

Psychotherapeutic Treatment of Bipolar Depression

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KEYWORDS

• Bipolar depression • Psychotherapy • Review • Clinical recommendations

KEY POINTS

- There are several evidence-based psychotherapy options for bipolar depression: cognitive-behavioral therapy, family focused therapy, interpersonal and social rhythms therapy, mindfulness-based cognitive therapy, and dialectical behavior therapy.
- There are promising additional psychotherapy options that are evidence-based for unipolar but need research for bipolar depression: behavioral activation, unified protocol, cognitive behavioral analysis system of psychotherapy, and others.
- Different psychotherapy approaches address different aspects of bipolar depression. Using evidence-based assessments, recommendations can be made for the most appropriate psychotherapy treatment of a particular patient.
- Psychotherapy for bipolar depression is intended as an adjunctive to medication management and should include several key elements, such as psychoeducation, increasing awareness of mood, establishing routines, and targeting medication adherence.

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OVERVIEW

Bipolar disorder is a debilitating and costly condition,¹ and most of the treatment research has focused on the manic or hypomanic episodes that occur in the course of the disorder.^{2,3} However, depressive episodes within bipolar disorder, referred to as *bipolar depression*, occur with higher frequency than manic/hypomanic episodes^{4,5} and are also associated with premature death,⁶ elevated risk for suicidal behaviors,⁷ and significant functional impairment.^{8,9} Thus, bipolar depression, independent from mania and hypomania, is an important target of intervention.

Although there have been impressive breakthroughs in the treatment of bipolar disorder with psychiatric medication,¹⁰ none of the available mood-stabilizing drugs show sufficient efficacy in treating bipolar depression.^{11–13} The response rate of patients with bipolar disorder to these drugs is only about 50%, even in patients with low psychiatric comorbidity rates.¹⁴ Furthermore, mood stabilizers can potentially cause serious long-term health problems, such as the development of metabolic and cardiovascular diseases. Even for those for whom medication is successful, evidence has found a high rate of noncompliance with medication (up to 50%)¹⁵ and an elevated frequency of residual depressive symptoms outside major mood episodes.^{16,17} Taken together, these findings suggest that current treatments need improvement to better address bipolar depression.

In addition to mood stabilizers, adjunctive psychotherapy can greatly improve treatment outcomes.¹⁸ Evidence has accumulated that brief, manualized psychotherapies are as efficacious as medication in reducing acute unipolar depression severity, have fewer side effects, and may be more efficacious in preventing relapse.^{19,20} In this review, the authors present several psychotherapy options with direct evidence for bipolar depression as well as some promising avenues for intervention that are in need of research with bipolar disorder.

ASSESSMENT OF BIPOLAR DEPRESSION

Existing psychotherapies conceptualize bipolar depression as a collection of problems that can be addressed in therapy; therefore, detailed assessment of such problems is a necessary step in developing a treatment plan and evaluating progress. When a patient reports a history of depression (**Table 1**), history of manic or hypomanic behaviors should be assessed using the Structural Clinical Interview for DSM Disorders²¹ or the Mood Disorder Questionnaire.²² A bipolar disorder diagnosis should indicate that the provider should consider initiating medication (if not already administered), providing psychoeducation about the disorder, and targeting medication adherence.

Once providers have assessed (major) depression, it is recommended to examine whether patients ever had a background of manic or hypomanic episodes (as defined in the *Diagnostic and Statistical Manual of Mental Disorders* [Fifth Edition] [DSM-5]). Indicators that should make the provider particularly prudent and make him or her assess carefully for past history of hypomanic or manic episodes are

1. A family history of bipolar²³
2. Atypical features, such as presence of hypersomnia^{24,25} or leaden paralysis²⁶
3. Psychosis²⁷
4. Melancholic features^{28,29}
5. Psychomotor disturbance^{17,25,30}
6. Early age of onset, particularly before 21 years of age³¹
7. High frequency of episodes²⁵

