Cognitive behavioural case formulation in bipolar disorder

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# Abstract

Bipolar disorder has only recently been studied from a psychological perspective. There is now increasing evidence for the importance of cognitive behavioural therapy in improving functioning and reducing risk of relapse. This chapter briefly describes the rationale for a psychological approach to bipolar disorder before introducing a clinical heuristic as a context within which to appreciate the clinical examples and case formulations that follow. Key features of the assessment and therapy process with bipolar clients will be described. Targets for therapy include the stabilisation of routines and helping clients to deal more adaptively with mood fluctuations. Potential pitfalls in therapy are noted and possible solutions identified.

# Prevalence and severity

Bipolar disorder is a severe and chronic mental health problem characterized by recurrent episodes of depression and mania / hypomania. Lifetime prevalence estimates are 1.0% for bipolar disorder I and 1.1% bipolar disorder II (Merikangas et al., 2007). Bipolar disorder I involves periods of severe episodes of mania to depression. Bipolar disorder II involves a milder form of mood elevation (hypomania) with periods of severe depression.

Whilst bipolar disorder is sometimes associated with achievement and artistic creativity (Goodwin and Jamison, 2007; Murray and Johnson, 2010), it is often associated with considerable burden for individuals including elevated rates of anxiety, substance use, suicidality, disability and unemployment (Fajutrao et al., 2009). Bipolar disorder it is now placed within the top 20 most disabling illnesses in the world (Vos et al., 2012) and approximately 20-25 % of individuals will attempt suicide at some point in their lifetime (Merikangas et al., 2011). The estimated cost to the English economy is £5.2 billion per year (McCrone et al., 2008) and in the US Kleinman et al. (2003) estimated total annual costs were $US45.2 billion (1991 values). Bipolar disorder represents a considerable financial burden to society, with many individuals unable to work due to inadequate treatment.

It is only in the last 15-20 years that the importance of psychological, and particularly cognitive behavioural, treatment has been recognised for bipolar disorder (Lam et al., 2010; Basco and Rush, 2007; Johnson and Leahy, 2005; Newman et al., 2001). The assumption that bipolar disorder is primarily a genetic/biological illness, with a relatively benign presentation between episodes, had led to medication with lithium or a similar medication (Scott, 1995; Scott and Colom, 2005; Vieta and Colom, 2004) being seen as the mainstay of treatment for mood stabilization. Consistent with this approach there is clear evidence that Lithium is more effective than placebo in preventing relapse in bipolar disorder (Burgess et al., 2001) and that it is likely to be more effective than more recently investigated mood stabilisers such as carbamazepine and sodium valproate (Kessing et al., 2011; NICE, 2006).

However, medication is not adequate on its own, and lithium is not always beneficial for individuals with bipolar disorder (Goodwin, 2009; Geddes, 2004; Cipriani et al., 2005). A 1990 National Institute of Mental Health (NIMH) report noted that 40% of individuals treated with lithium did not experience a signiﬁcant improvement in clinical state or relapse risk (Prien and Potter, 1990). Furthermore, Denicoff et al. (1997) reported over 30% of patients stopped taking either lithium or carbamazepine within a year due to lack of efficacy. Other reports have concurred that many individuals with bipolar disorder continue to relapse despite prophylactic lithium treatment (Geddes et al., 2004; Burgess et al., 2001).

Since the publication of the NIMH report, which called for the development of eﬀective psychosocial interventions for the treatment of bipolar disorder (Prien and Potter, 1990), there has been rapid development of psychological treatment approaches for this disorder, as will be described below. The National Institute for Health and Care Excellence (NICE) Bipolar Disorder Guideline recommends that individual structured psychological treatment is offered to individuals with a diagnosis of bipolar disorder (NICE, 2006).

The growing recognition of the effectiveness of psychological therapies for bipolar disorder is also reflected in recent launch of the Improving Access to Psychological Therapies (IAPT) for Severe Mental Illness (SMI) project. IAPT-SMI aims to increase public access to a range of NICE approved psychological therapies for psychosis, bipolar disorder and personality disorders.

This chapter will brieﬂy describe the rationale for a psychological approach to bipolar disorder before introducing a clinical heuristic as a context within which to appreciate the clinical examples and case formulations that follow. Key features of the assessment and therapy process with bipolar clients will be described. Potential pitfalls in therapy will be noted and possible solutions identified.

# Stress-vulnerability issues

The stress-vulnerability approach to mental health problems assumes that the individual has an inherent vulnerability which is impacted upon by life events and other stressors. The extent of the vulnerability and the amount of stress interact to determine whether and when that individual experiences a period of illness. There is increasing evidence that psychological and social factors have an important impact on the onset and course of bipolar disorder. Numerous studies have now reported that life events are associated with onset, severity and duration of both manic and depressed episodes (Alloy et al., 2005; Johnson and Roberts 1995; Johnson and Miller, 1997). There is also evidence to suggest that stressful life events may be a consequence of bipolar disorder (Hosang et al., 2012), highlighting the importance of developing adaptive coping strategies in response to these events. Furthermore, studies of family atmosphere have indicated that relapses of manic and depressive symptoms are associated with high levels of expressed emotion (Butzlaﬀ and Hooley 1998; Rosenfarb et al., 2001).

