

# A Review of Evidence-Based Psychosocial Interventions for Bipolar Disorder

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Various forms of psychosocial intervention have been found efficacious as adjunctive treatments for bipolar disorder, including family-focused therapy, interpersonal and social rhythm therapy, cognitive-behavioral therapy, and individual or group psychoeducation. When used in conjunction with pharmacotherapy, these interventions may prolong time to relapse, reduce symptom severity, and increase medication adherence. Family-focused therapy seeks to reduce the high levels of stress and conflict in the families of bipolar patients, thereby improving the patient's illness course. Interpersonal and social rhythm therapy focuses on stabilizing the daily and nightly routines of bipolar patients and resolving key interpersonal problems. Cognitive-behavioral therapy assists patients in modifying dysfunctional cognitions and behaviors that may aggravate the course of bipolar disorder. Group psychoeducation provides a supportive, interactive setting in which patients learn about their disorder and how to cope with it. This article discusses each of these interventions and summarizes the evidence for their efficacy in randomized trials. Recommendations for implementing psychosocial interventions in clinical practice are also given. (*J Clin Psychiatry* 2006;67[suppl 11]:28–33)

*I cannot imagine leading a normal life without both taking lithium and having had the benefits of psychotherapy. . . . Ineffably, psychotherapy heals.*

—Kay Jamison, Ph.D., *An Unquiet Mind*

**P**atients with bipolar disorder face many challenges in leading a stable and healthy life. When given in conjunction with medications, psychosocial interventions can be effective tools in improving outcomes and helping patients come to terms with their disorder. Randomized controlled trials have examined different forms of psychotherapy and found them to be effective in the treatment of bipolar disorder. This article reviews the evidence showing that psychosocial interventions enhance the efficacy of pharmacotherapy in promoting stabilization and should be a key component of the outpatient management of most bipolar patients.

## EVIDENCE-BASED PSYCHOSOCIAL INTERVENTIONS FOR BIPOLAR DISORDER

As researchers learn more about the nature, course, and treatment of bipolar disorder, psychosocial interventions

have become more sophisticated and disorder-specific. The newer psychosocial interventions are specifically designed to ameliorate the stress and vulnerability processes that affect the course and outcome of bipolar disorder. These interventions include family-focused therapy (FFT), interpersonal and social rhythm therapy (IPSRT), cognitive-behavioral therapy (CBT), and individual or group psychoeducation. FFT is derived from the observation that bipolar patients who live in high-conflict and high-stress households relapse more frequently than those patients in low-conflict and low-stress environments. IPSRT is based on the observation that disruptions in daily and nightly routines lead to recurrences of mania; therefore, its overriding purpose is to stabilize daily routines and sleep-wake cycles. CBT for bipolar depression is adapted from CBT for depression. It views bipolar symptoms as correlated with dysfunctional cognitions and styles of information processing that are amenable to modification through cognitive restructuring. Individual and group psychoeducation emphasize the role of social support and didactic information-sharing in a patient's adaptation to and stabilization from bipolar illness.

These interventions have different foci and formats, but they include common elements that are vital to any psychosocial therapy for bipolar disorder. All of the interventions encourage the patient to be an active collaborator in his or her own treatment. They all seek to educate the patient about bipolar disorder, thereby fostering the patient's acceptance of his or her illness and the need for treatment. Each intervention encourages medication adherence and ongoing collaboration with the treating psychiatrist.

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Participants in all of the psychotherapies are taught to monitor their mood symptoms daily. Clinicians administering these interventions strive to enhance the relationships between patients and their caregiving relatives, although only FFT involves relatives regularly. They also teach patients and relatives to identify warning signs of new episodes and assist them in developing relapse prevention plans. Additionally, patients are assisted in how to manage life circumstances affected by their disorder and reengage with their social and professional or academic milieus. Each of the psychosocial interventions includes components that examine patients' assumptions about bipolar disorder and its future course and treatment.