Table 1 Assessment tools for bipolar depression and associated problems		
Problem	Assessment Type	Measures
Bipolar depression (presentation and severity)	Semistructured interview	<ul style="list-style-type: none"> • Structured Clinical Interview for <i>DSM-IV-TR</i> Patient Edition^{21,126} • Schedules for Affective Disorders and Schizophrenia–Lifetime Version¹²⁷ • Hamilton Rating Scale for Depression¹²⁸
	Self-report	<ul style="list-style-type: none"> • Beck Depression Inventory^{129,130} • Patient Health Questionnaire-9^{131,132} • Mania Rating Scale¹³³
Dysfunctional cognition and behaviors	Self-report	<ul style="list-style-type: none"> • Automatic Thoughts Questionnaire¹³⁴ • Dysfunctional Attitudes Scale¹³⁵ • Beck Hopelessness Scale¹³⁶ • Ruminative Responses Scale¹³⁷
Emotional expressivity	Semistructured interview	<ul style="list-style-type: none"> • Camberwell Family Interview¹³⁸
	Behavioral assessment	<ul style="list-style-type: none"> • Category System for Partner Interaction¹³⁹ • Five-minute speech sample¹⁴⁰
Interpersonal deficits	Self-report	<ul style="list-style-type: none"> • Social rhythm metric¹⁴¹ • Social Adjustment Scale¹⁴² • Inventory of interpersonal problems¹⁴³
Suicidality	Semistructured interview	<ul style="list-style-type: none"> • The Suicide and Self-Injury Interview⁸⁴
Comorbid anxiety	Semistructured interview	<ul style="list-style-type: none"> • Anxiety Disorders Interview Schedule¹⁴⁴
	Self-report	<ul style="list-style-type: none"> • Beck Anxiety Inventory¹⁴⁵
Emotion dysregulation	Self-report	<ul style="list-style-type: none"> • The Difficulties in Emotion Regulation Scale¹⁴⁶ (cutoff of 97 used to define high emotion dysregulation and enroll in DBT⁸⁷) • The Avoidance and Action Questionnaire^{147,148} • The Cognitive Emotion Regulation Questionnaire¹⁴⁹
Mindfulness	Self-report	<ul style="list-style-type: none"> • Five Facet Mindfulness Questionnaire¹⁵⁰ • Mindful Awareness Attention Scale¹⁵¹

Abbreviation: DSM-IV-TR, Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition, Text Revision).

Data from Refs.^{21,84,87,126–151}

8. Comorbid anxiety disorders, such as obsessive-compulsive³² or panic disorder³³
9. Presence of severe suicidal behavior^{17,30}
10. Major depressive episode refractory to at least 2 lines of antidepressants³⁴

After bipolar disorder has been diagnosed, it is also recommended that providers assess hallmark problems or complaints that increase the specificity of the clinical presentation. Within bipolar depression, psychotherapies have been designed to address problems, such as anhedonia and depressed mood, lack of motivation, suicidal behaviors, interpersonal difficulties, maladaptive thoughts, inconsistent routines, and difficulties managing emotions. Using evidence-based measures can help determine the presence and severity of such problems (see **Table 1**). Depending on which presenting problems are most severe, providers can recommend a psychotherapy protocol that meets the patients’ particular needs. Effective psychotherapies for

bipolar depression include cognitive-behavioral therapy (CBT), family focused therapy (FFT), and interpersonal and social rhythm therapy (IPSRT) or mindfulness-based treatments, such as dialectical behavior therapy (DBT) and mindfulness-based cognitive therapy (MBCT). These psychotherapy modalities and their evidence are presented in the following sections. (Fig. 1 contains a decision-making model of referring patients to an appropriate psychotherapy modality.)

COGNITIVE BEHAVIORAL THERAPIES

CBT³⁵ is a structured psychotherapy based on Beck’s³⁶ cognitive theory that describes maladaptive thoughts and behavioral patterns that are instrumental for the development and maintenance of depression. CBT involves the use of several techniques, such as teaching patients to identify and modify maladaptive thoughts (eg, beliefs of worthlessness) or engaging in behavioral experiments to examine assumptions (eg, avoiding social interactions because of fear of rejection). CBT has been more recently adapted^{37,38} to address thought and behavioral patterns specific to bipolar disorder.³⁹

