Manual-Based Group Psychotherapy for Bipolar Disorder: A Feasibility Study

Mark S. Bauer, M.D.; Linda McBride, M.S.N.; Catherine Chase, D.O.;
Gary Sachs, M.D.; and Nancy Shea, R.N.-C.S.

Background: The Life Goals Program is a structured, manual-based group psychotherapy program for bipolar disorder that seeks to improve patient participation in medical model treatment (phase 1) and assist patients in meeting functional status goals (phase 2). The goals of this initial study were (a) to determine whether the procedures could be exported from the authors to other therapists and (b) to quantify tolerability and impact of procedures on patients.

Method: Four therapists across 2 sites and 29 patients from the Veterans Affairs (VA) Medical Center were studied in an open feasibility study. Therapists were trained, and subsequent compliance with manual procedures was quantified. Several process indices measuring tolerability and impact on patients were analyzed.

Results: Therapists covered 90% to 96% of phase 1 psychoeducational content, indicating excellent fidelity to manual procedures. Sixty-nine percent of patients completed phase 1, and participation scores were in the good to excellent range for 56%. Completion of phase 1 was associated with significant increase in knowledge about bipolar disorder. Fourteen (70%) of 20 patients enrolled in phase 2 reached their self-identified, behaviorally based goal (48% of the total sample who began phase 1 of the program). Mean ± SD time to goal completion was 8.7 ± 5.3 months (median [95% confidence interval] = 7 [5.1–12.3 months]; range, 2–17 months).

Conclusion: The manual-based intervention can be exported with fidelity to other therapists and sites (for phase 1). Data indicate reasonable tolerability and good achievement of process (for phases 1 and 2) for those who accept this group modality. Comparison with other manual-based psychotherapies indicates remarkable consistency regarding content for psychotherapy for bipolar disorder; major differences among the psychotherapies include mode of delivery and relative emphasis of specific components.

(J Clin Psychiatry 1998;59:449–455)

Bipolar (manic-depressive) disorder can be successfully treated by several types of medication, including mood stabilizers and, when necessary, by antidepressants and neuroleptics.[1] However, the disorder is typically characterized by chronic symptoms and high rates of relapse and rehospitalization.[1,2] Available evidence indicates that patients with bipolar disorder frequently do not participate effectively in medical model treatment. For instance, rates of medication noncompliance are high and may lead to discontinuation of medication in high proportions of patients.[3,4] If techniques can be developed to help patients to participate more effectively in medical model treatment, then it stands to reason that more effective delivery of efficacious medications can be achieved and outcome can be improved.

Several types of individual, group, and family psychotherapy have been developed for bipolar disorder, and have been reviewed recently.[2,5,6] Several themes emerge, as shown in Table 1. Most therapies have focused primarily on symptom reduction. Virtually all of these studies acknowledge the importance of medication treatment, although few have taken improving the patient's participation in treatment as the main focus. Several have improvement of social and occupational function as a secondary goal. A minority of these therapies are based on manuals with explicit instructions to therapists[7,9,10,12]; the presence of such instructions is one of the prerequisites for conducting a successful controlled trial.

The Life Goals Program was developed to address the dual themes of improving patients' illness management skills and improving their functional (social and occupational) status. These 2 themes are linked in their emphasis on developing in the patient the tools required to live a reasonably well-adjusted life despite carrying the burden of a chronic illness.

This report has 3 purposes. First, it provides a brief overview of the structured group psychotherapy program, the Life Goals Program, which is described in detail in the published manual.[2] Second, this report presents data regarding the exportability of the manual-based procedures to other therapists and sites. Third, the report summarizes findings from an open trial that quantified tolerability and impact of procedures on patients. Note that since this feasibility study was an open rather than controlled trial, data on process goals but not overall clinical outcome are presented.

