Psychological therapies for people with bipolar disorder: where are we now, and what is next? ISBD Psychological Interventions Taskforce—Position paper

Wright, K.; Koenders, M.; Douglas, K.M.; Faurholt-Jepsen, M.; Lewandowski, K.E.; Miklowitz, D.J.; ... ; Mesman, E.

DOI: 10.1111/bdi.13418

BIPOLAR DISORDERS
AN INTERNATIONAL JOURNAL OF PSYCHIATRY AND NEUROSCIENCES
WILEY

EDITORIAL

Psychological therapies for people with bipolar disorder: Where are we now, and what is next? ISBD Psychological Interventions Taskforce—Position paper

Bipolar disorder (BD) is generally acknowledged to be a complex and multifactorial disorder with biological and psychosocial vulnerabilities. In recent decades, research into BD has demonstrated that psychological factors contribute to ongoing vulnerability to mood instability and decreased functional and personal recovery. This has led to increased awareness among clinicians and patients that, in conjunction with mood-stabilizing medication, psychological intervention is an important component of evidence-based treatment. Nevertheless, psychological interventions are often not systematically considered or offered as a treatment option.

As the International Society for Bipolar Disorders' (ISBD) Psychological Interventions Taskforce, we aim to facilitate the development, refinement, and evaluation of evidence-based psychological interventions (EBPs) for BD and promote access to these. This position paper aimed to give an overview of the state of the field of EBPs for BD and to make recommendations for improving clinical practice and research into adjunctive psychological care. First, we briefly summarize the evidence base for psychological interventions for people with BD. Second, we consider potential mechanisms of action and describe how understanding these mechanisms could help to refine intervention strategies. Third, we discuss challenges and opportunities related to access to EBPs. Finally, we offer recommendations for future research and implementation.

1 | EVIDENCE FOR THE EFFICACY OF PSYCHOLOGICAL INTERVENTIONS IN PEOPLE WITH BD

The literature on EBPs for BD is relatively scant compared to that for major depressive disorder and schizophrenia; however, several interventions such as psychoeducation, cognitive behavioral therapy (CBT), and family-focused therapy (FFT) have been evaluated across multiple trials, while a smaller number of studies have investigated other modalities including interpersonal and social rhythm therapy (IPSRT) and "third-wave" cognitive and behavioral interventions such as dialectical behavior therapy (DBT) and acceptance and commitment therapy (ACT) (see Box 1). A network meta-analysis of 39 randomized clinical trials found that manualized psychological interventions, when provided alongside mood-stabilizing medication, were associated with improved outcomes in terms of mood stabilization relative to usual care conditions (typically, psychopharmacological treatment alone or in combination with supportive therapy[1]). Specifically, psychoeducation with guided skills training, CBT, and FFT were associated with lower mood episode recurrence rates compared with usual care, while CBT, IPSRT, and FFT outperformed usual care in the reduction of depression symptoms. Given the strong and growing evidence base for psychotherapeutic interventions, contemporary treatment guidelines recommend that best practice care for people with BD is a combination of psychopharmacological treatment and psychotherapy.

The multitude of EBPs for BD provide both a challenge and an opportunity. Few trials have identified moderators of treatment effects. As a result, clinicians cannot point to trial results as a basis for selecting one EBP over another. There is, however, a significant degree of overlap between EBPs, which raises the potential of synthesis across protocols into a set of core components. For example, components common to multiple EBPs include psychoeducation, self-monitoring, sleep/circadian rhythm training, attitudes and behaviors in relation to medication taking, and problem-solving. We return to this point in the recommendations section.

Appropriate outcome measurement that is consistent across trials presents a challenge to the field. In line with other severe and chronic psychiatric disorders (e.g., psychotic disorders), the aims of EBPs for BD tend not to be limited to symptom reduction, but can also include relapse prevention and improvement in quality of life, everyday functioning, and sense of personal recovery. Greater standardization of outcome measurement, within an assessment framework that considers outcome domains prioritized by patients and clinicians,[2] would assist with evidence synthesis across trials. It could also lead to a better understanding of treatment mechanisms and moderators, enabling a more personalized approach to psychotherapeutic intervention.

