Cognitive Therapy for Bipolar Disorder
A Therapist's Guide to Concepts, Methods and Practice
Second Edition
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Since the publication of the first edition in 1999, the last decade has witnessed a proliferation of randomised controlled trials to test the prophylactic efficacy of adding psychological therapies, specifically developed for bipolar disorders, to routine medication. These include cognitive behavioural therapy, interpersonal social rhythm therapy, family-focused therapy and complex psycho-education.

This book describes our attempts at working with bipolar patients as a form of prophylactic psychotherapy in conjunction with medication. The results of a large randomised controlled study (Lam et al. 2003; Lam, Hayward et al. 2005) showed that our approach of combining cognitive behavioural therapy and medication could provide a desirable effect for bipolar patients who have not done well with prophylactic medication alone. Patients randomly assigned to the cognitive behavioural therapy group had significantly fewer days in bipolar episodes, fewer mood symptoms and higher social functioning. We also demonstrated the beneficial effect of our approach in our health economy study. Despite the cost of therapy, our approach is significantly less expensive than routine care (Lam, McCrone et al. 2005).

The treatment package described in this book contains elements from traditional cognitive therapy for depression (Beck et al. 1979). It also includes elements specifically devised for treating the particular difficulties experienced by individuals with bipolar illness. This is based on the combined work of the authors over several years in developing a treatment approach that is practical and acceptable to clients, whilst also based on a current understanding of the psycho-social aspects of bipolar illness.

This book is in two parts. The first part (incorporating the first four chapters) aims to provide readers with a basic knowledge about bipolar disorders, treatments available so far, the psycho-social aspects of bipolar disorders and our model for psychological intervention. The second part describes the treatment package. It consists of chapters on the pre-therapy assessment, how to introduce the model to patients, specific cognitive and behavioural techniques for bipolar disorders, and self-management and coping with prodromes. It also describes long-term issues, the sense of the self, family and social aspects, interpersonal issues in therapy and issues related to services in the context of bipolar disorders.
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Chapter 1

INTRODUCTION TO BIPOLAR DISORDER

This book describes the use of cognitive behavioural therapy in the treatment of bipolar disorder. Although the terms ‘manic depression’ and ‘bipolar disorder’ have been used interchangeably in the past, the latter is now more commonly used in both the United States of America and Europe. Bipolar disorder is a mood disorder, characterized by mania and depression. The diagnostic criteria for bipolar disorder are taken from the current *Diagnostic and Statistical Manual IV* (American Psychiatric Association 1994) and will be described in more details below. This identifies that depression, mania, hypomania and mixed affective episodes can exist within a bipolar diagnosis. In our approach, it is accepted that bipolar disorder is a significant mental health problem. Bipolar disorder affects a substantial proportion of the adult population and usually strikes in early adulthood. The course of bipolar illness tends to be relatively severe with many people suffering from multiple episodes. Recurrence of illness can be associated with a range of factors, which include substance abuse, family and relationship difficulties, and persistence of subsyndromal symptoms between episodes. In addition to a pattern of recurrent episodes, there is a substantial risk of completed and attempted suicide associated with bipolar illness. These issues are highlighted in this introductory chapter to indicate the potential scale and severity of problems with which people with this diagnosis can be faced.

An important issue in approaching the psychological treatment of bipolar disorder is whether people can identify developing symptoms at relatively early (prodromal) stages. If such prodromes exist and can be identified then opportunities may exist for effective psychological intervention at those points. The ability of patients to detect and cope constructively with prodromes is therefore discussed in some detail as intervention in this area forms an important part of the therapeutic strategy discussed later in the book.
Individuals with a history of bipolar disorder will often have experienced periods of heightened creativity and increased productivity during periods of elevated moods. It is therefore not surprising that patients will report missing these periods when their bipolar disorder is stabilized by medication. Conversely, individuals with chronically unstable mood may tend to use substances or alcohol in an effort to self-medicate.

In addition to bipolar disorder, there are a range of bipolar spectrum conditions which do not meet full DSM-IV criteria. Angst et al. (2003) and Akiskal et al. (2000) have both investigated the nature of these conditions and reported on their clinical importance. Although the severity of mood symptoms is apparently less severe in these disorders, the clinical and functional outcomes for the individual can still be serious. These conditions will therefore be considered.

The social costs of bipolar illness are substantial. People tend to break down at what would usually be the beginning or early part of their careers, with very few sustaining their chosen line of work. Difficulties with family relationships are common and rates of divorce are high. Social functioning even between episodes tends to be impaired. These factors create a picture of multiple difficulties present throughout the course of the illness.

