Interpersonal and Social Rhythm Therapy: A Means of Improving Depression and Preventing Relapse in Bipolar Disorder

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Interpersonal and social rhythm therapy (IPSRT) was designed to directly address the major pathways to recurrence in bipolar disorder, namely medication nonadherence, stressful life events, and disruptions in social rhythms. The efficacy of IPSRT has been supported by two large studies examining it in conjunction with pharmacotherapy in patients with bipolar illness. In this article, the author discusses the advantages of IPSRT as both an acute intervention and a prophylactic treatment for bipolar depression. The author outlines the four phases of IPSRT, indicating the appropriate focus and duration for each, and discusses IPSRT as a modular treatment. The article concludes with a case example that further illustrates the basic therapeutic methods and processes of IPSRT. © 2007 Wiley Periodicals, Inc. J Clin Psychol: In Session 63: 463–473, 2007.

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Instability Is Fundamental to Bipolar Disorder

In their classic text on manic-depressive illness, Goodwin and Jamison (1990) argued that instability is the "fundamental dysfunction in manic depressive illness" (p. 594). Our own work (Ehlers, Frank, & Kupfer, 1988; Ehlers, Kupfer, Frank, & Monk, 1993) has emphasized the relationship between psychosocial stressors (and, equally important, non-"stressful" alterations in the patterning of daily life) and changes in biological rhythms. We believe that many apparently benign (from a traditional psychological standpoint) life events that are associated with changes in daily routines place considerable stress on the body's attempt to maintain the synchronized sleep–wake, appetite, energy, and alertness rhythms that are the hallmark of the euthymic state.

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Circadian rhythm researchers refer to the exogenous environmental factors that set the circadian clock as zeitgebers or "time givers" (Aschoff, 1981). The primary and most powerful zeitgeber is the rising and setting of the sun, a physical zeitgeber. However, in modern society where light is freely available 24 hr a day, social factors such as the timing of work, the timing of meals, and even the timing of specific television programs can have an important influence on circadian rhythms. We assert that changes in such social time cues lead to brief disruptions in circadian rhythms for all of us. These changes are experienced as transient somatic and cognitive symptoms. Think of jet lag or even transition from standard to daylight savings time. For most of us, these symptoms abate rapidly as we accustom ourselves to the new routine.

However, we hypothesized that individuals who are vulnerable to mood disorders have a more difficult time adapting to such changes and, in a sense, get stuck in the somatic and cognitive state associated with disrupted circadian rhythms and then go on to experience that state as fully syndromal episodes of depression or mania. Figure 1 presents a schematic of how this chain of events might unfold. We subsequently demonstrated that life events characterized by disruption in daily routines are, indeed, associated with the onset of depression and, particularly, of mania (Malkoff-Schwartz et al., 2000; Malkoff-Schwartz et al., 1998).

If the loss of social zeitgebers (i.e., time givers) and/or the presence of significant zeitstörers (i.e., rhythm disrupters) are important in triggering affective episodes in vulnerable individuals, then principles of social rhythm stabilization should be an important

