Psychosocial Treatment of Bipolar Disorder: Clinician Knowledge, Common Approaches, and Barriers to Effective Treatment

Bradley D. Stein, M.D., Ph.D., Karen L. Celedonia, M.P.H., Holly A. Swartz, M.D., Rachel M. Burns, M.P.H., Mark J. Sorbero, M.S., Rayni A. Brindley, M.Ed., B.C.B.A., Ellen Frank, Ph.D.

Objective: Nonphysician mental health clinicians were surveyed to understand their knowledge about bipolar disorder, treatment approaches, and perceived barriers to optimal treatment.

Methods: Nonphysician mental health clinicians (N=55) from five community mental health clinics reported on their therapeutic approach, knowledge, and skill related to treatment of bipolar disorder. Chi square and t tests were used to detect differences in responses by clinician characteristics.

Results: Most clinicians wished to improve their treatment for bipolar disorder. They felt best prepared to provide counseling and least prepared to identify medication side effects. Among psychotherapies, CBT was the most familiar to clinicians. Although knowledgeable overall about bipolar disorder, the clinicians were less knowledgeable about pharmacotherapy. The most commonly reported treatment barrier was comorbid substance use disorders.

Conclusions: Clinicians would benefit from additional training in effective therapeutic approaches for bipolar disorder as well as information about pharmacotherapy and supporting individuals with comorbid substance use problems.

Psychiatric Services 2015; 66:1361–1364; doi: 10.1176/appi.ps.201400004

Bipolar disorders type I and II (herein referred to as bipolar disorder) represent potentially devastating, chronic disorders affecting 2.6% of the U.S. adult population in a given year (1), with a lifetime prevalence of 3.9% (2). Psychosocial interventions can play an essential adjunctive role when combined with pharmacologic treatments for individuals with bipolar disorder. The most effective psychosocial interventions utilize common strategies, such as psychoeducation, promotion of medication adherence, encouragement of regular daily routines and sleep, mood monitoring, and detection of early warning signs of relapse (3). Incorporating evidence-informed interventions into routine community clinical practice could potentially improve outcomes for many individuals with bipolar disorder. Implementation strategies for evidence-based treatment could be made more effective if they build on the extant knowledge and skills of the clinicians involved in providing treatment. However, we are unaware of empirical information about the strategies routinely used by clinicians in community practices to provide care for bipolar disorder. To address this gap in the literature, we present results from a survey of nonphysician community mental health clinicians from five community mental health clinics.

METHODS

We surveyed nonphysician mental health clinicians from five community mental health clinics who had consented to participate in a study funded by the National Institute of Mental Health examining alternative approaches to implementing interpersonal and social rhythm therapy (IPSRT) (4), an evidence-based psychosocial intervention for bipolar disorder, in community mental health settings. Participating clinics were in urban, suburban, and rural communities serving primarily disadvantaged populations, were not academically affiliated, and had not made any systematic efforts to improve care for bipolar disorder. All nontrainee clinicians treating adults with bipolar disorder were eligible to participate, and 55 of the 57 (96%) eligible clinicians participated in the study. IPSRT training was provided as part of the larger study, but the survey was completed before the training to gather information for use in subsequent analyses of variation in IPSRT implementation. The University of Pittsburgh and RAND IRBs approved the study.

We used responses on the Clinician Techniques and Beliefs (CTB) measure, the clinician self-report version of the validated Psychotherapy Practice Scale for IPSRT (5), to

assess clinicians' therapeutic approach. The 28 items used a 4-point Likert scale to assess the frequency with which clinicians reported treating adults with bipolar disorder by using therapeutic techniques consistent with cognitive-behavioral therapy (CBT) (Cronbach's α=.71); IPSRT (Cronbach's α=.75); other therapeutic approaches, such as psychodynamic techniques or supportive or expressive techniques (Cronbach's α=.68); or nonspecific techniques (Cronbach's α=.66).

We assessed knowledge of bipolar disorder with 13 statements about etiology, course, and treatment of bipolar disorder. Clinicians responded to each statement with a 5-point Likert scale. "Strongly agree" and "agree" were considered correct responses to true statements, and "strongly disagree" and "disagree" were considered correct responses to false statements. Content of questions was grounded in the empirical literature on bipolar disorder and targeted a knowledge level comparable to that of a first-year medical student after completion of a general course in psychiatry.

