Bipolar disorder in adults: Psychoeducation and other adjunctive maintenance psychotherapies

AUTHORS: Eduard Vieta, MD, PhD, Francesc Colom, PhD, PsyD, MSc
SECTION EDITOR: Paul Keck, MD
DEPUTY EDITOR: David Solomon, MD

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INTRODUCTION

Psychoeducation includes helping patients accept their condition, explaining the clinical features and treatment options, and encouraging them to anticipate problems and be proactive in managing the illness. Educating bipolar patients about their illness can improve adherence to treatment and the course of illness. The word “doctor” is derived from the Latin verb *docere*, which means to teach.

This topic reviews psychoeducation and other adjunctive maintenance psychotherapies for preventing or delaying recurrent bipolar mood episodes. Choosing maintenance treatment (including pharmacotherapy) for bipolar disorder is discussed separately. (See "Bipolar disorder in adults: Choosing maintenance treatment".)

DEFINITION OF BIPOLAR DISORDER

Bipolar disorder is a mood disorder that is characterized by episodes of mania (table 1), hypomania (table 2), and major depression (table 3) [1]. The subtypes of bipolar disorder include bipolar I and bipolar II. Patients with bipolar I disorder experience manic episodes, and nearly always experience hypomanic and major depressive episodes. Bipolar II disorder is marked by at least one hypomanic episode, at least one major depressive episode, and the absence of manic episodes. Additional information about the clinical features and diagnosis of

bipolar disorder is discussed separately. (See "Bipolar disorder in adults: Clinical features" and "Bipolar disorder in adults: Assessment and diagnosis", section on 'Diagnosis'.)

OVERVIEW

Psychotherapies that are used as adjunctive maintenance treatment for bipolar disorder include [2-4]:

- Group and individual psychoeducation
- Detecting early warning signs (prodromal symptoms)
- Family therapy

These psychotherapies are time limited, structured, and typically administered according to manuals [5-7]. In addition, adjunctive psychotherapy is typically administered to euthymic patients during maintenance treatment [8]. Psychoeducation is a core element of adjunctive cognitive-behavioral therapy, family therapy, and interpersonal social rhythm therapy [2].

Evidence supporting the use of adjunctive psychotherapy for maintenance treatment of patients with bipolar disorder includes randomized trials [2,3]. As an example, a meta-analysis of eight trials compared adjunctive psychotherapy (eg, psychoeducation or cognitive-behavioral therapy) with treatment as usual in 532 patients, and found that psychotherapy reduced the risk of relapse (relative risk 0.7, 95% CI 0.6-0.9) [9,10].

Although adjunctive psychoeducation for bipolar disorder can be administered in an individual format (one therapist with one patient) [11,12], we generally utilize a group format. Group psychoeducation has been studied more often than individual psychoeducation, and multiple randomized trials indicate that adding group psychoeducation to pharmacotherapy for maintenance treatment of bipolar disorder is beneficial (see 'Evidence of efficacy' below). By contrast, a meta-analysis of three randomized trials (n = 252) compared adjunctive individual psychoeducation with usual care and found that relapse was comparable for the two groups (relative risk 0.81, 95% CI 0.64-1.02) [9,10,13].

Cognitive-behavioral therapy (CBT) is not a standard psychotherapy for preventing or delaying recurrent bipolar mood episodes; the benefit of adjunctive CBT is not clear due to conflicting results across randomized trials. (See 'Cognitive-behavioral therapy' below.)

Psychotherapies administered through the internet have been developed as add-on maintenance treatments for bipolar disorder (see 'Electronic resources' below); however, we generally do not use this approach. Rather, we typically prescribe face-to-face psychotherapy.

GROUP PSYCHOEDUCATION

Group psychoeducation for bipolar disorder is a simple intervention that is relatively easy to implement in most clinical settings [14]. The therapy does not have a highly developed theoretical background and is thus readily comprehended by most patients, does not require complex or long training for clinicians, and targets the limited specific goals of empowering patients through knowledge to care for themselves and avoid recurrent mood episodes. A variety of formats have been studied, including groups that consist only of patients with bipolar disorder, as well as groups that include both patients and caregivers. Use of group psychoeducation is consistent with multiple treatment guidelines [15-18].

Evidence of efficacy — Multiple randomized trials indicate that adjunctive group psychoeducation can delay or prevent recurrent bipolar mood episodes and hospitalizations in patients receiving pharmacotherapy, and that the benefits persist over time:

- In a meta-analysis of five randomized trials (367 remitted patients) that compared group psychoeducation with a control condition, relapse was less likely with adjunctive psychoeducation than the control condition (odds ratio 0.4, 95% CI 0.2-0.6) [19].