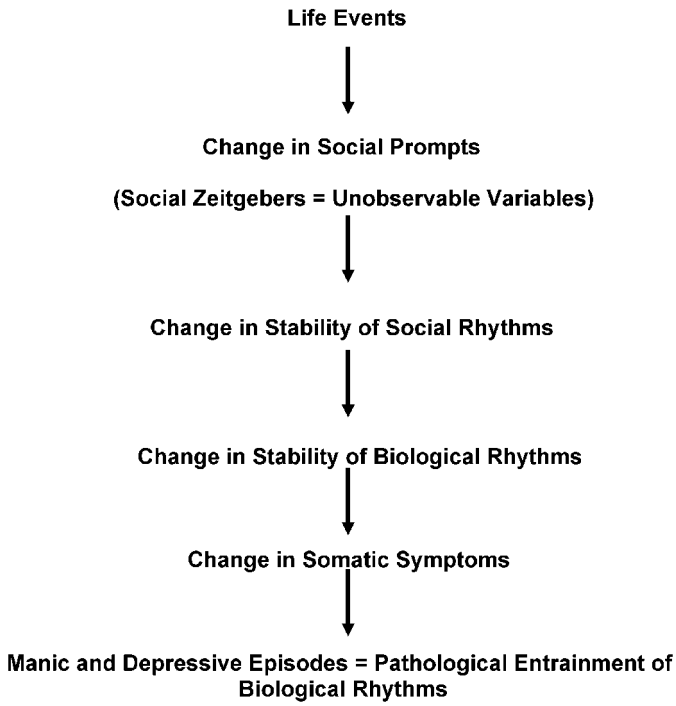

Figure 1. Schema for the social zeitgeber hypothesis. From "Social Zeitgebers and Biological Rhythms: A Unified Approach to Understanding the Etiology of Depression," by C. L. Ehlers, E. Frank, & D. J. Kupfer, 1988, *Archives of General Psychiatry*, 45, pp. 948–952. Copyright 1988 by Archives of General Psychiatry. Reprinted with permission of the publisher.

part of the treatment, especially prophylactic treatment, of bipolar disorder. Indeed, other treatments for mood disorders, including Beck, Rush, Shaw, and Emery's (1979) cognitive therapy (through mastery and pleasure scheduling) and Klerman, Weissman, Rounsaville, and Chevron's (1984) interpersonal psychotherapy (through resolution of family disputes and successful negotiation of life role transitions), indirectly aid in the establishment of social routines.

Interpersonal and social rhythm therapy (IPSRT) takes a more direct approach to applying social rhythm theories to therapy for affective disorder. The specific goals of IPSRT are to stabilize patients' social rhythms or routines while improving the quality of their interpersonal relationships and satisfaction with social roles. Using this multipronged approach, IPSRT seeks to improve current mood and functioning and to teach patients skills that will enable them to protect themselves against the development of new affective episodes.

There are probably three paths to recurrence in those individuals who suffer from bipolar illness and are being treated with mood stabilizer medications: (a) medication nonadherence, (b) stressful life events, and (c) disruptions in social rhythms. IPSRT specifically addresses each of these potential pathways to new episodes of illness. By providing, in addition to medication-adherence training, a forum in which patients can explore their feelings about the disorder, grieve for what we have called "the lost healthy self," and come to terms with how the disorder has altered their lives, IPSRT reduces denial and increases acceptance of the lifelong nature of the disorder and its never-to-be-underestimated propensity to recur. By addressing interpersonal and social role problems in the patient's life, IPSRT attempts to reduce the number and severity of patients' interpersonally or socially based stressors. By paying careful attention to the regularity of daily routines (both the timing of events and the amount of stimulation they produce) and the extent to which both positive and negative life events may influence these daily routines, IPSRT increases the stability of social rhythms in patients' lives and their vigilance with respect to maintaining that stability.

We see the reduction of interpersonal stress in individuals with bipolar disorder as being important to their wellness for several reasons. First, stressful life events can have a direct effect on circadian integrity through increased autonomic arousal, leading to reductions in sleep and appetite. Second, many stressful (and not so stressful) life events lead to marked changes in daily routines. Even a small event, such as a child's moving from elementary to middle school and needing to be at the bus stop an hour earlier, can prove very challenging for someone with bipolar illness. Third, major life stressors, such as losing one's job or getting divorced, not only have the capacity to affect mood directly but also lead to marked changes in social rhythms.

When IPSRT targets these three prominent pathways to new episodes, it is associated with longer time to recurrence of both mania and depression in patients with bipolar I disorder (Frank et al., 2005) and with shorter time to remission of depression in patients suffering from bipolar I or bipolar II disorder and with improvement in their quality of long-term remission (Miklowitz et al., in press). Equally or, perhaps more important, IPSRT is associated with significant reduction in suicide attempts in a population highly vulnerable to suicide (Rucci et al., 2002).

