Positive and Negative Effect and Bipolar Disorder. Are the Psychosocial Therapies: Cognitive Behavioural Therapy, Family Focused Therapy and Group Psychoeducation in Adjunction with Pharmacotherapy Effective in the Management of Relapses of Manic and Depressive Episodes in Bipolar Disorder?

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Positive and Negative Effect and Bipolar Disorder. Are the Psychosocial Therapies: Cognitive Behavioural Therapy, Family Focused Therapy and Group Psychoeducation in Adjunction with Pharmacotherapy Effective in the Management of Relapses of Manic and Depressive Episodes in Bipolar Disorder?

Author(s): Qazi E, Siddiqui MR

Abstract

Aim
Are the psychosocial therapies: Cognitive Behavioural Therapy, Family Focused Therapy and group psychoeducation in adjunction with pharmacotherapy effective, in the management of relapses of manic and depressive episodes in Bipolar Disorder?

Method
Three studies were selected to assess the effectiveness on the following psychotherapies in adjunction with pharmacotherapy: Cognitive-Behavioural therapy, Family Focused Therapy, Group Psychoeducation

Relevant studies were collected by searching through databases. Databases used were SCOPUS, EBSCO and Google Scholar.

The Inclusion/ Exclusion criteria were used to select relevant studies. Once articles were selected the studies were critically appraised to assess the strength of the study.

Findings
Cognitive Behavioural Therapy decreases recurrences of episodes in participants with less than 12 episodes per year, but this therapy was found to be ineffective in participants who have more frequent episodes.

Group Psychoeducation was found to reduce the number of recurrences of episodes of mania/depressive or mixed episodes in Bipolar Disorder.

Multifamily group therapy found no significant effect in decreasing recurrences of episodes in Bipolar Disorder.

Conclusion
Psychotherapies are found to be effective in preventing recurrences of episodes in mania/depression in Bipolar Disorder, particularly Group Psychoeducation and Cognitive Behavioural Therapy. However, Family Focused Therapy has found to have no significant effect in preventing recurrence of episodes in Bipolar Disorder.

Introduction

Bipolar disorder
Bipolar Disorder is a chronic condition (1) defined as ‘an episodic disturbance with interspersed periods of depressed and elevated mood; the latter is known as hypomania, or mania when severe.’ (2)

In the past Bipolar Disorder was known as ‘Manic-Depressive’ illness, the term coined by Kraepelin in 1921 (3). The older name quite adequately describes the symptoms of a patient diagnosed with Bipolar Disorder. In which the patient experiences a fluctuation of moods, from the feelings of extreme happiness and elation termed as mania to the feelings of intense despair and low moods, termed as depression (4). The DSM-IV classifies Bipolar Disorder into two different subtypes (6):

- **Bipolar Type I**: Patients would experience one high or manic episodes that lasts for one week. Some patients would only experience manic episodes, although most patients would have experienced depressive episodes as well. Manic episodes which are not treated usually lasts up to 3 to 6 months and untreated depression episodes...
lasts 6 to 12 months without treatment (7).

- **Bipolar Type II**: Depressive episodes are more severe and more frequent than manic episodes. The manic episodes are not as severe as Bipolar type I but the patients with Bipolar Type II experiences at least one hypomanic episode (1).

**Onset of Bipolar Disorder**

The first episode of bipolar disorder maybe characterised by either a manic or depressive episode(7). The peak age of the onset of these episodes usually arises in the teens and early twenties(7). However, some patients may have their first onset in much earlier ages; these onsets can occur in ages ten years or younger(7). Ninety per cent of patients would have had their first episode before the age of fifty (8).

**Recurrence risk of episodes in untreated bipolar disorder**

A recurrence by the DSM-IV criteria was defined of the emergence of a new acute episode(9). The recurrences of episodes of mania or depression are unpredictable (1). However, on average if bipolar disorder is left untreated a patient would experience ten episodes of either mania or depression, within their lifetime(1).

An episode of mania or depression would occur within one year in about half of cases and within four years, 3 out of 4 people would have had another episode(1).

The duration of ‘normal’ moods is also shortened between mania or depressive episodes and episodes starts to become more frequent and prolonged, if left untreated(1).

