
Further information on publisher website:
http://projecteuclid.org

Publisher’s copyright statement:
‘Current Opinion in Psychiatry will permit the author(s) to deposit for display a “final reviewed manuscript” (the final manuscript after review and acceptance for publication but prior to the publisher’s copyediting, design, formatting, and other services) 12 months after publication of the final article on his/her personal web site, university's institutional repository or employer's intranet.’

The definitive version of this article is available at:
http://dx.doi.org/10.1097/YCO.0b013e32834b7c5f

Always use the definitive version when citing.

Use Policy:
The full-text may be used and/or reproduced and given to third parties in any format or medium, without prior permission or charge, for personal research or study, educational, or not for profit purposes provided that:

• A full bibliographic reference is made to the original source
• A link is made to the metadata record in Newcastle E-prints
• The full text is not changed in any way.

The full-text must not be sold in any format or medium without the formal permission of the copyright holders.
Corresponding author

Dr. Daniel Schöttle, M.D.
Psychosis Early Detection and Intervention Centre (PEDIC)
Department of Psychiatry and Psychotherapy
Centre for Psychosocial Medicine
University Medical Centre Hamburg-Eppendorf
Martinistr. 52, 20246 Hamburg, Germany
Email address: d.schoettle@uke.de
Phone number: +49-152-22816853

Psychotherapy for Bipolar Disorder:

a Review of the Most Recent Studies

Schöttle D¹, Huber CG¹, Bock T¹, Meyer TD²

¹ Psychosis Early Detection and Intervention Centre (PEDIC), Department of Psychiatry and Psychotherapy, Centre for Psychosocial Medicine, University Medical Centre Hamburg-Eppendorf, Martinistr. 52, 20246 Hamburg, Germany

² Institute of Neuroscience, Newcastle University, NE1 7RU Newcastle upon Tyne, United Kingdom

Abstract

Purpose of review: The aim of this review is to give an update on recent randomized controlled trials (RCTs) evaluating psychotherapy for bipolar disorder.

Recent findings: Methodological issues like the inclusion of differing patient populations, differences in who (patients, family members, caregivers) received psychotherapy, and varying follow-up periods make it difficult to compare RCTs. Despite heterogeneous results, the majority of the studies showed relevant positive results in terms of reduced relapse rates, increased quality of life, better functioning or more favorable symptomatic outcome.

Summary: Recent RCTs evaluating psychosocial interventions for bipolar disorder have added to the evidence and thereby broadening existing therapeutic options. These promising results should encourage future studies leading to a better understanding of what kind of patient or caregiver will benefit from what kind of therapy, and how efficient psychosocial interventions can be under routine conditions.

Keywords: Psychotherapy; psychosocial intervention; cognitive behavioral therapy; group therapy; psychoeducation
Introduction

Bipolar Disorder (BD) is a highly recurrent illness often beginning in the critical life period of late adolescence and early adulthood, and having a major impact on the social, educational and occupational development [1, 2]. Increasingly, patients are discharged from hospitals as soon as they are stabilized, but not fully remitted. This is partly due to economic reasons, but also because community mental health care has improved. Furthermore, faster reintegration of the patients is considered beneficial. However, this comes at the cost of an increased burden on the patients’ families.

Non-adherence to pharmacotherapy can significantly contribute to negative outcome. But even when taken regularly, medication often cannot sufficiently diminish the burden of disease for the patients and their families [3]. Enhancing psychopharmacological therapy, additional therapeutic support is necessary for the patients and their caregivers.

A range of psychotherapeutic interventions is available for this purpose, including cognitive behavioral therapy (CBT) [4-7], psychoeducation (PE) [8-11], family therapy (FT) [12-14], interpersonal and social rhythm therapy (IPSRT) [15], and collaborative approaches including PE-elements [16-18]. Most psychosocial interventions go beyond encouraging medication adherence and informing about the illness [19, 20], allowing important psychological issues, e.g., self-esteem problems, boundary issues, and dysfunctional performance expectations, to be considered. Several reviews on the efficacy of psychosocial interventions for BD are already available [21-31]. The aim of the current review is to give an update on the most recent evidence available regarding psychotherapy for BD, focusing on randomized controlled trials (RCTs) published in the last 18 months (10/2009 – 04/2011).