IPSRT is relatively easy to implement in motivated patients who have accepted their illness as a fact of their life. Patients who are still in partial denial about the power of bipolar disorder to take over their lives or its lifelong nature represent more of a challenge for the IPSRT clinician; however, IPSRT also targets the denial that so frequently stands in the way of treatment adherence and good outcome through a focus on their grief for the lost healthy self.

Basic Elements of IPSRT

The basic elements of IPSRT, like those of its predecessor interpersonal therapy (IPT), are the management of affective symptoms and the amelioration of interpersonal relationships. When offered as an acute treatment (which is when it appears to be most potent), the goals of IPSRT are the improvement of the affective symptoms and the resolution of the interpersonal problem(s) most closely linked to the onset of the current affective episode. When offered as a prophylactic maintenance treatment, the goals of IPSRT are the maintenance of a euthymic mood state and improvement and prevention of crises in the patient's interpersonal life and social role functioning.

For patients with bipolar I disorder, the management of affective symptoms is accomplished through the use of pharmacotherapy and through efforts to regularize their social rhythms. For patients with bipolar II disorder, depending upon the severity of the mood symptoms, IPSRT may be offered either as a stand-alone intervention or along with pharmacotherapy. In either case, stabilizing social rhythms is a key aspect of the management of mood symptoms. Resolution of the patient's interpersonal difficulties and maintenance of good interpersonal and social role functioning is accomplished by selecting an interpersonal focus from among the interpersonal problem areas specified by Klerman and colleagues (Klerman et al., 1984; Weissman, Markowitz, & Klerman, 2000) and using largely the same strategies and tactics as those employed in IPT for unipolar patients.

IPSRT is a four-phase treatment. Whether the patient is first seen in an acute episode or in remission, the *initial phase* of treatment begins with a focused history-taking that emphasizes the extent to which disruptions in social routines and interpersonal problems have been associated with affective episodes, and is intended to develop the rationale for the treatment. In this initial phase, the therapist also provides the patient (and his or her family, when indicated) with education about his or her mood disorder, taking into consideration what the patient already has or has not learned about bipolar illness. The therapist then assesses the quality of the patient's interpersonal relationships through a process known as the *Interpersonal Inventory* and assesses the regularity of the patient's social routines by asking him or her to complete an instrument called the *Social Rhythm Metric* (SRM; Monk, Flaherty, Frank, Hoskinson, & Kupfer, 1990). Figure 2 presents a sample of the first two pages of the version of the SRM as modified for use in the initial study of IPSRT. Figure 3 presents the shorter version of the SRM.

Finally, the therapist and patient collaboratively select an interpersonal focus, from among the four IPT problem areas (i.e., grief, role transitions, role disputes, interpersonal deficits), that will become the initial focus of therapy. This initial phase typically lasts three to five sessions, depending on the length and complexity of the patient's affective history and interpersonal relationships as well as the amount of psychoeducation required.

Having concluded the initial phase of treatment, the therapist moves on to the *intermediate phase* of therapy. Here, the focus is on regularizing the patient's social rhythms and intervening in the selected interpersonal problem area. Typically, IPSRT is conducted weekly in the initial and intermediate phases, but other schedules may be appropriate if the patient is either very symptomatic, in which case more frequent visits may be needed, or fully remitted and in treatment primarily to improve current functioning and prevent future episodes.

The *continuation*, or *maintenance*, phase of IPSRT is one in which the therapist works to establish patients' confidence in their ability to use the techniques learned earlier in the treatment. These include maintaining regular social rhythms, even in the face of challenges such as vacations, job changes, and unexpected life disruptions, and maintaining or further improving their interpersonal relationships. Specific techniques for

Respondent # _____ **Week of:** _____

PEOPLE
1 = Other just present
0 = Alone
2 = Others actively involved
3 = Others very stimulating

