A Comparison of the Efficacy of Medication and Psychotherapy for Bipolar Disorder

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***Abstract*—The main purposes of this study are: 1. To analyze the role of several classical pharmacological and psychotherapeutic treatments for bipolar disorder, as well as the process of their implementation. 2. List and compare the advantages and disadvantages of these medications and psychotherapies. 3. Summarize which treatment is better overall and more commonly used by people with bipolar disorder. In today's fast-paced era, the environment often puts more pressure on people. When the pressure is too great and cannot be vented, some mental illnesses may develop. For example, the number of people suffering from bipolar disorders is increasing. Bipolar disorder is a mental illness that includes mania, anxiety, and depression. Patients are often unable to control their emotions, which can seriously affect their quality of life and social functioning. Currently, treatment for this disorder is divided into medication and psychotherapy. In recent years, the advantages and disadvantages of treatments for bipolar disorder are still controversial, so this paper analyzed and compared the advantages and disadvantages of the more commonly used pharmacological and psychotherapeutic treatments. According to the investigation and comparison in this paper, both medical therapy and psychotherapy have their own advantages and disadvantages. However, during the course of the study, it was found that a structured combination of the two could have better results, which is known as combine therapy.**

***Keywords*—bipolar disorder, medical therapy, psychotherapy**

I. Introduction

Bipolar Disorder (BD), also referred to as Manic-Depressive Disorder (MDD). It is a specific form of manic depression. Patients in the manic phase typically display elation and impulsivity, aggression, over-saturated mood, high ability, active thinking, and so on; whereas in the depressive phase, bipolar symptoms including exhaustion, loss of appetite, indifference, reluctance, and even decreased movement can be noted [1]. Additionally, the high suicide and self-harm rates of bipolar illness patients can be very upsetting to families [2].

Some BD patients experience mood swings within a week or a few days, or even in one day or a few days a week, or even multiple times a day. A light manic episode is sometimes accompanied by a depressive condition. Mania is sometimes accompanied by depression, and the two are mixed [1]. Also, it's hard to thoroughly cure this illness. Even with treatment, around 37% of patients still recur in about 1 year. Around 60% of them relapse in 2 years [3]. Lenonhard established a novel notion of unipolar and BD in 1957 after dividing BD into two components—Bipolar I and Bipolar II—and proposed a new concept of mono-bipolar affective disorder. He stated that separating depressive episodes only from bipolar disorder can make a different disease entity, which is characterized by both high and low mood polarity. The method to separate Bipolar I and Bipolar II is to check the degree of manic episodes. If the person is usually not accompanied by psychotic manic episodes that are not accompanied by psychotic symptoms and don't endanger himself or others are called mild mania. Having mild manic episodes and depressive episodes is called Bipolar II affective disorder. Having strong manic episodes and depressive episodes is called Bipolar I affective disorder [3].

The prevalence of bipolar disorder worldwide is about 4% [4], and the rate of recurrence is up to 90% [5]. With persistent residual symptoms and drug side effects, the social functioning and quality of life of bipolar disorder patients are significantly impaired even in remission [6]. The quality of life of adult bipolar disorder patients is comparable to that of schizophrenic patients [7]. Also, the Epidemiological studies suggested that 1% of the whole population could get bipolar type I for a lifetime prevalence [8]. A cross-sectional design, which discovered people in 11 countries, the lifetime prevalence for BD was 2.4%. This included bipolar type I's 0.6% and bipolar type II's 0.4% [9]. As people are gaining more stress, the number of patients keeps increasing. Therefore, the priority of psychologists is to be able to try to prevent the disease not relapse after treatment, otherwise it would only form a permanent vicious circle [3].

II. Literature Review

There are several approaches to the treatment of BD, depending on the focus of treatment. The treatment of BD can be divided into two categories: pharmacotherapy and psychotherapy. Both approaches have their own benefits and drawbacks [10]. The following section focuses on the

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common medications and modalities used in these two approaches.

