Title
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Journal
Psychiatric annals, 53(2)

ISSN
0048-5713

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Publication Date
2023-02-01

DOI
10.3928/00485713-20230119-01

Peer reviewed

HHS Public Access

Author manuscript

Psychiatr Ann. Author manuscript; available in PMC 2023 May 19.

Published in final edited form as:

Psychiatr Ann. 2023 February ; 53(2): 58–62. doi:10.3928/00485713-20230119-01.

Psychotherapy in Bipolar Depression: Effective Yet Underused

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Abstract

Psychotherapy is an important part of managing bipolar depression and its associated impairments. There is considerable evidence that psychotherapies are effective adjuncts to pharmacotherapy in delaying or preventing episodes of bipolar depression. Individuals with bipolar depression may be reticent to consider these treatments. This paper surveys the utility, evidence base, effective treatment components, and controversies surrounding adjunctive psychosocial interventions.

> But, ineffably, psychotherapy heals. It makes some sense of the confusion, reins in the terrifying thoughts and feelings, returns some hope and control and possibility of learning from it all…. Psychotherapy is a sanctuary; it is a battleground; it is a place I have been psychotic, neurotic, elated, confused, and despairing beyond belief. But, always, it is where I have believed—or learned to believe—that I might someday be able to contend with all of this.
>
> —K. Jamison, *An Unquiet Mind*[1]

As poignantly conveyed by Dr. Kay Jamison, psychotherapy can be a crucial part of managing bipolar disorder and is an important component of evidence-based outpatient treatment for this highly impairing chronic condition.[2] However, individuals with bipolar depression may not consider engaging in this vital treatment. In this article, we discuss the utility of psychotherapy as adjunctive to medications for bipolar depression and identify controversies. We explore why psychotherapy is helpful, its potential role in medication adherence, future directions to advance the field, and access to psychotherapeutic care.

Bipolar disorder is a lifelong condition involving extreme changes in affective symptoms ranging from depression to mood elevation.[3] It is the leading cause of years lost to disability worldwide.[4] Although mood elevation and increased activation are notorious bipolar symptoms, depression is considered more disabling than mania.[5]

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Disclosure: DJM is a book author for John Wiley and Sons and Guilford Press. The remaining author has no relevant financial relationships to disclose.

In a prospective naturalistic study over 13 years, depression was experienced three times more frequently than mania and five times more than mixed symptoms in bipolar I.[3] In bipolar II,[6] depression occured 39 times more frequently than hypomania and 22 times more than mixed mood. When depression and mood elevation are compared longitudinally, each increase in depression severity impacts psychosocial disability to a greater degree than mania.[7] This reflects the strong impact of minor or subsyndromal depressive symptoms on psychosocial functioning, such as the ability to work and have successful relationships.[7] In a treatment study across seven countries, bipolar depression was consistently associated with lower community functioning,[8] exemplifying its impact on individuals across cultures. Consider this brief case example:

> "Having bipolar disorder means I have a chemical imbalance in my brain. I don't see how talking about depression is going to help. I just need the new medications to start working."
>
> —An individual in bipolar specialty care.

In the following sections, we examine how a clinician might respond to this individual and encourage them to consider psychotherapy.

Medications are the first-line treatment for acute depression and mania. Unfortunately, medications are often not enough to fully manage the disabling effects of bipolar disorder. Adaptation of the chronic disease management model[9] has been suggested, in which a combination of medications and psychotherapy is offered to optimize bipolar treatment. Strong evidence from randomized controlled trials for adjunctive psychotherapy to treat bipolar depression comes from the Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD) study.[10] In STEP-BD, 293 people with bipolar depression were randomly assigned to receive three different intensive (up to 30 weekly sessions) psychotherapies—all of which had active psychoeducation and skill-training components —or a much briefer psycho-education (three weekly sessions) while taking medications as part of a larger trial. The intensive therapies were family-focused treatment (FFT),[11] interpersonal and social rhythm therapy,[12] and cognitive behavioral therapy (CBT).[13] Each of these intensive psychotherapies had good evidence for treatment of bipolar disorder, but the study evaluated their comparative efficacy in treating bipolar depression. At 1-year follow-up, individuals treated with any of the intensive psychotherapies experienced higher bipolar depression recovery rates than those who received psychoeducation alone, with no differences in efficacy among the modalities.[10] Patients who received intensive psychotherapy with medications were 1.58 times (95% confidence interval, 1.17–2.13) more likely to be clinically stable at follow up than those who received brief psychoeducation and medications ($P = .003$).