This introductory chapter identifies the above issues to highlight the nature, severity, frequency and impact of this illness. It underlines the urgency with which more effective treatment approaches, which acknowledge both the psychological and pharmacological aspects of the disorder, need to be identified. It is hoped that the approach described within this book will form one part of this endeavour. The topics covered in this chapter are diagnostic criteria, epidemiology, factors in recurrence of the illness, bipolar prodromes, cyclothymia/bipolar spectrum disorders and high social costs.

**Diagnostic Criteria for Bipolar Disorder**

Kraepelin (1913) described manic-depressive illness as encompassing the categories then employed of circular psychosis, simple mania and melancholia. This overall category was distinguished from dementia praecox in terms of course and prognosis in particular. Manic-depressive illness was seen to be a disorder of fluctuating course in which periods of normality were interspersed with periods of illness and prognosis was thought to be less bleak than the inevitable ongoing decline in functioning attributed to dementia praecox. Leonhard (1957) distinguished between bipolar and monopolar forms of manic-depressive illness: the former identifying patients with a history of mania and the latter those who suffered depression only. The distinction between bipolar and unipolar depression as currently used was introduced into the *American Diagnostic and Statistical Manual III* (DSM-III: American Psychiatric Association 1980) and has more

**DSM-IV Criteria**

The current DSM-IV (American Psychiatric Association 1994) is the diagnostic scheme which has been employed in our research into the role of psychological treatments in bipolar disorder and will therefore be referred to in some detail in this section.

Bipolar disorder is characterized as a mood disorder within DSM-IV. The criteria specify first the mood episodes that can be included within a diagnosis of bipolar disorder. These are (1) major depressive episode, (2) manic episode, (3) mixed episode and (4) hypomanic episode. The precise details of each episode type are described in the DSM-IV manual (American Psychiatric Association 1994). An indication of the relevant symptoms is provided below.

**Major Depressive Episode**

A major depressive episode is characterized by depressed mood or loss of interest or pleasure along with symptoms including changes in weight and sleep, problems with concentration and decision making, reduced energy, and either agitated or slowed psychomotor activation. Other possible symptoms include feelings of guilt and thoughts concerning death or suicide. At least five of these nine possible symptoms listed in DSM-IV must be present for a minimum of two weeks, always including either depressed mood or loss of interest or pleasure. Symptoms must be of sufficient severity to cause clinically significant distress or impairment in occupational, social or other important areas of functioning.

**Manic Episode**

In contrast, a manic episode mood is required to be ‘abnormally and persistently elevated, expansive or irritable’ for a period of at least a week. Additional possible symptoms experienced in mania include increased self-esteem even to the point of grandiosity, increases in activity including becoming more talkative and engaging in potentially risky behaviour and distractibility. Some individuals report racing thoughts and flights of ideas, whilst for many individuals reduced need for sleep is common during mania.

DSM-IV requires at least three (four if mood is only irritable) of the symptoms listed in the manual in addition to mood disturbance for a
period of at least a week to meet diagnostic criteria. Disturbance again has to be sufficiently severe to cause marked impairment in occupational functioning, usual social activities, or in relationships with others. It may require hospitalization and may include psychotic features in the symptom presentation.

**Mixed Episode**

A mixed episode is described as one in which symptom criteria for both manic and major depressive episodes (with the exception of the duration criterion) are met nearly every day over a period of a week at least. The disturbance of mood needs to be 'of sufficient severity to cause marked impairment in occupational functioning, in usual social activities or relationships with others'.

**Hypompanic Episode**

A hypompanic episode has the same symptoms as those of manic episode except delusions or hallucinations may not be present. Mood disturbance required is for **only four days** rather than a full week and has to be 'clearly different from usual undepressed mood' rather than 'abnormal', which suggests less severe disruption of mood. In contrast to mania disruption in social or occupational functioning is not marked, hospitalization is not required and psychotic features are absent.

**Bipolar I Disorder**

Bipolar I disorder requires the presence of at least one manic episode during the person’s psychiatric history. A diagnosis of the first manic episode also falls within the bipolar I disorder heading. Other variants of bipolar I disorder are: (1) most recent episode hypompanic; (2) most recent episode manic; (3) most recent episode mixed; (4) most recent episode depressed or (5) most recent episode unspecified (in this category symptom, but not duration, criteria are met for at least one of the above disorders of mood).

