Adding cognitive therapy to minimal psychiatric care prevents short term, but not long term, relapse in people with bipolar disorder


Q Does cognitive therapy plus minimal psychiatric care reduce the risk of long term relapse in people with bipolar disorder?

CONCLUSIONS
Cognitive therapy plus minimal psychiatric care reduces time in relapse over 2.5 years compared with minimal psychiatric care alone. Cognitive therapy reduces overall relapse rates in the first year, but not after the first year.

Commentary
The prognosis for bipolar disorder remains poor with frequent relapses and recurrences along with significant interepisode symptomatology. Despite maintenance pharmacotherapy, the chance of recurrence within the first year is more than 50%, increasing to 90% after five years. The limited success of medications has provided the impetus to augment maintenance pharmacotherapy with psychosocial interventions in an effort to improve treatment outcome. These efforts parallel similar earlier initiatives for schizophrenia. The report by Lam et al. adds to a few studies evaluating other psychosocial interventions supporting psychotherapy efficacy in the management of bipolar disorder. However, sample sizes are often small, random assignment is rare, and outcome raters are often not blind to treatment condition.

Lam et al. randomly assigned 103 people with bipolar I disorder, vulnerable to relapse, to either cognitive therapy (CT) plus medication or medication alone for a period of six months. Participants were assessed for two years by raters blinded to treatment assignment. CT significantly reduced relapse rates during the first 12 months, however, there was no reduction in relapse over the last 18 months of the study period. Nevertheless, over the last 18 months of the study the CT group spent 12% fewer days in bipolar episodes and demonstrated improved mood ratings, social functioning, coping with bipolar proclivities, and reduced dysfunctional cognitions.

Whether the current intervention is considered successful depends in part on how outcome is defined. These results provide preliminary support for adding CT to current treatment regimens, as CT provides some benefit with little risk. Future research replicating or improving upon the results of this study (for example, by adding maintenance CT to current treatment benefits long term) and demonstrating the specificity of CT’s efficacy compared to other psychosocial interventions would provide additional incentive for combining CT with pharmacotherapy.

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3 Tohen M, Watermox CM, Tsuang MT. Outcome in mania: a 4-year prospective follow-up of 75 patients utilizing survival analysis. Arch Gen Psychiatry 1990;47:1106–11.