Integration of Pharmacotherapy and Psychotherapy for Bipolar Disorder

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There is no question that pharmacotherapy is the treatment of choice for bipolar disorder. However, an integration of psychotherapeutic techniques with pharmacotherapy has been recommended by the American Psychiatric Association practice guideline for the treatment of bipolar disorder. Psychotherapy aims to address risk factors and associated features that are difficult to address with pharmacotherapy alone. The most common psychotherapeutic approaches added to pharmacotherapy for bipolar disorder include psychoeducation, individual cognitive-behavioral therapy, marital and family interventions, individual interpersonal therapy, and adjunctive therapies such as those for substance use. Each of these approaches is described in detail, and research regarding their efficacy is presented.

(J Clin Psychiatry 2000;61[suppl 9]:68–75)

Without doubt, pharmacotherapy is the treatment of choice for bipolar disorder. However, an integration of psychotherapeutic techniques with pharmacotherapy has been recommended by the American Psychiatric Association practice guideline for the treatment of bipolar disorder.[1] Psychotherapy aims to address risk factors and associated features that are difficult to address with pharmacotherapy alone. Preliminary research suggests that the use of psychotherapy may facilitate a better overall response to pharmacotherapy in bipolar patients.

RATIONALE FOR COMBINATION APPROACH

Risk Factors and Associated Features

A number of risk factors are associated with bipolar disorder that make patients more vulnerable to relapses and resistant to recovery. There is a high rate of nonadherence to medications in bipolar disorder, estimated at 32% to 45%.[2,3] There are also high rates of marital conflict, separation, divorce, unemployment, and underemployment in bipolar patients. Stress often precipitates episodes.[4] In addition, high levels of family expressed emotion (e.g., hostility, negative criticism, or emotional overinvolvement) have been associated with mood episodes and relapses.[5–8] Bipolar disorder obviously impacts heavily on the patient's functioning. One third of bipolar patients show deficits in work functioning 2 years after hospitalization, and only 20% work at their expected levels of employment during the 6 months following an episode.[9,10] Marital discord is higher in bipolar patients than in the general population,[11,12] and the suicide risk rate is 10% to 15%.[13] All of these factors may limit the effectiveness of pharmacotherapy for bipolar patients unless addressed directly.

Goals of Combination Approaches

There are several related goals of augmenting pharmacotherapy with psychotherapy. The most important is increasing the patient's medication adherence, which includes both taking the prescribed medication and taking the prescribed dose.[14] Therapy also aims to decrease the number and length of hospitalizations and relapses, enhance social and occupational functioning, and improve the patient's quality of life. Toward these ends, psychotherapy seeks to increase the patient's and family's ability to manage stressors by improving coping skills to deal with stress, decrease social risk factors (e.g., social isolation), increase the patient and family's acceptance of the disorder, and reduce the patient's suicidal risk. It aims to enhance the potentially protective effects of the social and family environment, for example, by training the family in communication skills. It is also important to deal in an adaptive manner with the patient's and family's feelings and symptoms following an acute episode and hospitalization.

Psychotherapeutic Approaches

The most common psychotherapeutic approaches added to pharmacotherapy for bipolar disorder include psychoeducation, individual cognitive-behavioral therapy (CBT), marital and family interventions, individual interpersonal therapy, and specialty therapies such as for comorbid substance abuse. Each of these approaches is described in detail below.

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Overview of Psychotherapy Stages

It has been argued that different interventions are needed at different stages of the disorder, just as with medication. Miklowitz[15] divides the course of bipolar treatment into 3 stages. During the acute stage, therapy is often limited to assessment, developing the therapeutic alliance, and offering support and reassurance. During the stabilization stage, structured and task-oriented interventions may be introduced to facilitate medication adherence and to empower the patient. In long-term maintenance, more intensive therapy may be possible. Most of the interventions described below are meant for post-hospitalization stages; however, many begin toward the end of hospitalization when discharge planning is beginning.

