to re-hospitalization, than some individual approaches (8). It follows that families must be ensuring patients adhere to treatment especially when the index patient is young or non-compliant (9).

Reinares et al. (10) have recently reported preliminary controlled data assessing the effects of family psychoeducation for relatives of 30 bipolar patients in remission. While scores for objective burden, as measured on the Social Behavior Assessment Schedule (SBAS) remained the same, scores for subjective burden decreased significantly (0.96 vs. 1.24, $P = 0.05$) and the family's knowledge about bipolar disorder increased significantly (1.56 vs. 1.12, $P = 0.01$). These results might be interpreted to mean that although the individual's real-life situation namely residual symptoms, unemployment, divorce, or numerous other problems, is unchanged, the ability of the patient and family to cope with these hardships is greatly improved. On the other hand, the combination of family-focused therapy and individual psychotherapy is also a powerful add-on treatment for bipolar patients in remission (11).

In general, information plays a fundamental role in the daily treatment of bipolar disorder. A lack of knowledge about this illness often engenders despair and can lead to the development of misconceptions encouraging substance abuse and resulting in treatment non-compliance. A recent survey conducted in Europe by Morselli et al. (12) asked bipolar patients about their main reasons for concern about taking their prescribed medications. The most frequently cited reasons were 'feeling dependent', 'feeling that taking medications is slavery', 'feeling afraid', 'concern about long-term side-effects', and 'feeling ashamed'. It is remarkable that all these justifications can be traced back to a lack of sufficient information whilst other reasons traditionally considered to be important by psychiatrists, such as side-effects, were cited by fewer than 5% of patients. Therefore, many of these concerns that are founded on erroneous information or a lack of information can perhaps be diminished with suitable psychoeducation (13). Tailored interventions for compliance, such as the 'Concordance model' by Scott are useful for improving compliance (14), but the benefits of psychoeducation clearly go beyond enhancing adherence. For instance group psychoeducation has been shown to be effective in the prevention of all types of recurrences and the 'revolving door' phenomenon (15). A crucial point warranting emphasis is that psychoeducation should be

always performed when the patient is well, i.e. during euthymia, as depressed patients tend to absorb only the negative aspects of psychoeducational information, and manic patients can be disruptive and may not absorb the information at all. Hence, in our study (15), patients were required to have maintained a euthymic state (Young Mania Rating Scale [YMRS] < 6, Hamilton Rating Scale for Depression [HAM-D] < 8) for at least 6 months prior to study entry. Participants were then assigned either to an unstructured group intervention or to a psychoeducational group comprising 8–12 patients. Groups met for twenty 90-min sessions under the direction of two trained psychologists with expertise in managing bipolar disorder. The content, which followed a medical model with a directive style, encouraged participation and focused on the illness rather than on psychodynamic issues. Topics included information about the high recurrence rates associated with the illness; drugs and their potential therapeutic actions and side-effects; early detection of prodromal symptoms; the importance of avoiding street drugs; maintaining routines; and managing stress. Patients who did not receive the information also had group meetings; however, bipolar disorder was deliberately avoided as a topic for discussion. All patients continued their standard pharmacological treatment, and no other psychological intervention was permitted. At baseline, the two age- and gender-matched groups had comparable severities of illness, treatment histories, and current treatments. After 2 years of follow-up, significantly more patients in the active intervention group remained well ($P < 0.001$). More than this, even those patients highly compliant with psychoeducation may experience significantly better outcomes than those who do not undergo psychoeducation, as shown in a trial with bipolar I compliant patients developed by our group (16). Interestingly, psychoeducation appears to be an especially useful technique when applied to the most difficult-to-treat bipolar population as shown in a recent subanalysis (17) in which axis-II comorbid patients responded remarkably well.

Acute-phase treatment of bipolar disorder using psychological interventions

Up to 85% of psychiatrists begin treating bipolar depression with a combination of pharmacotherapy and psychotherapy (18). Only 15% consider initiating treatment with medication alone. However, despite this clinical reality, to date, there is a distinct paucity of well-constructed, controlled studies demonstrating the efficacy of psychological

interventions in the treatment of the acute phases of bipolar disorder. The most successful psychosocial interventions for the treatment of depressive symptoms are cognitive and cognitive-behavioural approaches and schema-focused therapy (19). For example, in a pilot study of cognitive therapy as an adjunct in bipolar disorder, Scott et al. (20) randomized 42 patients to receive either immediate cognitive therapy or 6 months on a waiting list, followed by cognitive therapy. After 6 months, patients who had already received cognitive therapy had significantly greater improvements in depressive symptoms, [as measured by the Beck Depression Inventory (BDI), the Global Assessment of Functioning (GAF), and the Internal State Scale-Activation (ISS-Actn)]. Furthermore, 6 months after cognitive therapy had ended, there was only a slight statistically non-significant increase in symptoms from the point at which therapy had ended. The authors noted that cognitive therapy was more complex for bipolar than for unipolar patients, a point echoed by Ball and colleagues (19), but even so the results they obtained are especially encouraging given that bipolar depression is more problematic to treat with pharmacotherapy than is bipolar mania (21).

