

Cognitive-Behavioral Therapy for the Bipolar Disorder Patients

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"When you are high, it is tremendous. Shyness goes, the right words and gestures are suddenly there, the power to seduce and captivate others a felt certainty. Feelings of ease, intensity, power, well-being, financial omnipotence and euphoria now pervade one's marrow. But somehow, this changes.

The fast ideas are far too fast and there are far too many, overwhelming confusion replaced by fear and concern. You are irritable, angry, frightened, uncontrollable, and enmeshed totally in the blackest caves of mind... It goes on and on and finally there are only other people's recollections of your behaviour – your bizarre, frenetic, aimless behaviour..."

A patient's account from Goodwin & Jamison (1990)

1. Introduction

This chapter reviews cognitive therapy (CT) for bipolar disorder (BD). The poor outcome of patients diagnosed with BD supports the addition of a psychosocial intervention for the treatment of this recurring disorder. The psychoeducational nature of CT, the effectiveness in increasing compliance to pharmacological treatment and the ability to prevent relapse in unipolar depression are used in the treatment of mania and BD. Results indicate that CT may be an effective intervention for the treatment of BD. Specifically CT may be useful in improving quality of life and functioning, increasing compliance, helping early symptom recognition, decrease relapse and decrease depressive and manic symptomatology. Understanding the cognitive process in BD can refine our cognitive interventions in BD.

This discussion is best initiated by considering some of the limitations of somatic treatment. Despite the significant pharmacopeia for bipolar disorder, the most common outcome continues to be a clinical course characterized by repeated episodes. For example, despite the use of mood-stabilizing agents, longitudinal data suggests relapse rates as high as 40% in 1 year, 60% in 2 years, and 73% in 5 or more years (Gitlin et al., 1995; see also O'Connell et al., 1991). Resolution of bipolar depression is also characterized by poor outcomes for patients despite the regular application of mood stabilizers (Keck et al., 1998), and overall, adherence to medication treatment brings with it its own challenges, with poor medication compliance evident in one-half to two-thirds of patients within the first 12 months of treatment (Keck et al., 1998, Keck et al., 1996). All of these findings encourage the search for additional modalities of intervention for bipolar disorder.

Between 1960 and 1998, there were over 30 published outcome studies describing the combined use of psychological and pharmacological treatments in BP. However, the majority were small scale, with an average sample size of about 25, giving a total sample for all studies was just over 1000 participants.

The majority of the papers addressed group ($n=14$) or family approaches ($n=13$), with only four papers reporting on individual therapy. Most importantly, about 20 of the studies were open cohort studies with no control treatment to compare with the experimental psychotherapy.

Although the studies also had many methodological limitations, it was clear in many of these studies that those receiving adjunctive psychological treatments had better subjective clinical and social outcomes than those receiving usual treatments (comprising mainly of mood stabilizers and outpatient support), and there was some evidence of observer-rated differences that reached statistical significance. These encouraging results facilitated the development of randomized controlled trials of more targeted interventions that have now been tested in more sophisticated randomized treatment trials.

The occurrence of negative life events has also been found to influence the course of recovery from episodes in patients with bipolar disorder. For example, in a study of 67 patients recruited during hospitalization for mania or depression, negative life events were associated with a threefold increase in time to recovery (Johnson and Miller, 1997). Similar effects were evident in a study of relapse prevention. Ellicott et al. (1990) found that rates of relapse were 4.5 times higher among patients with high negative life-event scores during a 2-year follow-up study.

Cognitive style also appears to play an important role in modulating the impact of life events on symptoms. For example, in combination with negative life stressors, bipolar individuals with dysfunctional attitudes or depressogenic attributional styles are more likely to develop affective symptoms (Alloy et al., 1999). These findings support the rationale for utilizing cognitive-behavioral interventions aimed at modifying maladaptive cognitive styles and decreasing the impact of environmental stress.

In the last 5 years, interest in psychosocial interventions in BP has increased dramatically with about 20 randomized controlled trials underway in the USA, UK and Europe. Given the current emphasis on the use of brief evidence-based therapies in clinical guidelines for the treatment of unipolar disorders, it is not surprising that the new treatment trials for BP have focused on psychoeducational models, the three most well-researched manualized psychological approaches: interpersonal social rhythms therapy (IPSRT), cognitive therapy (CT) and family focused therapy (FFT), or techniques derived directly from these manualized therapies. The latter are used primarily to improve illness awareness, medication adherence, to teach recognition of prodromes and relapse prevention techniques. Eight of the completed studies have produced data that can be included in a systematic review of relapse rates and allow a meta-analysis of relapse rates for adjunctive psychological treatments compared to usual psychiatric treatment (either routine or standardized).

The first five studies (Lam et al., 2000; Perry et al., 1999; Scott et al., 2001; Frank et al., 1999) were relatively small scale and used a variety of approaches, but predominantly focused on

either cognitive behaviour therapy (CBT) or cognitive and behavioural techniques, or interpersonal social rhythms therapy (IPSRT). These RCTs, which used either treatment as usual or treatment as usual plus support or symptom management sessions as the control condition, demonstrated that psychological treatments appear to have some benefit in preventing relapse, but that the effect was more impressive for total relapses or depressive relapses rather than manic relapses.

The three largest studies published in the literature used either CBT (Lam et al., 2003), Family Therapy (Miklowitz et al., 2003) or Group Psycho-Education (Colom et al., 2003). A separate meta-analysis of outcome data from these RCTs using fixed and random effects models demonstrate that the odds ratio for relapse in the active as compared to the control treatment groups is similar to that reported for the earlier studies. There appear to be some differences in ORs between studies, but these may relate to sample characteristics (e.g. proportion of participants who met criteria for BP I or BP II) as well as similarities or differences in the style and content of the treatments. Importantly, the interventions all have a significant effect on rates of depressive relapses as well as reducing the frequency of manic episodes. So perhaps the treatment of syndromal and sub-syndromal depressive symptoms of BP might be improved by the use of these more complex and more extended interventions.

