Zur Evidenzlage der psychotherapeutischen Akut- und Erhaltungsbehandlung Bipolarer Störungen – erste Ergebnisse eines neuen Cochrane-Reviews

Cognitive behavioural therapy (CBT) for bipolar disorder

Protocol information

Review number: P04

Authors

Stephan Mühlig[1], John Geddes[2], Stefanie Fuchs[1], Martin Hautzinger[3], Michael Bauer[4], Peter Sedlmeier[1], Frederik Haarig[1]

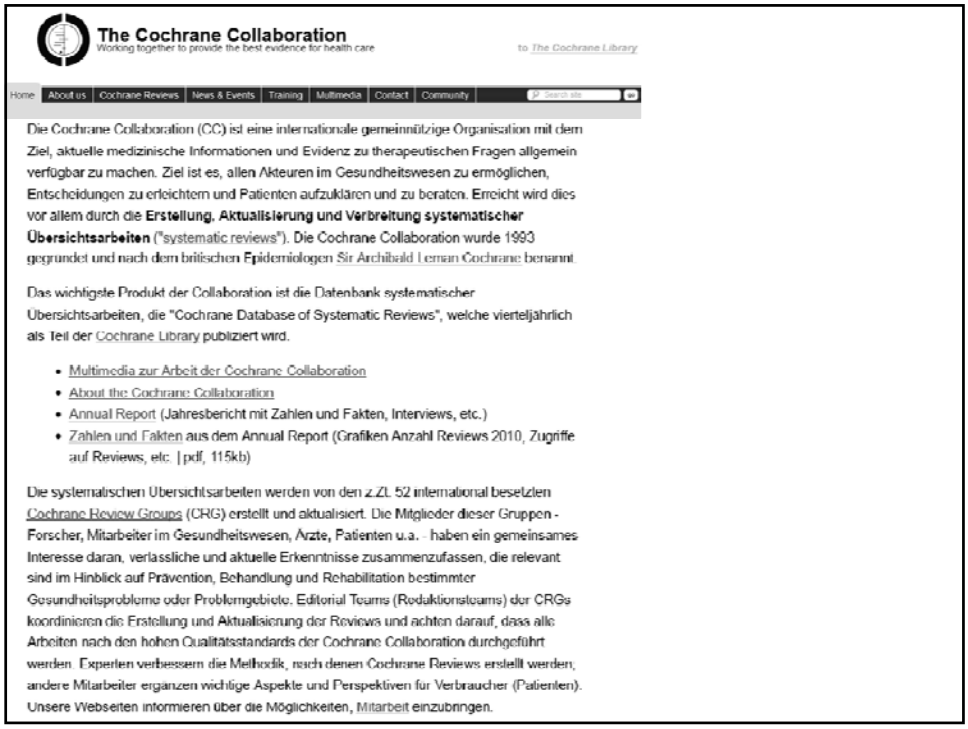
[1]Department of Psychology, Chemnitz University of Technology, Chemnitz, Germany
[2]Department of Psychiatry, University of Oxford/Warneford Hospital, Oxford, UK
[3]Chair of Clinical Psychology and Life Span Psychology, University of Tuebingen, Tuebingen, Germany
[4]Department of Psychiatry and Psychotherapy, University Hospital Carl Gustav Carus/Dresden University of Technology, Dresden, Germany

DGBS
Deutsche Gesellschaft für Bipolare Störungen e.V.

12. JAHRESTAGUNG
BIPOLAR IN EINER BESCHLEUNIGTEN WELT
27. – 29. September 2012
Medizinische Hochschule Hannover

Hintergrund

- **Psychotherapie** hat sich als eine **Säule der (adjuvanten) Behandlung bipolarer Störungen** international in der Praxis fest etabliert.
- Es liegen mittlerweile **zahlreiche klinische Studien** vor, die die **Wirksamkeit psychotherapeutischer Verfahren** in der **Akut- und Erhaltungstherapie** sowie in der **Rückfallprophylaxe** mehr oder weniger deutlich belegen.
- Obwohl deren Ergebnisse in einigen Übersichtsarbeiten referiert wurden, **fehlt bislang eine systematische Zusammenfassung der Evidenzlage** auf der Basis einer **metanalytischen Auswertung** der methodisch besten RCT's in Form eines Systematic Cochrane Review.
- Hier sollen die ersten Ergebnisse eines **aktuellen Cochrane Review** vorgestellt werden.



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Die Cochrane Collaboration (CC) ist eine internationale gemeinnützige Organisation mit dem Ziel, aktuelle medizinische Informationen und Evidenz zu therapeutischen Fragen allgemein verfügbar zu machen. Ziel ist es, allen Akteuren im Gesundheitswesen zu ermöglichen, Entscheidungen zu erleichtern und Patienten aufzuklären und zu beraten. Erreicht wird dies vor allem durch die **Erstellung, Aktualisierung und Verbreitung systematischer Übersichtsarbeiten** ("systematic reviews"). Die Cochrane Collaboration wurde 1993 gegründet und nach dem britischen Epidemiologen Sir Archibald Leman Cochrane benannt.

Das wichtigste Produkt der Collaboration ist die Datenbank systematischer Übersichtsarbeiten, die "Cochrane Database of Systematic Reviews", welche vierteljährlich als Teil der Cochrane Library publiziert wird.

- Multimedia zur Arbeit der Cochrane Collaboration
- About the Cochrane Collaboration
- Annual Report (Jahresbericht mit Zahlen und Fakten, Interviews, etc.)
- Zahlen und Fakten aus dem Annual Report (Grafiken Anzahl Reviews 2010, Zugriffe auf Reviews, etc. | pdf, 115kb)

Die systematischen Übersichtsarbeiten werden von den z.Zt. 52 international besetzten Cochrane Review Groups (CRG) erstellt und aktualisiert. Die Mitglieder dieser Gruppen - Forscher, Mitarbeiter im Gesundheitswesen, Ärzte, Patienten u.a. - haben ein gemeinsames Interesse daran, verlässliche und aktuelle Erkenntnisse zusammenzufassen, die relevant sind im Hinblick auf Prävention, Behandlung und Rehabilitation bestimmter Gesundheitsprobleme oder Problemgebiete. Editorial Teams (Redaktionsteams) der CRGs koordinieren die Erstellung und Aktualisierung der Reviews und achten darauf, dass alle Arbeiten nach den hohen Qualitätsstandards der Cochrane Collaboration durchgeführt werden. Experten verbessern die Methodik, nach denen Cochrane Reviews erstellt werden; andere Mitarbeiter ergänzen wichtige Aspekte und Perspektiven für Verbraucher (Patienten). Unsere Webseiten informieren über die Möglichkeiten, Mitarbeit einzubringen.

Cochrane Systematic Reviews

- **Anspruch: Bestmögliche Evidenz ➔ strengste Auswahlkriterien von RCT (Goldstandard)**
- **Prinzipien der Cochrane Collaboration:**

> *"Our vision is that healthcare decision-making throughout the world will be informed by high quality, timely research evidence. The Cochrane Collaboration will play a pivotal role in the production and dissemination of this evidence across all areas of health care."*

Collaboration	by internally and externally fostering good communications, open decision-making and teamwork
Building on the enthusiasm of individuals	by involving and supporting people of different skills and backgrounds
Avoiding duplication	by good management and co-ordination to maximise economy of effort
Minimising bias	through a variety of approaches such as scientific rigour, ensuring broad participation, and avoiding conflicts of interest
Keeping up to date	by a commitment to ensure that Cochrane Reviews are maintained through identification and incorporation of new evidence
Striving for relevance	by promoting the assessment of healthcare interventions using outcomes that matter to people making choices in health care
Promoting access	by wide dissemination of the outputs of the Collaboration, taking advantage of strategic alliances, and by promoting appropriate prices, content and media to meet the needs of users worldwide
Ensuring quality	by being open and responsive to criticism, applying advances in methodology, and developing systems for quality improvement
Continuity	by ensuring that responsibility for reviews, editorial processes and key functions is maintained and renewed
Enabling wide participation	in the work of the Collaboration by reducing barriers to contributing and by encouraging diversity

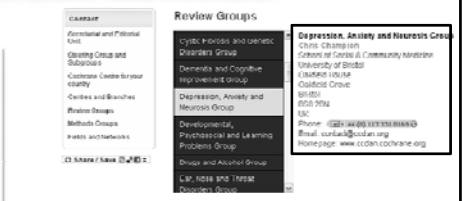
- ➔ **höchste methodische Standards + maximale Standardisierung**
- ➔ **Hoher Formalisierungsgrad, strenge Vorgaben + weniger Freiheitsgrade als bei anderen MA o. LL (Handbook: 650 S.!)**
- ➔ **RevMan & GRADE**

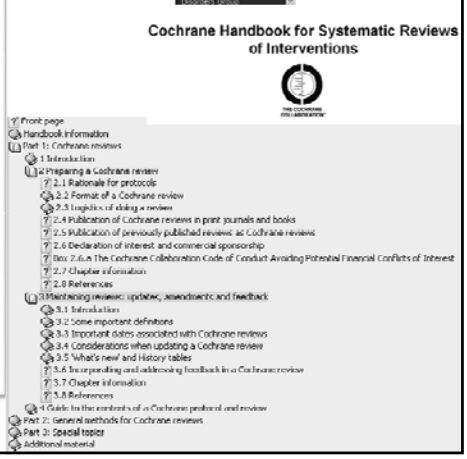
Cochrane Systematic Reviews

Einteilung in 52 störungsspezifische AGs: (Review Groups)

- **Cochrane Handbook:** stetige Updates (März 2011 („What´s new?“)
- **Komplette Anleitung für die Vorbereitung & Durchführung** eines Cochrane Reviews (online-Version & Papierversion; 650 S.)

