

Cognitive behavioral therapy for the treatment of acute major depressive episodes in bipolar disorder type I

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Original article

SUMMARY

Although pharmacotherapy is the essential treatment for bipolar disorder type I depression, a significant percentage of patients continue experiencing affective episodes. Cognitive behavioral therapy (CBT), interpersonal psychotherapy and social rhythm and focused family therapy, as well as psycho-education, share the emphasis on the empowerment of the patient so they become an active participant in treatment, become aware of the nature of the disorder they have, and learn to recognize early symptoms of depressive episodes in order to prevent their recurrence. The addition of CBT aims to alleviate depressive symptoms, restore psychosocial functioning, and prevent the appearance of new affective episodes.

Objectives

This paper aims to demonstrate the importance and usefulness of CBT as an adjuvant to the pharmacological management of depression in bipolar disorder type I in those areas which cannot be resolved by pharmacological treatment (residual symptoms, adherence to and compliance with treatment, awareness and understanding of bipolar disorder, identification of prodromal symptoms and developing coping skills).

Method

Controlled clinical trials about the usefulness of CBT as an adjunctive treatment for patients with depression due to bipolar disorder type I are reviewed.

Results

CBT increases adherence to drug therapy, decreases the frequency of relapses, and diminishes residual symptoms, the need for hospitalization, and the duration time of depressive episodes; it also improves psychosocial functioning. However, these effects diminish over time and the results are lower in patients with more affective episodes and greater comorbidity.

Conclusions

There is evidence of the usefulness of CBT as a tool to improve the evolution of the condition in depressed patients due to bipolar disorder

type I and for the need to extend the time of this and other psychosocial interventions, since this disorder is a condition that lasts a lifetime and causes significant impact on the psychosocial functioning of the person.

Key words: Bipolar disorder type I, bipolar depression, treatment, psychotherapy, cognitive behavioral therapy, interpersonal therapy and social rhythm, focused family therapy.

RESUMEN

A pesar de la farmacoterapia, tratamiento esencial del trastorno bipolar I, un porcentaje importante de pacientes experimenta nuevos episodios afectivos. La terapia cognitivo conductual (TCC), la psicoterapia interpersonal y ritmo social y la terapia familiar focalizada, lo mismo que la psicoeducación, enfoques psicosociales útiles en el tratamiento del trastorno bipolar, comparten el énfasis en el empoderamiento del paciente para convertirlo en participante activo de su tratamiento. La adición de la TCC al tratamiento tiene como objetivos aliviar los síntomas depresivos, restablecer el funcionamiento psicosocial y prevenir la aparición de nuevos episodios afectivos. Aunque la investigación es limitada, en este trabajo se describen las bases teóricas y los estudios empíricos que avalan el uso de la TCC como una intervención psicosocial indispensable.

Objetivos

El presente trabajo tuvo como objetivo demostrar la utilidad de la TCC como tratamiento coadyuvante en la depresión del trastorno bipolar I para los síntomas residuales, la adherencia y el cumplimiento del tratamiento, la conciencia y la comprensión del trastorno bipolar, la identificación temprana de los síntomas de los episodios afectivos y el desarrollo de habilidades de afrontamiento.

Método

Se revisaron los ensayos clínicos controlados acerca de la utilidad de la TCC como tratamiento del paciente con depresión del trastorno bipolar I.

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Resultados

La TCC aumenta la adherencia al tratamiento farmacológico, disminuye la frecuencia de recaídas en el primer año, los síntomas depresivos residuales, las hospitalizaciones y la duración de los episodios y mejora la adherencia terapéutica y el funcionamiento psicosocial; su utilidad es similar a la terapia familiar focalizada y la psicoterapia interpersonal y ritmo social. Los efectos terapéuticos disminuyen a lo largo del tiempo y sus resultados son menores en pacientes con mayor número de episodios afectivos (>12) y mayor comorbilidad.

Conclusiones

La TCC es una intervención que mejora la evolución del trastorno bipolar tipo I.

Palabras clave: Trastorno bipolar tipo I, depresión bipolar, psicoterapia, terapia cognitivo conductual, terapia interpersonal y ritmo social, terapia familiar focalizada.

