Relapse Prevention in Patients With Bipolar Disorder: Cognitive Therapy Outcome After 2 Years

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Objective: In a previous randomized controlled study, the authors reported significant beneficial effects of cognitive therapy for relapse prevention in bipolar disorder patients up to 1 year. This study reports additional 18-month follow-up data and presents an overview of the effect of therapy over 30 months.

Method: Patients with DSM-IV bipolar I disorder (N=103) suffering from frequent relapses were randomly assigned into a cognitive therapy plus medication group or a control condition of medication only. Independent raters, who were blind to patient group status, assessed patients at 6-month intervals.

Results: Over 30 months, the cognitive therapy group had significantly better outcome in terms of time to relapse. However, the effect of relapse prevention was mainly in the first year. The cognitive therapy group also spent 110 fewer days (95% CI=32 to 189) in bipotar episodes out of a total of 900 for the whole 30 months and 54 fewer days (95% CI=3 to 105) in bipotar episodes out of a total of 450 for the last 18 months. Multiwariate analyses of variance showed that over the last 18 months, the cognitive therapy group exhibited significantly better mood ratings, social functioning, coping with bipotar prodromes, and dysfunctional goal attainment cognition.

Conclusions: Patients in the cognitive therapy group had significantly fewer days in bipolar epinodes after the effect of medication compliance was controlled. However, the results showed that cognitive therapy had no significant effect in relapse reduction over the last 18 months of the study period. Further studies should explore the effect of booster sessions or maintenance therapy.

(Am J Psychiatry 2005; 162:324-329)

in the last few years, evidence for the efficacy of psychotherapy specific for bipolar disorder is emerging (1-3). We recently reported a randomized controlled study of a relapse prevention approach that showed significant beneficial short-term effects of cognitive therapy for up to 1 year (4). Over the 12-month period, the cognitive therapy group had significantly fewer bipolar episodes, fewer days in bipolar episodes, and fewer bipolar admissions. The cognitive therapy group also had significantly higher social functioning and showed less mood symptoms on the monthly mood questionnaires. However, given the frequent relapsing nature of bipolar disorder (5, 6), a longerterm follow-up period is of paramount importance if cognitive therapy is to be a successful form of treatment. Furthermore, cognitive therapy traditionally has a large skill acquisition component. If therapy results in skill acquisition, it should delay or prevent relapses. Hence, a longerterm follow-up period will provide an estimate of the enduring effect of cognitive therapy.

The purpose of this article is to report an additional 18 months of follow-up data for the original treatment trial, resulting in a total of 30 months of data (6 months of treatment and 2 years of follow-up evaluations). Apart from important clinical data such as bipolar episodes, the length of episodes, and social functioning, we also report changes in

coping with bipolar prodromes and in cognitive dysfunctional beliefs.

Our primary hypotheses were as follows:

- Relative to subjects in a control condition, patients assigned to cognitive therapy would have fewer bipolar episodes and fewer days in bipolar episodes.
- Relative to subjects in a control condition, patients assigned to cognitive therapy would have higher social functioning, better coping strategies for bipolar prodromes, and lower dysfunctional high goal attainment attitudes.

Our secondary hypotheses were that compared with subjects in a control condition, patients assigned to cognitive therapy would have lower depression and mania mood scores and show better medication compliance.

Method

Procedure and Assessment

After the study had been fully explained, written informed consent was obtained. Patients who were found suitable for the study were randomly allocated either to the control condition (N=52) or to the cognitive therapy group (N=51). The computer-generated allocation sequence was concealed in sequentially numbered and sealed opaque envelopes. Patients in the control condition

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Table of Contents Relapse Prevention In Bipolar

- 1. Understanding the eBook Relapse Prevention In Bipolar
 - The Rise of Digital Reading Relapse Prevention In Bipolar
 - Advantages of eBooks Over Traditional Books
- 2. Identifying Relapse Prevention In Bipolar
 - Exploring Different Genres
 - o Considering Fiction vs. Non-Fiction
 - Determining Your Reading Goals
- 3. Choosing the Right eBook Platform
 - Popular eBook Platforms
 - Features to Look for in an Relapse Prevention In Bipolar
 - User-Friendly Interface
- 4. Exploring eBook Recommendations from Relapse Prevention In Bipolar
 - Personalized Recommendations
 - $\circ\,$ Relapse Prevention In Bipolar User Reviews and Ratings
 - Relapse Prevention In Bipolar and Bestseller Lists
- 5. Accessing Relapse Prevention In Bipolar Free and Paid eBooks
 - Relapse Prevention In Bipolar Public Domain eBooks
 - Relapse Prevention In Bipolar eBook Subscription Services
 - Relapse Prevention In Bipolar Budget-Friendly Options

- 6. Navigating Relapse Prevention In Bipolar eBook Formats
 - ePub, PDF, MOBI, and More
 - Relapse Prevention In Bipolar Compatibility with Devices
 - Relapse Prevention In Bipolar Enhanced eBook Features
- 7. Enhancing Your Reading Experience
 - Adjustable Fonts and Text Sizes of Relapse Prevention In Bipolar
 - Highlighting and Note-Taking Relapse Prevention In Bipolar
 - o Interactive Elements Relapse Prevention In Bipolar
- 8. Staying Engaged with Relapse Prevention In Bipolar
 - Joining Online Reading Communities
 - Participating in Virtual Book Clubs
 - Following Authors and Publishers Relapse Prevention In Bipolar
- 9. Balancing eBooks and Physical Books Relapse Prevention In Bipolar
 - Benefits of a Digital Library
 - Creating a Diverse Reading Collection Relapse Prevention In Bipolar
- 10. Overcoming Reading Challenges
 - Dealing with Digital Eye Strain
 - Minimizing Distractions
 - Managing Screen Time
- 11. Cultivating a Reading Routine Relapse Prevention In Bipolar
 - Setting Reading Goals Relapse Prevention In Bipolar
 - Carving Out Dedicated Reading Time
- 12. Sourcing Reliable Information of Relapse Prevention In Bipolar
 - Fact-Checking eBook Content of Relapse Prevention In Bipolar
 - Distinguishing Credible Sources
- 13. Promoting Lifelong Learning
 - Utilizing eBooks for Skill Development
 - Exploring Educational eBooks
- 14. Embracing eBook Trends
 - Integration of Multimedia Elements

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