Review of Randomized Controlled Trials

Systematic research of the currently available literature in PubMed, psychinfo and the Web of Knowledge using the search terms “Bipolar Disorder”, “RCT”, “psychotherapy”, “cognitive behavioral therapy”, “group therapy”, and “psychoeducation”, revealed nine RCTs for inclusion in the current review (for an overview, see Table 1):
Castle et al. [32] compared treatment-as-usual (TAU) with and without an additional manualized group-based intervention (for further details see [51]) in 84 remitted individuals with BD. Participants who were assigned to additional group intervention had significantly lower rates of any relapse (hazard ratio (HR) = 0.43, 95%-CI: 0.20–0.95). This was mainly due to a significantly lower rate of depressive relapses (HR = 0.18, 95%-CI: 0.04–0.85). There was a higher frequency of manic and mixed relapses in the control group, but since there were no manic/mixed relapses in the treatment group at all, a hazard ratio could not be estimated. Participants of the treatment group spent significantly less time unwell (Mann–Whitney z = 2.29, p = 0.02), but no significant differences in secondary outcomes were found. Limitations of the study were that neither patients nor raters were blind to treatment allocation. Furthermore, contact time, which was lower in the control group, could also be a confounding factor.

The effectiveness of adjunctive cognitive behavioral group therapy (CBGT; 18 weekly sessions with a duration of 90 min.) in the prevention of relapses was evaluated by Gomes et al. [33]. 50 euthymic bipolar patients were randomly allocated to take part in CBGT plus TAU or received only TAU (control condition). Intention-to-treat analysis did not reveal any difference with respect to time until any relapse (Wilcoxon W = 0.667; p = 0.414), nor for depressive (W = 3.328; p = 0.068) or manic episodes (W = 1.498; p = 0.221). However, when only looking at those who relapsed, median time to relapse was longer for patients in the CBGT group compared to TAU (Mann-Whitney z = –2.554; p = 0.011).

Costa et al. [34] evaluated the effectiveness of 14 weekly sessions of CBGT in addition to pharmacotherapy compared with pharmacotherapy alone. CBGT was able to reduce or prevent deterioration of manic (p < 0.001), depressive (p < 0.001) and anxiety symptoms (p < 0.001). In their discussion of the performed regression analysis, the authors
state that CBGT especially improved depressive symptoms. The inclusion of a control group strengthens the results of this study, but interpretation is limited by the small sample size.

In a pilot study by D’Souza et al. [35], 58 remitted bipolar patients were randomized to receive either PE or TAU sessions together with a companion. The authors used the “Systematic Illness Management Skills Enhancement Programme-Bipolar Disorder” (SIMSEP-BD) for their PE sessions [36]. After 12-weeks of SIMSEP-BD, patients in the intervention group were switched to TAU, and all patients were followed until week 60. Patients in the intervention group were less likely to have a relapse (OR = 0.16; 95%-CI: 0.04–0.70) and had an 11 week longer time to relapse ($\chi^2(1)=8.48, p < 0.01$). In addition, at the last study visit, they had lower clinician rated manic, but not depressive scores, compared to the TAU group. Medication adherence was improved and predicted survival time ($G^2(1)= 3.12, p<0.001$).

Gonzalez-Isasi et al. [37] analyzed the efficacy of psychosocial group treatment in addition to pharmacotherapy versus pharmacotherapy alone in a small pilot study with 20 patients with a treatment refractory course of BD. “Treatment refractory” was not defined according to published guidelines, but as “severe or bad prior course despite adequate pharmacological treatment” [37, p. 162]. Relapse rates did not differ between groups, but the intervention had positive effects on Quality of Life (QoL) according to the authors based on the GAF and not a specific QoL measure after 12 months, but not after 6 months. The study did not control for additional psychological or psychiatric consultation during follow-up.