INTRODUCTION

"Manic depressive disease is [...] complex in origin, diverse in its expression, unpredictable in its course, severe in its recurrence, and often fatal in its evolution."¹

Some 1.3% of the Mexican population may suffer from bipolar disorder type I in their lifetime, affecting males (1.6%) more than females (1.1%).² In the DSM-IV-TR,³ the American Psychiatric Association includes bipolar disorder type I in the category of *Bipolar disorders*, and in the DSM-5 it is categorized under *Bipolar and other related disorders*.⁴ This disorder is characterized by the presence of manic, mixed, and depressive episodes, although the presence of one or more manic episodes is required for a diagnosis (as long as these do not form part of a bipolar-type schizoaffective disorder). Manic and depressive episodes may or may not have mixed, psychotic, or catatonic characteristics; depressive episodes may or may not also show atypical symptoms or symptoms of melancholy.⁴ Depressive episodes are much more frequent than manic episodes, with the consequent impact on the life of the person. The diagnosis and treatment of bipolar depression constitutes a frequent clinical situation in the case of these patients.

METHOD

Through the revision of controlled clinical trials, the objective of this work was to demonstrate the importance and usefulness of cognitive behavioral therapy (CBT) as a coadjuvant treatment to pharmacological management of depression in bipolar disorder type I which cannot be resolved by pharmacological treatment (residual symptoms, adherence to and compliance with treatment, consciousness and comprehension of bipolar disorder, early identification of symptoms of affective episodes, and development of coping mechanisms).⁵ In order to do this, transcendental parameters were considered for clinical psychiatric practice: the effect of the patient's adherence to pharmacological treatment, the number, intensity, and duration of depressive episodes, the increase in the duration of periods of euthymia, and improvement in quality of life and psychosocial function.

RESULTS

The use of mood stabilizers, the combination of olanzapine with fluoxetine and quetiapine are accepted pharmacological treatment alternatives in patients with depression in bipolar disorder type I.⁶ Psychotherapy should form part of the treatment plan due to the psychosocial consequences of manic and depressive episodes suffered in the past, the vulnerability of the person to suffering new episodes in the future, and the persistence of significant residual symptoms. Psychotherapy is very often a stabilizing force in the life of patients. The majority of patients that are not in psychotherapy do not feel the need to reflect upon their emotions or their actions, they do not take the time to identify their problems, and as such, they do not establish goals to improve. By focusing on the monitoring and solution of symptoms, and avoiding new episodes of bipolar disorder, cognitive behavioral therapy (CBT) provides the patient with a solid structure that will favor their wellbeing.

The American Psychiatric Association's Treatment Guide for Bipolar Disorder mentions CBT, focused family therapy, and interpersonal and social rhythm therapy within the psychotherapeutic *armamentarium*.⁷ The unofficial revised version of these guides describes the usefulness of focused family therapy on symptoms (fewer relapses and greater periods of stability and adherence to treatment) as well as CBT to reduce the number of relapses, the duration of episodes, and the need for hospitalization.⁸ Before beginning a description and analysis of CBT, it should be pointed out that Freud made very brief reference to bipolar disorder in *Mourning and Melancholia*.⁹ For Freud, the origin of episodes of mania and melancholy (depression) were due to an unconscious intra-psychic conflict stemming from the individual's development. In melancholy, the conflict manifests itself in a direct manner: the loss of an object –or person– experienced as abandonment, generates hostility. The Ego cannot direct this aggressive impulse towards the lost object, and prefers to re-direct it towards themselves, thereby originating the symptoms of depression. In mania, the phenomenon manifests itself through the opposite phenomenon: a boundless energy.⁹ However, despite a hundred years having passed since this proposal, the evidence for the effectiveness of psychodynamic interventions, whether it be

in the form of classic psychoanalysis (restructuring of the personality) or psychodynamic psychotherapy (understanding of the origin of symptoms through *insight*) by means of interpretation, the elaboration of the pathogenic conflict and the conscious comprehension of unconscious conflicts have not been appropriately studied, and as such have not had their usefulness proven.

CBT shares a series of characteristics with other useful psychotherapies in the treatment of bipolar depression, both in its format (highly-structured treatments based on a diathesis-stress model, explanation of the origin of the problem, basis of treatment, learning, and use of skills, and increase in the person's sense of capability) and its content (psycho-education, changes in lifestyle, establishing daily routines, adherence to treatment, and prevention of new episodes).¹⁰

What follows is a description and details of the bases, techniques, and empirical evidence around the usefulness of CBT when added to pharmacological treatment of depression in bipolar disorder type I.