METHOD

The Life Goals Program

Development of the program. The Life Goals Program was developed as a group treatment program at the Providence Veterans Affairs (VA) Medical Center by the first 2 authors (M.S.B., L.M.) over the course of several years of work with patients with bipolar disorder. During this time, 4 major themes emerged as key to reasonable quality of life for our patients (reviewed in detail in reference 2, pp. 87–120). First, quality of life is poor if the illness is not under reasonable control. Second, as noted above, patients frequently do not participate optimally in medical model treatment. Third, most patients manifest significant social and occupational limitations, even after the illness comes under optimal control. Fourth, achievement of desired functional goals that are important to the patient are seldom addressed with patients.

In view of these perceived needs, the authors developed the Life Goals Program, which was structured as a 2-phase treatment modality. The goal of phase 1 is to improve illness management skills so that individuals may be more effective collaborators in medical model treatment and managers of their symptoms. The goal of phase 2 is to improve social and occupational function in ways that the individuals themselves identify as meaningful to them.

The Life Goals Program was developed as a group-based rather than individual-based or family-based psychotherapy for 3 reasons. First, although we knew that the family may play a critically important role in the management of bipolar disorder (e.g., references 6, 11, 12, and 22), the unfortunate truth is that many bipolar patients have no family either because they never married or because the illness or related factors led to the dissolution of their family. This is particularly true among the more severely ill and the more socioeconomically disadvantaged typically seen in public sector programs, a subpopulation of patients whose needs we particularly wished to address. Second, group rather than individual modality was chosen to take advantage of the peer support and peer feedback that cannot be provided in the dyadic individual format. Third, we reasoned that reduced cost in terms of

Table 1. Summary of Studies of Psychotherapeutic Modalities for Bipolar Disorder

Study	Main Focus
Individual modalities	
Frank et al[7,8]	Symptom status, interpersonal conflict resolution
Basco and Rush[9]	Symptom status, compliance
Family modalities	
Davenport et al[10]	Symptom status
Miklowitz and Goldstein[11]	Symptom status, interpersonal skills acquisition
Miller et al[12]	Interpersonal conflict resolution, symptom status, compliance, functional status
Group modalities	
Shakir et al[13]	Intrapsychic themes,[a] compliance
Cochran[14]	Compliance, symptom status
Kripke and Robinson[15]	Symptom status, functional status
Wuslin et al[16]	Intrapsychic themes[a]
Pollack[17,18]	Intrapsychic themes[a]
VanGent and Zwart[19]	Compliance (intervention for spouses only)
Cerbone et al[20]	Symptom status, functional status
Graves[21]	Intrapsychic themes[a]

[a]Intrapsychic themes include psychodynamic, self-esteem, and other factors that are internal and subjective. They are typically hypothesized by the authors to impact on psychosocial function, quality of life, and, probably, symptom status and treatment behavior.

therapist contact hours per person would make a group format more available to individuals in the public sector or under tightly managed care.

Brief overview of the procedures. The Life Goals Program is structured into 2 sequential components, phase 1 and phase 2. The groups enroll a fixed cohort of 5 to 6 members with 1 therapist and do not have ongoing enrollment owing to the highly structured nature of the intervention. Groups meet weekly for 60-minute sessions.

Phase 1 (presented in detail in reference 2, pp. 123–183) consists of 5 weekly psychoeducation sessions that are highly structured. The first session provides an overview of the illness and its possible causes and treatments. The second 2 sessions focus on depression, and the next 2 sessions on mania and hypomania.

Specifically, these sessions focus on the members' identifying their own specific pattern of illness, including their early warning signs for relapse, triggers for episodes, and their helpful and counterproductive coping strategies. Each session consists of a number of psychoeducational focus points that the therapist is expected to cover. The members complete a series of worksheets, culminating in the individuals' development of "action plans" by which they identify the adaptive coping responses they wish to use to minimize or truncate impending symptoms.

The focus of phase 1 is primarily psychoeducational and supportive. Intrapsychic and conflict-laden material is purposely avoided, given the evidence that such uncovering therapies do not tend to benefit individuals with major mental illnesses.[23]

In phase 2 (presented in detail in reference 2, pp. 185–230), the patient identifies 1, and subsequently several, social, occupational, or leisure goals that have not been

reached owing to the disruption caused by bipolar disorder. While phase 1 is agenda-driven (i.e., 5 set sessions with a series of predetermined focus points in each), phase 2 is goal-driven and without the degree of a priori structure characteristic of phase 1. Rather, duration of treatment and pace of progress are member-specific and dictated by progress on specific goals. Membership continues as long as the individual wishes to work on goals.