- In a meta-analysis of two randomized trials (166 remitted patients) that compared group psychoeducation with nonspecific support (which controlled for attention), relapse occurred less often with group psychoeducation (relative risk 0.8, 95% CI 0.6-0.9) [9,10].

  The largest study was a 21-week trial that compared group psychoeducation with a nonspecific support group as add-on treatment in bipolar patients who were euthymic for at least six months (n = 120) [20]. Both groups met weekly for 90 minutes. Patients were followed for up to two years after treatment, during which relapse occurred in fewer patients who received psychoeducation than nonspecific support (67 versus 92 percent). Follow-up assessments for up to five years after treatment found that the average number of recurrences per patient was lower in the group that received psychoeducation rather than nonspecific support (four versus eight) [21]. In addition, psychoeducation led to fewer hospitalizations per patient. Subgroup analyses in patients with bipolar II disorder (n = 20) [22] and in patients with comorbid personality disorders (n = 37) [23] also found that psychoeducation was superior to nonspecific support.

Subsequently, a relatively large study compared group psychoeducation with an active comparator and found no advantage for patients receiving group psychoeducation. A 21-week trial randomly assigned patients with bipolar disorder who were euthymic for at least four weeks (n = 304) to either group psychoeducation plus pharmacotherapy or unstructured peer

support plus pharmacotherapy; both groups met weekly for two hours [24]. Patients were followed for up to 96 weeks after study entry, during which the rate of relapse was comparable for adjunctive group psychoeducation and unstructured peer support (58 and 65 percent of patients). However, prespecified analyses that examined number of prior mood episodes as a moderator found that among patients with relatively few prior episodes (one to seven), time to relapse was longer with group psychoeducation than unstructured peer support (hazard ratio 3.6, 95% 1.5-8.3), suggesting that group psychoeducation may be more effective early in the course of illness [24,25]. In addition, the results of this trial and the one described immediately above suggest that group psychoeducation may be better suited for patients who have been euthymic for a longer period of time (eg, six months rather one month).

Group psychoeducation that involves only caregivers of bipolar patients can also reduce recurrences. A randomized trial compared group psychoeducation with a control condition in euthymic bipolar patients (n = 113) treated with pharmacotherapy, who were living with a caregiver [26]. Caregivers in the experimental group attended 12 weekly group psychoeducation sessions, each lasting 90 minutes; patients did not attend the groups. The control condition provided no specific intervention. During the one-year follow-up, recurrent mood episodes occurred in fewer patients in the experimental group than the control group (42 versus 66 percent).

Health care expenses also appear to decline for patients treated with group psychoeducation, commensurate with reductions in recurrent mood episodes and hospitalizations [27].

Group psychoeducation also maintains and improves adherence to medications. (See "Bipolar disorder in adults: Managing poor adherence to maintenance pharmacotherapy", section on 'Group psychoeducation'.)

General principles — Bipolar disorder is a chronic condition and patients who do not learn to cope with it are at risk of feeling incapable of leading their own lives. Patients may thus have a predominantly painful life experience of learned helplessness (“No matter what I do, I will relapse” or “I will never get a job or get married”) that limits their functioning and quality of life.

Psychoeducation attempts to increase patient comprehension of the disorder, alleviate stigma and guilt, and prevent learned helplessness. The goal is to replace denial of the illness with awareness, guilt with responsibility, and helplessness with proactive care [14]. Patients learn that psychiatry already understands situations that may cause shame and isolation. Through psychoeducation, patients “know that we know,” which may improve the therapeutic relationship.

Patients are encouraged to adopt a proactive attitude in dealing with bipolar disorder, through acknowledging the need for proper training. It is not necessarily true that “patients are experts in their own condition”; although patients live with the condition, they nevertheless require certain types of knowledge they may lack.

However, patient education goes beyond information. Although knowledge about the disorder is a key element of psychoeducation, merely transmitting information may have little therapeutic effect [28]. Rather, psychoeducation is an information-based behavioral training program aimed at assisting patients to adjust their lifestyle to cope with bipolar disorder and improve outcomes [29]. Patients are empowered with tools (eg, enhanced treatment adherence and early detection of relapse) that allow them to be more active in their treatment and self-manage the illness.

We encourage clinicians to provide group psychoeducation early in the course of illness. In a randomized trial that found group psychoeducation was superior to a nonspecific support group in delaying recurrence of bipolar mood episodes [20], a subgroup analysis found that the benefit occurred in patients with a lifetime history of six or fewer mood episodes [30]. Among patients with seven or more episodes, time to recurrence was comparable for the two groups.

Group sessions are intended to be interactive and include exercises and patient-patient interactions. We encourage debate on any topic.

