

Psychosocial Interventions as an Adjunct to Pharmacotherapy in Bipolar Disorder

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Objective: To summarize the evidence and make treatment recommendations regarding the use of psychosocial interventions as an adjunct to pharmacotherapy for bipolar disorder.

Methods: We reviewed published outcome studies since 1975 identified in MEDLINE and PsychLIT searches.

Results: Available studies are initial and of highly variable methodological rigour. Evidence is most robust for the efficacy of psychoeducation and family therapy, and these received the highest level of recommendation as interventions. Group therapy, cognitive-behavioural therapy, and behavioural family management therapy are supported by weaker evidence and received a lower-level treatment recommendation. Availability of only a single interpersonal and social rhythms therapy trial limited the confidence of the recommendation for this intervention.

Conclusions: Controlled trials are needed to replicate early outcome studies and guide treatment recommendations. Accumulated evidence of favourable psychosocial intervention outcomes supports, with variable confidence, their use as adjuncts to pharmacotherapy in the treatment of bipolar disorder.

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Key Words: bipolar, psychosocial, pharmacotherapy, psychoeducation, family therapy, group therapy, cognitive therapy, behavioural family management therapy, interpersonal therapy, social rhythm therapy

Bipolar disorder is often associated with severe social and occupational deficits that persist after the acute phase and during maintenance on pharmacotherapy (1-3). The majority of discharged bipolar patients experience functional impairment after discharge from hospital (4). These issues

reflect the impact of a number of problems relating to the disorder: acceptance of the illness by the patient and family, adherence to medication and other management, alcohol and substance abuse, and social risk factors. Financial and employment difficulties (5), self-esteem injury, divorce (6), and relationship dysfunction (5) are all losses the bipolar patient may have to face. Anticipated lack of fulfilment in future relationships or educational and occupational plans may also contribute to a sense of loss. Because bipolar disorder is a chronic illness with recurrences and relapses, denial, anger, ambivalence, and anxiety may develop as the patient and family adjust to the diagnosis (7). Denying or minimizing the vulnerability of relapse is a coping mechanism often adopted by those with the illness and their caregivers. Prodromal mood instability preceding the development of the disorder frequently predisposes the patient and family to conflict (8).

Maladaptive coping frequently involves ignoring recommended pharmacotherapy regimens, which results in illness exacerbation (9). In recent-onset manic patients, partial compliance rates with lithium have been reported to be as high as 70% (3), and noncompliance rates often reach 60% on this medication (10-12). Almost all compliant patients seriously

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consider discontinuing lithium at some stage, and if they do, they discontinue it abruptly (13). Patients receiving carbamazepine may have higher rates of adherence (14). The prediction of medication noncompliance is complicated by the contribution of numerous factors, including the nature of the patient–physician relationship (15), the patient’s understanding of the illness (16), younger age, male gender, recent onset of illness, previous history of poor medication adherence (7), and patient dislike of having “mood controlled” (10). Abrupt discontinuation of medication carries with it a high risk of relapse (17).

The frequency and the timing of illness episodes are probably affected by social environment stressors (18). Prior to illness recurrence, bipolar patients seem to experience more life events than controls without mental illness (19,20), and in a prospective study, the relative risk of recurrence was markedly elevated in those with high life stress scores (21). Several prospective studies have reported a positive correlation between high expressed emotion as a measure of family affective tone and poor outcome among bipolar patients (3,22).

Various psychotherapeutic approaches have been used with bipolar patients with putative mechanisms of change hypothesized to involve closer monitoring of affective symptomatology, earlier environmental modification following life events, enhanced compliance with pharmacotherapy, enhanced social support, improved familial adjustment, regulation of daily routines, and enhancement of coping strategies (23). The major psychotherapeutic modalities that may be helpful for some patients are psychoeducation, group therapy, cognitive–behavioural therapy, family therapy, and the 2 newer therapies of interpersonal and social rhythm therapy, and behavioural family management for bipolar disorder. The evidence supporting these interventions suffers from considerable methodological shortcomings. The recommendation to include a psychosocial dimension of care in selected patients is based on a strong clinical consensus that there is at least preliminary support for psychosocial interventions as an adjunct to pharmacotherapy. This situation may soon be improved as several methodologically rigorous trials using manualized psychotherapies as an augmentation to medication maintenance are now in progress (24). Although the recommended psychosocial modalities will be discussed separately, clinical practice often involves a synthesis of approaches adapted to the patient’s needs and preferences, as well as the therapist’s resources.

Psychoeducation

Psychoeducation has been an important component of many of the group and family interventions reported below, with evidence suggesting that this psychoeducational component was important in facilitating compliance with treatment

and favourable clinical outcome. Several controlled studies used the psychoeducational approach exclusively and reported enhanced compliance with lithium. A 6-session psychoeducation intervention, designed from a cognitive therapy perspective, improved lithium compliance and clinical outcome in a randomized controlled trial (25). In that study, patients receiving the intervention had a lithium noncompliance of 21% and significantly fewer hospital admissions than the control group, which received “treatment as usual” and had a lithium noncompliance rate of 57%. In another study, bipolar patients randomized to formal educational lectures on video tape and a written transcript significantly enhanced both their attitude toward and compliance with lithium as compared with the control group (26,27).