- **Ständig ergänzte bzw. aktualisierte Methodenpapers + Vorgaben**





BMBF-Projekt:
Cochrane-Review Wirksamkeit von Psychotherapie bei Bipolarer Störung

Design: Insgesamt 4 Metaanalysen zur Wirksamkeit von Psychotherapie in der Behandlung bipolarer Störungen

CBT

IPSRT

FFT

PE

Auswahlkriterien

Criteria for considering studies for this review

Types of studies

Inclusion criteria: All relevant randomised controlled trials (RCTs) evaluating CBT in bipolar disorder should be included. Studies will not be excluded on the basis of country of origin or publication status.

Exclusion criteria: Case series, pre- and post-intervention studies and those studies with a non-random allocation.

Types of participants

Inclusion criteria: Adolescent and adult individuals diagnosed with bipolar I disorder or bipolar II disorder based on standardised psychiatric criteria (including Research Diagnostic Criteria, DSM-III, DSM-III-R, DSM-IV, DSM-IV-TR, ICD-9 or ICD-10) exclusively to ensure sample homogeneity. Adults should be included at any stage of the disorder and in a cognitive behavioural treatment setting. There will be no upper age limit.

Exclusion criteria: The review will exclude studies where:

1. the primary diagnosis was another disorder (for example panic, eating disorders);
2. participants were selected on the basis of a non-psychiatric medical condition (for example, cancer, AIDS/ HIV);
3. people aged sixteen or under;
4. 'at risk' populations who have not yet received a definite diagnosis of bipolar disorder.

Types of interventions

Inclusion criteria: Cognitive behavioural therapy to treat people with bipolar disorder at any stage of the disease (according to Miklowitz 2006). Including cognitive reframing and restructuring (disputation), improving self-management and self-regulation as well as behavioural techniques for reducing environmental stress and promoting social adaptation.

Exclusion criteria: Studies where the cognitive behavioural treatments are described insufficiently or where both groups simultaneously receive cognitive behavioural therapy to treat depressive or manic symptoms (for example CBT versus CBT in addition to medication).

Outcomes (Bsp. CBT)

Cognitive behavioural therapy (CBT) for bipolar disorder

Protocol information

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[1]Department of Psychology, Chemnitz University of Technology, Chemnitz, Germany
[2]Department of Psychiatry, University of Oxford/Warneford Hospital, Oxford, UK
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[4]Department of Psychiatry and Psychotherapy, University Hospital Carl Gustav Carus/Dresden University of Technology, Dresden, Germany

Types of outcome measures

Primary outcomes

The primary measures proposed by international treatment guidelines for BD (NICE 2006; SIGN 2005) address parameters of symptom reduction and relapse prevention as available at 3, 6, 12, 18 and 24 months or more after baseline. Thus the primary outcomes have been chosen accordingly :

- changes in the status of symptoms (depressive symptoms and manic symptoms, psychotic symptoms, comorbidities)

These will be assessed by continuous measures of symptoms with standard scales:

1. depression, e.g. on Beck Depression Inventory; BDI (Beck 1961); Hamilton Depression Rating Scale; HDRS (Hamilton 1960); Montgomery-Asberg Depression Rating Scale; MADRS (Montgomery 1979); Hospital Anxiety and Depression Scale; HAD (Zigmond 1983);
2. mania on Bech Rafaelsen Mania Scale (Bech 1978); Young Mania Rating Scale (Young 1978); Longitudinal Interval Follow-up Evaluation; Schedule for Affective Disorders and Schizophrenia-SADS, Brief Psychiatric Rating Scale-BPRS; LIFE (Keller 1987b); Internal States Scale (Bauer 1991); Altman Mania Scale (Altman 1997)

or any other validated scale.

- relapse rates and duration of (hypo)manic and depressive episodes vs. length of remission/ duration of symptom-free intervals

These will be assessed in terms of days of manic, hypomanic, mixed or depressive episodes and time to affective episodes/ days in remission.

Secondary outcomes

1. hospitalisations
2. social functioning (social, interpersonal and occupational functioning) as measured by social functioning/interpersonal functioning, occupational functioning (e.g. MRC Social Performance Scale (Hurry 1983); percentage of people who were hospitalised; social and family functioning (UCLA-Social Attainment Survey, Family Assessment Device - FAD), Global Assessment of Functioning (GAF) Scale, or any other validated scale).
3. treatment compliance and medication adherence: compliance Assessment consists of attendance at psychosocial treatment appointments, changes in medication use (mg equivalents of chlorpromazine, imipramine, diazepam, lithium, valproate, carbamazepine), number of participants who dropped out because of lack of efficacy, number of participants who dropped out because of symptoms worsening.
4. quality of life: patient's subjective judgements are measured by quality of life scales (EuroQol, SF-36, World Health Organisation Quality of Life Scale - WHOQOL, or any other validated scale) and perceived control over illness (Lam 1997);measure of acceptance of the intervention, satisfaction with treatment approach
5. dropout rates at endpoint.

The outcomes may encompass measures of symptoms and outcomes presented as dichotomous (hospitalisation/ no hospitalisation) or continuous (time to recurrence of episodes; means and standard deviations on rating scales).

Suchstrategie (Termini): CBT + BD

Diagnose		Intervention		RCT*
("affective disorder*" or "affective disorder*, psychosis" or "bipolar depression" or "bipolar I disorder*" or "bipolar II disorder*" or "depression, psychotic" or "depression, recurrent" or "excited psychosis" or "major affective disorder*" or "mania" or "manic disorder*" or "bipolar affective disorder*" or "bipolar not otherwise specified" or "schizoaffective disorder*" or "psychoses" or "psychotic disorder*" or "bipolar disorder*" or "manic episode" or "manic symptom" or "hypomani*" or "dysphoric mania" or "rapid cycling disorder*" or „bipolar" or "manic*depress*" or "bipolar I illness" or "bipolar II illness" or "bipolar I disease" or "bipolar II disease")	AND	(("cognitiv*" and "behavio*" and "therap*") or ("cognitiv*" or "behavio*" and ("technique*" or "therap*" or "restructur*" or "challeng*" or "psychotherap*" or "intervention" or "train*" or "retrain*" or "treatment" or "modification")) or ("attribution*" or "reattribution*" or ("self" and ("instruct*" or "management*"))) or ("RET" or ("rational" or "emotiv*")) or ("commitment*" or "acceptance*" or "mindfulness*" or "psychoeducat*"))	AND	1. MJ treatment effectiveness evaluation. 2. MJ clinical trials. 3. MJ mental health program evaluation. 4. MJ placebo. 5. TI placebo* or AB placebo*. 6. AB randomly. 7. TI randomi?ed or AB randomi?ed. 8. TI trial or AB trial. 9. sing* or doubl* or trebl* or tripl* n3 blind* or mask* or dummy. 10. TI (control* n3 trial* or study or studies or group*). 11. AB (control* n3 trial* or study or studies or group*). 12. TI factorial* or AB factorial*. 13. TI allocate* or AB allocate*. 14. TI assign* or AB assign*. 15. TI volunteer* or AB volunteer*. 16. TI (crossover* or cross over*) or AB (crossover* or cross over*). 17. quasi N experimental or random*. 18. MR "2000". 19. or/ 1-18
Title, abstract, keywords bzw. TS/Topic (=Abstract, Title, Keywords bei Web of Science)				

* [Notes: TI = Title, AB = Abstract, KW = Keywords, MI = Word in Major Subject Heading, MR "2000" = Methodology, Code 2000 = treatment outcome/clinical trial]

Suchstrategie (Quellen): CBT + BD

elektronischen Datenbanken	JournalDatenbanken
Datenbank	Bipolar Disorders
COCHRANE-Library	Journal of Affective Disorders
MEDLINE	Depression and Anxiety
PSYCINFO	Archives of General Psychiatry
PSYCARTICLES	British Journal of Psychiatry
PSYNDEX (Englisch)	American Journal of Psychiatry
PSYNDEX (Deutsch)	Cognitive Therapy and Research
WEB OF SCIENCE	Journal of Abnormal Psychology
CINAHL	Journal of Clinical Psychiatry
LILACS	Journal of Cognitive Psychotherapy
EMBASE	Journal of Consulting and Clinical Psychology
	Psychiatry Research

