This is an excellent article on treating bipolar disorder and how to complement the use of appropriate medication. FYI

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Psychotherapy for Bipolar Disorder: Treatments to Enhance Medication Adherence and Improve Outcomes CME/CE

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Release Date: April 18, 2005; Valid for credit through April 18, 2006

Target Audience

This activity is intended for clinicians who can make referrals or offer psychoeducation to patients with bipolar disorder.

Goal

The goal of this activity is to teach clinicians about specific forms of psychotherapy that enhance medication adherence and improve patient outcomes.

Learning Objectives

Upon completion of this activity, participants will be able to:

1. *Recognize that medications alone do not help patients cope with the stressors that may precipitate episodes.*
2. *Identify 3 evidence-based forms of psychotherapy that improve outcomes for patients with bipolar disorder.*
3. *Describe at least 7 critical active ingredients of these therapies.*

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Contents of This CME/CE Activity

1. *Psychotherapy for Bipolar Disorder: Treatments to Enhance Medication Adherence and Improve Outcomes*
   Introduction
   Cognitive Therapy
   Family-Focused Therapy
   Interpersonal Social Rhythm Therapy
   Group Therapy
   Summary
   References

Psychotherapy for Bipolar Disorder: Treatments to Enhance Medication Adherence and Improve Outcomes

Introduction

While advances in pharmacotherapy for bipolar disorder have been substantial, many patients do not attain optimal levels of healthy functioning when medication is their sole treatment. Patients may have poor medical tolerance, experience adverse reactions to side effects or symptom breakthrough, or become nonadherent for a variety of reasons. Medications alone do not provide patients with opportunities to learn skills to cope with psychosocial stressors, which may trigger symptom episodes.[1] Psychosocial therapy models have therefore been developed to assist in the overall treatment regimen for bipolar disorder,[2] including cognitive therapy (CT),[3] family-focused therapy (FFT),[4] interpersonal and social rhythm therapy (IP-SRT),[5] and various forms of structured group therapy.[6-8]

Cognitive Therapy

In recent years, a growing body of data has indicated that CT has significant additive value in combination with pharmacotherapy in the treatment of bipolar disorder.[9-14] Cognitive therapists

start with a cognitive formulation of patients' disorders and a data-based case conceptualization to guide treatment, which is conducted in the context of a strong therapeutic alliance. While cognitive therapists might use any of the strategies described in other sections of this article, treatment manuals[3,15,16] specific to CT for bipolar disorder have emphasized the following overarching goals:

1. *Teaching bipolar patients the psychological skills of problem-solving, emotion-regulation, and adaptive responding to negative cognitions to deal more effectively with their stressors;*
2. *Helping patients recognize early warning signs of symptom episodes when preventive actions may be effective in decreasing symptom severity and duration;*
3. *Addressing patients' maladaptive beliefs about their medications to make peace with their necessity and improve adherence;*
4. *Fostering a sense of personal empowerment, within normal limits, while simultaneously reducing social isolation and stigma; and*
5. *Improving hopefulness and a better quality of life, now and in the future, which reduces the need for hospitalizations and the risk of suicide.*

These interventions are described below.

Psychological Skills

A hallmark of CT is its emphasis on monitoring, assessing, and modifying maladaptive thinking styles, toward the goal of helping patients become more objective and functional in how they view situations and make decisions. When patients learn and practice such skills, they are more apt to feel a sense of well being and self-efficacy and less likely to fall prey to helplessness and hopelessness, states of mind associated with depression and suicide.[17,18] Cognitive therapists teach their patients to catch themselves when their ideation becomes unrealistic (often cued by significant affect) and to orient themselves to seek concrete evidence and social consensus for their perceptions before acting on them. This applies to instances when patients feel emotions associated with depression (eg, despair, guilt, worthlessness), hypomania or mania (eg, overexuberance, euphoria, excessive libido), or mixtures of the 2, as in rapid-cycling or mixed states (eg, irritability, agitation, rage). The goal is not to invalidate patients' thinking, but rather to instruct them in the methods of realistic appraisal and utilization of cognitive checks and balances. Specific techniques include:

- *A worksheet to help patients respond adaptively to their dysfunctional thinking[19];*
- *Role-playing;*
- *Seeking further information and counsel from trusted others;*
- *Imposing a period of reflective delay before acting on impulses (eg, learning how to be "the master of your impulses");*
- *Implementing controlled breathing and other methods of relaxation (to reduce levels of arousal);*
- *Weighing the pros and cons of various decisions before taking action;*
- *Moderating activities; and*
- *Using "redundant systems"[20] of self-reminders and documentation to stay organized and focused on important tasks and obligations, including taking medications as prescribed.*

For example, a hypomanic patient may be taught that before he allows himself to act on a new business venture, he must demand of himself that he wait 48 hours, get at least one good night's sleep, and consult with his wife, brother, and a financial advisor before proceeding. The therapist would take great care to explain the clinical rationale for this self-inhibiting intervention, and would implement the plan with an air of collaboration and respect.

Another example would be a patient in a depressed state who is encouraged to plan and schedule activities for the upcoming week that would provide him with a sense of accomplishment and pleasure, such as working in the garden, visiting with friends, seeing a movie, straightening up his apartment, and/or going to the gym. Competent, caring cognitive therapists acknowledge that patients may not initially believe that they have enough energy to accomplish such tasks, but gently encourage them to do experiments to test this idea, and they remain supportive and problem-solving focused, no matter what the outcome.

Recognition of Prodromes

One of the most critical skills for bipolar patients to learn is to recognize, and respond appropriately to, early warning signs of symptom episodes. Bipolar patients who can spot the signs of impending mood problems are better equipped to make the behavioral and attitudinal preparations necessary to moderate their activity levels, enlist social support (and perhaps supervision), and promptly check with their psychiatrists on the need to make adjustments in their medications.[21]

A typical homework assignment is for patients to generate a list of experiences that illustrate "normal mood states," as well as a corresponding list of criteria that may signify an abnormal shift. This homework is enhanced by input from family members and close friends. For example, patients may note that feeling confident and attractive is indicative of a normal, good mood, until they start to do or say things that others find too bawdy, provocative, or interpersonally inappropriate. Similarly, patients may affirm that feeling irritable at work is a normal mood state, until it gets to the point where they have a strong impulse to leave the job in the middle of the day and go home to get into bed.

When they determine that they are experiencing prodromes, patients implement a coping plan they have previously devised (in writing) with the help of their cognitive therapists, then contact their mental healthcare providers for professional assistance and enlist the moral support of those to whom they are personally close.

Enhancing Medication Adherence

Medication adherence is a major problem for patients with bipolar disorder. Rates of nonadherence are estimated to be from about 30%[22,23] *to 54%.*[24] *Nonadherence is cited as the strongest factor in recurrence of episodes*[24] *and rehospitalization*[23] *and is the best predictor of long-term outcome.*[25,26]

According to Scott and Pope,[22] *a number of factors are involved in patients being nonadherent to taking mood stabilizers. Patients who have been prescribed medication for a long time and who have a past history of being nonadherent are at greater risk than patients whose medication has been more recently prescribed and who do not have a history of being nonadherent. Nonadherent patients tend to view medication in general in a negative way and are resistant to taking medication for its prophylactic effect. They also tend to deny the severity of their disorder. While several researchers cite side effects as an important cause of nonadherence, it may be the fear of side effects rather than the actual experience of side effects that is the more important factor.*

CT has been shown to be effective in helping patients increase their medication adherence, including patients with bipolar disorder. [11,12,27] *This form of psychotherapy has traditionally stressed 3 components essential to increasing adherence: the development of a collaborative working alliance with patients, practical problem-solving, and helping patients respond effectively to their negative cognitions that underlie emotional distress and dysfunctional behavior (including nonadherence). A number of authors have described useful cognitive and behavioral techniques to enhance medication compliance,* [3,28-33] *and a summary of basic techniques appears below.*

Psychoeducation

An essential first step in gaining medication adherence with patients who have bipolar disorder is adequate psychoeducation. Many patients (and sometimes family members) benefit from hearing how the clinician arrived at the diagnosis, along with a strong (verbal and written) rationale for medication, during both acute episodes and for prophylaxis. For additional psychoeducation, The Bipolar Disorder Survival Guide[32] is an excellent resource for both patients and their families.