**Preventative Pharmacotherapy of relapse/recurrence of manic/depressive episodes in Bipolar Disorder**

Bipolar disorder cannot be ‘cured’, but treatment is given to help manage patients’ episodes by preventing relapse or shortening the manic or depressive episodes(1).

For the prophylactic recurrence of episodes in Bipolar Disorder, pharmacotherapy and/ or psychotherapy can be used.

Doctors usually prescribe pharmacological interventions to improve patients’ symptoms(9). Medications which doctors prescribe to help prevent relapse of episodes of hypomania, mania and depression, are all termed as ‘mood stabilisers’(1).

These types of medications are first line therapy for the prevention of relapse of episodes. These medications are usually taken as a long term therapy for the management of relapse of episodes in bipolar disorder (10).

The Clinical Knowledge Summary review concluded ‘lithium, valproate, lamotrigine, and olanzapine are effective as maintenance therapy for the prevention of relapse in bipolar disorder. Olanzapine and lithium are effective for the prevention of manic relapses. Valproate and lamotrigine are effective for the prevention of depressive relapses. (10).

**Relapse rate of episodes of Bipolar Disorder of patients with Pharmacotherapy**

However, the recurrences of episodes are still high and the remission rates are low for patients with Bipolar Disorder who take pharmacotherapy. The relapse rate of patients with good adherence to pharmacotherapy is 73% in a 5 year period and the remission rate for episodes of bipolar disorder is 24% (15,16).

Furthermore non- compliance in taking medication for the prophylaxis of bipolar disorder is a problem and occurs in 42% of patients (17).

Therefore the aim of this review is to see if psychotherapy in adjunction with long term ‘mood stabilising’ drugs are effective for the management of relapses of manic and depressive symptoms in Bipolar Disorder.

For this review I would select a study each assessing the effectiveness on the following psychotherapies in adjunction with pharmacotherapy:

- Cognitive- Behavioural therapy
- Family Interventions
- Group Psychoeducation

The studies would then be critically appraised, analysed and a conclusion would be drawn of how effective psychotherapy is in adjunction with pharmacotherapy in preventing relapse of manic/depressive episodes in Bipolar Disorder.

**Preventative psychotherapy for relapse of mania/depression of Bipolar Disorder**

According to the NICE clinical guidelines mostly all patients with Bipolar Disorder have psychosocial interventions are combined with pharmacological interventions for the prophylaxis of recurrent Bipolar Disorder, due to theory of the Stress- Diathesis Model (18).

The Stress-Diathesis Model indicates that people, who are genetically or biologically predisposed to Bipolar Disorder, would trigger episodes of Bipolar Disorder when the person is in a stressful environment(18).
Cognitive- Behavioural therapy (CBT)(19):
The goals of CBT for patients with bipolar disorder, involves:

- Facilitate acceptance of the disorder and the need for treatment
- Recognising Psychosocial stressors and interpersonal problems
- Improving medication adherence
- Developing coping strategies for depression and hypomania
- To recognise prodromal episodes of mania and depression
- To identify and modify negative automatic thoughts and dysfunctional thinking

The clinical rationale for using CBT is based on an approach by Basco and Rush, 1995 (20):
This approach incorporates the stress- diathesis model as it takes in mind that biological factors are involved in mood shifts(19).

This model shows the association with CBT therapy and pharmacological interventions, for the management of Bipolar Disorder by emphasising the link of the patients’ cognitions, feelings, moods and psychosocial symptoms and biological symptoms (particularly sleep disturbance) with the interactions of the environment i.e. stressful events or experiences that are a cause or consequences of other shifts)(19).

Therefore the rationale for using CBT therapy for the management of Bipolar Disorder makes the patient aware that changes in moods, behaviour and biological symptoms are all linked together in Bipolar Disorder(19).

When the patient identifies this relationship the patient would understand the reason and rationale of using CBT therapy as well as the understanding of the importance of adherence to medication(19).

Family Focused Therapy (FFT):
The theoretical basis for Family Focused Therapy is that studies had shown that impaired family functioning decreases the rate of recovery from a depressive episode also high levels of expressed emotion (excessive criticism or emotional over involvement) within the family have shown to increase the likelihood of relapse after hospital discharge for patients with depression (21).