ACTIVITY	TIME	AM or PM	DAY OF WEEK MON	TUE	WED	TH	FRI	SAT	SUN
OUT OF BED	Earlier								
	8:00								
	8:15								
	8:30								
	8:45								
Mid-point of your normal range →	9:00								
	9:15								
	9:30								
	9:45								
	10:00								
	10:15								
	10:30								
	Later								
	Check if did not do								
FIRST CONTACT (In person or by phone) or with another person	Earlier								
	9:15								
	9:30								
	9:45								
	10:00								
	10:15								
Mid-point of your → normal range	10:30								
	10:45								
	11:00								
	11:15								
	11:30								
	11:45								
	Later								
	Check if did not do								

Respondent # _____ **Week of:** _____

PEOPLE
1 = Other just present
0 = Alone
2 = Others actively involved
3 = Others very stimulating

ACTIVITY	TIME	AM or PM	DAY OF WEEK MON	TUE	WED	TH	FRI	SAT	SUN
HAVE MORNING BEVERAGE	Earlier								
	9:15								
	9:30								
	9:45								
	10:00								
	10:15								
Mid-point of your normal range →	10:30								
	10:45								
	11:00								
	11:15								
	11:30								
	11:45								
	Later								
	Check if did not do								
HAVE BREAKFAST	Earlier								
	9:15								
	9:30								
	9:45								
	10:00								
Mid-point of your normal range →	10:15								
	10:30								
	10:45								
	11:00								
	11:15								
	11:30								
	11:45								
	Later								
	Check if did not do								

Figure 2. Initial pages of the Social Rhythm Metric II (SRM-II).

accomplishing the latter of these goals are outlined in the IPT manual (Klerman et al., 1984). As the treatment moves from the intermediate to the continuation or maintenance phase, the frequency of visits is typically reduced from weekly to bimonthly, and eventually to monthly.

The *final phase* of IPSRT involves work toward termination of therapy or further reduction in the frequency of visits. When termination is seen as an appropriate goal or is

DIRECTIONS
Please complete this form at the end of each day for the period of two consecutive weeks. *Write day of the week (Su, M, T, W, H, F, Sa) and write date (mm/dd/yy)* for which the form was completed. For each activity, *indicate the time* you started it. *Circle "AM" or "PM"* so we know whether the time you entered is in the morning or evening. If you did not do a particular activity, *place an "X" over the box for that activity.*

Day of Week	Date	Out of Bed	First Contact (in Person or by Phone) with Another Person	Start Work, School, Housework, Volunteer Activities, Child or Family Care	Have Dinner	Go to Bed
Su	*05 / 23 / 02*	*6 : 30* AM PM	*7 : 00* AM PM	*9 : 00* AM PM	___:___ AM PM	*11 : 00* AM PM
	___/___/___	___:___ AM PM	___:___ AM PM	___:___ AM PM	___:___ AM PM	___:___ AM PM
	___/___/___	___:___ AM PM	___:___ AM PM	___:___ AM PM	___:___ AM PM	___:___ AM PM
	___/___/___	___:___ AM PM	___:___ AM PM	___:___ AM PM	___:___ AM PM	___:___ AM PM
	___/___/___	___:___ AM PM	___:___ AM PM	___:___ AM PM	___:___ AM PM	___:___ AM PM
	___/___/___	___:___ AM PM	___:___ AM PM	___:___ AM PM	___:___ AM PM	___:___ AM PM
	___/___/___	___:___ AM PM	___:___ AM PM	___:___ AM PM	___:___ AM PM	___:___ AM PM
	___/___/___	___:___ AM PM	___:___ AM PM	___:___ AM PM	___:___ AM PM	___:___ AM PM

Figure 3. SRM-II Short Version.

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necessitated by financial concerns or relocation, this is usually accomplished over the course of three to five monthly visits. Alternatively, the final phase may involve a further reduction in the frequency of visits, such as occasional check-ups or booster sessions.

When the contract is for short-term treatment only, the initial phase of treatment may need to be somewhat compressed and focus intently on social rhythm regulation. Even when IPSRT is provided as a short-term treatment, it is probably advisable to reduce the frequency of the sessions toward the end, allowing for three to four bimonthly sessions during which the termination work is accomplished.

