Primary Psychiatry. 2003;10(5):65-71

Cognitive-Behavioral Strategies for the Management of Bipolar Disorder

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Focus Points

- Cognitive-behavioral therapy methods can be used to alter the course of depression and mania by targeting cognitions and behaviors known to exacerbate the illness, such as medication noncompliance and overstimulation.
- The conceptualization of noncompliance is expanded to consider the various stages of adjustment to having a chronic illness, beginning with denial and ending with integration of the disorder into the patient's lifestyle and goals.
- Traditional cognitive therapy methods that challenge distorted cognitions are applied to hypomanic thoughts, such as grandiosity, as a means of aiding patients in differentiating the emergence of mania and normal creative processes.

Abstract

Bipolar disorder is a chronic and severe psychiatric disorder characterized by recurrent episodes of depression and mania. Although considered to be biological in nature, the symptoms of bipolar disorder can be influenced by environmental, behavioral, and cognitive factors. Such factors include psychosocial stressors, medication noncompliance, and negative thinking. Cognitive-behavioral therapy can be beneficial as an adjunctive treatment to help patients anticipate and respond to early exacerbations of illness with the goal of preventing full recurrences of depression, mania, and mixed states. Early evidence suggests that educating patients about the nature of their illness, developing methods for early detection of recurrent symptoms, and improvements in medication compliance can lead to better outcomes than standard pharmacologic treatment. This article introduces cognitive-behavioral interventions for the management of bipolar disorder. Case examples, which illustrate the implementation of such treatment strategies, are provided.

Introduction

Bipolar I disorder is a severe and persistent mood disorder characterized by episodes of depression, mania, hypomania, and mixed states. The *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition,[1] and the text-revised version[2] provide criteria for diagnosis of major depression, mania, and mixed episodes (Tables 1, 2, and 3). A diagnosis of bipolar I disorder can be made after the occurrence of one episode of mania, and is maintained despite future episodes of major depression.[1] A diagnosis of bipolar II disorder can be made after an individual has experienced at least one episode of hypomania and at least one episode of major depression.[1] Bipolar II is often mistaken for major depressive disorder because hypomanic episodes rarely come to the attention of health care providers and may not be self-identified as an abnormal state, especially if the affective changes are positive in nature. A diligent assessment of symptoms, preferably using structured diagnostic methods, is recommended to maximize diagnostic accuracy.[3]

Episodes of depression, mania, hypomania, and mixed states produce changes in mood, cognitive processing, and regulation of vegetative functioning. Typical affective changes can include sadness or euphoria in depression and mania, respectively, but either state can produce irritability, anxiety, and anger. Cognitive functioning changes occur in both process and content. Process changes are characterized by slowing of thought in depression and increased speed of thought in mania, while content changes include negativity in depression and in mixed states and grandiosity or paranoia in manic states. These changes in mood and cognition inevitably give rise to behavioral changes, typically increases in activity in mania and decreases in activity in depression, all of which can negatively affect the individual's psychosocial functioning.[4] For example, decreased work efficiency, less attention to household or family responsibilities, and neglected social activities bring negative consequences to patients as well as to those in their primary support groups. In mania, risk-taking behaviors, disorganized hyperactivity, reduction in sleep time, and omission of medication dosages quickly exacerbate symptoms, reduce quality of functioning, and create significant psychosocial problems. Bipolar disorder is a stress-sensitive illness. Therefore, the new difficulties produced from emerging symptoms can drive the progression of episodes of illness, creating a cycle that feeds symptoms and further worsens functioning.

Cognitive-behavioral therapy (CBT) for bipolar disorder[3] was developed to aid patients and clinicians in breaking this cycle of illness by providing interventions that reduce the intensity of emerging affective and cognitive symptoms as well as control behavior changes, thereby reducing impairments

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Disclosure: The authors report no financial, academic, or other support of this work.

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in functioning. Implementation of these methods is dependent upon recognition of the appearance of symptoms early in their course while patients are still able to exercise some control over their thoughts and actions.