The sequence of tasks in phase 2 is built around a behavioral plan. First, the group member identifies a reasonable goal with the therapist's assistance. The goals may be as apparently simple and mundane as getting a driver's license reinstated or beginning a hobby, or may be as complex as getting a job. They then jointly develop realistic behavioral stepwise plans to address this goal. The plans are structured to maximize the probability of success. Stated goals and progress are outlined in behaviorally measurable terms so that both therapist and member can identify successes and roadblocks.

As with phase 1, a series of work sheets are completed so that both therapist and member can track progress and identify roadblocks. Sometimes, merely structuring a behavioral plan is sufficient to make the tasks seem less overwhelming, and with a bit of peer support a goal can be reached. More typically, however, the therapist works with individual members around problem areas called "roadblocks" and helps the member to address them using behavioral, cognitive, or interpersonal group interventions. When an identified goal is reached, the patient may opt to choose another goal or to terminate participation in the group.

Study Procedures

Overview of procedures. Four therapists at the Providence VA Medical Center or the Massachusetts General Hospital were trained by one of the authors as outlined below. Individuals with bipolar disorder were enrolled in each of the 5 groups, 5 to 7 members per group. Groups were initiated between November 1993 and November 1994. Since phase 2 is open-ended, some patients are continuing in group at this time; however, only the time to attainment of first functional goal serves as the interval for analysis. Data of interest were collected prospectively or, in the case of goal attainment in phase 2, reconstructed from chart records. Institutional review board approval was given for patient data collection procedures.

Therapist sample. The 4 therapists were recruited from staff and trainee volunteers at the Providence VA Medical Center or Massachusetts General Hospital who had an interest in psychotherapeutic treatment of bipolar disorder. They were trained by studying a draft version of the manual and reviewing questions with 1 of the authors. Therapists received 1 afternoon of training plus several follow-up supervision sessions during the course of treatment. Therapists included 1 master's-prepared nurse, 1

intern with a master's degree in social work, 1 fourth-year psychiatry resident, and 1 junior staff psychiatrist in his first postresidency year. All had at least 1 year of clinical care experience with patients with major mental illnesses; only 1 of these had had more than 1 year in working with patients with bipolar disorder in a specialty program, although each of the 4 therapists had occasionally treated bipolar patients.

Patient sample. The sample for analysis of patient response was drawn from a specialty program for bipolar disorder at the Providence VA Medical Center. The sample for this study (N = 29) comprises all patients who accepted referral from group psychotherapy. Inclusion criteria included DSM-III-R[24] diagnosis of bipolar disorder type I or type II (recoded for this report according to DSM-IV[25] criteria), outpatient status, and willingness to participate in group therapy modality. Exclusion criteria were minimal because of our desire to study a sample typical of the bipolar clinical population in general practice in the public sector. Patients were excluded if they had a diagnosis of comorbid dementia. Patients with comorbid active substance dependence or hypomanic or manic episodes able to be managed as outpatients were not excluded.

Neither hypomanic nor significant depressive symptoms were criteria for exclusion. In fact, during phase 1 patients were symptomatic during the majority of sessions. In 93 patient sessions, mood state was globally estimated by the therapist based on behavior during the session (see form in reference 2, p. 244). In only 45% (42/93) of sessions were patients rated as euthymic, while only 10% (3/29) were rated as euthymic throughout all 5 sessions. Patients were rated as hypomanic in 9% (8/93), subsyndromally hypomanic in 14% (13/93), moderately depressed in 10% (9/93), and mildly depressed in 23% (21/93) of sessions. Thus, patients were predominantly symptomatic during treatment in phase 1.