The basic aims of therapy in bipolar disorder (BP) are to alleviate acute symptoms, restore psychosocial functioning, and prevent relapse and recurrence. The mainstay of treatment has been and currently remains pharmacotherapy. However, there is a significant 'efficacy-effectiveness' gap in the reported response rates to all mood stabilizers (Scott, 2001; Scott and Pope, 2002) and even under optimal clinical conditions, prophylaxis protects fewer than 50% of individuals with BP against further episodes (Dickson and Kendell, 1994). Given this scenario, the development of specific psychological therapies for BP appears a necessary and welcome advance. However, until recently, progress in this area was slow.

Historically, individuals with BP were not offered psychological therapies for three main reasons (Scott, 1995). First, aetiologic models highlighting genetic and biological factors in BP have dominated the research agenda and largely dictated that medication was not just the primary, but the only appropriate treatment. Second, there was a misconception that virtually all clients with BP made a full inter-episode recovery and returned to their premorbid level of functioning. Third, psychoanalysts historically expressed greater ambivalence about the suitability for psychotherapy of individuals with BP than those with other severe mental disorders. Fromm-Reichman (1949) suggested that in comparison to individuals with schizophrenia, clients with BP were poor candidates for psychotherapy because they lacked introspection, were too dependent and were likely to discover and then play on the therapist's 'Achilles heel'. Others, particularly clients and their significant others argued strongly in favour of the use of psychological treatments (Goodwin and Jamison, 1990). However, the relative lack of empirical support (prior to the last 5 years, few randomized controlled trials had been published) meant that clinicians had few indicators of when or how to incorporate such approaches into day-to-day practice.

Over the last decade, two key aspects have changed. First, there is increasing acceptance of stress-vulnerability models that highlight the interplay between psychological, social and biological factors in the maintenance or frequency of recurrence of episodes of severe mental

disorders. Second, evidence has accumulated from randomized controlled treatment trials regarding the benefits of psychological therapies as an adjunct to medication in treatment-resistant schizophrenia and in severe and chronic depressive disorders (Thase et al., 1997; Sensky et al., 2000). Although there has been only limited research on the use of similar interventions in BP, there are encouraging reports from research groups exploring the role of 'manualized' therapies in this population (American Psychiatric Association, 1994). For persons with BP who reported about a quarter of a century ago that psychotherapy could help them adjust to the disorder and overcome barriers to the acceptance of pharmacotherapy (Jamison et al., 1979), these developments are long overdue.

2. Goals of Cognitive Therapy for bipolar disorders

The main goal of Cognitive Behavioral Therapy (CBT) for bipolar disorder is to maximize adherence with pharmacotherapy and other forms of treatment over time. The emphasis on attenuation of compliance assumes that even under the best circumstances, most people will be unable to comply perfectly with treatment at all times, particularly if treatment is lifelong. If the goals and methods of treatment are acceptable to patients, the effort of CBT is to increase the likelihood that treatment will be followed as it is prescribed. This is accomplished by identification and removal of factors that can interfere with compliance. To beneficially affect the course of bipolar, there are at least six separate targets for treatment. The first five of these concern relapse prevention, and the last directly targets the treatment of bipolar depression, see table 1:

1	MEDICATION ADHERENCE
2	EARLY DETECTION AND INTERVENTION
3	STRESS AND LIFESTYLE MANAGEMENT
4	TREATMENT OF COMORBID CONDITIONS
5	TREATMENT OF BIPOLAR DEPRESSION

Table 1. Main targets for CBT to Bipolar Affective Disorders.

The strength of CBT is in altering the course of bipolar disorder over time. Each time a relapse of depression, mania, or mixed states occurs it is an opportunity to learn more about the factors that precipitate recurrences for a given patient. If the patient is not ready to accept the illness, the treatment, and the lifestyle restrictions, CBT will not help.

Sometimes patients have experienced a crisis but have already developed a plan or taken action toward its resolution and merely wish to report to the therapist what has transpired. Telling the story, however, can fill an entire session. When setting the agenda, the therapist should quickly assess whether or not the crisis has been resolved and how much time will be needed for further discussion.

Many institutional settings inadvertently socialize people with bipolar disorder to be passive recipients of care rather than to be active consumers of or participants in their care. A passive view of the patient's role in treatment is in opposition to the collaborative view espoused by this treatment manual. As therapists, we often assume that our patients have basic social skills such as how to get information, how to cope with stress, how to interact with others in various social situations, or how to make decisions about activities of daily

living. Some patients who have had bipolar disorder since prior to adulthood may need help to develop these basic skills. These people may have to go through several episodes before they are willing to accept the fact that the illness is recurrent and that they must take control over it rather than letting the illness control them. Involvement of family members in the therapy process can be very useful. It provides family members with an opportunity to meet the therapist and to be informed about what happens during therapy sessions; it demystifies the process of treatment; and it encourages supportive others to be facilitators of care rather than to oppose it. Countering the institutional belief of patients as passive recipients of care can be accomplished by eliciting active participation in the patient. Living through several episodes of depression and mania leaves most people with bipolar disorder feeling fearful and lacking in confidence. The fear is that the symptoms will return especially if they stress or push themselves; see main main objectives of CBT in the treatment of bipolar disorder (Jurueña, 2001).

Of individuals with BP, 30–50% also meet criteria for substance misuse or personality disorders, which usually predict poorer response to medication alone. Many of these disorders precede the diagnosis of BP. Bipolar disorder has a median age of onset in the mid-20s, but most individuals report that they experienced symptoms or problems up to 10 years before diagnosis. Thus, the early evolution of BP may impair the process of normal personality development or may lead the person to employ maladaptive behaviours from adolescence onwards. Comorbid anxiety disorders (including panic and PTSD) and other mental health problems are common accompaniments of BP, whilst 40–50% of subjects may have interepisode sub-syndromal depression (Judd et al., 2002). Although many individuals manage to complete tertiary education and establish a career path, they may then experience loss of status or employment after repeated relapses. A period of 1 year after an episode of BP, only 30% of individuals have returned to their previous level of social and vocational functioning. Interpersonal relationships may be damaged or lost as a consequence of behaviours during a manic episode and/or the individual may struggle to overcome guilt or shame related to such acts. The above psychological and social sequelae identify a need for general psychological support for an individual with BP.