THERAPEUTIC APPROACHES USED IN THE TREATMENT OF BIPOLAR DISORDER

Psychoeducation

Based on a biopsychosocial medical model, psychoeducation gives patients a theoretical and practical approach toward understanding and coping with the consequences of their illness. Studies with other chronic illnesses such as diabetes have shown education to be effective in decreasing the impact of the illness, lowering the frequency of episodes, and improving the quality of life for the patient and family.[16,17]

Goals. Psychoeducation is designed to provide information on bipolar disorder and successful treatment/recovery and usually focuses on medication adherence. Education is provided about bipolar disorder, side effects of medications, the course of the illness, and obstacles to recovery. Goals of education include enhancing illness awareness and destigmatization; preventing or mitigating recurrences; enhancing treatment compliance; avoiding drug abuse; identifying relapse symptoms; fostering stress management; enhancing knowledge and coping with psychosocial consequences of past and future episodes; preventing suicidal behavior; improving interpersonal and social interepisodic functioning; coping with subsyndromal symptoms, residual symptoms, and impairment; and increasing well-being and quality of life. It is assumed that through education and discussion, many of the resistances to accepting the illness, the symbolic meaning of medication-taking, and worries about the future can be brought to light and discussed openly. Education is a component in almost all psychotherapeutic approaches used with bipolar patients. Additionally, education may be used during individual, family, or group treatment modalities.

Research. Research results have supported the use of psychoeducation in bipolar disorder. In fact, there is more research support for psychoeducation than any other psychotherapeutic approach or component for bipolar disorder. In an 18-month naturalistic study of 37 bipolar adolescents, those who did not adhere to medication regimens had a 92.3% relapse rate, while those who adhered had only a 37.5% relapse rate.[18] In a randomized trial, it was found that bipolar patients who received 9 psychoeducational lectures on bipolar disorder adhered better to medication at 5-month follow-up than those who did not receive such lectures.[19]

In a study on a minimal educational intervention,[20] 60 patients were assigned to view a 12-minute video and receive a handout on lithium either immediately or 6 weeks later. The former group was more knowledgeable and favorable toward lithium. Medication adherence improved after the video for both groups.[20] In a randomized study of education with partners,[21] the partners of 26 bipolar patients were randomly assigned to receive or not to receive psychoeducation regarding bipolar disorder without the patient present. The partners in the training group were more knowledgeable and supportive, but adherence was no better in either group at posttreatment or at a 6-month follow-up.[21]

Ten medicated female bipolar patients were provided monthly psychoeducation sessions and were compared with a group that received medication only. After 2 years, the psychoeducation group improved more than the medication-only group in terms of knowledge about the disorder, but not in relapse rates or compliance. When patients with personality disorders were excluded from the analyses, there was a trend for those in the psychoeducation group to have lower relapse rates and higher medication compliance.[22] In an uncontrolled report, 15 bipolar patients received 2 years of Yalom-type long-term interactional group therapy. These patients had lower average hospitalization stays and increased medication adherence compared with their previous 2-year averages, although there was no control or comparison group.[23,24]

After 9 sessions over 5 months in a mixed diagnostic group (44 schizophrenic, 16 bipolar, and 7 unipolar depressed), patients who received a psychoeducational intervention had fewer problems with medication adherence and were less fearful of side effects and drug dependency than patients who did not receive this intervention.[19] Regarding treatment adherence, in a 5-year follow-up study with 26 patients, there was a 50% improvement in lithium compliance and a 60% decline in hospitalizations compared with each patient's own baseline.[21]

Conclusions. Thus, the majority of psychoeducation interventions have resulted in some form of improvement with respect to medication adherence and/or number or length of hospitalizations or relapses. However, the length and nature of these interventions have varied significantly, and control groups were not used in all studies.