IPSRT as a Modular Treatment

In some respects, IPSRT can be thought of as a series of modules—an education module, a social rhythm regularization module, and several interpersonal problem modules—that can be employed and re-employed throughout a course of treatment. Which modules the therapist uses at which points in time depends upon the patient's pretreatment affective state and what happens in the patient's life over the course of treatment. These modules, in turn, are all nested in a context of supportive clinical management that could be considered still another module.

IPSRT initially was designed for a study of acutely ill patients who, once their acute symptomatology had remitted, would be followed for 2 years of maintenance treatment (Frank et al., 2005). Because of the design of that study, however, one fourth of the patients did not begin IPSRT until their acute episode was fully remitted. In the process of conducting that study, we found that IPSRT *can* begin when patients are either acutely ill or in a state of remission; however, the significant benefit of IPSRT in protecting patients against new episodes was seen only in the group who began treatment with IPSRT while they were acutely ill or were very early in the recovery process.

It has been our experience that it works best to incorporate most of the psychoeducation about bipolar disorder into the history-taking process, but there were certainly times when we found that we needed to return to the education "module" later in the treatment. If a patient experiences a new episode of the opposite polarity to the one that brought him or her to treatment, that often becomes an occasion for additional psychoeducation.

The clinician generally places considerable emphasis on the social rhythm stabilization early in treatment through weekly completion and careful in-session review of the SRM. Once a patient has established fairly regular routines, the therapist may want to briefly review the patients SRMs to be sure that the regularity is being maintained, but not spend much time on this module of the treatment. A key to successful IPSRT is the weaving of "social rhythm talk" into the interpersonal interventions drawn from traditional IPT.

Although it is typically best to select *one* interpersonal problem area to focus upon in the beginning of treatment, other interpersonal "modules" sometimes prove useful later in the therapy, particularly if the patient's interpersonal circumstances or social roles change.

Sometimes, the interpersonal problem area most closely linked to the onset of the patient's episode (e.g., a marital role dispute) is too threatening as an initial focus of treatment. The therapist who insists upon focusing on such a problem runs the risk of early termination. In that case, it is best to begin therapy with an alternate focus that is acceptable to the patient. The skillful therapist is usually able to return to the more salient, but more threatening, problem area when the patient is less severely ill and the therapeutic alliance is stronger. In other cases, new interpersonal or social role problems arise *during* treatment (e.g., a change in the patient's job responsibilities). When this occurs,

the IPSRT clinician makes use of the role-transition "module" of the treatment, possibly scheduling a few more closely spaced visits at the time of the role change.

IPSRT allows for considerable flexibility to use those parts of the treatment package that seem most appropriate to the patient's clinical state and interpersonal circumstances at various times. The following case example illustrates many of the general points made earlier.

Case Illustration

Presenting Problem/Client Description

Louisa began IPSRT at the age of 20 years, seeking relief from an episode of depression that had begun 4 months earlier. Louisa had been struggling with bipolar disorder since junior high school, but prior to this episode of depression, she had been relatively euthymic for more than 2 years, doing well in her medical assistant training. She had taken her first job 5 months before entering treatment.

When Louisa's first paycheck arrived, she decided to move into an apartment with Stacey, a close friend from high school. A series of problems quickly emerged. Louisa knew Stacey was accustomed to keeping her living space in immaculate order, but she hadn't really thought about what effect that might have on their relationship when she asked Stacey if she would want to share an apartment with her. They soon began arguing almost daily about the condition of the kitchen or the bathroom, or both. In addition, Louisa was finding that her paycheck did not stretch as far as she thought it would, a problem she handled by simply opening an endless series of new charge accounts. Soon, Louisa was seriously in debt.

As Louisa got more and more depressed, she found it harder and harder to drag herself out of bed and into the shower in time to get to work, let alone clean the bathroom. When she got home from work, it was all she could do to microwave some frozen soup before collapsing on her bed. The sink was filled with dirty soup bowls, and Stacey was losing patience with her. And it wasn't just the mess in the apartment that was a disappointment to Stacey. She had expected some company in the evenings: someone to watch TV with or to go out with. Instead, Louisa was sleeping all evening. Then, just as Stacey was ready to go to sleep, Louisa would find herself wide awake and, unable to get back to sleep, would turn on the TV for company, with the sound blaring until the early hours of the morning. Louisa hated the tension that had developed between them, but she was just too depressed to do anything about it. She felt like she couldn't meet any of her roommate's expectations even though she knew they were reasonable.

