Cognitive treatment reduced symptoms and improved functioning in bipolar disorder


**QUESTION:** In patients with bipolar disorder (BD), does cognitive treatment (CT) reduce symptoms and improve functioning?

**Design**
Randomised (unclear allocation concealment*), unblinded,† controlled trial with 18 months of follow up.

**Setting**
Newcastle, UK.

**Patients**
42 patients who were >18 years of age (mean age 39.6, 60% women), had a lifetime diagnosis of BD I or II, and had ≥1 episode of affective disorder in the past 2 years. Exclusion criteria were BD secondary to organic disorder, severe physical illness, or cognitive impairment. All patients were included in the analysis.

**Intervention**
Patients were allocated to 25 sessions of CT (n=21) or to 6 months waiting list control (WLC) (n=21). CT involved education about BD within a CT framework and formulation of treatment goals, exploration of skills for coping with depression and mania, dealing with barriers to treatment adherence, and recognising relapse and developing coping techniques.

**Main outcome measures**
Change in symptoms and functioning using scores on the Global Assessment of Functioning (GAF), the Beck Depression Inventory (BDI), the Internal State Scale (ISS) with 4 subscales (activation [ISS-ACT], depression [ISS-DEP], perceived conflict [ISS-PC], and wellbeing [ISS-WB]), and the brief rating of work and social adjustment (WASA).

**Main results**
After adjustment for age, age of onset of disorder, sex, and baseline ratings, CT groups showed greater reductions in symptoms after 6 months than the WLC group (BDI, p=0.02; ISS-DEP, p=0.01; ISS-ACT, p=0.007; and ISS-PC, p=0.01) and greater improvement in global functioning as shown by change on the GAF (p=0.05) (table). CT group patients showed greater improvement in social activities than WLC group patients as measured by the WASA subscales (p<0.01).

**Conclusion**
In patients with bipolar disorder, cognitive treatment reduced most symptoms and improved functioning.

*See glossary.

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>CT (baseline)</th>
<th>WLC (baseline)</th>
<th>Difference in change from baseline (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>BDI</td>
<td>13.4 (20.7)</td>
<td>19.5 (17.0)</td>
<td>9.8 (6.2 to 13.4)</td>
</tr>
<tr>
<td>ISS-DEP</td>
<td>37.2 (89.1)</td>
<td>73.5 (80.1)</td>
<td>45.3 (17.3 to 73.2)</td>
</tr>
<tr>
<td>ISS-ACT</td>
<td>50.9 (106.7)</td>
<td>83.8 (95.1)</td>
<td>44.5 (12.9 to 76.0)</td>
</tr>
<tr>
<td>ISS-PC</td>
<td>39.4 (74.1)</td>
<td>70.7 (80.6)</td>
<td>32.4 (−2.4 to 52.0)</td>
</tr>
<tr>
<td>GAF</td>
<td>84.5 (68.1)</td>
<td>77.1 (73.2)</td>
<td>12.5 (−7.6 to 32.6)</td>
</tr>
</tbody>
</table>

*BDI=Beck Depression Inventory; ISS=Internal State Scale; DEP=depression; ACT=activation; PC=perceived conflict; GAF=Global Assessment of Functioning. Mean difference and CI calculated from data provided by author.

**COMMENTARY**

Psychosocial factors account for almost half of the outcome variance in BD, but psychological treatments have not been investigated to the same degree as biological treatments. Scott *et al*’s study shows the effectiveness of psychosocial intervention in patients with BD and psychiatric comorbidity who are representative of the realities of clinical practice.

Their findings are as would be expected; however, the apparent failure of the intervention to show improvement in specific social functioning measures is contrary to 1 previous study. Scott *et al*’s methodology is sound, although a survival analysis, more specific definitions of “relapse”, and more specific measures of social functioning may have yielded more interesting results, despite the small sample size.

Scott *et al*’s study dovetails with 2 previous studies. Cochran’s study compared CT and standard clinical care and showed that compliance was greater for the intervention group, with a tendency to decline over the follow up period. Perry *et al*’s study examined the efficacy of a CT based intervention that identified early signs of relapse and created crisis management plans, and found that CT reduced relapse rates in the manic, but not the depressive poles of BD.

The authors also noted that improvements in overall social functioning and employment were greater for CT.

It is worth noting that a modified form of the manual based Interpersonal Psychotherapy used by Frank’s group in Pittsburgh reduces the relapse rate of the depressive pole of BD, but not the manic pole.

The “take home” message of Scott *et al*’s paper is that CT based interventions are worthwhile for typical patients with BD and pole specific improvements in outcome can be expected. Clinicians can realistically expect an improvement in their patients’ overall social functioning as a result of CT.

Michael D Robertson, FRANZCP
Mayo-Wesley Centre for Mental Health
Tarre, New South Wales, Australia

---

4 Frank E. *International and social rhythm therapy prevents depressive symptomatology in bipolar I patients.* Presented at the Third International Conference on Bipolar Disorder; June 17, 1999; Pittsburgh, Pennsylvania, USA.