Ergebnisse + Treffer: *CBT*

	Anzahl der Treffer	Anzahl der relevanten Treffer
Datenbanken		
COCHRANE-Library	44	20
MEDLINE	4918	25
PSYCINFO	201	9
PSYCARTICLES	99	0
PSYNDEX (Englisch)	131	2
PSYNDEX (Deutsch)	0	0
WEB OF SCIENCE	3874	23
CINAHL	725	20
LILACS	34	3
EMBASE	189	1
Handsearch		
Zeitschriften (Bipolar Disorders, Journal of Affective Disorders, Depression and Anxiety, Archives of General Psychiatry, British Journal of Psychiatry, American Journal of Psychiatry, Cognitive Therapy and Research, Journal of Abnormal Psychology, Journal of Clinical Psychiatry, Journal of Cognitive Psychotherapy, Journal of Consulting and Clinical Psychology, Psychiatry Research)	80	25
Kontaktierung relevanter Autoren		
Insgesamt wurden 199 nationale und internationale Experten und Autoren persönlich angeschrieben, von denen ein Großteil geantwortet hat.	0	7
Unpublizierte oder laufende Studien		
Clinicaltrials.gov (http://clinicaltrials.gov/)	269	4
World Health Organization (WHO) International Clinical Trials Registry Platform Search Portal (http://apps.who.int/trialsearch/)	714	7

- Relevante **Treffer** (bereinigt): **41 Studien**
- **Excluded** (1. Schritt): **13**
- **Included** (für Konsensus-Meeting): **28**

KONSENSUS-TREFFEN:
Systematic Cochrane Review:
Cognitive Behavioural Therapy (CBT) for Bipolar Disorder

THE COCHRANE COLLABORATION®

Rater:
Martin Hautzinger, Michael Bauer, Peter Sedlmeier & Stephan Mühlig

Projektmitarbeiter:
Stefanie Fuchs, Frederik Haarig

16.06.2011

Klinische Psychologie

Auswahlkriterien

Cognitive Behavioural Therapy (CBT) for Bipolar Disorder [CBT-BD]

Study eligibility form — **Study ID:**

Type of study

Is the study randomised or quasi-randomised?

Yes → Go to Next question; Unclear → Go to Next question; No → **Exclude**

Participants in the study

Are participants:

adult people (> 16 years) with bipolar I disorder, bipolar II disorder based on standardised psychiatric criteria (including Research Diagnostic Criteria, DSM-III, DSM-III-R, DSM-IV, DSM-IV-TR, ICD-9 or ICD-10)

Yes → Go to Next question; Unclear → Go to Next question; No → **Exclude**

Type of intervention

Cognitive behavioural therapy to treat people with bipolar disorder at any stage of the disease

Yes → Go to Next question; Unclear → Go to Next question; No → **Exclude**

Intervention

Is there an intervention and a control group?

CBT vs. TAU (including medication like lithium prophylactic therapy, antidepressants as needed, and regular appointments with health professionals as well as a waiting list control condition)

CBT + TAU vs. TAU

CBT vs. other psycho-social treatments

Yes → Go to Next question; Unclear → Go to Next question; No → **Exclude**

Was the intervention the only planned difference between the groups?

Yes → **INCLUDE** and clarify unclear points; Unclear → Go to Next question; No → **Exclude**

What intervention to exclude?

IPSRT (Interpersonal & Social Rhythm Therapy)
Psychoeducation
FFT (Family-focused Therapy/ Treatment)

What was the intervention?

PHARMA / PSYCHOSOCIAL / DIET / OTHER

Extraction sheet

Generic data extraction sheet for Cognitive Behavioural Therapy (CBT) for Bipolar Disorder [CBT-BD].

NB: use parallel Excel file to collect numerical data eg Ns, mean and standard deviations for all data collection points.

Study ID xxxx 100x	Initials of person extracting data xxx
Type of report (e.g. peer reviewed journal article, full report, brief report, letter, unpublished data) xxxx **Language of report** xxxx **Full citation** xxx	
Design of study (e.g. controlled trial, crossover trial) xxxx	
Site of intervention (e.g. single site, multiple sites, country) xxxx	
Setting of intervention (e.g. in patient, out patient, mixed) xxx **Ethics committee approval** xxx	
Age of participants (e.g. mean, SD, range) xxx	
Sex of participants xxx	

Final Selection: Included Studies (CBT)

No.	authors	year	title
01	Lam, D. H., J. Wright, et al.	2000	Cognitive therapy for bipolar illness - a pilot study of relapse prevention
02	Schmitz, J. M., P. Averill, et al.	2002	Cognitive behavioral treatment of bipolar disorder and substance abuse: a preliminary randomized study
03a	Lam, D. H., L. K. Watkins, et al.	2003	A randomized controlled study of cognitive therapy for relapse prevention for bipolar affective disorder: Outcome of the first year.
03b	Lam, D. H., P. Hayward, et al.	2005	Relapse prevention in patients with bipolar disorder: cognitive therapy outcome after 2 years
04	Scott, J. et al.	2001	A pilot study of cognitive therapy in bipolar disorders.
05a	Scott, J., F. Paykel, et al.	2006a	Cognitive behavioural therapy for severe and recurrent bipolar disorders: randomized controlled trial
05b	Scott, J., F. Paykel, et al.	2006b	Cognitive behavioural therapy does not reduce overall episode recurrence in people with recurrent bipolar disorder
06	Ball, J. K., F. D. Mitchell, et al.	2006	A randomized controlled trial of cognitive therapy for bipolar disorder: focus on long-term change.
07a	Miklowitz, D. J., M. W. Otto, et al.	2007a	Intensive psychosocial intervention enhances functioning in patients with bipolar depression: results from a 9 month randomized controlled trial.
07b	Miklowitz, D. J., M. W. Otto, et al.	2007b	Psychosocial treatments for bipolar depression: a 1-year randomized trial from the Systematic Treatment Enhancement Program.
08	Weiss, R. D., M. L. Griffin, et al.	2007	A randomized trial of integrated group therapy versus group drug counseling for patients with bipolar disorder and substance dependence.
09	Zaretsky, A., W. Lancee, et al.	2008	Is cognitive behavioural therapy more effective than psychoeducation in bipolar disorder?
10	Weiss, Roger D., Griffin, Margaret L., Jaffee, William B. et al.	2009	A "community-friendly" version of integrated group therapy for patients with bipolar disorder and substance dependence: A randomized controlled trial
11	Castle, D., White, G., Chamberlain, J. et al.	2010	Group-based psychosocial intervention for bipolar disorder: randomised controlled trial.
12	Gomes BC; Abreu LN; Erlichke E; Caetano SC; Kleinman A; Nery F; Lafer B	2010	A randomized controlled trial of cognitive behavioral group therapy for bipolar disorder
13	González Isasi, A., E. Echeburúa, et al.	2010a	How effective is a psychological intervention program for patients with refractory bipolar disorder? A randomized controlled trial
14	González Isasi, A., E. EcheburÃºa, et al.	2010b	Long term efficacy of a psychological intervention program for patients with refractory bipolar disorder: a pilot study.
15	Meyer, T.D & Hautzinger, M.	Lprep.	Kognitive Verhaltenstherapie zur Rezidivprophylaxe manisch depressiver Störungen
16	Lenz, G., Bergthaler, A., Breit-Gabauer, B. et al.	2009	Cognitive Behavior Therapy (CBT) versus Psychoeducation (PE) in bipolar disorder: a randomized controlled study
17	Crane, C., T. Dannhofer, et al.	2008	Mindfulness-Based Cognitive Therapy and Self-Discrepancy in Recovered Depressed Patients with a History of Depression and Suicidality
18	Williams, J. M. G., Y. Alatiq, et al.	2008	Mindfulness-based Cognitive Therapy (MBCT) in bipolar disorder: Preliminary evaluation of immediate effects on between-episode functioning
19	Miklowitz, D. J., Alatiq, Y., Goodwin, G. M., Geddes, J. R., Fennell, M.J.V., Dimidjian, S. & Hauser, M.	2009	A Pilot study of Mindfulness-based Cognitive Therapy for Bipolar disorder

Vergleiche

Studie	CBT + TAU vs. TAU	CBT + TAU vs. Minimal-interv.	CBT + TAU vs. other interv.	CBT + TAU vs. Min.-interv. (BD + SUD)	CBT + TAU vs. other interv. (BD + SUD)	MBCT + TAU vs. TAU ?
Lam, 2000	x					
Lam, 2003/ Lam, 2005	x					
Scott, 2001	x					
Scott, 2006	x					
Ball, 2006	x					
Gomes, 2010	x					
González Isasi, 2010a	x					
González Isasi, 2010b	x					
Meyer, 2011			x			
Lenz, 2011		x				
Miklowitz, 2007		x	x			
Zaretsky, 2008		x				
Castle, 2010		x				
Schmitz, 2002				x		
Weiss, 2007					x	
Weiss, 2009					x	
Crane, 2008						x?
Miklowitz, 2009						x?
Williams, 2008						x?