There has been some research for the expressed emotion theory in bipolar disorder (22).

Consequently Family Focused Therapy was grown by the expressed emotion theory. Therefore, this therapy focuses on the patient and the family/ caregivers to tackle expressed emotions(21).

FFT is a three step therapy, in which involves:(21,23)

1) Psychoeducation of Bipolar Disorder. Information about the nature, aetiology, treatment and self-management of Bipolar Disorder also to teach the relapse of these episodes to the family.

2) Enhance communication so to resolve conflicts and decrease negative feelings within the family.

3) Problem-solving skills training to manage conflicts in the family.

The treatment involves 21 sessions over 9 months, and sometimes booster sessions are given, when the formal treatment ends(19).

Group Psychoeducation:
This therapy is where information and education is given to the patient/ carer in a group programme(9). Information, support and different management strategies are given to the patient/ carer including(9):

- Illness awareness
- Treatment compliance
- Early detection of prodromal symptoms and relapse
- Lifestyle regularity

According to the psychoeducation treatment these goals are achieved partly through knowledge about the illness and behaviour change directly but also through the attitudes to treatments so to improve adherence to medications (24).

Locus of Control is thought to be an explanation of the outcomes of psychoeducation. Locus of control refers to the degree to which an individual perceives their life experiences related to their own behaviour or to external factors(24). Therefore, psychoeducation helps patients to gain more ‘control’ in managing Bipolar Disorder(24).

Methods

Methods
Multiple resources were used to access relevant information for this review’s aim. Initially, background research was done about Bipolar Disorder.

To gain relevant studies and articles, databases were used; the databases that were used for this review were SCOPUS, EBSCO and Google Scholar.

Resources used for background information
Initially, background research was done about Bipolar Disorder. Books were obtained from the Harold Cohen Library, for background reading and relevant E-Books were also accessed from the University of Liverpool.
Library intranet.
In addition, Google was used, where keywords were entered e.g. 'Bipolar Disorder' and 'Psychotherapies'. Websites which were most relevant to the keywords were accessed and explored.

For recent information on the guidelines and management of Bipolar Disorder, National Institute of Clinical Excellence website was researched.

For comprehensive information, studies, journals and articles specifically on the review's aim, databases were used.

**EBSCO search strategy**

EBSCO was one of the online databases used for this review.

EBSCO online database was accessed through the University of Liverpool Library intranet. For the authorisation of access of viewing full text articles and not just the abstract of some articles, compared to if accessed directly through the EBSCO website.

For finding relevant articles in a manageable amount, firstly the databases were limited which was listed on EBSCO, the databases that were selected were:

- Academic Search Complete
- AMED - The Allied and Complementary Medicine Database
- CINAHL Plus, Humanities International Complete
- MEDLINE with Full Text
- PsycARTICLES, PsycINFO
- University of Liverpool Catalogue and Accessible Archives

Secondly, Boolean terms were used such as 'AND', 'NOT' and 'OR' also limitations were applied to the search databases, using the inclusion/ exclusion criteria (see Table 4).

An example of the EBSCO search history is shown in Table 3.

When articles were selected, sometimes articles cited other journals. These secondary referencing was also accessed and explored, so to gain more information. Of which, was frequently referenced was The British Journal of Psychiatry (BJPsych). Articles in the BJPsych were also researched.

**Inclusion/ Exclusion Criteria**

The inclusion/ exclusion criteria were used whilst searching for articles, to focus on more relevant articles, for this review.

The studies would be critically appraised along the course of the review, to help assess the strength of the study.

**Discussion**

Since the aim of the review is to see if CBT, FFT and Group Psychotherapy are effective in managing the recurrence of manic/ depressive episodes in Bipolar Disorder; aspects of the studies and therapies would be critically appraised to come to a conclusion about the effectiveness of the psychotherapies.

**Study Design**

Overall, all studies(26,31,9) uses a Randomised Control Trial (RCT) design, which is considered as the ‘Gold Standard’ study design, which reduces bias and confounding factors compared to other study designs and causes an increase in validity of results.