**Bipolar II Disorder**

Bipolar II disorder describes individuals who experience recurrent major depressive episodes with hypompanic episodes, but without meeting manic episode criteria during their psychiatric history.
Rapid-Cycling Specifier

In both bipolar I and II disorders a rapid-cycling specifier is added when four or more episodes occur within a given year.

Cyclothymic Disorder

Cyclothymic disorder requires the chronic presence of ‘numerous periods’ of hypomanic and depressive symptoms over a two-year period which do not meet full criteria for either mania or a major depressive episode. At no time during the initial two-year period must criteria for major depression, mania or mixed state be met. Symptom-free intervals during this period must be of no longer than two months’ duration. Mood disturbance must be sufficient to cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. This is differentiated from rapid-cycling bipolar disorder by not reaching full symptom criteria for any of the three categories above during the course of the disorder.

Although DSM IV includes this as a separate mood disorder, it is clear that there is the potential for diagnostic confusion between this and milder forms of bipolar disorder. Furthermore, whilst not included as a personality disorder within DSM IV, cyclothymia is described elsewhere as a personality type – this is discussed further later in the chapter.

EPIDEMIOLOGY

Recent epidemiological studies indicate lifetime prevalence rates of bipolar disorder I/II of around 2%, with rates rising to 5% when subthreshold bipolar conditions are included (Grant et al. 2005; Merikangas et al. 2007). Adolescence represents the period of greatest increase in risk of bipolar disorder with a peak onset between ages 15 and 20 years (Kupfer et al. 2002; Merikangas et al. 2007). Perlis also reported that individuals with an early onset (prepubertal-adolescent) experienced higher rates of comorbidity, self-harm, violence and recurrence of illness compared to those with later adult onset of bipolar disorder (Perlis et al. 2004; Perlis et al. 2005). Clearly, therefore, this indicates a disorder that usually develops within early adulthood, can be present in teenage years and is associated with worse clinical outcomes when onset is early. Studies are consistent in reporting similar prevalence rates for men and women.

For individuals with this disorder there appears to be a pattern of significant social disability and likely relapse in many cases. Winokur et al. (1969) estimated that 80% of individuals with an initial diagnosis of mania would go on to have further episodes. More recently, Bromet found that 35% of patients who had been hospitalized for a first episode of bipolar disorder relapsed within a year of achieving remission and 61% over the
four-year study period (Bromet et al. 2005). In spite of this pattern of recurrence, and in contrast with schizophrenia, there is little evidence of downward social drift associated with bipolar illness. Thus, most studies of social class in relationship to bipolar disorder suggest that either there is no association or that rates of disorder predominate in middle and upper social or professional groups (Weissman and Myers 1978; Coryell et al. 1989). There appears to be no consistent evidence to support elevated prevalence rates according to marital status or to city or rural locations.

COURSE OF BIPOLAR DISORDER

In a general population study of bipolar I disorder (in this case using DSM-IIIR criteria) conducted in America it was found that there was a 0.4% lifetime prevalence of this disorder, with a similar 12-month prevalence rate (Kessler et al. 1997). All cases apparently reported at least one other DSM-IIIR disorder and in almost 60% of cases these predated the onset of bipolar illness. This study indicates, therefore, that for many people with bipolar illness they may well have additional psychiatric difficulties beyond those associated with this specific diagnosis.

Interestingly, this general population study also identified that only 45% of those identified as currently experiencing bipolar illness were in treatment. Whilst this may in part be due to patchy availability of mental health services, so that some people who may have welcomed psychiatric help had difficulty accessing it, it is unlikely that this is a sufficient explanation. Additional factors are likely to include the limitations of currently available pharmacological treatments and limited availability of alternative or additional forms of treatment such as psychotherapy. Thus Prien and Potter (1990) estimated that lithium may be ineffective in up to 40% of cases whilst Miklowitz et al. (2003) recently reported relationships between medication and outcome for manic but not depressive episodes in individuals receiving family psycho-education. Thus, some people with a bipolar diagnosis may not significantly benefit from their particular medication regime either through lack of efficacy or non-adherence which would both be likely to be associated risk of dropping out of contact with mental health services in general. Those who have done so will tend not to appear in studies of the course of bipolar illness and hence there is some risk that the information currently available is skewed towards those patients who are responsive to and/or adherent with treatment.

Number of Episodes

Early estimates suggested that few patients experienced more than three episodes of mania or depression in total. However, this seems to have been