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Psychosocial Interventions in Bipolar Disorder

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Abstract

Bipolar disorder is a chronic condition marked by episodes of mania and depression, significant functional impairment, and challenges with treatment adherence. Current guidelines highlight the importance of both medication and psychosocial approaches in treatment. This review explores the primary psychosocial interventions for bipolar disorder.

Psychoeducation helps recognize early symptoms, improves medication compliance, and prevents relapses. It is simple to implement and cost-effective. Family-Focused Therapy (FFT) enhances family communication, reduces emotional expression, and lowers the frequency of depressive episodes. Interpersonal and Social Rhythm Therapy (IPSRT) supports maintaining social stability by addressing disturbances in biological rhythms. Cognitive Behavioral Therapy (CBT) decreases depressive symptoms and boosts treatment adherence by restructuring automatic thoughts. Additionally, cognitive and functional rehabilitation programs improve attention, memory, and executive functioning. Peer support groups and digital e-health tools, though supportive, have limited evidence of effectiveness.

In summary, multicomponent psychosocial interventions serve as a valuable addition to medication, helping to prevent relapses, improve functioning, and enhance quality of life in individuals with bipolar disorder.

Introduction

Episodes of mania and depression characterize bipolar mood disorder. It has a lifetime prevalence of 1.2%. It occurs at similar rates across different societies and genders. It can start between the ages of five and fifty and may cause psychosocial impairment and disability.

Insight into bipolar disorder can be diminished not only during episodes but also between episodes.[1] Multiple episodes, particularly manic episodes, and the presence of psychotic symptoms during episodes are reported to reduce insight further.[2, 3, 4] Insight is a crucial concept in group therapy, as members can gain insight through their interactions with others and awareness of their own experiences.[5]

Treatment non-adherence in bipolar disorder ranges from 10% to 60%, leading to disease progression and functional impairment. Thirty to 60% of patients fail to regain their occupational and social skills. Persistent depressive symptoms have also been shown to negatively impact occupational and social functioning. Early

detection of symptoms and prevention of relapse are important elements in disease management.[6] During remission, problems with executive functions, memory, and attention may persist.[7] Individuals with bipolar disorder frequently encounter internalized social stigma. This internalized stigma is linked to increased challenges in cognitive functioning and interpersonal relationships.[8]

The APA Bipolar Disorder Treatment Guidelines report that psychosocial interventions are helpful for illness management, medication adherence, early symptom recognition, and interpersonal relationship problems. However, they note that dynamic and supportive therapies are ineffective.[9] The Texas treatment algorithm suggests that adding psychoeducation and cognitive therapies to pharmacological treatments may be beneficial.[10] Canadian treatment guidelines indicate that psychoeducation helps prevent relapse, that Cognitive Behavioral Therapy (CBT) is beneficial but controversial due to its cost, and that Interpersonal and Social Rhythm Therapy (IPSRT) has shown positive long-term outcomes. A family-centered approach has been shown to reduce risky behaviors, caregiver burden, and depressive symptoms. Psychosocial interventions are reported to improve treatment adherence and functioning, while also reducing the rates of relapse and hospitalization.[11] The NICE (National Institute for Health and Care Excellence) bipolar disorder treatment guide states that psychosocial approaches are highly effective in both episode and maintenance treatment.[12]

While CBT and psychoeducation are more effective when provided to patients in a euthymic state, Family-Focused Therapy (FFT) and IPSRT are more useful when started immediately after the acute phase. [11,13, 14, 15] The use of psychotherapy in acute mania is limited, with priorities being ensuring safety, reducing stimuli, ensuring adherence to pharmacotherapy, and implementing a crisis plan. [11] Psychoeducation is recommended as the initial psychosocial intervention in guidelines because it is easy to implement and cost-effective. CBT, FFT, and IPSRT require experienced therapists and tend to be more costly. [16]

Psychosocial interventions have been shown to reduce the recurrence rate of attacks by 40%. [14] While AOT, ACT, CBT, and e-CBT are more effective at shortening depressive episodes and preventing depressive recurrence, psychoeducation and systematic care programs are effective in preventing manic recurrence.[16–20] Psychoeducation, IPSRT, FFT, and structured skills-based group therapies are used in the maintenance phase. [6,21]

AOT is believed to be more helpful for families with highly expressed emotion, while IPSRT might be more beneficial for patients with interpersonal problems that contribute to mood symptoms.[15,16] A reduction in the number of depressive days has been observed when psychoeducation and CBT are used together.[22] Dialectical behavior therapy (DBT) has also been reported to be effective in preventing suicide in bipolar disorder, particularly in young individuals.[23] In recent years, digital versions of psychotherapies, phase-specific approaches, and transdiagnostic models have come to the forefront.[6]

Psychoeducation

Psychoeducation aims to identify early signs of relapses, improve medication adherence, utilize symptom-triggered strategies, sleep and social rhythm regulation, and preserve life.[24,25] It can be conducted by trained psychiatrists, psychologists, and social or government workers in 6-21 sessions, either in group or individual settings. İndividuals need to be in a healthy state to maintain learning and attention.[26] Structured group psychoeducation has been reported to be protective against relapse risk. [21] Therefore, psychoeducation is considered an important component of public health.

