ABSTRACT

While pharmacotherapy is the cornerstone of therapeutic management for bipolar disorder, psychotherapy is an important dimension of treatment, which may be instituted during the euthymic phase of the disorder. The goals of nonpharmacologic therapy are to prolong remission and prevent relapse by educating patients about medications, reinforcing strategies to enhance compliance with the regimen, and teaching patients how to identify prodromal symptoms. Techniques such as cognitive behavioral therapy will assist patients in coping with maladaptive patterns of thought, and institute behaviors to prevent lapses into acute episodes of mania or depression. This article discusses these aspects of the therapeutic relationship, as well as highlighting the need to practice the art of patient care to achieve the highest level of relationship with patients—that of collaboration.


W

While pharmacologic management is the mainstay of treatment for affective disorders due to the strong evidence that exists as to its biological foundations, psychosocial interventions, including various forms of psychotherapy, are also extremely helpful to patients and families. In particular, these come into play during the maintenance phase of treatment, and assist patients and significant others in identifying prodromes, in adhering to treatment regimens and lifestyle improvements, and to offer techniques for coping with stressors that might predispose patients to relapse.

The first step in accomplishing these milestones is to build a sound therapeutic relationship with the patient. In many ways, the therapeutic relationship is the crucible where healing occurs, and a crucible is a good analogy, because the crucible has to deal with the heat of crisis and then deal with the cooling period of stability. Building a therapeutic relationship is an art familiar to nurses, and is based upon making a connection with the patient, paying attention to what he/she is saying, and building trust within that alliance that the nurse as the provider is engaged in helping patients to heal. Levels of relationship vary considerably and include compromise, cooperation, and collaboration. Clinical effectiveness is probably at its pinnacle with collaboration, but it takes time and effort to build that level of engagement whereby 2 individuals work together as equal partners, negotiating treatment strategies, and using unique skills and strengths toward the best clinical outcome. Getting to the point of collaboration with a given patient can be challenging, as it requires at its foundation a level of trust that usually accompanies the tests of time. While a clinician may have to pass through lesser levels of relationships, such as cooperation or compromise on the way to collaboration, it is important to recognize that coercive elements have no place in the therapeutic relationship as it stands in the way of developing a sound working relationship, particularly by means of erosion of trust.

Hence, a positive alliance opens the door to engagement in a relationship that supports collaboration toward enhanced outcomes, including better adherence to therapeutic regimens. It encompasses the willingness on the part of patients to disclose sensitive
information about themselves and feeling safe to do so, even if they are particularly vulnerable, such as during an exacerbation of symptoms. This sort of interaction can only occur securely in a relationship that is built on trust, and engenders open communication as a fundamental principle in treatment.

**The Role of Psychosocial Therapies**

For patients who may be struggling with the stigma of bipolar disorder, psychosocial therapies can play a number of crucial roles, including communicating an understanding of the stress diathesis. This theory purports there is a hereditary predisposition for some individuals toward demonstrating bipolar symptoms under stress. For example, if any clinician were to observe a number of people under significant stress, what would become obvious is that the responses to the given stressor will be as varied as the people experiencing the stressful event. One person might respond with symptoms related to migraines, while another might develop sleep disturbances or symptoms related to irritable bowel. For the person who lives with the experience of bipolar illness, the stressor may yield symptoms related to the bipolar illness itself. This example describes the dynamics of the stress diathesis, and the expression of symptoms as a consequence of overwhelmed capacity to cope in an otherwise more adaptive fashion. Symptom expression under stress in people with bipolar illness often represents a shift in the stability of circadian rhythms and of impaired regulation of the motivational system controlling approach and reward. It is proposed that disruption of sleep and routine leads to prodromal symptoms as sleep is an exquisitely sensitive index of symptom control in persons diagnosed with bipolar illness. The exact nature of life events and social disruptions may determine the specific prodromal symptoms that occur, be they mania or depression.  

Psychotherapy can assist patients to learn new responses to familiar patterns of symptoms. In particular, early identification of prodromal symptoms, knowledge of triggers for acute episodes, and expanding the repertoire of responses to triggers all are vital adjuncts to pharmacotherapy in terms of heading off manic or depressive events. As with patients themselves, family therapy and/ or psychoeducation of families and significant others is important to help them help the patient identify prodromal symptoms and manage medications so that every-
a patient may need assistance in finding the right balance for him/her in terms of rest and stimulating activities. Once that has been established, patients dealing with the illness may also need assistance in maintaining this balance and dealing with any necessary or unexpected changes in their routine.