However, there is a difference between the general non-specific benefits of combined pharmacotherapy and psychotherapy and the unique indications for psychosocial interventions, see details in table 2. For a specific psychological therapy to be indicated as an adjunct to medication in BP it is necessary to identify a psychobiosocial model of relapse that:

- i. Describes how psychological and social factors may be associated with episode onset. For example, social rhythm disrupting life events may precipitate BP relapse and so stabilizing social rhythms is a key additional element in Interpersonal Therapy as applied in BP.
- ii. Provides a clear rationale for which interventions should be used in what particular set of circumstances. For example, the use of Family Focused Therapy (FFT) is supported by research demonstrating that a negative affective style of interaction and high levels of expressed emotion in a family are associated with an increased risk of relapse in an individual with BP.

1	To Educate Patients, Family And Friends About BD, Its Treatment And Difficulties Associated With The Disease
2	To Help The Patient Take A More Participating Role In The Treatment
3	To Teach Methods Of Monitoring Occurrence, Severity And Course Of The Manic-Depressive Symptoms.
4	To Facilitate Compliance With The Treatment
5	To Offer Nonpharmacological Options For Dealing With Problematic Thoughts, Emotions And Behaviors.
6	To Help The Patient Control Mild Symptoms Without The Need To Modify The Medication.
7	To Help The Patient Cope With Stress Factors Which May Either Interfere With The Treatment Or Precipitate Manic or Depressive Episodes.
8	To Encourage The Patient To Accept The Illness
9	To Reduce Associated Trauma And Stigma.
10	To Increase The Protective Effect Of The Family.
11	To Teach Strategies For Dealing With Problems, Symptoms And Difficulties.

Table 2. The main objectives of CBT in the treatment of bipolar disorder.

The need for additional strategies for medication adherence in bipolar disorder is striking. Despite the planned, long-term use of mood stabilizers, a variety of evidence suggests that adherence often fails within the first several months of treatment (Johnson and McFarland, 1996).

The pharmacological management of bipolar disorders faces some of the same challenges of any preventive program of medication; at the time the pill is taken, there may be no disorder-related symptoms, and particularly no symptom relief, to either cue or reward pill taking. Under these conditions, pill use is primarily motivated by the memory of past symptoms and concerns that they may recur. Moreover, emergent side effects may sap this motivation and punish pill taking.

Although all preventive programs may share in these basic factors, bipolar disorder brings additional challenges (Jamison and Akiskal, 1983, Keck et al., 1996). Patients may remember past hypomanic episodes fondly and may desire future episodes. Also, patients may not be convinced of the need for preventive treatment. Under these conditions, it is no surprise that adherence to mood stabilizers is so poor, despite the evidence for a clear link between non-adherence and relapse (e.g., Keck et al., 1998).

A variety of social-psychological research suggests that compliance with requested behaviors is enhanced when an individual's assent to that action is elicited as his or her own opinion (see Cialdini, 1993). That is, it is not the psychiatrist's task to tell the patient why medications are necessary, rather it is her or his task to elicit, with careful questioning, why the patient thinks that ongoing treatment may be helpful. Use of a life-history approach (Post) may be a useful strategy for eliciting relevant patient information on the impact of bipolar episodes on personal and family goals. The life-history method asks patients to construct a timeline of their disorder that depicts manic, hypomanic, and depressive episodes, and the life context that surrounded these episodes. This evidence can then be used to help the patient decide whether an alternative treatment, or greater adherence to current treatments, is a reasonable strategy to adopt.

In focusing on the patient's recommendations in the context of a straightforward and dispassionate presentation of the facts about her or his history of disorder, the prescribing physician will be adopting strategies from "Motivational Interviewing", an empirically supported strategy for enhancing engagement in treatment (Rollnick and Miller, 1995, Yahne and Miller, 1999). Regular adoption of these techniques is encouraged for the treatment of bipolar patients. Moreover, repeated presentation of this information during the initial months of treatment appears to be indicated given evidence for memory and attention deficits in bipolar disorder (Deckersbach et al., 2000b), and evidence that rates of non-adherence are at their average intensity at approximately three months of treatment (Johnson and McFarland, 1996).

Enhancing motivation for medication use is only part of adherence interventions. Indeed a variety of cognitive-behavioral strategies are available to help patients establish a regular habit of medication use. For example, as part of a single-session intervention to improve medication adherence for outpatients with HIV, Safren et al. (2000) recommends the use of imaginal and role-play rehearsal of times and cues for pill storage and use, as well as the use of simple reminders to establish new pill-taking regimens (i.e., colored dots that are placed by the patient in everyday locations—in appointment books, on telephones, in the home bathroom, etc.—that can be a cue for pill taking as well as for reviewing motivation for medication use).

Certainly these strategies can be delivered by independent cognitive-behavioral therapists, but perhaps it is most important for pharmacologists to adopt these strategies directly. At the time of the review of symptoms and diagnosis, the pharmacologist can begin the process of offering expert information on bipolar disorder, combined with a review of the patient's history of disorder and treatment, as part of a motivational intervention. The pharmacologist is engaged in helping establish the patient in the role of a responsible co-therapist on the case, seeking to help the patient define the importance for him- or herself of medication use for control of bipolar disorder. For BD patients, CT always consists of a number of phases. Since BD is a chronic disorder, the educational element is important in facilitating cooperation. The patient is encouraged to ask questions concerning the disorder, its causes and its treatment. As in every type of cognitive therapy, the cognitive model is shown and the patient learns to identify and analyze cognitive changes, as well as automatic thoughts and thought distortions, which occur in depression and mania.