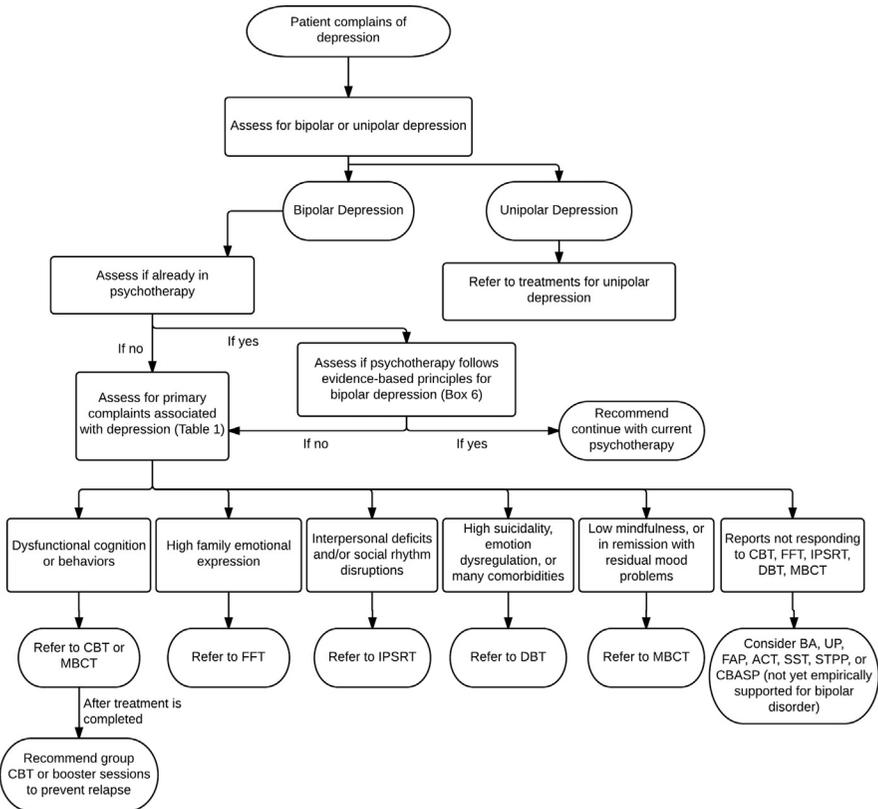


Fig. 1. Recommendations for referral to appropriate evidence-based psychotherapies for bipolar depression for medical providers. ACT, acceptance and commitment therapy; BA, behavioral activation; CBASP, cognitive behavioral analysis system of psychotherapy; DBT, dialectical behavior therapy; FAP, functional analytical psychotherapy; SST, self-systems therapy; STPP, short-term psychodynamic psychotherapy; UP, unified protocol.

Empirical evidence has demonstrated that CBT is effective in treating the bipolar depression.⁴⁰ In several randomized controlled trials (RCTs), CBT for bipolar (**Box 1**), administered by experienced clinicians, led to significantly higher reductions in depression severity and improvements in functioning as compared with a wait-list control³⁹ and to treatment as usual (TAU)^{41,42} when controlling for baseline depression. Specifically, depression severity scores were cut in half over 20 sessions of CBT.³⁷ CBT may be less effective with patients with severe bipolar with numerous previous episodes.⁴³

CBT was also examined during the Systematic Treatment Enhancement Program for Bipolar Disorder, a multi-site study that compared 30 sessions of intensive psychotherapy (including CBT) with a minimal psychosocial intervention in treating bipolar depression.⁴⁴ Compared with previous trials, this RCT had the most stringent control treatment, which included elements such as psychoeducation, relapse-prevention strategies, and illness management. Nonetheless, more patients recovered from their depressive episode within a year if they received intensive psychotherapy than the control treatment. Specifically, CBT significantly improved patients' relationship functioning and life satisfaction by teaching them to engage with others and challenge negative thoughts about relationships.⁴⁵ Taken together these findings support the efficacy of CBT for bipolar depression.

In addition to individual CBT, group CBT may also be effective in treating bipolar depression.^{46–48} When compared with TAU, a 14-week CBT group treatment reduced depression severity significantly more and led to significantly higher improvements in social and emotional functioning.^{47,48} Another clinical trial found only a trend in reduced depression severity after patients completed both phases of a 12-week CBT group treatment, with evidence that completing both phases was needed to improve social functioning.⁴⁶ These findings suggest that group CBT may be particularly useful to improve psychosocial functioning in patients with bipolar depression.

Box 1

Cognitive Behavioral Therapies for bipolar disorders

1. Theory: Depression is associated with maladaptive patterns of thought (eg, negative attitudes about the self) or behavior (eg, withdrawing from social contact). Thoughts, actions, and emotions all influence each other.
2. Goal: Patients and therapists agree on short- and long-term goals to address problem thinking or behaviors.
3. First phase: Psychoeducation about bipolar disorder and about the theoretic framework used in therapy is conducted.
4. Second phase: Patients and therapists work together on cognitive and behavioral coping skills that include
 - a. Increasing awareness of cues that trigger mood shifts
 - b. Cognitive restructuring to change negative thinking patterns
 - c. Engaging in positive behaviors and within regular routines
 - d. Keeping medication compliance high
5. Homework assignments encourage patients to practice skills in their daily lives.
6. Group CBT: Patients receive psychoeducation (phase 1) and practice skills (phase 2) in group settings.

Adapted from Basco MR, Rush AJ. Cognitive-behavioral therapy for bipolar disorder. New York: Guilford Press; 2005.

Both individual and group CBT show long-term maintenance of gains that are superior to control treatments for bipolar depression. Ball and colleagues⁴¹ found that patients in the CBT group had a significantly longer remission than control patients. Lam and colleagues⁴⁹ also assessed the long-term effects of CBT on preventing relapse among patients with bipolar who were in remission. After 12 to 18 sessions and 2 boosters of a manualized CBT protocol, patients treated with CBT had fewer depression relapses and hospitalizations than did those treated with medication alone. However, CBT's effectiveness at preventing relapse was reduced at a 12-month follow-up and was no longer significant at the 18-month follow-up, even though coping strategies and social functioning continued to be improved.⁵⁰

Although more longitudinal research is needed, the existing findings suggest that CBT (whether administered in individual or group format) is effective in treating and preventing relapse of bipolar depression; but the benefits are strongest during the course of treatment or shortly thereafter. Efficacy of CBT may be lower in patients with bipolar depression of high severity and with many past episodes of depression. These patients may, thus, need a more intensive level of care.