Cognitive-Behavioral Therapy

Cognitive-behavioral therapy has been quite effective in treating major depression.[25–27] In addition, CBT has standardized techniques for inpatient and outpatient set-

tings, which means it is measurable, and, thus, its efficacy can be explored. Therefore, applying CBT to the treatment of bipolar disorder as well seems logical.[28,29]

Goals. Goals for CBT with bipolar patients include (1) educating patients and family members about bipolar disorder, its treatment, and common difficulties; (2) teaching patients methods for monitoring the occurrence, severity, and course of manic and depressive symptoms so early interventions can be made; (3) facilitating medication adherence via removal of obstacles to adherence; (4) providing nonmedical strategies for coping with cognitive and behavioral sequelae of mania and depression; and (5) teaching skills for coping with common psychosocial problems that are thought to be precipitants or sequelae of mania or depression.

Treatment techniques. Basco and Thase[29] use 3 "levels" of symptom detection to teach patients and families how to watch for symptom breakthroughs: (1) historical time lines charting episodes of illness over time, (2) symptom summary sheets, and (3) daily ratings of mood and other symptoms likely to change early in an episode. Behavioral contracting is used to enhance treatment compliance, first by helping patients identify obstacles to compliance and then couching medication adherence as a goal rather than a demand. Specific treatment techniques are used for specific symptoms.

For impaired concentration, the patient is advised to reduce noise and overstimulation and to focus thinking on one thing at a time. Relaxation techniques can sometimes help with mania. For the evaluation and modification of cognitive distortions, traditional cognitive techniques are incorporated, typically by looking at logical evidence for and against a thought and using Dysfunctional Thought Records to assist in identifying target thoughts. With manic thoughts that entail grandiose plans involving risk, weighing the advantages and disadvantages of the plan, as well as encouraging the patient to wait to act, can sometimes be helpful. Behavioral interventions in both depression and mania consist of setting goals, planning, and carrying out a finite set of activities.

Another major aim of CBT is to reduce psychosocial stressors. This includes teaching problem-solving and communication training. Communication rules are taught to aid patients in sending and receiving accurate messages.

Research. Twenty-eight patients on lithium therapy were randomly assigned to receive either medication alone or medication plus 6 weekly 1-hour sessions of individual CBT designed to alter specific cognitions and behaviors thought to interfere with medication adherence. At posttreatment and at 6-month follow-up, the intervention group had significantly better medication adherence and fewer hospitalizations and mood episodes.[30] Post et al.[31] also used a behavioral approach successfully.

A small clinical study designed to explore the use of group-format CBT with bipolar patients was conducted by Palmer et al.[32] The group comprised only 4 patients and was not controlled, but pretreatment and posttreatment measures were administered. The group met for 17 weekly 90-minute sessions and 6 monthly follow-up sessions. In addition to CBT techniques described previously, the group incorporated Bauer and colleagues'[33] idea that activity is the core of mania and used activity records to monitor and decide when activity levels needed to be decreased. They also used Newman and Beck's[34] rules such as "wait 48 hours before acting" and "make no irreversible decisions." All subjects showed some improvements from pretreatment to posttreatment or pretreatment to follow-up on some clinical scales, and 3 subjects showed improvements in social/occupational functioning at posttreatment.

Conclusions. CBT is a natural elaboration of psychoeducational interventions with bipolar patients. One well-developed protocol has been published.[29] Nevertheless, empirical studies of CBT for bipolar disorder are sparse. To date, there is only 1 controlled trial of CBT.[30] While the data from that study are promising, larger randomized, controlled trials are needed to establish the efficacy of CBT in this population.

Family Therapy Interventions

Several studies have suggested that marital and family interactions can be problematic and that stressful relations at home predict relapse and poor functioning in bipolar disorder. In a well-controlled prospective study, it was found that stressful life events, even events independent of patients' behavior (e.g., the death of a parent), occurred with greater frequency for bipolar patients before episodes than for nonpsychiatric patients over a similar period of time.[35] These authors also found that bipolar patients with stressful events were 5 times more likely to have an episode than bipolar patients without stressful events. Four independent prospective studies of bipolar families' expressed emotion indicated poorer outcomes for bipolar patients in high-expressed emotion versus low-expressed emotion families.[6–9] Expressed emotion consists of criticism, hostility/rejection, or emotional overinvolvement. Expressed emotion may be amenable to modification via therapy.