The idea of establishing a cotherapist on the case also extends to other prevention efforts, particularly to efforts at early detection and intervention. In our specialty bipolar clinic, we routinely use a treatment contract and self-monitoring as part of standard pharmacotherapy to formalize the process of engaging the patient in planning for the management of future episodes. The treatment contract itself includes sections that review:

1. The purpose of the contract (aiding the patient in the management of bipolar disorder).
2. Names and contact numbers for other members of the treatment team (including friends or family members who may be asked to intervene at warning signs or crises associated with future episodes).
3. A patient's characteristic symptoms of depressive or hypomanic episodes and the early intervention strategies the patient and her or his treatment team are to enact when faced by these symptoms (Reilly-Harrington et al., 2001).

This contract is an outgrowth of previous work geared towards actively engaging patients in written plans for managing bipolar illness (Bauer and McBride, 1996, Hirshfeld et al., 1997).

Without an organized treatment plan that includes the education and involvement of the patient and significant others, care providers and family members are left to make decisions on behalf of the patient at times of crisis. A treatment contract provides both the patient and clinician with a forum for discussing what the patient would like her or his treatment team to do in the event of early signs of relapse (or a full relapse). The treatment team members should include people with whom the patient has regular contact, and may include health-care providers, family members, significant others, friends, or coworkers. Typically, patients invite family or support system members to sessions focusing on the development of the treatment contract.

After identifying the treatment team, the contract instructs patients to identify specific thoughts, feelings, and behaviors that may serve as early warning signs for episodes of depression and mania. In addition, the patient is asked to outline personal actions to be taken in the event of an impending episode. Of particular importance is the identification of the initial signs of hypomania, to allow early detection and protective action against a potential manic episode. Next, patients develop a set of directives, stating ways in which they and their support systems can be helpful in preventing and managing acute episodes. Strategies of this kind (early detection and intervention) have been found to significantly reduce the rate of occurrence and number of manic episodes (Perry et al., 1999).

Finally, all members of the extended treatment team are asked to review, ask questions, address concerns, and then sign the contract. Once the plan is in place, the clinician(s) and others who apply the contract become agents of the patient's planning, rather than people imposing their own restrictions on the patient.

Even though much of the contract is in a checklist format, it will take time to complete. However, clinicians should consider the contract as an investment against all the time and difficulties associated with future episodes. With the contract in place and relevant contact information and actions pre-specified, clinicians should be able to save time through efficient intervention at times of crisis, or through prevention of future crises.

Current CBT protocols (Basco and Rush, 1996; Newman et al., 2001) also tend to emphasize early-intervention strategies to reduce the impact of hypomanic or manic episodes should they occur. These interventions are designed to reduce the likelihood of poor financial, social, or sexual decisions that may occur in the context of an episode. These strategies range from specification of whom and under what conditions a member of the support network should be able to temporarily cancel a credit card to the specification of rules for risky action. For example, Newman et al. (2001) describe a "Two-Person Feedback Rule", where patients are taught to test out any new plan or idea with at least two trusted advisors. Patients are told of the hypomanic bias of ideas "feeling" good or correct even though they may not "be" correct. With the two-person feedback rule, patients are taught that if an idea really is that good, then two other people should be able to find the idea at least reasonable.

Newman et al. (2001) also discuss a "48 Hours Before Acting Rule" in which patients are encouraged to wait two full days and get two full nights of sleep before acting on any new

plan or idea. Patients are encouraged to think to themselves, “If it’s a good idea now, it will be a good idea then”. This two-day period of reflection also allows an opportunity to put the “Two-Person Feedback Rule” into effect. Any interventions that can potentially disrupt spontaneous or risky decision-making are warranted when working with hypomanic patients.

The approach outlined in Fig. 1 (adapted from Basco & Rush, 1995) is particularly useful when working with individuals with bipolar disorder as it allows the therapist to emphasise a stress-diathesis model that may also include biological factors as precipitants of symptom shift. In order to use this approach, the therapist should first ask about the patient's own views on the causes of the disorder and the associated problems. The patient's aetiological theory is then incorporated within the framework of the model. Links between the individual's cognitions, behaviour, mood and other symptoms (particularly sleep disturbance) and the interaction between these and the environment (stressful events or experiences that are a cause or a consequence of other shifts) are emphasised. This rationale is used to engage the patient in cognitive therapy through monitoring and linking changes in thoughts, behaviours, feelings and the biological symptoms of bipolar disorder. The model also acknowledges that sleep disturbance may be a useful predictor of biological and/or psychosocial disruption and may act as an early-warning sign of shifts from euthymic to abnormal mood states (Wehr et al, 1987). When the connections between the biological and other aspects of their experience are exposed, patients are able to understand the reasons for using cognitive therapy as well as medication. This establishes the rationale for cognitive and behavioural interventions, and also provides a starting point to explore attitudes towards the use of, and adherence to, medication.

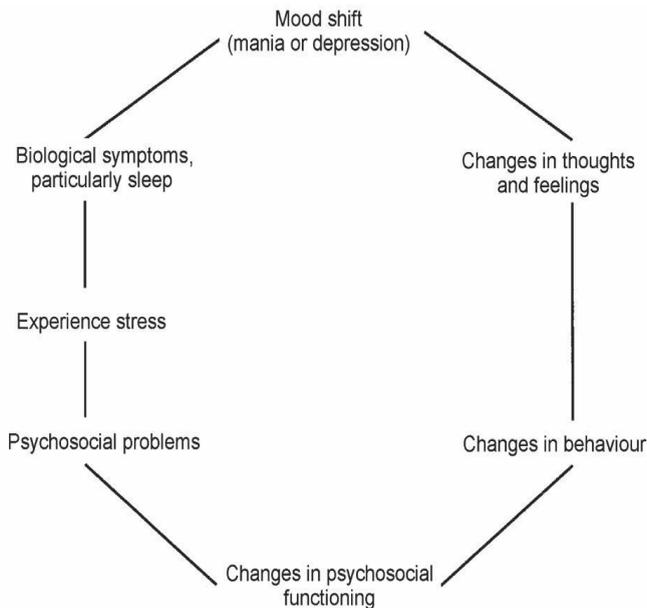


Fig. 1. Conceptualisation of bipolar disorder (adapted from Basco & Rush, 1995).