Therapeutic Alliance

Many patients require a strong therapeutic alliance with the clinician before they are willing to take their medication as prescribed. Clinicians need to continually demonstrate essential counseling skills such as empathy, concern, and accurate understanding. Patients are more likely to be adherent when they experience the clinician as competent, supportive, optimistic, and encouraging. Experiencing their healthcare provider in a negative light and/or the medical setting as aversive may interfere with patients' motivation to take medication.[31,34]

Practical Issues

On a practical level, clinicians also need to ensure that patients will be able to obtain their medication. Clinicians should check to see that patients have sufficient financial resources and are sufficiently organized to fill the prescription. They may also need to make suggestions to patients about how they can remember to take their medication. Using time-of-day pillboxes, monitoring sheets, and/or beeping watches, cell phones, or personal desk assistants can help, as can reminders from family members, notes on bathroom mirrors and refrigerators, and notations in an appointment book.

Eliciting Patients' Concerns

Clinicians should make it clear that they want to hear patients' concerns about taking the medication, as unaddressed questions and uncertainties often lead to nonadherence. Typical concerns include fears of side effects (especially fatigue, sexual impairment, weight gain, and loss of creativity), criticism from family or others, and general stigmatization. Clinicians should also question patients to discover if family members or significant others have concerns that may undermine adherence.

Assessing Likelihood of Adherence

Until patients demonstrate a clear pattern of adherence, clinicians should ask, "How likely are you to take [this medication] ___ times a day, every day, as we talked about?" Patients who reply with a high degree of certainty may be ready to take the written prescription and leave the office. Patients who are somewhat uncertain are likely to be at least somewhat nonadherent without the use of some of the techniques below.

Uncovering Nonadherence

Clinicians should ask specific questions to assess a patient's level of adherence. "Were you able to take this medication?" will invariably elicit an affirmative reply, even if there has been substantial nonadherence. Instead, clinicians need to ask (in a nonjudgmental tone), "How often since I saw you last did you skip [or were you unable to take] [this specific medication as prescribed]?"

Conceptualizing Difficulties

When a patient has not been fully adherent, clinicians need to determine whether nonadherence was related to a practical problem (such as forgetfulness, reliance on an unreliable family member, physical illness, and so on), which calls for straightforward problem-solving. Alternatively, problems may be psychological in origin (ie, related to patients' dysfunctional cognitions), which calls for cognitive restructuring through the use of techniques described below.

Eliciting Negative Cognitions

Upon discovering nonadherence and establishing that the problem was not just practical in nature, the clinician should ask the patient: "Can you tell me about one of the times when you skipped the medication? What was going through your mind?" Patients' dysfunctional cognitions typically fall into several categories: negative ideas about medication (eg, "It won't help"), about mental health professionals (eg, "They don't really know what they're doing"), about bipolar disorder (eg, "I should be able to get over this on my own"), about the self (eg, "Taking medication means I'm weak"), or about others (eg, "If they know I'm on medication, they'll judge me negatively"). For an extensive description of how to elicit (and Socratically evaluate) patients' cognitions, see J. Beck (1995).[19]

Socratic questioning to evaluate dysfunctional thinking. *Having identified a dysfunctional thought such as, "Medication can't help," therapists can label this cognition as an idea and indicate that the idea can be tested. A number of standard questions can be used to help patients evaluate their cognitions: What is the evidence that this idea is true? What is the evidence on the other side, that perhaps this idea is not true, or not completely true? Is there an alternative explanation or viewpoint? What's the worst that could happen in this situation and how would you [patient] cope if it did happen? What's the best that could happen in this situation? What's the most realistic outcome? What's the effect of telling yourself this idea? What could be the effect of changing your thinking about this? What would you tell [a close friend or family member] if he/she were in this situation and had this thought? Clinicians need to take care to undertake this questioning process collaboratively and sensitively.*

Correction of misinformation. *The first question above, "What is the evidence that this thought is true?" may reveal that patients (or their families) have been misinformed by something they heard in the media, on the Internet, or from other people. It is important, on an ongoing basis, to elicit and address patients' concerns and especially misinformation that contributes to nonadherence.*

Examination of advantages and disadvantages. *Many patients benefit from a careful examination of pros and cons of taking their medication. Often they respond better if the clinician first asks them about and writes down the disadvantages they perceive, before helping them identify the many potential advantages. Clinicians often need to suggest potential benefits to patients, asking whether patients see them as advantageous before writing them down. When indicated, clinicians can also help patients reframe disadvantages through careful, empathic questioning, leading to a conclusion such as "[Taking this medication is disadvantageous because] it may slow me down and make me less productive BUT being overly productive goes along with poor judgment, which has led to disaster in the past."*