We assessed self-reported skill in treating patients with bipolar disorder by measuring use of six clinical strategies associated with evidence-based treatments for bipolar disorder (3), such as identifying early warning signs of possible recurrence and providing psychoeducation for a patient's family members. Use of each strategy was assessed by using a 4-point Likert scale ranging from not at all skilled to very skilled.

We identified barriers to providing optimal mental health treatment to individuals with bipolar disorder by using 15 items modified from the Partners in Care study that describe potential barriers to treatment (6). Response options included "does not limit," "limits somewhat," or "limits a great deal."

We calculated descriptive statistics of self-reported personal and clinical characteristics, such as professional discipline (social work or other), year in which training was completed, average number of sessions with adults per week, percentage of clinical sessions conducted with individuals diagnosed as having bipolar disorder, and average session length. For each individual, we calculated a therapeutic approach score for each technique by calculating the mean score for related CTB items and assessed the internal consistency for the therapeutic approach score for each technique by generating a Cronbach's alpha. We examined the correlation between scores for knowledge and skills. We also used chi square and t tests, as appropriate, to test whether clinician characteristics were significantly associated with therapeutic approach, skill, knowledge, and barriers to optimal treatment.

RESULTS

Slightly more than half (N=31, 56%) of the mental health clinicians were social workers; the remaining 44% (N=24) were from other professional disciplines, such as psychology and marriage, family, and child counseling. They had an average of 12.9±9.9 years of experience as a therapist and reported 18±9 visits per week with adult clients; for the majority of clinicians, patients with bipolar disorder represented more than one-quarter of their caseload. [A table summarizing survey results is available as an online supplement to this report.]

The therapeutic approach endorsed by clinicians most frequently was CBT (mean±SD score=3.2±.5), followed by IPSRT (2.9±.4), nonspecific techniques (2.8±.4), and other therapy techniques (2.2±.4). There were no significant differences in therapeutic approach score by professional discipline, years of experience, overall caseload, or proportion of caseload represented by patients with bipolar disorder.

Clinicians reported feeling knowledgeable about and relatively skilled in treating individuals with bipolar disorder. Self-reported skill was rated highest for counseling (3.5±.6), followed by psychoeducation (3.3±.7) and identifying warning signs of possible recurrence (3.3±.7). Providing psychoeducation for family members (3.0±.9) and identifying medication side effects (3.0±.8) were rated lower. In response to the statement, "I am very knowledgeable in the treatment of individuals with bipolar disorder," 67% of participants (N=36) agreed or strongly agreed, 24% (N=13) neither agreed nor disagreed, and 9% (N=5) disagreed.

Thirty-three percent (N=18) of clinicians correctly answered more than 84% of 13 true-false questions about bipolar disorder, 58% (N=32) correctly answered 50% to 84% of the questions, and 9% (N=5) correctly answered fewer than 50% of the questions. Questions most often answered correctly included, "Management of sleep habits is a very important part of treating bipolar disorder," "Psychotherapy improves outcomes for patients with bipolar disorder when administered with medications," and "The maintenance phase of treatment for bipolar disorder focuses on preventing recurrence." Questions answered correctly by less than 60% of the clinicians included "The depressive phase of bipolar disorder takes longer to treat than the manic phase" (N=30), and "Antidepressant medications should only be prescribed for a patient with bipolar disorder if they are receiving concurrent treatment with a mood stabilizer" (N=26). Clinician knowledge and self-reported skill in treating individuals with bipolar disorder were significantly correlated (r=.45, $p<.001$). There were no significant differences in self-reported skill or knowledge related to bipolar illness by professional discipline, years of experience, overall caseload, or proportion of caseload represented by patients with bipolar disorder.

Many clinicians (N=27, 49%) reported that substance use problems interfered with treatment of bipolar disorder, and a comparable number (N=24, 44%) reported that substance use problems were often more pressing compared with symptoms of bipolar disorder. Poor adherence to treatment was another barrier endorsed by the majority of clinicians (N=31, 56%). Less commonly endorsed barriers were poor reimbursement for services or limited benefits (N=8, 15%), short sessions (N=5, 9%), or inadequate follow-up (N=4,

7%). There were no significant differences in reported barriers by professional discipline, years of experience, overall caseload, or proportion of caseload represented by patients with bipolar disorder.

DISCUSSION

Most clinicians we surveyed reported that when treating patients with bipolar disorder, they most commonly used CBT techniques, and they reported being relatively knowledgeable about many aspects of treating these disorders. Fewer reported familiarity with other effective techniques. Many identified ongoing challenges to effectively treating bipolar disorder, especially the need to address concurrent substance use problems and treatment adherence.