A second study by Gonzalez-Isasi et al. [38] with 40 patients also focused on “treatment refractory patients”. Between group comparisons revealed that the experimental group showed fewer hospitalizations than the control group at 12-months (p=0.007), and reported lower levels of depression and anxiety at 6-months (p = 0.015; p = 0.027) and 12-months (p = 0.001; p < 0.001). Significant differences were also found in relation to mania and adjustment to everyday life post-treatment (p=0.004; p<0.001) that were sustained during follow-up (p < .005 for all contrasts) favoring the intervention group. Looking at within group comparisons, patients in the experimental group reported reductions in levels of mania
(p<0.001), depression (p=0.001), anxiety (p=0.003), and better adjustment to everyday life (p<0.001). In the control group, the authors found an increased number of hospitalizations (p=0.016), as well as higher levels of mania (p=0.030), anxiety (p<0.001), and impaired adjustment to everyday life (p=0.003). Unfortunately, between- and within-group changes were analyzed separately, which makes it difficult to draw conclusions about any treatment by time interactions, i.e., to assess if the course of the parameters of interest was different over time in both groups.

Instead of focusing on the patient, Perlick et al. [39] applied a novel variation of Family-Focused Treatment [40] that was solely targeted at caregivers to enhance their illness management skills and self-care. This approach was chosen as caregivers often experience high indirect burden of disease, increasing the risk for physical and mental health problems. The therapeutic protocol consisted of 12 to 15 sessions of family-focused, cognitive-behavioral intervention (FFT-HPI), or 8 to 12 sessions of health education (HE) intervention delivered via videotapes. Caregivers’ self-rating depressive symptoms significantly decreased after having received FFT-HPI (Cohen’s d=0.5), and the same was true for health risk behavior (d= 0.99). The patients’ depressive (d=0.67) and manic symptoms (d= 0.34) were significantly reduced as well in the intervention group. Looking at potential variables explaining these changes, Perlick et al. found that patients’ reduction in depression was partially mediated by reduced depressive symptoms in caregivers. Furthermore, the reduction in caregivers’ depression was partially mediated by a reduction in the level of avoidance coping of the caregivers.

Madigan et al. [41] administered a caregiver-focused psychoeducation program consisting of Multifamily Group Psychoeducation (MFGP), Solution Focused Group Psychotherapy (SFGP), or TAU, in a community-based setting. There were hardly any differences between MFGP and SFGP, but with regard to the sample sizes per group (n = 5-13), it is difficult to judge whether this is due to lack of power. Conducting specific contrasts between MFGP and TAU showed significantly improved knowledge (p < 0.001), reduced psychological distress (p = 0.025), and reduced overall burden (p < 0.001) in the MFGP-
group within year 1. Some of these changes were maintained at the end of year 2. Patients whose caregivers participated in the intervention groups reported higher QoL at year 1 and 2, and there was a trend for improved functioning in year 1 but not year 2 (p = 0.185).

Lobban et al. [42] conducted a cluster randomized controlled feasibility trial on enhanced relapse prevention for community mental health team workers (CMHT). Compared to TAU, 12 hours of CMHT training increased survival time regarding any affective episode by 8.5 weeks (HR 0.79, 95%-CI: 0.45–1.38), and lead to a significant improvement in social and occupational functioning (regression coefficient 0.68, 95%-CI: 0.05–1.32). When controlling for confounding variables such as the number of prior episodes and education, the results were favoring the enhanced relapse prevention training.

**Methodological issues limiting comparability**

Studies differed in several issues like study population, psychotherapeutic approaches used, the target population and outcome parameters.

**Study population**

Some studies excluded patients with comorbidities [34, 35, 42], while others specifically included these patients [33] or recruited patients from a naturalistic setting [32]. Sacrificing sample “purity” to gain better generalizability can be important to better demonstrate effectiveness under real-world conditions. However, especially for studies with small samples, this can increase variance, making it more difficult to detect significant effects. This makes reporting effect sizes even more important.