However, the CBT therapy study by Scott et al(26) and the Group Psychoeducation theory by Colom et al(9), did not regulate or monitor the pharmacotherapy which patients received from the psychiatrists. Some participants may receive more potent medication than others or participants may not have the same medication as other participants.

The FFT study by Solomon et al(31), provided participants the same medications, as other participants, thus minimising confounding variables, however, some medications may have different effects on people, i.e. selected medications may have different effects on managing episodes of mania/ depression in each participant.

All these factors can decrease the accuracy of the studies’ results(26,31,9).

**Sample**

**Generalisability**

All studies(26,31,9), due to ethical reasons, only participants who gave their consent to take part in the study were selected, this can cause bias since these participants may have differing characteristics compared to participants who did not give their consent to take part in the study.

In addition, the CBT study by Scott et al(26) only selected participants who could read and write English and FFT study by Solomon et al(31), only selected participants who could speak English, therefore, these study’s results cannot be generalised to people who cannot read, write or speak in English.

However, the CBT study by Scott et al(26) selected participants from different cities around the UK, these results can be generalised to patients with Bipolar Disorder in the UK, but in different countries, and similarly the Group Psychoeducation study by Colom
et al (9) only selected patients from the Hospital Clinic at the University of Barcelona (Spain). This decreases the external validity and therefore a cause-effect relationship cannot be applied to other countries. The FFT therapy by Solomon et al (31) did not specifically mention where participants were selected, apart from “a university-affiliated psychiatric hospital” (31) and therefore this questions, if participants were selected from a variety of places, or one localised area, hence diminishing the outlook of participants variables and results.

Since the FFT study by Solomon et al (31), only selected patients who received therapy from hospitals causes a bias compared to other patients who had no contact with hospital therapy.

Power Analysis

A power analysis was done in the CBT study by Scott et al (26), this shows that the sample was large enough to show a statistical significance in the results are reliable and accurate. However, the FFT study by Solomon (31) and the Group Psychoeducation study by Colom (9) did not mention any power analysis and therefore there are doubts if the results are reliable and accurate.

Baseline Characteristics

All of the studies (26, 31, 9) were checked if participants had similar baseline characteristics by the Inclusion/exclusion criteria, this increases the accuracy of the results, since there is a decreased uncertainty that the results were not caused by other factors.

However, the studies (26, 31, 9) does not specify how much females or males are in the study and does not specify the proportions of age-groups involved in the study. Since these factors may have an impact on the results.

Data Collection

The CBT study by Scott et al (26) uses a purely interview technique, the method of the FFT study by Solomon et al (31) bases purely on structured questionnaires, letting the patient rate their mood on the questionnaire. The Group Psychoeducation study by Colom et al (9), uses both structured questionnaires and interview techniques.

The disadvantages with interviews are that it relies on self-report and some data may be untrue also there could be interviewer bias in an interview approach. Therefore, interviews may not be very reliable.

Questionnaires have the same disadvantage, in terms of the participants giving inaccurate information.

Outcome

The group psychoeducation study by Colom et al (9) had concluded from their results that group psychoeducation has reduced the number of recurrences of episodes in bipolar disorder and increased the length of time to manic/depressed/mixed recurrences (9). Therefore, group psychoeducation is effective in decreasing in recurrences of episodes in Bipolar Disorder.

Cognitive Behavioural therapy according to the Scott et al (26) study shows that only patients who experiences less than 12 previous episodes shown improvement by CBT therapy for decreasing the number of recurrences in bipolar disorder. However, the patients who experiences more frequent episodes of mania/depression, CBT therapy has no significant effect in decreasing recurrences of mania/depression in Bipolar Disorder (26).

For the multifamily group therapy there was no significant effect in decreasing recurrences of episodes in Bipolar Disorder, however, this therapy did decrease the hospitalisation rates of patients (31).

Criticisms of Therapies

Cognitive Behavioural Therapy

The advantages for CBT is that it teaches patients managing skills and necessary tools on how to cope with their thinking and teaches them, identifying and managing stressful experiences, so patients can use these coping skills, independently, in their life. The disadvantage is that CBT therapy just focuses on the individual and on their cognitions and does not consider any other factors in a patients’ life e.g. the patients’ family.