The psychoeducation program includes the following topics:[24,27]Session 1: The therapist introduces

themselves and the group members. The concept of psychoeducation is explained. Participants' goals and expectations for psychoeducation are discussed. The aims of psychoeducation are outlined. The program and group rules are explained. General characteristics of bipolar disorder, such as age of onset and frequency, are covered.

Session 2 focuses on recognizing the symptoms of bipolar disorder. It describes the symptoms patients have experienced during previous episodes. Symptoms are organized by disease stage. Specific symptoms of bipolar disorder, including manic and depressive states, are clarified. Information is provided about mixed episodes and the psychotic symptoms that can occur during episodes. The session also discusses the differential diagnosis of mood disorders with psychotic symptoms and other psychotic disorders.

Session 3 covers biological causes and environmental triggers, like stress and sleep issues, that contribute to bipolar disorder. It explains gene-environment interactions and explores the roles of brain structures and neurotransmitters in the condition.

Session 4 covers mood swings. The concepts of euthymic, elevated, depressed, and dysphoric moods are explained. Participants create mood charts showing the progression of mania and depression in bipolar disorder. The differences between mania and hypomania are clarified. The session discusses the chronic nature of the illness, relapse, and recurrence. Residual symptoms during non-episode periods are explained. Participants are encouraged to develop their own life charts. The frequency and severity of episodes, as well as the factors that trigger and prolong them, are identified.

Session 5 lists and groups pharmacological treatments currently used by patients and those they have used in the past. Their mechanisms of action categorize these into antidepressants, mood stabilizers, antipsychotics, and other options. The effects of medications on neurotransmitter system dysfunction are explained. Information on medication effects, dosages, duration of use, and common side effects is included. The rationale for using drug combinations, their effectiveness, and side effect profiles are discussed.

Session 6 focuses on relapse treatment and prevention, specifically addressing therapeutic and toxic dose ranges for mood stabilizers and the importance of monitoring blood levels. It is noted that these medications can have adverse effects on the liver, kidneys, heart, and blood values. The session emphasizes the importance of proper physiological functioning in the metabolism and excretion of drugs. It highlights the need for regular blood tests to assess liver, kidney, and thyroid function, as well as monitoring blood sugar levels and electrocardiograms (ECGs). Important considerations include the timing of these tests and avoiding medication before blood draws.

Session 7 covers patients' histories of treatment discontinuation, the reasons for discontinuation, and how these factors affect disease progression. It emphasizes the importance of maintaining treatment adherence and explains why lifelong maintenance therapy is essential, as well as how stopping treatment can lead to worsening of the disease. Besides medications, the session includes psychosocial interventions like CBT and IPSRT, along with psychosomatic treatments such as electroconvulsive therapy (ECT).

Session 8: Life charts are reviewed to assess triggering and maintaining factors. Early symptoms that occur before an attack are discussed. Close monitoring is recommended because these symptoms can worsen over time.

Session 9: Medication and lifestyle modification options are discussed if relapse symptoms persist or

worsen. This process includes identifying relatives and how to seek help (financial, transportation, social support, etc.), which healthcare provider to contact for an examination, methods of communication with the doctor, and the responsibilities of the patient, physician, and family member.

Session 10: Explains the concept of biological rhythm and discusses the link between biorhythms, social rhythms, and mood symptoms. It emphasizes that changes in daily routines can trigger attacks in bipolar disorder.

Session 11: Biological and social rhythms are evaluated using the social rhythm metric. The social rhythm metric is a 17-item questionnaire developed by Monk et al. (1990) that asks individuals to record the times and people they interact with during their daily routines (e.g., getting out of bed, first contact, breakfast, starting work). At the end of the session, a weekly social rhythm metric is assigned as homework.

Session 12: Patients' social rhythm metric records are reviewed. Difficulties in organizing daily routines are identified, and efforts are made to improve them.

