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ARTICLE

A Relapse Prevention Group for Patients with Bipolar and Substance Use Disorders

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Abstract—*Although bipolar disorder is the Axis I disorder associated with the highest risk of having a coexisting substance use disorder, no specific treatment approaches for this dually diagnosed patient population have thus far been developed. This paper describes a 20-session relapse prevention group therapy that the authors have developed for the treatment of patients with coexisting bipolar disorder and substance use disorder. The treatment uses an integrated approach by discussing topics that are relevant to both disorders and by highlighting common aspects of recovery from and relapse to each disorder. © 1998 Elsevier Science Inc.*

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STUDIES OF COMMUNITY samples (Kessler et al., 1997; Regier et al., 1990) and treatment populations (Brady, Casto, Lydiard, Malcolm, & Arana, 1991; Keller et al., 1986; Mirin, Weiss, Griffin, & Michael, 1991; Ross, Glaser, & Germanson, 1988; Rounsaville et al., 1991) have consistently shown a high rate of co-occurrence of bipolar disorder and substance use disorders. Indeed, the National Institute of Mental Health Epidemiologic Catchment Area study (Regier et al., 1990) revealed that bipolar disorder was the Axis I disorder associated with the highest risk of having a coexisting substance use disorder; the likelihood of an individual with bipolar disorder having a substance use disorder (SUD) was six times greater than that of the general population (i.e., odds ratio = 6.6). People with bipolar-I disorder (i.e., those who have been hospitalized for mania) had an even higher risk of having an SUD, with an odds ratio of 7.9.

Studies of clinical populations have also revealed high rates of comorbidity between bipolar disorder and substance use disorders. Surveys of patients being treated for bipolar disorder have revealed prevalence rates of substance use disorders ranging from 21 to 31% (Brady et al., 1991; Hasin, Endicott, & Lewis, 1985; Keller et al., 1986; Miller, Busch, & Tanenbaum, 1989; Reich, Davies, & Himmelhoch, 1974). In addition, patients seeking treatment for substance abuse or dependence have an elevated rate of bipolar disorder (Hesselbrock, Meyer, & Keener, 1985; Mirin et al., 1991; Ross et al., 1988; Rounsaville et al., 1991). While epidemiologic studies (Kessler et al., 1994; Weissman et al., 1988) have shown that 1.2 to 1.6% of the United States population have a lifetime diagnosis of bipolar disorder, studies of treatment-seeking substance abusers have typically shown prevalence rates of bipolar disorder ranging from 2 to 9% (Hesselbrock et al., 1985; Mirin et al., 1991; Ross et al., 1988; Rounsaville et al., 1991).

There is some evidence that the coexistence of bipolar disorder and SUD worsens prognosis. Keller et al. (1986), for example, found that patients who had bipolar

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disorder with associated alcoholism had an increased likelihood of rapid cycling and a slower time to recovery from affective episodes. Morrison (1974) and Feinman and Dunner (1996) have both reported a substantially increased rate of suicide attempts among alcoholic patients with bipolar disorder, when compared with nonalcoholic bipolar patients. Reich et al. (1974) and Brady et al. (1991) found that patients with coexisting bipolar and substance use disorders were twice as likely as patients with bipolar disorder alone to require hospitalization. Keck, McElroy, Strakowski, Bourne, and West (1997) and Maarbjerg, Aagaard, and Vestergaard (1988) have reported that having a substance use disorder increased the likelihood of medication noncompliance in patients with bipolar disorder. Finally, in a 4-year prospective follow-up study of 75 patients who recovered from an index manic episode, Tohen, Waternaux, and Tsuang (1990) found that a history of alcoholism was a predictor of poor outcome for the bipolar disorder.

Despite the high prevalence rate of substance use disorders among patients with bipolar disorder and the poor prognosis associated with this dually diagnosed population, there have been very few studies of treatment for patients with coexisting substance use and bipolar disorders. Indeed, we know of only three small open pharmacotherapy trials (Brady, Sonne, Anton, & Ballenger, 1995; Gawin & Kleber, 1984; Nunes, McGrath, Wager, & Quitkin, 1990), with a total sample size of 24 patients; we are aware of no trials of psychotherapeutic treatment for this population.