Medical model — Group psychoeducation is based upon the medical model, which views bipolar disorder as a biological and chronic clinical syndrome, distinct from the patient’s personality. The explanation of the diagnosis should liken bipolar disorder to general medical illnesses ("It’s no different than asthma, diabetes, or hypertension"). In addition, therapists should stress that [31]:

- The patient probably has an inherited vulnerability to bipolar disorder
- It is not the patient’s fault for developing the disorder (“just like it is not someone's fault for developing asthma”)
- Bipolar disorder does not represent a character flaw

Clinical setting — In one bipolar specialty outpatient clinic that has improved outcomes by administering group psychoeducation, notable features of the clinic include the following [14,20]:

- Open door policy – The clinic encourages patients to “drop in” whenever they detect early signs of recurrent mood episode, rather than waiting until they are moderately or severely

ill.

- Multidisciplinary treatment team – The team approach enables the clinic to always make someone available for patients, and the different types of clinicians (eg, psychiatrist, psychologist, and nurse) on the team provide a broad range of expertise.

- Therapeutic relationship built upon collaboration between patients and clinicians – Patients are encouraged to be proactive in their well-being rather than passively relying upon the authority of clinicians.

Mechanism of action — The mechanism of action for group psychoeducation is not known. The group format for psychoeducation may facilitate peer group learning, provide mutual support and acceptance, reinforce useful coping strategies and positive behaviors, reduce stigma, and widen the participants' social network [26,29]. Although the intervention improves treatment adherence, psychoeducation improves outcomes even in patients who are fully compliant [32]. (See 'Evidence of efficacy' above.)

Administering treatment — The following issues are relevant to organizing a psychoeducation group [5,29]:

- **Therapists** – Therapists should have experience treating bipolar patients and leading therapy groups, and training in social skills and bipolar group psychoeducation. It is preferable for the group to be led by two therapists rather than one. The role of therapist can be served by psychiatrists, psychologists, psychiatric nurses, or social workers.

- **Patients** – It is preferable to enroll euthymic patients [20,33], particularly patients who have been euthymic for relatively longer periods of time (eg, six months rather one month) [24,25]. However, it is acceptable to include patients who are mildly ill and reasonably stable [11,34]. In addition, group psychoeducation may be better suited for patients with relatively few prior mood episodes (eg, one to seven), as well as patients with less comorbidity (eg, anxiety disorder or substance use disorder) [11,24,25]. It is also preferable to balance groups with regard to gender. If possible, patient ages should be homogeneous enough such that members feel they belong and can model behavior for one another, but heterogeneous enough to allow patients to learn from each other. It is also desirable to balance bipolar subtypes, because patients with bipolar II disorder may be less likely to adhere to the group program due to discomfort with several issues relevant to patients with bipolar I disorder (eg, forced hospitalization or psychosis). This discomfort may lead to denial and disengagement.

- **Closed group structure** – Psychoeducation groups are closed, meaning that after the first group session, new members are not allowed to join.

- **Size** – The optimal size of a psychoeducation group is between 8 and 12 patients. Although it is possible to work with fewer than eight patients, this can lead to insufficient patient contributions. Working with more than 12 patients interferes with group processes and may result in poor adherence to the group program. Dropout rates are about 25 percent [20,35], so it may be useful to start the group with approximately 15 patients, which ends up being reduced to 10 to 12 patients after the first several sessions.

- **Number and structure of sessions** – The number of sessions provided in studies of group psychoeducation programs has varied from 6 to 21 [20,35,36]. Sessions last approximately 90 minutes. In one program, the therapists started each session with a 30 to 40 minute presentation on a topic (eg, course of illness), after which patients completed an exercise related to the topic (eg, drawing a life chart depicting their course) [20,32].

Content — The main topics covered in group psychoeducation include:

- Illness awareness
- Symptoms
- Medication options and adherence
- Identifying prodromal signs of recurrent mood episodes
- Avoiding substance abuse
- Regulating habits

Illness awareness — Many bipolar patients have difficulty accepting the illness and engage in denial, which is probably related to nonadherence with treatment. Lack of insight may be due neuropsychological impairment, social stigma, and myths surrounding bipolar disorder (and psychiatric conditions in general).

We suggest addressing illness awareness in the first session, as it introduces concepts that are necessary in later sessions. Patients generally accept the medical model of bipolar disorder quickly (see 'Medical model' above), which may help them cope with stigma and guilt, enhance acceptance of the illness, and ultimately improve treatment adherence. The session on illness awareness is usually less structured to provide the therapists time to learn about patients' illness models and prejudices about the origin and nature of bipolar disorder [29]. Therapists can use this information to help patients engage in the intervention and cope with guilt and barriers to effective illness management.