Session 13: It is explained that children have an increased risk of occurrence due to genetic predisposition. Changes will be evaluated based on risk categories; the teratogenic effects of some changes may vary. Planned changes in reproduction may be regulated, while reproductive and postpartum changes could increase the risk of recurrence. The treatment processes related to reproduction are also discussed. The effects of alcohol and substances on the central nervous system, their connection with mood symptoms, their impact on drug metabolism, and the risk of triggering or worsening attacks are examined.

Session 14: Explains the concepts of acute and chronic illness, functionality, and disability. Covers job opportunities, benefits, potential work-related issues caused by illness symptoms, the impact of shift work on health, rest, disability, and disability reports. Provides information on legal issues, including guardianship, legal counseling, criminal liability, and mandatory treatment. Discusses the criticism and stigma patients face or observe, and addresses what can be done when patients experience adverse reactions.

Session 15: A family group meeting is held with members, such as the mother, father, sibling, spouse, or children, who live with the participant or have close contact with them. It involves sharing information about symptoms, the progression of the illness, and treatment. Problem areas are discussed, relationships are explored, and potential solutions are suggested.

Session 16 covers recovery and partial remission information, seeking insights into budgetary findings. The psychoeducation program ends with patients giving feedback on the psychoeducation process.

Biorhythm Therapy

Periodic changes in humans caused by time are called "biological rhythms," or simply "biorhythms," and the environmental factors that influence them are known as time regulators. The most effective of these are sunlight and the secretion of melatonin.[28] Social factors, such as work schedules and mealtimes, also act as time regulators.[15] Disruptions in biological rhythms are observed in mental illnesses. Insomnia has been shown to double the risk of depression.[29] Sleep deprivation can also trigger manic and hypomanic episodes in 4-6% of patients with bipolar disorder.[30] Exposure to sunlight is linked to seasonal depression, and bright light therapy has been effective in treating this condition.[31]

Patients with bipolar disorder should strive to get a consistent 7-9 hours of sleep each night. They should also avoid sleep deprivation related to work, limit afternoon naps to 30 minutes or less, and refrain from consuming coffee, smoking cigarettes, engaging in stimulating activities, and participating in intense discussions before bed. Research suggests that adhering to a regular wake-up time is more beneficial than adhering to a fixed bedtime. People on lithium should steer clear of activities that lead to salt loss, like visiting saunas, vomiting, or excessive sweating. They should also avoid overeating and strict dieting, as these can raise stress levels. In some instances, exercise might trigger a manic episode. Although exercise is beneficial during euthymic or depressive phases, it can lead to overstimulation during a manic episode, potentially worsening symptoms.

Family-Focused Therapy (FFT)

Patients with bipolar disorder who experience negative family attitudes and high levels of expressed emotion are more likely to relapse and have lower functioning. Family-focused therapy helps families identify symptoms and warning signs, develop coping and problem-solving strategies, address high levels of emotional expression, improve communication, and enhance overall functioning. The therapy, initiated immediately after the acute phase, consists of 21 sessions. Family members, including parents, children, spouses, siblings, close relatives, or caregivers, are welcome to participate.

The first part covers psychoeducation, the second focuses on communication development, and the final part addresses problem-solving.[32] At a 2-year follow-up, patients who received family-focused therapy experienced fewer relapses and hospitalizations than those who received individual therapy.[33] It has also been shown that patients undergoing family-focused therapy had quicker resolution of depressive symptoms and fewer depressive episodes during the two years. However, it did not affect the symptoms of mania.[16] Although AOT has been reported to be more effective for depressive episodes, some studies suggest it may influence manic and hypomanic episodes but not depressive or mixed episodes.[34] Considering the widespread presence of extended families in our country and that patients usually live with their families, psychoeducation for families is likely to be more beneficial.[35]

Technology-assisted Family-Focused Therapy is efficacious in improving family communication, reducing caregiver burden, and decreasing crisis frequency, especially in young patients.[36]

Interpersonal and Social Rhythm Therapy (IPSRT)

Social factors are known to influence biological rhythms. All life events, whether positive or negative, disrupt patients' social rhythms, which can then affect their circadian rhythms and contribute to the development of bipolar disorder symptoms. Interpersonal and social rhythm therapy uses behavioral techniques to help patients organize their daily routines, address interpersonal issues, and maintain consistent medication adherence.[15] Lifestyle changes encompassing diet, physical activity, sleep, alcohol and substance use, and social relationships have been reported to have positive effects on symptoms and functionality. [37]

The IPSRT program comprises four phases and typically spans 16 to 20 sessions.[15] In the first phase, a history of past illnesses is taken, and the structure of the patient's interpersonal relationships and problem areas is examined. During the second phase, weekly meetings are held to organize the patient's daily life and address areas of concern in interpersonal relationships. Education on sleep hygiene is provided, and factors affecting circadian rhythms—such as the menstrual cycle, season, and excessive fatigue—are identified. Using the social rhythm metric, the frequency and impact of social

interactions, like meetings with friends, are evaluated, and their frequency and intensity are adjusted as needed. Plans are made to address potential disruptions in balance, such as scheduling several stable days before engaging in vigorous physical activity. Efforts are also made to maintain consistent social rhythms, even in unexpected situations.