Ergebnisse Kernfragestellung 1. Meta-Analyse: CBT vs. TAU

(insgesamt N=8 Studien)

Ergebnisse CBT: *Beck Depression Inventory – BDI1*

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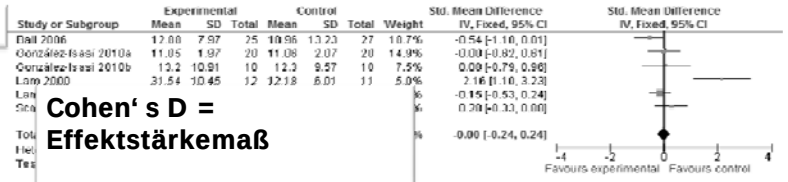

Cohen‘ s D = Effektstärkemaß

Konvention:
Bis 0.2 < 0.5 = schwach
0.5 < 0.8 = mittel
> 0.8 = stark

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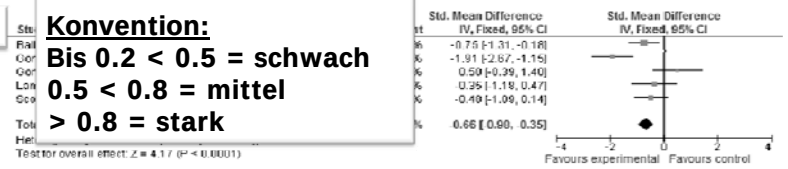

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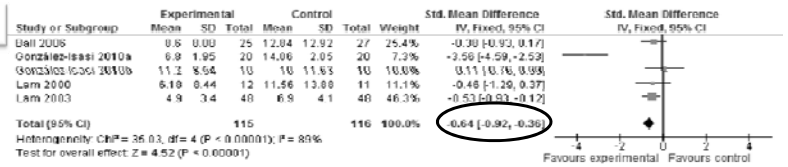

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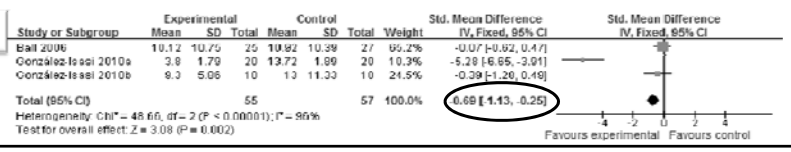

Ergebnisse CBT: *BHS (Beck Hopelessness Scale)*

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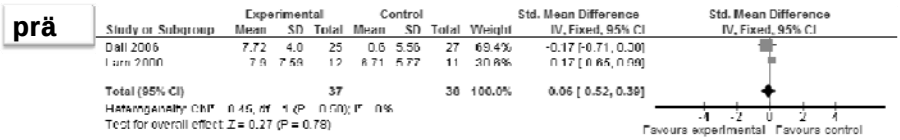

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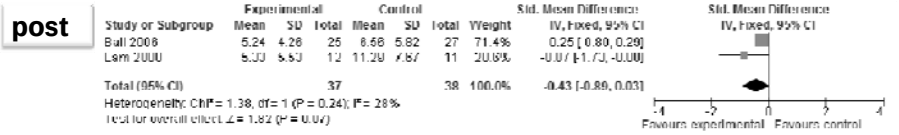

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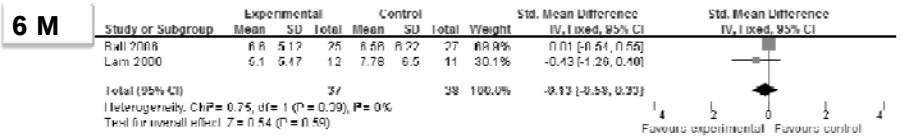

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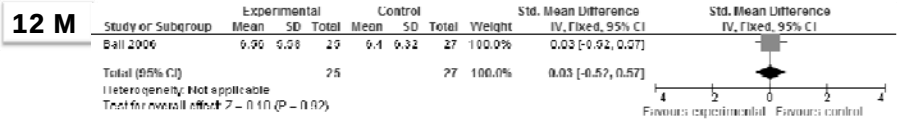

Ergebnisse CBT: *HAMD-17*

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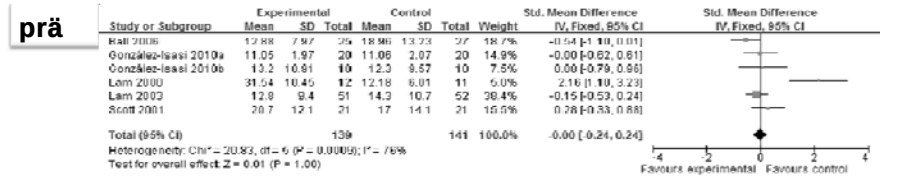

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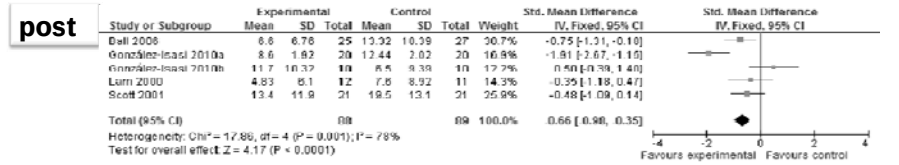

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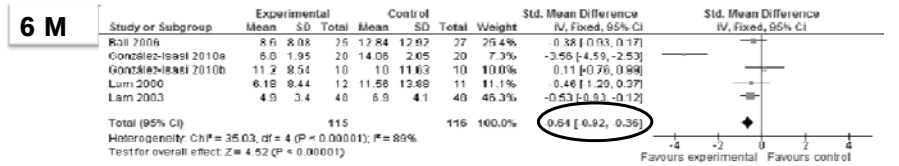

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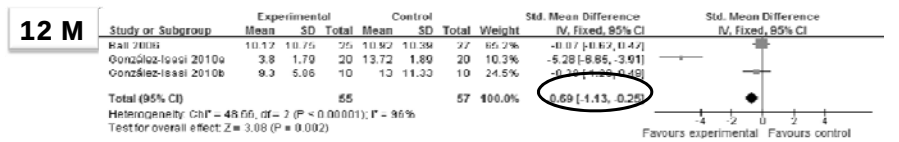
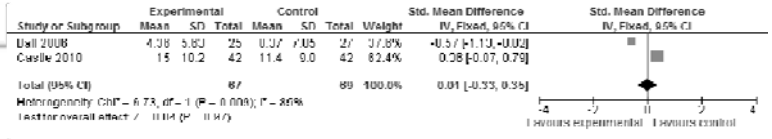


Ergebnisse CBT: *Montgomery-Asberg Depression Scale (MADRS)*

prä



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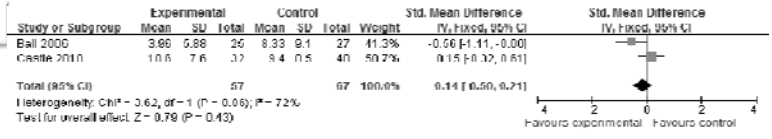

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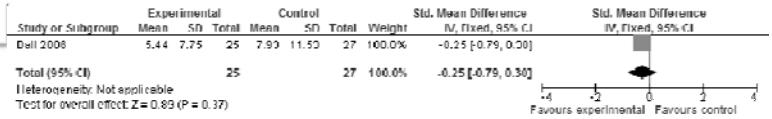

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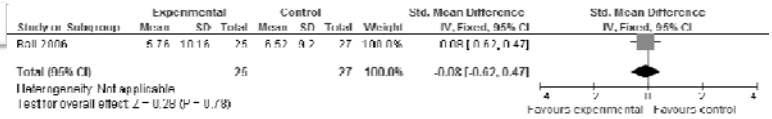
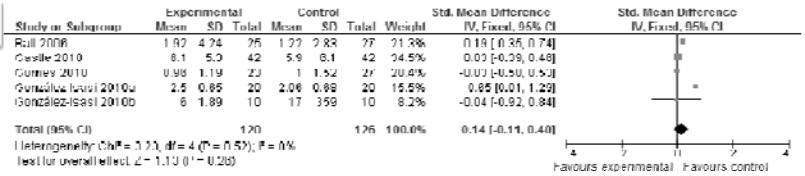


Ergebnisse CBT: *Young Mania Rating Scale - YMRS*

prä



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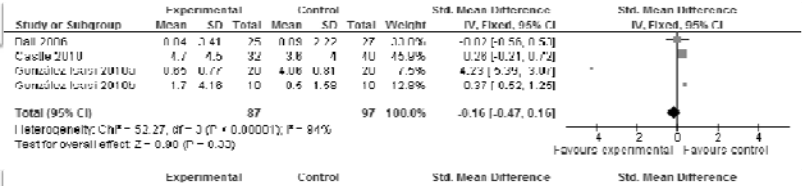

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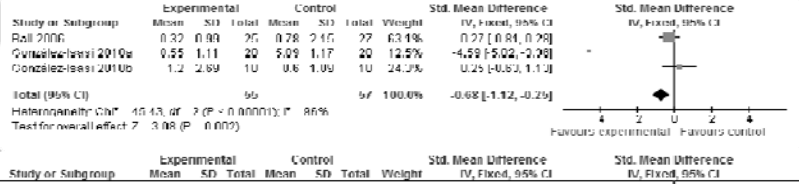

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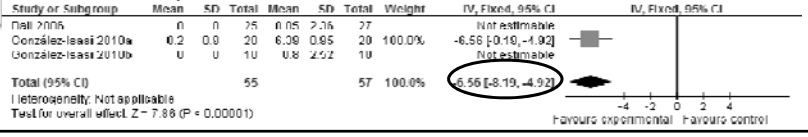
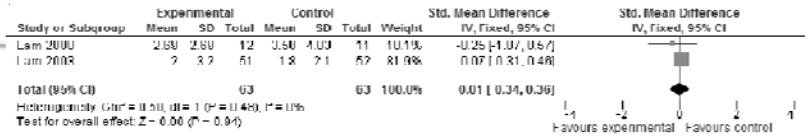