EFFECTIVE COMPONENTS OF PSYCHOTHERAPY

The results of STEP-BD and other studies of psychotherapy indicate the importance of psychoeducation as a component of psychotherapy for bipolar depression. Robust evidence for psycho-education is provided by group treatment addressing four clinical issues: (a) illness awareness; (b) treatment adherence; (c) early detection of prodromal symptoms

and recurrence; and (d) maintaining a regular lifestyle.[14] At 5-year follow-up, people who received structured group psychoeducation spent 75% less time depressed compared with those in an unstructured support group.[15]

There are several caveats. It is not clear whether psychoeducation is more or less effective when patients receive treatment during a symptomatic or a remitted period. Studies of group psychoeducation (eg, Colom et al., 2003) have initiated treatment after a 6-month period of remission. Patients in STEP-BD had subthreshold depressive symptoms when psychoeducation was started, and significant treatment effects were still evident.[10] Second, it is controversial whether psychoeducation as a stand-alone intervention is effective with depression[16] or if it is best conceptualized as a component of evidence-based psychotherapy.[17] Third, there appear to be differences in how psychoeducation is delivered between group and individual treatment. In a pooled analysis of randomized controlled clinical trials among 186 individuals with bipolar disorder in remission, individuals receiving group psychoeducation were 2.08 times (95% confidence interval, 1.05–4.12) more likely to have not relapsed into depression compared to placebo control or treatment as usual.[16] No differences were found in depression relapse in people receiving individual psychoeducation. Group therapy can be a powerful approach to help individuals feel less alone in their struggles with bipolar depression and accept support from others.

The mechanisms by which psychotherapy affects bipolar depression are poorly understood. In a recent network meta-analysis[2] to address this issue, cognitive restructuring, regulating daily rhythms, and family communication training were the most effective components of psychotherapy to reduce bipolar depression. Interestingly, each of these components are parts of the intensive therapies (FFT, interpersonal and social rhythm therapy, and CBT) from the STEP-BD study. However, there is a long-standing controversy about psychotherapy mechanisms between proponents of specific approaches to psychotherapy (eg, cognitive restructuring) and those who suggest that universal aspects of psychotherapy, called common factors,[18] are effective. Common factors include empathy, collaboration, and qualities of the therapeutic relationship.[19] This controversy plays out in differences between bipolar treatment guidelines[20] in that some (eg, Canadian Network for Mood and Anxiety Treatments) recommend specific psychotherapy approaches in contrast to others (eg, Royal Australian and New Zealand College of Psychiatrists) that recommend psychotherapy in general. The efficacy of psychotherapy for bipolar depression is likely a dynamic combination of both specific and common factors.

MEDICATION ADHERENCE

Despite the benefits of medications to manage bipolar disorder, it can be incredibly difficult for individuals to take them. In a review of 25 studies in individuals with bipolar disorder, medication nonadherence rates ranged from 25% to 68%.[21] Medication adherence has many facets, including patient, treatment, and health-care systems factors.[22] Ironically, the first person with bipolar disorder who took lithium struggled with taking it regularly even though it was helpful.[23]

Psychotherapy can play an important role in bipolar medication adherence.[23] Individuals who underwent FFT during maintenance drug treatment had higher drug adherence scores compared with those who received a less intensive psychoeducational program.[24] Common factors, such as an individual's perception that they feel understood by their clinician, are associated with increased medication adherence.[25] Several psychotherapeutic approaches appear to be effective in addressing medication adherence (CBT, FFT).[22] There is also preliminary evidence for motivational interviewing in addressing medication adherence,[26] particularly brief interventions that address an individual's ambivalence toward medications.[27]

Should we continue psychotherapy with individuals who choose not to take medications? Psychotherapy is not a substitute for medications. However, the decision to continue psychotherapy is often complex, in which the transtheorectical model for change[28] may be useful. Psychotherapy could be appropriate for individuals in contemplation or preparation stages of change, signifying an intention to start medications in the near or immediate future, respectively.