BOX 1 Overview of common psychological intervention packages for people with bipolar disorder

Psychoeducation

Target: Self-management skills, acceptance, treatment adherence, and social rehabilitation

Ages: Effective intervention for people with bipolar disorder across the lifespan

Format: Individual, group, and family settings

Components:

- Increase knowledge about the etiology of bipolar disorder, its symptoms, the role of psychopharmacology, and triggers associated with recurrence (including stress, sleep disruption, treatment withdrawal, and alcohol or illicit substances)
- Teach strategies for recognizing and responding to symptoms, stress management, problem-solving, daily routines, and medication adherence

Family-focused therapy (FFT)

Target: Assist patients and caregivers in illness management, coping with experiences and reestablishing functional family relationships

Ages: Effective intervention for people with bipolar disorder across the lifespan

Format: Includes both the patient and one or more family members

Components:

- Psychoeducation about bipolar disorder and the importance of medication adherence
- Family training on how to respond to symptoms and cope effectively
- Communication enhancement training
- Effective problem-solving skills

Cognitive behavioral therapy (CBT)

Target: Symptom reduction (except acute mania), enhancing drug treatment, self-management, and comorbid disorders

Ages: Effective intervention for people with bipolar disorder across the lifespan

Format: Individual psychotherapy (includes families when the patient is a child)

Components:

- Psychoeducation about bipolar disorder, including symptoms, the biological basis of the illness, the importance of good sleep hygiene, and the need to take medication on a consistent basis
- Education on how thoughts, feelings, and behaviors influence one another
- Skills training to identify and change maladaptive thoughts and behaviors
- Behavioral activation assignments to modulate engagement with rewarding activities

Interpersonal and social rhythm therapy (IPSRT)

Target: Improve self-management and prevent relapse through indirect regulation of the circadian system

Ages: Effective intervention for people with bipolar disorder across the lifespan

Format: Individual psychotherapy

Components:

- Identify interpersonal problem area(s)
- Track daily routines to identify disruptions that can increase the risk of mood episode onset and recurrence
- Address problem area(s) through behavior change
- Develop strong daily routines to help stabilize mood

Dialectical behavior therapy (3rd-wave behavior therapy)

Target: Emotion dysregulation

Ages: Preliminary evidence of effectiveness for people with bipolar disorder across the lifespan

Format: Group therapy

Components:

- Mindfulness
- Interpersonal effectiveness
- Emotion regulation
- Distress tolerance

Acceptance and commitment therapy (3rd-wave behavior therapy)

Target: Aims to expand psychological flexibility in line with personal values and goals

Ages: Preliminary evidence of effectiveness for people with bipolar disorder across the lifespan

Format: Individual or group therapy

Components:

- Emotional avoidance and its consequences
- Mindfulness
- Identify personal values
- Focus on thoughts, feelings, and self-esteem
- Developing acceptance toward aversive symptoms, thoughts, and feeling
- Committed action and relapse prevention plan

2 | OPTIMIZING PSYCHOLOGICAL INTERVENTIONS BASED ON AN UNDERSTANDING OF TARGET MECHANISMS AND PERSON-SPECIFIC FACTORS

To better tailor generic therapy approaches to the needs of people with BD, it is important to identify processes that contribute to BD symptoms and related difficulties. The psychological risk factors associated with BD are often transdiagnostic, for example, (self-) stigma, environmental stressors, family system problems, perfectionism, self-esteem, neuroticism, sleep problems, cognitive dysfunction, trauma sequelae, and emotion regulation. Nevertheless, evidence also exists for specific mechanisms for BD, which can be specifically targeted by therapies. Since a (hypo)manic mood state is the most distinctive characteristic of BD, there is particular interest in addressing factors that increase vulnerability to (hypo) mania. Psychological and biobehavioral factors implicated in the risk of mania include heightened sensitivity to reward and goal attainment, dysregulation of approach behavior, disruption to circadian rhythms, particular appraisal styles in relation to success and energized internal states, difficulties in emotion regulation (particularly regulation of high activation positive affect), and specific personality traits (hypomanic or hyperthymic traits).[3] Several models have been proposed that describe how at least some of these factors interact to generate or maintain manic episodes, with varying degrees of empirical support. To help optimize treatment, the field would benefit from a comprehensive psychological model of mania onset and maintenance that has sufficient explanatory power to account for the variability in illness presentations, including such phenomena as dysphoric mania and rapid cycling.