Until recently, psychotherapeutic approaches to patients with bipolar disorder received scant research attention. Jamison, Gerner, and Goodwin (1979) found that patients with bipolar disorder were far more likely to value psychotherapy than were physicians who treated bipolar patients, despite the fact that most of the physicians surveyed were practicing psychotherapists. Psychotherapy for patients with substance use disorder, which was similarly long held in disfavor (Vaillant, 1981), has also recently been the subject of renewed interest (Najavits & Weiss, 1994). Although promising new approaches for patients with bipolar disorder (Frank et al., 1994; Miklowitz & Goldstein, 1990; Miklowitz, 1996) and substance use disorder (Najavits & Weiss, 1994; Onken, Blaine, & Boren, 1993; Project MATCH Research Group, 1997) have been developed, these have not specifically focused on patients with these coexisting disorders. Since this patient population is quite prevalent and typically has a particularly poor prognosis, we decided to focus on developing a treatment approach for this group.

We chose group therapy as a promising intervention for this patient population because group therapy is a staple of substance abuse treatment, and because several reports (Cerbone, Mayo, Cuthbertson, & O'Connell, 1992; Davenport, Ebert, Adland, & Goodwin, 1977; Graves, 1993; Kripke & Robinson, 1985; Volkmar, Bacon, Shakir, & Pfefferbaum, 1981; Wulsin, Bachop, & Hoffman, 1988) have shown encouraging results for patients with bipolar disorder who receive group therapy in conjunction with pharmacotherapy. Previous studies of group therapy for patients with bipolar disorder have had certain characteristics in common. These have included (a) an emphasis on educating patients about bipolar disorder, (b) a forum for patients to share their experiences with the illness and offer mutual support, (c) discussion about medications, ambivalence about taking them, and the importance of complying with the prescribed regimen despite this ambivalence, (d) difficulties with interpersonal relationships, and (e) the importance of accepting one's illness despite the wish to deny it. However, none of these studies specifically addressed the issue of drug use; only one (Kripke & Robinson, 1985) mentioned alcohol use; and one (Graves, 1993) excluded patients with substance use disorders. Moreover, manuals were neither developed nor employed in any of these studies.

Why should we develop a specific treatment for this population, rather than relying on either a more generalized dual diagnosis treatment approach, an approach that is geared toward depression, or a treatment strategy that is aimed at chronically psychotic patients with substance use disorders? We have previously argued (Weiss, Mirin, & Frances, 1992) that the term *dual diagnosis* is an oversimplification, and, in actuality, represents a heterogeneous group of patients with various combinations of types and severity of both substance use disorders and other psychiatric illnesses. Moreover, bipolar disorder has certain unique characteristics that would theoretically make patients with this disorder and substance use disorder especially suitable for a specific treatment intervention. First, there is some evidence that patients with bipolar disorder are at higher risk to use drugs or alcohol when hypomanic or manic, as opposed to when depressed (Weiss, Mirin, Griffin, & Michael, 1988; Zisook & Schuckit, 1987). Second, patients with bipolar disorder differ from those with unipolar depression in that substance use and noncompliance with medication regimens in the former group are often related to their *positive* attitudes toward their hypomanic symptoms. Jamison et al. (1979), for example, found that bipolar patients were more likely to comply with medication due to a fear of depression rather than a fear of mania. Indeed, in studies of patients hospitalized for cocaine dependence, we have previously reported that the majority of the patients with bipolar spectrum disorder whom we interviewed claimed to use cocaine primarily when hypomanic, in part to enhance their endogenous symptomatology (Weiss et al., 1988; Weiss, Mirin, Michael, & Sollogub, 1986). We decided to offer a separate group for bipolar patients rather than a heterogeneous group including patients with schizophrenia, because, unlike the latter group, when patients are in remission from a bipolar episode, they may experience few symptoms. Indeed, this absence of symp-

toms can be a major reason for medication noncompliance (Jamison et al., 1979).