FAMILY FOCUSED THERAPY

Psychotherapy interventions targeted toward dysfunctional family interactions have also been found effective in treating bipolar depression. FFT was originally developed to target high expressed emotion (ie, critical, aggressive, or overly involved emotional expressions) in families of those who were at risk for schizophrenia.⁵¹ Basic research has also associated bipolar disorder with high-expressed-emotion families and with maladaptive interpersonal interactions.⁵² Thus, FFT was adapted and tested for bipolar disorder⁵³ (**Box 2**).

Several clinical trials have found that FFT effectively reduced bipolar depression.⁵⁴ Miklowitz and colleagues⁵⁵ compared 2-year outcomes of FFT and a crisis management intervention after acute mood episodes and found that FFT reduced depression severity significantly more than the control treatment. Improvements in family communication skills (especially nonverbal behaviors) were associated with improvements in

Box 2

Family Focused Therapy

1. Theory: Bipolar disorder is associated with high expressed emotion in families and maladaptive interpersonal interactions.
2. Goal: The goal is increasing positive interactions within a family and engaging the patients' support network in treatment and relapse prevention.
3. FFT protocol consists of 21 individual psychotherapy sessions conducted with the patients and their relevant family members.
4. First phase: Psychoeducation about bipolar disorder and the family communication style as a maintaining factor is conducted.
5. Second phase: Communication training is conducted (eg, learning and practicing effective communication skills, such as active listening or making eye contact).
6. Third phase: Problem solving is conducted (eg, assessing conflicts and developing solutions to address them).

Adapted from Miklowitz DJ, Goldstein MJ. Behavioral family treatment for patients with bipolar affective disorder. Behav Modif 1990;14:457–89.

bipolar depression.⁵⁶ FFT was as effective as CBT but more effective than a control intervention in leading to recovery from bipolar depression within 1 year.⁴⁵ In addition, FFT was also shown to be more effective in treating adolescent bipolar depression than a psychoeducational control group.⁵⁷ Participants in FFT had shorter depressive episodes, quicker recovery, and less depression severity over 2 years.

FFT may also have long-term relapse prevention effects. When compared with supportive individual therapy, FFT was equally effective in reducing bipolar depression during 1 year of active treatment. However, FFT prevented significantly more relapses than individual therapy within the year following the active treatment.⁵⁸ The investigators hypothesized that the long-term benefits of the therapy may be due to patients in FFT having the support of their family in monitoring mood and practicing coping skills. Therefore, FFT may be a preferred treatment of patients with bipolar depression who report family problems and poor social functioning, if their families are willing to be involved.

INTERPERSONAL AND SOCIAL RHYTHM THERAPY

IPSRT is a treatment developed specifically for bipolar disorder and consists of 2 primary components: social rhythm therapy (SRT) and interpersonal psychotherapy (IPT). SRT is rooted in research showing that disruptions of circadian rhythms, sleep-wake cycles, or social rhythms (ie, relationships or social demands that establish and maintain biological rhythms) may lead to subsequent affective episodes.⁵⁹ Although disruptions of biological rhythms tend to be more closely associated with the onset of manic episodes,⁶⁰ social rhythm disruption (eg, loss of a significant relationship or change in job) can be the precipitant of both manic and depressive episodes. Thus, the SRT aspect of IPSRT has the advantage of targeting both ends of the bipolar mood spectrum.

IPT is a well-established treatment of unipolar depression.^{59,61} A systematic review⁶² identified 13 outcome studies that evaluated the efficacy of IPT as compared with any other form of treatment, placebo, or a wait-list control. As compared with antidepressant medication, IPT had a similar rate of remission both acutely and during the maintenance phase. Combining medication with IPT led to higher acute remission rates than either treatment alone. Thus, IPT seems to be an efficacious treatment of unipolar depression, which led to its merging with SRT in the development of IPSRT to target depression among adults with bipolar disorder. IPSRT expands the IPT targets to include grief over the loss of the self: the person they could or would be if they did not have bipolar disorder. This additional element helps the client cope with any losses or changes in lifestyle and ambitions that come with accepting the limitations associated with the bipolar diagnosis. See **Box 3** for a description of IPSRT.