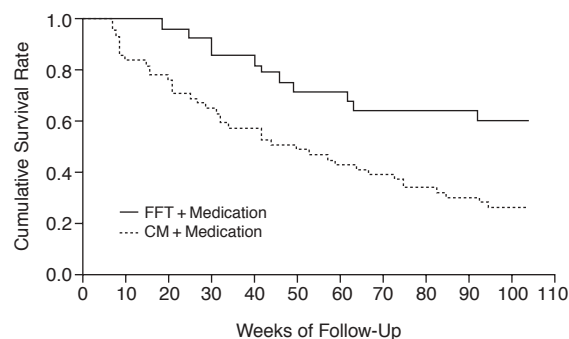
More generally, clinicians using any of the interventions provide nonspecific therapeutic support. They endeavor to empathize with the patient and recognize his or her need for autonomy and control within his or her treatment and life.

### FAMILY-FOCUSED THERAPY

FFT for bipolar disorder focuses on the patient's family or marital relationships and seeks to improve communication, understanding, and support within the family.<sup>1</sup> This outpatient treatment is conducted in 21 sessions over 9 months and involves patients and either their spouses or their parents. When patients begin FFT, they are usually not fully stabilized from a recent acute episode. FFT begins with an initial assessment of the patient and the family, including problems that exist in their relationships. Assessment is followed by 3 treatment modules: psychoeducation, communication enhancement, and problem-solving training.

The psychoeducation module of FFT addresses the symptoms, course, treatment, and self-management of bipolar disorder. It begins with a discussion of the events leading up to the most recent illness episode and, if relevant, a discussion of the hospitalization experience. After a delineation of the expected course of bipolar disorder, FFT psychoeducation focuses on the etiology, treatment, and self-management of bipolar disorder, including how the family can help the patient recover and a "relapse drill" in which patients and their family members identify early warning signs of recurrences and rehearse an early preventive intervention plan. The psychoeducation module continues with a discussion of types of resistance to bipolar treatment that often arise in patients. Patients and family members learn about the manifestations of denial and resistance and how they may be anticipated and preempted. Further discussion focuses on how the symptoms of bipolar disorder and disagreements about their causes can become a source of family conflict. Finally, clinicians examine the patient's and family members' beliefs and feelings about ongoing medication maintenance and discuss ways to maximize treatment adherence.

Figure 1. Survival Curves for Adjunctive Family-Focused Therapy Versus Adjunctive Crisis Management<sup>a</sup>



<sup>a</sup>Reprinted with permission from Miklowitz et al.<sup>4</sup>  
Abbreviations: CM = crisis management, FFT = family-focused therapy.

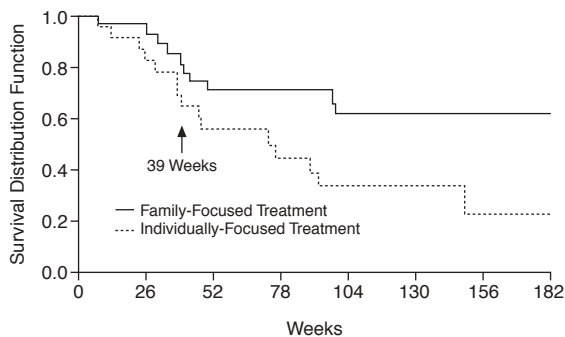
The communication enhancement portion of FFT consists of behavioral rehearsal of effective speaking and listening strategies to improve the affective climate of the postepisode family environment. Communication enhancement training specifically seeks to reduce uncontrolled expressions of negative affect. The clinician begins by explaining the rationale and mechanics of communication enhancement, including 4 basic communication skills: active listening, giving positive feedback, making positive requests for changes in others' behaviors, and giving constructive criticism.

During the problem-solving module, patients and family members identify specific problems usually related to family life, the resumption of social and occupational roles following an episode, intimacy, boundaries, intrafamilial communication, and treatment adherence. They are then taught problem-solving skills that assist them in developing plans to reinforce adaptive, desirable behaviors within the family.

