The evolution of psychoeducation for bipolar disorder: from lithium clinics to integrative psychoeducation

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Coping and living with bipolar disorder is complex and sometimes counterintuitive. It demands a number of attitudes and aptitudes that include a huge emotional insight, healthy and regular lifestyle, skills to identify subtle changes and motivation to reach full treatment adherence. Patients' engagement and proactive attitude are a must for a successful therapeutic outcome. This may partly explain the therapeutic impact of psychoeducational programs in this disorder.

However, the history of group psychoeducation in bipolar disorder is full of ups and downs. Interestingly enough, worldwide-respected opinion leaders in group therapy were initially not very enthusiastic with the use of such strategy with bipolar patients. I. Yalom, for instance, defined a bipolar patient as "one of the worst calamities that could befall group therapy" (1). Since then, the practice of psychoeducation has been evolving together with the conceptualization of bipolar disorder.

THE PIONEERS: LITHIUM CLINICS

The ancestors of psychoeducation have to be found in the so-called "lithium clinics", which appeared both in Europe and the US in the 1970s, and were typically run by a team consisting of a psychiatrist and support staff (nurses and sometimes psychologists). The focus was on pharmacological treatment monitoring, although some information and mutual support was also offered. This would correspond to a 100% biological understanding of the disorder which, perhaps, was trying to counterbalance psychodynamic views in the pre-lithium era. The efficacy of such a setting has been described in several reports (e.g., 2), unfortunately without an appropriate comparative methodology.

INFORMATION-BASED PSYCHOEDUCATION

After the era of lithium clinics, several reports of information-based psychoeducation appeared in the literature, mainly produced in the US and in the Netherlands, a country with a long tradition of both bipolar psychoeducational efforts and self-help and advocacy groups. The studies by E. van Gent (3) showed, initially, a remarkable effect on stigma and self-esteem and, later on, in a three-year follow-

up, a significant decrease of adherence problems and hospitalizations amongst patients receiving psychoeducation. However, this information-based view of psychoeducation reflected a poorly integrated approach to bipolar disorder, where proactiveness was not seen as a core issue in the treatment.

ATTITUDES & APTITUDES PSYCHOEDUCATION PROGRAM

In 2003, our group (4) published the first randomized controlled trial of the efficacy of psychoeducation in the prevention of recurrences in bipolar disorder. The model used stressed the importance of illness awareness, self-management, early-warning signs identification, habits regularity, treatment adherence and avoiding drug misuse. It has been defined as "behavioural psychoeducation", but we rather think of it as an "attitudes & aptitudes" psychoeducation program. This definitely corresponded to a view of bipolar disorder as a complex condition involving not only biological etiological factors but also psychological and social variables that may act as triggering factors, modulators or mediators. The Barcelona Psychoeducation Program showed a huge efficacy in preventing all sort of recurrences both at two-year and five-year follow-up (5). This study has been successfully replicated using exactly the same intervention, showing excellent results regarding admission prevention (6).

THE LIMITATIONS OF THE CURRENT MODEL

However, even this highly disseminated program had some relevant limitations which, perhaps, may reflect the view regarding the disorder that we had when the program was started (middle 1990s). The program hardly promoted physical health – by means of prescribing a regular diet, promoting regular exercise, etc. – an issue that nowadays is well known to be essential in the management of any chronic psychiatric condition, and bipolar disorder and schizophrenia in particular, due to the increased risk of obesity and metabolic syndrome (e.g., 7). Moreover, recent studies showed that a behavioral weight-loss intervention significantly reduced weight over a period of 18 months in

overweight and obese adults with serious mental illness (8), although the effect of physical exercise on mood is limited according to a recently published controlled trial (9).