Frank et al. (22) conducted a randomized controlled trial assessing the effects of an adjunctive individual psychotherapy: interpersonal and social rhythm therapy (IPSRT), which focuses on assisting patients to maintain an appropriate and consistent routine that includes regular meals and circadian rhythms. In this study, 82 patients were stabilized using pharmacotherapy plus either IPSRT or intensive clinical management (ICM); after 1 year of follow-up, patients who had been maintained consistently on the same therapy from the beginning had significantly lower recurrence rates and symptoms than those who had switched therapeutic modality. Adjunctive interpersonal psychotherapy clearly reduces the rates of suicidality (23), making psychotherapy a key element in the management of bipolar depressed patients. In a Canadian matched case-control pilot study, Zaretsky et al. (24) compared the efficacy of CBT plus mood stabilizers in bipolar depression ($n = 11$) with that of CBT alone in unipolar depression ($n = 11$). They found that bipolar depressed patients had similar levels of reduction in depressive symptoms, although there was less improvement in more pervasive dysfunctional attitudes.

Clearly, there is a need for further research in the acute psychological treatment of bipolar depression and perhaps a specific case can be made for mild bipolar depression that occurs in bipolar III patients, as these patients are especially

sensitive to the risk of antidepressant-induced switching. When considering mania and hypomania, however, there is little to summarize as there are no available psychosocial treatments for these states and at present there is probably not a pressing need since pharmacological treatments are sufficiently efficacious and increasingly better tolerated. Not surprisingly, psychotherapy in rapid-cycling bipolar disorder is also a total unknown and the only available literature is case-report based. However, even this points to a possible role for psychological interventions, and given the malignancy of bipolar illnesses this merits further investigation.

Even the best-optimized pharmacotherapy available today provides less than ideal prophylaxis in bipolar patients. Several adjunctive psychoeducational and/or psychotherapeutic approaches appear to improve the efficacy of pharmacotherapy alone, especially in delaying the emergence of new episodes, although the evidence for this assertion is relatively recent. Fortunately, current guidelines have included psychoeducation and cognitive-therapy as an add-on treatment to medication and consider it to be an important part of the long-term management of bipolar disorders (25,26). This will hopefully translate to a greater uptake in routine clinical practice. To this end, it is essential to begin training young psychiatrists and psychologists in the use of evidence-based psychotherapies in bipolar disorders; however, hand in hand with this, further research is needed in order to ascertain the precise role of psychological interventions in the treatment of acute episodes, especially bipolar depression. Finally, in the prevention of suicide, psychological treatments have been found to have effect and hence are a necessary consideration in the management of bipolar patients with comorbid axis II disorders because of the greater risk of self-harm these patients incur.

In conclusion, the addition of a tested psychotherapy constitutes a valid augmentation of the effect of medication and should be a routine consideration in the management of bipolar patients, so as to improve both symptomatic and functional outcome. After an era of 'wishful thinking' about psychological cure and what can be considered to be our dark age of denial as regards any role for psychotherapy in the treatment of bipolar disorder, it is now time to embrace the emerging body of evidence that demonstrates their usefulness and implement psychoeducation and related psychological therapies as part of usual care in the management of bipolar disorder.

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Declaration of interest

The authors state that there is no potential conflict of interest related to the content of this article.