### Research Supporting Family-Focused Therapy

Randomized studies<sup>2-6</sup> have shown FFT to be efficacious as adjunctive treatment for bipolar disorder. In a study<sup>4</sup> of recently episodic bipolar I patients, FFT plus psychopharmacology was compared to 2 sessions of family education and ongoing crisis management plus psychopharmacology. The 2-year study followed 101 bipolar patients who began in manic, mixed, or depressive episodes. After a baseline family assessment, 33% of patients were assigned to 21 sessions of FFT plus medication, and 67% of patients were assigned to crisis management (2 sessions of family education, naturalistic follow-up, and crisis management sessions as needed) plus medication. The combination of FFT and medication was more effective than crisis management plus medication in delaying relapses of bipolar disorder (Figure 1).<sup>4</sup> Patients receiving

Figure 2. Time to Rehospitalization for Family-Focused Therapy Versus Individual-Focused Therapy<sup>a</sup>



<sup>a</sup>Reprinted with permission from Rea et al.<sup>6</sup>

FFT and medication endured an average of 20 weeks longer without relapse than patients in the comparison group over 2 years. Patients in FFT were 3 times more likely to survive the 2-year follow-up without relapsing. FFT patients also stabilized with less severe residual symptoms than the comparison patients. These effects were significant for patients who began in depressive, mixed, or manic states, although the treatment effect sizes during the follow-up phase were stronger for depression than for mania symptoms.

A study by Rea and colleagues<sup>6</sup> attempted to maximize internal validity by examining whether FFT was more effective than an equally intensive individual intervention that controlled for variables like therapist attention and treatment duration. Participants were 53 hospitalized bipolar I manic patients. Compared with 21 sessions of individual-focused psychoeducational therapy and medication, FFT plus medication was superior in preventing rehospitalizations and relapses over a 2-year follow-up. However, the superior effects were not noticeable until the end of the first study year during which the active treatments were provided. Although there were no differences between rehospitalizations of FFT and individual therapy patients during the 39-week active-treatment period, rehospitalization of individual therapy patients rose to 60% by year 3, whereas only 12% of FFT patients were rehospitalized (Figure 2).<sup>6</sup> Thus, involving the family in treatment provided a significant advantage over a comparably intensive individual therapy.

**Medication adherence.** In the study<sup>4</sup> described earlier, the effects of FFT on medication adherence were examined. Based on self-report, blood levels, and any other accessible information, adherence to medication was monitored in the 101 patients over each 3- to 6-month interval of the 2-year follow-up. Patients were categorized as non-adherent, partially adherent, or fully adherent. Among patients receiving FFT, 45% were fully adherent throughout the follow-up (i.e., took all mood-stabilizing medica-

tions consistently) while only 21% of the crisis management patients were fully adherent. Partial adherence (inconsistent adherence with no evidence of discontinuation) was comparable between FFT and comparison patients (39% vs. 34%), but nonadherence (discontinuing all medications against medical advice) was almost 3 times higher in comparison patients than in FFT patients (44% vs. 16%).

**Positive interactional behavior among families.** Simoneau and colleagues<sup>2</sup> examined the interactions of families of patients with bipolar disorder by observing how family members talked to each other in a laboratory setting when asked to solve a family problem. After 1 year, FFT had improved family interactions such that members were engaged in more productive problem-solving, acknowledgment of each other's points of view, and positive nonverbal behavior. However, FFT was no more effective than the crisis management comparison treatment in reducing negative communication, including criticism and negative solutions to problems. Improvement in the patient's communication with relatives was correlated with improvement in the patient's mood disorder symptoms over a 1-year interval.

Thus, FFT appears to be an effective adjunct to psychopharmacology in delaying recurrences, stabilizing symptoms, enhancing medication adherence, and improving family interactions. Current research on FFT<sup>7</sup> is focused on the effectiveness of this treatment model in juvenile-onset bipolar patients. Not all bipolar patients are associated with families, however. A variety of individual therapy models exist for bipolar patients, as reviewed below.

## INTERPERSONAL AND SOCIAL RHYTHM THERAPY

IPSRT is based on the interpersonal psychotherapy of depression, which has been found in numerous studies to be effective in stabilizing major depressive episodes and preventing recurrences.<sup>8</sup> IPSRT for bipolar disorder, developed by Frank and colleagues,<sup>9</sup> has 3 main goals. One goal is to help patients with bipolar disorder stabilize their daily routines and sleep-wake cycles. Another goal is to assist patients in gaining insight into the bidirectional relationship between moods and interpersonal events. Finally, IPSRT seeks to ameliorate interpersonal problems related to grief, role transitions, role disputes, and interpersonal deficits.