In addition to psychosocial factors, there is evidence that bipolar episodes are also associated with disruptions of circadian functioning. Thus, sleep disruption has been noted as a factor in mania in particular (Leibenluft et al., 1996; Wehr et al., 1987), and numerous markers of circadian instability have been reported for individuals with bipolar disorder during episodes (Millar et al., 2004; Teicher 1995; Wolﬀ et al., 1985). There is also evidence that circadian disturbances are present outside periods of acute mood disturbance. Sleep circadian activity disruption has been observed in individuals who are remitted (Jones et al., 2005; Millar et al., 2004; Harvey at al., 2005) and individuals at risk for developing bipolar disorder (Jones et al., 2006; Ankers and Jones, 2009). Additionally, research highlights the importance of cognitive styles in bipolar disorder which can exacerbate the initial disruptions caused by life events or circadian disturbance (Jones et al., 2006; Johnson and Jones 2009). Alloy et al. (2005) suggest that the cognitive styles of individuals with bipolar disorder are distinguished by features which are characteristic of high Behavioural Activation System (BAS) sensitivity, including increased goal striving, perfectionism, self-criticism and autonomy. Jones (2001) further suggests that self-dispositional appraisals of circadian disturbance can exacerbate initial symptoms of both mania and depression (discussed further below).

# An instability heuristic for understanding bipolar disorder

Instability has long been proposed as a key feature of bipolar disorder (Goodwin and Jamison, 2007). For the purposes of developing psychological treatment approaches, the issue of instability has been integrated into relatively simple vulnerability-stress models (e.g., Figure 9.1; Lam et al., 2010). This indicates that social routine, sleep and life events interact with biological vulnerability to cause circadian disruption. These in combination then trigger the early warning sign stage. The manner in which the individual deals with this early warning sign stage, whether or not an intervention is put in place, is a key determinant of whether or not an episode develops. The early warning sign stage can develop into a full blown episode or an individual can revert back to more stable mood, dependent on the person’s coping strategies.

<Figure 9.1 here>

This model has been extended to consider more closely how the disruption of circadian functioning might lead to the observed symptoms of bipolar disorder (Jones, 2001). This extended model integrates circadian approaches with a multilevel model of emotion, based on the SPAARS (Schematic Propositional Associative and Analogical Representation Systems) model (Power and Dalgleish, 1997). A particular feature of this approach is that it suggests that the individual’s interpretation of circadian disruption, as much as the disruption itself, may be crucial in the development of episodes of mania and depression. Circadian rhythms are indicated by patterns of behavioural and physiological activity that cycle over an approximately 24-hour light/dark period. Disruption of such rhythms is deemed to occur when these patterns become less strongly entrained to the 24-hour period. When such disturbances of circadian functioning occur the individual will initially tend to experience dysphoria, fatigue and possibly problems with attention and concentration. These are commonly recognised as features of jet-lag following travel across diﬀerent time zones. When circadian rhythm disruption is more severe the individual can experience feelings of increased arousal, energy and alertness. Under normal circumstances changes of this type would be expected to be self-correcting. However, when the individual tends to make stable internal attributions for the initial physiological changes associated with circadian disruption there is a risk of early warning signs exacerbating. Speciﬁcally, there will be an increased tendency to engage with the initial changes in mood and behaviour and therefore increase the impact of the initial disruption.

A multilevel model of emotion also encompasses other important clinical features of bipolar disorder. First, it identiﬁes that there is more than one route to mood change. Thus, although cognition plays an important role, it is not the sole determinant of mood change. Another important route highlighted in SPAARS is associative. This level of processing is accessed by experience and salience rather than language. As this level is directly related to emotional outputs, it is likely to have a powerful eﬀect on emotion.

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A multilevel model is also important as it captures the conﬂicting emotions which are a key feature of bipolar disorder – often the combination of ‘feeling’ something is right and ‘knowing’ something is wrong. A heuristic to summarise the potential relevance of this approach in clinical terms is described in Figure 9.2. This indicates that the ways in which the individual with bipolar disorder responds to and interprets instability is crucial. A relationship is proposed between this process and a number of psychological and social factors associated with the disorder, all of which are based on available research evidence. The heuristic suggests that sensitivity to circadian disruption is associated with frequent physiological ﬂuctuation, which is in itself associated initially with dysphoric mood. A further proposal is that internal attributions are made for the instability caused by these ﬂuctuations (Jones et al., 2006; Anker and Jones, 2006). This could be seen as leaving the person in a situation of uncertainty, both with respect to mood and physiology, and hence struggling to evaluate situations objectively. More speciﬁcally, the heuristic proposes speciﬁc reactions which have been noted clinically and for which some research evidence exists.

Two coping styles are indicated in response to this instability:

1. An avoidant coping style, in which initial changes are ignored or colluded with until mood change is too signiﬁcant to avoid and most likely to be associated with mania. This is consistent with research into early warning signs (Lam and Wong 1997; Lam et al., 2001) which reported substantial variability in individuals’ responses to early signs of mood change, including responses which could be deﬁned as avoidant. This avoidant pattern has also been confirmed in studies of response styles in both high risk and bipolar groups ([Thomas and Bentall, 2002; Thomas et al., 2007)](http://www.sciencedirect.com/science/article/pii/S0165032706004563#bib40).
2. There is evidence for the contrasting ruminative style in aﬀective disorders in general (Nolen-Hoeksema, 1991, 2000) and also in healthy but high risk individuals more strongly associated with depression (Thomas and Bentall, 2002). Furthermore, studies demonstrate that individuals with bipolar disorder ruminate in response to negative affect in depressive states (Johnson et al., 2008; Van der Gucht et al., 2009).

