The treatment of bipolar disorder has from early been pharmacological, which remains the primary treatment modality especially for the acute phases of the illness, the depressive and manic episodes. For the majority of the patients, however, long-term pharmacotherapy is expected for prophylactic reasons even though the long-term results suggest high relapse rates even when medicated. This inability of drug treatments to keep people well in the long term and also the high rates of medication non-compliance in this population has made welcome a number of psychological therapies, all of which tend to work in combination with drug treatments.

Lithium has been the most popular medication for the treatment of acute manic episodes and prophylaxis from further episodes (Schou, 1999). Anti-convulsant medications such as carbamazepine and sodium valproate (Bowden, Brugger et al. 1994) are also used in the treatment of acute mania, along with antipsychotic medications such as chloropromazine and olanzapine for more rapid amelioration of acute mania or maintenance treatment (Vieta and Goikolea, 2005). Anti-depressant medications are often used for the treatment of bipolar depression but usually in combination with mood stabilisers in order to avoid switches to hypomania or mania (Moller and Grunze, 2000). The anticonvulsant lamotrigine (Calabrese, Huffman et al. 2008) appears to be promising for bipolar depression without having the risk for hypomanic/manic switches. Similar medications are used for bipolar II disorders but there is an increasing concern that the pharmacological treatments for bipolar II disorders are not adequate. Nevertheless, quetiapine, an atypical antipsychotic medication (Keating and Robinson, 2007) was recently approved by the FDA as an effective treatment for bipolar II depression.

Currently there are approximately four psychosocial treatments for bipolar disorder with at least one randomised control trial to demonstrate their efficacy. These include Cognitive Behaviour therapy (Lam, Watkins et al. 2003), Interpersonal and Social Rhythm Therapy (Frank, Kupfer et al. 2005), Family-focused therapy (Miklowitz, George et al. 2003), and Group Psycho-education (Bauer and McBride 2003; Colom, Vieta et al. 2003). Despite differences in the treatment targets of each therapy, they all emphasise patient education, mood and routine monitoring and medication compliance.

key references

Schou, M. 1999. Perspectives on lithium treatment of bipolar disorder: action, efficacy, effect on suicidal behavior. Bipolar Disord, 1, 5-10.

Moller, H. J. & Grunze, H. 2000. Have some guidelines for the treatment of acute bipolar depression gone too far in the restriction of antidepressants? Eur Arch Psychiatry Clin Neurosci, 250, 57-68.

Keating, G. M. & Robinson, D. M. 2007. Quetiapine: a review of its use in the treatment of bipolar depression. Drugs, 67, 1077-95.

Lam, D. H., Watkins, E. R., Hayward, P., Bright, J., Wright, K., Kerr, N., Parr-Davis, G. & Sham, P. 2003. A randomized controlled study of cognitive therapy for relapse prevention for bipolar affective disorder: outcome of the first year. Arch Gen Psychiatry, 60, 145-52.