Two studies focused explicitly on patients having a severe course of BD [37, 38], demonstrating that even these patients can benefit from group psychotherapy. Recruitment was usually focused on euthymic or remitted patients [32, 33, 35, 42] or allowed only limited subsyndromal symptoms [34, 37, 38]. This is in line with most of the published trials [28], and seems based on the assumption that BD patients should only be engaged in psychological treatment when they are sufficiently stable and remitted. However, there is some evidence
that individuals with BD might benefit from psychotherapy although they are symptomatic at the time of therapy, especially concerning depressed patients [15, 43]. In view of the high rates of medication non-adherence, opening up psychological treatment to currently symptomatic patients will broaden therapeutic options and get the patients engaged at times of high stress levels.

The number of lifetime mood episodes, especially in patients with more than 12 episodes, has been discussed as a potential confounding factor leading to heterogeneous results [4, 28, 31]. Only one study by Gonzalez-Isasi et al. [44] examined the influence of this parameter. Using data from a previous study [38], the authors evaluated the predictors of good outcome using binary logistic regression. After controlling for CBT, a lower number of prior hospitalizations and higher self-esteem were statistically significant predictors of a better outcome. Although there is an ongoing discussion if the number of lifetime episodes can be assessed with sufficient reliability or will always be a rough estimate with too much uncertainty, it seems essential that studies on psychological treatment for BD try to include indicators of illness severity to examine their influence on outcome.

All but one study [41] included patients with type-I and type-II BD, but none was sufficiently powered to analyze the subsample of type-II BD patients. This would have been interesting, considering that depressive symptoms dominate the course of type-II BD [45], being responsible for reduced functioning and diminished QoL, and adding substantially to the burden of disease [46]. Colom et al. [9] undertook a post-hoc analysis of their landmark study [8] at 5-year follow-up [47] for a subsample of 20 type-II BD patients. Although study design and power calculations had not been optimized to specifically assess outcomes of type-II BD patients, the authors could demonstrate that intensive group psychoeducation leads to a significantly lower frequency of episodes (4.1 vs. 10.6), shorter duration of episodes, and a higher level of functioning.

Swartz et al. [48] conducted a proof of concept study delivering IPSRT as monotherapy to unmedicated patients with a type-II BD depression, showing a 53%
response rate at the end of week 20. The study sample, however, was small and did not include a control group.

**Psychotherapeutic approaches used**

Most studies used a group therapy approach. Group settings are cost effective and provide the participants with the opportunity to share their experiences. Methods administered were CBT [33, 34, 37, 38], PE [35, 42], (36, 40) and FT [39, 41]. In one study [32], patients received a therapeutic mix of CBT, PE, motivational interviewing, social rhythm and dialectic behavior therapy.

**Target population of psychotherapeutic interventions**

Interventions were administered to patients [32-34, 37, 38], the patient and a companion [35], or the caregivers alone [39, 41, 42]. Considering the choice of the therapeutical target population, the results of Perlick et al. [39] are of considerable significance for public health considerations. Perlick and colleagues could demonstrate that caregivers might benefit from family-based psychotherapy even without presence of the patient. This underlines the importance of involving family members into treatment. These effects might even extend to the patient him-/herself. If caregivers are willing to engage in interventions at an early stage of BD [41], this could increase optimism about the future course of illness and help to prevent frustration, and patients could benefit from reciprocal emotional and practical support and proactive coping in the family. These issues should be the object of further research.

**Outcome parameters**

The reported results were heterogeneous with regard to relapse rates as main outcome variable. Psychotherapeutic interventions generally resulted in lower relapse rates [32, 35] or hospitalizations [38], but some studies did not find evidence for reduced relapse rates. Instead, they found that the median time to relapse was longer [33, 42]. In summary, the majority of studies found some kind of positive effects when adding psychosocial
interventions to the standard treatment of patients and caregivers. Although there is no information on the superiority of any of the examined therapeutic methods [43], affective symptoms are probably influenced in a specific manner depending on the chosen therapeutic approach. Emphasizing medication adherence and early recognition of mood symptoms will probably have a greater impact on manic symptoms, whereas treatments that focus on cognitive and interpersonal coping strategies will have stronger effects on depressive symptoms [30], with sometimes patients benefitting from a combination of therapeutic interventions [11]. Some of the psychopathological changes, e.g., changes in the level of subsyndromal depressive symptoms, could also reflect more general effects of psychotherapeutic interventions such as an increase in hope or an increased feeling of control over one’s life or changes in the patients’ perspective, respectively.