The pattern of uncertainty referred to above can be expected to impact on the processing of both social and non-social information. The former is indicated by evidence of social cognition deﬁcits in bipolar individuals (Scott and Pope, 2003; Scott et al., 2000; Donohoe et al., 2012), while other researchers have identiﬁed deﬁcits in information processing (Green et al., 1994; Neuchterlein et al., 1991; Serper, 1993). Instability, dysphoria and social cognition deﬁcits would also be consistent with research ﬁndings which indicate vulnerability to family atmosphere, speciﬁcally high expressed emotion (Miklowitz et al., 1988; Hooley et al., 2007). This suggests, then, that the bipolar individual is presented with demands associated with an unpredictable environment, an unstable internal environment, fragile self-esteem, ready distraction from focal tasks and vulnerability to exacerbations of early mood change. This indicates the importance of a comprehensive approach to bipolar disorder which seeks to address both instability itself and also responses to this through work on thoughts, assumptions and coping strategies.

**How does treating bipolar disorder differ from other disorders?**

For most disorders the rationale for therapy is self-evident to the client. A person who is depressed, anxious or worried will normally request therapeutic help to remove the core symptoms of their conditions which are interfering with their lives. Many bipolar clients will enter therapy when either remitted or mildly depressed. They will often say that they wish to have help with improving their mood and may well also want to avoid having episodes which lead to hospitalisation. However, as Post et al. (2003) among others has demonstrated, the majority of people with bipolar disorder spend relatively short periods in mania (compared with depression) during their illness course. Similarly, in a study of 146 individuals with bipolar I disorder, Judd et al. (2002) found that participants showed depressive symptoms 31.9% of the weeks throughout an average of 12.8 years, compared to 8.9% of weeks spent in mania or hypomania. Many clients wish not only to address depression but also to achieve stable hypomania which does not tip into mania. This is understandable since many clients’ may have experienced positive aspects of their mood experiences, which they do not want to lose such as increased energy, optimism, creativity , sociability, faster thinking and often objective improvement in functioning in the initial stages of hypomania (Murray and Johnson, 2010; Lobban et al., 2012). Unfortunately, such mood states are often associated with an ascent into mania with significant consequences to work, family and social life both at the time and once mood has stabilised. Until this pattern is clear to the individual client, it is reasonable to expect ambivalence towards therapy. It is therefore crucial that the therapist is open to the client’s perspective regarding their mood experiences and that the therapy makes sense in terms of this, weighing up both the costs and benefits of elevated mood.

Ambivalence towards treatment is common for people with bipolar disorder (Leahy, 2007). It has been argued that this should be recognised as important information to integrate into therapy rather than being dismissed as unhelpful resistance to therapeutic suggestions. As Lobban et al. (2012) reported, some people highly valued their bipolar experiences across elevated, depressed and euthymic mood states and were resistant to the idea of losing these. Recently Liebert (2013) critically reviewed the stance that ambivalence is a barrier to treatment adherence, arguing that instead, clinicians should regard ambivalence as a source of insight and expertise to help identify the client’s diagnostic and treatment preferences.

## Diagnosis

Understanding the client’s route to diagnosis is important to take into account when first working with bipolar individuals. The average duration from onset to correct diagnosis is over 10 years (Hirschfield et al., 2003; Russell and Browne, 2005). A missed diagnosis can lead to serious consequences and the client may have spent long periods of time receiving inadequate and poor quality care. This may have fostered mistrust in services, and work may be needed to rebuild this trust. Exploring the meaning of the client’s diagnosis is also an important factor. Diagnosis may be helpful for some individuals to explain and validate their mood experiences. However, for others it may have encompassed a loss of identity and stigma, resulting in a damaging experience. The therapeutic approaches here are applicable to mood instability and do not require that the client specifically endorse a bipolar diagnosis for them to be clinically beneficial.

## Flexibility

As mentioned above, there may be many individuals whose approach to psychological and psychiatric intervention is ambivalent. Studies of cognitive style in individuals meeting criteria for bipolar disorder indicate the importance of autonomy and achievement. In therapy this can translate to a desire to retain control of the therapeutic encounter and to focus on personally relevant issues, which may or may not appear to be directly relevant to clinically defined problems.

Maintaining a flexible approach to therapy is crucial for working with individuals with bipolar disorder. At times, engagement may be challenging. This may be due to prior negative experiences of services or residual psychotic symptoms. In other cases it may be due to low mood and associated motivational difficulties or conversely subsyndromal mood elevations. Some clients will attend therapy ready to engage in approaches to address their difficulties, however for others patterns of alliance and motivation will fluctuate in tandem with their mood state. Their individual preferences may well vary over time, there may be weeks when they are fully engaged in homework tasks and then the following session appear to have lost all interest.