Ergebnisse CBT: *Bech Rafaelsen Manie Skala - BRMAS*

prä



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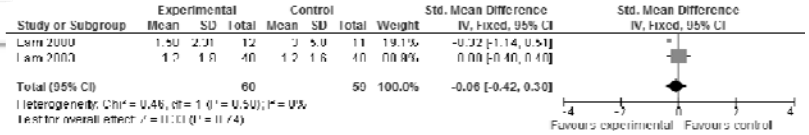

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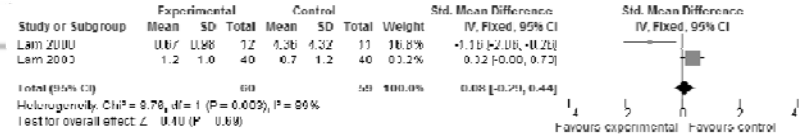
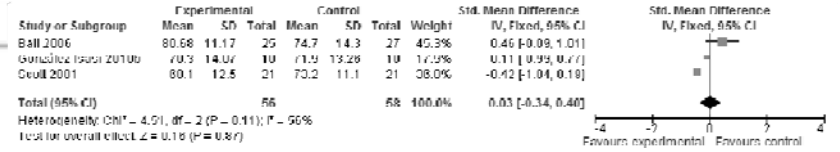


Ergebnisse CBT: *Global Assessment of Functioning - GAF*

prä



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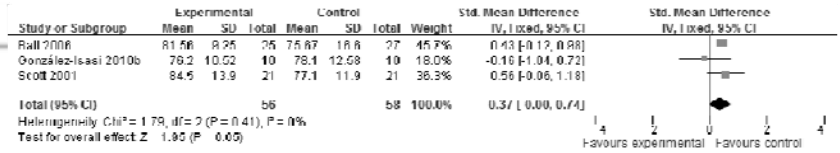

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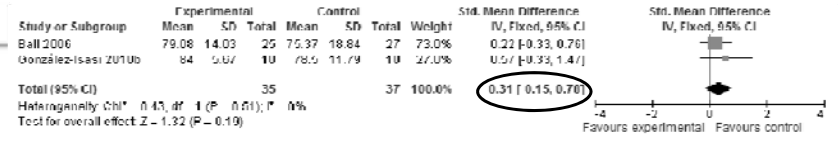

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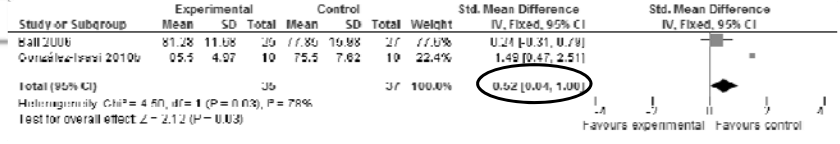
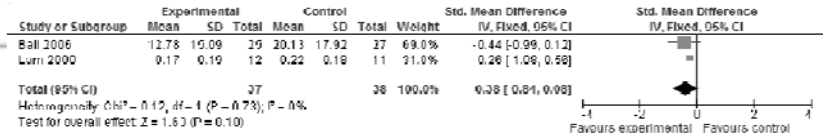


Ergebnisse CBT: *SPS (Social performance scale)*

prä



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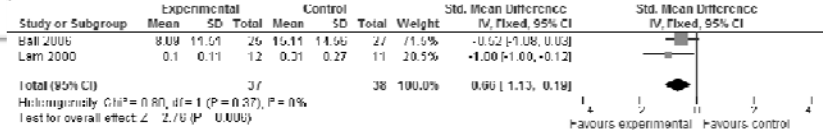

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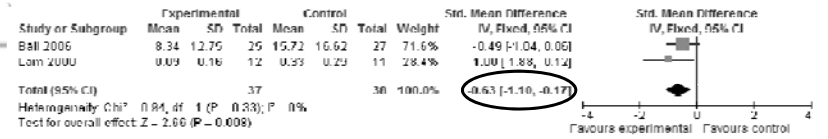

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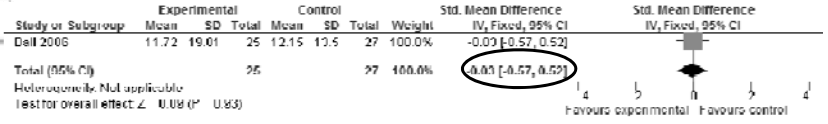
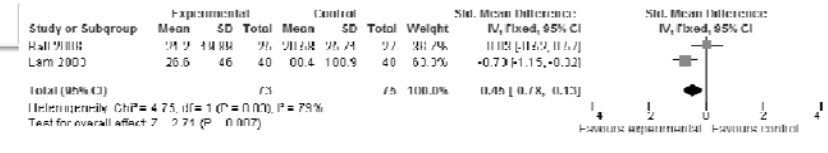


Ergebnisse CBT: *Duration of Affective Episodes (in days)*

post



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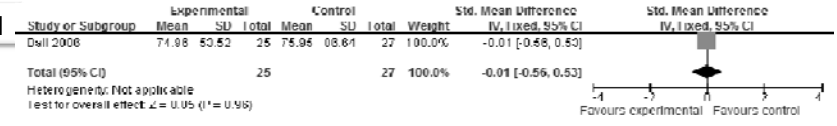
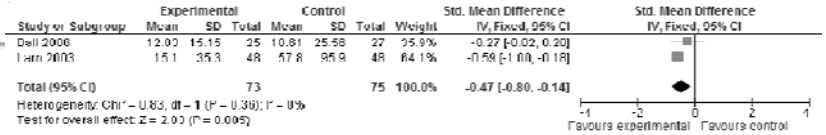


Ergebnisse CBT: *Duration of Depressive Episodes (in days)*

post



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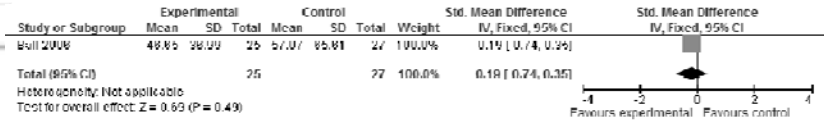
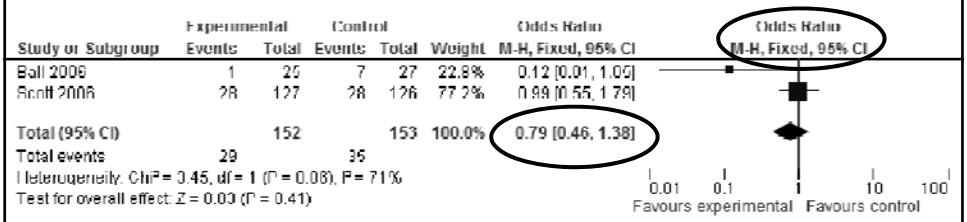
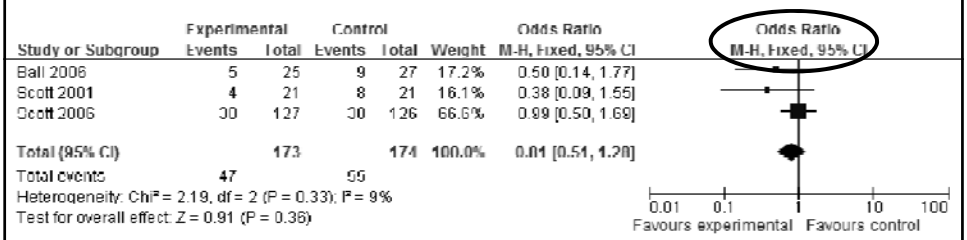


Ergebnisse CBT: *Relapse Rate (depressive episode)*



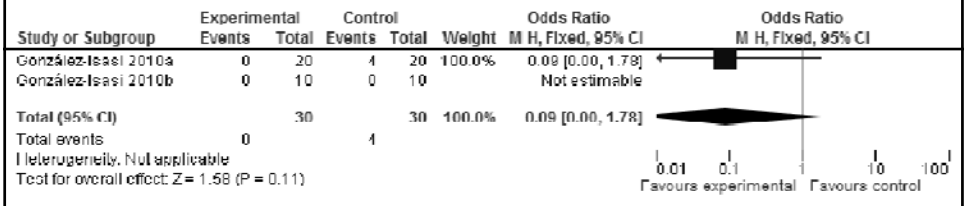
Ergebnisse CBT: *Relapse Rate (affective episode)*



Study or Subgroup	Experimental Events	Total	Control Events	Total	Weight	Odds Ratio M-H, Fixed, 95% CI
Ball 2006	5	25	9	27	17.2%	0.50 [0.14, 1.77]
Scott 2001	4	21	8	21	16.1%	0.38 [0.09, 1.55]
Scott 2006	30	127	30	126	66.6%	0.99 [0.50, 1.69]
Total (95% CI)		173		174	100.0%	0.81 [0.51, 1.28]
Total events	47		55			