Furthermore, the program did not contemplate the importance of illness progression or sensitization. Although in the middle 1990s kindling theories (10) were an outstanding research topic, the current knowledge on cognitive impairment and illness staging (see 11) was yet to be achieved. Interestingly, many psychological interventions – including psychoeducation, cognitive-behavioral therapy and family psychoeducation – lose efficacy when implemented in patients with a high number of previous episodes. In a 18-month follow-up randomized controlled trial, Scott et al (12) did not find significant differences in terms of recurrences between two groups of patients with severe and recurrent bipolar disorder, receiving respectively 22 sessions of cognitive-behavioral therapy and treatment as usual. A post-hoc analysis demonstrated that adjunctive cognitive-behavioral therapy was effective compared with treatment as usual only in those patients with fewer than 12 previous episodes.

The importance of introducing psychological interventions as soon as possible has also been highlighted in a sub-analysis by Colom et al (13), showing the lack of efficacy of group psychoeducation in patients with more than 15 previous episodes who were euthymic at the study onset. Both the likelihood of suffering from cognitive impairment and the difficulties of changing habits may be more common in more veteran patients, which could contribute to the lack of efficacy of psychoeducation in this subgroup. Similarly, Reinares et al (14) showed that, despite the general good outcomes associated with family group psychoeducation, its efficacy seemed to be limited to patients in the initial stages of the illness (15). There may be a progressive impairment of coping abilities in patients in advanced stages, increasing vulnerability and decreasing resilience as the illness progresses. These coping abilities could possibly be resumed with a proper intervention.

PSYCHOLOGICAL TREATMENTS OF TOMORROW: TOWARDS INTEGRATIVE PSYCHOEDUCATION

The integrative approach to bipolar disorder should target both syndromal and functional recovery. Unfortunately, most of the available treatments – both pharmacological and psychological – are usually more successful at reaching just clinical rather than full recovery. Interestingly enough, the first randomized controlled trial of the efficacy of a brand new therapy labeled “functional remediation” has been recently published (16). This is a 21-session group program that includes neurocognitive techniques, training, psychoeducation on cognition-related issues and problem solving, aiming to avoid problems with generalizability of similar programmes adopted in the field of schizophrenia. The mentioned study was a three-arm multicenter trial

comparing the efficacy of functional remediation with psychoeducation and with treatment as usual, including a total of 268 outpatients. Functional remediation had a large effect on functioning – mostly on occupational and interpersonal domains – and did differ from treatment as usual, but did not significantly differ from psychoeducation, which however had a smaller effect on functioning.

An integrative model of psychoeducation should, hence, include strategies which are useful not only to patients in earlier stages of the illness but also to those with some impairment. It should also promote healthy habits, including the regular practice of physical exercise. Moreover, given the problems in social cognition which persist even when the patient is asymptomatic (17), a more significant effort to address these issues should be made.

On the other hand, functional remediation and psychoeducation may take different places in the available arsenal of psychotherapies for bipolar disorders. Whilst psychoeducation may be the first choice treatment as a prophylactic add-on for many bipolar patients (mostly for those in early and medium stages of the illness), functional remediation is the treatment of choice for patients showing a clear cognitive and functional impairment who would probably respond poorly to psychoeducation.

There is a need to better clarify what works for whom in the field of bipolar therapies, also considering the impact on preventing manic vs. depressive episodes. Polarity index is a novel and validated metric depicting the relative antimanic vs. antidepressive prophylactic efficacy of an intervention in the maintenance treatment of bipolar disorder (18) and may apply both to pharmacological and non-pharmacological treatments. According to this index, patient group psychoeducation, although being the most balanced intervention, may have a greater effect in preventing depressive episodes, whilst caregiver psychoeducation may have a greater effect in preventing manic episodes (19).

In conclusion, since psychoeducation is inspired both by the current understanding of bipolar disorder and by our sensitivity to our patients’ needs, it cannot be a static and unchangeable treatment, but rather a dynamic program which will evolve following the evolution of that understanding and those needs.

Acknowledgements

The author acknowledges the support and funding of the Spanish Ministry of Health, the Instituto de Salud Carlos III and CIBERSAM. He is also funded by the Spanish Ministry of Economy and Competitiveness.

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DOI 10.1002/wps.20091