# Research evidence for CBT

Research has focused primarily on relapse prevention in individuals with an established course of bipolar disorder who enter therapy whilst euthymic. The most effective versions of CBT seem to be individual interventions focussed on providing a comprehensive approach to understanding and coping effectively with mood fluctuation. A number of randomised controlled trials of individual CBT have been published (Perry et al., 1999; Lam et al., 2000, 2003, 2005; Zaretsky et al., 1999; Scott el al., 2001; Ball et al., 2006; Miklowitz et al, 2007; Meyer and Hautzinger, 2012). In all the studies reported, psychological interventions have been delivered in conjunction with pharmacotherapy.

To date traditional CBT has been most effective in reducing depressive symptoms and preventing episodes in participants out of an acute episode (Lam et al., 2010). Structured psychological therapies are now recommended in the NICE guidelines for bipolar disorders (for reviews see Jones, 2004; Morriss et al., 2007; Miklowitz, 2008).

## Recovery focused CBT

The studies described above have primarily focussed on CBT and psychoeducational approaches designed to reduce relapse risk but with little explicit focus on functional outcomes including personal recovery. This is a limitation as recovery informed interventions are now recommended by the UK government (Department of Health, 2009, 2011). An RCT study from our group is in the process of evaluating a recovery focused CBT intervention (RfCBT) with a particular emphasis on individualised functional or symptomatic goals rather than primarily relapse prevention for individuals with early bipolar disorder (Jones et al., 2012)

# Therapy structure

Cognitive therapy extends from 16–24 sessions over a period of approximately six months to accommodate its clinical complexity and to offer the clinician the opportunity to help the client apply skills learnt across diﬀerent mood states. Cognitive therapy is usually oﬀered as an addition to psychopharmacological interventions, but it is not a ‘medication compliance’ intervention. The importance of developing greater stability in terms of both mood and activity may appear self-evident to the therapist at an early stage in therapy, but this will often not be a view shared by the client. Therapists need to be aware that their “sensible” therapeutic suggestions can readily be viewed by clients as seeking merely to reduce their freedom and spontaneity. As indicated below, the time taken to ensure that client and therapist have a shared rationale for change will be crucial for both engagement and eﬀective clinical and functional outcomes.

# General treatment strategy

There are many components to the formulation-driven cognitive behavioural treatment of bipolar disorder. In summarising a general treatment strategy, however, there are essentially four key areas:

1 Psycho-educational model: Clients are provided with information about a vulnerability-stress approach to bipolar experiences.

2 Cognitive behavioural skills to cope with early warning signs: Clients identify changes in mood and behaviour which represent early warning signs for depression or mania. Once such signs are identiﬁed the client and therapist develop a programme of strategies to intervene to prevent progression into full clinical episodes.

3 Importance of routine and sleep: It is an important aspect of therapy to work with the client to improve stability in both of these areas where necessary .

4 Dealing with long-term vulnerabilities: Particular themes for bipolar clients include a high need for autonomy and extreme achievement-driven behaviour. Later sessions can be used to explore these issues and to test out less rigid beliefs.

The majority of clients will enter therapy in remission or suﬀering from subsyndromal symptoms. The basic structure above will apply to clients of this type. The evidence base for cognitive therapy for clients who are acutely ill at entry into therapy is limited. It appears that acute depression responds well to cognitive behavioural therapy (Zaretsky et al., 1999; Miklowitz et al., 2007). Virgil et al.’s (2010) review provides evidence from existing trials that supports a small but significant impact on manic symptoms (even though the studies were not designed to address this). There is a need for research studies that specifically target individuals during the acute stages of mania. However, the instability inherent in bipolar disorder means that most clients will experience signiﬁcant changes in mood state during intervention. When it is clear that mood is heading towards depression or mania, then treatment priorities will be diﬀerent. If the client does experience an exacerbation of symptoms during therapy, the utilisation of effective coping strategies during this early warning sign stage can be a useful way to consolidate treatment.

# Assessment and formulation

Given the complexity of bipolar disorder, a number of factors need to be borne in mind during the initial assessment and engagement process. First, the assessment (and subsequent therapy) must be carried out in a spirit of guided discovery. It is also important to collaborate in identifying therapy goals, while also respecting the client’s need for autonomy. Beck (1983) proposed that bipolar disorder might be characterised by oscillations between sociotropy and autonomy as people move from depressed to manic states. Clinically, however, the autonomy element appears to predominate in the remitted phase of the illness (Lam et al., 2010).

Research has also reported that elevated behavioural activation system activity is found in both bipolar individuals and those at high risk (Alloy et al., 2008; Urosevic et al, 2008; Johnson, 2005). These ﬁndings concur with clinical observations reported elsewhere (Lam et al., 2010) that many individuals with bipolar disorder presenting for treatment aspire to an autonomous, perfectionistic, striving approach to life. Such individuals therefore need to establish that important issues for therapy come from their own experience and make sense in terms of their own priorities. Our clinical experience indicates that the presence of any sort of didactic approach early in therapy will lead to failure to engage.

A clinical example will illustrate some of the features typical of many individuals with bipolar disorder (Box 9.1).

<Box 9.1 here>

For many people with bipolar disorder, it will often be the ﬁrst time that they have managed to develop an integrated, chronological account of their experiences. Many patients recall events with regard to illness history in terms of their emotional salience. Although this makes some sense in psychological terms it can often leave the individual with vivid memories of apparently unconnected intense experiences. This process can then serve to reinforce their perception of life as being chaotic and of illness episodes as coming ‘out of the blue’.