Demographic and clinical characteristics of the sample are summarized in Table 2. Although we recruited all patients who met the inclusion and exclusion criteria for this feasibility study, we did not record those who were approached but refused participation. However, the group resembled the overall clinic sample (N = 103) from which they were drawn[26] in major demographic and clinical characteristics. In terms of demographics, this subsample appears to have somewhat higher proportion of patients with more than a high school education (63% vs. 47% in the overall sample) and lower proportion with VA disability payments. In terms of clinical characteristics, this subsample appears to have a somewhat lower proportion of bipolar I patients but higher proportions of suicide attempts, rapid cycling, current alcohol dependence, and current drug dependence.

Therapist variables of interest. Three parameters determined adherence of therapists to manual procedures.

Table 2. Patient Demographic and Clinical Characteristics

Variable	This Sample (N = 29)	Entire Clinic[a] (N = 103)
Age (y), mean ± SD	50 ± 7	50 ± 13
Male	95.5%	94%
Race = white	87%	93%
Education level		
< High school degree	5%	19%
High school degree/GED	32%	34%
> High school degree	63%	47%
Marital status		
Never married	9%	18%
Married/cohabiting	41%	48%
Separated/divorced	50%	34%
Veterans Affairs psychiatric disability	23%	42%
Bipolar type I	57%	76%
History of psychosis	59%	64%
History of suicide attempts	64%	54%
Current rapid cycling	19%	12%
Current alcohol dependence	33%	22%
Current drug dependence	19%	10%

[a]Data from reference 26.

Table 3. Therapist Adherence Monitor Results for Phase 1

Variable	Focus Points	Content Aspects	Process Aspects
Maximum for 5 sessions	18	25	45
Percentage covered by			
Therapist A, %	84	76	81
Therapist B, %	100	100	100
Therapist C, %	100	100	97
Therapist D, %	96	84	98
Mean, %	95	90	94

To rate adherence, one of the authors (L.M.) observed sessions or reviewed audiotapes and rated the content of each session using the standardized Therapist Monitor (see form in reference 2, pp. 234–241). First, each focus point for each session was rated as completely covered, partially covered, or not addressed according to the degree to which the content of the focus point was conveyed by the therapist. Second, the therapist was rated on 5 generic content aspects common to all 5 sessions (e.g., appropriate use of visual aids, accurate response to patient queries about the illness and its treatment). Third, the therapist was rated on 9 generic process aspects common to all 5 sessions (e.g., avoidance of judgmental feedback in response to patient contributions in group, empathic response to verbal cues by patients). For each of these 3 elements, therapists scored 1 if the element was fully covered, 0.5 if partially covered, and 0 if not covered, and percentages were calculated using the sum of full or half credits divided by the total possible score. Ratings across the 5 sessions for each therapist were summed, yielding therapist adherence scores for focus points, content aspects, and process aspects.

Patient variables of interest. Key patient indicators for success of phase 1 included (a) patient attendance, (b) level of patient participation and completion of group assignments as determined by standardized behavioral measures, and (c) patient knowledge of bipolar disorder as assessed by pre/post-testing on a standardized instrument. Key variables for phase 2 included (a) duration of patient enrollment in phase 2 and (b) patient achievement of chosen functional goals.

To assess tolerability of phase 1, the percentage of retention rate at the end of phase 1 and the number of sessions missed by those who completed phase 1 were recorded. In addition, a participation score (see form in

reference 2, p. 244) was calculated that indicated the level of patient participation in group sessions, required for successful completion of the program. This score was generated on a 0–5 scale for each session (0 = no-show, 1 = attended only part of session, 2 = apparently distracted, 3 = attentive with limited verbal contribution, 4 = contributed generic information only, 5 = contributed personal information) and summed over 5 sessions to a maximum of 25 points.

The degree to which phase 1 met its stated goals was determined by comparing pretest versus posttest scores on the Knowledge Base Assessment, a 25-point questionnaire (see form in reference 2, pp. 246–247) that was given prior to the beginning of the first session and after 5 weeks of phase 1.

