Family focused psychoeducational therapy decreases relapse and rehospitalisation in people with a manic episode and bipolar disorder

Rea M, Tompson M, Miklowitz D et al. ***Family-focused treatment versus individual treatment for bipolar disorder: results of a randomized clinical trial.*** *J Consult Clin Psychol 2003;**71**:482–492.*

QUESTION: Does family therapy improve outcomes compared with individual therapy in people with mania?

Design
Randomised controlled trial.

Setting
Psychiatric outpatient clinic, Los Angeles, USA.

Participants
53 people with bipolar disorder, mean age 25.6 years (range 18–46 years), who were recently in hospital for an episode of mania. Inclusion criteria were willingness to adhere to medication and having families willing to participate in therapy. People with chronic alcohol or substance dependence or organic brain disease were excluded.

Intervention
Participants were randomised to 21 sessions of family therapy (1 hour sessions attended by participant and 1 or more family members) or individual therapy (30 minute sessions for individuals only) for 9 months (weekly for months 1–3, every 2 weeks for months 4–6 and monthly for months 7–9). Family therapy included training in problem solving and communication, and psychoeducation about bipolar disorder. Individual therapy sessions were designed to educate participants about bipolar disorder, increase awareness of symptoms and reduce life stress. All participants also received individual medication management sessions with a research psychiatrist, plus crisis intervention if required for 12 months.

Main outcome measures
Relapse or hospitalisation rates at least 2 years after study entry. Psychiatrists assessed adherence to medication every 3 months.

Main results
At 2 years, family therapy significantly reduced relapse rates and hospital admission rates compared with individual therapy (risk of at least 1 relapse: 28% with family therapy *v* 60% with individual therapy, $p < 0.05$; hospital admission: 12% family therapy *v* 60% with individual therapy, $p < 0.1$). There were no significant differences in adherence to medication between groups.

Conclusions
Family therapy decreased relapse and readmission to hospital in people with bipolar disorder after an episode of mania. However, these results may not generaliseable to people with a depressive episode or those with poor medication compliance or less supportive families.

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COMMENTARY

In this randomised trial, Rea *et al* demonstrate the effectiveness of a structured, family-focused psychotherapy for bipolar disorder. To put this result in context, we might consider three questions.

For Whom? – A few characteristics of the study sample deserve mention. First, all participants were enrolled following hospitalisation for a manic episode. Compared to most outpatient samples, these participants probably experienced more severe illness and a greater preponderance of manic rather than depressive symptoms. Second, only patients with at least one family member able to participate were approached. We do not know what proportion of all patients hospitalised for symptoms of mania satisfied this criterion. Finally, those unwilling to continue mood stabiliser treatment were excluded.

Compared to What? – The comparison treatment (individually focused psychotherapy) was a relatively intensive programme (21 sessions over 12 months) incorporating best-practice content to improve self-management of bipolar disorder. Given this intensity of treatment in the comparison group, any benefit of family-focused intervention is notable.

For What Outcomes? – No significant differences were observed in medication compliance. Differences in rates of symptom relapse were modest. Large differences were seen in rates of re-hospitalisation, especially during long-term follow-up. This pattern suggests that the intervention may have had greatest effect on the capacity of family systems to manage symptom exacerbations without resorting to hospitalisation and that this effect was most obvious once the direct support of intervention staff was withdrawn.

This trial complements other recent studies[1–3] supporting the effectiveness of structured psychotherapies for patients with bipolar disorder. A few general conclusions from these studies deserve emphasis. First, psychotherapies for bipolar disorder have been developed, tested, and proven as supplements to appropriate pharmacotherapy. Second, psychotherapeutic or psychoeducational interventions may be more effective for the prevention or treatment of manic symptoms than for symptoms of depression. Third, effective interventions appear to share several areas of emphasis including medication adherence, self-monitoring for signs of relapse, and specific self-management skills.

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2 Scott J, Garland A, Moorhead S. A pilot study of cognitive therapy in bipolar disorders. *Psychol Med* 2001; **31**: 459–67.
3 Perry A, Tarrier N, Morriss R, McCarthy E, Limb K. Randomised controlled trial of efficacy of teaching patients with bipolar disorder to identify early symptoms of relapse and obtain treatment. *BMJ* 1999; **318**:149–53.