The development of a life chart can provide a useful summary of key episodes. They can help the individual to look for patterns of illness, stresses, occupational and educational achievements. An initial life chart for Laura is presented below. This illustrates how mood variability was a characteristic prior to the onset of her first manic episode. It also indicates how mood ﬂuctuation appears to be associated with relationship issues, and success and failure experiences.

<Figure 9.3 here>

Additional formal assessment measures are often helpful to provide information on the following areas:

Current mood state

* Beck Depression Inventory (Second Edition; BDI-II; Beck et al., 1996)
* The Altman Self Rating Mania Scale (ASRM; Altman et al., 1997)
* The Beck Hopelessness Scale (BHS; Beck and Steer, 1988)

Bipolar symptomatology

* The Internal States Scale (ISS; Bauer et al., 2000)

Cognitive style

* The Hypomania Interpretations Questionnaire (HIQ; Jones et al., 2006

Recovery

* The Bipolar Recovery Questionnaire (BRQ; Jones et al., 2013)

Quality of life

* The Brief Quality of Life in Bipolar Disorder (QoL.BD; Michalak and Murray, 2010)

Early Warning signs and coping skills

* Early Warning Signs Checklists (Lobban et al., 2011)
* The Coping with Prodromes Interview (Lam et al., 2001)

A small battery of tests can usefully be employed at the beginning and end of therapy. These would normally include the BRQ, QoLBD and the BHS. The BDI and ISS may be employed on a sessional basis to obtain crucial clinical information in an eﬃcient manner.

Information from symptom and life histories and formal measures will form the basis for working with clients to develop both a goal list and an initial formulation. Many clients will generate a goal list which includes a combination of functional and symptom-related goals.

The process of generating the formulation provides the clinician with the opportunity to work with the client to identify relationships between both functional and symptom issues, which leads to enhanced engagement. The formulation is also used to individualise the treatment protocol and to assess the relative importance of the diﬀerent elements that it might contain. At times, presenting large, detailed formulations can feel overwhelming for the client. In this case, it can be helpful to begin with simple maintenance formulations that can be elaborated as the therapy progresses as proposed by Kinderman and Lobban (2000).

A simple formulation was developed for Laura (see Figure 9.4a), based on the vulnerability-stress model (Lam et al., 2010) presented at the beginning of the chapter (see Figure 9.1). This formulation is based on the manic episode experienced before meeting her husband John. Laura had started a new job and keen to impress, had taken on additional responsibilities. In order to complete these extra tasks she often stayed late at work and had also began socialising with new work colleagues. The combination of a marked change in social and sleep routine, interacting with her underlying biological vulnerability (to cause circadian disruption), triggered the early warning sign stage. As Laura was unaware that she was experiencing a change in her mood, she continued to engage in activities which further disrupted her sleep, social and work routine, leading to a full blown manic episode. A formulation of this type allows the individual to see how successful intervention during the early warning sign stage can prevent the escalation of a full blown episode.

<Figure 9.4a here>

Generating a formulation can sometimes have a negative as well as a positive effect on clients. Highlighting the significant negative features of a person’s life can serve to confirm beliefs about their ‘flawed’ character rather than motivate change. It is important to identify examples of positive coping where possible so that positive formulations can be presented alongside problem formulations. This balanced approach can greatly enhance clients’ engagement and also their motivation for change as they are being provided with evidence from their own lives that such change is within their grasp. In the case of Laura, it was important to identify times in the past when she had coped in a positive way in response to her mood fluctuations. This information should be included in the formulation (see Figure 9.4b).

<Figure 9.4b here>

# Key features of intervention

As noted above, CBT for bipolar disorder is best delivered on the basis of an individual formulation. However, the research conducted to date has indicated that a number of features of therapy are likely to be important in reducing instability and relapse risk. These are outlined below.

## Initial sessions

### Information/development of therapeutic alliance

This provides the client with an introduction to a diathesis-stress model of bipolar disorder, often of the type outlined above (Lam et al., 2010). The role of thoughts and behaviour will be introduced at this stage and referred to throughout the therapy.

Individual symptom history will also be collected during initial sessions and the importance of early signs highlighted with respect to previous episodes. This then forms the basis for work in later sessions on identifying early warning signs for relapse prevention. Another important aspect of early sessions is normalisation. Many individuals see themselves as having a fundamental ﬂaw which separates them from ‘normal’ people. Clearly this can impede therapy and needs to be challenged at an early stage. The process of anchoring episodes in social and psychological contexts can be very important in this process. Additionally, identiﬁcation of the experiences of others and the prevalence of mood episodes in the general population can also be relevant to this process.

### Socialising to therapy/goal setting

As noted above, goals need to be individualised to the client. Laura’s goals were both functional (she wanted to build up a social life, apply for a different job and for her husband to have more understanding of her condition) and symptom-focussed (self-manage mood fluctuations). However, these initial goals were very broad.

