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Psychosocial Treatments in Bipolar Disorder

by Nancy A. Huxley, Ph.D., and Ross J. Baldessarini, M.D.

Bipolar disorder is a common and often disabling major mental illness. It accounts for a high proportion of idiopathic psychotic illnesses, and, together with psychotic disorders, the combined lifetime prevalence may exceed 3% of the general population. Their treatment has been revolutionized by modern pharmacotherapies in the past half-century (Baldessarini and Tarazi, in press). However, these treatments have strongly encouraged contemporary psychiatry to explain these complex disorders biologically and to treat them with maximum apparent cost efficiency (Baldessarini, 2000). An associated trend is to undervalue and under-utilize psychosocial interventions in the treatment and prevention of these disorders, despite growing evidence that such methods can significantly augment the effects of pharmacotherapy alone (Huxley et al., 2000a, 2000b, in press).

Antipsychotic, mood-stabilizing and antidepressant drugs are very effective in managing many prominent and distressing symptoms of these illnesses, but as many as one-third of medically treated patients diagnosed with schizophrenia or bipolar disorder relapse within two years of an index hospitalization (Hogarty, 1984; Baldessarini et al., 2000). Moreover, the limited but potentially modifiable tolerability of most psychotropic agents limits their long-term acceptance and thus their actual effectiveness (Baldessarini, 1994). The fact that medications alone may not be able to optimize coping abilities or address the personal, social and functional complications of having a major mental disorders indicates the potential importance of adjunctive psychosocial treatments in a sound, comprehensive program of clinical care.

Many clinicians are well aware of the shortcomings of cost- and time-limited treatments for recurrent or chronic major mental disorders, and they have sought alternatives to enhance the effectiveness of medication. An encouraging and growing body of evidence supports the implicit thesis that, when combined with appropriate pharmacotherapy, well-designed psychosocial interventions can enhance clinical outcomes cost-effectively. Benefits are particularly likely for outcomes based on measures of functioning or satisfaction and sparing of rehospitalization, as well as on symptom-oriented assessments. Psychosocial treatments that are widely employed and increasingly investigated for bipolar disorder patients include individual, group and family therapies.

There are many specific identifiable benefits of psychosocial approaches. These include:

1. support and encouragement arising from interactions with others having shared experiences;
2. education of patients and their families to encourage collaboration in treatment;
3. more effective identification and management of adverse effects of medication that tend to limit its acceptance;
4. increased compliance with recommended medication;

5. enhanced detection of early signs of impending illness, and improved skills aimed at minimizing stressors contributing to recurrence risk; and
6. improved interpersonal and family relationships affected by the illness, and promotion of higher functional achievements.

Psychosocial Treatments in Bipolar Disorder

Psychosocial treatments for bipolar disorder have been much slower to evolve than for major depression, and less than half as many research studies have been reported concerning bipolar disorder as for schizophrenia (Huxley et al., 2000a, 2000b). This underdevelopment may reflect several factors: a former tendency to lump psychotic bipolar illnesses with schizophrenia; a tacit assumption that unipolar and bipolar depression can be treated similarly; or bias against the feasibility of psychotherapy in patients with bipolar disorder, arising mainly from encounters with inadequately medicated patients or in diagnostically heterogeneous groups (Yalom, 1985). Stereotyped characterizations of patients with bipolar disorder emphasize their prominent denial of illness and other hypomanic tendencies, as well as a hostile, impulsive and erratic interpersonal style and poor judgment-all making them unattractive candidates for insight-oriented, cognitive or interpersonal treatments as individuals or in groups (Fromm-Reichman, 1949; Winther, 1994).

There is a striking lack of research on individual psychotherapy for bipolar disorder. Indeed, only five studies have been published on the topic. As in unipolar major depression, most studies have involved cognitive-behavioral methods, with rare investigations of interpersonal methods. Such individual interventions have been associated with increased medication compliance, fewer manic episodes and improvements in depressive symptoms as well as in social and vocational functioning (Huxley et al., 2000b, in press). Despite the dearth of research support in bipolar disorder, individual therapies of various types are widely employed in clinical practice.

Group therapies have been somewhat more extensively evaluated in over a dozen studies, although only three included control or comparison conditions (Huxley et al., 2000b). The approaches employed were similar to those used in the treatment of unipolar depressive patients. Most studies involved a combination of interpersonal and psychoeducational approaches, and there is at least one study of cognitive-behavioral treatment (Palmer et al., 1995). Although occasional patient-subjects were disruptive or uninsightful, such problems were almost always manageable. Benefits associated with group interventions included reduced time in hospital, increased knowledge of the illness and of individual response patterns, enhanced medication compliance, and improved social and vocational functioning. Most of the more than a dozen studies of family therapies for bipolar disorder involve interpersonal and psychoeducational approaches resembling techniques developed for schizophrenia. There are no studies comparing or combining group and family methods, or either of these with individual psychotherapy, and formal studies of formal rehabilitation efforts and social skills training remain rare in bipolar disorder.

Conclusion

This brief overview of recent research and trends in psychosocial interventions for comprehensive treatment of bipolar disorder patients supports several impressions. First, such methods are feasible, appear to be effective and seem to justify their modest direct costs, particularly by decreasing hospitalization and increasing functioning and ability to work. However, the number and scientific quality of relevant studies remain limited, particularly for patients with bipolar disorder and their families. Additional research would be very helpful in clarifying many remaining questions concerning indications and long-term effects of specific psychosocial and rehabilitative interventions, in quantifying costs and benefits of particular methods or combinations, and in suggesting

rational bases for selecting particular approaches for individual patients.

Such information is particularly important for efforts to balance current market forces tending to overvalue the considerable-but limited-benefits of medication alone and to redress a growing imbalance between biomedical and psychosocial approaches in contemporary psychiatric therapeutics. Finally, it seems particularly ironic that psychosocial treatments for bipolar disorder-an illness with potentially devastating disability and premature mortality, but striking potential for treatment responsiveness-have been severely neglected in comparison to major depressive and even chronic psychotic disorders.

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