

Psychotherapy and Preventing Relapses

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Abstract:

Despite the use of mood stabilisers, a significant proportion of bipolar patients suffers from frequent relapses. Some continue to be re-hospitalised. In view of these findings, psychological treatments have been developed as part of a combined treatment for bipolar patients.

Bipolar disorder is a complex illness, and various treatments are likely to be needed for different phases of the illness. The effectiveness of any treatment program would probably largely depend on its ability to target selective problems in specific phases of the illness. Psychological strategies designed for prevention of relapses may have to be different from those strategies designed to target an acute episode and may be minimally effective for an acute episode. Hence, it is important to be clear whether the goal of intervention is to treat the acute episode or prevent future relapses in patients out of an acute episode. So far, the evidence from randomised controlled studies supports the efficacy of combined drug and psychological treatment in relapse prevention in patients who are out of an acute episode.

Efficacy evidence from randomised controlled studies for psychological therapy in bipolar disorder varied from individual work^(1, 2, 3), group work⁽⁴⁾ and family work^(5,6). All these studies reported a significant effect in relapse prevention.

Introduction:

Despite the use of mood stabilisers, a significant proportion of bipolar patients suffers from frequent relapses^(7,8). Some continue to be re-hospitalised⁽⁹⁾. Non-adherence to medication is part of the reason for the failure of drugs to protect bipolar patients. However, some patients reported to have adhered consistently to prophylactic medication and yet they still ex-

perienced relapses. In view of these findings, psychological treatments have been developed as part of a combined treatment for bipolar patients.

Recent Developments in Psychological Therapies:

Four major randomised controlled studies are reviewed in this paper. These include teaching

patients to recognise early warnings and seek early help⁽¹⁾, cognitive behaviour therapy by Lam et al.^(2,3), psycho-education⁽⁴⁾ and focused family therapy^(5,6). Interpersonal social rhythm therapy⁽¹⁰⁾ is not included as the final results have yet to be published at the write up of this paper. The broad aims of psychological therapy are the prevention of relapses, the enhancement of medication compliance, reduction of mood symptoms, and the promotion of social functioning, promoting good coping skills and promoting communication within the family.

A diathesis-stress model is adopted in all the structured focused psychotherapy specific for bipolar disorder reviewed in this paper. Biology predisposes individuals to be vulnerable to bipolar disorders. Yet, stress can both bring on the illness and affect its course. Hence, all randomised controlled psychotherapy studies cited below are combined treatments of medication and psychological therapy: The thinking is that medication may deal with the biological side and stabilise the patient's mood. Psychotherapy may deal with issues that may affect the course of the illness such as teaching patients to recognise early warnings and adopt adaptive coping. It also targets chaotic daily routines.

Teaching patients to detect early warnings and seek early help:

In a randomised controlled study⁽¹⁾, the sole active therapeutic component was detection of prodromes and seeking early treatment of an episode. Sixty-nine bipolar patients who had one relapse within the previous twelve months were recruited and allocated to an intervention group of seven to twelve sessions or to a treatment-as-usual group. The study found that treatment reduced the number of relapses of manic episodes, but not episodes of depression, relative to treatment as usual. The intervention group also had significant overall improvement in social functioning, especially in the domain of employment.

Family focused therapy:

Family-focused treatment was based on Expressed Emotion findings⁽¹¹⁾ that bipolar patients from families with critical, hostile or emotionally over-involved key relatives had a worse course of the illness. Treatment starts with families after patients had been discharged from hospital. The package consisted of psycho-education about the illness, communication training and problem-solving skills training. In an intervention study^(5,6), patients were as-

signed to family focused therapy (N=31) or two family education sessions and follow-up crisis management (N=70). The family focused therapy group had fewer relapses and longer delays before relapses during the study year than did the crisis management group. The family focused therapy group also showed greater improvements in depressive (but not manic) symptoms. Interestingly it was found that patients with critical, hostile or emotionally over-involved key relatives benefited most from the study.

Cognitive therapy:

Both promoting a good daily routine and the detection and coping with prodromes involve monitoring and regulating. Highly-driven and dysfunctional beliefs behind lack of sleep and poor daily routine should also be tackled. Cognitive therapy is well suited to teaching bipolar patients these relevant skills and can provide patients with additional skills to cope with their illness better and to improve their level of social functioning. In Lam et al's study^(2,3), one hundred and three DSM IV bipolar 1 patients, suffering from frequent relapses, were randomised into a CT plus medication group or a control group of medication only. Patients were recruited out of an acute episode. A significant proportion of patients recruited suffered from residual depression symptoms. Cognitive therapy lasted up to six months of 16 sessions of therapy. Independent raters, who were blind to the patients' group status, assessed patients at 6-month intervals. Patients in the cognitive therapy group had longer survival time to relapse for both mania and depression as well as less depression symptoms and higher social functioning up to one year⁽²⁾. Over 30 months, the COGNITIVE THERAPY group was significantly better in terms of time to relapse. However, the effect of relapse prevention was mainly in the first year. The cognitive therapy group also spent 110 fewer days (CI 32 to 189 days) in bipolar episodes out of 900 in total over the whole 30 months and 54 fewer days (CI 3 to 105 days) in bipolar episodes out of about 450 in total over the last 18 months.

