PSYCHOSOCIAL TREATMENT FOR BIPOLAR DISORDER

Noreen Reilly-Harrington, PhD

Introduction

Medication is the mainstay of treatment for bipolar disorder. However, no medication will be effective if patients do not take it, and the rates of medication compliance in bipolar disorder are very low. Johnson and McFarland[1] found that the modal length of compliance with a mood stabilizer was only 2 months. Keck and colleagues[2,3] found that 50% to 66% of patients with bipolar disorder exhibit poor compliance within the first 12 months of treatment. In addition, even with adequate medication compliance, high rates of relapse persist.

Psychosocial Treatment for Improved Outcomes in Bipolar Disorder

Adjunctive psychosocial treatments can help reduce relapse and provide patients as well as their families with tools to manage bipolar disorder more effectively. Several forms of intensive psychotherapy have shown promise for the treatment of bipolar disorder. In the Systematic Treatment Enhancement Program for Bipolar Disorder, Miklowitz and colleagues[4] compared three forms of intensive interventions: cognitive-behavioral therapy (CBT), interpersonal and social rhythm therapy, and family-focused treatment. These were compared to a brief, 3-session psychoeducational intervention known as collaborative care. A total of 293 depressed patients with bipolar type I or type II disorder were treated with protocol pharmacotherapy and were randomly assigned to either one of the three intensive interventions or the brief psychoeducational intervention.

The three intensive interventions provided up to 30 sessions of treatment over a 9-month period. The collaborative care intervention consisted of three sessions administered over a 6-week period. The authors found that patients who received one of the intensive interventions had a median time to recovery 110 days earlier than patients who had received the collaborative care conditions.[4] Patients who received one of the three intensive psychotherapies also had significantly higher year-end recovery rates, and are more than 1 to 1.5 times more likely to be clinically well during any study month. No statistically significant differences were found between the 3 intensive treatments.[4]

Cognitive-Behavioral Therapy

This article will focus primarily on CBT and include interventions that are useful for patients with bipolar disorder. CBT is based on the premise that thoughts, feelings, and behaviors are tightly interrelated (Slide 1). It is a present-oriented psychotherapy that is structured. When working with patients, treatment is directed toward solving current problems and helping to modify dysfunctional thinking and behavior. CBT was initially developed for unipolar depression in the 1960s, and a wealth of data support its efficacy in unipolar depression.[5]

CBT for bipolar disorder draws upon this well-tested approach to unipolar depression and incorporates creative strategies for coping with and preventing the manic phase of the illness. It is understood that the thinking of both depressed and manic patients contains cognitive or perceptual distortions. In the depressed phase, patients are often catastrophizing and thinking about worst-case scenarios. During the hypomanic phase, patients' thinking is often distorted in the opposite direction; patients may engage in hyperpositive thinking, such as "I can get away with anything." One of the goals of CBT is to help patients identify and modify these types of cognitive or perceptual distortions.

Life stress also affects the course of bipolar disorder. Thus, the clinician or psychiatrist engages in a great deal of problem solving with patients around life stressors. Medication compliance is also very important, and CBT is focused on challenging dysfunctional beliefs about medications as well as helping patients manage drug side effects, such as weight gain. It is important not only for patients but also families to become experts in bipolar disorder. Therefore, education and problem solving around managing and preventing episodes is key. Often, the patient's family is invited into several sessions geared to developing a treatment contract.

As mentioned previously in this supplement, bipolar disorder rarely occurs alone, and so CBT is often focused on treating comorbid anxiety that co-occurs with bipolar disorder. In addition, CBT has been empirically validated for conditions such as panic disorder,[6] obsessive-compulsive

SLIDE 1
What is CBT?

Thoughts → **Feelings** → **Behaviors**

Present-oriented psychotherapy

Structured

Active

Directed toward:
- Solving current problems
- Modifying dysfunctional thinking and behavior.

CBT=cognitive-behavioral therapy.

Dr. Reilly-Harrington is a clinical psychologist at Massachusetts General Hospital Bipolar Clinic and Research Program, director of training and assessments, National Institute of Mental Health Bipolar Trials Network, and instructor in psychology at Harvard Medical School, all in Boston.

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disorder,[7] and social anxiety.[8] Lastly, CBT involves behavioral techniques to help patients regulate their schedule to monitor their moods on a daily basis and to recognize the earliest warning signs of relapse.

Treating Mania

It is often difficult to utilize cognitive and behavioral strategies when a patient is acutely manic (Slide 2). Thus, recognizing early warning signs of hypomania and intervening early is essential. Patients with bipolar disorder may have idiosyncratic early warning signs of mania, which is why helping patients to identify their own personal warning signs of hypomania is very important. Impulsive hypomanic patients also often have a potential to engage in risky and dangerous behavior. In therapy, patients are encouraged to develop what is termed a "cabinet of advisors." This group would include trusted friends or family members with whom the patient can consult before making any kind of major decision. When noticing the earliest signs of hypomania, the clinician certainly should first explore medical solutions. This would include contacting the patient's psychiatrist and exploring medication or dose changes.