Framing a medication trial as an experiment. *Reluctant patients may be more willing to try a medication if the clinician suggests that they try it for a set period of time. ("Sounds as if you're still not sure that this medication will help. Would you be willing to try an experiment? You could just take it for [a month], and see what you think. If it doesn't seem to be working, or if you have side effects that bother you and don't wear off, we can then talk about Plan B.")*

Giving credit. *When patients are nonadherent, it is important to find out what they tell themselves immediately after taking the medication. Thoughts such as, "This shows I'm crazy," will obviously undermine their motivation to keep taking it. It is important to help patients recognize the importance of giving themselves credit (eg, "Taking this shows I'm really taking control of my life").*

Recording important ideas. *Finally, given research that suggests patients forget much of what they hear in a physician's office, it is helpful to have the clinician or patient write down the most important ideas discussed during the session. These ideas may include dosing information, psychoeducation, advantages and disadvantages, and responses to dysfunctional thoughts. Encouraging patients to read these notes daily also improves adherence.*

Personal Empowerment

Patients with bipolar disorder often have to face adversity in a number of ways. Aside from the difficulties inherent in dealing with the chronic risk of abnormal mood swings, these individuals also have to live in a society that still stigmatizes those colloquially known as "manic-depressives." Persons with bipolar disorder have usually experienced obstacles to employment, advanced schooling, and adoption.[35] In An Unquiet Mind, Kay Redfield Jamison describes her anguish when her physician matter-of-factly told her that she ought never to have children as a result of her illness.[36] Jamison adds that disclosure of her experiences with bipolar disorder was a great personal risk, and could easily have derailed her career, as it has others'. These harsh realities often combine with the patients' subjective sense of failure and helplessness in the face of their bipolar illness to create even more life stress, which presents further risks for the triggering of symptom episodes.

Cognitive therapists work with their patients to self-monitor and modify their self-stigmatizing beliefs, such as when they assume that they are "defective," or "misfits," along with other pejorative, demoralizing self-statements. Patients learn to see themselves as complex individuals who have strengths and weaknesses, who can improve their lives through effective problem-solving and through adhering to treatment. Patients then have the potential to serve as excellent role models; their behavioral demonstrations of self-respect and improved functioning tell others that people with manic-depression can live, love, work, and strive for goals just like anyone else in society.

Improving Hopefulness and Reducing the Risk of Suicide

Therapists who treat individuals with bipolar disorder are well aware that the issue of suicidality is frequently high on the agenda. It has been estimated that about 15% of persons with bipolar disorder will ultimately die by suicide,[37] although a more conservative re-evaluation of this figure has also been suggested.[38] Thus, cognitive therapists carefully assess their bipolar patients' ideation about their quality of life and their view of their future. As hopelessness has been empirically linked to the increased risk of suicide,[17,18] cognitive therapists take a number of measures to monitor and address patients' negative views about themselves, their lives, and the future.

For example, it is customary for patients in CT to fill out brief, empirically validated measures such as the Beck Depression Inventory[39] and Beck Hopelessness Scale[40] prior to every session. Patients' responses on their questionnaires cue the therapists about exacerbations in symptoms, which may provoke or worsen suicidal ideation or intent. CT, as a model and method of treatment that was originally developed to treat depressed and suicidal individuals, puts great emphasis on improving patients' outlook on life, and on taking concrete steps to improve patients' self-care and overall safety.

Homework assignments are often geared to help patients improve important interpersonal relationships and keep them productively engaged in important individual pursuits, while working steadily to monitor and modify their most harmful beliefs, such as, "My loved ones would be better off without me," or "The only way to end my emotional pain and suffering is to kill myself," among other "suicidogenic" beliefs.[3,41] Additionally, cognitive therapists are mindful to help their patients pursue goals that are personally meaningful, yet within normal limits.

It is important to help patients recognize their progress, assessing their adherence to medication, scores on mood inventories, and frequency and severity of episodes of suicidality and/or hospitalization. It is also necessary to focus on patients' goals of holding a job, finishing school, preserving family ties, increasing social support, and other reasons to get up in the morning with enthusiasm and hope. In other words, cognitive therapists are not content with helping their bipolar patients get back to baseline functioning -- they want their patients to improve their lives significantly. This stance strengthens the therapeutic alliance and reduces the risk of suicide, especially as patients who are happy with their therapy may be more likely to take their medication.