Psycho-education:

In Colom et al's study⁽⁴⁾, patients were recruited after they had been stable (Young Mania Rating Scale <6; 17-item Hamilton Depression Rating Scale <8) for at least six months. Patients were randomly allocated to a psycho-education group or a control group of non-structured group meetings. Psycho-education consisted of twenty-one 90-minute group sessions of nine

to twelve patients. The content of psycho-education included information about the illness, medication, pregnancy, alcohol and drugs, early detection of prodromes, life style regularity, stress management and problem solving. Over 24 months, the psycho-education group had significantly fewer relapses and increased survival time to an episode relative to patients in the control group. Patients in the treatment group also had a significantly fewer number of hospitalisations and shorter length of hospitalisation per patient.

Summary of outcomes:

To sum up, the effect of structured focused psychotherapies specially tailored for bipolar disorder had beneficial effects in relapse prevention. However, there were also some mixed findings. Perry et al's study⁽¹⁾ reported only a beneficial effect for mania but not depression. The other three studies^(3,4,6) reported some beneficial effects for both mania and depression even though both Miklowitz et al.⁽⁶⁾ and Lam et al.⁽³⁾ reported a stronger effect for depression than mania. Hence the evidence suggests that learning to detect and cope adaptively with bipolar prodromes had a short-term beneficial effect for manic episodes as is evident in Perry et al.'s study¹ which only lasted for eighteen months and Lam et al.⁽³⁾ study which only lasted for twelve months. In the longer term, therapy seemed more efficacious for depression.

Discussion:

Three observations are worth mentioning. The first issue relates to time of recruitment. Bipolar disorder is a complex illness and various treatments are likely to be needed for different phases of the illness. Psychological strategies designed for prevention of relapses may be minimally effective for an acute episode. Some strategies designed to target an acute episode may be different to strategies designed for relapse prevention and vice versa. Hence, it is important to be clear whether the goal of intervention is for the acute episode or relapse prevention for patients out of an acute episode. So far, the evidence for efficacy of combined drug and psychological treatment is mainly in relapse prevention for patients who are out of an acute episode⁽²⁾ or very stable patients⁽⁴⁾.

Secondly, psychotherapy for bipolar disorder is complex. It requires therapists to master good psychological skills as well as a sound knowledge about the illness itself and its medical treatments. Such knowledge enables therapists to discuss treatment options intelligently with

patients and gain credibility. Therapists must be able to detect early stages of a manic relapse and institute strategies to prevent early stages escalating to full-blown episodes. For example, if patients are already in an over-aroused state, therapists should exercise their clinical judgement and reduce the length of the session. The bulk of the shortened session should focus on helping patients to agree to behavioural strategies to cut out unnecessary activities that may stimulate them further and to promote calming activities. Often working with bipolar patients require a close liaison with the prescribing physician. Prompt medical intervention may be necessary for patients with a history of rapid swings into mania.

Thirdly, as summarised in this paper above, evidence for the efficacy of psychological therapy in bipolar disorder varied from individual work^(2,3), group work⁽⁴⁾ and family work^(5,6). The choice of mode of delivery depends on patients' current mood state and patients' needs. For example, complex psycho educational groups should only be considered when patients have been stable for several months. Focused family work may be preferred if the patient comes from a highly critical or hostile family.

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Reviewer 1:

The article by Lam highlights four main evidence based approaches to psychological treatment for bipolar disorder. In addition another psychological treatment called interpersonal and social rhythms therapy (IPSRT), given in an acute bipolar episode an continued into the maintenance phase, improves social rhythms and reduces variance in symptoms; if these oc-

cur by the end of the acute episode, then there is a longer time interval before another acute bipolar episode ⁽¹⁾.

There now a range of evidence based psychological treatments, which can be employed in different phases of the disorder with a different set of purposes. IPRST might be employed to gain stability in social rhythms where a chaotic sleep pattern and daily routine appears to have precipitated or exacerbated a manic or depressive episode. Family focussed therapy can be employed soon after recovery from an acute bipolar episode and is best utilized when there is high expressed emotion (hostility and criticism) or a lot of family problems that seem to being have an adverse effect on the patient's bipolar symptoms. As Lam states detection of prodromes with seeking early treatment can be employed once the patient has recovered from a bipolar episode and is most useful to prevent further manic episodes in a patient with predominantly manic episodes. Cognitive behaviour therapy and group psychoeducation, which both employ detection of prodromes and seeking early treatment, have added benefits on depressive episodes in patients who experience more depressive than manic episodes. Patients with bipolar disorder need to be stable (recovered from an episode of bipolar disorder for some months) before these treatments are employed. As Lam pointed out top up sessions are required at one year after the end of treatment.

The Institute of Medicine⁽²⁾ discussed the problem of bridging the chasm between what is possible to achieve in evidence based treatment under ideal conditions and what is actually delivered to patients in routine health care. Psychological treatment for bipolar disorder illustrates the depth of this chasm. With the exception of the detection of prodromes and early help seeking intervention, which seems to be quite widely used, all of these treatment approaches require many sessions of time (typically 16 or more) from highly skilled therapists who have also obtained a lot of first hand experience of working with patients who have bipolar disorder. Traditional psychotherapy services and psychologists have neither the experience of working with bipolar disorder patients nor the skills in working in quite specific ways in these treatments; for instance in cognitive behaviour therapy for bipolar disorder, the emphasis is on working on negative thinking and coping in relation to prodromes of illness, establishing a regular routine, adherence to medication and a certain number of particular dysfunctional assumptions.

If services wish to employ psychological treatments for bipolar disorder they are probably better off training mental health professionals who have a lot of experience of working with bipolar disorder patients in the psychological therapies rather than taking skilled psychotherapists and exposing them to people with bipolar disorder. The psychological treatments they will be using are different anyway to the usual psychological treatment approaches, such as cognitive behaviour therapy and family therapy, for patients with other mental health problems.

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