The largest study of IPSRT to date recruited 175 participants to receive IPSRT or intensive clinical management, a manualized medication management approach for bipolar disorder.⁶³ All participants were treated with lithium, augmented with antidepressant or antipsychotic medication when indicated. Results showed that participants in the IPSRT group remitted more quickly during the acute phase; among participants who remitted, those treated with IPSRT were less likely to experience an additional affective episode over the following 2 years. Most patients began the study in a depressed phase, and IPSRT was better than medication management at preventing a recurrence of either manic or depressive affective phases. Follow-up analyses indicated that improvement in social rhythm was a mechanism of change in IPSRT⁶³ and that participants in IPSRT showed better occupational improvement over the course of treatment.⁶⁴

Box 3**Interpersonal Social Rhythm Therapy**

1. Theory: Disruptions of circadian rhythms, the sleep-wake cycle, or social rhythms (ie, relationships or social demands that establish and maintain biological rhythms) lead to affective episodes. In addition, interpersonal problems are seen to be a maintaining factor for depression.
2. Goal: The goal is maintaining consistency in biological and social rhythms and improving interpersonal relationships.
3. IPSRT protocol consists of variable-length individual psychotherapy sessions targeting key elements:
 - a. Key SRT targets⁶⁶
 - i. Wake time
 - ii. Time of first social interaction
 - iii. Time of start of daily activities
 - iv. Evening meal time
 - v. Bedtime
 - a. Key IPT targets⁶¹
 - i. Unresolved grief
 - ii. Role transitions
 - iii. Role disputes
 - iv. Interpersonal deficits
 - v. Grief over loss of the self
4. IPSRT treatment phases include the following⁵⁹:
 - a. Initial phase (4–16 weeks):
 - i. Psychoeducation about bipolar
 - ii. Identify an interpersonal target
 - iii. Orientation to social rhythm monitoring
 - a. Preventative phase (2+ years, monthly)
 - i. Maintain treatment gains
 - ii. Prepare for potential future disruptions to social rhythms
 - iii. Crisis management as needed
 - b. Intermediate phase (3–12 months)
 - i. Develop strategies and skills to maintain daily rhythms
 - ii. Manage mood changes
 - iii. Improve target interpersonal relationships
 - b. Termination phase
 - i. Identify sources of support and resources available after therapy has ended
 - ii. Prepare to tackle future difficulties without therapist

Data from Refs. ^{59,61,66}

More recently, Swartz and colleagues⁶⁵ have published promising pilot data indicating that IPSRT may be effective as a monotherapy for depressive episodes in bipolar II disorder. They report that 16 depressed patients with bipolar II who had been tapered off all medications had achieved remission after 12 to 20 weeks of IPSRT. Two additional studies found evidence that group IPSRT reduces depression severity in patients with bipolar disorder: one found this decrease after 16 group IPSRT sessions⁶⁶ and the other after 6 group IPSRT sessions in conjunction with 2 individual sessions and a telephone call at 12 weeks.⁶⁷ Miklowitz and colleagues⁴⁴ also demonstrated that patients treated with IPSRT recovered significantly faster from a depressive episode and were more likely to maintain remission than patients treated with just collaborative care. In summary, the existing data suggest that IPSRT is a promising treatment for reducing bipolar depression severity and preventing relapse in bipolar depression.

MINDFULNESS-BASED COGNITIVE THERAPY

Mindfulness-based cognitive therapy (MBCT⁶⁸) is a group treatment protocol that uses a combination of meditation practices and CBT exercises to change the relationship that people have to their thoughts and emotions. This program, which is well

established for treatment of unipolar depression,⁶⁸ has been successfully adapted for bipolar depression⁶⁹ (Box 4). The empirical literature evaluating MBCT demonstrates strong support for the reduction of depressive relapse, residual depression, and anxiety severity.^{70–72} Some studies have shown positive results using standard MBCT for bipolar I and II disorders⁷³; but most have modified MBCT in order to add attention to warning signs of anxiety and mania escalation, expanding the model that standard MBCT has for signs of depression and suicidal ideation.

Outcomes of MBCT for bipolar⁶⁹ investigations have shown that at the end of treatment, participants have a greater ability to observe thoughts and feelings in a less judgmental and reactive manner and experienced less depression.^{73–75} In addition, they have greater concentration, less rumination, less emotional reactivity, and better cognitive and overall functioning.⁷⁶ These studies have had success reducing depression severity and relapse in remitted patients with bipolar disorder^{73,75} as well as patients who are currently depressed.⁷⁴ One study compared MBCT for bipolar with TAU and showed significantly greater reduction in anxiety but not in depression severity.⁷⁷

Experimental examinations using physiologic and functional MRI measures have shown that MBCT improves emotional processing,⁷⁸ attentional readiness,⁷⁹ emotion regulation, and mindfulness.⁸⁰ Taken together, these findings highlight that MBCT is most effective in treating cognitive and emotional processing problems associated with depression and can be used to reduce residual symptoms and relapse. Although