In the introductory phases of IPSRT, the clinician reviews the patients' history of illness, with special emphasis on prior episodes that might have been precipitated by sleep-wake cycle disruptions. The clinician introduces and encourages the patients' use of the Social Rhythm Metric (SRM), a therapeutic tool that tracks wake time, sleep time, activities, and mood (Figure 3).<sup>10,11</sup> When logging activities on their SRMs, patients also note whether the

Figure 3. The Social Rhythm Metric<sup>a</sup>

**THE SOCIAL RHYTHM METRIC (SRM)**  
 MacArthur Foundation Social Health Research Network I  
 Please fill this out at the end of the day

Day of Week: Sun. Date: 5-28

MOOD RATED (Check one)	SRM	CHECK & DO NOT DO		CHECK	CHECK IF ALONE	PEOPLE
		CLOCK TIME	AM			
Stipulated mood available						
ACTIVITY						
SAMPLE ACTIVITY (for reference only)		6:25	✓			2
OUT OF BED		9:30	✓			
FIRST CONTACT (IN PERSON OR BY PHONE) WITH ANOTHER PERSON		10:20	✓			2
HAVE MORNING BEVERAGE		9:30	✓			1
HAVE BREAKFAST		10:00	✓			2
GO OUTSIDE FOR THE FIRST TIME		10:45	✓			2
START WORK, SCHOOL, HOUSEWORK, VOLUNTEER ACTIVITIES, CHILDCARE OR FAMILY CARE						
HAVE LUNCH		12:40				3
TAKE AN AFTERNOON NAP						
HAVE DINNER		7:20		✓	✓	
PHYSICAL EXERCISE		5:30		✓	✓	
HAVE AN EVENING SNACK (DRINK)		9:30		✓	✓	
WATCH EVENING TV NEWS PROGRAM		10:40		✓	✓	
WATCH ANOTHER TV PROGRAM						
ACTIVITY A <u>Prime time programming</u>		9:20		✓		2
ACTIVITY B						
RETURN HOME (LAST TIME)		7:10		✓		2
GO TO BED		10:40			✓	

<sup>a</sup>Reprinted with permission from Monk et al.<sup>10</sup> and Miklowitz.<sup>11</sup>

activity was done alone or with others. After several weeks of using the SRM, they begin to identify the connections between their sleep-wake cycles, patterns of social activity, and moods, which may, in turn, motivate them to regulate their daily and nightly routines.

The introductory phase of IPSRT also includes education about bipolar disorder and an interpersonal inventory. The purpose of the interpersonal inventory is to identify the current members of the patient’s social and familial network and to identify a major problem area on which to focus. Interpersonal problem areas may include grief, disputes, role transitions, and interpersonal deficits. For example, the depressive episode of a woman with bipolar disorder may be closely related to ongoing marital conflicts. In another instance, a socially isolated man with bipolar disorder may be experiencing a depressive episode that is closely associated with the grief he feels over the loss of his healthy self, the person he was before he became ill.

The intermediate and long-term maintenance phases of IPSRT are designed to stabilize the patient’s daily rhythms and improve his or her interpersonal relationships. During the intermediate phase, the therapist and patient conjointly develop a plan to stabilize the patient’s social and circa-

dian rhythms. This plan usually involves the patient agreeing to maintain consistent sleep and wake times and keep intense, irregular bursts of social stimulation to a minimum. Also, the patient and clinician work together to examine and resolve the patient’s key interpersonal problems, which often involves helping the patient to gain insight into his or her own role in creating or perpetuating those problems. During the maintenance phase of IPSRT, the clinician and patient explore ways to further stabilize social routines and prevent the same interpersonal problems from recurring in the future.