Keeping an early bedtime schedule is a significant sacrifice for a night person, particularly those who are tired and sluggish in the morning and only begin to find their pace in the late afternoon. If the evening dose of prescribed drugs causes sleepiness, it is often delayed and later forgotten or consciously omitted altogether to avoid the drowsiness that can interfere with activities. Without the protection of mood-stabilizing medications, a recurrence of full-blown mania is almost certain. After years of observation and experimentation, many people with bipolar disorder learn to work with the ups and downs in their mood. They may allow a short flurry of hypomania but know when to put on the breaks, regulate their medication, get some sleep, and slowdown their lifestyle. This is accomplished with varying levels of success. Some wait too long to intervene because they want to enjoy the high or because they do not recognize the mania until they have got-ten into trouble or begin to decompensate. Most hate the lows but feel helpless to stop their progression. More mood-stabilizing medication may not help and can leave them more sluggish. Antidepressants run the risk of inducing mania. Getting medical attention as soon as symptoms of depression begin to emerge is complicated, if not impossible, for most who do not have the advantage of private care and for many who do.

Cognitive processing is also altered during episodes of depression and mania. Speed, clarity, logic, organization, perception, and decision-making ability are compromised. These deficits can have a negative effect on a person's ability to cope with daily hassles and major life difficulties and, in fact, can cause new psychosocial stressors. Improvements in cognitive processing can, therefore, break the evolving cycle of depression and mania at the point of behavior change, impairment in psychosocial functioning, or when psychosocial problems develop.

Although impaired in both depression and mania, the disruption indecision-making ability is qualitatively different in each type of episode. As the cognitive symptoms of depression worsen, self-doubt tends to increase. People do not trust their decisions, fearing failure or disapproval if the "wrong" choice is made. Mental slowing and tunnel vision make it difficult to generate new solutions to problems. And as anxiety increases, it becomes easier to imagine the worst-case scenario for any solutions considered. The magnitude of problems is perceived as great and the consequences overwhelming, and as a result, there is often a paralysis in decision making. Impaired judgment, grandiosity, and impulsivity can all affect the decisions made during hypomanic and manic episodes. Magnification of positives and minimization of negatives can interfere by providing an unbalanced view of the risks and benefits of any plan. It is not unusual for people in a manic phase to act on impulsive urges without pausing to consider alternative actions or solutions. Poor judgment is not always an indicator of impaired decision making. Actions taken in poor judgment can result from a failure to slow down long enough to attempt problem solving.

Activity monitoring and scheduling is a regular component of many cognitive-behavioral treatments of depression (Beck, 1995, Beck et al., 1979, Nezu et al., 1998). Monitoring is used to identify whether the patient suffers from under or overactivity, and whether the patient has a structure for providing breaks and pleasurable events during the week. In depression treatment, efforts are devoted to helping the patient construct a schedule that allows for rewarding activities in areas of both productivity and pleasure, and that helps a patient restart a program of activity if depression has waylaid this area of functioning.

For the management of bipolar disorder, lifestyle management also includes attempts to protect the sleep/wake cycle, to provide a balance in the patient's level of activities, and to monitor for increases in activity that may herald a hypomanic episode.

For sleep management, therapeutic progress proceeds in two stages. In the first, the clinician educates the patient about the role of disruptions in the sleep/wake cycle in heralding new episodes, and discusses with the patient what level of activity and sleep seems most reasonable for the patient. Once the desired hours of sleep have been identified, the clinician should help the patient calculate a regular bed time relative to daily demands and waking times. To aid compliance, the clinician should also identify cues for that target bedtime (e.g., if the patient finds herself watching television to the end of "Letterman", the sleep time has been ignored).

Also, to reduce the impact of other risk factors for episodes—namely, family stress and the impact of negative events—stress management procedures that include training in problem solving, communication skills, and cognitive-restructuring may be valuable. Given that these procedures are a regular part of cognitive-behavioral treatments for depression, these skills may be introduced in the context of interventions for bipolar depressive episodes.

People who have bipolar disorder have daily hassles with which to deal just as everyone else does. They must try to stay on top of problems to keep them from accumulating while they contend with their mental illness and their day-to-day responsibilities. Keeping stress under control may require periodic assessments of life circumstances and regular efforts at solving problems.

Although people make decisions every day without going through each step in the problem-solving sequence, there are times when casual decision making does not adequately address the issues. The most common time to use formal problem solving is when there are obvious difficulties in everyday activities, for example, when there are unresolved problems at home, on the job, or in interpersonal relationships. Formal problem solving is most useful when (1) the problem persists despite the patient's efforts, or (2) the patient has been unable to identify a reasonable solution to the problem.

During the first few therapy sessions, patients and their therapists can work together to construct Life Charts. The process of constructing a Life Chart can be very educational for the patient, especially when medication noncompliance has predated recurrences of symptoms. The first step in constructing a Life Chart is to draw a reference line in the middle of the page that represents a euthymic or "normal" state. Many patients report that they have never felt "normal"; therefore, the reference line must represent relative normalcy, that is, relative to the extremes of depression and mania that the person has experienced. If an individual has had numerous episodes of illness, the construction of a Life Chart may be difficult. In other cases, the course of bipolar disorder does not begin with an easily defined, distinct episode of depression or mania. There may have been problems at school, at home, or on the job, or there may have been some difficulty in getting along with others. It is usually easiest to start with the most recent episode and work backward in time. It can also be helpful for the patient to try to recall hospitalizations or emergency room visits and use these events as reference points for episodes. Reviewing medical records or talking with family members can also help flesh out the patient's course of illness for a Life Chart.

