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

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Abstract

Objective—To survey non-physician mental health clinicians in order to understand their knowledge about bipolar disorders, treatment approaches, and perceived barriers to optimal treatment.

Methods—55 non-physician mental health clinicians from five community mental health clinics self-reported therapeutic approach, knowledge, and skill in treating bipolar disorders. We calculated descriptive statistics and used chi-square and t-tests to test for differences by clinician characteristics.

Results—Most clinicians wished to improve their treatment for bipolar disorders. Clinicians reported feeling best prepared to provide counseling and least prepared to identify medication side effects. Among psychotherapies, they were most familiar with CBT. Clinicians were

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knowledgeable about bipolar disorders overall, but less knowledgeable about pharmacotherapy for treating them. The most commonly reported treatment barrier was comorbid substance use disorders.

Conclusion—Clinicians would benefit from additional training in effective therapeutic approaches, principles of pharmacotherapy for bipolar disorders, and approaches to supporting individuals with comorbid substance use problems.

Keywords

bipolar disorder; psychotherapy; therapists; substance use disorder

Introduction

Bipolar disorders represent potentially devastating, chronic disorders affecting 2.6 percent of the U.S. adult population in a given year,[1] with a lifetime prevalence of 3.9 percent.[2] Most effective psychosocial interventions for individuals with bipolar disorders, which can play an essential adjunctive role to pharmacologic treatments, utilize common strategies such as psychoeducation, promotion of medication adherence, encouraging regularity of 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 disorders. Effective implementation strategies for evidence-based treatment could build upon extant clinician knowledge and skill, but we are unaware of empirical information about the strategies that clinicians in community practices routinely use to provide care for bipolar disorder.

To address this gap in the literature, we present results from a survey of non-physician community mental health clinicians from five community mental health clinics. Our findings are a first step toward understanding of what frontline non-physician mental health clinicians know about bipolar disorders and how they treat them.

Methods

We surveyed non-physician mental health clinicians from five community mental health clinics who had consented to participate in an NIMH funded study 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; 97% (55 of 57) of the eligible (e.g. non-trainee clinicians treating adults with bipolar disorder) clinicians participated in the study. The survey, completed before IPSRT training that is part of the larger study, gathered information to be used as covariates in subsequent analyses examining variation in IPSRT implementation. The University of X and XXXX IRBs approved the study.

We used responses on the **Clinician Techniques and Beliefs** measure, the clinician self-report version of the validated Psychotherapy Practice Scale-IPSRT version,[5] to assess clinicians' **therapeutic approach.** The 28 items used a 4-point Likert scale to assess the frequency with which clinicians reported using therapeutic techniques consistent with CBT (Cronbach's alpha = 0.71), IPSRT (Cronbach's alpha = 0.75), other therapeutic approaches such as psychodynamic or supportive/expressive techniques (Cronbach's alpha = 0.68), or non-specific techniques (Cronbach's alpha = 0.66), in treating adults with bipolar disorder.

We assessed **knowledge of bipolar disorder** with 13 statements that assessed knowledge about etiology, course, and treatment of bipolar disorders. Clinicians responded to each statement with a 5-point Likert scale (from strongly agree to strongly disagree). Correct responses were identified by strongly agree or agree responses to true statements, or strongly disagree or disagree responses to false statements. Content of questions was grounded in the empirical literature on bipolar disorders and targeted a knowledge level comparable to that of first year medical student completing a general course in psychiatry.

We assessed **self-reported skill** in treating patients with bipolar disorder using a 4-point Likert scale (from not at all skilled to very skilled) for 6 clinical strategies associated with evidence-based treatments for bipolar disorders,[3] such as identifying early warning signs of possible recurrence and providing psychoeducation for a patient's family members.

We identified barriers to providing optimal mental health treatment to individuals with bipolar disorders using 15 items describing potential barriers to treatment, modified from the Partners in Care study.[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 worker or non-social worker), year that training was completed, average number of sessions with adults per week, percent of clinical sessions conducted with individuals diagnosed with bipolar disorder, and average session length. We created a therapeutic approach score for each type of strategy by calculating the mean score for the items for each technique for each individual and assessed the internal consistency for each series of items by generating a Cronbach's alpha. We examined the correlation between knowledge and skills, and used chi square and t-tests as appropriate to test for differences by clinician characteristics in therapeutic approach, skill and knowledge, and barriers to optimal treatment.