Additional rules to counteract impulsivity, such as giving car keys or credit cards to someone to hold, establishing rules about staying out late or giving out their phone number to strangers, avoiding alcohol and substance abuse, and avoiding confrontative situations are all worthwhile initiatives (Slide 3).[9] There are a number of other strategies useful for these patients that provide them with time to review decisions and curb impulsivity. One is called the "48 hours before acting rule," where the patient is encouraged to wait 2 days and get two full nights of sleep before making any kind of major decision, such as investing in real estate or quitting their job. Sometimes simply minimizing stimulations, spending more time sleeping, spending more time in a dark room, and engaging in relaxation strategies, can help to quiet the patient's earliest symptoms of hypomania.[9]

SLIDE 2
Strategies for Intervening With Hypomania

Explore medical solutions (eg, dosage or medication changes)

Rules to counteract impulsivity
- Give car keys or credit cards to someone to hold
- "Rules" about staying out late or giving out phone number
- Avoid alcohol and substance use

Avoid confrontative situations

SLIDE 3
Coping With Hypomanic Symptoms[9]

Two-person feedback rule

Minimize stimulation

Activity scheduling

48-hours-before-acting rule

Imagery about negative consequences

Relaxation techniques

Address patient's wish to stay manic

Creating a Treatment Contract

Bipolar disorder is difficult for the patient to cope with alone. As previously mentioned, the patient's support system should be invited to several of the patient's sessions. During these sessions, the clinician, patient's family, and patient can collaborate on the patient's "treatment contract." The treatment contract is a plan that the patient creates when they are euthymic, for periods of decompensation that may occur in the future. In this way, the patient and their family have an action plan to activate in case of future episodes. This involves a great deal of education about symptoms and coping mechanisms.[10]

Patients themselves have the opportunity to take part in the planning of their treatment plan and to exercise choice in control. Also, family members and the clinician become agents of the patient's plan—not people imposing restrictions on the patient (Slide 4).[10]

The first step in establishing a treatment contract is selecting a support team. In the beginning of treatment, the support team may only include the patient's therapist. However, over time, patients are encouraged to identify trusted friends or family members to include on the contract. The next step is establishing the early warning signs and symptoms of depression, and creating a plan for how their support system can help them when they are depressed. Following this step, patients establish the early warning signs of mania, and give specific instructions to their support system about ways that they can be helpful to them during a manic or hypomanic episode. Other modules can target comorbid conditions, such as substance abuse or gambling.[10]

Mood Charting

Daily mood charting is one of the best ways for patients to develop awareness about their illness.[11] This enables early and accurate identification of changes in mood, which is often very helpful in allowing for early intervention prior to severe episodes. The mood chart is also helpful in tracking medication doses and compliance with treatment. Patients track their hours slept and their sleep/wake time, and they make notes on psychosocial stressors, which may serve as triggers for relapse. For clinicians, a mood chart is helpful to have patients bring to each clinical visit as this provides their clinician with a snapshot of what has happened in between clinical visits.

Activity Scheduling

Typically, mood symptoms lead to changes in activity levels for patients with bipolar disorder. For example, patients

SLIDE 4
Treatment Contract: Rationale[10]

Patient plans while euthymic for periods of decompensation.

Patient and family have "action plan" to activate in case of future episodes.

Involves education about symptoms and coping mechanisms.

Patient has the chance to take part in the planning and exercise choice and control.

Family members and clinicians become agents of the plan, not people imposing restrictions on the patient.

are often less active when they are depressed, and are overactive when they are manic. To stabilize shifting patterns, patients are encouraged to keep their daily schedules as regular as possible.[12] As discussed, life stressors, such as loss of a job or birth of a child, can affect patients' schedules and influence their moods. Patients should stabilize their mood by regulating daily schedules of activity including their sleep/wake cycle, their meal times, and their work schedules. Of course, when patients are depressed, they should remember to schedule in positive events or activities.

Case Presentation

Casey is a 21-year-old college student in Boston who began presenting for therapy during her freshman year of college shortly after her first episode of bipolar disorder (Slide 5). One of the first steps in working with Casey was helping to educate her about bipolar disorder. She only had one episode and she did not want her symptoms to become chronic. Her accepting the illness and educating her about the chronic nature of bipolar disorder was very important. It was also important to empower her to realize that there were strategies that she could use to help prevent the likelihood of relapse.

Skills used for this patient included ways to remember medication doses, such as leaving her medication in places where she would see it, as well as behavioral techniques for setting her alarm clock. As a college student, activity scheduling was incredibly important, particularly during testing to prevent her from negative behaviors such as engaging in "all-nighters." Reducing the influences of drugs and alcohol and scheduling daily times to exercise were also important interventions for this patient.

She experienced mood fluctuations around the time of her menstrual cycle. Mood charting and helping her to identify these changes was important in giving her strategies to handle these changes that occurred each month. For Casey, her panic disorder was often more problematic than her mood episodes. Thus, using cognitive and behavioral tools to cope with the sense of panic, use of relaxation strategies, and then to decrease any agoraphobic avoidance was a very helpful strategy for this patient.

Engaging Casey's family was also an essential part of treatment. Her family needed education about the meaning of bipolar disorder and the need for medication. In meeting with her family, communication patterns were also discussed. In bipolar disorder, it is essential to reduce critical or hostile comments from patient's family, such as "You are lazy," or, "Why are not you trying hard enough?" and try to help to sensitize her family to what Casey was going through in terms of her bipolar disorder.

Although she does continue to have episodes from time to time, those episodes have become shorter and less severe. She has also been able to stay at the university is now in her senior year, with the tools for managing her illness more effectively.

SLIDE 5
Case Example: Casey, 21-year-old college student

- Psychoeducation/acceptance of illness
- Medication adherence – tools to remember doses
- Activity scheduling – no all-nighters, avoiding substances, daily exercise
- Mood charting – premenstrual mood fluctuations
- Treatment of comorbid panic disorder
- Reducing risky behaviors
- Improving family communication patterns

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