Once the life and symptom history information is agreed, it is then helpful to try to work with the client to elaborate and clarify their goals for therapy. In Laura’s case this involved working through each goal and setting realistic targets. She wanted to build up a social life but wasn’t sure how to approach this. We brainstormed a number of ideas and she decided that she wanted to join some local community groups where she would hopefully meet people with similar interests. Laura wanted to apply for a different job and this transpired as wanting more responsibility. We spent time thinking through the options and then the steps involved in finding a new role. Laura also wanted her husband to have more insight into her condition. This involved him understanding the patterns of her episodes and not over-reacting to small shifts in her mood. We decided it would be a good idea for him to attend a few sessions toward the end when we developed a relapse prevention plan.

## Intermediate sessions

Cognitive techniques are taught, discussed and applied during this stage of therapy.

### Mood Monitoring

For individuals with bipolar disorder, mood fluctuations have often previously been associated with distress. Therefore people can become anxious and fearful in relation to what would be typically considered as normal mood fluctuation. As a result, individuals may present at therapy with fairly rigid and unrealistic views regarding their mood fluctuations which can often be reinforcing their difficulties. It can be helpful at the beginning of each session to ask them to rate their mood on a -10 to +10 scale. On this scale +10 marks the most extreme positive mood ever experienced and −10 the most extreme low mood. A range of −5 to +5 is assumed to indicate the region within which normal ﬂuctuations of mood occur.

In the case of Laura before we were able to engage in her functional related goals, we spent time exploring her mood states. Each session I asked Laura to rate her mood on a Likert scale ranging from -10 to +10. At the beginning of therapy Laura was adamant that her rating ‘should’ always be 0, however it was often between -5 and +5, which would leave her feeling fearful that her mood may escalate. As a result Laura had restricted her activities and treated any fluctuation in mood as pathological. We spent time understanding her mood fluctuations with the view that it would be impossible and unhealthy for anyone’s mood to remain at 0 consistently. Laura needed to discover where she felt comfortable on the scale and in time that would build her confidence in her ability to self-manage her mood fluctuations. Over time we mapped out Laura’s mood on the scale and identified her idiosyncratic early warning signs that were associated with her ratings, see Figure 9.5. This was then used later on in our relapse prevention sessions to help develop a set of coping strategies. The shaded areas demonstrate where Laura felt she needed to take action.

As Laura began to feel more confident in the management of her mood we were able to develop a plan where she felt supported to achieve her long-term goals.

<Figure 9.5 here>

### Understanding the relationship between mood and activity

The National Institute for Clinical Excellence Clinical Guidelines for Bipolar Disorder and the American Psychiatric Association Practice Guideline for the Treatment of Patients with Bipolar Disorder (APA, 2002; NICE, 2006) both recommend regular social and sleep routine as part of promotion of a healthy lifestyle. The completion of mood and activity sheets is a key feature of cognitive therapy with individuals with bipolar disorder. This will often begin early in therapy and continue throughout the active intervention. Many clients, although clearly very intelligent individuals, will struggle to appreciate the connections between what they do, the experiences they have and their mood. This ﬁts with the heuristic outlined above, in which an internal attribution bias is proposed. If individuals are attributing change to features of themselves, they will not be alert to other possible explanations of mood change. It is therefore important that the therapist employs a repeated approach to guided discovery of mood–activity relationships. Single demonstrations of such patterns will be insuﬃcient.

The forms used are adapted from standard activity scheduling forms. They diﬀer in two main respects: First, they make provision for the recording of activity throughout a 24-hour period rather than assuming that people will be active during the day and asleep at night; second, clients record a summary assessment of mood for each day. This is rated on a −10 to +10 scale (see mood monitoring for explanation of scale). See Figure 6 for an example of the times between 6pm and 6am.

<Box 9.2 here>

### Challenging positive thoughts

The issue of addressing negative thinking and beliefs has been dealt with extensively elsewhere. Most bipolar individuals, even when euthymic, will present at times with patterns of negative thinking which can be addressed in the normal way, through thought records and evidence gathering. A more complex problem can be that of dealing with positive thoughts.

In the ﬁrst instance the clinician needs to have a picture of when positive thoughts are associated with mood elevation and when they are merely a function of good mood. This is best done proactively when the client is not in a period of elevated mood. Reviewing periods of mood elevation, it is possible to encourage the client to identify retrospectively the thoughts associated with these periods and to use evidence to challenge them. This process can also be used to work with the client to identify the diﬀerences between thoughts during these periods and normally positive thoughts. Hypomanic positive thoughts are usually characterised by their rigidity and lack of relationship to external inputs – the evidence base for such thoughts is usually the individual’s feelings rather than concrete outcomes or feedback from others. It is also usual in this process to work out with the client at what level of mood elevation these thoughts would normally occur. This can then lead to a joint agreement between therapist and client to use challenges developed by the client when and if such thoughts recur. The client can be asked to give advance permission for the therapist or a trusted relative to raise this matter if mood change above the speciﬁed threshold occurs. The important issue is that the client’s own words with respect to these thoughts are used at that point rather than those of the therapist or worried relatives.

### Working with unrealistic positive ideas

Sometimes positive thoughts and associated mood elevation occur before it has been possible to identify strategies for challenging these. During periods of elevated mood people can over-estimate their personal abilities and attributes, become very optimistic about the world and find it hard to conceive of any negative consequences for their actions. This has traditionally been referred to as ‘grandiose’, however, we feel that this has acquired some negative connotations, therefore we will refer instead to unrealistically positive ideas.