For these and related reasons, several family and marital therapies have been developed. One of the most well-defined of these is family-focused treatment (FFT) developed by Miklowitz and Goldstein[36] and elsewhere alternatively referred to as Behavioral Family Management for Bipolar Patients (BFM-BP).[16]

Goals. The goals of FFT include increasing medication adherence through education, decreasing resistance to accepting the illness, and exploration of the symbolic meaning of medication-taking and worries about the future. Enhancing both social functioning and occupational functioning and the ability to manage stressors are also goals of treatment. A major thrust of treatment is to enhance the protective effects of the patient's social and family envi-

ronment, primarily achieved by training the family in communication skills and the reestablishment of functional family relationships after mood episodes. Therapy addresses the patient's and family's posttraumatic symptoms following an acute episode and hospitalization, taking into account what a stressful and potentially traumatic event the hospitalization and behavior preceding it may have been. It is also important to teach the patient and family how to differentiate premorbid personality traits such as narcissism, impulsivity, and dependence from symptoms of the disorder and the significance of stress as a trigger for recurrences.

Stages in FFT. There are well-defined stages in FFT. The first is the initial assessment phase. A structured family interview for expressed emotion is administered, and a structured family interaction assessment is conducted. The next stage consists of 7 sessions that focus on education about bipolar disorder. These sessions cover the signs and symptoms of mania and depression and the variable course of the disorder. Theories of etiology and the vulnerability-stress model are presented. The rationale for various treatments and how the family can help are discussed. Lastly, the stigmatization of the disorder and hospitalization and how it may represent a trauma for the patient and family are addressed.

The next stage of FFT focuses on communication enhancement training, which lasts at least 7 sessions, but often requires more. The communication skills taught include role-playing, active listening, giving positive feedback, making positive requests for behavior change, and requesting changes in undesirable behaviors.

The last formal stage of FFT includes 4 or 5 sessions of problem-solving skills, which involve defining the problem, "brainstorming" possible solutions, evaluating the pros and cons of each proposed solution, and choosing and implementing one or a combination of solutions. Crisis intervention is provided as needed throughout therapy. The "relapse drill" is taught to prepare the patient and family for the next episode and to identify possible warning signs.

Research. A small pilot study (N = 9) indicated that only 1 patient (11%) of 9 relapsed following 21 hour-long home sessions of FFT over 9 months.[36] This rate compares favorably to a 61% relapse rate with medication alone over 9 months[6] or a 50% relapse rate over 1 year in a lithium carbonate protocol.[37] There are currently 2 large randomized, controlled trials of FFT in progress, one at the University of California at Los Angeles and another at the University of Colorado at Boulder.[16]

In the Colorado Treatment Outcome Study, patients are randomly assigned to 1 of 2 treatment conditions: (1) medication plus 21 sessions of FFT over 9 months or (2) medication plus crisis management including 2 home-based family psychoeducation sessions. Patients in both conditions are assessed every 3 months for the first year and every 6 months for the second year. No treatment beyond medication and crisis intervention is offered in the second year to either group. Miklowitz et al.[38] reported that 101 patients have been enrolled with 31 assigned to the FFT group and 70 to the crisis management group. No data have been reported except for attrition and retention rates, which are similar for both FFT and medication-only groups.

Other Family Therapies

At Cornell, Clarkin et al.[39] have developed an inpatient family intervention (IFI) for families of inpatients including bipolar patients. IFI consists of an average of 9 weekly or twice a week sessions and involves patients, their families, and other key relatives. The focus is on how to cope with hospitalization and improve functioning after discharge. IFI encourages all to (1) accept that the disorder is real and probably chronic and that medication and therapy are very likely needed after discharge, (2) identify stressors within and outside the family that may precipitate further episodes, and (3) learn ways to modify family patterns and cope with future stressors. In a randomized clinical trial of 186 inpatients assigned to hospitalization and medication with or without IFI, female patients with affective disorders who received IFI were more improved at discharge and more improved on global functioning and symptomatic domains at 6- and 18-month follow-up than those who did not receive IFI. However, strong conclusions are difficult as only 21 patients met criteria for bipolar disorder and only 14 were female. No differences between IFI and medication-only groups were found for male bipolar patients.