Personalizing the psychotherapeutic approach is important to maximize benefits. For example, patients with BD II may want to prioritize addressing depressive moods and thus focus on cognitive restructuring and behavioral activation; a young patient who has just been diagnosed may especially benefit from family psychoeducation; and for patients who are susceptible to mood lability, information and skills about regular routines and sleep stabilization may best address their needs. Nevertheless, improvements in the personalization of therapies could be made through a better understanding of what works for whom and at what stage in their life or their condition. Patients' goals for treatment are diverse and often focus on functional recovery (e.g., returning to work or improving relationship quality), rather than symptom remission per se. Personalizing treatment plans and therapy delivery using individualized formulation and patient goals alongside bipolar-specific treatment targets is likely to yield the best outcomes. However, little research has focused on treatment moderators and few studies report on patient-valued outcomes and goals. Consequently, knowledge about which therapy is most likely to meet a particular patient's needs is limited.

Furthermore, recognition that the heterogeneous and episodic nature of BD impacts treatment response for pharmacological and psychological interventions has contributed to interest in staging models of the condition and its treatment. However, these models require additional refinement and validation to support their clinical utility in the delivery of psychological interventions.

3 | THE CHALLENGE OF ACCESSING EVIDENCE-BASED PSYCHOLOGICAL INTERVENTIONS

In addition to prioritizing and optimizing psychotherapies for BD, availability and accessibility are a major challenge internationally. For example, in the UK, a nation with a strong tradition of offering state-supported EBPs free at the point of delivery, a recent report found that 69% of people with BD had been offered or received state-supported psychological therapy, with 26% being told they did not qualify for this therapy despite it being recommended in guidelines.[4] One patient reported, "*I have never been offered psychological therapies despite numerous episodes of severe symptoms leading to inpatient admissions. It seems my episodes are only ever managed at crisis point with no follow-up until a further episode*" (pp. 17).

Across the globe, there are opportunities to improve the provision and uptake of EBPs for BD. Patient and clinician awareness of psychological therapies and attitudes toward them, including cultural and family factors and assumptions about psychological therapy in general, may help or hinder access. Thus, medical providers and community health workers who are on the front lines of treating BD should have an understanding of the nature and potential contribution of these interventions.

Moreover, adequate numbers of appropriately trained health professionals are required not only to deliver EBPs for BD but also to train and supervise others to ensure future capacity. This is a challenge across the globe, particularly in economically developing countries. In countries where psychological therapies are available to people with BD, such constraints can effectively limit widespread provision to only one or two of the EBPs, for example, CBT and psychoeducation but not IPRST or FFT. EBPs vary in the costs of training and delivery, which affects their accessibility.

There may be broader systemic factors that impinge upon access to EBPs by people with BD. For example, in some countries, such as the United States, where private insurance is common, services from many providers—especially those with specialized training—are not covered by insurance companies and, consequently, are unaffordable to most people. Relatedly, complicated administrative and reimbursement procedures can limit the number of providers opting to see insured patients, resulting in long delays in treatment access even for those who are insured.

While there is a growing body of evidence to support the efficacy of psychological interventions for BD, relatively little research has examined the optimal implementation of these interventions. Thus, there is little to guide health service providers in determining the sequencing of EBPs, the workforce(s) who should deliver them, and how best to integrate and sustain these interventions within existing service structures.