A. Medical Therapy

1) Sertraline

Sertraline, appearance is usually a white flat tablet or a white powder capsule, which antidepressant medicine from the Selective Serotonin Reuptake Inhibitors (SSRIs) class. Serotonin is a kind of chemical inhibitor that is found in the central nervous system. The function of it is to regulate mood, personality, and alertness. Blocking serotonin reuptake is effective in diseases such as major depressive disorder [11], bipolar disorder, Obsessive-Compulsive Disorder (OCD) [12], panic disorder, Post-Traumatic Stress Disorder (PTSD) [13], Social Anxiety Disorder (SAD), and so on. It can help the body to absorb more serotonin and at last make that person gain more happiness. It's mainly through selective inhibition of cellular reuptake of 5-HT, increasing the concentration of 5-HT in the protruding interstitial space in order to improve depressive symptoms. There was a study about the efficiency of Sertraline, and the data show the overall effective rate was 73.5%, and the average onset of action time was (14.0 ± 2.8) d. This can prove that the efficacy of this drug is obvious, and the adverse effects are low. Therefore, it is widely used in clinical practices [14]. Another study compared Sertraline with venlafaxine hydrochloride. Patients treated with Sertraline hydrochloride had fewer effects on their manic symptoms, and the drug was effective in restoring cognitive function to normal levels, according to the researchers. This drug can effectively help patients regain normal cognitive function while also improving their quality of life without increasing the risk of adverse drug reactions. There was no increase in the risk of adverse drug reactions. Finally, sertraline hydrochloride outperforms venlafaxine hydrochloride in the treatment of bipolar disorder. Sertraline hydrochloride had a better clinical effect than venlafaxine hydrochloride in the treatment of bipolar disorder, which could improve patients' cognitive function [15]. However, there are still adverse effects. The most common side effects include syncope, nausea, sweating, lightheadedness, confusion, fatigue, rhinitis, hallucinations, a disorder of ejaculation, and female sexual disorder [16]. It would also cause a bleeding risk, because it would inhibit platelet aggregation. When taken over a period, the body becomes dependent, so it is very difficult to stop taking the drug. Also, like other antidepressants, it might increase the possibility of suicidal ideation and other behaviors in groups from children to young adults with major depression, which is also the same for bipolar disorder [17]. It should be used with caution in people 65 and older. The Beers Criteria classifies it as a high-risk medicine in geriatric adults because it can cause a syndrome of inappropriate antidiuretic hormone or hyponatremia [18]. Women who are pregnant can't take sertraline, because it can increase the possibility of cardiovascular-related malformations such as ventricular septal defects in infants [19].

2) Quetiapine

BD is treated pharmacologically with mood stabilizers (lithium, valproate, carbamazepine, quetiapine and lamotrigine) and second-generation antipsychotics. For more than 60 years, lithium (which is the most important ingredient in Quetiapine), the prototype mood stabilizer, has remained a first-line medication in the treatment of acute mania and bipolar maintenance treatment. Although there are already a lot of studies with design supporting the safety and efficacy of lithium, there are still few contemporary randomized controlled studies, especially on lithium in the treatment of BD depression. Quetiapine has been found to help patients calm down and overcome manic episodes [20]. The first randomized comparative effectiveness study of lithium (along with other necessary therapies) under conditions representative of real-world practice, using quetiapine (along with other necessary pharmacologic therapies) as the comparator, is the Clinical and Health Outcomes Initiative in Comparative Effectiveness for Bipolar Disorder (Bipolar CHOICE) study. The Bipolar CHOICE trial data supported lithium and quetiapine having equivalent efficacy and tolerability [21]. In another experiment, a hospital gathered up 66 people with BD and divided them into observation groups and control groups. They aimed to test the effectiveness of Quetiapine in treating BD. They found out that when treating bipolar disorder, lithium carbonate is frequently used, quetiapine can improve mental stability. Quetiapine has a strong affinity for the 5-HT2A receptor, exhibits strong antagonistic activity, effectively blocks nerve transmission, and inhibits the development of depressive disorders. With great safety, quetiapine can effectively treat depressive episodes. In this study, patients in the observation group had a better therapeutic outcome than those in the control group, demonstrating that the use of quetiapine plus lithium carbonate for the treatment of bipolar affective disorder has a very significant effect and high safety, which is superior to the treatment using only the quetiapine drug and merits promotion [22].

