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UP AND DOWN: FINDING BALANCE WITH COGNITIVE BEHAVIOURAL THERAPY

LAM, D.H., S.H. JONES & P. HAYWARD (2010) *Cognitive Therapy for Bipolar Disorder: A Therapist's Guide to Concepts, Methods and Practice* (Leicester, UK: Wiley-Blackwell) 334 pp., 23 cm, ISBN 978-0470779378, €112.

The authors have treated patients with bipolar disorder (BD) for decades. D.H. Lam is Professor of Clinical Psychology, Head of Clinical Psychology Department and Programme Director of Doctoral Degree in clinical psychology at the University of Hull. His research interests are mood disorders, including BD. Steven H. Jones is Professor of Clinical Psychology and Director of the Spectrum Centre for Mental Health Research at Lancaster University. His field of research is mental health, and for the last decade his primary interest has been the diagnostics and treatment of BD. Both of them have published widely on intervention and treatment of BD. As a cognitive behavioural therapist, Peter Hayward PhD has worked with patients with several mental problems on a clinical basis. He is retired now but continues his practice in private.

The book describes the treatment approach of cognitive behavioural therapy with bipolar disorder patients. The authors accept that BD is a serious and important mental illness; patients suffer from multiple episodes, which have immediate and/or long-term consequences in several areas of their lives. The authors emphasise that cognitive behavioural psychotherapy is an effective adjunctive to pharmacological intervention that helps clients to cope with the disorder. The second and updated edition of the guide incorporates the latest research and studies in the field of BD. The 13 chapters of the book can be divided into two parts. The first four chapters summarise the basic knowledge about BD, treatment, psycho-social aspects and the authors' model for psychological approach. The second, main part focuses on the therapeutic treatment in detail, based on the cognitive behavioural concept.

The first chapter describes the diagnostic criteria for BD taken from the current Diagnostic and Statistic Manual IV; epidemiology, severity and impact of the disorder are discussed. Patients may face several episodes with different lengths. The detection of prodromes can help clients to cope with their illness and cause less frequent relapses. The chapter highlights that people can spontaneously identify when they experience prodromal manic and (to a lesser extent) depressive symptoms. Some of them are common in the disorder, but many symptoms are very idiosyncratic. Manic phases are more public, more noticeable, have more positive aspects, benefits, and may have immediate or long-term negative consequences associated with occupational or financial loss and social embarrassment. Depression may also hinder social functioning; it can cause financial difficulties, child neglect, marital

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problems, loss of status and prestige, etc. Recurrence is associated with more factors, e.g. substance abuse, domestic atmosphere; the risk of mortality is also increased among patients with BD, so all these problems are presented.

The pharmacological approach has played the most important role in the treatment of BD, as discussed in Chapter 2. Lithium was the first described treatment, and is nowadays among the often prescribed medications. Recently, other medications, like antiepileptics and second-generation antipsychotics have come to be used in acute mania, depression and in rapid-cycling disorder. The side effects and non-compliance might hinder the effectiveness – despite the efficacy – of a pharmacological treatment. Psychotherapy was often ignored or just not prescribed. Psychotherapy was mainly used in a non-acute phase of the disorder. The authors provide a summary of some of the current therapy methods, like focused family therapy, group psychoeducation, teaching skills and individual cognitive behavioural therapy and individual interpersonal social rhythm therapy. There are only few controlled studies – and mostly pilot – of the effectiveness of the psychological approach and the authors urge more improvement in studies. At the end of this chapter, the authors summarise the difficulties patients face and the areas where the therapy can intervene.

Life events play an important role in onset and relapse in BD, but there is a discussion about which particular type of event or life stress is particularly important. The duration of stress, goal attainment, life events and its exaggerated positive or negative evaluation, events which disrupt social rhythm, personality and belief system seem to be important factors of the disorder. Among these questions Chapter 3 discusses that studies have shown that dysfunctional attitudes and assumptions are present in the disorder. The authors postulate for example that high goal attainment beliefs may interact with the illness and predispose clients to have a more severe course of the disorder, since it leads to extreme behaviour and irregular daily routine, which can make the course of the disorder more chronic and difficult to treat. Three diathesis-stress models – like (1) the behavioural activation system and reward responsiveness, (2) behavioural sensitisation and kindling, and (3) circadian disturbance and internal appraisal are presented. All of them share a diathesis stress approach in which biological, psychological and social elements are equally important. There is evidence that they have an effect on BD; however, it is not clarified exactly whether they are competitive or complementary models.