As QoL does not necessarily imply total absence of symptoms and vice versa, measuring QoL seems to be a valid outcome parameter enhancing research only focused on symptom reduction [37, 41]. Few of the presented studies consider this important outcome criterion, pointing out the need for more studies on this research area.

Improving QoL can be associated with better social and occupational functioning. This is a challenging treatment goal in BD, and whereas some studies could show an improvement concerning these outcome parameters [37, 42], others didn’t find any significant changes [41].

With regard to caregivers, Madigan et al. [41] could corroborate the results of Reimages et al. [49]: The authors demonstrated increased knowledge and reduced burden of care in the intervention group. Keeping in mind the immense involvement of family members and caregivers, these results are promising and future studies should be conducted focusing on this issue.
Conclusion

The methodological differences outlined above reflect known problems impeding comparability of studies focused on psychosocial treatments [50]. The heterogeneity of the studies concerning the characteristics of included patients, the target population of the psychotherapeutic intervention, and the follow-up periods, makes comparisons between studies difficult.

In summary, we currently know that adding some kind of psychosocial intervention to an existing treatment plan is better than TAU or waiting for treatment. We still do not know who will benefit from what kind of psychotherapeutic treatment approach, and the main focus is still on relapse prevention. Future research should additionally focus on symptom reduction, and on improvement of QoL of everyone involved in patient care. Furthermore, studies are needed that compare short-term treatment (e.g., 20 sessions of CBT over 6 months) and treatment options which allow to support an individual patient over time across episodes, being able to adapt the psychological input to a patient’s need at different times. While recent studies seem to favor group settings, which is sensible and in line with economic constraints, we also have to ensure understanding of when a group setting is favorable over an individual therapy setting and vice versa, and of the factors that influence outcomes in group settings (e.g. open versus closed groups, group cohesion, group composition with regard to gender and type of BD).

Another important issue is that therapies are usually delivered at a very high standard (including, e.g., weekly supervision, video-taping, special training, and expert status) and are provided as part of a study protocol. This limits the generalizability of study results regarding routine conditions.

Importantly, a new line of research is emerging with a focus on the mental health and well-being of caregivers (families and professionals). This seems essential, since depression rates are high among caregivers and indirectly also affect the patients via several routes (e.g., via increased irritability of the caregivers, withdrawal, sick leave, and therapeutic
pessimism). Finding effective ways of helping caregivers to better cope with their distress will, in the end, also show positive effects on the outcome of BD for our patients.
Key points

- The majority of studies focusing on psychosocial treatments showed positive results in terms of reduced relapse rates, improved quality of life, improved functioning and more favorable symptomatic outcome.

- Methodological differences regarding patient characteristics, target population for psychotherapy, and follow-up periods, impede study comparability.

- Efficacy studies including difficult-to-treat patients in naturalistic settings should be conducted.

- Involving caregivers is important because they take a massive burden and may also have positive indirect effects on the patients.

- We still do not know who will benefit from what kind of approach in what phase of illness. Further studies are needed, especially for patients with type-II bipolar disorder.
Acknowledgements
References


Highly interesting study on prevalence of bipolar disorder, its impact, comorbidity and service utilization assessed in 61,392 adults in 11 countries. Results provide evidence for bipolar spectrum disorder as a valid concept.


The authors studied level of functioning in euthymic patients, and tried to identify potential predictors of functioning. Patients with bipolar disorder often experienced interepisodic psychosocial impairment with previous mixed episodes, current subclinical depressive symptoms, previous hospitalizations, and older age as predictors of functional impairment.


Few studies focussed on bipolar disorder II patients. This is an exploratory subanalysis of PE in bipolar II patients at 5-year-follow up. The PE-group had fewer depressive or hypomanic recurrences and a higher functioning-level. The study demonstrated the need for more studies of this subgroup of patients with bipolar II disorder that should consider for example if these therapies demand modifications in duration and content.


First study to show the effect of group psychoeducation for caregivers of patients with bipolar disorder. Patients whose caregivers received the intervention were having less recurrences, particularly hypomania and mania.