Box 4

Mindfulness-Based Cognitive Therapy for bipolar disorder

1. Theory: Automatic and maladaptive ways of thinking and engagement in contraproductive behaviors (eg, rumination, self-critical thinking, or avoidance behaviors) increase negative emotions and may lead to the development and maintenance of depression.
2. Goal: The goal is to increase early detection of depression relapse, change relationship to thoughts and feelings, and learn skills to change thinking and behavioral patterns that may lead to or maintain depression.
3. MBCT protocol consists of twelve 2-hour group therapy sessions in addition to biweekly individual sessions with patients where meditation and cognitive exercises are taught and practiced.
 - a. CBT skills are taught, including behavioral activation and cognitive restructuring of maladaptive thoughts.
 - b. Mindfulness component: In order to develop enhanced awareness, improve attentional control, and cultivate ability to detach from negative thoughts, patients engage in extensive meditation practice.
4. Beginning sessions: Recognize automatic pilot modes of thinking, feeling, and behaving and implement more effective strategies (cognitive-behavioral skills or mindfulness techniques) instead.
5. Middle sessions: Recognize warning signs of depression, anxiety, and mania escalation and cultivate self-compassion.
6. Later sessions: Develop an action plan to effectively respond to early warning signs of relapse into depression.
7. Homework: Homework includes 40 minutes of mindfulness practice daily and use of the CBT skills as needed.

Adapted from Deckersbach, T, Hölzel, B, Eisner, L, et al. Mindfulness-Based Cognitive Therapy for Bipolar Disorder. New York: Guilford Press; 2014.

patients experiencing a major depressive episode can benefit from MBCT, the research supports recommending this approach to patients with bipolar depression in full or partial remission who experience residual depression or anxiety.^{70,74}

DIALECTICAL BEHAVIOR THERAPY

DBT^{81,82} is a behavioral therapy developed originally for suicidal patients with borderline personality disorder (BPD). DBT (**Box 5**) is aimed toward patients who are multi-diagnostic, difficult to treat, suicidal, or who have difficulties managing emotions. DBT was developed using an emotion dysregulation conceptualization of BPD: those who meet the criteria for this disorder are thought to be more sensitive and more reactive to emotional cues as well as to have more difficulty returning to emotional baseline after an emotional response occurred. This biological vulnerability is worsened by insufficient learning in how to effectively regulate emotions and by overuse of maladaptive regulation strategies, such as suicidal behaviors, drug use, avoidance, or suppression.^{81,83} DBT has been shown to be effective in reducing the use of maladaptive regulation strategies in BPD when compared with treatment by psychodynamic experts.⁸⁴

Box 5

Dialectical Behavior Therapy

1. Theory: Heightened vulnerability to emotional cues coupled with lack of skills to effectively regulate emotions and overuse of maladaptive strategies to change emotions leads to pervasive emotion dysregulation that is common in BPD as well as several other mental health disorders.⁸⁵
2. Goal: Increase understanding and awareness of emotions and improve emotion regulation and problem solving.
3. DBT protocol consists of weekly individual psychotherapy sessions focused on enhancing motivation and problem solving; weekly 2-hour group skills training sessions focused on teaching adaptive ways to regulate emotions, tolerate distress, be mindful, and address interpersonal problems; weekly consultation team for the therapist; and as needed phone coaching and crisis management to enhance use of skills in the natural environment. Typical duration is 6 months or 1 year. Adaptations of DBT have examined combinations of these 4 different components.
 - a. DBT skills include mindfulness, emotion regulation, distress tolerance, and interpersonal effectiveness.
 - b. Individual therapy is principle based and uses cognitive and behavioral techniques, such as behavioral and solution analyses, cognitive restructuring, and exposure strategies. It also includes DBT-unique strategies, such as dialectical, communication, commitment, and attachment strategies.
 - c. DBT offers several evidence-based protocols to manage suicidality, therapy-interfering behaviors, calls outside of session, and case management.
4. Beginning 4 sessions include the following: Orientation and commitment to treatment targets, including addressing problems in a hierarchical fashion, prioritizing life-threatening behaviors, followed by therapy-interfering behaviors, and problems interfering with having improved quality of life.
5. Postorientation phase: Identify client goals and work through situational analyses to learn how to reach goals via use of skillful behavior.
6. Homework: Homework includes daily diary card tracking suicidality, goals, and use of skills.

Data from Refs. ^{81,82,85}

This conceptualization of BPD as an emotion regulation disorder can be extended to other disorders whereby problems managing emotions have been documented,⁸⁵ including unipolar depression.⁸⁶ There is mounting evidence that DBT adaptations are effective treatments for depression. For example, DBT skills training was significantly more effective than an active control group in reducing emotion dysregulation and increasing skill use in a transdiagnostic group of adults who met the criteria for anxiety or depressive disorders (excluding bipolar) and who reported difficulties with emotion regulation.⁸⁷ In addition, DBT components have been shown to successfully reduce (with large effect sizes) depression severity in treatment-resistant depressed adults^{88,89} when compared with medication alone⁸⁸ or a wait-list control.⁸⁹ Depression severity also significantly decreased in an intensive outpatient program that included 5 weeks of daily DBT skills training and weekly individual therapy among multi-diagnostic patients (20% with bipolar disorder).⁹⁰

Taking an emotion dysregulation conceptualization of pediatric bipolar disorder, Goldstein and colleagues^{91,92} showed in a pilot open trial that DBT was feasible and acceptable and then in a follow-up RCT that DBT was successful in reducing suicidal behavior, emotion dysregulation, and depression severity in bipolar adolescents above and beyond TAU (differences correspond to moderate to large effect sizes). The treatment adapted standard DBT by including family members in the skills training groups (similar to other adolescent models⁹³), offering fewer individual and group sessions, and providing bipolar-specific psychoeducation as part of the group intervention.