3) Depakine

Another really important part psychologists need to solve for bipolar disorder is to inhibit manic episodes and ensure that patients can improve their sleep [23]. The main ingredient of Depakine is valproate hemisodium. It's a salt of valproic acid, a well-established anti-epileptic medication, also usually used in the acute and chronic management of bipolar illness [24]. Sodium valproate has demonstrated success in both the treatment of manic episodes and the prevention of relapses, and it is regarded as a first-line therapy, along with other mood stabilizers or antipsychotics [25]. It can help them to calm down, so they can have a good sleep. However, in bipolar disorder, valproate was studied almost exclusively as valproate hemisodium. There was few information about why they changed to Depakine. Therefore, a group of testers did a study to search for the reason. The result shows that the main reason for BD patients changing other valproate treatments to Depakine is because, from the data, 82.6% of them have efficacy, 68.4% of them

have compliance, and 53% of them have adverse events. After 3 months of Depakine treatment, there is a large improvement in all three parts. Another particularly important aspect is that during the treatment period, the mean daily dosage of the drug decreased [26]. All of those shows that using Depakine is a better choice. Although it has a lot of advantages, there are still side effects. Long-term use of these medications is associated with impaired liver and kidney function, as well as weight changes, hair loss, menstruation abnormalities, hirsutism, osteoporosis, and other adverse effects. The effect on the gums is due to the influence of this class of pharmaceuticals on the pituitary-adrenal system. The effect on the gums is related to the medications' inhibition of the pituitary-adrenal system. Gingival hyperplasia is caused by pituitary-adrenal system suppression, adrenocorticotropic hormone suppression, glucocorticoid production, and collagen proliferation. The effect on the gingiva is related to suppression of the pituitary-adrenal system, glucocorticoid secretion, collagen tissue proliferation, and hence gingival hyperplasia, or the effect on granulocyte abnormalities and gum bleeding [27].

B. Psychotherapy

1) Acceptance commitment therapy

Acceptance Commitment Therapy (ACT), centered on mindfulness, paying attention to patients' emotional shifts throughout team activities, avoiding their negative emotions and cognition, and assisting patients in applying the techniques and ideas they have learned to real-life situations so they may get back to their social lives as soon as feasible [28]. The treatment of mental illness demonstrates a strong therapeutic value for acceptance commitment therapy. The most prevalent third-generation experiential behavioral therapy is acceptance commitment therapy, which has six basic steps: mindfulness, acceptance, cognitive dissociation, self-context, defined values, and committed action [29]. The purpose of acceptance commitment therapy is to enhance psychological flexibility by assisting patients in recognizing their own existing thoughts, learning appropriate coping mechanisms for uncomfortable feelings, and lastly adjusting in line with their own ideals.

Acceptance commitment therapy has recently demonstrated a positive clinical impact on the treatment of mental illness, garnering both domestic and international academic attention [30]. One study tried to treat BD patients with ACT and analyzed the effects of ACT on the quality of life and executive function of patients. They split 80 patients into two groups: one group would only receive routine care, and the other group would receive care according to the ACT, which focuses on mutual awareness, listening, accepting unpleasant emotions, living in the moment, accepting oneself, dissociation, self-awareness, determining one's own value, and ending group treatment. In conclusion, patients with BD were found to benefit greatly from ACT in terms of lowering their negative feelings. Nursing care (the one according to ACT) can be more precisely targeted to force patients to confront themselves and subtly control their own emotions through extremely thorough and hierarchical nursing services [28].