The use of *treatment manuals* is widespread in the field of psychotherapy research. Treatment manuals are believed to assist the therapist by providing a theoretically based rationale for a set of therapeutic techniques, a detailed description of techniques, and a logical organization of treatment content. They also provide a documented treatment that can be replicated in future studies, thus enhancing the rigor of treatment outcome research (Rounsaville, O'Malley, Foley, & Weissman, 1988). Although manuals for relapse prevention treatment of substance use disorders exist (Daley, 1986; Wanigaretne, Wallace, Pullin, Keaney, & Farmer, 1990), we are aware of no manuals that have been developed specifically for patients with coexisting substance use and bipolar disorders.

Our goal was to develop an *integrated* treatment of the two disorders. The treatment of dually disordered patients frequently occurs in either sequential (e.g., the patient receives substance abuse treatment, after which he/she is treated for bipolar disorder) or parallel (the patient simultaneously receives treatment for each disorder at two different clinics) fashion (Weiss & Najavits, 1998). A number of clinicians and researchers have recommended integrated treatment of dually diagnosed patients, that is, treatment of both disorders at the same time in the same setting by the same clinicians who are familiar with both disorders (Mueser, Bellack, & Blanchard, 1992). Although this approach has been advocated for a number of years, there have been relatively few empirical studies of integrated treatment for dually diagnosed patients (Drake, McHugo, & Noordsy, 1993; Hellerstein, Rosenthal, & Miner, 1995; Kofoed, Kania, Walsh, & Atkinson, 1986; Lehman, Herron, & Schwartz, 1993; Najavits, Weiss, & Liese, 1996).

Finally, we decided to develop a manual based on a relapse prevention approach for several reasons. First, this cognitive-behavioral treatment modality, which seeks to prevent relapse through the use of self-control strategies, skill training, identification of high-risk situations, impulse control, advantage-disadvantage analysis, and lifestyle changes, has been used with some success in the treatment of patients with a variety of substance use disorders (Carroll et al., 1994; Project MATCH Research Group, 1997). Second, the flexibility of relapse prevention therapy and its adaptability for a variety of populations (Carroll, Rounsaville, & Keller, 1991) is an advantage; relapse prevention techniques have been directly modified for use with certain other Axis I disorders (Gossop, 1989). Third, relapse prevention treatment addresses some of the major issues that patients with both substance use disorder and bipolar disorder frequently face, including ambivalence about complying with treatment; coping with high-risk situations; self-monitoring of drug craving, moods, and thought patterns; and modifying lifestyle to improve self-care and develop better interpersonal relationships. Finally, Cochran (1984) has provided empirical evidence of the potential utility of a cognitive-behavioral intervention for patients with bipolar disorder. She found that a six-session course of modified cognitive-behavioral therapy significantly enhanced lithium compliance in 14 bipolar patients, when compared with an equal number of patients who did not receive this treatment. Basco and Rush (1996) have recently published a cognitive-behavioral manual for the treatment of patients with bipolar disorder, although it is not specifically tailored for patients with coexisting substance use disorder.

DEVELOPMENT OF THE TREATMENT

The overall goal of our project has been the development and pilot testing of an integrated manualized relapse prevention group therapy for patients with coexisting bipolar disorder and substance use disorder. The group has been designed to focus on and integrate themes that are relevant to each disorder. The treatment, which is described below, has been developed as part of a Stage I (i.e., developmental and pilot testing) study, conducted under the auspices of the National Institute on Drug Abuse Behavioral Therapies Development Program. Future papers will discuss the outcome of this treatment.

Characteristics of the Patient Population

The group treatment is designed for men and women between the ages of 18 and 65 who have current *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (*DSM-IV*; American Psychiatric Association, 1994) diagnoses of both bipolar disorder and psychoactive substance use disorder. In order to enroll in the group, patients need to be in remission from their most recent episode of bipolar disorder because the group is not appropriate for patients with acute symptoms of the disorder. Rather, it requires a level of attention and concentration generally not present in patients with acute symptoms of bipolar disorder. In order to enter the group, patients must be seeing a psychiatrist who is prescribing their medication, and must give us permission to contact their psychiatrist if necessary (e.g., if a patient arrives at a group acutely manic or suicidal). Patients have been recruited while hospitalized at McLean Hospital, and they then begin the group after they have been discharged.