The increasing support for DBT as a treatment of depression in adults, the adolescent data on bipolar disorder, and basic research findings connecting bipolar disorder with high suicidality^{7,30} and emotion dysregulation,^{24,94} are indicators that DBT may be an effective treatment of adult bipolar disorder. Unfortunately, there is limited empirical research on DBT for adults with bipolar disorder. In one pilot study, when compared with a wait-list control group, a 12-week adaptation of DBT skills showed a trend toward significantly higher reductions in depression severity and improvement in emotional control in adults diagnosed with bipolar disorder.⁹⁵ Thus, more data are needed to support the use of DBT for bipolar disorder, especially in adults. Nevertheless, DBT is recognized as a promising option for the treatment of patients who are multi-diagnostic, difficult to treat, highly emotionally dysregulated, or engage in suicidal behavior.

COMMON PRINCIPLES FOR EFFECTIVE TREATMENT

Although the psychotherapy models available are based on very different theoretic foundations, effective treatments for bipolar depression converge on a few common principles. First, psychoeducation is a fundamental and primary step. In all empirically supported treatments presented, therapists educate patients about (1) the disorder, (2) cues and early warning signs of mood episodes, and (3) the importance of adherence to mood-stabilizing medication. Psychoeducation is such a crucial aspect that it can produce improvement on its own.⁹⁶ Second, patients with bipolar depression benefit from careful monitoring, increasing awareness, and understanding mood changes. Patients learn to keep track of their behavior and moods to identify *prodromal symptoms* (ie, early signs of a mood episode). In the presence of such cues, a stable daily routine helps patients intervene and prevent relapses. For example, disrupted sleep (eg, reduced need for sleep) is a prodromal cue that can indicate an increased risk for a mood episode; in this case, adhering to regular sleep cycles can prevent the onset of mania or depression.⁹⁷ Therefore, evidence-based

psychotherapy protocols include maintaining regular routines in addition to psychoeducation. Finally, the importance of medication adherence is consistently emphasized. These common elements may serve as indicators to non-psychotherapy-trained providers about the quality of the psychotherapy intervention their patients might receive (**Box 6**).

Additional treatment recommendations come from research examining the importance of continuing the same type of psychotherapy versus having different treatments at different stages of bipolar disorder.⁹⁸ Empirical examinations found that maintaining the same treatment had a higher impact on preventing relapse than using different treatments during the acute and the remission phases of the disorder.⁹⁹ Therefore, it is recommended to follow a stable psychotherapy protocol with patients even through the different phases of the disorder.

The various psychotherapy protocols presented differ in the theoretic conceptualization regarding the cause and maintenance of depression. Nevertheless, currently it is unclear which of the hypothesized mechanisms provides the best approach to bipolar depression and whether moderators of treatment response (eg, sex, age) should be considered when offering different types of treatment.¹⁰ In the absence of such research, the authors base our psychotherapy recommendations on primary complaints and how they match with existing approaches (see **Fig. 1**).

FUTURE MODELS

The psychotherapy models for bipolar depression presented earlier started as effective treatments for unipolar depression. Therefore, other empirically supported treatments for unipolar depression may offer promise for bipolar depression. Additional evidence-based protocols for unipolar depression that do not yet have research for bipolar depression are

1. Short-term psychodynamic psychotherapy^{100–102}
2. Acceptance and commitment therapy^{103–107}
3. Behavioral activation (BA)^{108,109}
4. Cognitive behavioral analysis system of psychotherapy (CBASP)^{110,111}
5. Functional analytical therapy^{112–115}
6. Self-systems therapy¹¹⁶
7. The unified protocol (UP)^{117–121}

The authors highlight the 3 approaches that they think show the most promise for bipolar depression.

Box 6

How to know if a therapist provides evidence-based psychotherapy for bipolar depression

1. Does the psychotherapy offered include psychoeducation about bipolar disorder?
2. Does the psychotherapy address medication compliance?
3. Is there a clear component of monitoring problems, mood, and/or medication?
4. Is establishing routines encouraged and directly addressed in therapy?
5. Can the therapist describe his or her training in the modality of the therapy offered?
6. Is the therapy offered an evidence-based treatment of bipolar depression or unipolar depression?