Empirical Support for Cognitive Therapy for Bipolar Disorder

The history of empirical support for CT goes back over 20 years, starting with a study that illustrated that a very brief course of CT (6 weeks) designed to improve medication adherence did in fact show a significant advantage over treatment as usual. The CT group had far fewer patients discontinue their medication and significantly fewer hospital admissions.[42] Over the years, CT has been applied to concerns beyond medication adherence alone. Based on findings that suggest that specific cognitive styles serve as risk factors for bipolar patients, goals of CT have expanded to help bipolar patients modulate their perfectionistic beliefs, improve autobiographical recall, reduce excessive goal-directedness, change faulty attributions, and moderate beliefs related to sociotropy and autonomy.[3]

More recently, a number of randomized, controlled trials have suggested that CT significantly adds to the overall efficacy of the treatment regimen for bipolar disorder, above and beyond medication alone.[43] These studies, using relatively short courses of CT (up to 6 months) with patients who typically were deemed to be either refractory to pharmacotherapy and/or at high risk of relapse, have uniformly produced data that attest to the promise of CT for this population.[9-14] Patients receiving CT in these trials consistently have demonstrated relatively fewer symptom episodes, hospitalizations, and suicidal behaviors, along with greater levels of general adaptive functioning, longer interepisode periods, and improved medication adherence. For example, Scott and colleagues found that the percentage of bipolar patients in CT demonstrating medication nonadherence was only 21%, a dramatic, clinically significant reduction from the figure of 48% in the treatment-as-usual condition.[11]

Momentum gained from the above studies has encouraged a number of additional trials that are still in progress, including follow-ups and extensions of the aforementioned projects, as well as a 20-site longitudinal study in the United States examining outcomes for bipolar disorder combining pharmacotherapy and psychosocial interventions (the Systematic Treatment Enhancement Program for Bipolar Disorder or STEP-BD).[44] There is also a large, 5-center trial involving 250 patients with bipolar disorder being conducted in the United Kingdom, further demonstrating the excitement that has been generated by the results of CT trials to date.[43]

Family-Focused Therapy

This psychosocial approach is derived from the empirical literature demonstrating the efficacy of family psychoeducation and skills training in improving the functioning of schizophrenic patients.[45] When applied to bipolar disorder, FFT[4] consists of 5 modules in the context of an

outpatient program: (1) assessment of the family, (2) education about bipolar disorder, (3) communication-enhancement training, (4) problem-solving training, and (5) termination. The model has been tested as a 9-month, 21-session treatment.

A central concept in FFT is the clinical importance of reducing high levels of expressed emotion in the families of patients with bipolar disorder. As in the case of schizophrenic patients, bipolar patients have been found to be at increased risk for relapse if their home environment is characterized by interpersonal interactions that are highly critical, hostile, and/or overprotective, and if patients and their families attribute negative motives to each other's behavior.[46-48] In FFT, therapists help patients and families modulate the emotional tone of their conversations, reduce accusations and blame, and express more tolerance and acceptance of each other. Each participant is given important, protreatment responsibilities; patients maybe asked, for example, to chart their moods, activities, and sleep patterns, while parents, spouse, or others in the household document their own constructive attempts to help the patient cope, function, and stick to the treatment plan. Role-playing is used extensively in session as practice for improved communication, and as preparation for relapse scenarios that call for cooperation and collaborative problem-solving. One open study and 2 randomized trials have supported FFT as an efficacious adjunct to the overall treatment of bipolar disorder.[49-51]

Interpersonal Social Rhythm Therapy

A new "hybrid" psychosocial therapy is IP-SRT,[52] which is derived from interpersonal therapy[53] for depression, but adds the major component of focusing on patients' lifestyle issues pertinent to their circadian rhythms. This approach is predicated on the observation that the course of bipolar disorder -- along with patients' adherence and responsivity to pharmacotherapy -- is affected by patients' individual life and sleep-wake cycles. Specifically, the IP-SRT model assumes that instability and irregularity in the interpersonal relationships and social role functioning of bipolar patients are risk factors for relapse and poor prognosis overall. In response to these problems, the chief goals of IP-SRT are to optimize the regularity of the patients' daily routines and help resolve social role and interpersonal difficulties that might otherwise lead to biopsychosocial destabilization and dysregulation, which in turn may provoke symptom episodes. This approach hypothesizes that by helping patients achieve a better sense of peace and contentedness with their interpersonal life, social roles, and place in the life cycle, it is likely that they will sleep better and have more effective, reliable ways of navigating everyday life. Such a condition is anticipated to be conducive to maintaining longer states of remission from bipolar illness.[52]