Symptoms — Symptoms of hypomania (table 2), mania (table 1), and major depression (table 3), are discussed, as well as mood episodes with mixed features or psychotic features. (See "Bipolar disorder in adults: Assessment and diagnosis", section on 'Mood episodes'.)

Medication options and adherence — Promoting adherence with pharmacotherapy is one of the main components of psychological interventions in bipolar disorders. The efficacy of group psychoeducation for maintaining and improving adherence to medications is discussed separately. (See "Bipolar disorder in adults: Managing poor adherence to maintenance pharmacotherapy", section on 'Group psychoeducation'.)

Group psychoeducation regarding pharmacotherapy includes the following points [20,29]:

- Pharmacologic treatment is individualized and depends upon:
  - Efficacy data
  - Symptoms
  - Potential side effects
  - Patient and family history of response to medications
- Types of medications used for bipolar disorder:
  - Lithium
  - Anticonvulsants
  - First and second generation antipsychotics
  - Antidepressants
  - Benzodiazepines
- Brand names of medications and the difference between the brand name and generic name.
- Purpose of each medication; one drug may have more than one purpose.
- Appropriate administration of medication (eg, dose, when to take it, and what to do if a dose is forgotten).
- Common side effects of medications.
- Techniques to manage side effects (eg, chewing sugar free gum for dry mouth).
- Importance of monitoring serum concentrations of lithium, valproate, and carbamazepine, as well as other laboratory parameters (eg, renal and thyroid function when using lithium, liver function tests when using valproate, complete blood count when

using carbamazepine, and fasting plasma glucose and fasting lipid profile for second generation antipsychotics).

- Identifying the signs of severe toxicity with lithium and other drugs.
- Drug-drug and drug-food interactions.

Specific interactions between medications may be determined using the Lexicomp drug interactions tool (Lexi-Interact Online) included in UpToDate.

It is useful to encourage group members to discuss their beliefs, fears, and prejudices regarding medication for psychiatric diseases. Patients often have erroneous information about their medications (eg, "Lithium will destroy my kidneys") or the need for ongoing maintenance treatment (eg, "I haven't had an episode for months and don't need the medications"). One common fear is the risk of becoming dependent upon psychopharmacologic agents; therapists should state that psychotropic drugs for bipolar disorder are not addictive, except for benzodiazepines if improperly used. Therapists should also explicitly state that psychotropic medications do not "brainwash" or cause "idiocy" (both fears are frequently expressed by patients), and that most medications are neither sedatives simply intended to keep patients quiet, nor stimulants that replace the will of patients who take them.

Another issue is the social stigma associated with psychotropic drugs. In many cases the patient's social group or family do not understand the need to take medication and may say things such as "You are going to become stupid from so much medication," "If you try harder you wouldn't need so many pills," or "This medication is drugging you; you look like a zombie." We typically advise patients to speak about their need for treatment with emphasis upon the biological aspects of bipolar disorder. In addition, we ask patients, "If you had asthma or diabetes, would you be ashamed of using inhalers or insulin?"

Other issues to address are the teratogenic and the postnatal effects of pharmacotherapy, which are discussed separately.

- (See "Antenatal exposure to selective serotonin reuptake inhibitors (SSRIs) and serotonin-norepinephrine reuptake inhibitors (SNRIs): Neonatal outcomes" and "Teratogenicity, pregnancy complications, and postnatal risks of antipsychotics, benzodiazepines, lithium, and electroconvulsive therapy".)
- (See "Antenatal use of antidepressants and the potential risk of teratogenicity and adverse pregnancy outcomes: Selective serotonin reuptake inhibitors".)
- (See "Antenatal exposure to selective serotonin reuptake inhibitors (SSRIs) and serotonin-norepinephrine reuptake inhibitors (SNRIs): Neonatal outcomes" and "Teratogenicity,

pregnancy complications, and postnatal risks of antipsychotics, benzodiazepines, lithium, and electroconvulsive therapy".)

Detecting prodromal signs — Teaching patients to detect and manage prodromal (early warning) signs of a recurrent mood episode is a central element of psychoeducation. Patients construct one list of symptoms that herald oncoming hypomania/mania and a separate list for oncoming depression. An early warning sign should be a specific behavior, operative, different from the usual behavior, subtle, easy to recognize, and well known to the patient. Each list consists of approximately 10 items. The process is based upon the general principle that early prodromal symptoms are idiosyncratic to each patient [37]. In addition, these lists should be more sensitive than specific, and may thus generate false alarms (false positives).

Patients are asked to check these lists daily and implement an emergency plan if a few (eg, three or more) early warning signs are present. The emergency plan includes contacting clinicians, and it is useful for patients to have contact telephone numbers on hand.