Education and Symptom Detection

CBT begins with an educational phase where information is provided on the symptoms of the illness, episode progression, and treatment options.[5] This is best accomplished in session using the patient's experiences to illustrate the phenomenology of the illness. It can be helpful to supplement this explanation with written materials. To assess the patient's knowledge and to clear up potential inaccuracies, physicians should begin by asking patients what they already know about their illness and to provide clarification and elaboration as needed.

With the goal of sensitizing patients to their unique symptom presentations within episodes, a symptom summary worksheet[4] is used to list the physical, emotional, cognitive, and behavioral symptoms that occur during both manic and depressive episodes. A marker board divided into three columns labeled "normal," "depressed," and "manic" can aid the discussion. Physicians should ask patients to describe what they are like when they are depressed, manic, and when feeling fine. The listing of symptoms should begin with the episode type most recently experienced.

In the "depressed" column a patient may indicate inability to concentrate well enough to read, in the "manic" column the patient may indicate having racing thoughts, while in the "normal" column the patient may note reading the paper daily and having no difficulty staying on task. Physicians should begin the symptom summary worksheet during the session and assign its completion as homework. They should encourage the patient to elicit feedback from family members and friends regarding symptoms. To make the most out of this exercise, copies of the symptom summary should be provided for the treating psychiatrist or therapist, the patient, and the patient's family members or friends who might aid in monitoring symptoms.

Mood graphs can be used to track daily changes in affect, cognition, behavior, or physical symptoms.[4] Simple scales can be developed by the patient with the therapist's assistance or a simple likert-type scale can be utilized. The most useful mood graphs are those that are easy to use, convenient, and meaningful to the patient. Mood ratings should be adapted to another daily activity such as looking at a personal calendar, watching a daily television show, or taking medication. Ratings can be made one or more times each day depending on the mood fluctuations experienced by

Table 1
***DSM-IV-TR* Criteria for Manic Episode[2]**

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week or requiring hospitalization
B. Three or more of the following symptoms are present (four with irritable mood):
1. Inflated self-esteem or grandiosity
2. Decreased need for sleep
3. More talkative than usual or pressure to keep talking
4. Flight of ideas or subjective experience that thoughts are racing
5. Distractibility
6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
7. Excessive involvement in pleasurable activities that have a high potential for painful consequences

C. Not a Mixed Episode
D. Symptoms cause impaired functioning or need for hospitalization
E. Not due to a general medical condition, substance abuse, or antidepressant treatments

DSM-IV-TR=Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition Text-Revision.

Basco MR, Merlock M, McDonald N. *Primary Psychiatry.* Vol 10, No 5. 2003.

Table 2
***DSM-IV-TR* Criteria for a Major Depressive Episode[2]**

A. Five (or more) of the following symptoms must have been present during the same 2-week period and must represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure. Symptoms are not due to a general medical condition or psychotic symptoms.
1. Depressed mood most of the day, nearly every day
2. Markedly diminished interest or pleasure in activities
3. Significant change (increase or decrease) in weight and/or appetite
4. Insomnia or hypersomnia
5. Psychomotor agitation or retardation
6. Fatigue or loss of energy
7. Feelings of worthlessness or excessive or inappropriate guilt
8. Diminished concentration or indecisiveness
9. Recurrent thoughts of death, recurrent suicidal ideation, or suicide attempt or plan

B. Not a Mixed Episode
C. Symptoms cause clinically significant distress or impaired functioning
D. Not due to a general medical condition or substance abuse
E. Not better accounted for by bereavement

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Table 3
***DSM-IV-TR* Criteria for a Mixed Episode[2]**

A. Criteria are met for both a manic episode and for a major depressive episode nearly every day during a period of at least 1 week.
B. Symptoms cause clinically significant distress or impaired functioning, or need for hospitalization
C. Symptoms are not due to a general medical condition, substance abuse, or antidepressant therapy

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the patient. Mood graphs facilitate medication and therapy visits because the provider can quickly see the pattern of symptom progression over the weeks since the last visit. A treatment manual for bipolar disorder created by Basco and Rush,[4] provides several examples of mood graphs that can be photocopied for patient use.