In an update, Clarkin's group[40] assessed the benefits of adding a structured psychoeducational intervention to standard medication treatment for married bipolar patients and their spouses. Patients (N = 42) were randomly assigned to medication treatment alone or medication treatment plus a 25-session marital intervention with their spouses over an 11-month period. Significant effects were found for the intervention group for overall functioning and medication adherence, but not symptom levels.

In a controlled study at Brown,[41] 14 bipolar patients were randomly assigned to standard treatment with or without 8 to 12 sessions of family therapy that began during hospitalization and continued for 18 weeks postdischarge. At a 2-year follow-up, the group that received family therapy showed significantly better family functioning, higher recovery rates (defined as 2 consecutive months without mania or depression), and 50% fewer hospitalizations than the standard treatment group.

Studies of other forms of family therapy have also supported its efficacy. Haas et al.[42] assigned 169 psychiatric patients (60 of whom had affective disorders) to 1 of 2 groups: family therapy plus medication or individual therapy plus medication. The family therapy lasted for 6 sessions and included psychoeducation, communication skills training, and problem-solving training designed to

improve illness awareness, identify precipitants for previous episodes and future stressors, identify and modify family interactions that cause stress, design coping strategies, and increase family acceptance of the need for chronic treatment. Family therapy patients fared better than the others at 6-month and 18-month follow-up.

Conclusions. Several family therapy interventions have been developed for use with bipolar patients and their families. Several studies with small samples have been published, but most included control groups. Results generally suggest the efficacy of family interventions for bipolar patients. Large randomized, controlled studies underway currently may provide more definitive data to establish the use of family interventions.

Interpersonal and Social Rhythm Therapy

Family-focused treatment needs the patient's significant others to participate, but that is not always possible or desirable. Frank et al.[43] developed interpersonal and social rhythm therapy (IP/SRT) based on Klerman and collegues'[44] interpersonal psychotherapy of depression and Ehlers and collegues'[45,46] social rhythm stability hypothesis. IP/SRT assumes that a core deficit in bipolar disorder is instability,[12] based on the idea that stable mood arises from the stability of social "rhythms," patterns of daily activity and social stimulation, and biologically based circadian rhythms.

Goals. There are 3 key objectives of IP/SRT: regulate patients' social rhythms and sleep-wake cycles, understand and work on interpersonal events associated with mood disorder symptoms, and master interpersonal conflicts.

Stages in IP/SRT. There are 3 main stages in IP/SRT: the initial phase, the intermediate and later phases, and the termination phase. In the initial phase, the therapist first obtains a history of the illness and an interpersonal inventory and educates the patient about bipolar disorder. The Social Rhythm Metric[43] is started, and an interpersonal problem area is identified. In the intermediate and later phases of IP/SRT therapy, the first task is to develop a symptom management plan. This includes a search for triggers of social rhythm disruption in an attempt to regulate daily social and circadian rhythms. The aim is to find a healthy balance between rhythm regularity, activity, stimulation, and mood state. The main work centers on exploring and resolving interpersonal problem areas. These may include grief over loss, grief over the lost healthy self, interpersonal disputes, interpersonal deficits, and/or role transitions. In the termination phase of IP/SRT, the therapist and patient review the patient's treatment progress and anticipate future stressors with an eye toward preventing future episodes, and the therapist attempts to instill a sense of hope.

Research. Patients who received IP/SRT had more stable daily rhythms over a 52-week period than patients who only tracked their social rhythms without the interpersonal component.[47] Similarly, Frank et al.[48] reported that 18 bipolar I patients assigned to IP/SRT showed significantly greater stability in routines with increasing time in treatment than 20 patients in a medication-only group. There is currently a controlled trial of IP/SRT ongoing at the University of Pittsburgh.[49]

Conclusions. Preliminary data suggest that IP/SRT may be effective in stabilizing routines for bipolar patients. Outcome data from a controlled trial of IP/SRT are forthcoming that may indicate whether this form of intervention is effective in improving medication adherence, hospitalization rates, and relapse rates.