Behavioral Activation

BA^{108,109} is based on the theory that depression develops because of insufficient positive reinforcement within the daily lives of those who become depressed.¹²² Most appropriate for those patients whose primary complaint is anhedonia and amotivation, BA encourages patients to monitor their moods and actions in order to understand the relationship between what one does and how one feels. The main intervention is to develop strategies to increase pleasant (positively reinforcing), value-driven activities and decrease unpleasant activities in daily life. BA interventions have been shown to be effective in treating unipolar depression,¹²³ and the technique of scheduling and monitoring activities is strongly connected with reductions in depression severity.¹²⁴ BA's effectiveness with those with cognitive impairments^{108,125} offers an advantage over CBT or MBCT; therefore, this intervention might meet the need of patients with bipolar depression who are too impaired to benefit from a highly cognitively based psychotherapy. See **Box 7** for a case example of using BA with a patient with bipolar depression.

Box 7

Case example

Robert was a 46-year-old man who was referred to the authors' clinic by the inpatient ward where he had been treated following a suicide attempt. When he presented for his initial evaluation, Robert was severely depressed, expressing hopelessness and suicidal ideation, although he was committed to safety and denied any intent to act on his ideation. Robert had previously been treated with psychodynamic psychotherapy by a psychiatrist in private practice. He described that he had been in and out of treatment, coming in at times of crisis and canceling or missing appointments during periods when he felt better. He reported that a recent loss of his employment had left him perceiving himself as an utter failure, a pervasive assessment he made regarding the totality of his life and his self. He described his marriage as rife with intense conflict, which he habitually responded to by submitting to his wife's demands or accusations and making apologies. He labeled himself a doormat and noted his humiliation when describing his patterns of coping.

Treatment began with a focus on value-driven behavioral activation, engaging him in activities, including gardening, hiking, and cooking, that brought him some joy—a marked contrast to the anhedonia he had been experiencing for many months. Robert began generating hope and built a sense of mastery by maintaining these activities regardless of mood. This first phase included monitoring of mood and activity and noting the fluctuations of mood that corresponded with interpersonal stressors and self-care, including eating regularly and maintaining a stable sleep schedule. The importance of medication compliance was emphasized, and self-efficacy was enhanced through strategies including phone reminders and visual reminders. Therapy also involved bringing his wife in and working with the couple on validation, conflict resolution, and understanding behavioral principles of reinforcement and shaping. DBT skills were incorporated to enhance his interpersonal effectiveness through building assertiveness and exploring boundary setting and maintenance; Robert practiced apologizing only if he was actually sorry and otherwise tolerating his wife's anger without making unnecessary apologies. Although these skills were challenging for him, he reported feeling empowered and competent, beginning to redefine his perception of his abilities and reducing his self-loathing. At this point, Robert became willing to reach out to friends whom he had been avoiding because of shame about his job loss and suicide attempt. These interactions provided positive reinforcement that supported his engagement in activities; the friends gave Robert feedback about his likable personal qualities, including kindness, humor, and creativity. This feedback increased his confidence and strengthened his ability to see that the self-loathing was rooted in his depression and the content of conflicts with his wife, allowing him to question the validity of such thoughts.

Cognitive Behavioral Analysis System of Psychotherapy

CBASP integrates behavioral and psychodynamic approaches into a treatment that is designed specifically for chronic depression.¹¹¹ The treatment encourages therapists to provide genuine feedback to patients as a way to shape in-session interpersonal behavior. The goal of this approach is to increase problem solving in important relationships through the use of situational analyses, which helps patient to closely examine their interpersonal behavior. In the largest RCT of CBASP, 681 chronically depressed patients were treated with nefazodone (an antidepressant), CBASP, or their combination.¹¹⁰ CBASP alone had a 48% treatment response rate (as effective as nefazodone alone), whereas the combined treatment produced a significantly better response rate (72%). These results indicate that CBASP may be a promising treatment of individuals with bipolar disorder who tend to be in a chronically depressed or dysthymic (rather than euthymic) mood state when they are not in a hypomanic phase.

Unified Protocol

Based on observations that there is a great deal of overlap between the different anxiety and mood disorders, Barlow and colleagues¹¹⁸ have been developing a transdiagnostic treatment approach that includes 8 treatment modules focusing on psychoeducation, emotional awareness and tolerance, cognitive and behavioral strategies, and relapse prevention.¹²¹ This approach has been shown to be efficacious for treating anxiety with comorbid depression (but excluding bipolar) in a recent RCT.¹²⁰ Although empirical research with patients with bipolar disorder is needed, the UP may be a useful option when patients with bipolar disorder are also diagnosed with several anxiety disorders.

SUMMARY

These additional approaches offer promise for treatment of bipolar depression. The authors encourage researchers to evaluate their application and efficacy with bipolar depression. In addition, mental health care providers who have found other evidence-based treatments unsuccessful are also encouraged to use some of these additional protocols in their treatment plans.

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