Family Focused Therapies

Advantages for FFT are that it helps the family aware of the patient’s illness; this can help the family understand and support the patient with their Bipolar Disorder. This approach, unlike Group Psychoeducation and Cognitive Behavioural Therapy is that it can help in managing episodes with patients who have learning disabilities or other mental health needs. Disadvantage with FFT is that the therapist does not give much emphasis on the patient themselves, and highlight issues with the patient.

Group Psychoeducation

Advantages for group psychoeducation are similar to CBT; helps patients develop the knowledge and skills for managing Bipolar Disorder themselves.

For the patient being in a group with people, who have the same illness, this helps patients motivate each other and patients can receive more information based on real life experiences (32). Disadvantages are that
group members may have a negative effect on the patient also the patient may wish to have one-to-one contact with the psychotherapist and may hesitate in any input or questions which they would like to ask (33).

**Future Research**

Since only three psychotherapies were researched in this review other psychotherapies can be researched in the effectiveness of recurrences in manic/depressive episodes in Bipolar Disorder for example Interpersonal Social Rhythmic Therapy or different elements of Psychoeducation. Comparison of psychotherapies could be researched to see which psychotherapy is effective in managing Bipolar Disorder.

It would be interesting to research on therapies on adolescents with Bipolar Disorder to see if therapies are effective on adolescents.

**Conclusion(s)**

Pharmacological interventions do alleviate and prolong symptoms of Bipolar Disorder, but this does not necessarily mean that patients would not have recurrent episodes of mania/depression. Psychotherapies have shown to improve these recurrent episodes of Bipolar Disorder.

In general, Cognitive behavioural therapy, Family Focused Therapy and Group Psychoeducation has shown that it has shown some therapeutic effect on Bipolar Disorder. In particular, Group Psychoeducation and Cognitive Behavioural Therapy in preventing the recurrences of mania/depression in Bipolar Disorder. Family Focused Therapy did not show a significant effect in decreasing the recurrence of mania/bipolar disorder, but has shown to decrease re-hospitalisation.

**References**

Symptoms of mania or a manic episode include:

<table>
<thead>
<tr>
<th>Mood Changes</th>
<th>Behavioural Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>A long period of feeling &quot;high,&quot; or an overly happy or outgoing mood</td>
<td>Talking very fast, jumping from one idea to another, having racing thoughts</td>
</tr>
<tr>
<td>Extremely irritable mood, agitation, feeling &quot;jumpy&quot; or &quot;wired.&quot;</td>
<td>Being easily distracted</td>
</tr>
<tr>
<td>Increasing goal-directed activities, such as taking on new projects</td>
<td>Having an unrealistic belief in one's abilities</td>
</tr>
<tr>
<td>Being restless</td>
<td>Having an unrealistic belief in one's abilities</td>
</tr>
<tr>
<td>Sleeping little</td>
<td>Being restless or irritable</td>
</tr>
<tr>
<td>Having an unrealistic belief in one's abilities</td>
<td>Changing eating, sleeping, or other habits</td>
</tr>
<tr>
<td>Behaving impulsively and taking part in a lot of pleasurable, high-risk behaviours, such as spending sprees, impulsive sex, and impulsive business investments</td>
<td>Thinking of death or suicide, or attempting suicide.</td>
</tr>
</tbody>
</table>

Symptoms of depression or a depressive episode include:

<table>
<thead>
<tr>
<th>Mood Changes</th>
<th>Behavioural Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>A long period of feeling worried or empty</td>
<td>Feeling tired or &quot;slowed down&quot;</td>
</tr>
<tr>
<td>Loss of interest in activities once enjoyed, including sex.</td>
<td>Having problems concentrating, remembering, and making decisions</td>
</tr>
<tr>
<td>Being restless or irritable</td>
<td>Being restless or irritable</td>
</tr>
<tr>
<td>Changing eating, sleeping, or other habits</td>
<td>Thinking of death or suicide, or attempting suicide.</td>
</tr>
</tbody>
</table>

Table 1: Symptoms of Mania and Depression (5)
Illustration 2

Table 2: Medications used as long term therapy for the management of manic/depressive episodes of Bipolar Disorder in regards to NICE clinical guidelines and Clinical Knowledge Summary