Another way in which the CBT approach to compliance differs from traditional behavioral contracting is that no external reward is provided. The focus of the intervention is on patients being consistent with treatment because it makes them feel better. Clinicians can help, but taking medications regularly is ultimately the responsibility of the patient. The consequences for noncompliance are internal and personal. The rewards for compliance must be as well. The behavioral contracting intervention for improving compliance begins with a clear definition of treatment plans or goals.

2.1 Treating comorbidity

High rates of psychiatric comorbidity typify patients with bipolar disorder. For example, in a study of 288 outpatients with bipolar disorders, McElroy et al. (2000) found that 42% met criteria for a comorbid anxiety disorder, 42% for comorbid substance use disorder, and 5% for an eating disorder. These disorders were not differentially prevalent among those with bipolar I compared to bipolar II disorder, and in general these findings replicated those from a number of epidemiologic studies (e.g., Chen and Dilsaver, 1995, Kessler et al., 1997).

Treatment of comorbid conditions is an additional role for CBT. For example, anxiety comorbidity in bipolar disorder is associated with longer times to remission (Feske et al., 2000), underscoring the potential importance of managing this comorbidity as part of an overall treatment strategy. At present, CBT and pharmacotherapy (particularly, treatment with antidepressants) represent the treatment modalities with the best empirical support for efficacy with anxiety disorders. Specifically, CBT has been shown to rival or surpass the efficacy of medication in meta-analytic reviews of the anxiety literature, and tends to offer longer-term maintenance of treatment gains (Christensen et al., 1987, Gould et al., 1995). In many treatment contexts, patients can choose from these empirically-supported alternatives based on preference and availability. However, patients with bipolar disorder may be greatly limited in the choice of pharmacologic strategies for anxiety disorders by the risk of induction of manic episodes associated with antidepressant use. Moreover, there is initial evidence that bipolar patients with significant anxiety may have more difficulties with medication side-effects. As a consequence, CBT has the potential to offer bipolar patients effective treatment without the risk of medication-induced manic episodes or the limitations associated with pharmacotherapy side effects.

Major life events are associated with increased stress and can precipitate an exacerbation of symptoms in the patient with bipolar disorder. Stressful events, especially catastrophic events such as the death of a friend or family member, severe financial crises, major accidents, or illnesses in patients or their significant others, can tax a patient's internal coping resources. Positive life events can also be stressful. They require alterations in routine, including eating and sleeping patterns, and may affect symptom control. During these times, the patient may need to rely on more formal problem-solving strategies to cope with the changes associated with the event. Life changes generally have an impact beyond the arena in which they are occurring. For example, job changes can affect life at home and vice versa. Periods of change, therefore, are also times in which more formal problem solving can be useful. Expected role transitions can be similarly stressful and place the patient at increased risk for an exacerbation of symptoms. Role transitions can affect the patient directly (e.g., getting married) or indirectly by means of changes in other family members (e.g., the youngest child moving away from home).

Developmental role transitions, like any other change or event, can be disruptive to the patient's mental health. One reason that life transitions produce stress is that they often change the amount and content of interactions and communication between patients and their significant others. In the next chapter, common interpersonal problems experienced by people with bipolar disorder are covered, including methods for preventing and resolving relationships stresses.

2.1.1 Cognitive model of bipolar disorder

CT's approach to the treatment of bipolar disorder is based on many underlying assumptions. The first assumption is that thoughts, feelings and behaviors of individuals are strongly connected, each influencing the other. Changes in mood and changes in cognitive process, beginning with depression and mania, would inevitably influence behavior. The behavioral responses can reinforce the process of defective information and affective states that have prompted the behavior - a kind of self-fulfilling prophecy.

As noted, CBT has a long history of success in the treatment of unipolar depression. These methods (e.g., Beck, 1995, Beck et al., 1979, Nezu et al., 1998) are also being applied to bipolar depression. For example, in a small pilot study, Zaretsky et al. (1999) found similar reductions in depressed mood for CBT applied to patients with bipolar depression as compared to patients with unipolar depression, see details in table 3. These core strategies are followed by a much broader package of emotional and social problem-solving strategies, combined with modules that target specific difficulties patients may have with emotional regulation, assertiveness, or comorbid anxiety disorders (see also, Henin et al., 2001).

1.	Patients are usually not acute patients during the educational sessions and skills training
2.	Skills will be taught in a didactic manner
3.	Only few cognitive-behavioral techniques will be taught
4.	The agenda for each session is a protocol conducted in opposition to the conduct of the patient

Table 3. CT for bipolar disorder differs from more traditional forms of cognitive therapy.

Early in treatment, patients are provided with a model of the disorder and a rationale for treatment procedures, combined with instruction in a cognitive-behavioral model of the interplay between thoughts, feelings, and behavior. Patients are asked to then complement this didactic information by observing their own experiencing, testing the model, and identifying for themselves the role of thoughts in particular in influencing mood. Each session is presented in a problem-solving format that includes review of the previous week's learning, formulation of an agenda for the session, completion of the agenda with attention to in-session practice of concepts, and then assignment of home practice of skills.

This format maintains a consistent focus on the step-by-step, goal-oriented, skill-acquisition approach that is at the heart of cognitive-behavioral treatments (e.g., Beck, 1995). To make treatment accessible to patients, attention is placed on the use of vivid metaphors and stories to crystallize important information on the nature of the disorder, the process of change, or a specific assignment or skill.