The authors' model presented in Chapter 4 assumes an interaction between stressors and biological vulnerabilities. Disruption of routine and sleep can lead to bipolar episodes through the disruption in circadian rhythms. Prediction, anticipation and prevention of such disruption in routine and sleep by stresses – not all life events, but irregular lifestyle, acute stress – can be an important aspect in the psychological management of BD.

Consistent with the cognitive model of affective disorders, the authors accept the thought that mood and behaviour affect each other. Patients are more sensitive to environmental signs of award (they lead to goal-directed activity) or frustrative non-rewards (that lead to non-engagement) leading to manic/depressive episodes.

The mood state can lead to selective abstracting mood-congruent information in the environment to feed the vicious cycle. Similarly, misattribution of bodily symptoms to personal weakness or self-potency or patients' behaviour during the prodromal stages can influence the course of an episode.

Patients go through prodromal stages of mania or depression of various lengths in an idiosyncratic way. Identifying symptoms, and coping with them during the prodromal stage can have important implications for the development from prodromal stages to full-blown episodes since mania can fuel itself and depression can spiral down. The best time to intervene is at an early stage of the course.

The authors argue that individual cognitive behavioural therapy can be useful in psycho-education, teaching cognitive behavioural skills to cope with prodromes, to maintain routine and sleep, and to deal with long-term vulnerabilities.

Cognitive behavioural therapy is adjunctive to medication, based on the collaboration between patient and therapist. The chapter closes with a short outline of treatment, some aspects of which are described in the following chapters in detail.

The second main part starts with the pre-therapy assessment in Chapter 5. The patients' personal and family history are very important, like early experiences, upbringing, education, important authentic figures, relationship with others, history of the illness, the perception of current and past treatment in order to put the illness in the clients' context, etc. The history of the disorder can be summarised in a life chart; the therapist and patient can together examine the pattern of the symptoms, prodromal symptoms, the course of the illness, the effect of medication and/or the neglect of medication and its consequences.

Clients' perception of the illness and treatment compliance and stigmatisation are discussed. Relevant core beliefs, dysfunctional attitudes are present by the patients. Clients' current mood state should be evaluated using tests, self reports and observation of the clients. Some clients are pessimistic about their future and their illness, so hopelessness and the risk of suicide should be assessed before the therapy starts. Social performance, like employment, intimate relationship, social presentation are also influenced by the disorder; these might be very idiosyncratic. Social support, its structural and functional aspects, satisfaction and dissatisfaction, expectations, formal and informal form are also to assess.

Introducing the model to the patient is very important; it helps the client to understand the model and the intervention and helps to develop a collaborative work with patients as described in Chapter 6. In the practice of the authors an information leaflet is given to the patient, which helps the client and the therapist to discuss the disorder and its treatment. They emphasise the interrelationship among thought, emotion, behaviour and environment, and that stress can trigger episodes. The life chart method helps the client to understand the model from the patient's own experiences and give an insight into the therapy methods. Problems, like denial of the disorder or major trust in pharmacology are also discussed.

Goal setting is so important in therapy that an entire chapter (7) is dedicated to it. Goals are identified in relation to the disorder at the beginning of the ther-

apy, but throughout the sessions of therapy additional goals may emerge. Different topics – like symptom reduction, medical compliance, functional goals, gaining greater control over patients' emotional, cognitive processes, building and using social services – can emerge. It is suggested to start with an immediate goal, which is realistic and attainable, while longer-term goals can be targeted later.

In Chapter 8 other specific cognitive techniques are discussed that can be used with patients, particularly when they are relatively stable, moderately depressed or hypomanic. Mood monitoring in a 24-hour period is recognised as being a key component and it is also important to teach the clients the distinction between normal and abnormal mood swings. In mood states, present dysfunctional, biased thoughts can be identified (e.g. need for approval, perfectionism or bad attainment), collected and changed in both depressive and hypomanic states. Some thoughts and themes are connected to the prodromal phases of the disorder in mania/depression, so they can be examined and reframed as symptoms. Some patients evaluate their hypomanic phase as positive, so they can analyse the cost and benefits of the disorder. In a hypomanic phase patients tend to act before they realistically evaluate their activities, so clients can learn delaying strategies to avoid negative consequences of their disorder. The identification and challenging of dysfunctional assumptions are part of the therapy; the questioning of unhealthy rules help to work out how to meet a new, healthy rule.