It is encouraging that many clinicians reported using CBT techniques in treating adults with bipolar disorder, given that CBT has been shown to be an efficacious treatment for these conditions (7). However, clinicians were less likely to have endorsed techniques from other efficacious interventions, despite the fact that alternative techniques, such as attending to circadian rhythm regularity and addressing sleep-wake routines, may also be important in managing the disorder (8), and cognitive-behavioral approaches may not be best suited for all patients (7). Optimally, clinicians would feel comfortable using a broad range of techniques and interventions, from which they could choose on the basis of clinical details and patient preferences. However, the challenges in training frontline clinicians to effectively implement any single evidence-based practice are well known. It may be unrealistic to expect clinicians to learn and master multiple evidence-based interventions for individuals with bipolar disorder, particularly in general clinics where such individuals represent a minority of patients. Instead, alternative efforts are increasingly being made to give frontline clinicians a range of treatment skills (9), for example, by helping them learn and use core components of effective interventions.

It is encouraging that clinicians appeared relatively knowledgeable about many aspects of bipolar disorder; however, knowledge related to medication use was weaker. Safe medication use is the foundation of treatment for many individuals with bipolar disorder and, although prescribing physicians are primarily responsible for medication management, ensuring that the entire treatment team is knowledgeable about medication effects and side effects can enhance monitoring of patients and encourage medication adherence among patients who may have questions about their medications or who are experiencing side effects. Our findings suggest an important opportunity to improve care of individuals with bipolar disorder by enhancing the knowledge of nonphysician mental health clinicians about psychotropic medications used to treat bipolar disorder, potentially through team approaches in which physicians and nonphysicians meet with patients together or at least meet to review the patients' progress. Because clinicians identified treatment adherence as a specific barrier to managing individuals with bipolar disorder, increased knowledge about psychotropic medications may provide clinicians with a particularly important tool to promote treatment adherence.

In addition to medication adherence, effective engagement of individuals with serious mental illness in treatment is an ongoing challenge (10), and lack of successful engagement is associated with a range of negative outcomes (10–12). Interventions such as motivational interviewing and motivational enhancement have been shown to increase engagement among other populations of individuals with serious mental disorders (13). Our study suggests that incorporating such components into the development and dissemination of effective psychotherapies for bipolar disorder should receive greater consideration.

Comorbidity of substance use and bipolar disorder is common, but we are unaware of empirical studies documenting the extent to which community mental health clinicians believe that comorbid substance use disorder complicate the treatment of individuals with bipolar disorder. Optimally, individuals with such comorbidities would receive effective treatment for both disorders, but provision of evidence-based care for both diagnoses is relatively rare because of a range of challenges (14). As a result, consideration should be given to more formally integrating components of interventions designed to address substance misuse in treatment for individuals with bipolar disorder. One intervention shown to be effective in addressing substance misuse is motivational interviewing (13), giving further impetus to considering using this approach as an adjunctive strategy to management of bipolar disorder.

Our findings must be considered in the context of our study's limitations. Participating clinicians were part of a larger study to examine alternative approaches to implementing an evidence-based practice for bipolar disorder in community mental health clinics; such individuals (and the clinics in which they work) likely had a higher level of interest in and motivation to improve treatment for individuals with bipolar disorder compared with many community mental health clinicians. Participating clinicians were from a select number of clinics and were all located in a single state with relatively robust public-sector mental health services. We do not know to what extent our findings would generalize to a larger sample of clinicians practicing in multiple states or regions. Our results were based on a clinician survey, and without objective observations, we do not know the extent to which clinician self-reports accurately reflected their knowledge and skills or the actual treatment provided during patient sessions.

CONCLUSIONS

Within the context of these limitations, we found that the clinicians we surveyed were interested in augmenting their skills in order to better manage treatment of patients with bipolar disorder. Although the clinicians felt confident in

their abilities to treat these patients, our findings suggest that they would benefit from additional training in effective therapeutic approaches for bipolar disorder beyond CBT, as well as in pharmacotherapy, in order to help their patients cope with the often complicated regimens prescribed for their illness. Clinicians endorsed concerns about comorbid substance use disorders and treatment adherence, issues for which motivational interviewing and motivational enhancement may be helpful. Given these identified needs, the challenge facing the field is how to effectively, efficiently, and sustainably help community mental health clinicians develop these skills while working in agencies with limited resources and a range of competing demands (15). Research in such approaches is needed to ensure that patients can benefit from the tremendous progress made over the past several decades in the development of efficacious interventions for bipolar disorder.