Patients in IP-SRT learn to do a great deal of self-assessment in order to spot problematic patterns in their lives. For example, an illness history time-line is generated in which patients trace their periods of symptomatic episodes, juxtaposed with corresponding events, changes, and treatments in their lives. Along with this assessment, patients are asked to evaluate the quality of their most important relationships across this time line. Forming, preserving, and repairing interpersonal ties then become relevant goals for treatment, especially when patients have long histories of isolation or rifts in relationships.

Another self-monitoring tool is the Social Rhythm Metric. The first month of monitoring focuses on obtaining a baseline of social rhythms and an identification of behaviors that negatively affect the patient's health and well being (eg, skipping meals, turning down social invitations, spending late nights on the computer, oversleeping for work or school). This is followed by the development of a plan involving graded lifestyle changes toward greater stability, predictability, and health (eg, refraining from making phone calls or sending e-mails while feeling angry, eating dinner by 7:00 pm at least 5 nights a week, getting to bed by 11:00 pm at least 6 nights a week).

Empirical tests of IP-SRT include a study of bipolar depression in which patients receiving IP-SRT recovered significantly faster than those in a clinical management condition[54] and a study in

which IP-SRT was shown to produce more stable social rhythms in bipolar patients.[55] A randomized treatment trial for IP-SRT is in progress, with a 2-year follow-up period under current evaluation.[42]

Group Therapy

Patients who garner helpful social support tend to fare better than those who are more isolated.[56] Sometimes attending regular, informal support groups serves this function, as when bipolar patients are active in organizations such as the National Alliance for the Mentally Ill and the Depressive and Bipolar Support Alliance. However, some programs have been developed to combine the benefits of general social support with the specific efficacy of interventions such as psychoeducation, life skills training, and cognitive-behavioral instruction.

For example, in a randomized, controlled trial of a cognitive-behavioral group intervention, Hirschfeld and his associates found that the patients who took part in the adjunctive 11-session group program had significantly longer periods of euthymia and significantly fewer new symptom episodes than control patients treated with pharmacotherapy alone. Notably, this favorable result held up at follow-up assessments.[6] Colom and colleagues also tested a psychoeducational group in a randomized, controlled trial involving 120 stable bipolar patients. In the psychoeducational condition, patients were taught how to manage their illness properly through medication adherence, recognition of prodromes, and reducing a sense of stigma. Twenty-one sessions of this psychoeducational approach led to enhanced medication adherence and longer latency to relapse in comparison with unstructured group meetings.[7]

Another group-based psychoeducational and skills training model is the Life Goals Program developed by Bauer and McBride.[8] The groups typically consist of 5-10 patients, with sessions lasting 60-75 minutes each. The first phase of the program focuses on an in-depth understanding of bipolar illness, with each participant identifying his or her symptom profile, including early warning signs of impending episodes. The group learns the basics of problem-solving and quickly begins to apply this skill to the issues of medication adherence and coping with stigma. The second phase of the group treatment is more open-ended and goal-driven, with patients learning more advanced applications of problem-solving in the context of their social, vocational, and familial functioning, and then evaluating outcomes. Bauer reported that early empirical tests of the Life Goals Program have been promising for those who have remained in the group[57] and at 12-month follow-up. Patients in the Program have shown less depression and a reduction in mania compared with the control group.[58]

Summary

A number of psychosocial treatments have been developed and successfully tested for patients with bipolar disorder. Important ingredients generally include a strong working alliance, psychoeducation, structured sessions, a goal orientation, a problem-solving focus, inclusion of family members in treatment, improving important relationships, and an emphasis on skills training: interpersonal communication, emotional regulation, responding to dysfunctional cognitions, and identification of prodromal symptoms with an action plan to address these symptoms. A number of specific techniques can be used to enhance medication adherence.

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