There is an important clinical distinction between individuals who take medications and stop in comparison to those who struggle to ever take medications. In our opinion, terminating psychotherapy with patients who have stopped taking their medications is contradictory. This behavior is common among patients with bipolar disorder, especially those who feel medication has failed them. This may be the time when they need psychotherapy the most. However, there can be safety and liability issues. Consultation with interdisciplinary treatment and legal teams can assist in deciding on a treatment plan for individuals refusing medications. Often, setting a timeline for restarting medications, along with enabling contact with family members (who may or may not know about the patient's nonadherence), are important agreements that may facilitate the individual's eventual acceptance of a medication regimen.

For individuals struggling to take medications at all, close collaboration between therapists and psychiatrists may be critical to address poor response and difficult side effects.[22] Severity of bipolar illness can guide these decisions. When working with adolescents or young adults with unspecified bipolar disorder, psychotherapy could be provided with the expectation that individuals will start medications if symptoms worsen. For adults with bipolar I, a motivational interviewing approach could assess ambivalence and, if present, facilitate a change process geared toward taking medications.[27]

FUTURE DIRECTIONS: ROLE OF TRAUMA

Negative life events are associated with depression relapse.[29] Traumatic events play a role in the symptom fluctuations of bipolar disorder. Notably, people with bipolar disorder who experienced childhood traumatic events suffer from more depressive episodes.[30] However, the association between adverse childhood events and the course of bipolar disorder is moderated by many factors. In a study in which people with bipolar I experienced traumatic events across the lifespan, those who developed post-traumatic stress disorder (PTSD) had higher levels of depression compared with those who did not.[31]

People with bipolar disorder may be vulnerable to developing PTSD. The lifetime prevalence of PTSD among individuals with bipolar disorder is as high as 40%.[32] In a naturalistic study among people with bipolar disorder living in New York City and Boston during the September 11, 2001 attacks who were indirectly exposed (eg, watched media, knew people who died in the attacks, or lived close to the twin towers), manic and hypomanic mood was associated with developing PTSD.[33]

Many aspects of elevated mood may increase the risk of being involved in a traumatic event and developing PTSD. For example, inflated self-esteem may lead to an inaccurate assessment of harmful situations, and increased libido may increase the risk of sexual assault or abuse.

Trauma-based treatment is underused in bipolar depression protocols. Evidenced-based approaches such as cognitive processing therapy may be effective for individuals with co-morbid bipolar disorder and PTSD.[34] One PTSD treatment designed specifically for people with bipolar disorder[35] uses aspects of cognitive processing therapy, although to date, there have been no trials examining this approach. There are many issues that need resolution, such as which condition to treat first or whether bipolar symptoms and PTSD can be addressed concurrently.[32]

Access to Psychotherapy

Miklowitz and colleagues[2] recommended that a combination of evidence-based pharmacological and psychotherapeutic treatment should be offered to all individuals with bipolar disorder during outpatient treatment, while acknowledging the difficulties of bringing this to fruition. Since the COVID-19 pandemic, telehealth has increased access, but it is not enough. Others have suggested that psychotherapy components, such as psychoeducation, be delivered without a psychotherapist.[16] However, in a recent meta-analysis of smartphone-based interventions that delivered CBT, psycho-education, and self-monitoring without a clinician, there was no evidence that these interventions reduced the severity of bipolar depression or improved functioning, quality of life, or perceived stress.[36] Although smartphone technology may have a role in outpatient bipolar depression care, such as obtaining real-time mood data, its usefulness in providing psychotherapy without a clinician appears lacking. Efficacious psychotherapy for bipolar depression may require involvement of a psychotherapist to facilitate a dynamic process that requires training, clinical experience, and continual learning.

CONCLUSIONS

We hope that the previous sections convey that psychotherapy for bipolar depression is “more than just talk.” It is an intentional, evidence-based treatment, targeted at addressing risk and protective factors in managing bipolar disorder. We have reviewed evidence for why psychotherapy is helpful, its potential to increase medication adherence, the importance of addressing potential PTSD, and issues with access to psychotherapeutic care. Although psychotherapy is not a panacea, there is strong evidence it can provide a place to heal.

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