In addition, patients can also be taught to use preventative behavioral and cognitive techniques when warning signs occur [5,29]. For prodromal signs of mania or hypomania, it may be helpful for patients to limit their activities and avoid stimulating substances. Suggested responses to prodromal signs of depression include exercising, avoiding daytime sleep, and maintaining one's usual level of activity despite feeling lethargic. Negative, maladaptive thoughts that occur as a prodrome to depression (eg, "I'm no good" or "It's my fault that the project failed") can be ameliorated by questioning their validity, examining the evidence for them, and discussing alternative, rational explanations for the situation that prompted the dysfunctional thoughts.

Additional information about detecting prodromal signs is discussed elsewhere in this topic. (See 'Detecting early warning signs' below.)

Lifestyle regularity — Regular habits are important in bipolar disorder and constitute one of the foundational ingredients of interpersonal and social rhythm therapy. (See 'Interpersonal and social rhythm therapy' below.) Psychoeducation encourages patients towards healthy habits, particularly with regard to sleeping habits and social rhythms; sleeping and social rhythm disruptions may have mood-destabilizing effects. The general advice is as follows [29]:

- **Sleeping habits** – Sleep between seven to nine hours each night, arise at the same time each day, avoid daytime sleep, and use sleep as an aid to deal with oncoming mood episodes that are foreshadowed by prodromal signs. It may be possible to manage incipient depression by reducing sleep a few hours (eg, one to three), and incipient hypomania or mania by increasing the number of sleep hours by a few hours.

- **Circadian rhythm** – Patients are informed about the importance of regular schedules and consistent structuring of activities, and the need to balance schedules that maintain euthymia with schedules that favor social adjustment and quality of life. Many bipolar patients organize their time erratically. Although techniques such as recording activities may be useful, they are reserved for individual (one therapist with one patient) interventions because there is usually not enough time in a psychoeducation group to implement such interventions.

Other topics — Group psychoeducation for bipolar disorder may also address [20,29,38,39]:

- Factors and stressors that trigger mood episodes.
- Course of illness.
- Avoiding substance abuse – Patients with bipolar disorder as well as a moderate to severe substance use disorder may require specific programs that address both disorders. Substance abuse can also be an early warning sign of relapse. (See 'Detecting prodromal signs' above.)
- Pregnancy and heritability – (See "Bipolar disorder in women: Contraception and preconception assessment and counseling".)
- Alternative therapies – Bipolar patients often seek ineffective alternative therapies for bipolar disorder.
- Stress management.
- Problem solving – Patients identify and define their problems, and for each problem, consider the barriers to its resolution, set an achievable goal, list and evaluate the advantages and disadvantages for all available solutions (brainstorming), choose one option, develop an action plan and implement it, and evaluate the outcome.
- Stigma of mental illness.

DETECTING EARLY WARNING SIGNS

Teaching patients to recognize and manage early (prodromal) signs and symptoms of recurrent mood episodes may help prevent full blown recurrences. Detecting early warning signs is one element of group psychoeducation, and is often part of other psychotherapies such as cognitive-behavioral therapy and family therapy. A meta-analysis of six randomized trials (n =

690 bipolar patients) compared interventions that included identifying early warning signs with usual care, and found that time to recurrence was longer with detecting early warning signs (hazard ratio 1.8, 95% CI 1.2-2.6) [40].

In addition, learning to recognize early warning signs can be used on its own without the additional elements of other psychotherapies. Evidence for using early warning signs alone includes a randomized trial that tested an intervention in which bipolar patients were trained to identify manic and depressive prodromes and seek early treatment; the intervention was administered individually over 7 to 12 sessions, each lasting one hour [37]. Patients (n = 69) were assigned to the intervention plus usual care or usual care alone, and assessments were conducted 18 months after randomization. Time to a manic relapse was longer in patients who received the intervention, whereas time to depressive relapses was comparable. In addition, social and occupational functioning were each more improved in patients who received the intervention.

Additional information about detecting early signs is discussed elsewhere in this topic. (See 'Detecting prodromal signs' above.)

COGNITIVE-BEHAVIORAL THERAPY

The benefit of adjunctive cognitive-behavioral therapy (CBT) in preventing or delaying recurrent bipolar mood episodes is not clear due to conflicting results across studies [2,34]. However, CBT appears to be useful for improving adherence to treatment, which is discussed separately. (See "Bipolar disorder in adults: Managing poor adherence to maintenance pharmacotherapy".)

CBT combines cognitive therapy and behavioral therapy, which train patients to recognize and change harmful thought patterns and behaviors [3]. Cognitive therapy attempts to modify automatic dysfunctional thoughts, beliefs, and attitudes (eg, “I’m no good”); behavioral therapy focuses upon modifying problematic behavioral responses to environmental stimuli or dysfunctional thoughts through techniques such as stimulus control and exposure with response prevention. In addition, CBT may also include educating patients about bipolar disorder and teaching coping skills for psychosocial stressors. CBT for bipolar disorder resembles other forms of CBT that are used to treat disorders such as unipolar major depression, anxiety disorders, and bulimia nervosa.