### Reframing

One way of managing unrealistically positive ideas is to help clients reframe them as indicators of elevating mood. This can be a difficult task to perform ‘in the moment’, therefore it can often be helpful to ask the client to practice this retrospectively when they have a relatively stable mood. The therapist should ask the client to recall a recent episode of mania or hypomania. Using careful questioning, the therapist should elicit any changes in thinking which occurred before the unrealistic positive thoughts, the content of the unrealistic positive thoughts and the consequences of these.

The client is then asked to evaluate whether these thoughts were a good idea and reframe any subsequent ideas as indicators of elevating mood, termed as early warning signs and a decision should be made regarding how they would like to respond to these in the future. It is important to differentiate between ideas that are inherently unrealistic e.g., ‘I want to be a platinum selling pop star’ and positive thoughts that are unrealistic within the current context when perhaps the client is still unwell and has little financial support, e.g., ‘I want to open a new restaurant within the next six months’. The latter may (or may not) be positive or realistic when the client is more stable, therefore it is important that the therapist does not inadvertently give the message that all positive planning should be banned.

### Delaying tactic

Another strategy for managing unrealistically positive ideas is to set up mechanisms which allow clients to delay acting on these ideas for a certain period of time. This was initially proposed by Basco and Rush (1996), and has proved to be an eﬀective intervention. Time delay rules can be set up where the client agrees to not act upon ideas when they are in either an elevating or high mood. During the ‘delay’ period the client can utilise a range of cognitive strategies to enable them to step back and evaluate their ideas in more detail.

It can often be helpful to develop a set of pre-defined questions where the client can ask themselves to assess why delaying may be a good idea and the quality of the idea itself. The questions should use the clients own words as far as possible as they have a much higher chance of resonating when they are in an elevated mood and perhaps reluctant to hear another point of view. The questions should be highly personally relevant and based on past experiences e.g., ‘remember how gutted you were when you maxed out your credit card on X? You can spend your money on Y next week when you get paid, but you can’t get your money back on your credit card once you’ve spent it , worn the clothes and then changed your mind?’

Examples of the types of questions it can be helpful for clients to ask themselves are as follows:

* Would you lose anything by delaying?
* Could you gain anything from waiting?
* What would your friend / partner say?
* What would you say to your friend / partner if they had this idea?
* What would it be useful to do before taking action to make sure you are making the right decision?

A key advantage of such a rule is that there is no presumption that the clinician knows best. If the idea is a actually a good one by engaging with this process people can prove it to those around them

## Final sessions

### Coping with early warning signs

Early warning signs (previously termed as ‘prodromes’) are early signs of mood episodes, not symptoms of being in a full episode. A prodrome has been defined as the interval from ﬁrst recognition of symptoms to the time of maximum symptom severity (Molnar et al., 1988), which in a vulnerability-stress model of bipolar disorder is when an important opportunity for relapse prevention occurs.

By this phase of therapy, the client will have skills in identifying mood ﬂuctuations and relating these to behaviours and thoughts, including examples where early warning signs have been experienced. They will also normally have some experience of the impact that they can have on their mood with changes which they make in thinking or in activity. This is therefore the appropriate stage at which to bring together all this information with the client to identify early warning signs for both mania and depression. In general, individuals tend to ﬁnd that mania signs are easier to identify, as many of the symptoms are clearer changes from ‘normal’ functioning.

### Identifying early, middle and late early warning signs

Helping the client to detect early warning signs is best done with open-ended questioning to elicit both symptoms and the idiosyncratic responses which the individual associates with mood change. It is crucial that the client brainstorms as many signs as possible. It is helpful to prompt the client to consider mood, behaviour and thoughts when considering signs of mood change. It is also important that such changes are anchored in the social context: Issues concerned with social interaction and also the responses of others should be considered. Often the early warning signs reported will be a combination of changes which the client picks up and those which are reported to them by trusted friends or relatives.

Some clients may struggle to identify idiosyncratic signs, in this case there are a number of lists of commonly endorsed signs that can be used as a starting point (e.g., Smith and Tarrer, 1992; Lobban et al., 2011). Once a list of early warning signs has been identiﬁed then the card sort technique reported by Perry et al. (1999) is an eﬃcient method for organising early warning signs. Each symptom is written separately on a card. The client then sorts the cards into early and late symptoms, allocating middle stage symptoms by default. Once these stages have been identiﬁed the client then estimates the approximate duration of each stage. Once this has been agreed, an early warning signs list is drawn up.

Figure 9.7 shows Laura’s three stages for mania (early, middle and late signs). In her case, the entire period lasts approximately 10 days.

<Figure 9.7 here>

### Pairing early warning signs with coping skills

Once early, middle and late signs have been identiﬁed, the next task is to identify what coping approaches might best be applied at each stage. In doing this the therapist will review in some detail the coping approaches which the client has used in the past, as well as the skills developed during therapy. It is often the case that clients have previously addressed some early symptoms, but either have not systematised this response or have failed to employ it because the signiﬁcance of a particular symptom has been missed. When they are drawn together in this way it becomes more obvious why a coping response might be needed. It can be helpful here to ask the client to review previous early warning signs and to visualise how they think particular approaches might have impacted on their symptoms had they applied them.