Characteristics of the Therapists

Thus far, therapists who have conducted the group have met the following criteria: a master's or doctoral degree in an area that includes training in psychopathology (e.g., MSW, PhD, MD); at least 1 year of experience in a general psychiatric setting; at least 1 year of substance use disorder treatment experience; and at least 1 year of group therapy experience. Therapists are supervised weekly, based on videotaped group sessions; supervision has em-

phasized keeping patients engaged in treatment, maintaining a compassionate, nonconfrontational attitude toward patients, following the relapse prevention model, and presenting an integrated approach to the treatment of the two disorders.

The major goals of the group program are as follows:

1. Educate patients about the nature and treatment of their two illnesses.
2. Help patients gain further acceptance of their illnesses.
3. Help patients offer and receive mutual social support in their effort to recover from their illnesses.
4. Help patients desire and attain a goal of abstinence from substances of abuse.
5. Help patients comply with the medication regimen and other treatment recommended for their bipolar disorder.

Structure of Group Sessions

The group therapy consists of 20 hour-long weekly sessions, each devoted to a specific topic. Several topics of particular importance are repeated (see below), but most are covered in one session. Each session consists of several core components, similar to a group therapy model our group has developed for women with posttraumatic stress disorder and substance use disorder (Najavits et al., 1996). The group begins with a "check-in," in which group members report how they are progressing with the major goals of the treatment. In this part of the session, all members say whether or not they used any drugs or alcohol in the preceding week; how their overall mood was during the week; whether they took their medications as prescribed; whether they experienced any high-risk situations; whether they used any positive coping skills that they have learned in the group; and whether they anticipate any high-risk situations in the upcoming week. Patients have approximately 2 minutes apiece for their check-in reports.

After the check-in, the group leader reviews the highlights of the previous week's session, and then introduces the current group topic. The remainder of the group consists of a didactic session and a discussion of the day's topic. At each group, patients receive a session handout that summarizes the major points of the group in approximately two pages. Resource lists are also available at each session; these include information about self-help groups for substance abuse, bipolar disorder, and dual diagnosis issues.

Content of Sessions

Whenever feasible, group sessions are designed to discuss topics that are relevant to both disorders. Each session is designed to function independently so that the treatment can be carried out in an "open" format, that is, patients can enter at any time; the group sessions thus cycle, rather than building on each other. We chose an open format because one of the difficulties inherent in recruiting patients for group treatment is the fact that a therapy group needs a critical mass of patients in order to begin. If the period of time from initial recruitment until the actual start of the group is too lengthy, then recruited patients may lose interest in the group. However, since our waiting period has been kept to 1 to 4 weeks, we have been able to recruit patients and retain them until the beginning of the group. A list of topics and a brief description of each session follows.

Specific Session Topics

"It's Two Against One, But You Can Win." The relationship between substance use disorder and bipolar disorder is reviewed; the session emphasizes the capacity of certain drugs to trigger manic or depressive episodes; the potential adverse effect of substance use on medication adherence; the effect of manic or depressed thinking on judgment, including decision-making about substance use (Beck, Wright, Newman, & Liese, 1993); and the similarity between addictive, depressive, and manic thinking (e.g., irrationality, failure to consider the consequences of one's actions).

"Identifying and Fighting Triggers" (2 Sessions). Patients are taught about the nature of "triggers," that is, high-risk situations. They are taught about both internal (depression, anger) and external (seeing one's drug dealer) triggers. Patients are asked to identify major triggers for their substance use, depression, and mania. Mechanisms for coping with triggers are reviewed, including using the "3As" (e.g., *avoiding* triggers when possible, avoiding facing triggers while *alone*, and distracting oneself with *activities*).