Psychoeducation may also be effective in improving patients’ partners’ knowledge about the illness, medication, and social support strategies for at least 6 to 18 months (28,29), but the effect of these interventions on major mood disorder relapse and retention of educational benefit is not known.

Overall, the quality of evidence for psychoeducation is “1,” that is, there is at least one randomized controlled trial, and the working group classification of recommendation was “A,” that is, good support for the intervention to be considered in clinical practice (please see p 67S for the definitions of the ratings).

Family Therapy

Early reports of eclectic-based family therapy in bipolar patients without systematic follow-up concluded that this intervention could enhance lithium compliance, reduce relapse, and improve family communication (30). Subsequently, several other more systematic family therapy studies have reported improvement in global outcome. A randomized controlled trial of 6 inpatient family intervention sessions in 169 inpatients assessed global function outcome 18 months after discharge. Of the 21 bipolar patients (14 female) in the treatment group, the female patients demonstrated immediate and long-term improvement in social, family, leisure, and occupational performance, as well as family attitude toward treatment, compared with the female controls and male bipolar patients, who demonstrated either no benefit or negative effect (31,32). Interpretation of this study is limited by unreported rates of illness relapse or rehospitalization and uncertainty about control of the medication regimen.

Overall, the quality of evidence for family therapy is “1,” that is, at least one randomized control trial, and the working group classification of recommendation was “B,” that is, fair support for the intervention to be considered in clinical practice.

Group Therapy

Several open, uncontrolled trials provide the most robust assessment of group therapy (plus lithium) in the treatment of bipolar patients. The overall frequency and length of hospitalization per year diminished (16.8 to 3.6 weeks of hospitalization per year), while rates of regular employment and lithium compliance significantly improved over 2 years among 13 lithium-responsive bipolar patients involved in interpersonal group therapy (33). A follow-up report on this trial noted a generally higher rate of lithium compliance in the group therapy patients. Delineating the psychotherapy-specific effects from the nonspecific effects of close follow-up, however, is not possible (34). Outpatient group therapy in bipolar patients (12 women, 10 men) focusing on interpersonal relationships has been reported to reduce hospital admissions over a 4-year period (35). The significance of these results is uncertain given a dropout rate of greater than 50%. The persistence of reduced hospitalization rates and improved psychosocial and economic functioning was perceived to have been a benefit of group therapy and has extended beyond a decade of the intervention (36). Group psychotherapy in combination with psychoeducation and case management may also be an effective approach in the male geriatric outpatient population (37).

Overall, the quality of evidence for group therapy was “2.3,” that is, very significant results from uncontrolled trials from more than one centre comparing results with and without interventions, and the working group classification of recommendation was “C,” that is, poor support for the intervention to be considered in clinical practice.

Cognitive Therapy

The cognitive-behavioural literature in the treatment of bipolar disorder is sparse. Cognitive therapy principles were employed in the psychoeducation intervention described earlier. Open reports have suggested a role for cognitive therapy in bipolar depression (23; Zaretsky 1997, unpublished observations). A cognitive-behavioural therapy and psychoeducation-oriented treatment manual was recently designed for the purpose of improving medication compliance and promoting patient awareness of maladaptive information processing in an attempt to prevent illness relapse (38).

Overall, the quality of evidence for cognitive therapy rated a “3,” that is, opinions of respected clinical authorities based on clinical experience, descriptive studies, or reports of expert committees, and the working group classification of recommendation was “B,” that is, fair support for the intervention to be considered in clinical practice. This recommendation was made despite the limited amount of evidence in view of the strong evidence for its efficacy in unipolar depression and

the likelihood that cognitive therapy does not pose significant risks of side effects or a switch into mania.

Behavioural Family Management Therapy

Adapted from a therapeutic approach used in schizophrenia treatment, this social skill- and education-based family therapy consists of a functional assessment of the family unit, psychoeducation, and training in communication and problem-solving skills (39,40). Twenty-one sessions over 9 months, with additional crisis intervention as required, comprises the treatment. A small (N = 9) uncontrolled trial of this therapy conducted in the setting of close medication monitoring revealed an 11% rate of mood disorder recurrence during a 9-month posthospital follow-up (39). Randomized controlled behavioural family management clinical trials are currently in progress (40).

Overall, the quality of evidence for behavioural family management therapy merits a “3,” that is, opinions of respected clinical authorities based on clinical experience, descriptive studies, or reports of expert committees, and the working group classification of recommendation was “C,” that is, poor support for the intervention to be considered in clinical practice.