<table>
<thead>
<tr>
<th>Medications</th>
<th>Medical Uses</th>
<th>Effect on Recurrence of episodes in Bipolar Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lithium</td>
<td>- The ‘Gold standard’ treatment as a ‘mood stabiliser’ for Bipolar Disorder is Lithium(11).</td>
<td>‘Lithium versus placebo: Five RCTs (n = 1102) compared lithium with placebo. Lithium was more effective than placebo at reducing manic relapses but unlikely to make a difference with regard to depressive relapses (10).’</td>
</tr>
<tr>
<td></td>
<td>- Lithium is used for the treatment of mania, for the prophylaxis of recurrence in bipolar disorder(12).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Used as an adjunction therapy with anti-depressants for patients with bipolar disorder who had an incomplete response to treatment of acute depression also used for prophylaxis of recurrent depression (12).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- A study has shown that recurrence of episodes was 18.7 fold higher in patients who was not taking lithium compared to those who were (13).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- The Clinical Knowledge Summaries, found:</td>
<td></td>
</tr>
</tbody>
</table>
### Valproate
- Valproate is used only for the treatment for manic episodes (12).
- Used as prophylaxis of recurrence of Bipolar Disorder (12).
- Used in adjunction in with Lithium for patients who have frequent relapse or with functional impairment (12).
- Long-term combination therapy of Valproate shows that the drug does decrease the frequency of episodes, however long term monotherapy still needs to be proven (14).

### Olanzapine
- Olanzapine is used for long term treatment for bipolar disorder (9).
- It is also used as a treatment for acute mania (9).
- For patients with frequent relapse and functional impairment (9).
- A study which The Clinical Knowledge Summary noted:

  **Olanzapine versus placebo:**
  One RCT ($n = 361$) assessed the efficacy of olanzapine with placebo, and found that olanzapine was more effective than placebo in reducing manic relapse in olanzapine responders. (10)
<table>
<thead>
<tr>
<th>Carbamazepine</th>
<th>Lamotrigine</th>
</tr>
</thead>
</table>
| • Carbamazepine is used for the prophylaxis of bipolar disorder in patients unresponsive to a combination of other prophylactic drugs (12).<br>  
   • Studies have shown that ‘Carbamazepine, used either as monotherapy or in combination with other agents, may decrease the recurrence of episodes of both mania and depression’ (10). | • Lamotrigine is prescribed to patients if other prophylactic drugs are ineffective for the relapse of bipolar disorder (12).<br>  
   • A study which The Clinical Knowledge Summary noted: ‘Lamotrigine versus placebo’
   Three RCTs (n = 822) compared the efficacy of lamotrigine with placebo. Lamotrigine was no more effective than placebo, except for those people with rapid-cycling bipolar disorder where it was more effective than placebo. (10)’ |
Illustration 3

Table 3- EBSCO search history

<table>
<thead>
<tr>
<th>Number</th>
<th>Searches</th>
<th>Results Obtained</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Bipolar Disorder</td>
<td>5483</td>
</tr>
<tr>
<td>2</td>
<td>Relapse in Bipolar Disorder</td>
<td>223</td>
</tr>
<tr>
<td>3</td>
<td>Number 1 and Psychotherapy</td>
<td>331</td>
</tr>
<tr>
<td>4</td>
<td>Relapse in Bipolar Disorder and Psychotherapy</td>
<td>28</td>
</tr>
<tr>
<td>5</td>
<td>Number 1 ‘AND’ Cognitive Behavioural therapy (CBT)</td>
<td>21</td>
</tr>
<tr>
<td>6</td>
<td>Number 1 ‘AND’ Family Focused Therapy (FFT)</td>
<td>27</td>
</tr>
<tr>
<td>7</td>
<td>Number 1 ‘AND’ Group Therapy</td>
<td>90</td>
</tr>
<tr>
<td>9</td>
<td>Number 2 ‘AND’ Cognitive Behavioural Therapy (CBT)</td>
<td>6</td>
</tr>
<tr>
<td>10</td>
<td>Number 2 ‘AND’ Family Focused Therapy (FFT)</td>
<td>5</td>
</tr>
<tr>
<td>11</td>
<td>Number 2 ‘AND’ Group Psychoeducation</td>
<td>9</td>
</tr>
<tr>
<td>13</td>
<td>Number 2 ‘AND’ Number 9 ‘AND’ Number 10 and Number 11.</td>
<td>1</td>
</tr>
</tbody>
</table>