2) Family therapy

Family is the most basic cell unit in the social environment, which is also the first place of learning for children. Parents, as the main success of the family members, are primary bearers of children's socialization. It plays an important role in the psychological development of children. It has also been demonstrated that a child's mental health may be influenced by the actions, words, and thoughts of family members. A child with bipolar disorder must also have supportive family members in order for the youngster to once again feel the warmth of the outside world, which gradually relieves the need for positive clothes [31]. Therefore, psychologists design a therapy called Family Therapy. It is a method approach to clinical practice that contains conceptualizing a person's psychological problems and the treatment would depend within the family context [32]. The effectiveness of family therapy for treating clinical issues in children and adolescents is supported by Meta-analyses. It demonstrates that family therapy is a successful intervention for a variety of child and adolescent issues, such as disruptive behaviors and substance use disorders that are externalizing behavioral issues, as well as internalizing behavioral issues, such as depression and anxiety, and eating disorders. Family therapy is also a crucial component of multimodal treatment programs for psychiatric disorders. The first open trial of Family Therapy (FFT) outside of the United States was carried out in Izmir, Turkey. A few format or content modifications to the 21-session protocol were necessary for Turkish BD patients or families. Over a year, the 10 study participants improved in terms of overall functioning and Clinical Global Impression scale ratings [33]. One research discovered that patients who were consecutively assigned to 4–6 months of family-focused psychoeducation had significant gains in social functioning and carers showed decreases in load compared to a normal care group in a nonrandomized experiment enrolling 137 patients with BD in Italy [34]. As a result, it would be a good method for patients and their families, but the very first precondition is that they need to work with experts [35].

3) Group therapy

For Group Therapy, there are mainly two types: group therapy and unstructured group therapy. Through contact, education, and communication among group members, group therapy helps patients become more socially adaptable so they may better understand and accept themselves [36]. Unstructured groups are activities that the group leader guides and facilitates based on the level of communication that is currently present [37]. There was an experiment that wanted to figure out how unstructured group therapy can affect BD patients' mental state, quality of life, and health behavior. In each week, they had a 90-minute group therapy activity, and it lasted for 12 weeks. It showed that the BRMS (mania

scale) scores of the BD patients in the two groups after intervention were lower than before intervention, which implies that mood stabilizers help lessen mania symptoms. By adding group psychotherapy, patients are encouraged to gradually rectify their self-cognition, accept themselves, and develop correct cognition and thinking through activities including sharing events, questions, and recommendations. By participating in group sharing activities, participant questions, participant analyses, and other activities, the aspect of depression can be further improved. Therefore, unstructured group psychological intervention can improve patients' quality of life effectively [38]. In another experiment, testers gathered 70 BD patients and randomly separated them into a study group and a control group. The study group employed group therapy, and the control group would just use medicine. The whole experiment lasted for 3 months. The result showed that group therapy can significantly improve their manic symptoms. Also, it can improve patients' coping styles with BD during recovery. Through communication and communication among group patients, patients can find a sense of belonging in the group, fully and honestly expose their symptoms, reduce stigma, share their feelings with one another, and adjust the discrepancy between self-concept and experience [39]. In a different study, 60 BD patients were randomly selected and divided into a control and an intervention group. While the intervention group received ACT treatment for a total of 6 weeks, the control group was kept on the same medication. The clinical symptoms, social functioning, medication adherence, and psychological adaptability of BD patients were found to be further improved by ACT [40].