Heterogeneity: Chi² = 2.19, df = 2 (P = 0.33); I² = 9%
Test for overall effect: Z = 0.91 (P = 0.36)

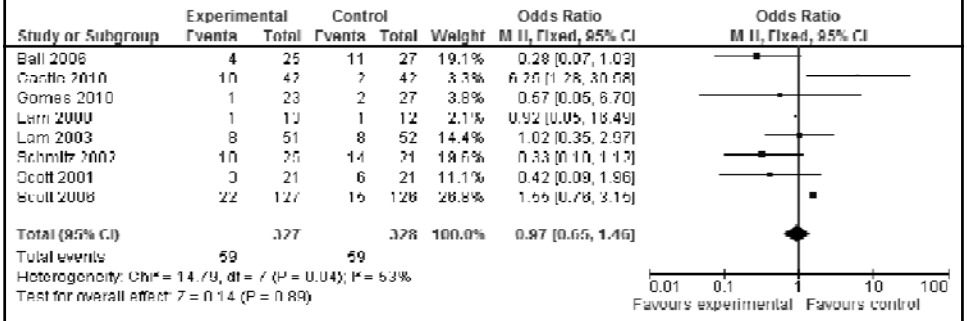
Ergebnisse CBT: *Hospitalisation Rate (days)*



Study or Subgroup	Experimental Events	Total	Control Events	Total	Weight	Odds Ratio M H, Fixed, 95% CI
González-Isasi 2010a	0	20	4	20	100.0%	0.09 [0.00, 1.78]
González-Isasi 2010b	0	10	0	10		Not estimable
Total (95% CI)		30		30	100.0%	0.09 [0.00, 1.78]
Total events	0		4			

Heterogeneity: Not applicable
Test for overall effect: Z = 1.58 (P = 0.11)

Ergebnisse CBT: *Drop out*



Ergebnisse Kernfragestellung 2. Meta-Analyse: Interpersonal and Social Rhythm Therapy (IPSRT) vs. Alternativtherapien

(insgesamt N=4 Studien)

Latest Selection: Included Studies

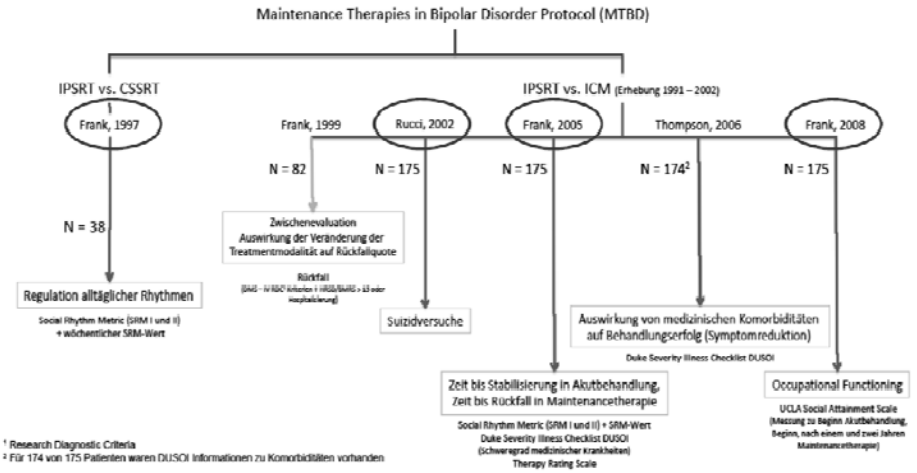
7 Artikel - 4 Studien - 3 Projekte

No	Authors	Year	Title	
01	Frank, E. E., Hlastala, S. S., Ritenour, A. A., Houck, P. P., Tu, X., Monk, T. H., & ... Kupfer, D. J.	1997	Inducing Lifestyle Regularity in Recovering Bipolar Disorder Patients: Results from the Maintenance Therapies in Bipolar Disorder Protocol	MTBD [1] Ellen Frank, University of Pittsburgh
02	Frank, E., Kupfer, D. J., Thase, M. E., Mallinger, A. G., Swartz, H. A., Fagiolini, A. M., & ... Monk, T.	2005	Two-Year Outcomes for Interpersonal and Social Rhythm Therapy in Individuals With Bipolar I Disorder	
03	Frank, E., Soreca, I., Swartz, H. A., Fagiolini, A. M., Mallinger, A. G., Thase, M. E., & ... Kupfer, D. J.	2008	The Role of Interpersonal and Social Rhythm Therapy in Improving Occupational Functioning in Patients With Bipolar I Disorder	
04	Rucci, P., Frank, E., Kostelnik, B., Fagiolini, A., Mallinger, A. G., Swartz, H. A., & ... Kupfer, D. J.	2002	Suicide Attempts in Patients With Bipolar I Disorder During Acute and Maintenance Phases of Intensive Treatment With Pharmacotherapy and Adjunctive Psychotherapy	
05	Miklowitz, D. J., Otto, M. W., Frank, E., Reilly-Harrington, N. A., Kogan, J. N., Sachs, G. S., & ... Wisniewski, S. R.	2007	Intensive Psychosocial Intervention Enhances Functioning in Patients With Bipolar Depression: Results From a 9-Month Randomized Controlled Trial	STEP –BD [2] David J. Miklowitz, University of Colorado
06	Miklowitz, D. J., Otto, M. W., Frank, E., Reilly-Harrington, N. A., Wisniewski, S. R., Kogan, J. N., & ... Sachs, G. S.	2007	Psychosocial Treatments for Bipolar Depression: A 1-Year Randomized Trial From the Systematic Treatment Enhancement Program	
07	Swartz, H.A., Frank, E., Cheng Y.	2012	A randomized pilot study of psychotherapy and quetiapine for acute treatment of bipolar II depression	

[1]MTBD – Maintenance Therapie in Bipolar-Disorder Protocol, [2]STEP-BD – Systematic Treatment Enhancement Programm for Bipolar Disorder

Publikationen - MTBD

Akutbehandlung + Maintenancetherapie:
randomisierte Zuordnung zu einer Akutbehandlung, wenn euthym (4 Wochen) randomisierte Zuordnung zu einer Maintenancetherapie (Dauer 24 Monate)
Outcomes: Je nach Artikel wurden unterschiedliche Outcomes berichtet, in jeder Sitzung HAM-D und BRMAS erhoben



[1] Research Diagnostic Criteria
[2] Für 174 von 175 Patienten waren DUSOI Informationen zu Komorbiditäten vorhanden

Vergleiche

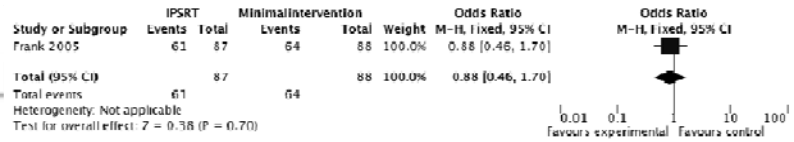
Studie	IPSRT vs. CBT acute depressive	IPSRT vs. FFT acute depressive	Minimalintervention: IPSRT vs. CSSRT[1] acute and maintenance	Minimalintervention: IPSRT vs. ICM[2] acute and maintenance	Minimalintervention: IPSRT vs. CC[3] acute depressive	TAU Pharmakotherapie[4]
Frank, 1997			x			
Frank, 2005				x		
Frank, 2008				x		
Rucci, 2002				x		
Swartz, 2012						x
Miklowitz, 2007a	x	x			x	
Miklowitz, 2007b	x	x			x	

[1] CSSRT – Clinical Status and Symptom Review Treatment, [2] ICM – Intensive clinical management, [3] CC – Collaborative Care, [4] quetiapine

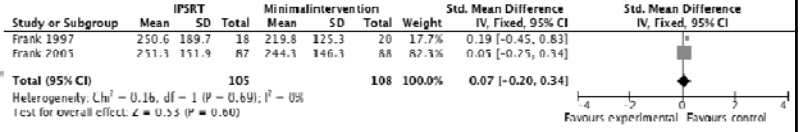
Erste Ergebnisse IPSRT vs. Minimalintervention[1] (MTBD) – post-treatment