Treatment Compliance

Poor compliance with treatment is a common problem for patients with bipolar disorder,[6,7] but patients err in their consistency with treatment for a variety of reasons. Compliance is not a character trait, but a behavioral pattern that varies over time. While denial of illness is the most commonly cited explanation for this behavior, there is only limited empirical evidence that it plays a role in treatment compliance.[8] In fact, data suggests that while lower levels of denial may facilitate compliance, achievement of acceptance of the illness does not guarantee adherence.[9]

Using the model of adjustment proposed by Kubler-Ross[10,11] for coping with grief and loss, acceptance of a lifetime diagnosis of bipolar disorder requires passage through the phases of denial, anger, bargaining, and depression, each of which can influence the degree to which patients are cooperative with treatment.[12]

During the *denial* phase, which can reoccur as the patient experiences recurrences of mania as well as when euthymic, treatment may seem unnecessary since the illness does not exist. To cope with denial, the clinician must explore the patient's reasoning using logical analysis techniques such as the common CBT method of Socratic questioning[13] or asking the patient to generate and test alternative explanations for their symptomatology, such as having a mental illness.[12]

During the *anger* phase, patients complain of the unfairness of their plight, lash out against health care providers for failing them, or blame their parents for their genetic or psychological contributions to the problem. They may reject treatment because it represents validation of the problem, which they would prefer to ignore. To aid patients in this time of distress it is most helpful to validate the unfairness inherent in having a major psychiatric illness rather than to move too quickly to resolving any cognitive distortions or urging them to be less angry.[12]

The *bargaining* phase is exemplified by patient self-adjustments in medication dosing schedule, most of which are unsystematic and/or impulsive. Adding or reducing doses, changing the timing, or omitting some or all medications are ways in which patients bargain with themselves and their psychiatrists about taking medications. Some may tell themselves that they will change sleeping or other behavioral habits so that less medication will be needed. Others bargain with themselves, family members, or even physicians to decrease their alcohol or illicit drug intake in exchange for a reduction in prescribed medications. To cope with bargaining, clinicians can raise the issue of how or when the amount of medication taken might be lessened. Many clinicians give their patients some control over the treatment by providing some medications on a PRN rather than daily basis or by working on systematic ways to evaluate the minimum doses necessary to contain symptoms. While some clinicians may be wary of such discussions, directly addressing a patients' desire to take as little medication as necessary will reduce the likelihood that patients will make adjustments on their own.[12]

Before fully accepting the meaning of their diagnosis, but after denial has been replaced with understanding of their situation, some individuals may go through a *depression* phase in which they become very distressed over the reality of their predicament and prospects for the future. They mourn the loss of normalcy and grieve over the life that might have been. These feelings of sadness should not be too quickly addressed with CBT techniques that address catastrophic thinking. Instead, patients should be allowed to work through grief at their own pace. A cognitive therapist can pose questions for patients' consideration including what having the illness means to them, their futures, and their relationships. Exploration of the real versus imagined impact on their lives of having bipolar disorder and development of ways to cope with the inevitable disruptions that will occur may help patients feel a greater sense of control. Feeling less hopeless, they will begin to plan ahead, take precautions, and assume greater responsibility for the factors that influence their course of illness.[12]

Control of Subsyndromal Symptoms

When beginning a new episode of mania, but still within the hypomanic range of symptoms, patients will present with positively biased, but inaccurate thoughts, creative ideas, and overconfidence that borders on grandiosity.[4] Those who have been educated regarding the symptoms of mania will know that creative ideas can be a sign of hypomania, even when they feel confident that their idea is a winner. For example, Doug provided an excellent example to his bipolar support group of having a "really great idea," but feeling concerned that mania may be impairing his judgment. With the assistance of the support group members, Doug was able to use a traditional cognitive therapy intervention of listing evidence to support the notion that his newest business venture was surely a winner. Included in the list was his assessment of the feasibility of the project, demand for the product of interest, likely financial gain, and agreement from a trusted family member that his idea was sound. Doug spoke loudly and rapidly, making it somewhat difficult for the group leader to interrupt and direct his efforts.