4 | FUTURE DIRECTIONS

In conclusion, there is accumulating evidence that EBPs should play a significant role in the treatment of BD. Having outlined key opportunities and challenges for future optimization and dissemination of these interventions, this Taskforce believes future efforts should include the following:

1. Large-scale, coordinated efforts to develop, refine, and implement adjunctive EBPs for people with BD. Building multi-site, international collaborations focused on psychological interventions for BD will enable (i) the sharing of EBP resources and implementation protocols to wider communities, including the potential to synthesize and refine therapy protocols to increase comparability across studies and reduce complexity and cost of implementation; (ii) opportunities to harmonize outcome measurement and existing data sets across sites that offer measurement-based care for BD; and (iii) multi-site grant applications to improve the testing and development of psychosocial interventions for BD. The development of the Psychological Interventions Taskforce of the ISBD is a vital first step in this direction.
2. Optimization of psychological interventions for BD by improving our understanding of treatment moderators (what works for whom and when). More research is urgently required into clinical factors that predict differences in benefits and/or risks of EBPs.[5] We recommend future research to investigate moderators more systematically, which could include (i) designing trials to compare theoretically relevant treatments for important subpopulations (stage, diagnosis, comorbidity, etc.); (ii) testing modularized psychotherapies, where personalization has a transdiagnostic logic and strong translational potential; and (iii) expanding the focus to include mechanisms of action, testing for theory-driven personalized causal pathways. Building on the suggestion in recommendation (1), personalization would be enhanced by creating a common core protocol with evidence-based components that can be tailored to individuals with different clinical presentations. Continued development and testing of theoretical models that explain the development and maintenance of common presenting issues will help to guide this endeavor.
3. Work toward realizing rapid, equitable access to adjunctive EBPs for BD across the globe. We recommend (i) a focus on capacity building through coordination of training efforts and resources, for instance, open-access training webinars for professionals and development of training packages in the common components of EBPs that are themselves supported by evidence[1]; (ii) coordination of advocacy for evidence-based psychological interventions directed toward the public, clinicians, and health policy-makers;

(iii) incorporation of methods grounded in implementation science within future research on existing or novel psychosocial interventions for BD, to maximize their public health impact; and (iv) further research into alternative or adjunctive therapy delivery formats, such as digital delivery (blended care or only digitally delivered) and delivery by diverse workforces, including peer-supported interventions.

It is our intention that these recommendations will support the international coordination of research and implementation efforts by the scientific and clinical community to better meet the needs of those living with BD.

AUTHOR CONTRIBUTIONS

All authors contributed to the conceptualization and writing of the manuscript and have approved the final version.

ACKNOWLEDGEMENTS

This paper was authored by a subgroup of the Psychological Interventions Taskforce of the International Society for Bipolar Disorders. The authors would like to thank additional members of the Taskforce including Jennifer B. Levin and Karin Van Den Berg who provided comments on an early draft of the manuscript. The authors would also like to thank Mary Miller and Bryher Mehen for administrative assistance. K.M.D. would like to acknowledge fellowship funding from the Health Research Council of New Zealand, by way of a Sir Charles Hercus Health Research Fellowship (19/082), during preparation of this manuscript.

CONFLICT OF INTEREST STATEMENT

K.W. receives occasional payment for the delivery of workshops on psychological therapy to educational and healthcare organizations. K.M.D. uses software for research at no cost from Scientific Brain Training Pro. T.R. has been paid through a company he is the director of to deliver training about working with bipolar disorder and will receive royalties from a book he is editing on psychological therapies for bipolar disorder. L.M.W. receives book royalties from Oxford University Press.

DATA AVAILABILITY STATEMENT

Data sharing not applicable to this article as no datasets were generated or analysed during the current study.