Cognitive Behavioral Therapy (CBT)

CBT is a brief type of psychotherapy with limited objectives, created by Aaron Beck almost 50 years ago. Initially proposed for the treatment of depression, it has also been useful as part of therapy for various other mental disorders. The primary focus of this therapeutic model is to identify and change the maladaptive patterns of processing information and behavior. Although its theoretical framework is totally psychological, this psychotherapy is completely compatible with biological theories and therapies. Additional cognitive behavioral intervention generates better results than just administering medications.¹¹

Cognitive model of depression in bipolar disorder: an explanatory, not etiological model

CBT is based on the cognitive model where the interpretation of events influences the emotions and behaviors of a person; feelings and behaviors depend on the way in which the person interprets the situations. In terms of CBT, bipolar disorder consists of a vicious circle in which the depressive symptoms produce changes in cognition and behavior, giving rise to poor functioning with the consequent psychosocial problems. An increase in stress levels gives rise to new symptomatic, depressive, or manic episodes. A more complex cognitive model includes the biological factors –diathesis, hereditarity, or genetic predisposition– of bipolar disorder, in constant interaction with life events. The patient's coping mechanisms are not strong or adaptive enough due to their style of interpretation (cognitive), making them vulnerable to relapsing and presenting new affective episodes.¹² CBT modifies the cognitive, behavioral, and affective

elements, therefore helping the patient to manage their illness, delaying or stopping its progression.¹³

Like other types of psychotherapy for bipolar disorder, CBT begins with psycho-education around the condition, and the way in which the patient's environmental factors, thoughts (cognitions) and behaviors affect the course of the illness. There are various purposes for including this psycho-educational element within the framework of CBT: 1. if the patient knows the manifestations of the depressive and manic phases of bipolar disorder, they can develop the capacity to detect symptoms early. The emergence of sub-clinical symptoms of mania and depression indicate recurrence or relapse. CBT also allows a plan of action to be established to try and avoid or deal with new episodes.¹⁴ 2. If the evolution of bipolar disorder and the usefulness of drugs to detain its cycles is known, CBT can improve compliance with psycho-pharmacological treatment. Between 40% and 60% of patients do not adequately comply with their treatment plan. CBT allows the reasons for non-adherence to be identified, and therefore strategies to be developed to overcome these obstacles.¹⁴

CBT strategies also allow for a reduction in the effects of stressful events in the patient's environment, by providing support in decision-making, stress management, and resolving problems in their relationships. It facilitates adherence to therapy, reduces relapses, and helps the person to manage the psychosocial consequences of the illness. As well as 1. the psycho-educational focus and 2. the development of a warning system to anticipate new episodes, CBT also includes 3. the improvement and maintenance of adherence to pharmacological treatment, as well as 4. modifications to lifestyle –reducing stimulation, activities, and stress, and introducing good sleep hygiene– critical elements in achieving emotional stability. The therapeutic element of CBT includes 5. cognitive strategies –challenging maladaptive automatic thoughts and assumptions through Socratic questioning, cognitive re-structuring and confirmation through behavior– and behavioral strategies –gradual return to activity and a regular routine– for the control of symptoms and 6. methods to reduce psychosocial stressors –by means of training in problem-solving– frequently present as interpersonal, financial, and work problems.¹³ Interventions directed towards the treatment of comorbidities should be considered within CBT.

How useful CBT is depends to a great degree on the strength of the therapeutic alliance. The patient's confidence in their therapy is critical, as when symptoms reappear, it is vital that the patient feels confident to talk about them, and accept the proposals of their therapist. On the other hand, the therapist must in turn accept that the course of therapy is not traditional, and that further to helping the patient to achieve an improvement in their depressive symptoms and manage the psychosocial repercussions of the illness, they should also prepare the patient for new episodes. Visits should start weekly, then once every two weeks, then once a month in ac-

cordance with the development of the symptoms, but more frequent visits may need to occur should symptoms return due to stressful events and life transitions. One fundamental difference in treatment with CBT for "unipolar" and bipolar depression is the duration of treatment (20 sessions or 12 weeks for the former; not defined for the latter). Another important difference is due to the patient's symptoms and their "functioning" in the psychotherapy sessions: when the patient is in a depressive episode, slow in ideation and behavior, it is different to when they are manic or hypomanic.¹³