"Managing Bipolar Disorder Without Abusing Substances" (2 Sessions). The concept of depressive thinking and manic thinking are reviewed. Characteristics of depressive and manic thinking (e.g., irrationality, difficulty with priorities, pathological pessimism/optimism) are discussed. Patients are taught ways to cope with mood changes, with an emphasis on both behavioral methods (e.g., identifying and fighting the urge to "give up") and the importance of reporting early mood changes to one's psychiatrist.

"Dealing With Friends and Family Members" (2 Sessions). The purpose of this module is to help patients understand the common difficulties that people with bipolar disorder and substance use disorder frequently experience in their relationships with family members and friends. Patients are helped to put their own experiences in perspective by hearing what other group members have gone through, and they are helped to identify ways

in which they can improve their family relationships. This topic typically elicits more affect—especially sadness—than any other session, as patients often report that their families have "given up" on them. The therapist tries to help patients to accept what they can and cannot expect from their friends and family members.

"Denial, Ambivalence, Admitting, and Acceptance." The concepts of denial, ambivalence, admitting, and acceptance are all reviewed. Patients are taught that having ambivalent feelings about sobriety and bipolar disorder treatment is very common. However, they are told that while acknowledging feelings of ambivalence can be helpful, acting on these feelings by using substances or stopping bipolar disorder treatment can be quite dangerous. Patients are taught to identify their ambivalent feelings and their early manifestations of denial.

"Reading Your Signals: Recognizing Early Signs of Trouble." Typical early warning signs of relapse to mania, depression, and substance abuse are discussed. Patients are taught to monitor their moods and their desire for substance use as a way of identifying these early warning signs. The concept of the "abstinence violation effect" is reviewed in this session, and the difference between a "lapse" (slip) and a relapse is discussed (Marlatt & Gordon, 1985).

"Refusing Alcohol and Drugs." Alcohol- and drug-refusal skills are discussed in this session. Patients are told that they need to know what they will say if someone offers them a drink or a drug. This group emphasizes the idea that alcohol and drug refusal skills are the last line of defense against using. Rather, avoiding high-risk situations and using other people for support can help reduce the likelihood of being offered drugs or alcohol.

"Using Self-Help Groups." Self-help groups for addiction and for bipolar disorder are both discussed. Patients' experiences in these groups are reviewed, with an emphasis on both positive and negative experiences that patients have encountered. Much of the group is devoted to a discussion of how they can overcome some of the common problems that dually diagnosed patients face when attending addiction self-help groups. For example, patients may be told by other self-help group attendees that their psychiatric symptoms are merely a result of their substance use, and that they should therefore stop taking their prescribed medication. This session focuses on how to distinguish between good and bad advice emanating from self-help groups, and emphasizes the importance of seeking the opinions of professionals when dealing with psychiatric issues.

"Taking Medication" (2 Sessions). This session focuses on taking medication for both bipolar disorder (e.g., mood stabilizers) and for substance use disorder (e.g., naltrexone, disulfiram). The group focuses on the difficulties that patients have had with medications, and tries to generate solutions to these problems. Common problems that are discussed include ambivalence about whether one needs to take medication at all; the stigma of being on psychotropic medications; physical and psychological side effects; and conflicts with one's prescribing psychiatrist.

"Recovery Versus Relapse Thinking." This session focuses on the differences between the type of thinking process that is characteristic of recovery versus relapse. The concept of "may as well" thinking is reviewed ("I may as well get high, I may as well stay in bed all day," etc.); this is contrasted with a recurring theme of the group, that "it matters what you do," that is, it matters whether one takes medication or not, and whether one decides to drink alcohol or not.

"Taking Care of Yourself." This group reviews two aspects of self-care: sleep hygiene and human immunodeficiency virus (HIV) risk behaviors. Sleep difficulties can increase the risk of relapse to bipolar disorder (Goodwin & Jamison, 1990) and are common in substance use disorder; concrete skills for establishing a healthy sleep pattern are thus reviewed. The increased likelihood of HIV-related risk behaviors associated with both bipolar disorder and substance use disorder is also discussed. We have found that by incorporating the discussion of HIV risk into a general discussion of self-care, patients are willing to discuss this very sensitive topic more openly.