Case Formulation

The patient's psychiatric history and presenting complaints indicated a diagnosis of Bipolar I disorder. She had been maintained on lithium (1200 mg) and had bupropion extended release (titrated up to 300 mg) added in the context of her current depressive episode. She then began a course of IPSRT on an outpatient basis for 22 sessions over the course of 6 months.

After taking a clinical history, Louisa's IPSRT therapist could see that a number of things would need to change for Louisa to recover from this depression. First, she would need to reduce her time in bed. Second, she would need to set a regular sleep/wake schedule that she could stick to even on the weekends. Third, she would need to become more active outside of work. Finally, she would need to either find a way to meet most of her roommate's expectations or find another place to live.

Since being independent seemed important to Louisa and moving back home would feel like one more defeat to her, her IPSRT therapist decided to see if she could engage

Stacey as a kind of coach or co-therapist. Louisa's illness was no secret to Stacey. She had remained a good friend even when others in their high school shunned Louisa after she was released the first time from the hospital. Still, Louisa's therapist assumed that Stacey had little real understanding of depression, its impact on someone's life, or of what kind of support Louisa needed on a day-to-day basis.

After carefully setting the stage for this suggestion, Louisa's therapist asked her whether she would be willing to ask Stacey to come to her next treatment session so that her therapist could explain to Stacey what was really going on and how Stacey might be helpful to her. Louisa felt she had nothing to lose and thought it was worth a try. To Louisa's surprise, Stacey seemed pleased and even relieved by the invitation.

Course of Treatment

During that next session, Louisa's therapist described what depression and depressive symptoms were. She asked Stacey how Louisa's depression was affecting her, and then explained that many of the things Louisa was doing that were so annoying to Stacey were a direct result of depression, not a function of being lazy or of wanting to be a miserable roommate. The therapist also explained how important it was that Louisa limit the amount of time she was spending in bed as a first step to getting over her depression. She then asked the two young women for suggestions on how they might work on this problem together. Louisa admitted that to get dressed properly, clean up after herself, and grab something to eat before she left for work, she needed to be up at 6:30 a.m., an hour earlier than she was typically getting up these days. Louisa's therapist suggested that she begin by trying to get out of bed just 15 min earlier each day for 3 days, and if that went all right, she should then try to be out of bed at 7:00. She then struck a bargain with Stacey: As long as Louisa was meeting her wake-up time goals, would Stacey be willing to bite her tongue about the bathroom and kitchen for just 2 weeks? The therapist's bargain with Louisa was that if she absolutely had to nap when she got home from work, she would set her alarm and not sleep more than 45 min. She suggested that the girls establish a routine of having dinner together, sitting down with their kitchen table set with silverware and napkins, at a specific time agreed upon each night . . . even if it was only to eat yet another bowl of soup. Finally, she suggested that Louisa find another, less stimulating way of getting back to sleep if she woke up in the middle of the night . . . and one that would be less disturbing to Stacey.

Within 3 weeks, Louisa found that she was able to get up regularly between 6:30 to 6:45 a.m. every work day. She signed up for some classes at a nearby YMCA on Saturday and Sunday mornings that helped her get out of bed by 7:00 even on weekends. If she didn't always clean the bathroom when she was done using it, at least her things were put away and Stacey had no trouble finding her own shampoo and deodorant. Sometimes Louisa did feel that she couldn't manage without a nap when she got home from work, but with Stacey's help, she seldom slept for more than the 45 min they all had agreed upon. She and Stacey were sitting down to real suppers together most nights and cleaning up together when they were done. Louisa even had the energy to go out with Stacey once or twice in the evening during those first 3 weeks after their meeting with the therapist. Most important, Louisa was getting good, consolidated sleep at night and typically woke up feeling rested and ready to take on her day.