[1] CSSRT, ICM

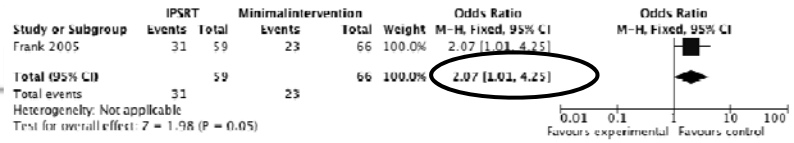
Remission



Zeit bis Remission

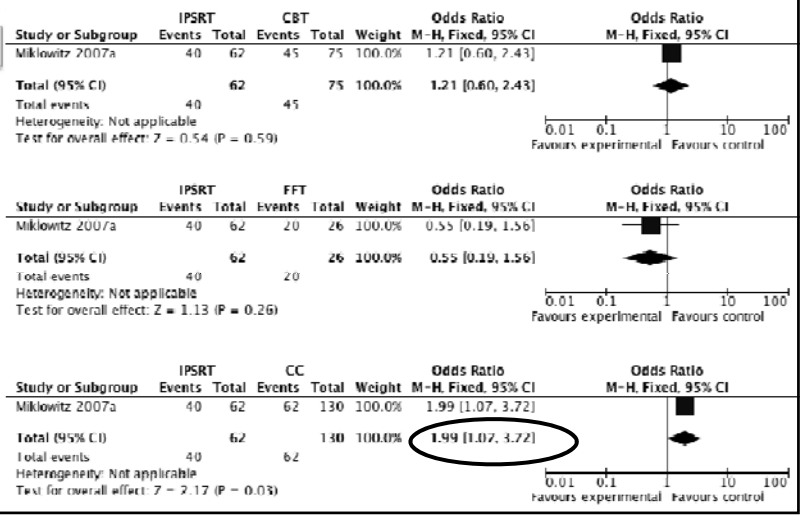


Rückfall



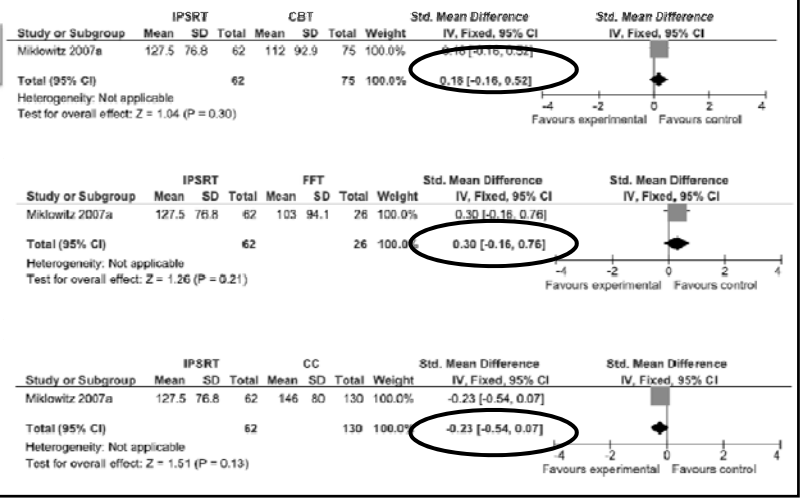
Erste Ergebnisse IPSRT vs. CBT, FFT und CC – STEP-BD – 3 Monate follow-up

Remission



Erste Ergebnisse IPSRT vs. CBT, FFT und CC – STEP-BD – 3 Monate follow-up

Zeit bis Remission



Ergebnisse Kernfragestellung 3. Meta-Analyse: Family Focused Therapy (FFT) vs. Alternativtherapien

(insgesamt N=3 Studien)

Latest Selection: Included Studies

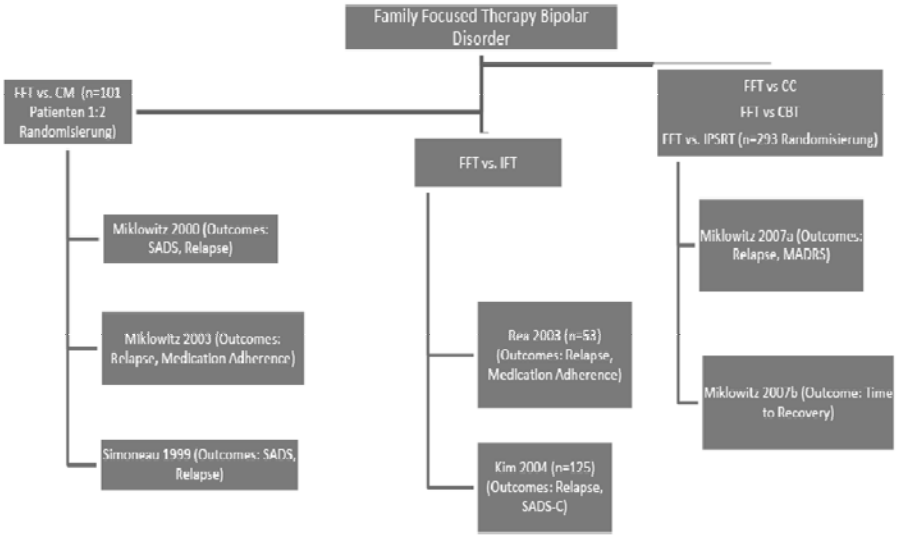
7 Artikel - 3 Studien - 2 Projekte

No	Authors	Year	Title
01	Kim, E.Y., Miklowitz, D.J.	2004	Expressed emotion as a predictor of outcome among bipolar patients undergoing family therapy
02	Simoneau, T. L., Miklowitz, D. J., Richards, J. A., Saleem, R., & George,E. L.	1999	Bipolar Disorder and Family Communication:Effects of a Psychoeducational Treatment Program
03	Rea, M.M., Thomsom, M.C., Miklowitz, D.J., Goldstein, M.J., Hwang, S., Mintz, J.	2003	Family Focused Treatment Versus Individual Treatment for BipolarDisorder: Results of a Randomized Clinical Trial
04	Miklowitz, D.J., George, E.L., Richards, J.A., Simoneau, T.L., Suddath, R.L.	2003	A Randomized Study of Family-Focused-Psychoeducation and Pharmacotherapy in the Outpatient Management of Bipolar Disorder
05	Miklowitz, D.J., Simoneau, E.L., George, E.L., Richards, J.A., Kalbag, A., Sachs-Ercsson, N., Suddath, R	2000	Family-Focused Treatment of Bipolar Disorder: 1-YearEffects of a Psychoeducational Program in Conjunction with Pharmacotherapy
06	Miklowitz, D. J., Otto, M. W., Frank, E., Reilly-Harrington, N. A., Kogan, J. N., Sachs, G. S., & ... Wisniewski, S. R.	2007a	Psychosocial Treatments for Bipolar Depression: A 1-Year Randomized Trial From the Systematic Treatment Enhancement Program
07	Miklowitz, D. J., Otto, M. W., Frank, E., Reilly-Harrington, N. A., Wisniewski, S. R., Kogan, J. N., & ... Sachs, G. S.	2007b	Intensive Psychosocial Intervention Enhances Functioning in Patients With Bipolar Depression: Results From a 9-Month Randomized Controlled Trial

STEP –BD [1]
David J. Miklowitz,
University of Colorado

1 STEP-BD = Systematic Treatment Enhancement Programm for Bipolar Disorder

Einordnung der FFT-Studien



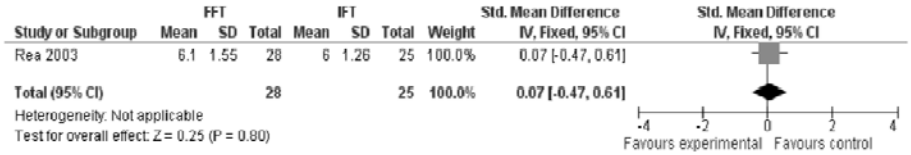
Vergleiche

Studie	FFT vs. CBT	FFT vs. IPSRT	FFT vs. CM[1]	FFT vs. IFT[2]	FFT vs. CC[3]
Simoneau, 1999			x		
Miklowitz, 2000			x		
Miklowitz, 2003			x		
Rea, 2003				x	
Kim, 2004				x	
Miklowitz, 2007a	x	x			x
Miklowitz, 2007b	x	x			x

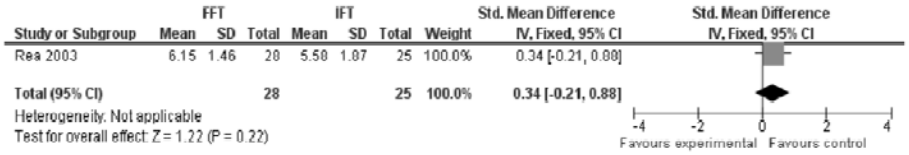
[1]CM=Crisis Management, [2] IFT= Individual Focused Therapy, [3] CC = Collaborative Care

Erste Ergebnisse FFT – Medication Adherence

Medication Adherence: 9 Month Follow up

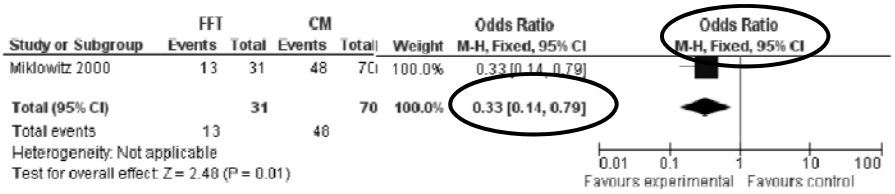


Medication Adherence: 12 Month Follow up

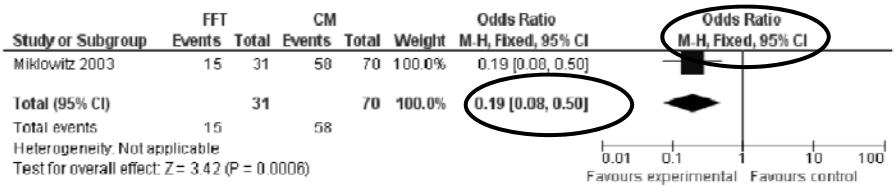


Erste Ergebnisse FFT – Relapesrate

Relapserate: 12 Month Follow Up



Relapserate: 24 Month Follow Up

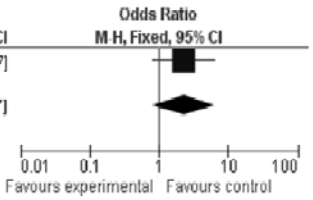


Erste Ergebnisse FFT vs. CBT und IPSRT -STEP-BD-

Remission: 9 Month Follow Up

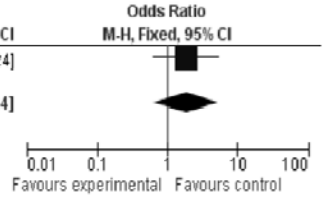
Study or Subgroup	FFT Events	FFT Total	CBT Events	CBT Total	Weight	Odds Ratio M-H, Fixed, 95% CI
Miklowitz 2007a	20	26	45	76	100.0%	2.30 [0.83, 6.37]
Total (95% CI)		**26**		**76**	**100.0%**	**2.30 [0.83, 6.37]**
Total events	20		45			