References

- 1 JUDD LL, AKISKAL HS, SCETTLER PJ et al. The long-term natural history of the weekly symptomatic status of bipolar I disorder. *Arch General Psychiatry* 2002;**59**:530–537.
- 2 VIETA E, COLOM F. Combining medication and psychoeducation for the prevention of relapse in bipolar disorder. *Bipolar Disord* 2003;**5** (Suppl. 1):21.
- 3 COLOM F, VIETA E, MARTINEZ A, JORQUERA A, GASTÓ C. What is the role of psychotherapy in the treatment of bipolar disorder? *Psychother Psychosom* 1998;**67**:3–9.
- 4 PERRY A, TARRIER N, MORRIS R, MCCARTHY E, LIMB K. Randomised controlled trial of efficacy of teaching patients with bipolar disorder to identify early symptoms of relapse and obtain treatment. *BMJ* 1999;**318**:149–153.
- 5 LAM DH, WATKINS ER, HAYWARD P et al. A randomized controlled study of cognitive therapy for relapse prevention for bipolar affective disorder: outcome of the first year. *Arch General Psychiatry* 2003;**69**:61–67.
- 6 MIKLOWITZ DJ, SIMONEAU TL, GEORGE EL et al. Family-focused treatment of bipolar disorder: 1-year effects of a psychoeducational program in conjunction with pharmacotherapy. *Biol Psychiatry* 2000;**48**:582–592.
- 7 MIKLOWITZ DJ, GEORGE EL, RICHARDS JA, SIMONEAU TL, SUDDATH RL. A randomized study of family-focused psychoeducation and pharmacotherapy in the outpatient management of bipolar disorder. *Arch General Psychiatry* 2003;**60**:904–912.
- 8 REA MM, TOMPSON MC, MIKLOWITZ DJ, GOLDSTEIN MJ, HWANG S, MINTZ J. Family-focused treatment versus individual treatment for bipolar disorder: results of a randomized clinical trial. *J Consult Clin Psychol* 2003;**71**:482–492.
- 9 REINARES M, VIETA E, COLOM F, et al. Impact of a psychoeducational family intervention on caregivers of stabilized bipolar patients. *Psychother Psychosom*, in press.
- 10 REINARES M, COLOM F, MARTÍNEZ-ARÁN A, BENABARRE A, VIETA E. Therapeutic interventions focused on the family of bipolar patients. *Psychother Psychosom* 2002;**71**:2–10.
- 11 MIKLOWITZ DJ, RICHARDS JA, GEORGE EL et al. Integrated family and individual therapy for bipolar disorder: results

- of a treatment development study. *J Clin Psychiatry* 2003;**64**:182–191.
- 12 MORSELLI PL, ELGIE R. The BEAM survey: information on current and past treatment of bipolar disorder generated by a patient questionnaire. *Bipolar Disord* 2002;**4** (Suppl. 1):131.
- 13 COLOM F, VIETA E. Non-adherence in psychiatric disorders: misbehavior or clinical feature? *Acta Psychiatr Scand* 2002;**105**:161–163.
- 14 SCOTT J, TACCHI MJ. A pilot study of concordance therapy for individuals with bipolar disorders who are non-adherent with lithium prophylaxis. *Bipolar Disord* 2002;**4**:386–392.
- 15 COLOM F, VIETA E, MARTÍNEZ-ARÁN A et al. A randomized trial on the efficacy of group psychoeducation in the prophylaxis of recurrences in bipolar patients whose disease is in remission. *Arch General Psychiatry*, 2003;**60**:402–407.
- 16 COLOM F, VIETA E, REINARES M et al. Psychoeducation Efficacy In Bipolar Disorders Beyond Compliance Enhancement. *J Clin Psychiatry*, 2003;**64**:1101–1105.
- 17 COLOM F, VIETA E, SÁNCHEZ-MORENO J et al. Psychoeducation in bipolar patients with comorbid personality disorders. *Bipol Disord*, in press.
- 18 SHARMA V, MAZMANIAN DS, PERSAD E, KUENEMAN KM. Treatment of Bipolar Depression. A Survey of Canadian Psychiatrists. *Can J Psychiatry* 1997;**42**:298–302.
- 19 BALL J, MITCHELL P, MALHI G et al. Schema-focused cognitive therapy of bipolar disorder: reducing vulnerability to relapse through attitudinal change. *Aust NZ J Psychiatry* 2003;**37**:41–48.
- 20 SCOTT J, GARLAND A, MOORHEAD S. A pilot study of cognitive therapy in bipolar disorders. *Psychol Med* 2001;**31**:459–467.
- 21 MALHI GS, MITCHELL P, SALIM S. Bipolar depression: Management options. *CNS Drugs* 2003;**17**:9–25.
- 22 FRANK E, SWARTZ HA, MALLINGER AG et al. Adjunctive psychotherapy for bipolar disorder: effects of changing treatment modality. *J Abnorm Psychol* 1999;**108**:579–587.
- 23 RUCCI P, FRANK E, KOSTELNIK B et al. Suicide attempts in patients with bipolar I disorder during acute and maintenance phases of intensive treatment with pharmacotherapy and adjunctive psychotherapy. *Am J Psychiatry* 2002;**159**:1160–1164.
- 24 ZARETSKY AE, SEGAL ZV, GEMAR M. Cognitive therapy for bipolar depression: a pilot study. *Can J Psychiatry* 1999;**44**:491–494.
- 25 GOODWIN GM. FOR THE BRITISH ASSOCIATION FOR PSYCHOPHARMACOLOGY. Evidence-based guidelines for treating recommendations from British Association for Psychopharmacology. *J Psychopharmacol* 2003;**17**:149–173.
- 26 CALABRESE JR, KASPER S, JOHNSON G et al. International consensus group on bipolar I depression treatment guidelines. *J Clin Psychiatry* 2004;**65**:569–579.

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