A description of the automatic thoughts present in different episodes of bipolar disorder type I is as follows:

Cognitive content of depressive (and manic) thought in patients with bipolar disorder

Cognitive schemas, the functional mental structures that interpret situations, give rise to rapid, brief, and spontaneous thoughts, or to thoughts which are the product of deliberation and reasoning; the term 'core belief' is used in practice as a synonym of 'schema'.¹⁵ Thoughts have a powerful influence on both the emotions and behaviors of a subject. The subject constantly and involuntarily assesses both their own internal events and external ones related to the situation. Thoughts, which are a product of schemas when not of deliberation or reasoning, are called automatic thoughts. As such, in accordance with the person's circumstance, automatic thoughts of threat or danger can appear, giving rise to fear (normal emotion) or anxiety (abnormal emotion). If the circumstance assessed through schemas causes thoughts of humiliation and dominance, this in turn gives rise to anger (normal emotion) or rage (abnormal emotion). Thoughts of loss and abandonment can give rise to sadness (normal emotion) or depression (abnormal emotion), and thoughts of capability, achievement, and opportunity give rise to happiness (normal emotion) or euphoria (abnormal emotion).¹² As well as appearing spontaneously and seeming plausible, automatic thoughts also have an important influence on emotions and behavior. When they have such a significant influence on the subject that they actually displace other reasonable and adaptive thoughts, they are termed hypervalent. Automatic thoughts are "filtered" through maladaptive assumptions or intermediate beliefs consisting of rules, attitudes, presumptions, and imperatives that are rigid, unrealistic, and applied regardless of the difficulties or risks.^{12,15}

Schemas (beauty-ugliness, success-failure, ability-inability, and knowledge-ignorance), maladaptive assumptions, and automatic thoughts dominate the landscape during depressive and manic episodes; automatic thoughts come to be cognitively distorted towards the negative/depressive or towards the positive/manic. Within these cognitive distortions can be found *fortune-telling*, *mind-reading*, *labelling*, *discounting*, *exaggerating outcomes*, and *emotional reasoning*.¹² As such, a per-

son thinking that they are going to be rejected is an automatic thought with the cognitive distortion called "fortune-telling", and thinking that they are ugly has the distortion of "labelling". The belief that others consider them incapable or foolish is a manifestation of the cognitively distorted automatic thought of "mind-reading". Other depressive-type ideas correspond to distorted automatic thoughts of personalization, over-generalization, elective abstraction, and dichotomous thinking (black or white). In the case of manic episodes, automatic thoughts are cognitively distorted in the same way, but with a positive slant. For example, if a euphoric patient believes that everyone considers them a genius, the corresponding cognitive distortion would be "fortune-telling" or "over-generalization".¹² Just as with emotions, automatic thoughts can also influence behavior. For example, during a depressive episode, a patient will avoid situations of conflict, rejection, and failure, trying to conserve their energy and give up before losing, all according to cognitively distorted automatic thoughts towards the negative.¹²

Treatment plan

The general treatment plan for bipolar disorder type I includes: initial assessment, interview with the family and others close to the patient, explaining to the patient the treatment process and the proper intervention and management of depressive symptoms (reducing desperation, monitoring emotions, behavioral activation, determining and modifying cognitive distortions and protection "inoculation or vaccination" against future depressive thoughts). Adherence to and compliance with treatment should also be fostered. Behavioral strategies follow two fundamental courses: 1) add positive behaviors and 2) to ensure that things go well, you must first ensure they do not get worse. To achieve this, it is recommended that the patient's level of activity be increased, firstly by doing what they can or must do, without forcing them and avoiding guilt due to inertia, and later moving on to assigning them progressively greater tasks.¹³ It is worth starting with lists A and B. List A includes things that need to be done every day; list B includes activities that are not a priority. Factors that could worsen the depression should be corrected or avoided; for example, the absence of enjoyable activities, lack of contact with people who care about the patient, exposure to negative stimuli such as sad films, music, and bad news reports, socializing with other depressed people or with those who make critical or unpleasant comments, and listening to economic problems. It is also vital to re-establish a sleep pattern (eight hours of sleep and not staying up).¹³