Review including RCT's, meta-analyses and reviews. The authors also state that there is a lack of studies investigating the cultural validity of therapies when implemented in different cultures.


Article providing information on recent developments of psychosocial therapies, demonstrating also overlapping components of the interventions.


Review article on the recent development of psychological interventions for bipolar disorders showing positive evidence for the use of these. The authors critically emphasize the need to study treatment- and patient intrinsic factors as well as factors being associated with the natural history of bipolar disorder to identify "specific intervention packages" for the individual patient.


Review focussing on cognitive-behavioral therapy for bipolar disorder. The authors state that CBT is effective but studies in BD-II patients, rapid-cycling BD and non-adherent patients are needed.


An extensive review of randomized controlled psychotherapy studies focussing on unipolar and bipolar affective disorders. The authors conclude that in major depressive disorder psychological therapies are as efficacious as medications but even with a more persistent effect, while in bipolar disorder these therapies augmented psychopharmacological therapies.

Review article showing that disorder-specific psychotherapies as adjunct to medication help to reduce relapse rates. Although being more cost intensive in the initial stage of therapy, long term effects could result in a cost reduction but further research is needed as well as to elucidate mediating mechanisms, target populations and adverse effects of psychosocial therapies.


Focussing in their review article on RCT of CBT the authors found low to medium overall effect sizes of CBT while costs without increasing treatment costs thus being recommend as adjunctive treatment.


Study questioning the assumption that patients with multiple relapses don´t benefit from psychological therapies. The authors were showing that there is no clear evidence for the moderating effect of relapse rates on therapy outcomes.


The intervention resulted in fewer relapses of any kind. The intervention was a mixture of different psychosocial interventions, thus the moderators and mediators of the therapy are hard to assess.


Study demonstrating that CBGT is effective in prolonging median time to relapse in euthymic BD patients.


Small study, but including a control group . The authors could demonstrate that CBGT especially improved depressive symptoms.

Including carers in a psychoeducational programme was effective not only in reducing relapse rates but also in improving medication-adherence thus strengthening the need for studies including significant others.


Although a small study, the authors focussed on a difficult-to-treat subgroup of patients that normally represent the clinical population. Even in this subgroup positive results could be achieved with a group-based short-term intervention.


The authors used a form of family-based psychotherapy and could find positive results not only for caregivers, but also in reducing depressive symptoms among patients. Highly interesting is the fact that patients can also benefit from family interventions even if they are not available for treatment.


One of the few studies with quality of life as outcome criteria. The authors could show that the intervention resulted in a better quality of life.


The study demonstrated that with a short training programme for caregivers not requiring intensive psychological training cost-saving public health benefits can be achieved. A training in relapse prevention resulted in an increased median time to next episode and lead to an improvement in social and occupational functioning in the intervention group.


Study focussing on predictors of good outcome to improve clinical utility of psychosocial programmes thus helping to create further more individualized treatment programmes.


Exceptional 5-year-long-term follow-up study, evaluating the efficacy of a psychoeducation programme for bipolar disorder. Even without booster sessions patients benefitted from the intervention in terms of longer time to recurrence, fewer recurrences and they spent less time being ill. It could be shown that group PE has a long-term maintained efficacy in people with bipolar disorders.


Although a very small study the authors could demonstrate that depressive episodes in patients with BPII could be treated with IPSRT as monotherapy. Further studies are needed to determine which subset of individuals could benefit from psychotherapeutic therapies alone.


References of special interest

- [2] The authors studied level of functioning in euthymic patients, and tried to identify potential predictors of functioning. Patients with bipolar disorder often experienced interepisodic psychosocial impairment with previous mixed episodes, current subclinical depressive symptoms, previous hospitalizations, and older age as predictors of functional impairment.

- [10] This is the first study to show the effect of group psychoeducation on caregivers of patients with bipolar disorder. Patients whose caregivers received the intervention had fewer relapses, particularly concerning hypomania and mania.

- [22] Article providing information on recent developments of psychosocial therapies, demonstrating also overlapping components of the interventions.

