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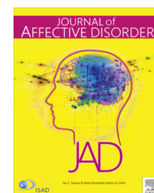

Special review article

Empirically supported psychosocial interventions for bipolar disorder: Current state of the research

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ABSTRACT

Objectives: Bipolar disorder requires psychiatric medications, but even guideline-concordant treatment fails to bring many patients to remission or keep them euthymic. To address this gap, researchers have developed adjunctive psychotherapies. The purpose of this paper is to critically review the evidence for the efficacy of manualized psychosocial interventions for bipolar disorder.
Methods: We conducted a search of the literature to examine recent (2007-present), randomized controlled studies of the following psychotherapy interventions for bipolar disorder: psychoeducation (PE), cognitive behavioral therapy (CBT), interpersonal and social rhythm therapy (IPSRT), dialectical behavior therapy (DBT), mindfulness-based cognitive therapy (MBCT), and family therapies such as family focused therapy (FFT).
Results: All of the psychotherapy interventions appear to be effective in reducing depressive symptoms. Psychoeducation and CBT are associated with increased time to mood episode relapse or recurrence. MBCT has demonstrated a particular effectiveness in improving depressive and anxiety symptoms. Online psychotherapy interventions, programs combining one or more psychotherapy interventions, and targeted interventions centering on particular symptoms have been the focus of recent, randomized controlled studies in bipolar disorder.
Conclusions: Psychotherapy interventions for the treatment of bipolar disorder have substantial evidence for efficacy. The next challenge will to disseminate these psychotherapies into the community.
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1. Introduction

Bipolar disorder is a chronic psychiatric condition characterized by periods of depression and mania or hypomania. In addition to

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mood instability, bipolar disorder is associated with significant functional impairment, lower quality of life, and higher rates of suicide compared to the general population (Kilbourne et al., 2004; Novick et al., 2010). Up to 50% of individuals with bipolar I disorder do not recover from severe manic episodes within one year, and only about 25% fully regain their previous level of functioning (Keck et al., 1998).

While psychotropic medications remain the foundation of treatment for bipolar disorder (Geddes and Miklowitz, 2013; Hirschfeld et al., 2002), pharmacotherapy alone leads a minority of patients to remission, and 40% of individuals typically experience an episode recurrence within one year (Gitlin et al., 1995). Furthermore, non-adherence to pharmacotherapy is common in bipolar disorder, increasing the probability of recurrence and associated negative consequences (Colom et al., 2005). Patients also often experience disruptive side effects associated with psychotropic medications, especially metabolic disturbance when taking second-generation antipsychotics (Cuerda et al., 2014). Thus, adjunctive psychosocial interventions are increasingly employed for bipolar disorder. Adjunct psychosocial interventions have been shown to improve outcomes in bipolar disorder because they teach patients strategies to manage their mood instability (Miklowitz, 2008; Swartz et al., 2012b). Evidence supporting the utility of psychotherapy to reduce the risk of relapse (as opposed to relieving acute affective episodes) in people with bipolar disorder has been particularly robust (Miklowitz, 2008).

Thus, this review examines the most recent studies of empirically based, manualized psychosocial interventions for bipolar disorder. In particular, we examined the following treatment modalities: psychoeducation (PE), cognitive behavioral therapy (CBT), interpersonal and social rhythm therapy (IPSRT), dialectical behavior therapy (DBT), mindfulness-based cognitive therapy (MBCT), and family therapies such as family-focused therapy (FFT). We also briefly discuss future areas of research to elucidate our understanding of evidence-based treatments for bipolar disorder. We briefly summarize the main interventions below.

PE is a psychosocial approach that views bipolar disorder as a medical condition that would most greatly be enhanced with education about the condition to empower patients to play a larger role in their treatment. PE for bipolar disorder is aimed at improving medication adherence and also includes strategies to enhance awareness of triggers and associated problem solving strategies. PE encourages patients to be active participants in their own treatment and is often delivered in a group format (Stafford and Colom, 2013). The focus of cognitive behavioral therapy (CBT) is to identify and modify dysfunctional thought patterns and behaviors. CBT also aims to help manage daily symptoms (e.g., reduce daily fluctuations in mood) to improve medication adherence and identify potential environmental stressors (Beck, 1970, 1979). Findings from prior clinical trials (for a review, see Sylvia et al. (2008)) also link CBT to higher social functioning, reduced mood fluctuations, and improved ability to cope with negative mood experiences (Lam et al., 2005, 2003).