Usefulness of cognitive behavioral therapy (CBT): empirical evidence

Adherence to treatment. Cochran was the first to determine that CBT was necessary to increase adherence to and com-

pliance with treatment with lithium: 38 patients had stable lithium levels over the three and six months of external follow-up appointments.¹⁶

Further to its effect on adherence to treatment and the prophylactic effect, does CBT have an anti-depressive effect? In a study of patients with frequent relapses despite appropriate prophylactic treatment (confirmed through analysis of serum levels), it was observed that the addition of CBT made relapses less frequent. In the first six months of the study, patients who continued with just pharmacological treatment relapsed in 50% of cases, and over a year, in up to 75%. Conversely, in the case of patients who also received CBT, relapses occurred in 28.3% in the first six months, and in 43.8% over the year. The beneficial effects of CBT on depressive symptoms was observed in 56% of patients who started with mild to moderate depression (Beck's Depression Inventory, BDI, score of 10 to 18) and moderate depression (BDI score of 19 to 29). The number of depressive relapses fell from 52.1% to 20.8%, with the same effect on manic episodes (from 31.3% to 16.7%). No patient in treatment with CBT required hospitalization for depressive episodes in comparison with the 12.5% of those treated with just medication. Although 14.4% required hospitalization despite CBT due to a manic episode, of those who did not receive it, 25% had to be admitted. Depressive episodes were also shorter; in patients with CBT, their average duration was 15.1 days in comparison with almost 58 days' duration of episodes in patients who only received medication treatment. Finally, patients with CBT had greater adherence to and compliance with pharmacological treatment and improvement in psychosocial functioning.¹⁷ The CBT consisted of 14 sessions in the first six months, plus two sessions during the second six months. Further to the habitual focus (monitoring, examining, and changing dysfunctional thoughts and behaviors associated to undesirable states of mood), regulation (establishing a daily routine, including sleep) and monitoring (managing prodromal symptoms) were added. Some 30 months into the study, although relapses were frequent, the addition of CBT had a protecting effect against affective episodes in general (84.3% vs. 63.8%) manic/hypomanic episodes (67.4% vs. 50%) and depressive episodes (66.7% vs. 38.6%). The risk reduction is approximately 50% for episodes in general and 38% for depressive episodes. Apparently, considering the previous number of depressive episodes and compliance with therapy, it did not have a significant effect (*hazard ratio*) on relapse in manic/hypomanic episodes. The protecting effect is significant during the first years, but over time it is lost. Conversely, the reduction over time in the duration of episodes in general and depression in particular, but not for mania/hypomania, persists beyond the first year and continues for up to the 30 months that the study lasted.¹⁸ The effect of CBT is also persistent in inter-episodic state of mood, psychosocial functioning, the ability to deal with prodromal symptoms in affective episodes, and management of dysfunctional cognitions.

Is CBT useful for all patients? In a study on less select patients (30% had substance abuse, had 20 to 30 affective episodes throughout their life, or had an affective episode at the time), the results were not as encouraging.¹⁹ In this study, the objectives of CBT, although explicit, were met in 60% (achieve the acceptance of diagnosis and the need for treatment, reduce daily cognitive affective symptomatology; recognize and manage psychosocial stressors and interpersonal problems; identify and modify automatic thoughts, maladaptive assumptions, and underlying beliefs; teach cognitive strategies to deal with depression; improve compliance with medication treatment; teach early recognition of recurring symptoms and techniques to deal with them). Based on these results, the authors propose that CBT is less effective for patients with recurring episodes (more than 12 episodes throughout their life) and recommend adding CBT to pharmacological treatment for patients who are in the early stages of bipolar disorder.¹⁹

Does the increase in adherence to and compliance with therapy explain CBT's usefulness?

In a year-long study in which compliance with treatment reached 90%, it was observed that patients treated with the addition of CBT: 1) tended to have fewer depressive symptoms, 2) had the dosage of administered antidepressants lowered by treating doctors in 80% of cases, 3) had less than 50% of days with depressive symptoms during the month, and 4) had the effects of CBT extended by six months after having it administered.²⁰

Is CBT as useful as other psychotherapies for treating depression in bipolar disorder type I?