**Research Supporting Interpersonal and Social Rhythm Therapy**

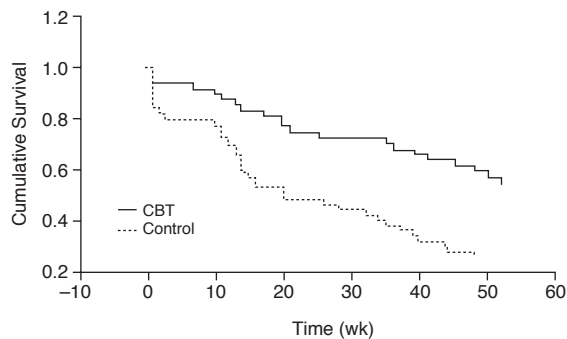
Studies<sup>5,12,13</sup> have found IPSRT to be helpful in treating bipolar disorder. The Maintenance Therapies in Bipolar Disorder study by Frank and colleagues<sup>13</sup> compared IPSRT and medication with a conventional clinic approach called active clinical management. Random assignment to treatment occurred during an acute treatment and, separately, a maintenance treatment phase. Active clinical management included medication and counseling sessions focused on clinical status and symptom review. Patients who received IPSRT weekly during the acute phase experienced significantly greater stability of daily routines as time in treatment increased compared with patients receiving active clinical management.<sup>12</sup> Moreover, IPSRT during the acute treatment phase was associated with more time prior to recurrences in the maintenance treatment phase than the comparison intervention. IPSRT was most effective in delaying recurrences during maintenance treatment when patients succeeded in stabilizing their daily routines and sleep-wake cycles during the acute treatment phase.<sup>13</sup>

Another study<sup>5</sup> found that the combination of IPSRT and FFT was more effective in delaying bipolar relapses than a brief psychoeducational crisis management treatment. This open trial used a nonrandomized comparison group from an earlier trial,<sup>3</sup> and both treatment arms were delivered in conjunction with medication. Patients who received an average of 30 sessions of IPSRT and FFT had longer periods of remission during 1 year than patients in the crisis management group. Thus, IPSRT appears to be an effective adjunct to pharmacotherapy in delaying recurrences of bipolar disorder.

**COGNITIVE-BEHAVIORAL THERAPY**

CBT challenges the patient’s beliefs or assumptions about his or her self, world, and future that contribute to the long-term vulnerability to mood disorder.<sup>14</sup> CBT for bipolar disorder includes a focus on restructuring dysfunctional high-goal attainment beliefs—beliefs that one is invulnerable, cannot lose, or can take risks without any consequences—that may predispose patients to mania. In addition to cognitive restructuring, CBT for bipolar

Figure 4. Survival Curves for Adjunctive Cognitive-Behavioral Therapy Versus Medication Alone<sup>a</sup>



<sup>a</sup>Reprinted with permission from Lam et al.<sup>14</sup>  
Abbreviation: CBT = cognitive-behavioral therapy.

disorder includes other cognitive-behavioral, psychoeducational, and routine-stabilizing components. The psychoeducational component focuses on understanding bipolar disorder as a product of biological vulnerability and stress. Clinicians work with patients to monitor their moods and early warning signs of relapse. They also help patients develop behavioral activation plans (e.g., scheduling pleasant activities) when depressed.

### Research Supporting Cognitive-Behavioral Therapy

Using this model of CBT for bipolar disorder, Lam and colleagues<sup>14,15</sup> compared patients (N = 103) who received 6 months of CBT (12–18 sessions) and medication or routine clinical care plus medication. Patients who began in remission and received CBT adjunctive to medication had higher rates of survival, spent fewer days in bipolar episodes, and had higher social functioning during year 1 than comparison patients (Figure 4).<sup>14</sup> The preventive effects of CBT on relapse were not maintained over the follow-up from month 12 to month 30, but CBT continued to show positive effects on number of days spent in episodes.<sup>15</sup>

Scott and colleagues<sup>16</sup> examined a somewhat different CBT model consisting of at least 20 sessions over 26 weeks. During weeks 1 through 5, patients were socialized into a cognitive therapy model, educated about bipolar disorder, and encouraged to create a life chart summarizing their previous episodes. In weeks 6 through 10, patients were taught and encouraged to self-monitor moods and dysfunctional behaviors such as substance misuse. Weeks 11 through 15 addressed dysfunctional cognitions associated with treatment nonadherence. Finally, during weeks 16 through 26, patients and clinicians identified patient-specific prodromal signs associated with the beginning of a relapse. The clinician and patient then worked together to develop cognitive and behavioral strategies to prevent relapse when the patient's "relapse signature" manifested itself.