Outcome and Prognosis

From that beginning, other depressive symptoms began to resolve as well. Louisa found that she could concentrate better at work, where she got a small bonus for exceeding her

productivity targets. She used her bonus to pay off one of her new credit cards (and close the account!). She gave the remaining three credit cards to Stacey to hold for her until she was able to pay off those bills as well. As she got more positive feedback at work, her self-esteem started to rebound. But most important, as she and Stacey started to get along well again, she found she was able to enjoy their friendship and a host of other things in her life.

Efficacy of IPSRT

Two large studies support the efficacy of IPSRT in combination with pharmacotherapy in the treatment of bipolar illness. In the first of these studies (Frank et al., 2005), 175 individuals in an acute episode of bipolar I depression, mania, or a mixed state were randomly assigned to one of four acute and maintenance treatments: acute and maintenance IPSRT (IPSRT/IPSRT), acute and maintenance intensive clinical management or ICM (ICM/ICM), acute IPSRT followed by maintenance ICM (IPSRT/ICM), or acute ICM followed by maintenance IPSRT (ICM/IPSRT). Patients were seen weekly in the acute phase and then biweekly and eventually monthly in the maintenance phase in both the IPSRT and ICM conditions. IPSRT sessions lasted about 55 min. ICM sessions, which focused primarily on psychoeducation about bipolar disorder and medication and side-effect management, lasted about 25 min. IPSRT and ICM were provided by the same clinicians. The preventative maintenance phase lasted 2 years. We observed no difference between the treatment strategies in time to stabilization of the acute episode, possibly because of the strong influence of acute pharmacotherapy on time to remission.

However, after controlling for significant covariates of survival time (i.e., marital status, anxiety disorder diagnosis, and medical comorbidity), we found that those individuals who were assigned to IPSRT in the acute treatment phase survived longer without a new affective episode, *irrespective of maintenance treatment assignment*. Patients in the IPSRT group had achieved higher regularity of social rhythms at the end of acute treatment than did their counterparts receiving ICM. Furthermore, the ability to increase regularity of daily routines during acute treatment was significantly related to reduced likelihood of recurrence during the maintenance phase. From this study, we concluded that IPSRT appears to add to the clinical armamentarium for the management of bipolar I disorder, particularly with respect to prophylaxis of new episodes.

IPSRT also was studied as one of three intensive psychosocial treatments in the Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD). This multisite investigation examined the benefits of four disorder-specific psychotherapies in conjunction with pharmacotherapy on time to recovery and the likelihood of remaining well following an episode of bipolar depression. A total of 263 individuals with bipolar I or II disorder were randomly assigned to an intensive psychotherapy ($n = 163$) or collaborative care (CC; $n = 130$), a brief psychoeducational intervention. Intensive psychotherapy was given weekly and biweekly for up to 30 sessions over 9 months, according to protocols for family-focused therapy, IPSRT, or cognitive-behavioral therapy. CC consisted of three sessions over 6 weeks. The primary outcomes of interest were time to recovery from depression and the proportions of patients classified as well during each of 12 study months.

Patients who received intensive psychotherapy had significantly higher year-end recovery rates (64 vs. 52%, respectively) and shorter times to recovery than did patients in CC control condition (hazard ratio = 1.47; 95% CI = 1.08–2.00). Patients in intensive psychotherapy were 1.58 times (95% CI = 1.17–2.13) more likely to be clinically well during any study month than were those in CC.

Clinical Issues and Summary

The treatment of bipolar disorder, and especially bipolar depression, remains a major clinical challenge. IPSRT, with its emphasis on increasing the regularity of daily routines and thereby possibly enhancing circadian integrity, provides one approach to this challenge. In fact, all of the psychotherapies supported to date for bipolar disorder put some emphasis on sleep hygiene or sleep–wake regulation. By working to enhance the regularity of all of the patient's social routines and doing so in a systematic manner, IPSRT is a useful tool for working with this challenging disorder.

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