"Balancing Recovery With the Rest of Your Life." This group reviews two common problems patients face as they try to balance their early recovery with other important aspects of their life. Commonly, people are busy with other life obligations, leaving little time for their treatment. Conversely, others spend so much time on treatment that they lose touch with the rest of their lives. The latter situation may lead patients to resent treatment, and some may suddenly stop treatment as a result. This session reviews the different stages of treatment and recovery, and discusses ways to recognize an imbalance between recovery and the rest of one's life. Potential strategies to overcome this lack of balance are reviewed.

"Getting Support From Other People for Recovery." The importance of developing healthy relationships and avoiding problematic relationships (e.g., relationships with active substance users) is discussed. Patients are taught that people who develop healthy relationships are more likely to have a successful recovery than are those who stay involved in their old, troubled relationships. Ways to develop supportive relationships are discussed, including the use of self-help groups, therapy groups, and the use of supportive friends and family members.

"Weighing the Pros and Cons of Recovery." In this session, patients are encouraged to discuss both the positive and negative aspects of their substance use disorder and bipolar disorder. The similarities between addictive thinking and bipolar disorder thinking are emphasized. Patients are taught ways of fighting this type of thinking through a concept known as "hanging up your disease." Addictive thoughts (e.g., "It's okay to get high") are likened to a telephone salesperson trying to sell someone something that he or she does not want; patients are taught to "hang up" rather than engage in this internal discussion.

"Taking the Group With You." This session discusses how patients can continue their recovery successfully after completing the group. Patients are given several guidelines to help them continue successfully after terminating from the group. These include building up other supports, either through individual or group therapy or self-help groups; continuing to review session handouts even after the group has ended; and identifying the recovery thoughts and recovery plans that specifically work well for them.

"Stabilizing Your Recovery: Thinking Through Your Decisions." The difficulties involved in early recovery from bipolar disorder and substance use disorder are discussed. These include resolving problems left over from their recent acute episode (e.g., debts from a manic spending spree); trying to break long-standing addictive habits; and difficulties related to long-standing poor decision-making. The idea of "thinking through solutions" is emphasized in order to help people to identify problems and develop better solutions. Patients are taught to think through the consequences of their behavior, and to discuss their decisions with other people who are supportive of their recovery.

Major Themes

Although a number of different topics are discussed in the group, several major themes have emerged. The first is the "central recovery rule," which is discussed in every group: "Don't drink, don't use drugs, and take your medication as prescribed, *no matter what*." The central recovery rule is held up as an example of "recovery thinking," which is contrasted with "relapse thinking," whereby patients give themselves permission to abuse substances in certain situations (for example, if they feel depressed, if they feel a need to "reward" themselves, or if they have been mistreated by a family member).

As stated above, the concept of "may as well" thinking is also discussed regularly as an example of relapse thinking, and is contrasted with the idea that "it matters what you do." This pattern of thinking is discussed with respect to both bipolar disorder and substance abuse. For example, some patients who continue to experience mood symptoms despite taking their medication as prescribed say, "Why bother taking these medications at all? If I'm going to get depressed or manic anyway, I may as well stop them altogether." Of course, this type of decision-making only exacerbates these patients' problems. Discussing "may as well" thinking is an example of our adaptation of the abstinence violation effect (which was described by Marlatt and Gordon (1985) for the treatment of substance abuse) for bipolar disorder. This is one way in which the themes of recovery and relapse that are common to both disorders are discussed in an integrated fashion.

FUTURE DIRECTIONS

The treatment that we have developed is the first known psychotherapeutic approach designed specifically for patients with bipolar disorder and substance use disorder. We are currently carrying out a research study to evaluate the effectiveness of this treatment when compared with a group of patients who meet the same diagnostic criteria, but who do not receive the group therapy. If these preliminary results are encouraging, we hope to conduct a controlled trial in the future to further test the efficacy of this treatment. It is our hope that this group therapy will prove to be an effective modality that clinicians in the field can use in the treatment of this patient population.

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