A large-scale (N = 253) multicenter trial<sup>17</sup> conducted in the United Kingdom compared 22 sessions of this form of CBT plus pharmacotherapy with usual care and pharmacotherapy. The patients were in a variety of clinical states before they entered the trial. CBT did not have an impact on time to recurrence. Patients with fewer than 13 prior episodes had fewer recurrences if treated with CBT than treatment-as-usual, but among patients with 13 or more episodes, treatment-as-usual outperformed CBT. Thus, CBT may be most suited to patients in the early stages of their disorder or those with a less recurrent course. Scott and colleagues<sup>16</sup> postulate that CBT may be useful in treating bipolar disorder but that a high level of therapist expertise is required due to the greater complexity of bipolar versus unipolar disorders.

### INDIVIDUAL AND GROUP PSYCHOEDUCATION

Psychoeducation has been given to patients with bipolar disorder in both individual and group formats. Perry and colleagues<sup>18</sup> examined the combination of individual psychoeducation and medication in comparison with usual care and medication. In 7 to 12 sessions, patients learned how to identify their early warning signs of relapse and obtain emergency medical treatment. Patients who received psychoeducation and pharmacotherapy had a 30% reduction in manic relapses, longer intervals prior to manic relapses, and better social functioning over 18 months. Psychoeducation did not affect time to depressive relapses.

A group psychoeducational model designed by Colom and colleagues<sup>19</sup> focuses on sharing information with patients about how to cope with the cycling of bipolar disorder. According to this model, groups of 8 to 12 euthymic patients receive 21 psychoeducational sessions of 90 minutes each, directed by 2 trained psychologists. Patients continue to receive standard pharmacologic treatment, but no other psychological intervention is allowed. Group psychoeducation follows the medical model, with a directive style of education, but participation by patients is encouraged.

In the randomized trial<sup>19</sup> of their model, Colom and associates found that patients participating in group psychoeducation as an adjunct to medication had better results than patients taking medicine and participating in an equally intensive unstructured support group. Group psychoeducation participants experienced fewer relapses and more well time between relapses over 24 months when compared with patients in the support group treatment arm.

Simon and colleagues<sup>20</sup> evaluated a multicomponent intervention that involved a group psychoeducation model developed by Bauer and McBride.<sup>21</sup> Participants were bipolar patients treated in a managed care network (N = 441) who were randomly assigned to pharmaco-

therapy only or a care-management program consisting of pharmacotherapy, telephone monitoring, care planning, and group psychoeducation. In the first year of the study, patients in the program had lower mania scores and spent less time hypomanic or manic than those in the comparison group, but there were no effects of the care management program on depressive symptom scores. Thus, studies support the use of individual or group psychoeducation in preventing and controlling mania symptoms.

### IMPLEMENTING PSYCHOSOCIAL INTERVENTIONS IN AN ERA OF MANAGED CARE

Due to the specialized and sometimes lengthy nature of the evidenced-based psychosocial interventions for bipolar disorder, clinicians may need to adapt the interventions for their practices. There are some specific ways in which this adaptation may be done. Clinicians can make use of the brief, efficient clinical training manuals<sup>1,8,11,21-23</sup> that are now available. Also, clinicians working within a limited time frame may implement particular techniques, such as stabilizing social rhythms or conducting relapse prevention drills, from the larger treatment manuals. Modularized treatments like FFT may be divided into self-standing treatment modules and implemented as such (e.g., 7 sessions of family education without the addition of the communication skills or problem-solving modules). After a limited number of sessions are given initially, clinicians should offer follow-up maintenance sessions as needed. Patients can be encouraged to use self-help manuals<sup>11</sup> with guided exercises, thereby guiding their own psychosocial intervention. Finally, educationally oriented mutual support groups may be a successful and inexpensive adjunct to pharmacotherapy.

### CONCLUSION

Psychosocial interventions can help patients with bipolar disorder and their families learn how to cope with the illness, prevent or prolong the time until relapse, and improve patients' medication adherence. Various forms of psychotherapy, including FFT, IPSRT, CBT, and individual or group psychoeducation, enhance the efficacy of pharmacotherapy in promoting stabilization. Adjunctive psychosocial treatment should be a key component of the outpatient management of most patients with bipolar disorder.

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

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