Evidence that suggests adjunctive CBT can prevent recurrent bipolar mood episodes includes the following [41]:

- A meta-analysis of three randomized trials (n = 150 remitted patients) compared CBT plus standard treatment with standard treatment alone; relapse was less likely with adjunctive CBT (odds ratio 0.2, 95% CI 0.1-0.5) [42].

- A meta-analysis of four randomized trials (n = 437 patients) that compared CBT with control conditions found that the probability of relapse was reduced with CBT (odds ratio 0.5, 95% CI 0.4-0.8) [33].

- Another meta-analysis of four randomized trials (n = 252 patients) that compared CBT with usual care found that CBT reduced the risk of relapse (relative risk 0.7, 95% CI 0.5-0.9) [9,10,13,43].

However, other studies have found that adjunctive CBT did not help bipolar patients avoid recurrences [13]:

- A meta-analysis of four randomized trials (n = 487 patients) that compared CBT plus treatment as usual with treatment as usual alone found that relapse in the two groups was comparable [44].

- A meta-analysis of five randomized trials (sample size not provided) that compared CBT plus standard care with standard care alone found a small clinical benefit that was not statistically significant [45].

- A subsequent 22-week randomized trial compared CBT plus usual care with usual care alone in 47 remitted bipolar patients; all patients were treated in a group therapy format and were followed for up to two years after study treatment [46]. Time to recurrence was comparable for the two groups.

In addition, other randomized trials that compared CBT with active control conditions for preventing relapses in remitted bipolar patients found that CBT provided no advantage and may be less efficient:

- One trial (n = 204) compared CBT plus pharmacotherapy with psychoeducation plus pharmacotherapy [36]. CBT was administered individually (one therapist and one patient) over 20 sessions, with each session lasting 50 minutes. By contrast, psychoeducation was administered in six sessions in a group format, with each session lasting 90 minutes. Recurrence of mood episodes was comparable for the two groups; further, administering group psychoeducation requires less training and skill than is needed for CBT [14].

- A nine-month trial (n = 76) compared CBT with supportive therapy; both treatments were added onto pharmacotherapy and administered individually over 20 sessions of 60

minutes duration [47]. During posttreatment follow-up lasting 24 months, relapse rates were comparable for CBT and supportive therapy (68 and 61 percent).

Mindfulness-based cognitive therapy, which combines cognitive therapy with mindfulness meditation, also does not appear to be efficacious as prophylaxis. A randomized trial compared mindfulness-based cognitive therapy (eight weekly group sessions, each lasting about two hours) plus pharmacotherapy with pharmacotherapy alone in 95 remitted bipolar patients; during the 12-month posttreatment follow-up, time to relapse was comparable for the two groups [48]. Additional information about mindfulness-based cognitive therapy is discussed separately in the context of unipolar major depression. (See "Unipolar major depression: Treatment with mindfulness-based cognitive therapy".)

Cognitive-behavioral therapy for insomnia — CBT for insomnia is an established treatment for the general population of patients with insomnia and has been modified to treat insomnia in patients with bipolar disorder [49]. The modifications for bipolar disorder include establishing a regular daily schedule, and administering chronotherapy (engaging in relaxing and sleep-inducing activities in dim light before sleep, and exposure to bright light upon wakening) and motivational interviewing (acknowledging that insomnia is a problem, making a commitment to change one's behavior, and taking action to change).

Evidence supporting the use of CBT for insomnia in bipolar disorder includes a randomized trial that compared CBT for insomnia plus pharmacotherapy with psychoeducation plus pharmacotherapy in remitted patients with insomnia (n = 58) [49]. Both adjunctive treatments were administered over eight sessions. During follow-up lasting six months, relapse of mood episodes occurred in fewer patients who received CBT for insomnia than psychoeducation (14 versus 42 percent); although this difference was not statistically significant, a difference of this magnitude if real, would be clinically meaningful. In addition, the mean number of days spent in mood episodes during follow-up was less with CBT for insomnia than psychoeducation (3 versus 26 days), and remission of insomnia occurred in more patients treated with CBT for insomnia (64 versus 21 percent).

The use of CBT for the general population of patients with insomnia is discussed separately. (See "Cognitive behavioral therapy for insomnia in adults".)