Interpersonal and social rhythm therapy (IPSRT), one of the first psychosocial treatments created specifically for bipolar disorder (Frank, 2007), centers on the relationship between mood and circadian systems. Increasing the regularity of patients' daily routines (e.g., meal times and sleep wake cycles) is thought to strengthen their circadian systems thereby preventing the recurrence of mood episodes and resulting in euthymia (Frank et al., 2007). In addition to promoting stable daily routines, it also targets areas implicated in relapse such as medication non-adherence and interpersonal stress (Frank, 2007). Group-based IPSRT has been found to reduce functional impairment, improve depressive symptomatology, and enhance social rhythm stability in non-randomized clinical trials (Bouwkamp et al., 2013; Hoberg et al., 2013).

Dialectical behavior therapy (DBT) was originally designed for borderline personality disorder, as it targets emotional dysfunction, suicidality, and self-harm behaviors (Linehan, 1987). It has been found effective in reducing hospitalizations, enhancing treatment adherence, and improving overall social functioning in adults with borderline personality disorder (Mehlum et al., 2014). Given that bipolar disorder involves similar affective dysfunctions, recent clinical trials have explored the potential of DBT to be an effective psychosocial treatment for bipolar disorder (Goldstein et al., 2015). Mindfulness-based cognitive therapy (MBCT) aims to develop a non-judgmental awareness of one's distressing thoughts, feelings, and sensations by integrating mindfulness-based meditation practices with cognitive therapy. MBCT differs from CBT in that it encourages the individual to view negative thoughts as fleeting mental events rather than as facts (Ma and Teasdale, 2004; Teasdale et al., 2000).

2. Methods

PubMed and PsycInfo were used to search for the following terms paired with the term "bipolar disorder": psychoeducation (PubMed: $n=186$, PsycInfo: $n=1282$), cognitive therapy (PubMed: $n=701$, PsycInfo: $n=2680$), behavior therapy (Pubmed: $n=801$, PsycInfo: $n=2657$), social rhythms therapy (PubMed: $n=38$, PsycInfo: $n=4$), dialectical behavior therapy (Pubmed: $n=13$, PsycInfo: $n=4$), mindfulness cognitive therapy (Pubmed: $n=29$, PsycInfo: $n=33$), and family therapy (Pubmed: $n=466$, PsycInfo, $n=167$). We narrowed our search by reviewing only those studies published in English between 2007 and 2015. Studies before 2007 have already been reviewed (Sylvia et al., 2008). We examined studies that were randomized, controlled studies centered on bipolar disorder that incorporated one or more of the above named psychotherapies. Common reasons for exclusion included pilot trials, not having a comparison/control group, and focus of treatment being another disorder (e.g., comorbid substance use). These studies examined key outcomes in bipolar patients and incorporated validated symptoms scales to assess such outcomes. Scales included measures of depressive (e.g., Hamilton Rating Scale for Depression, Montgomery-Asberg Depression Rating Scale; Hamilton, 1960; Montgomery and Asberg, 1979) and manic (e.g., Young Mania Rating Scale; Young et al., 1978) symptoms, quality of life (World Health Organization Quality of Life Scale; The WHOQOL Group, 1998), and overall mood symptom burden (Longitudinal Interval Follow-up Evaluation; Keller et al., 1987), among other measures. Please refer to Table 1 for study-specific outcomes.

3. Results

For studies using treatment as usual (TAU) as their comparison group, it is defined standard psychiatric care or standard pharmacological treatment, unless otherwise noted (see Table 1 for more information about the comparison groups).

3.1. Psychoeducation (PE)

Studies reviewed are summarized in Table 1. Colom et al. (2009) randomly assigned 120 bipolar individuals to either 21 weeks of group PE or a non-structured group therapy (i.e., no special instructions given). Individuals randomly assigned to group PE received 21 sessions based upon a manual (Colom and Vieta, 2006) aimed at improving treatment adherence, insight into the bipolar illness, identification of prodromal symptoms, mood

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