To contrast social rhythm therapy with cognitive therapy, cognitive therapy is less concerned directly with social functioning and focuses more fully on the impact of perceptual distortions and the impact of such distortions on thoughts and emotional responses to those thoughts. Cognitive therapy is a time-limited intervention that aims to help the patient to recognize distortions in perception and the cascading impact of these perceptions on emotional states. Cognitive behavioral therapy aims to teach patients to become more aware of their thoughts, moods, and behaviors and to then challenge and alter dysfunctional patterns. All of this is in an effort to break the recurring cycle that often occurs with bipolar disorder.

Cognitive behavioral therapy, which is based on teaching patients new coping skills, is particularly appropriate for persons dealing with bipolar disorder. Given evidence that this has been effective for unipolar depression, mastering coping skills and formulating positive behavioral responses are important in the course of bipolar illness as well. Once patients are taught to identify the prodromal symptoms of bipolar depression and/or mania, they may be able to avoid the consequences of a relapsing episode by engaging in the appropriate coping strategies before the symptoms worsen and behavioral patterns deteriorate. For example, in the early stages of mild hypomania, engaging in calming activities, increasing rest, reducing stimulation, and decreasing activity are useful strategies, whereas increasing activity levels based on one’s feeling of excess energy is counterproductive and places the patient at risk of escalating into mania. Similarly, with the prodromal period before a depressive episode, maintaining routines and seeking social support are associated with better outcomes. Social isolation and withdrawal from the usual activities of daily living are most likely to produce negative outcomes.

Bipolar illness is a chronic disease. As such, the need for ongoing treatment is evident in helping people who deal with this illness to cope more effectively. Treatment is likely to involve a combination of psychotherapy and medications that span periods of stability and intermittent crises.

**Monitoring the Course of Bipolar Disorder**

Regardless of the type of psychotherapy selected, monitoring the course of the disease is an important component of the therapeutic relationship. By assessing for symptoms at each visit, and using the constellation of presenting symptoms as a guide for diagnosis and practice principles (based on expert consensus statements such as those set forth by the APA), the clinician also provides a context in which the patient may negotiate care and treatment. In such a collaborative effort, the work will focus on what the patient brings to the relationship. It is not uncommon within the therapeutic relationship to deal with patterns of resistance to treatment, or to navigate treatment challenges that are the result of side effects or the consequences of partial adherence to a regimen of treatment. Clinical rating scales, such as the Beck Depression Inventory, the Mania Rating Scale, or the Positive and Negative Symptom Scale, can quantify symptoms and monitor symptoms’ trajectories. Use of these measures in practice aids the clinician in the monitoring of the impact of interventions, and documents problems that have arisen in treatment over time. For example, clinical instruments may help to document symptom exacerbations that may occur related to hormonal changes, seasonal variations, medical comorbidities, or other variables that yield changes in symptom presentations over time.

There are several types of rating scales. All of these instruments facilitate the work of monitoring exacerbations and remissions of illness. Some of the clinical instruments require that the clinician passively observe the patient but more commonly, clinical instruments utilize some form of a clinical interview. Some instruments are completed by the patient as a self-administered scale. When selecting clinical instruments to use in practice, assure that they are valid, reliable, and capable of measuring what you are interested in evaluating consistently over time. It is best to work with the same instrument consistently to allow for comparison of the results over time. Never alter an instrument by adding or removing questions as this will disturb the stability of the instrument and will jeopardize the validity and reliability of the original instrument. Instrument/rating scale development takes great effort in testing and refinement to assure stability, and changing a single item can negatively impact this.

Rating scales exist to examine (but are not limited
to) a wide variety of parameters, including depression, anxiety, psychosis, sleep, energy levels, positive and negative symptoms, and side effects of medications. Monitoring via these instruments is particularly helpful at certain milestones, including obtaining baseline data, when cross-tapering or changing medications, or in trying to establish patterns of moods related to seasonal cycles or hormonal influence.

ASSESSING SIDE EFFECTS OF PHARMACOTHERAPY

Monitoring for side effects actually begins with a discussion with the patient about the potential side effects of all medications available to treat the patient's condition, given the target symptom constellation and the impact of comorbid conditions. This allows the patient to select from a “menu” of reasonable choices. It is critical for the nurse to discuss potential strategies for counteracting emergent side effects, and to openly discuss the impact of side effects on adherence to the prescribed regimen. Not only does this educate the patient about their medication, but it also serves several other purposes within the context of the therapeutic relationship. It fosters communication, and conveys the message that the patient's success and well-being are important to the clinician. Equally important in the assessment of medication efficacy, it is important to monitor use or abuse of substances such as alcohol or other illicit drugs. People with psychiatric illnesses will use such substances in an attempt to deal with residual symptoms that may not be adequately dealt with by the prescribed regimen. As such, it is important to assess the patient's perception of the perceived benefit of the illicit substance on target symptoms, and to educate the patient about the impact of these substances on the course of the illness. Oftentimes, the patient needs help with symptom management, and the alcohol or other illicit drug use may represent right idea, wrong drug.