III. Discussion

A. Comments on Medical Therapy and Psychotherapy

Both Medical therapy and Psychotherapy have their characteristics and strengths. However, each of them also has disadvantages. According to the experimental data, medical therapy has a lot of benefits. It allows us to stabilize our physical condition as well as our emotions as quickly as possible. It does not cost very much in terms of time as well as labor. Just for example, sertraline can very well improve the patient's mood and activity; quetiapine can quickly help the patient to calm down; Depakene can help the patient to improve sleep and quickly solve the problem of being too excited or insomnia. However, for a wide view, all medicine would have side effects. Also, almost all medicines that are used to treat to BD have dependency, so it is hard for patients to stop taking the drug. With dependency, there would be drug withdrawal. For BD patients, suddenly stopping the drug would cause hallucinations and aggravation of the illness. Specifically, Sertraline, early use of medication would cause stomach discomfort sensations to arise, and more than half of people with mental illnesses cannot receive a full course of treatment. Some patients can withstand drug side effects, while others cannot, due to financial constraints and other factors [41]. The common adverse effects are, moreover, nausea, constipation, loss of appetite, diarrhea, dyspepsia, tremors, dizziness, palpitations, insomnia, drowsiness, dry mouth, excessive sweating, and sexual dysfunction. At the same time, it has the probability of causing patients to enhance suicidal thoughts or mild mania. For a few patients, it can lead to tachycardia, hypertension, hypotension, weight change, dysmenorrhea, and so on. Quetiapine, it causes the patient to gain weight, as well as be drowsy often. At least one increase in cholesterol, blood glucose, and a decrease in platelet count occurs. It was also found to cause a higher incidence of dysphagia than placebo in clinical trials of bipolar disorder. The drug even increased depression and suicidal thoughts in patients with bipolar disorder. Depakine, common side effects include anemia, weight gain, tremor, drowsiness, convulsions, memory disturbances, headache, nystagmus, dizziness, nausea, vomiting, gum abnormalities, stomatitis, epigastric pain, diarrhea, alopecia, hyponatremia, menstrual cramps, confusion, hallucinations, aggression, agitation, attention deficit disorder, and liver damage. A few patients get reversible Parkinson's syndrome, kidney failure, pancreatitis, and even death.

For psychotherapy, it would expose the patient to fewer chemicals and would have fewer side effects. There is also a greater likelihood of being cured and not relapsing, so there is no dependence or withdrawal. Psychotherapy would give the patient as well as the family a sense of hope because it is done in stages or years. The patient and family would understand treatments and results. Nonetheless, psychotherapy also can't completely solve the problem. Without drug control, there would be a lot of accidents happening during the treatment. For acceptance commitment therapy, its steps are very laborious, the most basic of which are six in number. Each of these steps requires a very high degree of cooperation, not only from the patient and the psychotherapist, but also from the family. More steps mean more time, which means more money at the same time. Also, the steps include positive thinking and committed action, which are not necessarily applicable to everyone. Some patients may not be able to concentrate during the chanting, so the results may not be as strong as they could be. For family therapy, the absence of systematically conducted research in China in the debate of the efficacy of family therapy suggests that there may be some publication bias. Additionally, the family is increasingly demonstrating its complexity and diversity against the backdrop of our nation's cultural diversity. As a result, when discussing family therapy techniques, it is important to base your decision on several clinical scenarios. Empiricism still plays a significant role in the field of family therapy, even though there is currently less available proof of practice [42]. For group therapy, there are many unpredictable problems associated with keeping a group of patients with similar conditions together to support each other, such as: if one or more of the patients experience emotional outbursts, there is a risk that the other patients may experience the same outbursts (recognizing that the patient's moods are not well

controlled without medication); when a patient shares an experience similar to that of another patient or patients, this may lead to a flashback to a bad experience, which can lead to emotional outbursts; etc. There was an experiment using group therapy for a group of patients with depression. The majority of the negative effects in the two groups were gastrointestinal in nature, including nausea, vomiting, and lack of appetite. Although the adverse reactions were mild, they still have an influence.

All in all, doctors could do everything possible to minimize the side effects of the medication and to control the dosage. However, it is still not possible to completely eliminate the side effects, and the medication can only serve as a stabilizing effect and does not allow the patient to be completely cured, which can lead to a higher level of dependency. Therefore, medication alone cannot cure a patient. On the other hand, the use of psychotherapy alone does not cure the patient very well, and it is even difficult to complete an entire course of treatment. Without the control of medication, patients are very susceptible to emotional outbursts, making it impossible to continue treatment. However, if the use of medication and psychotherapy is superimposed, the efficiency of treatment can be greatly increased.