The guide continues with behavioural techniques in Chapter 9, to make the patients able to manage the disorder. Mood and activity are connected; a chaotic lifestyle and stressful events may cause changes in mood, routine, sleep, circadian rhythm, which can trigger depressive/manic episodes as underlined in the diathesis-stress model. Regular lifestyle, the development of a regular sleep and wake cycle routine and food intake seem to be a key to maintaining a stable phase. Skills in planning and management in routines and activities can be developed. Clients with BD need to plan time for activities they like and enjoy, they need to avoid crises and need to learn how to set priorities among their activities. Other useful strategies like relaxation, sleep routine, problem solving, sitting, listening targets are also presented. Stimulus control is to help the client to identify idiosyncratic stimuli that are associated with prodromes, e.g. alcohol or drug use, caffeine consumption, financial control or other risky behaviour. The changes are often recorded, put in vivo and discussed.

Identifying prodromal symptoms and signs is important in coping with the disorder. They can be targeted and revealed in the therapy. Previous chapters discussed techniques and skills of helping the client take more active control in order to manage the disorder. The pattern of the course can differ from patient to patient; the stages of manic/depressive phases and the length of each stage can be sorted out. Within the therapy, clients are asked to identify the prodromes in the domains of mood, cognition and behaviour at a different (early, middle and late) stage of depression/mania as described in Chapter 10, and different actions, coping strategies are collaboratively developed for each phase that help the patients to moderate the

symptoms and find balance. Most clients can describe their prodromes and possible coping strategies spontaneously; some might find it difficult to identify them, but the collaborative working style can help both the client and the therapist. Other self-management techniques, like forming a good routine, setting up a professional support network, building on a social network are also discussed in this chapter.

The definition of the self and long-term issues is targeted in Chapter 11. Patients with BD may struggle with defining the self, who they are in reality, in a depressed or euthymic phase. Some of them cannot accept the disorder, they might deny it or some might use it as an excuse. Prejudice and stigmatisation are also a present problem of BD clients; they can hinder the acceptance of the disorder. Patients may suffer from them and face difficulties at work or in applying for a job. Stigma, guilt and shame during the depressive phase are often intertwined; clients take an exaggerated responsibility or demand. Main depressive episodes can result in losses of job, loved ones, status, existence, etc. and in a therapy the therapist can work with the client to adjust to the new circumstances with CBT techniques, emotional processing. Anger and avoidance are also discussed since they are also part of long-term difficulties.

The patients' social environment is also to be attacked as introduced in Chapter 12. To make family members help the client cope with the disorder, patients and therapists should understand labile mood and behaviour and the burden of the family, financial difficulties, family problems, identity, loss of jobs, status, etc. According to the studies not only manic but depressive phase-related behaviour might burden families; emotional, practical, social support can help the family members to cope with the disorder of the client. Sessions with the spouse might help to stabilise the partnership. Education, helping to find compromise, agreement, (ir)responsibility for family, employment, etc. can be among the topics discussed. The family member can help to carry on the activities, coping strategies at different prodromal stages (described in Chapter 10). The acceptance of autonomy, the distinction of normal and abnormal mood swings, trust, changes in libido in the different phases of the disorder are suggested to be targeted in the therapy.

Finally, Chapter 13 raises some interpersonal and service-related issues. So-called nonspecific therapeutic effects are also important, like therapeutic alliance with clients who show inconsistency in mood states, behaviour, trust, intimacy, which can be very difficult to handle for the therapist. Reliability and trust are important, especially when patients are getting into the hypomanic stage. Showing interest and acceptance, making an effort to understand the patients, and accepting patients' autonomy even in their grandiose ideas, increased self-confidence, motives and/or inappropriate behaviour are part of the therapeutic relationship. The function of trust and rapport fulfils its special role in 'holding'. At this point patients can be very irritable or resentful toward the therapy; they may feel that they are not understood or the therapy is useless. It is suggested not to take criticism personally, but creating a therapeutic relationship of support, empathy, focusing on usefulness and evidence of progress, finding strategies for calming down, etc. are some of the strategies and issues presented. In case of pharmacological noncompliance the patients'

resistance, problems and fears can be targeted through discussing the consequences of taking or not taking medication. Psychological therapy is usually one part of the therapy/service; some of its difficulties, e.g. communication or team work are issues professionals should be aware of.

This book is a helpful treatment manual of cognitive behavioural therapy for BD patients written for professionals. It provides a basic knowledge of BD, including the latest studies. The book offers easy-to-follow guidance and illustrates the process of the therapy with many case examples. A wide range of strategies, monitoring tools, and handouts for patients are also presented. Some of the techniques and strategies were adapted from traditional cognitive therapy for emotional disorders, while others were specifically developed for bipolar disorder. Reading the book, the authors' point seems convincing that besides pharmacotherapy, cognitive behavioural psychotherapy should be prescribed for the complex and more effective intervention and treatment of bipolar disorder in patients.