This search strategy is applied to other online databases.
### Illustration 4

**Table 4- Inclusion/ Exclusion Criteria**

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Article</td>
<td>Full text</td>
<td>Just Abstract shown</td>
</tr>
<tr>
<td>Language</td>
<td>English</td>
<td>Any language other than English</td>
</tr>
<tr>
<td>Publication date</td>
<td>1970- 2011</td>
<td>Anything other than the inclusion criteria</td>
</tr>
<tr>
<td>Participants</td>
<td>Patients with Bipolar Disorder</td>
<td>Patients without Bipolar Disorder</td>
</tr>
<tr>
<td>Study</td>
<td>• RCT’s</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Studies with psychotherapy in adjunction with pharmacotherapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Studies which just focuses on the relapse management</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Anything other than the exclusion criteria</td>
<td></td>
</tr>
</tbody>
</table>
Illustration 5

Review

Table 5- Scott et al: Cognitive-Behavioural Therapy for Severe and Recurrent Bipolar Disorders: Randomised Controlled Trial(26)

<table>
<thead>
<tr>
<th>Aim</th>
<th>Usual versus additional sessions of CBT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Study Design</td>
<td>RCT</td>
</tr>
<tr>
<td></td>
<td>Prospective intensive face-to-face 8-weekly re-evaluations of the participants’ symptom ratings and social functioning.</td>
</tr>
<tr>
<td></td>
<td>Matched pairs design</td>
</tr>
<tr>
<td>Sample</td>
<td>253 participants were selected for the study. 127 participants were in the CBT and TAU group. 126 were in the TAU group. Participants were randomly allocated to the treatment as usual group (TAU) or CBT with TAU group.</td>
</tr>
<tr>
<td>Inclusion Criteria</td>
<td>Adults</td>
</tr>
<tr>
<td></td>
<td>DSM-IV diagnosis of bipolar disorder (27)</td>
</tr>
<tr>
<td></td>
<td>A history of two or more episodes</td>
</tr>
</tbody>
</table>
### Exclusion Criteria
- Rapid-cycling bipolar disorder
- Bipolar disorder secondary to an organic cause
- Currently meeting DSM-IV criteria for mania (although these people could be included when their symptoms no longer met criteria for mania of the Structured Clinical Interview for DSM-IV) (28)

### Treatment Procedure
**Cognitive-behavioural therapy plus TAU group.**
Twenty sessions of CBT were held weekly until week 15 and then with gradually reducing frequency until week 26. Two ‘booster sessions’ were offered (at weeks 32 and 38) to review the skills and techniques learned.

**TAU group**
Usual medication, which participants were prescribed to take from their usual psychiatrists. No psychotherapy was given.
Measurements

Assessment interviews immediately prior to randomisation and then face-to-face interviews every 8 weeks for 72 weeks were done. Taking into account:

- Time of recurrence of an episode of bipolar disorder of sufficient severity to reach DSM-I criteria for major depressive, hypomania, mania or mixed episode, based on a SCID interview (22). Following at least 8 weeks below this level for that pole

- A longitudinal severity rating of overall symptom levels for each week since the last assessment interview (2 months), based on the Longitudinal Interval Follow-up Evaluation (29,30).

<table>
<thead>
<tr>
<th>Results</th>
<th>CBT effective in fewer episodes, less effective in greater episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conclusion</td>
<td>CBT effective in patients with less episodes but this is a minority of the patient population</td>
</tr>
</tbody>
</table>
Table 6- Solomon et al: Preventing recurrence of bipolar I mood episodes and hospitalizations: family psychotherapy plus pharmacotherapy versus pharmacotherapy alone (31)