Being as objective as possible, the group leader helped Doug enumerate the evidence against the notion that his was a "really great idea," and helped him realize it was a hypomanic fantasy. In the list of refuting evidence, Doug noted other symptoms of mania that he was currently experiencing. Others in the group reminded Doug of his earlier statements about feeling better than he had in years and about his purchase of a new car earlier that day. Doug was troubled by these observations, though he did not deny their accuracy. He added that he had been down the path of mania before when great ideas turned out to be poorly planned and problematic and that there was some similarity in this instance to times past. The leader added that he noticed how difficult it had been to interrupt Doug during his presentation—a common sign of hypomania.

Bravely agreeing to allow the group to vote on their assessment of the evidence, Doug turned to face the crowd as they raised their hands in support of the view that Doug was hypomanic and his current idea was suspect. In response to this feedback, Doug agreed to put his idea "on the back burner" as his psychiatrist had suggested when talking with him on the phone earlier in the day, monitor his mood changes more closely, make a special effort not to forget to take his medication, and see his doctor as soon as possible.

The behavioral symptoms of bipolar depression can be addressed using traditional CBT methods such as activity scheduling, graded task assignment, and increasing mastery and pleasure.[13] The goal is to increase and organize activity so that patients experience more pleasure and are able to achieve their goals. These behavior changes are associated with improved outlook for the future and better self-esteem.

In mania, the strategy is to reduce stimulation, in part by containing activity. Similar behavioral interventions to those used in depression can be adapted to mania. Organizing activity, setting limits on daily goals, and encouraging patients to complete the tasks that they initiate, help to reduce the overstimulation that comes from excessive and disorganized action.

Another strategy is to target external sources of overstimulation such as noise, busy environments, conflicts with others, or the Internet. Patients can usually identify the sources of overstimulation in their environments and make plans to limit their exposure. For example, Sally loved talking with her best friend at the end of the day, but the conversation was often so stimulating that she had difficulty falling asleep. Sleep loss seemed to induce hypomania in Sally as is the case for many people with bipolar disorder. To control this source of stimulation, Sally set an upper limit on the time to complete her phone call to her friend which allowed at least 1 hour before bedtime to engage in relaxation activities. Physically disengaging from the phone call proved to be relatively easy, however, mentally disengaging was more difficult as the conversation usually stimulated thoughts that were difficult to put out of her mind. To control her increased amount and rate of thought following the evening phone time, Sally turned off her television and radio, prepared for bed, and listened to a relaxation tape which emphasized sensory awareness.[14] This method is different from the more commonly used progressive muscle relaxation in that it distracts the patient by drawing his or her attention to mental images (eg, "Can you imagine looking at something that is very far away?") and various physical sensations (eg, "Can you be aware of one leg being more relaxed than the other?")

The increased creativity and ideas that many people experience early in the evolution of mania is a product of the illness, but can also serve to drive the episode further. While creativity should not be discouraged, patients can exert some control over the timing and duration of creative thought. The two principles regarding creative thought are "finish what you start" and "not so close to bedtime." Distractibility can keep people from finishing a task before starting the next, but with some self-awareness, patients can discipline themselves to complete what they start. The drive to switch activities prematurely is fueled by the fear that the "great idea" will be forgotten if not acted upon immediately. To solve this problem, patients can keep a running list of "great ideas" in a notebook, computer file, personal digital assistant, or as some patients prefer, on self-stick notes that are placed on a mirror or refrigerator door.