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Communication problems occur between at least two individuals, and it is easier for a therapist to help resolve such problems if both parties are present. This is not always possible or appropriate, however. In some cases, the second party is a boss, someone who lives a great distance away, or someone the patient is not likely to see again. In normal daily interaction, it is not usually necessary to impose any structure on communication. Structure is useful when communication is ineffective or exacerbates relationship difficulties, however. When preparing to discuss potentially conflictual issues, it is useful to review the basic rules of the communication game as listed in the following:

- Be calm: It is counterproductive to attempt to discuss difficult issues when angry or stressed in any way. An angry person may let emotions dictate the choice of words and the solutions offered. Solutions that seem reasonable in the heat of anger may prove inappropriate when examined later. It is better to wait until the emotion subsides than to risk making bad decisions.
- Be organized: It is best to approach the discussion of troublesome issues after having taken the time to think through what the problem is and what must happen in order to resolve it. Furthermore, it is useful to have a plan for discussing the issue.
- Be specific: Global complaints (e.g., "I'm not happy," "You're irresponsible,") cannot be easily resolved. It is necessary to specify the action, event, or process that is problematic: What does it look like? How would I know it was happening if I were watching you? What causes the discomfort?
- Be clear: Beating around the bush or speaking in vague terms leaves much room for misinterpretation of the message. It may appear that the intended message was received, but the message may not have been received accurately.
- Be a good listener: The best way to be heard is to be a respectful listener. Attentive listening without interrupting is important. The listener should not merely use the other person's talking time as an opportunity to prepare a response (or defense).
- Be flexible: The resolution of problems between individuals requires give and take. Although a plan to resolve the problems may have been developed before the actual discussion began, it is important to consider others' ideas before selecting a solution. Moreover, others are likely to have a different view of the problem, and all participants should approach the discussion as if the others' perspective is as valid as their own.

- Be creative: In generating a solution to a specific problem, it is useful to look beyond strategies used in the past, to be imaginative, and to try out new plans. If they do not work, another method can be used.
- Keep it simple: Those with communication difficulties should solve one problem at a time. When discussing a problem, they should describe it as simply as possible. If the conversation begins to digress into other areas, stop and redirect the conversation back to the original topic.

The most common source of disruption in communication is emotion. As discussed earlier, intense emotion such as sadness, frustration, or anger can influence the way in which information is conveyed and received. If any person's emotional level becomes uncomfortable or appears to interfere with the interaction, the discussion should stop until the intensity of the emotion has substantially decreased. It is essential that a plan be made to resume the discussion at a specified time.

The speed and efficiency of cognitive processing can improve early in the evolution of mania but disintegrate as thoughts increase in number and speed. Some people with bipolar disorder say they have their best ideas when hypomanic. Feeling free from the inhibiting nature of depression, the mind is open to new ideas and possibilities. Creativity during hypomania can result in taking chances at success otherwise inhibited by pessimism and low self-confidence. There is often an urge or need for stimulation that comes from changes in routine or activity. If judgment becomes impaired, the changes can create new problems for the individual such as quitting a job before having a new one available. If the quality of cognitions declines, and the person becomes disorganized or unfocused, changes are initiated but often not completed, see figure 3.

More often, however, the urge for change in the early phases of mania or hypomania manifest themselves in more benign forms such as changing hairstyle, clothing, or jewelry, or rearranging furniture at home or work. There can be a shift in interests so that more time is allocated to planning or research on the Internet or accumulating resources for a new project (Juruena 2004).

3. Psychoeducation

People with psychiatric illnesses do not always receive sufficient information about their disorders or their treatment. Symptoms such as impaired concentration, racing thoughts, distractibility, and anxiety may not always be apparent to clinicians but can reduce a person's comprehension or retention of information. Likewise, clinicians may not effectively convey information or may not take sufficient time to educate patients. The jargon used in daily interactions among mental health professionals is often confusing to patients. Patients can sometimes recall a diagnosis given in the past but may not understand what it means. They will not always ask for clarification because they are embarrassed to acknowledge that they did not understand a word or expression used to describe their illness or treatment. Sometimes health care workers fail to provide adequate information because they believe the patient is incapable of understanding, is uninterested, or has already been informed by a previous clinician. Despite good intentions, learning does not occur if information is not clearly sent and received.

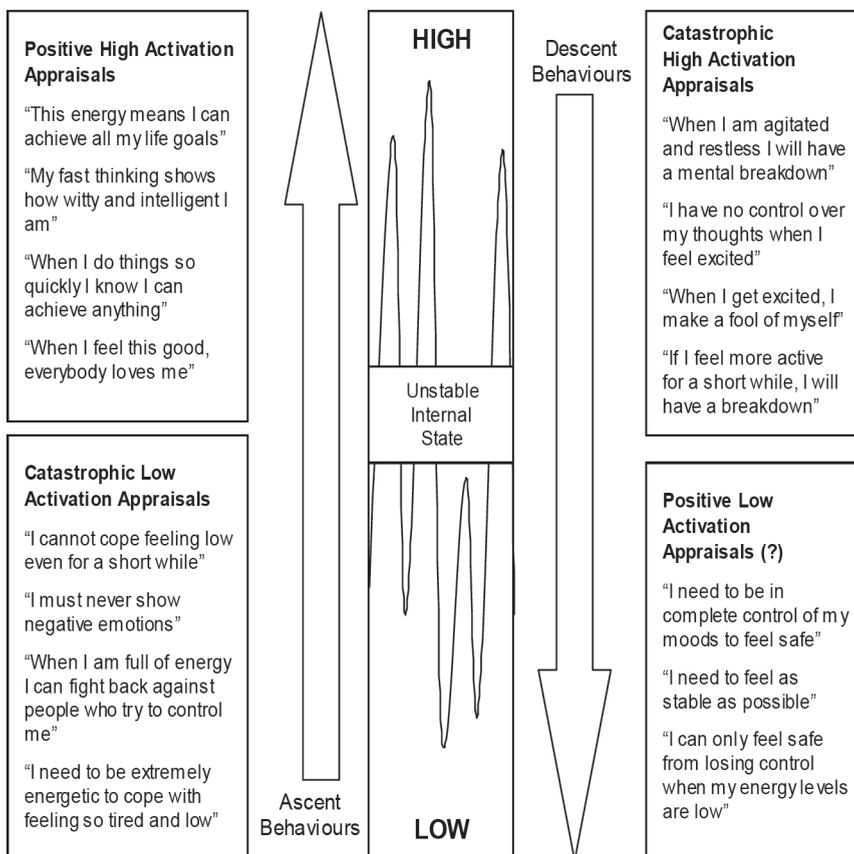


Fig. 3. Unstable Internal State in Bipolar Affective Disorders patients.