FAMILY THERAPY

Family therapy encompasses different types of interventions that vary in their theoretical orientation and focus. The therapy may address relationships between family members,

behavioral change, communication, problem-solving skills, psychoeducation, or the need to view the family as a single system. Evidence that family therapy prevents recurrences is inconsistent [50]. Two systematic reviews found adjunctive family therapy provided no additional benefit [42,51]. However, three other reviews concluded family therapy effectively prevented relapse and improved functional outcomes [10,52,53].

Additional information about family psychotherapy is discussed separately in the context of unipolar major depression. (See "Unipolar depression in adults: Family and couples therapy".)

INTERPERSONAL AND SOCIAL RHYTHM THERAPY

Interpersonal and social rhythm therapy is based in part upon interpersonal psychotherapy. Multiple randomized trials indicate that adjunctive interpersonal and social rhythm therapy does not prevent or delay recurrent bipolar mood episodes:

- A two-year randomized trial compared interpersonal and social rhythm therapy plus pharmacotherapy with pharmacotherapy alone in 175 patients with bipolar disorder who were euthymic; time to recurrence was comparable in the two groups [54].
- An 18-month randomized trial compared interpersonal and social rhythm therapy plus medication management with usual care in 88 stable bipolar patients and found that relapse of mood episodes was comparable [55].

Additional information about interpersonal psychotherapy, which can be efficacious for acute and maintenance treatment of unipolar major depression, is discussed separately. (See "Interpersonal Psychotherapy (IPT) for depressed adults: Indications, theoretical foundation, general concepts, and efficacy".)

HEALTHY LIFESTYLE

Augmenting pharmacotherapy with interventions that focus upon developing a healthier lifestyle may reduce relapses in patients with bipolar disorder. A 12-week randomized trial compared a healthy lifestyle intervention plus pharmacotherapy with usual care plus pharmacotherapy in patients with bipolar disorder who were in remission (n = 105) [56]. The lifestyle intervention consisted of individual sessions, lasting 45 to 60 minutes, which focused upon physical exercise, healthy diets, sleep hygiene, and smoking cessation. Patients were followed for up to one year posttreatment, during which relapse occurred in fewer patients treated with the adjunctive lifestyle intervention than usual care (9 versus 31 percent).

FUNCTIONAL REMEDIATION

Adjunctive psychotherapy can be used to improve psychosocial impairment in euthymic bipolar patients, rather than prevent recurrent mood episodes. Interventions directed towards functioning are generally termed functional remediation. One such intervention consists of a group program that includes 21 weekly sessions (each lasting 90 minutes) that address neurocognitive problems with attention, memory and executive functioning (eg, planning, decision making, and response inhibition), as well as daily functioning in domains such as interpersonal relationships, occupational functioning, finances, and leisure time [57,58].

Evidence supporting the use of adjunctive functional remediation includes a 21-week trial that randomly assigned euthymic bipolar patients with moderate to severe functional impairment (n = 239) to one of three treatments: pharmacotherapy plus functional remediation, pharmacotherapy plus psychoeducation, or pharmacotherapy alone [57]. Both adjunctive treatments were administered weekly in a group format. Follow-up assessments six months posttreatment found that functioning was superior with adjunctive functional remediation, compared with either pharmacotherapy alone or adjunctive psychoeducation [59]. Verbal memory also improved more with functional remediation than the other two treatments.

Another form of functional remediation is cognitive behavioral rehabilitation, which is a 12-session group intervention that addresses attention and memory, social cognition and communication, and relapse prevention [60]. A small randomized trial in 39 remitted bipolar patients found that add-on cognitive behavioral rehabilitation may improve some aspects of neuropsychological functioning [60].

ELECTRONIC RESOURCES

Although multiple internet-based psychological interventions (eg, psychoeducation) for bipolar disorder have been developed, there is little to no evidence that these therapies are efficacious for preventing recurrences of mood episodes [61-63]. The appeal of administering psychotherapy through computers and mobile telephones that are connected to the internet includes improved access, decreased costs, and anonymity. In addition, these electronic resources may enable patients to monitor their mood and behavior, and to receive real time information and advice tailored to their specific needs. However, randomized trials of various programs have generally found these web based, self-help programs are not efficacious for maintenance treatment.

SOCIETY GUIDELINE LINKS

Links to society and government-sponsored guidelines from selected countries and regions around the world are provided separately. (See "Society guideline links: Bipolar disorder".)

INFORMATION FOR PATIENTS

UpToDate offers two types of patient education materials, “The Basics” and “Beyond the Basics.” The Basics patient education pieces are written in plain language, at the 5th to 6th grade reading level, and they answer the four or five key questions a patient might have about a given condition. These articles are best for patients who want a general overview and who prefer short, easy-to-read materials. Beyond the Basics patient education pieces are longer, more sophisticated, and more detailed. These articles are written at the 10th to 12th grade reading level and are best for patients who want in-depth information and are comfortable with some medical jargon.