To assess the tolerability of phase 2, the number of months participating in phase 2 were recorded. To assess the degree to which phase 2 met its stated goals, the proportion of patients meeting at least 1 self-defined functional goal was tabulated based on review of group and clinic notes; any patient with ambiguous or missing information was counted conservatively as not having achieved a goal. In addition, the time to goal completion was noted in order to provide information needed for constructing a future randomized controlled trial.

Data analysis. By the nature of this study, many of the data are observational and as such are presented with relevant summary statistics without comparative statistics. Pretest and posttest scores on the Knowledge Base Assessment were analyzed with paired t test. Predictors of several measures of participation were analyzed by 2-group t test or chi-square test that compared those with and those without the particular characteristic of interest.

RESULTS

Therapist Adherence to Procedures

Therapist adherence monitor results are summarized in Table 3. Therapists covered a mean of 96% of focus points for the 5 sessions (intertherapist range, 84–100). In addition, therapists' content ratings for the 5 sessions averaged 90% (intertherapist range, 76% to 100%), while process ratings averaged 94% (intertherapist range, 81% to 100%). Thus, phase 1 manual procedures can be taught

Patient Results for Phase 1

Nine (31%) of 29 patients dropped out, yielding a retention rate for phase 1 of 69%. Patients who remained missed on average less than one session (mean ± SD = 0.6 ± 0.7). Mean ± SD participation score for all patients for whom data were available (N = 25), including dropouts, was 15.3 ± 7.7 (range, 1–25). Seven (28%) scored in the excellent range (21–25 points), 7 (28%) scored in the good range (16–20 points), 5 (20%) scored in the fair range (11–15 points), and 6 (24%) scored in the poor range (≤ 10 points).

The mean ± SD Knowledge Base Assessment score at baseline was 15.5 ± 5.1 (scale range, 0–25 points). At the conclusion of phase 1, the mean score increased to 17.5 ± 4.5, a modest but significant increase (t = 2.5, df = 14, p = .03).

Patient Results for Phase 2

All 20 patients who completed phase 1 chose to continue into phase 2. Patients spent 11.2 ± 2.9 months in phase 2 (median = 12, 95% confidence interval [CI] = 9.3 to 13). Fourteen (70%) of these 20 had clear documentation of reaching at least 1 self-defined functional status goal (48% of the total sample who began phase 1 of the program). The specific goals, which were chosen by the patients, varied widely. Examples that illustrate the breadth include the following: "Leave the house at least 3 times per week," "Abstain from alcohol and drugs," and "Leave my wife." Time to goal attainment varied from 2 to 17 months (mean ± SD = 8.7 ± 5.3, median = 7, 95% CI = 5.1 to 12.3).

Correlates of Retention and Participation

Our a priori hypotheses regarding patient characteristics predictive of retention and levels of participation were explored using 2-group analyses that divided the groups based on bipolar subtype (type I vs. type II), current rapid cycling versus not, current alcohol dependence versus not, and current drug dependence versus not. These analyses revealed no significant differences with regard to proportion of dropouts, number of phase 1 sessions missed, phase 1 participation score, or months in phase 2 (p > .30 for each).

DISCUSSION

Content Comparability to Other Structured Psychotherapies for Bipolar Disorder

There is remarkable concordance of content and orientation among the 4 manual-based psychotherapies for bipolar disorder with published summaries (this study and references 6, 8, and 9). These include most fundamentally the assumption that bipolar disorder is in large part biologically driven, and yet subject to modification by environmental events. Accordingly, each psychotherapy is designed to be administered within the context of medical model treatment using commonly available pharmacotherapy, and each seeks to some degree to improve compliance with medication management through psychoeducation.

