Treatments for people with bipolar disorder include medications, psychotherapy, and lifestyle changes. Medications such as lithium, lamotrigine, and antipsychotics are commonly used to manage manic and depressive episodes. Psychotherapy, particularly cognitive-behavioral therapy and family therapy, can also be beneficial. Lifestyle changes, including adequate sleep, diet, and exercise, can help manage symptoms of bipolar disorder.

The role of psychotherapy in the treatment of bipolar disorder remains widely debated. While some studies suggest that psychotherapy can be effective in managing symptoms and improving quality of life, others find limited evidence for its efficacy. The choice of treatment should be individualized, taking into account the patient's specific needs, preferences, and comorbid conditions.

The management of bipolar disorder requires a multidisciplinary approach, involving collaboration between psychiatrists, therapists, and other healthcare providers. Early intervention and ongoing management are crucial to prevent relapse and improve outcomes. Regular monitoring of symptoms and medication effects is essential to adjust treatment as needed.

In conclusion, while significant advances have been made in the treatment of bipolar disorder, there is still much to learn. Further research is needed to better understand the underlying mechanisms of the illness and to develop more effective and personalized treatment strategies.
sion. This is a crucial area of study for these new medications in order to determine whether they are bona fide mood stabilizers. The optimal duration of antidepressant treatment (in conjunction with a mood stabilizer) balanced against the largely unknown probability of switch induction in patients with bipolar I disorder is also unclear from the available research. The pharmacologic treatment of bipolar II disorder has been the most neglected. Remarkably, it is still not clear whether treatment with a mood stabilizer (as opposed to antidepressant treatment alone) is necessary for many of these patients.

Research regarding the prophylactic treatment of bipolar disorder has been dormant for many years. In addition, the efficacy of new psychotropic medications as long-term mood stabilizers has been very difficult to study in recent times; however, this is perhaps the most important aspect of the pharmacologic treatment of this recurrent illness (i.e., the development of well-tolerated medications with staying power over the long haul). Maintenance studies of lithium, divalproex, and carbamazepine indicate that these agents possess efficacy in this phase of illness management, but that only a minority of patients do well with treatment with any one of these agents alone. Although combinations of mood stabilizers and of antipsychotics and mood stabilizers are commonly used in maintenance treatment, such strategies have not yet been shown to be efficacious in rigorous studies. Similarly, when a combination of an antipsychotic and a mood stabilizer is used to treat acute mania, there are no data to indicate when to taper and discontinue the antipsychotic following resolution of the acute episode. Although olanzapine received an indication for the treatment of acute mania, its efficacy as a maintenance treatment has not been established. Some evidence suggests that, unlike typical antipsychotics, some of the atypical agents possess antidepressant properties, perhaps by virtue of their serotonin2 antagonist effects. If these antidepressant effects are borne out in clinical trials, they may thus have bidirectional (antimanic and antidepressant) thymoleptic effects, in short, mood-stabilizing properties.

As Frank et al (2000) note in their article, “sustained euthymia in bipolar disorder may remain an elusive goal in the absence of sophisticated treatments that address both the biological and psychological aspects of this disorder.” In developing interpersonal and social rhythm therapy (IPSRT), they have devised one of the few psychotherapeutic strategies based on theoretical and empirical findings regarding factors that influence the course of bipolar disorder. This effort marks the first time that a manual-based form of individual psychotherapy intended to address multiple aspects of bipolar disorder (prevention of manic, mixed, and depressive episodes; enhancement of treatment compliance) has been studied prospectively in a large, long-term randomized trial. Although the data presented are only preliminary findings, they are intriguing. First, only 23% of patients who entered the preventative phase of treatment entered on lithium alone, although lithium monotherapy was the pharmacologic treatment goal. Second, IPSRT helped patients achieve more stable social rhythms. Third, an association between social rhythm disruption and onset of manic episodes was apparent. Finally, changes in treatment in general increased the risk of relapse, and the loss of IPSRT, in particular, increased the risk of depressive relapse. Data from the completion of this study should provide important answers regarding the impact of this form of psychotherapy on the course of bipolar disorder.

Miklowitz et al (2000) attempted to improve the outcome of patients with bipolar I disorder using a different approach that also combined the effects of psychotherapy and pharmacotherapy. This randomized, 9-month, controlled trial compared manual-based family-focused psychoeducational treatment (FFT) with treatment as usual in patients recovering from an acute affective episode. This strategy is particularly targeted at the immediate postillness aftercare period, a time of heightened vulnerability to relapse and keen importance in facilitating rehabilitation. The results of this study suggest that FFT provided greater preventative benefit than treatment as usual for depressive episodes. The results also raised a number of interesting questions for further study, including whether the prophylactic effects of FFT endure beyond the period of participation, and whether these effects are as significant when compared with a control form of psychotherapy matched for amount and intensity of contact.

Overall, a number of unanswered fundamental questions regarding the treatment of patients with bipolar disorder remain. Primarily the pharmaceutical industry and private foundations have driven recent pharmacologic treatment advances. Two major initiatives undertaken in the late 1990s, the Stanley Foundation Bipolar Network (Leverich et al, in press) and the NIMH Bipolar STEP Network (Sachs et al 2000) should help make up for lost time in improving treatments for people with bipolar disorder.

Paul E. Keck, Jr

Biological Psychiatry Program
Department of Psychiatry
University of Cincinnati College of Medicine
231 Bethesda Avenue
P.O. Box 670559
Cincinnati OH 45267-0559
References