The psychoeducational characteristics of CT provide both to patients and to their families and their relationships, learning about what is bipolar disorder, providing and emphasizing the recognition of early symptoms, instructing on the longitudinal course and risk factors relapses and explaining and illustrating the importance and characteristics of treatment and the use of drugs and psychotherapy.

It is noteworthy that both psychoeducation and CBT share in common a focus on medication adherence and compliance, detecting early signs and seeking help. Although these treatments differ significantly in terms of theoretical assumptions, they share some of the same targets and strategies.

Almost all investigations that use CBT involve one or two sessions that provide information about the illness and its treatment, while most psychoeducational approaches include information about lifestyle changes. Both techniques teach patients about prodromal symptoms.

In general, psychoeducative interventions are more informative about illness and treatment, and the content is mainly aimed at improving adherence to treatment. CBT deals more with BD-related residual symptoms of depressive episodes, subthreshold symptoms and negative thoughts, and includes modules on self-esteem, coping skills, assertiveness and life organization.

One limitation of some of the studies examined is the lack of separate comparisons for each block of the intervention (early detection of prodromal symptoms, enhancement of treatment compliance, inducing lifestyle regularity, and so on). With the exception of the study of Perry et al. (1999) that had the advantage of including just one type of intervention, the other studies used several interventions together. In Colom et al. study (2004), psychoeducated patients had higher lithium levels at the 2-year follow-up study compared with control patients, which may suggest an effect of psychoeducation on pharmacotherapy adherence. They used three interventions together, so it cannot be concluded which part was useful, nor can the respective efficacy of each block be determined (Jurueña 2001).

Both treatment modes seek to improve the therapeutic approach that is provided in the hospital where research is being conducted, when the control group is treated as usual. Of course, these traditional treatments are not uniform across the board, although it is generally thought that the only treatment approaches that exist are either supportive or pharmacological. In a detailed study about the impact of an easy-access program, Bauer et al. described how treatment typically consisted of 30-min scheduled medication management visits to a psychiatrist, generally spaced 1-6 months apart. Need for care between appointments was addressed by the psychiatric triage team or the emergency room. Missed appointments were rescheduled at the earliest available time unless a known high-risk situation existed. Other studies do not provide such comprehensive information about how BD is usually treated.

Every contact with patients and their family members is an opportunity to educate them about living with bipolar disorder. The most obvious time is when the initial diagnosis is made. Often this occurs in an emergency room or inpatient unit when the patient is acutely ill. As patients' mental statuses clear, the education process begins. After patients' discharge from the hospital, the education process continues. Because, as was mentioned earlier, the symptoms experienced during the acute phase of treatment may have interfered with patients' abilities to grasp all the provided information, clinicians responsible for outpatient follow-up care can probe for how much information was retained and fill in any gaps. Information will be better retained if everyday experiences are used to illustrate the concepts being taught. Each outpatient visit offers an opportunity for clinicians to inquire about the experiences their clients may have had with the symptoms of bipolar disorder and the treatment. It is common for patients to change health care providers several times during the course of their lives. At each transition point, the education process begins again. Even if individuals previously received care from prominent clinicians with reputations for educating patients and their significant others, those who later care for patients should never assume that further education is unnecessary. Furthermore, as research continues to expand our understanding of the psychobiology and treatment of mood disorders, there will be new information to share (Jurueña, 2004).

4. Conclusion

We conclude that preliminary data on CT for BD are promising but more rigorous randomized trials are needed to confirm the efficacy of CT for BD. Another area of research should devote himself to understanding cognitive processes in BD which would allow us to refine and develop unique interventions for this disorder CT, seeking to assess the effectiveness of the cognitive approach, as important as drugs for the TAB.

Overall, it seems that there is promising but not conclusive data about the benefits of psychological treatments in BP. However, there is still much to learn and we need to evaluate whether our current views on psychological therapies in BP fit with the available evidence. For example, the main treatment guidelines on BP, like those on other mood disorders (e.g. American Psychiatric Association, 1993), acknowledge the role and importance of psychological therapies as well as medication. However, the guidelines all suggest that specialist psychological therapies are a precious resource that should therefore be targeted at the most difficult to treat cases. Whilst the notion that those with the most complex problems should be provided with the greatest input seems to make clinical sense, the data from the RCTs reviewed appears to undermine this idea. Persons who appear to consistently benefit from adjunctive psychological therapy are those at high risk of recurrence but do not have other complications or adverse clinical features that commonly accompany BP; i.e. the best candidates for psychological therapies are those with relatively fewer previous episodes, who are at above average risk of a further relapse, but who do not appear to have done well with medication and outpatient support, either because of some ineffectiveness of the prescribed medication or because they are not taking medication. Furthermore, the effect on depression is more marked than the benefit in reducing manic relapses. The latter is of interest because it has implications for psychological models of BP as many of them were initially developed to try to reduce the risk of mania (e.g. FFT to reduce EE and reduce mania; IPSRT to reduce circadian rhythm instability and social rhythm disrupting events and thus reduce manic swings) but appear to have a more overt effect on depression. The theoretical models underpinning the research clearly need to evolve further to maximize the effect on relapse rates. Further research is also needed to establish whether those individuals with more complex presentations of BP require a longer course of therapy e.g. CBT plus maintenance sessions, or whether a different model of psychological therapy needs to be introduced to help deal with the multiple psychological and social problems they confront over and above managing the consequences of BP.

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