The interpersonal and social rhythm therapy (IPSRT) procedures of Frank and coworkers[8] and the family focused treatment (FFT) of Miklowitz and coworkers[6,22] have phases oriented specifically to the phases of treatment for the illness (acute, continuation, and maintenance), while the cognitive-behavioral therapy (CBT) of Basco and Rush[9] and the Life Goals Program are less specifically structured for course-related variables. Each of the psychotherapies begins some aspect of treatment when patients are symptomatic. For formal controlled trials with IPSRT and FFT, patients have been identified while hospitalized, and the initial stages, which are mainly evaluative,[22] begin during acute treatment. In contrast, the Life Goals Program enrolls outpatients, although they are typically still symptomatic. Interestingly, IPSRT, FFT, and the Life Goals Program each emphasize customized patient-designed procedures for the prevention or minimization of relapse: the "relapse drill" for FFT, the "symptom management plan" for IPSRT,[22] and the "action plan" for the Life Goals Program.

Each of the psychotherapies includes some degree of emphasis on assisting patients to achieve functional goals. This may be accomplished through formal attention to skills training (FFT, Life Goals Program), conflict resolution with significant others (FFT, IPSRT, Life Goals Program), and/or addressing cognitive factors (CBT, Life Goals Program).

Differences among the treatments are mainly related to modality of delivery and relative emphasis on the various components of treatment. The treatments clearly differ in whether they are primarily directed toward the family (FFT; also see reference 12) or the individual (IPSRT, CBT, Life Goals Program), and whether they are delivered in a group format (Life Goals Program), family format (FFT; also see reference 12) or individual format (CBT, IPSRT). However, even these distinctions are beginning to blur, as some exploration of combining family FFT with individual IPSRT is underway.[22]

An example of differences in emphasis can be illustrated by comparing several components of IPSRT and the Life Goals Program. Both clearly address the role of environmental stressors and attempt to minimize their impact on the patient. The Life Goals Program addresses these through identification of "triggers" to episodes in phase 1, which include both psychosocial and environmental stressors; the Life Goals Program seeks to minimize their impact as one part of a multimodal "action plan." In contrast,

the social rhythm component of IPSRT attends in considerably greater detail to both the analysis and the modification of environmental stressors. Conversely, the Life Goals Program focuses on interpersonal conflicts only insofar as they prevent goal attainment during phase 2, whereas IPSRT analyzes and addresses these issues throughout all phases. The major aim in phase 1 of the Life Goals Program is to facilitate the patient's participation in medical model treatment, whereas phase 2 takes a heavily behavioral/cognitive approach to addressing functional deficits.

Regardless of the differences in emphasis and modality, what stands out most clearly in review of these programs is the consistency regarding the issues that must be addressed to improve outcome. These include the following: understanding of the illness and its treatment by the patient, contingency planning for managing symptoms, modulation of and response to environmental stress in order to minimize its destabilizing effects on the illness, development of skills to manage such environmental and interpersonal stress, and efforts to improve functional outcome directly or indirectly.

Therapist Adherence in the Life Goals Program

A high degree of fidelity to manual interventions was demonstrated, based on coverage of 95% of focus points for phase 1. Further, general content and process aspects of the therapy were well adhered to, based on ratings of, respectively, 90% and 94%. Inspection of each individual element revealed that no scores of zero were assigned to any therapist for any element. Thus score reductions were due to partial coverage rather than to missing elements entirely.

Inspection of individual therapist results indicated that therapist A tended to have lower scores than the others. This therapist actually had had more experience treating individuals with bipolar disorder prior to the study than had the others. The somewhat lower scores may have been due to giving supervisory feedback en bloc at the end of phase 1 rather than after individual sessions.

Overall, then, the manual-based Life Goals Program phase 1 intervention was able to be exported with fidelity to both content and style with modest amounts of training and standardization. Importantly, this was achieved with therapists who were not content experts or greatly experienced regarding bipolar disorder prior to beginning group sessions.

It should be noted that the fidelity ratings were done by one of the authors (L.M.), so we cannot exclude the possibility that ratings were somewhat inflated; no interrater reliability statistics were available for this study since only a single rater was used. However, as part of an ongoing VA Cooperative Study (No. 430, "Reducing the Efficacy-Effectiveness Gap in Bipolar Disorder") that investigates the impact of access and education on outcome in bipolar disorder, an interrater reliability study was done as part of training nurses to criterion in the Life Goals Program. In this context, agreement between independent raters was high, ranging from 94% to 100% over 5 rated sessions (89 total content, process, and focus points, 17 to 19 points per session).