B. Combination Therapy

It is possible to get better outcomes by combining medication treatment with psychological treatment because no one method can effectively solve the issue on its own. In addition to shortening and simplifying the treatment cycle, this would significantly lessen the symptoms of drug dependence and withdrawal. However, a lot of individuals also think that combining the two therapies would be more time- and money-consuming, and if it fails, the harm would be more severe. However, by analyzing comprehensively, I firmly believe that this dual control over the physical and psychological processes would lead to greater outcomes, the evidence which are illustrated below.

1) Combine medication treatment with acceptance commitment therapy

There's an experiment that combines medication with acceptance commitment therapy. In that experiment, they gathered 120 BD patients (66 men and 54 women), and randomly separate them into two groups, 60 patients for each group. All study participants would get BD medication; the control group would use this information to administer some routine care; the observation group would use this information to implement acceptance commitment therapy. It was discovered that the observation group outperformed the control group in all latitudes of the quality-of-life scale following the treatment. The satisfaction level with nursing care among the observation group was 93.33%, which was substantially higher than the satisfaction level among the control group, which was 78.33%. The experimenters concluded that there is currently no effective treatment for BD and that the efficacy and effectiveness of available drugs are inadequate. Teens' physical development is impacted in varying degrees by the harmful side effects of long-term drug treatment. Therefore, the combination of drug and non-drug treatment is the current direction of clinical exploration [43]. Through these, it can be found that acceptance commitment therapy can have better results when combined with drugs.

2) Combine medication treatment with family therapy

The testers aimed to record 108 BD patients and their relatives for one of the experiments. The 108 patients were subsequently split into two groups at random. In one group, medication would be combined with family therapy, while in the other, medication would be combined with a brief psychoeducational session. Following that, they were given tasks to perform as they went along. The patients would stay for more than two years and would be discharged every three to six months. The study's final finding revealed that the patient's mania was aggravated and that neither the brief psychoeducational group nor the family therapy group performed well when the relative showed a low level of inappropriate self-sacrifice. However, when the relatives were at a high level, the family therapy group had very good results, and it was discovered by the scale that the patients' mania diminished. The brief psychoeducational group did not perform well, and the patients' mania did not decrease. The brief psychoeducational group had no effect when the family members' levels of appropriate self-sacrifice were low, while the patients in the family therapy group had lower levels of depression [44]. In conclusion, family therapy combined with medication would have better results than ordinary psychoeducational therapy combined with medication. At the University of Colorado, an experiment was conducted in 2003. The researchers gathered 101 patients and randomly assigned them to either short-term psychoeducational comparative treatment or family therapy with conventional medication. The 24-month experiment was completed. Patients receiving family therapy had a greater rate of relapse-free survival over the research period—52%—than patients receiving psychoeducational therapy (17%). For patients receiving family care, the median survival duration was 73.5 weeks, compared to 53.2 weeks for individuals receiving psychoeducation. At two years, family treatment was likewise more effective than the other in lowering depression symptoms. Over a two-year period, family therapy patients would be more medicative and less likely to stop taking their medications than psychoeducational therapy patients. Medication adherence also reduced the severity of manic symptoms. Because of the protective function of the family, family therapy not only affects depression but also improves medication adherence, which affects mania [45, 46]. At UCLA, family therapy underwent another study. 53 patients with BD were randomly assigned to receive either Individually Focused Psychoeducational Therapy (IFPT) plus medication or family therapy plus medication, according to the testers. IFPT was conducted with the same frequency as family therapy (21 sessions over 9 months). In the first year of treatment, recurrence and rehospitalization rates did not

differ, according to later survival assessments. Patients receiving family treatment, however, were less likely than IFPT patients to experience a recurrence within 1–2 years of treatment (28% vs. 60%). Additionally, compared to the IFPT group, the re-hospitalization rate was 48% lower [47]. Therefore, family therapy combined with medication can give a better result.