<table>
<thead>
<tr>
<th>Aim</th>
<th>To compare 3 treatments for preventing bipolar recurrence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Study Design</td>
<td>• RCT</td>
</tr>
<tr>
<td>Sample</td>
<td>92 patients</td>
</tr>
<tr>
<td>Inclusion Criteria</td>
<td>• bipolar I mania, major depression, or mixed episode</td>
</tr>
<tr>
<td></td>
<td>• 18 to 65 years</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>• Alcohol/drug reliance</td>
</tr>
<tr>
<td>Treatment Procedure</td>
<td>Randomly assigned to individual family therapy plus pharmacotherapy, multifamily group therapy plus pharmacotherapy, or pharmacotherapy alone, which were provided on an outpatient basis.</td>
</tr>
<tr>
<td>Measurements</td>
<td>The Bech-Rafaelsen Mania Scale score (BRMS) was used for the recurrence of hypomania and mania. Hamilton Rating Scale for Depression scores were used for the recurrence of major depression.</td>
</tr>
<tr>
<td>Results</td>
<td>recurrence and hospitalization did not differ between the three groups</td>
</tr>
<tr>
<td>Conclusion</td>
<td>Patients with bipolar I may benefit from multifamily group therapy but further research is required</td>
</tr>
</tbody>
</table>
### Table 7- Colom et al: A Randomized Trial on the Efficacy of Group Psychoeducation in the Prophylaxis of Recurrences in Bipolar Patients Whose Disease Is in Remission (9)

<table>
<thead>
<tr>
<th><strong>Aim</strong></th>
<th>To see the efficacy of Group Psychoeducation in the Prophylaxis of Recurrences in Bipolar Patients Whose Disease Is in Remission</th>
</tr>
</thead>
</table>
| **Study Design** | • RCT  
• Single-blind trial with 20 weeks of treatment and 2 years of follow-up  
• The study consisted of 2 phases: the treatment phase comprised 21 weeks of randomized treatment in which all patients received standard psychiatric care with standard pharmacologic treatment; with no psychoeducation. The experimental group received additional psychoeducation, and the patients assigned to the control group met every week in groups of 8 to 12 patients without special instructions from the therapist.  
• The follow-up phase comprised 2 years, during which all patients continued receiving standard treatment without psychological intervention and were assessed monthly for several outcome measures. |
| **Sample** | 120 participants with either bipolar type I or II were involved in the study aged 18 to 65 years old. Pre-set sample size was 60 subjects per treatment group. |
Inclusion Criteria

- Inclusion criteria were a lifetime diagnosis of bipolar disorder type I or II elicited by a trained psychiatrist.
- Being euthymic (Young Mania Rating Scale [YMRS] score <6, Hamilton Depression Rating Scale [HDRS]–17 score <8) for at least 6 months
- Having sufficient data on the prior course of illness collected from a prospective follow-up of at least 24 months
- Written consent to participate in the study.

Exclusion Criteria

- Exclusion criteria were DSM-IV Axis I comorbidity except for caffeine and nicotine dependence
- Mental retardation (IQ <70); organic brain damage; or deafness. Patients currently receiving any kind of psychotherapy or enrolled in any pharmacologic trial were also excluded.
<table>
<thead>
<tr>
<th>Treatment Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Standard Psychiatric Care (All Patients)</td>
</tr>
<tr>
<td>All patients were seen by 2 psychiatrists every 4 weeks and were specifically told to go to the centre whenever they felt any change in their mood or any other problem.</td>
</tr>
</tbody>
</table>

<p>| |</p>
<table>
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</thead>
<tbody>
<tr>
<td>• Psychoeducation (Experimental Group)</td>
</tr>
<tr>
<td>Patients were enrolled in a psychoeducative programme, composed of 21 sessions of 90 minutes, each aimed at improving 4 main issues: illness awareness, treatment compliance, early detection of prodromal symptoms and recurrences, and lifestyle regularity.</td>
</tr>
</tbody>
</table>
Measurements
Follow-up of patients for the Bipolar Disorders Program of Barcelona for at least 2 years. This follow-up includes assessment of recurrences, symptom checking, and treatment registration, and is performed every 2 months. Baseline assessment includes the administration of the Structured Clinical Interview for DSM-IV (SCID I and SCID II), and also YMRS, HDRS-17, and the Holmes and Rahe inventory for stressful life events, which are also repeated every 2 months.

Results
The group in the psychoeducation group had fewer recurrences.

Conclusion
Group psychoeducation is efficacious in preventing recurrence in pharmacologically treated patients.
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