Tolerability and Impact of the Life Goals Program on Patients

The uncontrolled and nonblinded nature of this initial feasibility study must be considered in interpreting these data. Nonetheless, available data indicate that the Life Goals Program was reasonably tolerated and, for those who accepted and continued treatment, was able to achieve its stated goals. Comparison with data from FFT and IPSRT studies provides some perspective.

Some data are available from the FFT and IPSRT studies[22] with which to compare patient samples across these studies. The most obvious differences are that the current study's sample (see Table 2) was predominantly male compared with the FFT and IPSRT samples (63% and 61% female, respectively) and also substantially older (mean ± SD age = 36 ± 10 and 36 ± 9 years, respectively vs. 50 ± 7 years [range, 38–64]) for this study. Education levels are not directly comparable, although it appears that for each of the 3 studies the modal level of education was post–high school (mean years of education = 13.7 and 15.1 for FFT and IPSRT, respectively, vs. 63% with some post–high school education in this sample). The FFT or IPSRT studies also included patients with indices of severe bipolar disorder, studying bipolar I patients who were ill on average for over 10 years and who had experienced 5 to 10 previous episodes. This study included a majority of patients who had bipolar I disorder, were psychotic at some time, and had a history of suicide attempts. Further, 19% currently experienced rapid cycling. Thus, all 3 studies included patients with indices of severe illness. In addition, in this study 33% of the sample met criteria for current alcohol dependence and 19% for current drug dependence.

The retention rate for the Life Goals Program was 69%, somewhat lower than the extraordinarily high rates of 94% for FFT and 83% for IPSRT. It is not clear to what degree this difference reflects greater tolerability for the individual-focused intervention itself or the impact of sample differences among the studies. Alternatively, the intense research follow-up necessary for conducting formal controlled clinical trials of FFT and IPSRT may have supported high patient commitment and retention.

Nonetheless, those who did not drop out of phase 1 missed fewer than 20% of their sessions, compared with 75% of FFT and 55% of IPSRT patients who missed fewer than 33% of their sessions over the longer term. Further, participation scores in phase 1 indicate that the patients were active participants for most sessions, with

28% registering maximal participation for almost all group sessions. In addition, those patients who did not drop out continued in phase 2 for extended treatment for a mean of 11 months.

Initial data indicate that participation in phase 1 and phase 2 was associated with the achievement of stated goals. Knowledge Base Assessment scores after phase 1 increased significantly from already moderately high baseline scores, indicating that this psychoeducational component achieved its desired effect. In phase 2, patient-identified goals were achieved by over two thirds of patients. Of particular interest, goals were typically not achieved until several months into treatment, indicating that a long-lead approach to change in bipolar disorder is the rule rather than the exception. These findings support the use of long-term (9- or 12-month) trials in the study of FFT and IPSRT.

It is notable that several of the patient characteristics that we expected to be associated with poor participation, particularly active substance use disorders, were in fact not predictive. While a larger sample may document a statistical association, we were encouraged that the Life Goals Program appears to be tolerable and may be helpful for this needy group as well.

Conclusions

The Life Goals Program appears feasible to standardize across therapists and sites, tolerable to patients with bipolar disorder, and able to achieve its stated aims. It shares many common features with other manual-based, structured psychotherapies for bipolar disorder, although it is unique in applying group techniques in a manual-based format.

Although the achievement of process goals is encouraging both for this and for other therapies, it remains to be seen whether such interventions can improve outcome in bipolar disorder when added to standard medication management. If effective, an intriguing theoretical issue arises: whether the Life Goals Program and other psychotherapies add a unique psychosocial component to treatment or whether they simply codify and ensure the delivery of what would be considered empathic, sensible clinical care by clinicians who are experienced with bipolar disorder.