The "not so close to bedtime" principle encourages patients to set aside time after dinner for the mental activity that seems to occur while lying in bed. This might include a review of the day, conversations with people, or new ideas. A pad and pencil can help patients to organize their thoughts, jot down notes on what they will do tomorrow to address any remaining issues from the day, or sketch out new ideas. This activity should not take place in the bedroom, but in another location not associated with sleep and should be completed early enough in the evening to allow the patient to relax, quiet their minds, and prepare for sleep.

Efficacy of CBT for Bipolar Disorder

Though still in its infancy, some empirical studies of CBT for bipolar disorder have suggested that such treatment can be beneficial in increasing medication compliance, managing symptoms, and improving quality of life.[14-17] Cochran[15] conducted the first study of CBT targeting thoughts and beliefs that interfered with lithium compliance. Patients were randomly assigned to 6 weeks of CBT (n=14) or standard care (n=14). At posttreatment and 6-month follow-up, the CBT group was significantly more compliant, less likely to terminate lithium treatment against medical advice, and had significantly fewer hospitalizations and noncompliance-precipitated affective episodes than patients randomized to standard care.

More recently, Lam and colleagues[16] found that providing early detection and symptom management skills to patients with bipolar disorder using CBT led to fewer episodes and mood fluctuations, better coping skills for prodromal symptoms, and improved compliance at posttreatment and 6-month follow-up. Similarly, a test of CBT for relapse-prevention conducted by Scott and colleagues,[17] showed that patients receiving 6 months of CBT showed significantly fewer symptoms and improved social functioning compared to a wait-list control group.

Fava and colleagues[18] assessed the long-term efficacy of a CBT intervention aimed at reducing residual symptoms in 15 patients with bipolar I disorder who had relapsed while on lithium prophylaxis. Results showed significant decreases in residual symptoms and increased time to relapse.

Conclusion

Bipolar disorder is a severe and persistent mental illness characterized by recurring episodes of depression, mania, and mixed states. Although pharmacologic treatments have greatly improved in the past 30 years, a number of limitations in medication treatment still exist. Problems with poor medication compliance, symptom breakthrough, and psychosocial stressors that exacerbate the illness continue to place patients at high risk for relapse. New evidence is emerging for the efficacy of cognitive-behavioral strategies in the management of bipolar disorder. Particularly helpful are those strategies that help patients to identify the earliest signs of symptomatic relapse. Early identification of

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recurrent symptoms allows for quick intervention, which appears to reduce the rate of relapse and the need for hospitalization.

Using a symptom summary list for depression and mania sensitizes patients to the changes that are indicative of relapse. Mood and symptom graphs can be used as daily thermometers of affect, allowing patients to monitor and respond to subtle changes in mood, cognition, behavior, and physical symptoms. Traditional cognitive restructuring interventions can be used to reduce distortions in thinking that worsen depression, but can also be implemented to help evaluate hypomanic thoughts. Behavioral activation exercises typically prescribed for depression can be used to limit or control actions in the hypomanic and manic phases of the disorder. Reconceptualizing nonadherence to medication treatment from a character flaw to a behavior management problem allows clinicians to help patients trouble-shoot their medicine-taking habits, eliminate the obstacles to adherence, and increase the likelihood of compliance. Taken together, these cognitive and behavioral strategies provide patients and clinicians with the additional tools needed to manage bipolar disorder. ***PP***

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2003 Psychiatry Meetings

The following is a brief listing of major psychiatric conferences within the next few months.

American Psychiatric Association
156th Annual Meeting
May 17-22
San Francisco, CA

New Clinical Drug Evaluation Unit
43rd Annual Meeting
May 27-30
Boca Raton, FL

Royal College of Psychiatrists
Annual General Meeting
June 30-July 3
Edinburgh, Scotland

International Psychogeriatric Association
11th International Congress
August 17-22
Chicago, IL

International Association for Suicide Prevention
22nd Annual Congress
September 10-14
Stockholm, Sweden

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