Patients with bipolar disorder may experience a grieving-like process related to the loss of well-being following this illness, so treatment focuses on redefining what is healthy, encouraging the patient to accept their current situation, and developing appropriate attitudes. Mood swings caused by interpersonal conflicts and adaptive situations—such as marriage or starting a new job—can worsen the illness. Efforts are made to help the patient transition more adaptively by reassessing areas of difficulty, reducing sources of excessive stress-like leaving a managerial position for a more comfortable role—and discussing the benefits of new roles. Sessions also focus on helping the individual recognize their positive qualities, learn to interact with social groups, and appreciate the benefits of sharing with others. The third phase aims to help individuals maintain their social rhythms and improve their interpersonal relationships, even during more challenging times—such as holidays or job changes. In the final phase, session frequency gradually decreases, while efforts continue to sustain the gains achieved during therapy. IPSRT is more effective in individuals who do not experience anxiety and have recently gone through the acute phase, meaning those with high motivation to change.[38] An online or human-assisted hybrid IPSRT approach could increase reach; however, symptom-monitoring and risk-management protocols need to be developed.[39]

Cognitive and Functional Remediation

Functional remediation is a program designed to improve functional impairment and cognitive decline, consisting of 21 group sessions, each lasting 90 minutes.[40] These sessions take place at two locations: the clinic and the home. Patients develop skills in memory, attention, problem-solving, reasoning, multitasking, and organization through exercises, followed by paper-and-pencil tasks and group activities.

Cognitive remediation program content:

1. Introduction to functional remediation: The role of the family. Strengthening and expanding practice.
2. What are the most common cognitive impairments in bipolar disorder? Myths and facts.
3. Factors that influence cognitive impairment.
4. What is attention? Strategies for improving it.
5. Techniques for enhancing attention and applying them in daily life.
6. What is memory? Strategies for boosting it.
7. Memory aids: diaries and other external tools.
8. Internal methods for improving memory.
9. Additional strategies for enhancing memory and their use in daily life.
10. Reading and recall.
11. Puzzle: Retrieving information from the past
12. Executive functions: self-direction and self-monitoring
13. Executive functions: scheduling and organizing activities

14. Executive functions: planning activities, prioritizing, and time management
15. Executive functions: problem-solving techniques
16. Executive functions: problem-solving
17. Managing stress situations
18. Communication skills training
19. Improving communication
20. Improving autonomy and interpersonal relationships
21. Final session

Research has demonstrated a significant impact on functionality.[41] Studies on computer-based cognitive remediation also show a positive effect on cognitive functions.[42]

Cognitive Behavioral Therapy (CBT)

Cognitive behavioral therapy (CBT) can be used to treat depressive episodes in bipolar disorder and prevent relapses.[18] It involves addressing automatic thoughts, correcting cognitive distortions, improving medication adherence, preventing relapse, managing stress, preventing overactivation, and controlling mood symptoms.[43] Therapy typically lasts 20 to 25 sessions.[44]

In cases of bipolar disorder, structured, skill-focused, and material-based cognitive behavioral approaches and supportive, patient-centered, and emotion-focused approaches have been reported to be similarly effective in preventing relapse.[43]The effectiveness of CBT varies with factors such as the number of episodes experienced, comorbidities, level of functioning, and regular therapy attendance. [43] [45][44,46]A meta-analysis showed improvements in many areas beyond depressive symptoms. [47] It has been reported that patients who undergo CBT have increased treatment adherence and better functioning, but additional sessions are necessary because its effectiveness diminishes over time. [45,48,49] The group CBT program for bipolar disorder is conducted as a 90-minute session over 12 weeks, involving 8-10 individuals.[50]

The first module (Sessions 1-4) aims to increase patients' independence by supporting medication adherence and monitoring their mood. In the first session, group members and therapists introduce themselves, discuss expectations, and emphasize the importance of active participation. The second session focuses on attention, which underpins other cognitive skills. It includes exercises to improve attention and memory. The third session emphasizes the connection between medication adherence and attention, focusing on helping patients organize their chaotic environments to improve adherence. The fourth session introduces mood charts and stresses the importance of early detection of mood swings. Patients are also encouraged to cook to foster independence.