REFERENCES

1. Bauer M. Bipolar disorder. In: Tasman A, Kay J, Lieberman J, eds. Psychiatry. Philadelphia, Pa: Saunders; 1997;966–989

2. Bauer M, McBride L. The Life Goals Program: Structured Group Psychotherapy for Bipolar Disorder. New York, NY: Springer Publishing Co; 1996

3. Gitlin MJ, Cochran SD, Jamison KR. Maintenance lithium treatment: side effects and compliance. J Clin Psychiatry 1989;50:127–131

4. Jamison K. Manic-depressive illness: the overlooked need for psychotherapy. In: Beitman B, Klerman G, eds. Integrating Pharmacotherapy and Psychotherapy. Washington, DC: American Psychiatric Association; 1991:409–420

5. Scott J. Psychotherapy for bipolar disorder. Br J Psychiatry 1995;167: 581–588

6. Miklowitz D. Psychotherapy in combination with drug treatment for bipolar disorder. J Clin Psychopharmacol 1996;16:56S–66S

7. Frank E, Kupfer D, Ehlers C, et al. Interpersonal and social rhythm therapy for bipolar disorder: integrating interpersonal and behavioral approaches. Behav Therapist 1994;17:143–149

8. Frank E, Hlastala S, Ritenour A, et al. Inducing lifestyle regularity in recovering bipolar disorder patients: results from the maintenance therapies in bipolar disorder protocol. Biol Psychiatry 1997;41:1165–1173

9. Basco M, Rush AJ. Cognitive-Behavioral Therapy for Bipolar Disorder. New York, NY: Guilford Press; 1996

10. Davenport Y, Ebert M, Adland M, et al. Couples group therapy as an adjunct to lithium maintenance of the manic patients. Am J Orthopsychiatry 1977;47:495–502

11. Miklowitz D, Goldstein M. Behavioral family therapy treatment for patients with bipolar affective disorder. Behav Modif 1990;14:457–489

12. Miller IW, Keitner GI, Epstein NB, et al. Family treatment of bipolar disorder. In: New Research Program and Abstracts of the 145th Annual Meeting of the American Psychiatric Association; May 2–7, 1992; Washington, DC. Abstract NR597:194

13. Shakir S, Volkmar F, Bacon S, et al. Group psychotherapy as an adjunct to lithium maintenance. Am J Psychiatry 1979;136:455–456

14. Cochran S. Preventing medical noncompliance in the outpatient treatment of bipolar affective disorders. J Consult Clin Psychol 1984;52:873–878

15. Kripke D, Robinson D. Ten years with a lithium group. McLean Hosp J 1985;10:1–11

16. Wuslin L, Bachop M, Goffman D. Group therapy in manic-depressive illness. Am J Psychother 1988;42:263–271

17. Pollack L. Improving relationships: groups for inpatients with bipolar disorder. J Psychosoc Nurs Ment Health Serv 1990;28:17–22

18. Pollak L. Content analysis of groups for inpatients with bipolar disorder. Appl Nurs Res 1993;6:19–27

19. VanGent E, Zwart F. Psychoeducation of partners of bipolar-manic patients. J Affect Disord 1991;21:15–18

20. Cerbone M, Mayo J, Cuthbertson B, et al. Group therapy as an adjunct to medication in the management of bipolar disorder. Group 1992;16: 174–187

21. Graves J. Living with mania: a study of outpatient group psychotherapy for bipolar patients. Am J Psychother 1993;47:113–127

22. Miklowitz D, Frank E, George E. New psychosocial treatments for the outpatient management of bipolar disorder. Psychopharmacol Bull 1996; 32:613–621

23. Kanas N. Group psychotherapy with schizophrenia. In: Kaplan H, Sadock B, eds. Comprehensive Group Psychotherapy. Baltimore, Md: Williams & Wilkins; 1993:407–417

24. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised. Washington, DC: American Psychiatric Association; 1987

25. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. Washington, DC: American Psychiatric Association; 1994

26. Bauer M, McBride L, Shea N, et al. Impact of an easy-access clinic-based program for bipolar disorder: quantitative analysis of a demonstration project. Psychiatr Serv 1997;48:491–496