In the framework of the Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD) of the US National Institute of Mental Health, the usefulness of CBT, focused family therapy, and interpersonal and social rhythm psychotherapy were established, comparing this with so-called collaborative care. The psychotherapies consisted of 30 sessions over nine months; collaborative care, a minimal psychosocial intervention, consisted of a brief version of the most commonly used psychosocial strategies for bipolar disorder administered in three sessions over six months. The four maneuvers included psycho-education, plans to prevent relapses, and interventions for managing the illness. CBT consisted of: 1) psycho-education around the course of bipolar disorder, adherence to treatment, and stress management, 2) a daily diary to avoid inactivity and reduce over-stimulation, 3) cognitive restructuring, 4) training in problem resolution, 5) strategies for the detection and early intervention of affective episodes, and 6) selective interac-

tions for the management of comorbidity. The first sessions monitored activity and questioned negative thoughts, and later sessions questioned dysfunctional beliefs.²¹ Depressed patients did not completely correspond to bipolar disorder type I, but 31% had bipolar disorder type II, almost 70% had had more than ten manic and ten depressive episodes throughout their life, and 29% had rapid cycling. Patients that received any of the mentioned psychotherapies recovered more frequently (64.4% *vs.* 51.5%) and in less time. Over a year, the patients recovered from the depressive episode whose average duration had been around 200 days from entering the study, with focused family therapy at 77%, interpersonal and social rhythm therapy at 64.5%, and CBT at 60%. Collaborative care only allowed for an improvement of 51.5%. The average recovery time was 103 days for the first, 127 days for the second, and 112 days for CBT. One important observation is that the patients who recovered corresponded to those who had close families and this was greater in the final months of the study.

The potency of various therapies using odds ratios was similar: focused family therapy: 1.6, interpersonal and social rhythm therapy: 1.61, and CBT: 1.55.²¹

Are there negative studies around the usefulness of CBT?

A German study that compared CBT with support therapy and followed patients over two years found that both therapies had a similar effect and that the recurrence of affective episodes occurred in both groups of patients around week 66, depressive episodes in week 87, and manic episodes a little before and after week 100. The sample had various treatments (lithium, valproate, carbamazepine, antidepressants, and antipsychotics) and at the start, around 30% just took antidepressants or no drugs. The groups were made up of just over 30 patients; further data was not given on CBT, nor on what the support therapy consisted of. Although it is a detail, in one of the figures that noted the episodes present throughout the study, the sum does not correspond to the groups of patients with CBT (total affective episodes 12, depressive episodes seven, and manic/hypomanic episodes ten), nor that of the support therapy (total affective episodes 20, depressive episodes 14, and manic/hypomanic episodes eight). Neither was analysis made of whether the difference was significant in the number of relapses.²²

CONCLUSIONS

The adaptation of Beck's model for depression constitutes a theoretical framework that allows an understanding of depression within bipolar disorder and the reasons why the modification of cognitions and behaviors complements the effect of mood stabilizing drugs.

This work presented evidence around usefulness and the need to include within the scheme of therapy different psychotherapies as coadjuvants to treatment with mood stabilizers and other psycho-pharmaceuticals in the case of patients with a depressive episode due to bipolar disorder type I.

The addition of CBT reduces the number and duration of depressive episodes, residual or inter-episodic symptoms, and the need for hospitalization. Equally, it has a positive effect on psychosocial functioning. The interesting aspect of this finding is that the general effect lasts between six and 24 extra months after ending the cognitive intervention.

CBT is effective for recovered patients, those with sub-syndromatic symptoms, and those who have not had more than 12 affective episodes through the development of the condition. Obviously, its usefulness diminishes when there is greater comorbidity and chronicity.

However, it is necessary to consider that even with optimal treatments combining psychotherapy and pharmacotherapy, 50% to 75% of patients present relapses within a year.²³

The result of a meta-analysis of the use of CBT in bipolar disorder arrived at similar conclusions: "clear impact on symptoms and on the etiopathogenic mechanisms of CBT {...} A significant effect on therapeutic adherence, quality of life, and life/social adjustment {...} The usefulness of CBT during the first six months disappears after 12 months".²⁴

The findings described in this work indicate the need to maintain a scheme of medications with additional CBT in the long term – a logical proposal, considering that bipolar disorder type I persists throughout the life of the patient.

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