The second module (sessions 4-8) focuses on enhancing social cognition and communication. In the fifth session, patients are introduced to the concept of automatic thoughts. Cognitive distortions are discussed with examples from the participants' own experiences. During the sixth session, patients are encouraged to restructure their own thoughts through thought-recording exercises. The session also covers mental flexibility and empathy. In the seventh session, patients learn about effective communication and emotion recognition through role-playing exercises. The eighth session continues with the same agenda as the seventh.

The final module (sessions 9-12) focuses on improving problem-solving skills and preventing relapse.

The ninth session begins with identifying personal problems and highlights the importance of mental flexibility in generating multiple responses to each issue. In the 10th session, patients learn problem-solving techniques. The 11th session reviews progress and addresses patient questions. Sleep hygiene techniques are discussed, including the importance of maintaining regular routines and a consistent sleep schedule. The session ends with a relaxation exercise. The 12th session revisits the personal goals set in the first session and encourages patients to develop a relapse-prevention plan.

Mindfulness-based cognitive behavioral therapy is a helpful option for reducing avoidance behaviors and rumination, particularly in individuals with residual depressive symptoms and comorbid anxiety. [51]

Peer Groups

Peer groups are a key strategy believed to reduce self-stigma and isolation in bipolar disorder and boost treatment engagement.[52] However, caution is needed when using this approach, as it can be risky if peers leading the intervention lack proper training or support and offer perspectives that do not support treatment adherence or promote substance use. A study comparing the effectiveness of group psychoeducation and peer support found similar gains in illness knowledge. However, psychoeducation was considered more acceptable by participants and more effective in preventing relapse.[53] Peer interventions are included in guidelines as a third-line treatment option for maintenance therapy.

E-Health

E-health encompasses a wide range of topics, including computer-based self-help tools, online therapy, informational websites, social media platforms such as Facebook, health-related internet forums, personal blogs, and video games. Despite the practical use of digital applications, human interaction is considered more effective.[36] Social media and websites are well-known sources of psychoeducation about mental health issues. New platforms such as YouTube are becoming increasingly important for peer support. They also provide tools for monitoring symptoms such as mood charts, tracking daily routines, monitoring sleep duration and patterns, and raising awareness of social rhythms. [39]. Mobile brief ACT interventions that respond to symptom inputs in patients with bipolar disorder can be helpful between appointments or in situations where access to healthcare is limited. Still, integration with clinic referral systems is needed when identifying conditions such as suicidal risk and manic exacerbations. [20]While these methods are popular, only online therapy and video games have been studied for their effectiveness.[19] There is currently no published research on effective social communication strategies, including those employed on social media and blogs.

Conclusion

Current treatments for bipolar disorder, including biological therapies, can decrease the severity of the illness and improve its progression. However, they also encounter challenges, including patient adherence and preventing disease recurrence. After symptoms diminish following an acute episode, patients may believe they are completely healed, which can result in noncompliance with medications or stopping treatment altogether, raising the likelihood of additional episodes. Sometimes, the early signs of an episode may be overlooked, resulting in delays in treatment. Strategies such as psychoeducation, family-focused therapy, IPSRT, and cognitive-behavioral therapy have been successfully used to address these issues.

Psychoeducational interventions offer benefits, including helping patients recognize and understand their illness, ensuring their active participation in treatment, and enhancing coping skills. The thera-

pist's role in group and interpersonal interactions during psychoeducation can serve as a model for participants in other social settings. Studies indicate that greater benefits occur when CBT is combined with psychoeducation during a depressive episode. Because circadian rhythm irregularity is a risk factor for mood episodes, addressing this issue is believed to help prevent relapses. Cognitive remediation focusing on executive functions (organization, planning, time management, attention, memory, etc.) and CBT for managing depressive moods may benefit patients with bipolar disorder.

Evidence regarding psychosocial interventions in bipolar disorder is limited due to their inability to be used at every stage and the heterogeneity of study designs. While research on online psychotherapy and mobile applications is increasing, these studies often involve small sample sizes, short follow-up periods, and limited risk assessment and relapse-prevention measures. Future research should include longer-term, individualized, and human-supported digital models.

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All data generated or analyzed during this study are included in this article. Further enquiries can be directed to the corresponding author.

Abbreviations

FFT: Family-Focused Therapy

IPSRT: Interpersonal and Social Rhythm Therapy

CBT: Cognitive Behavioral Therapy

ECT: Electroconvulsive therapy

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