AUTHOR AND ARTICLE INFORMATION

Dr. Stein, Ms. Celedonia, Ms. Burns, and Mr. Sorbero are with the RAND Corporation, Pittsburgh, Pennsylvania (e-mail: stein@rand.org). Dr. Stein is also with the Department of Psychiatry, University of Pittsburgh School of Medicine, Pittsburgh, where Dr. Swartz and Dr. Frank are affiliated. Ms. Brindley is with Northwestern Human Services, Harrisburg, Pennsylvania.

The National Institute of Mental Health provided support for this study under award R34MH091319. Dr. Frank's time was also supported by a bequest from the Mueller family. The authors are indebted to Gina Boyd, M.L.I.S., for research assistance and assistance with the preparation of the manuscript and to the leadership of the community mental health provider organizations for their support of this project. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health.

Dr. Frank or her spouse owns stock in or is on the advisory board of Aliphcom, Health Rhythms, Psychiatric Assessments, Inc., Servier International, and Valdoxan. Her spouse owns the copyright for the Pittsburgh Sleep Quality Index. Dr. Frank receives royalties from Guilford Press for the IPSRT manual and from the American Psychological Association for a monograph on interpersonal psychotherapy. The other authors report no financial relationships with commercial interests.

Received January 16, 2014; revision received February 5, 2015; accepted March 16, 2015; published online September 1, 2015.

REFERENCES

1. Kessler RC, Chiu WT, Demler O, et al: Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry 62:617–627, 2005
2. Kessler RC, Berglund P, Demler O, et al: Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry 62:593–602, 2005
3. Bipolar Disorder: The Assessment and Management of Bipolar Disorder in Adults, Children and Young People in Primary and Secondary Care. Leicester, United Kingdom, National Institute for Health and Care Excellence, 2014. Available at guidance.nice.org.uk/CG185
4. Frank E: Treating Bipolar Disorder: A Clinician's Guide to Interpersonal and Social Rhythm Therapy. New York, Guilford, 2005
5. Miranda J, Hepner KA, Azocar F, et al: Development of a patient-report measure of psychotherapy for depression. Administration and Policy in Mental Health and Mental Health Services Research 37:245–253, 2010
6. Wells KB: The design of Partners in Care: evaluating the cost-effectiveness of improving care for depression in primary care. Social Psychiatry and Psychiatric Epidemiology 34:20–29, 1999
7. Scott J, Paykel E, Morriss R, et al: Cognitive-behavioural therapy for severe and recurrent bipolar disorders: randomised controlled trial. British Journal of Psychiatry 188:313–320, 2006
8. Frank E, Kupfer DJ, Thase ME, et al: Two-year outcomes for interpersonal and social rhythm therapy in individuals with bipolar I disorder. Archives of General Psychiatry 62:996–1004, 2005
9. Rotheram-Borus MJ, Daleiden EL, Bernstein A, et al: The old solutions are the new problem: how do we better use what we already know about reducing the burden of mental illness? Perspectives on Psychological Science 6:493–497, 2011
10. O'Brien A, Fahmy R, Singh SP: Disengagement from mental health services: a literature review. Social Psychiatry and Psychiatric Epidemiology 44:558–568, 2009
11. Lang K, Korn J, Muser E, et al: Predictors of medication nonadherence and hospitalization in Medicaid patients with bipolar I disorder given long-acting or oral antipsychotics. Journal of Medical Economics 14:217–226, 2011
12. Stein BD, Celedonia K, Kogan JN, et al: Facilitators and barriers associated with implementation of evidence-based psychotherapy in community settings. Psychiatric Services 64:1263–1266, 2013
13. Martino S, Carroll KM, O'Malley SS, et al: Motivational interviewing with psychiatrically ill substance abusing patients. American Journal on Addictions 9:88–91, 2000
14. Keyser DJ, Watkins KE, Vilamovska AM, et al: Improving service delivery for individuals with co-occurring disorders: new perspectives on the quadrant model. Psychiatric Services 59:1251–1253, 2008
15. Herschell AD, Kogan JN, Celedonia KL, et al: Understanding community mental health administrators' perspectives on dialectical behavior therapy implementation. Psychiatric Services 60:989–992, 2009