Adjunctive Therapies

Weiss et al.[50] describe a 20-session open enrollment relapse prevention group therapy that discusses topics relevant to both bipolar disorder and comorbid substance use treatment. The National Institute of Mental Health Epidemiologic Catchment Area study found that of all psychiatric disorders, bipolar disorder was associated with the highest risk for comorbid substance use disorder (SUD): 6 times greater than the general population.[51] In clinical studies, 21% to 31% of bipolar patients have comorbid SUD,[52–56] and 2% to 9% of individuals seeking treatment for SUDs also have bipolar disorder.[57–60] Patients with bipolar disorder and SUD may be at risk for poorer outcome. This comorbidity is associated with increased likelihood of rapid cycling and slower recovery from affective episodes, higher rates of suicide attempts, double the rates of patients who require hospitalization, and increased likelihood of medication noncompliance.[52,54,56,61–63]

Goals. The group aims to address numerous issues directly that are common to both SUD and bipolar disorder including ambivalence regarding treatment compliance; coping with high-risk situations; self-monitoring of drug craving, moods, and thought patterns; and modifying lifestyle to improve self-care and interpersonal relationships. This therapy is designed for patients in remission or in a postepisode stabilization phase, not during the acute phase of mood episodes.

Session topics. The relationship between substance use and bipolar disorder and the fact that certain substances can elicit manic or depressive episodes are emphasized. The nature of triggers or high-risk situations, including coping skills for dealing with triggers, are taught. Coping skills emphasize the "3As": Avoid triggers, avoid facing triggers Alone, and distract yourself with Activities. Common interpersonal problems, denial, and warning signs for relapse are discussed. Substance refusal skills are taught, emphasizing the avoidance of high-risk situations. Self-care areas such as sleep hygiene and HIV risk are discussed. Ways to develop healthy relationships and avoid problematic ones are taught. Finally, methods to continue recovery are presented.

Research. According to the authors, this is the first psychotherapeutic approach designed for the treatment of

bipolar patients with comorbid substance abuse disorders. Weiss' group is currently conducting research to test the effectiveness of this therapy, but have not published any outcome data yet.[50]

Conclusions. There are no data yet that establish the efficacy of this particular intervention with bipolar patients. However, the high rate of comorbid substance abuse and level of impact on bipolar patients clearly indicate the importance of integrating treatment for substance use in interventions for bipolar disorder.

Psychodynamic Interventions

Psychodynamic perspectives[64] maintain that the integration of pharmacotherapy and psychotherapy is useful to (1) establish therapeutic alliance, (2) help patients overcome denial of illness, (3) address issues in transference and countertransference, (4) manage medication, and (5) encourage significant others to provide ongoing mental status information. It is recommended that the clinician should not try to convince the patient of the illness, but rather explore more traditional themes, which may strengthen the bond between therapist and patient. The therapeutic alliance is seen as stabilizing until the medical regimen is adequate.[65]

The use of a mood chart to foster alliance and help with medication management is recommended by Salzman.[64] The bond between therapist and patient can help the patient to give up the grandiose sense of self and accept less-than-perfect treatment. The chart can also help the patient remain hopeful because it will refer to times of improvement and emphasize the potential for restabilization. Although the use of significant others can help identify early warning signs of an episode, it can raise transference issues. Countertransference can also emerge as the therapist goes from wonderful healer to evil, manipulative doctor. This perspective holds that it is a mistake to overinterpret responses and behaviors of the bipolar patient as symptoms of psychopathology when they may, in fact, represent dynamic issues which should be explored.[64]

Research. In one report, bipolar couples were assigned to 1 of 3 groups: lithium plus couples therapy, lithium alone, or referred out for other services. Ten years later, the combination group fared better with fewer relapses and better social and familial outcomes.[66]

Conclusions. Research for psychodynamic interventions is sparse. The one study reported better results for bipolar patients over a 10-year period who received psychodynamic couples therapy.[66] Although psychodynamic therapy is not easily quantified, more research is needed to support its efficacy with bipolar patients.