Results

Slightly more than half (n=31; 56%) of the participating 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 years ± 9.9 of experience as a therapist. (Online Appendix A) Clinicians averaged 17.75 (±9) adult clients weekly; for the majority of clinicians, patients with bipolar disorder represented more than one quarter of their caseload. (Online Appendix A)

The therapeutic approach most frequently endorsed by clinicians was CBT (mean of 3.2 ± 0.5; maximum 4), followed by IPSRT (mean of 2.90 ± .4), non-specific techniques (mean of 2.8 ± .44), and other therapy techniques (mean of 2.2 ± .44). There were no significant differences in therapeutic approach by professional discipline, years of experience, overall caseload, or proportion of caseload with bipolar disorders.

Clinicians reported feeling knowledgeable about and relatively skilled in treating individuals with bipolar disorder. Self-reported skill was highest for counseling (mean of 3.5±.6; maximum 4), psychoeducation (mean of 3.3±.7; maximum 4) and identifying warning signs of possible recurrence (mean of 3.3±.7; maximum 4), with lower perceived skill in providing psychoeducation for family members (mean of 3.0±.9; maximum 4) and identifying medication side effects (mean of 3.0±.8; maximum 4). Sixty-seven percent (n=36) agreed or strongly agreed with the statement, “I am very knowledgeable in the treatment of individuals with bipolar disorder,” 24% (n=13) neither agreed nor disagreed with the statement, and 9% (n=5) disagreed.

Thirty-three percent of clinicians correctly answered more than 84% of thirteen true-false questions about bipolar disorder, 58% of clinicians answered 50%-84% of the questions correctly, and nine percent of clinicians answered fewer than 50% of the questions correctly. (Online Appendix B) 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,” and “Antidepressant medications should only be prescribed for a patient with bipolar disorder if they are receiving concurrent treatment with a mood stabilizer.” Clinician knowledge and self-reported skill in treating individuals with bipolar disorder were significantly correlated (.45, $p<0.001$). There were no significant differences in self-reported skill or bipolar knowledge by professional discipline, years of experience, overall caseload, or proportion of caseload with bipolar disorders.

Clinicians also rated the degree to which a series of barriers limited their ability to provide optimal treatment for clients with bipolar disorder. Substance use problems were among the most commonly identified barriers: many clinicians (n=27; 49%) reported that substance use problems interfered with their treatment of bipolar disorder, and comparable numbers of clinicians reported that addressing substance use problems was often more pressing than addressing symptoms of bipolar disorder (n=24; 44%). (Online Appendix C). 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 with bipolar disorder.

Discussion

Most clinicians we surveyed reported using CBT techniques most commonly with patients with bipolar disorders, 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 of the clinicians reported using CBT techniques in treating adults with bipolar disorders, as CBT has been shown to be an efficacious treatment for this condition.[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 based on 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. Increasingly, alternatives, such as efforts to help clinicians learn and use core components of effective interventions, are being considered as a way to give frontline clinicians a range of treatment skills.[9]

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 disorders and, while prescribing physicians will be 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 for patients who may have questions about their medications or are experiencing side effects. Our findings suggest an important opportunity to enhance the knowledge of non-physician mental health clinicians about psychotropic medications used to treat bipolar disorders, potentially through team approaches in which physicians and non-physicians see or, at least review, patients' progress together. Because clinicians identified treatment adherence as a specific barrier to managing individuals with bipolar disorders, increased knowledge about psychotropic medications may provide them with a particularly important tool to promote treatment adherence.

In addition to medication adherence, effectively engaging 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, 11] Consistent with concerns about adherence endorsed by clinicians in our study, qualitative studies have also identified the challenge that intermittent attendance at sessions can pose for clinicians treating adults with bipolar disorders;[12] poor attendance can stem from a range of factors, including work or family commitments or transportation challenges. Interventions such as motivational

interviewing and motivational enhancement have been shown to increase engagement among other populations of individuals with serious mental health disorders.[13] Our study suggests that incorporating such components into the development and dissemination of effective psychotherapies for bipolar disorder should receive greater consideration.

High levels of substance use and bipolar disorder comorbidity are common, but we are unaware of empirical studies documenting the extent to which community mental health clinicians view comorbid substance use disorders as complicating the treatment of individuals with bipolar disorders. 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 this approach as an adjunctive strategy to management of bipolar disorders.

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 have a higher level of interest in and motivation to improve treatment for individuals with bipolar disorders than 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 are based on a clinician survey, and without objective observations, we do not know to what extent clinician self-report accurately reflects their knowledge and skills, or what actually occurs during patient sessions.

Conclusion

Within the context of these limitations, we found that the clinicians we surveyed were interested in augmenting their skills in order to better manage their patients with bipolar disorders. Although they felt confident in their abilities to treat these patients, our findings suggest that they would benefit from additional training in effective therapeutic approaches beyond CBT, as well as pharmacotherapy for bipolar disorder 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 develop these skills in community mental health clinicians 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 last several decades in the development of efficacious interventions for bipolar disorders.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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