3) Combine medication treatment with group therapy

In one study, 40 patients each from an experimental group and a control group of 80 BD patients were randomly assigned. Based on the quality of the medication in sufficient quantity and duration, the two groups were then switched, and the experimental group then established group supportive interventions on a case-by-case basis. This treatment regimen was then maintained for at least six months. Up to 12 weeks of continuous intervention would follow before the outcome is assessed. During the course of the trial, no changes to existing psychiatric medicines would be made. Family functioning evaluations, affective symptom ratings, manic symptom ratings, social functioning ratings, cognitive functioning ratings, and statistically derived summaries were all included in the measurements. The results showed that the experimental group significantly outperformed the control group on the APGAR (Family Caring Index Questionnaire) and SDSS (Social Functioning Deficits Scale) measures of positive coping but significantly underperformed on the HAMD-17 (Hamilton Depression Scale) and YMRS (Young's Mania Rating Scale) measures. It implies that patients' self-efficacy was improved with more optimistic beliefs as a result of group treatment, and the incidence of passive negative psychology and behavior was also decreased. A positive circle was created as a result of the improvement of social motivation and responsibility, as well as the improvement of family and societal responsibility. With impressive outcomes, new antipsychotic drugs are now often utilized in clinical settings to treat bipolar illness. Less focus, however, those drugs have been placed on helping patients avoid relapse, maintain excellent social functioning, regulate their emotions, and enhance their quality of life. As a result, patients have low quality of life, difficulty integrating into the community, a sense of shame, and recurring hospitalization [48].

C. Comments on Combination Therapy

Through the above-mentioned experiments, the answer is obvious that when medication and psychotherapy are combined, there would be better results. Psychotherapy is a good solution to the problems of drug compliance, relapse, and self-management that occur with drug therapy alone. At the same time, medication also solves the problems of psychotherapy: non-compliance, experience of pain, sense of responsibility, and so on. Specifically, acceptance commitment therapy combined with medication can help patients to avoid re-hospitalization and be willing to help patients to be familiar with society with a sense of social responsibility. Family treatment combined with medication can improve family communication, enable family members to see relapses early, and enable family members to get emergency treatment to avoid re-hospitalization. Group therapy combined with medication can assist patients in managing their emotions more effectively, enhancing medication compliance, enhancing cognitive function, minimizing discomfort, and reintegrating into society. Therefore, combining treatments is a very good and practical suggestion.

IV. Conclusion

By analyzing and comparing the above, the purpose of this paper—whether psychotherapy or medication is better or more effective for patients with bipolar disorder—may thus be answered. From the introduction section, bipolar disorder is a combination of depression and anxiety, and it is becoming more and more popular in recent times. This is one of the reasons why this study wants to investigate which treatment program is more effective. In the following pages, the paper lists and compares several classic pharmacological and psychological treatments. The final results are shown below. In conclusion, medication and psychotherapy each have their own strengths. For example, sertraline can be a good treatment for patients' depression, which can cheer up the patients' mood for a day; quetiapine can stabilize the patients' mood very quickly, so that the patients won't have some overreactions; diphenhydramine can help the patients to calm their moods and promote sleep; Acceptance of Commitment Therapy can help the patients calm their moods and promote sleep; Acceptance of Commitment Theory can help the patients to clarify their own values and enhance their psychological resilience; Family therapy can help patients understand and communicate with their family members and enhance social activities; Group psychotherapy can help patients find identity among people with similar conditions and enhance social activities. Although both treatments have great benefits, they also have their own side effects: medication has strong dependence and side effects; medication takes a long time and has many contingencies. Neither is likely to be the best treatment, but when used in combination, they can be more effective by reducing the harm of each. For example, the aforementioned experiment of psychotherapy combined with medication is mentioned in the discussion. It has been demonstrated through research that the combination of these two treatment programs can be a good way to build on the strengths and complement the weaknesses. Moreover, this approach is safer, and the chance of relapse is greatly reduced. Such a comparison would be more practical than using either treatment program alone. It is believed that with the support of mature research and theory, the program based on psychotherapy and supplemented by drug therapy will be more widely used, which is the conclusion of this paper. However, there is still plenty of room for development. In the future, researchers can use this value, people's emotional establishment, and value influence to establish and rebuild the concept of life, supplemented by drugs, and finally achieve a radical therapeutic effect. And finally, it can be oriented to the

market, form a commercial production chain, and better help patients.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

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