Group Therapy

Traditionally, bipolar patients were considered inappropriate for group therapy, but bipolar-only groups have been used in the last 10 to 15 years to improve medication compliance, provide information about the illness, destigmatize the illness, and solve problems associated with the illness. Groups vary in therapeutic orientation and often combine different types of interventions.

Powell et al.[67] found that group therapy limited relapse to 15% in the sample of 40 bipolar patients over a 12-month period. Shakir et al.[68] and Volkmar et al.[69] combined an emphasis on medication compliance with interpersonal therapy in groups. At 2-year follow-up, they found lower hospitalization rates and higher levels of lithium compliance in those who received combination therapy.

Kripke and Robinson[70] found relapse rates and social functioning to be improved by using a problem-solving approach in groups and monitoring blood levels for medication compliance. Bauer and McBride[71] have introduced their Life Goals Program, which consists of a psychoeducational phase and a phase focused on developing realistic steps to reach meaningful goals for participants. Unfortunately, no published data exist for this.

Hallensleben[72] reported on weekly, 90-minute long, group therapy in addition to lithium for 37 patients over a 10-year period in an outpatient clinic in Rotterdam. Group techniques were eclectic, ranging from supportive and structuring interventions with new patients to insight-oriented with older patients. The group goals were to help patients cope better with their illness, strengthen their self-esteem, and decrease hospitalizations. No data were presented, although the author reported that patients became more self-supporting and autonomous and experienced decreased hospitalizations.

Group treatment plus medication group did much better than medication alone in terms of rehospitalizations, marital failures, overall functioning, and family interactions.[66,73] Wulsin et al.[74] reported benefits for bipolar patients in a 4.5-year group. Cerbonne et al.[75] reported that patients in a year-long group experienced significant improvements in ratings of severity and duration of affective episodes, school/work productivity, interpersonal functioning, number of hospitalizations, and length of hospitalization and saw no changes in medication use.

Conclusions. Because the interventions used in groups vary so much, it is difficult to draw clear conclusions from empirical data across groups. Despite this, the data generally support the use of group therapy formats for interventions with bipolar patients. The most effective treatments to be used in such groups remain unclear without further empirical study.

For other recent critical reviews of psychosocial treatments for bipolar disorder, see Colom et al.,[76] Craighead et al.,[49] Miklowitz and Frank,[77] and Parikh et al.[78]

CONCLUSION

A considerable body of literature has begun to accumulate that examines the benefits of adding psychotherapeu-

tic interventions to pharmacotherapy in the treatment of patients with bipolar disorder. A variety of approaches have been used and studied including psychoeducation, CBT, family therapy, IP/SRT, psychodynamic therapy, and specialty interventions for bipolar patients with comorbid substance abuse disorders, and a number of different orientations have been conducted in group formats. Empirical data are not uniform. Many studies have used small samples, have not been randomized, or have not employed control or comparison groups. This, of course, limits drawing solid conclusions about the efficacy of any of these interventions. In terms of sheer number of studies, psychoeducation has the most research to support it. However, researchers have large randomized, controlled studies underway for family therapy and IP/SRT. Larger studies with better designs are needed to establish the superiority, if any, of one type of intervention over another for bipolar disorder.

Despite some of the shortcomings of the research to date, it is important to note that almost all studies that have examined the additive benefits of psychotherapy with bipolar patients have found significant improvement in one or more domains. These include increased medication adherence, decreased number and length of hospitalizations, fewer relapses, improved family functioning, improved social functioning, increased work productivity, and improved marital relationships. If taken together, the magnitude of positive findings is considerable and indicates that using psychotherapy of some form can contribute significantly to the recovery of bipolar patients, above and beyond what pharmacotherapy alone can accomplish. Clearly, pharmacotherapy is the foundation treatment. Nevertheless, the research to date suggests that better recovery is possible when psychotherapy is used in conjunction with pharmacotherapy.

Disclosure of off-label usage: The authors have determined that, to the best of their knowledge, no investigational information about pharmaceutical agents has been presented in this article that is outside U.S. Food and Drug Administration–approved labeling.

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