Here are the patient education articles that are relevant to this topic. We encourage you to print or e-mail these topics to your patients. (You can also locate patient education articles on a variety of subjects by searching on “patient info” and the keyword(s) of interest.)

- Basics topics (see "Patient education: Bipolar disorder (The Basics)" and "Patient education: Coping with high drug prices (The Basics)")
- Beyond the Basics topics (see "Patient education: Bipolar disorder (Beyond the Basics)" and "Patient education: Coping with high prescription drug prices in the United States (Beyond the Basics)")

The National Institute of Mental Health also has educational material explaining the symptoms, course of illness, and treatment of bipolar disorder in a booklet entitled "Bipolar Disorder," which is available online at the website or through a toll-free number, 866-615-6464. The web site also provides references, summaries of study results in language intended for the lay public, and information about clinical trials currently recruiting patients.

Another website with information for bipolar patients is maintained by the Bipolar Education Programme Cymru.

More comprehensive information is provided in many books written for patients and family members, including The Bipolar Disorder Survival Guide: What You and Your Family Need to Know, second edition, written by David J. Miklowitz, PhD (published by The Guilford Press, 2010);

An Unquiet Mind: A Memoir of Moods and Madness, written by Kay Jamison, PhD (published by Random House, 1995); and Treatment of Bipolar Illness: A Casebook for Clinicians and Patients, by RM Post, MD, and GS Leverich, LCSW (published by Norton Press, 2008).

The Depression and Bipolar Support Alliance (available at the website or 800-826-3632) is an organization in the United States that educates members about bipolar disorder and how to cope with it. Other functions include increasing public awareness of the illness and advocating for more research and services. The organization is administered and maintained by patients and family members, and has local chapters.

The National Alliance on Mental Illness (available at the website or 800-950-6264) is a similarly structured organization devoted to education, support, and advocacy for patients with any mental illness. Bipolar disorder is one of their priorities.

SUMMARY

- Bipolar disorder is a mood disorder that is characterized by episodes of mania (table 1), hypomania (table 2), and major depression (table 3). The subtypes of bipolar disorder include bipolar I and bipolar II. (See 'Definition of bipolar disorder' above and "Bipolar disorder in adults: Clinical features" and "Bipolar disorder in adults: Assessment and diagnosis", section on 'Diagnosis'.)

- Psychotherapies that are used as adjunctive maintenance treatments for bipolar disorder include psychoeducation, detecting early warning signs, and family therapy. Psychoeducation is a core element of family therapy. (See 'Overview' above.)

- Multiple randomized trials indicate that adjunctive group psychoeducation can prevent or delay recurrent bipolar mood episodes and hospitalizations, and that the benefits of treatment persist over time. (See 'Evidence of efficacy' above.)

- Patient education goes beyond information; psychoeducation is an information-based behavioral training program aimed at assisting patients to adjust their lifestyle to cope with bipolar disorder and improve outcomes. Patients are empowered with tools that allow them to be more active in their treatment and self-manage their illness. We encourage clinicians to provide group psychoeducation early in the course of illness. (See 'General principles' above.)

- Therapists for group psychoeducation should have experience treating bipolar patients and leading therapy groups, and training in social skills and bipolar group

psychoeducation. The role of therapist can be served by psychiatrists, psychologists, psychiatric nurses, or social workers.

It is preferable to enroll euthymic patients, particularly patients who have been euthymic for relatively longer periods of time. However, it is acceptable to include patients who are mildly ill and reasonably stable. In addition, group psychoeducation may be better suited for patients with relatively few prior mood episodes, as well as patients with less comorbidity.

Psychoeducation groups are closed, meaning that after the first group session, new members are not allowed to join. The optimal size of a psychoeducation group is between 8 and 12 patients. The number of sessions provided in studies of group psychoeducation programs has varied from 6 to 21. Sessions last approximately 90 minutes. (See 'Administering treatment' above.)

- The main topics covered in group psychoeducation include illness awareness, medication options and adherence, identifying prodromal signs of recurrent mood episodes, and regulating habits. Other potential topics include factors that trigger mood episodes, course of illness, avoiding substance abuse, pregnancy and heritability, ineffective alternative therapies, stress management, and problem solving. (See 'Content' above.)

- Other adjunctive psychotherapies that may help prevent recurrences of bipolar mood episodes include cognitive-behavioral therapy for insomnia, and healthy lifestyle interventions. (See 'Cognitive-behavioral therapy for insomnia' above and 'Healthy lifestyle' above.)

- Adjunctive psychotherapy can be used during maintenance treatment for purposes other than preventing recurrent mood episodes. As an example, functional remediation may improve cognitive impairment and psychosocial functioning. (See 'Functional remediation' above.)

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