When considering coping skills and early, middle and late signs, a crucial aspect of the rationale is to help the client to maintain choice and control. Many clients will have experienced these signs leading to episodes in which they have experienced admission to hospital, including involuntary admissions under the Mental Health Act. Even prior to this, many clients will recall having reached a stage when others were making decisions for them. This can be experienced as stressful and upsetting by the client, even if the actions were taken with the best of intentions. When the client understands that early detection of mood changes is associated with having choice and control over what happens, engagement with early warning sign work is enhanced

### Long-term issues

Final sessions should allow time to consider issues that are relevant to many people with a mental health history. Shame and guilt are commonly reported by individuals with bipolar disorder. Guilt is most common during the depressive and inter-episode phase of bipolar disorder and is commonly focused on actions that occurred during a manic episode. This can be related to behaviours engaged in when unwell, such as running up large debts or behaving in a sexually disinhibited manner. It can also be associated with having a label of mental illness and the reactions of others to this. Clinically, we have found that the process of working in a CBT manner with individuals is helpful in addressing some of these issues.

It can be helpful to review problem-solving approaches to the diﬀerent diﬃculties associated with their own experiences, to see these issues in a balanced way. The important work that Paul Gilbert (2009) has been doing with shame and self-criticism can also be useful when working with individuals with bipolar disorder. Stigma is another issue which can be helped by considering mental health problems from a CBT perspective. It cannot of course deal with the stigmatising beliefs of others, but can help individual clients to avoid adding to this problem by stigmatising themselves.

**Life span issues and bipolar disorder**

## The family and bipolar disorder

When engaging individuals with bipolar disorder in psychological therapy it is important to explore the role and context of the family. Research indicates that people in families with high expressed emotion attitudes (including criticism, hostility or emotional over-involvement) are 2-3 times more likely to relapse in the nine months post hospital admission than people in low expressed emotion families (Miklowtiz, 2004; 2007). In parallel, the caring role can place considerable pressure upon carers, with approximately 90% of family members reporting high levels of burden attributed to caring for someone with bipolar disorder (Perlick et al., 2007). This can impair their ability to care for the individual resulting in poorer clinical symptom and medication outcomes for service user and higher levels of burden and distress in the relative (Ostacher et al., 2008; Perlick et al., 2004). Research has demonstrated that family focused treatment can improve relapse rates for individuals with bipolar disorder (Miklowitz et al., 2003; Reinares et al., 2006). It can be helpful to ask a relative to attend one or more sessions which focus on the development of an early warning and coping plan. This will help the relative develop a better understanding of the client’s mood experiences and agreements can be put in place as to when they can become involved if they are worried that their mood is escalating.

## Older age and bipolar disorder

Bipolar disorder is present throughout adulthood (Goodwin and Jamison, 2007; Kennedy et al., 2005), however there is very little research or service development for older adults with BD (Charney et al., 2003). The NICE guidelines (2006) highlight significant limitations to the evidence base for the treatment of individuals with BD who are over the age of 65. However there is good evidence to suggest that cognitive therapy can be successfully adapted to meet the needs of older people with mental health problems. A Cochrane review (Wilson et al., 2008) supported the efficacy of CBT for depression in later life (Breckenridge, 1985; Scogin, 1987, 1989; Arean, 1993; Floyd, 1999). There is also an evidence base for the effectiveness of CBT in the treatment of anxiety disorders (Barrowclough et al., 2001; Stanley et al., 2003).

There is no reason to believe that the therapeutic approaches described throughout this chapter will not be effective for older individuals with BD. However, there are a number of issues that should be taken into consideration when working with individuals in the later stages of their life. There may be age-related changes in cognitions, such as a decline in working memory or cognitive speed and it is important that appropriate adaptations are made. This may include the way that the information is presented, slowing the pace of the sessions with frequent repetitions and summaries. Information may be presented both visually and orally and a trusted friend or relative may attend sessions so they are familiar with the CBT strategies. There are other common life stages that should be taken into account such as physical illness, retirement and job loss, loss of societal and financial status, and changes in interpersonal relationships due to illness or death (Sajovic, 2002).

# Conclusions

Bipolar disorder has only recently been studied from a psychological perspective. There is now increasing evidence for the importance of cognitive behavioural therapy in improving functioning and reducing risk of relapse. The adaptation of traditional CBT to target functional outcomes, including recovery (Jones et al., 2012) may offer promising results which corresponds with current UK government recommendations.

This chapter has identiﬁed a number of key aspects of cognitive therapy as applied to bipolar disorder. The targets of therapy include helping the client to stabilise routines and to deal more adaptively with mood fluctuations, although this is only eﬀective when the client is properly engaged. The likelihood of engagement is increased by taking the time to do a full psychological assessment, which includes developing a shared account of the client’s symptom and life history. This information is then configured into a formulation which is used to help guide therapy. Client and therapist work together to establish how making changes consistent with a CBT approach will help achieve important functional and symptom goals. The use of detailed mood and activity records is important in identifying mood variation and its relationship to external events. Identification of early warning signs and the development of coping strategies are important aspects of CBT for bipolar disorder and apply to both mania and depression. Successful completion of CBT will include work on longer-term issues which, if left untreated, might leave the client at risk of further relapse.

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