Interpersonal and Social Rhythm Therapy

This therapeutic model attempts to unify the social and interpersonal models of affective disorder and the social rhythm stability hypothesis (24,41–43). This hypothesis proposes that mood regulation is in part a function of the regularity of daily activity and social stimulation patterns insofar as these patterns affect biologically based circadian rhythms. According to this model, derived primarily from observations in unipolar depressed patients, mood-disordered patients are particularly susceptible to social and circadian rhythm change (18,42). The goal of interpersonal and social rhythm therapy is to standardize a patient's daily rhythms and resolve key interpersonal problems that destabilize the mood state and/or daily rhythm (24,43). Preliminary evidence from a randomized clinical trial suggests that this therapy with medication is associated with improved regularity of daily rhythms over 52 weeks as compared with control group patients from the same outpatient medication clinic (44). The effect of this intervention on medication compliance, global functioning, and illness course, however, is uncertain at this stage.

Overall, the quality of evidence is “1,” that is, there is at least one randomized controlled trial of this intervention, but the working group classification of recommendation was only “C,” in other words, there was poor support for the intervention to be considered in clinical practice in view of the reliance on a single study without sufficient replication and without extensive published data on the clinical

outcomes. The working group recognized, however, that like cognitive therapy, interpersonal and social rhythm therapy presents low risks to patients who are also on other adequate treatment and that the normalizing of social and biological rhythms can be beneficial.

Quality of Psychosocial Evidence

Few studies employed outcome measures that had been demonstrated to be both valid and sufficiently reproducible. Only psychoeducation, cognitive therapy, and brief inpatient family therapy interventions with follow-up during the continuation phase of the illness are supported by some trials, one of which was a single published trial in which bipolar patients were randomized to either the intervention of interest or control treatment (25,27,32). Small sample sizes often increase the risk of a type II error. To date there are no published randomized controlled trials examining the efficacy of interpersonal, behavioural, cognitive, marital and family, group, or social rhythm therapies in bipolar disorder maintenance treatment.

Clinical Recommendations

Available research and clinical experience provide strong evidence to support the use of psychoeducation, regardless of the phase of the disorder, but particularly in the first few episodes. The best format for psychoeducation—individual, group, or family-based intervention—remains unclear; each type has some demonstrated efficacy. Maintaining a treatment alliance must remain as a principal objective throughout all phases, relying on supportive therapy principles when the patient is more acutely ill. During the manic phase, no formal psychotherapies have been demonstrated to be useful; instead, psychotherapeutic techniques such as alliance building, limit setting, supportive measures, reduction of stimuli, and behavioural techniques may be needed. During the depressed phase, cognitive-behavioural therapy should be considered for selected patients, particularly those with mild bipolar depression. Some evidence exists to support the use of interpersonal and social rhythm therapy interventions during the continuation and maintenance phases of bipolar treatment. Substantial evidence suggests a role for family therapy intervention in selected cases to reduce stigmatization and negative expressed emotion, which may provoke relapse. Patient utilization of support and advocacy groups, for example, the Canadian Mental Health Association and the National Depression and Manic Depression Association, may also be beneficial.

Clinical Implications

- Maintaining a treatment alliance must remain a principal objective throughout all phases, relying on supportive therapy principles when the patient is more acutely ill.
- During the manic phase, no formal psychotherapies have been demonstrated to be useful; instead, psychotherapeutic techniques such as alliance building, limit setting, supportive measures, reduction of stimuli, and behavioural techniques are potential strategies.
- During the depressed phase, cognitive-behavioural therapy or interpersonal and social rhythms therapy should be considered for selected patients.
- Substantial evidence suggests a role for family therapy intervention in selected cases to reduce stigmatization and negative expressed emotion, which may provoke relapse.
- Psychoeducation can be a valuable tool in promoting therapeutic alliance and a collaborative approach to effective treatment.

Limitations

- Review of literature is narrative and data are not quantitatively analyzed.
- Evidence available is initial, is of variable methodological qual-

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Résumé

Objectif : Résumer les résultats d'études et faire des recommandations de traitement à l'égard du recours aux interventions psychosociales d'appoint à la pharmacothérapie du trouble bipolaire.

Méthodes : Nous avons examiné les études sur le dénouement publiées depuis 1975 qui ont été repérées au moyen de recherches menées dans MEDLINE et PsychLIT.

Résultats : Les études disponibles sont préliminaires et leur rigueur méthodologique varie beaucoup. Les résultats sont plus solides à l'égard de l'efficacité de la psychopédagogie et de la thérapie familiale, qui sont particulièrement recommandées en tant qu'interventions. La thérapie de groupe, la thérapie cognitivo-comportementale et la thérapie de gestion familiale du comportement sont appuyées par des résultats moins concluants, et elles sont recommandées comme traitements de moindre intensité. L'accès à un seul essai thérapeutique sur les rythmes interpersonnels et sociaux, fait en sorte que la recommandation de cette intervention inspire peu confiance.

Conclusions : Les essais contrôlés sont nécessaires à la répétition d'études préliminaires sur le dénouement et à l'orientation des recommandations en matière de traitement. Les résultats accumulés à l'égard des dénouements favorables d'interventions psychosociales appuient, avec une confiance variable, le recours à celles-ci en appoint à la pharmacothérapie pour traiter le trouble bipolaire.