Heterogeneity: Not applicable
Test for overall effect: Z = 1.60 (P = 0.11)



Study or Subgroup	FFT Events	FFT Total	IPSRT Events	IPSRT Total	Weight	Odds Ratio M-H, Fixed, 95% CI
Miklowitz 2007a	20	26	40	62	100.0%	1.83 [0.64, 5.24]
Total (95% CI)		**26**		**62**	**100.0%**	**1.83 [0.64, 5.24]**
Total events	20		40			

Heterogeneity: Not applicable
Test for overall effect: Z = 1.13 (P = 0.26)



Ergebnisse Kernfragestellung 4. Meta-Analyse: Psycoedukation vs. TAS

(insgesamt N=14 Studien)

Latest Selection: Included Studies (I)

No	Authors	Year	Title
1	**Van Gent**, E.M., & Zwart, F.M.	1991	Psychoeducation of partners of bipolar manic patients.
2	**Clarkin**, J.F., Carpenter, D., Hull, J., Wilner, P., & Glick, I.	1998	Effects of Psychoeducational Intervention for Married Patients with Bipolar Disorder and Their Spouses.
3	**Perry**, A., Tarrier, N., Morriss, R., McCarthy, E., & Limb, K.	1999	Randomised controlled trial of efficacy of teaching patients with bipolar disorder to identify early symptoms of relapse and obtain treatment.
4a	**Simon**, G.E., Ludman, E.J., Unützer, J., & Bauer, M.S. (2002).	2002	Design and implementation of a randomized trial evaluating systematic care for bipolar disorder.
4b	**Simon**, G.E., Ludman, E.J., Bauer, M.S., Unützer, J., & Operskalski, B.	2006	Long-term Effectiveness and Cost of a Systematic Care Program for Bipolar Disorder.
5a	**Colom**, F., Vieta, E., Martinez-Aran, A., Reinares, M., Goikolea, J.M., Benabarre et al.	2003	A randomized trial on the efficacy of group psychoeducation in the prophylaxis of recurrences in bipolar patients whose disease is in remission.
5b	**Colom**, F., Vieta, E., Sanchez-Moreno, J., Martinez-Aran, A., Reinares, M., Goikolea, J.M., & Scott, J. (2005)	2005	Stabilizing the stabilizer: group psychoeducation enhances the stability of serum lithium levels.
5c	**Colom**, F., Vieta, E., Sanchez-Moreno, J., Goikolea, J.M., Popova, E., Bonnin, C.M., & Scott, J.	2009	Psychoeducation for bipolar II disorder: An exploratory, 5-year outcome subanalysis.
5d	**Colom**, F., Vieta, E., Sánchez-Moreno, J., Palomino-Otiniano, R., Reinares, M., Goikolea, J.M., Benabarre, A., & Martínez-Arán, A.	2009	Group psychoeducation for stabilised bipolar disorders: 5-year outcome of a randomised clinical trial.
6	**Colom**, F., Vieta, E., Reinares, M., Martínez-Arán, A., Torrent, C., Goikolea, J.M., & Gastó, C.	2003	Psychoeducation Efficacy in Bipolar Disorders: Beyond Compliance Enhancement.
7	**Dogan**, S., & Sabanciogullari, S.	2003	The Effects of Patient Education in Lithium Therapy on Quality of Life and Compliance.
8a	**Bauer**, M.S., McBride, L., Williford, W.O., Glick, H.,...& Lavori, P.	2006	Collaborative Care for Bipolar Disorder: Part I. Intervention and Implementation in a Randomized Effectiveness Trial.
8b	**Bauer**, M.S., McBride, L., Williford, W.O., Glick, H.,...& Lavori, P.	2006	Collaborative Care for Bipolar Disorder: Part II. Impact on Clinical Outcome, Function, and Costs
9	**Reinares**, M., Colom, F., Sanchez-Moreno, J., Torrent, C., Martinez-Aran,A., Comes, M., Goikolea, J.M., Benabarre, A., Salamero, M., & Vieta, E.	2008	Impact of caregiver group psychoeducation on the course and outcome of bipolar patients in remission: a randomized controlled trial.
10	**Zaretsky**, A., Lancee, W., Miller, C., Harris, A., & Parikh, S.V.	2008	Is Cognitive-Behavioural Therapy More Effective Than Psychoeducation in Bipolar Disorder?
11	**D'Souza**, R., Pitkulic, D., & Sundram, S.	2009	A brief dyadic group based psychoeducation program improves relapse rates in recently remitted bipolar disorder: A pilot randomized controlled trial.
12	Fayyazi Bordbar, M.R., Soltanifar, A., & Talaei, A.	2009	Short-Term Family-Focused Psycho-Educational Program for Bipolar Mood Disorder in Mashhad.
13	**Sajatovic**, M., Davies, M.A., Ganocy, S.J., Bauer, M.S., Cassidy, K.A., Hays, R.W., Safavi, R., Blow, F.C., & Calabrese, J.R.	2009	A Comparison of the Life Goals Program and Treatment as Usual for Individuals With Bipolar Disorder.
14	**Eker**, F., & Harkin, S	2012	Effectiveness of six-week psychoeducation program on adherence of patients with bipolar affective disorder

Zusammenfassung

- **Add-on-Designs:** Nahezu alle PT-Studien untersuchen die *zusätzliche* Wirkung von PT bei pharmakologisch behandelten Ptn. (**Vergleich PT + TAU vs. TAU alone** oder **TAU + Alternative**); non-Intervention oder Placebo-Vergleiche liegen nicht vor ➔ **keine großen Effektstärken zu erwarten!!**
- **CBT/IPSRT/FFT/PE:** Unterschiedliche Datenbasis, heterogene Comparators, uneinheitliche Outcomes + Assessments
- **<u>Resultate CBT:</u>**
  - **mittlere bis sehr starke Effekte** auf ***Depressions-Symtomatik*** und ***Manie-Symptomatik***
  - **mittelstarke Effekte** auf ***Globale Funktionsfähigkeit*** und ***Soziale Funktionsfähigkeit***
  - **mittelstarke Effekte** auf ***Dauer affektiver Episoden***
  - **Keine signifikanten Effekte** auf ***Rückfall-***, ***Hospitalisierungs-*** und ***Drop-Out-Rate***

- **Resultate IPSRT:**
  - **Keine ausreichende Datenbasis zur *Symptomatik***
  - **sehr starke Effekte** auf ***Rückfallrate*** (1 Studie)
  - Effekt ***Rückfallrate*** **leicht besser als CBT**, aber **deutlich geringer als FFT**
  - ***Zeit bis zur Remission*** **leicht besser als CBT und FFT**
- **Resultate FFT:**
  - **Keine ausreichende Datenbasis** zur ***Symptomatik***
  - **Keine signifikanten Effekte** auf ***Medikamenten-Adhärenz***
  - **Sehr starke Effekte** auf ***Rückfallrate***
  - **Effekt *Rückfallprophylaxe* größer** als CBT und IPSRT (n.s.)
- **Resultate Psychoeducation:**
  - **???**

Conclusio

PT in der *adjuvanten* Behandlung bipolarer Störungen wirkt differenziell:

- ***CBT*** verbessert kurz- und mittelfristig deutlich die **depressive Symptomatik** und die **manische Symptomatik,** verbessert kurz- und mittelfristig deutlich die **allgemeine** und **soziale Funktionsfähigkeit, verkürzt** kurzfristig die **Episodendauer,** aber wirkt sich ***nicht*** **signifikant** auf die **Rückfallraten,** die **Hospitalisierungsrate** und die **Abbruchrate** aus ➔ **Akuttherapie?**
- ***IPSRT*** verbessert **Rückfallrate** und verkürzt **Episodendauer**, **Effekt auf Symptomatik unklar ➔ Maintenance?**
- ***FFT*** **überlegen bzgl. Rückfallrate**, aber **kein sig. Effekt** auf **Medikamenten-Adhärenz ➔ Maintenance?**

Limitations: kleine **Studienanzahl**, **heterogene Studienmerkmale**, **unvollständige Informationen**

Vielen Dank für Ihre Aufmerksamkeit!

Stephan.Muehlig@psychologie.tu-chemnitz.de