- [21] Review including RCTs, meta-analyses and reviews. The authors state that there is a lack of studies investigating the cultural validity of therapies when implemented in different cultures.

- [24] Review focusing on cognitive-behavioral therapy for bipolar disorder. The authors state that CBT is effective but studies in type-II BD patients, rapid-cycling BD and non-adherent patients are needed.

- [27] Focusing on RCT of CBT, the authors of this review article found low to medium overall effect sizes of CBT without an increase in overall treatment costs, and recommend CBT as adjunctive treatment.

- [31] Study questioning the assumption that patients with multiple relapses don’t benefit from psychological therapies. The authors showed that there is no clear evidence for a moderating effect of relapse rates on therapy outcome.

- [41] One of the few studies with quality of life as outcome criterion. The authors could show that the intervention resulted in an improved quality of life.

- [33] Study demonstrating that CBGT is effective in prolonging median time to relapse in euthymic BD patients.
• [34] Small study, but including a control group. The authors could demonstrate that CBGT especially improved depressive symptoms.

• [35] Including caregivers in a psychoeducational programme was effective not only in reducing relapse rates but also in improving medication-adherence. This underlines the need for studies focused on caregivers.

• [42] The study demonstrated that with a short training programme for caregivers not requiring intensive psychological training, cost-saving public health benefits can be achieved. A training in relapse prevention resulted in an increased median time to next episode and lead to an improved social and occupational functioning in the intervention group.

• [48] This very small study demonstrated that depressive episodes in patients with type-II BD could be treated with IPSRT as monotherapy. Further studies are needed to determine which subset of individuals could benefit from psychotherapeutic therapies alone.

References of outstanding interest

• [1] Highly interesting study on prevalence of bipolar disorder, its impact, comorbidity and service utilization assessed in 61,392 adults in 11 countries. Results provide evidence for bipolar spectrum disorder as a valid concept.

• [9] Only few studies focus on type-II BD patients. This is an exploratory subanalysis of PE in type-II BD patients at 5-year-follow up. The PE-group had fewer depressive or hypomanic recurrences and a higher level-of-functioning. The study demonstrates the need for more studies in this patient subgroup, for example considering if psychotherapeutic concepts have to be modified regarding duration and content.

• [23] Review article on the recent development of psychological interventions for bipolar disorders showing positive evidence for their use. The authors critically emphasize the need to study treatment- and patient-intrinsic factors as well as factors being associated
with the natural course of bipolar disorder to identify “specific intervention packages” for the individual patient.

- [25] An extensive review of randomized controlled psychotherapy studies focusing on unipolar and bipolar affective disorders. The authors conclude that, in major depressive disorder, psychological therapies are as efficacious as medication. Whereas psychotherapy had a more persistent effect in this diagnostic group, it augmented psychopharmacological therapy in patients with bipolar disorder.

- [26] Review article showing that disorder-specific psychotherapy as adjunct to medication can help to reduce relapse rates. Although being more cost-intensive in the initial stage of therapy, long-term effects could result in a cost reduction. Further research is needed to elucidate mediating mechanisms, target populations and adverse effects of psychosocial therapies.

- [32] The intervention resulted in fewer relapses of any kind. As the psychotherapeutic approach consisted of a mixture of different interventions, the moderators and mediators of the therapy are hard to assess.

- [44] Study focusing on predictors of good outcome to improve clinical utility of psychosocial programs and to help create more individualized treatment programs.

- [39] The authors used a form of family-based psychotherapy and found positive results not only for caregivers, as depressive symptoms among patients were reduced. Thus, patients can also benefit from family interventions even if they are not available for treatment, which is remarkable and a fact of considerable importance.

- [38] A small study, but nevertheless interesting, as the authors focused on a difficult-to-treat subgroup of patients that represents the normal clinical population. Even in this subgroup, positive results could be achieved with a group-based short-term intervention.

- [47] Exceptional 5-year long-term follow-up study, evaluating the efficacy of a psychoeducation program for bipolar disorder. Even without booster sessions, patients benefitted from the intervention in terms of longer time to recurrence, fewer recurrences
and less time being ill. It could be shown that the efficacy of group PE is maintained in people with bipolar disorder over a long period.