Kim Wright[1]
Manja Koenders[2]
Katie M. Douglas[3]
Maria Faurholt-Jepsen[4,5]
Kathryn E. Lewandowski[6,7]
David J. Miklowitz[8]
Emma Morton[9]
Greg Murray[10]
Thomas Richardson[11]
Luisa de Siqueira Rotenberg[12]
Sarah H. Sperry[13]
Anna R. Van Meter[14]
Andrea B. Vassilev[15]
Luisa Weiner[16]
Lauren M. Weinstock[17]
Esther Mesman[18]

[1]*Department of Psychology, University of Exeter, Exeter, UK*
[2]*Department of Clinical Psychology, Leiden University, Leiden, The Netherlands*
[3]*Department of Psychological Medicine, University of Otago, Christchurch, New Zealand*
[4]*Copenhagen Affective Disorder Research Center (CADIC), Psychiatric Center Copenhagen, Frederiksberg, Denmark*
[5]*Department of Clinical Medicine, Faculty of Health and Medical Sciences, University of Copenhagen, Copenhagen, Denmark*
[6]*McLean Hospital Schizophrenia and Bipolar Disorder Program, Belmont, Massachusetts, USA*
[7]*Harvard Medical School Department of Psychiatry, Boston, Massachusetts, USA*
[8]*Semel Institute for Neuroscience and Human Behavior, David Geffen School of Medicine at UCLA, Los Angeles, California, USA*
[9]*School of Psychological Sciences, Monash University, Melbourne, Victoria, Australia*
[10]*Centre for Mental Health, Swinburne University of Technology, Melbourne, Victoria, Australia*
[11]*School of Psychology, University of Southampton, Southampton, Hampshire, UK*
[12]*Bipolar Disorder Program (PROMAN), Department of Psychiatry, University of São Paulo Medical School, São Paulo, Brazil*
[13]*Department of Psychiatry, University of Michigan, Ann Arbor, Michigan, USA*
[14]*Department of Child and Adolescent Psychiatry, NYU Grossman School of Medicine, New York, New York, USA*
[15]*Los Angeles, USA*
[16]*Laboratoire de Psychologie des Cognitions UR 4440, Université de Strasbourg, Strasbourg, France*
[17]*Department of Psychiatry and Human Behavior, Brown University, Providence, Rhode Island, USA*
[18]*Department of Child and Adolescent Psychiatry/Psychology, Erasmus MC-Sophia Children's Hospital, Rotterdam, The Netherlands*

Correspondence
Kim Wright, Department of Psychology, University of Exeter, Exeter, UK.
Email: k.a.wright@exeter.ac.uk

ORCID

Kim Wright https://orcid.org/0000-0003-3865-9743
Manja Koenders https://orcid.org/0000-0001-5908-258X

Katie M. Douglas https://orcid.org/0000-0002-5344-2959
Maria Faurholt-Jepsen https://orcid.org/0000-0002-0462-6444
Kathryn E. Lewandowski https://orcid.org/0000-0003-1477-6187
David J. Miklowitz https://orcid.org/0000-0002-9647-6147
Greg Murray https://orcid.org/0000-0001-7208-5603
Thomas Richardson https://orcid.org/0000-0002-5357-4281
Luisa de Siqueira Rotenberg https://orcid.org/0000-0001-9175-7567
Lauren M. Weinstock https://orcid.org/0000-0001-9970-235X

REFERENCES

1. Miklowitz DJ, Efthimiou O, Furukawa TA, et al. Adjunctive psychotherapy for Bipolar disorder: a systematic review and component network meta-analysis. *JAMA Psychiatry*. 2021;78(2):141.
2. Retzer A, Sayers R, Pinfold V, et al. Development of a core outcome set for use in community-based bipolar trials—a qualitative study and modified Delphi. Frey R, ed. *PLoS One*. 2020;15(10):e0240518.
3. Koenders MA, Dodd AL, Karl A, Green MJ, Elzinga BM, Wright K. Understanding bipolar disorder within a biopsychosocial emotion dysregulation framework. *J Affect Disord Rep*. 2020;2:100031.
4. Bipolar UK. *Bipolar Minds Matter: Quicker Diagnosis and Specialist Support for Everyone with Bipolar*. 2022. https://www.bipolaruk.org/Handlers/Download.ashx?IDMF=d4fd68a7-ffae-42bb-acf4-f7be3d903f02 Accessed March 21, 2024
5. Birmaher B, Merranko JA, Gill MK, et al. Predicting personalized risk of mood recurrences in youths and young adults with bipolar spectrum disorder. *J Am Acad Child Adolesc Psychiatry*. 2020;59(10):1156-1164.