Particular adverse effects are drug- and dose-specific, but it is important that the patient be aware that mood stabilizers (lithium, antiepileptic medications [eg, divalproex, carbamazepine, lamotrigine], antipsychotic medications [eg, olanzapine, risperidone, aripiprazole], and benzodiazepines) may yield side effects that impact upon quality of life (see article by Susan Simmons-Alling). Side effects will vary according to class (selective serotonin reuptake inhibitors, tricyclic antidepressants, monoamine oxidase inhibitors, etc) and these side effects need to be distinguished from more serious adverse effects such as episodes of hypomania or mania related to use of antidepressants in persons who have bipolar illness.

Each category of medication carries its own risk for potential side effects. Antipsychotic medications, particularly the second-generation antipsychotics, have recently been the focus of concern from the perspective of potential metabolic disturbances that carry significant risk to the patient. Among the concerns related to the second-generation antipsychotic (sometimes referred to as atypical antipsychotics) side-effect profile are issues of weight gain, potential for insulin resistance and type 2 diabetes, dyslipidemia, and associated cardiovascular and cerebrovascular events. Additionally, prolongation of the QTc interval, prolactin elevation and related sexual dysfunction, extrapyramidal side effects, negative cognitive effects, and sleep disturbance are all possible. In particular, weight gain may be induced by antipsychotic medicines due to dysregulation of appetite from effects on hypothalamic monoamines and peptides, histamine antagonism, and/or hormonal effects (elevated androgens in females and lowered androgen levels in males).

It is particularly important to pay close attention to sleep-related symptoms due to the fact that sleep may be the best indicator of relapse within treatment.

Close monitoring is therefore necessary to minimize liability to the patient's overall health status, in addition to avoiding damage to the therapeutic relationship if the patient feels that the potential for these side effects has not being adequately discussed and addressed in the course of the work between the patient and the nurse. In addition, there is the risk of professional liability unless there is evidence of adherence to practice guidelines that serve to guide the nurse in the delivery of quality care and treatment.

ASSESSING NONADHERENCE

Along with monitoring medications, another vital component to the therapeutic relationship is determining how well the patient is adhering to the management plan. A number of factors place a patient at risk for partial adherence or nonadherence. These factors include poor insight, as previously mentioned, which may be an inherent characteristic of select affective disorders, particularly during periods of mania. Other risk factors for issues with adherence are homelessness, substance abuse, and shorter duration of illness. Furthermore, when a patient has a prior history of partial or nonadherence, the reasons behind these patterns are often complex, and may be worsened with
weak support networks, or inadequate provisions for care after a hospitalization. Combined, these factors all place the patient at risk for a poor outcome. If a patient does not feel comfortable taking medication, if he/she has cognitive deficits, or is unwilling to collaborate with healthcare providers, it is more likely that he/she will relapse. The consequences of this include repeated hospitalization, emergency room visits, and other socioeconomic effects that impact on the patient (such as the risk of homelessness and deteriorated quality of life). All of these trends impact cost to society in the form of high economic burden. For example, in the United Kingdom in 2000, the annual National Health Service cost of managing bipolar disorder was estimated to be £199 million. The most recent statistics available for the United States are from 1990, and these estimate the economic burden of bipolar disorder to be $1.7 million annually.

**CONCLUSION—IMPROVING OUTCOMES**

One of the important challenges to treatment adherence and to maintaining a strong and productive therapeutic alliance with patients who have bipolar disorder is the dissonance that may be evident between the patient’s subjective appraisals of the effectiveness of treatment regimens and objective evidence for these clinical interventions, evidenced in therapeutic outcomes. Sometimes, cognitively focused dialogues help patients resolve the dissonance between the subjective and objective appraisals, and this type of dialogue can ideally help to enhance the quality of the therapeutic relationship.

Use of concrete problem-solving strategies in combination with cognitive behavioral therapy is endorsed as an appropriate plan for persons with bipolar disorder. Additionally, educational and other strategies that help the patient to come to a more comprehensive appreciation of the dimensions of his/her illness are of great benefit. Offering a menu of pharmacologic options and providing anticipatory guidance and careful monitoring of side effects fosters a collaborative approach with the patient and engages providers in practical, beneficial techniques. The treatment team may highlight the secondary gains from these strategies for patients and families, including fewer relapses, fewer hospitalizations, gains in medication knowledge, improved social functioning, and enhanced insight.

In summary, treatment of persons with bipolar illness involves long-term planning with collaboration between provider and patient as the key element to success. From the clinician’s perspective, it is important to utilize evidence-based assessment approaches in conjunction with valid and reliable clinical instrumentation to design plans of care and to strive for optimal adherence. From the patient’s perspective, it is critical to have a relationship with a knowledgeable and competent clinician who will be present and available through the tests of time that are common to healing relationships.

**REFERENCES**