

# Cognitive behavioral therapy for bipolar disorders

## Terapia comportamental cognitiva para pessoas com transtorno bipolar

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### Abstract

*Objectives and main techniques of cognitive behavior therapy for the treatment of bipolar disorder patients are described.*

**Keywords:** *Cognitive therapy, Bipolar disorder/therapy; Bipolar disorder/psychology; Mood disorders; Psychotherapy*

### Resumo

*Descrição dos objetivos e principais técnicas da terapia comportamental cognitiva usadas para a psicoterapia das pessoas com transtorno bipolar.*

**Descritores:** *Terapia cognitiva, Transtorno bipolar/terapia; Transtorno bipolar/psicologia; Transtorno do humor; Psicoterapia*

### Introduction and objectives

Bipolar Disorder (BD) has a strong biological component and is principally treated with mood stabilizers. However, the role of psychotherapy in the treatment of BD is considerable and the potential of this treatment has been little explored. We are confronting a chronic illness, which must be monitored and controlled over the lifetime of the patient. Therefore, patient cooperation is important, and therapy may be of assistance. The syndrome is influenced by stress factors and has significant psychosocial and interpersonal consequences, in addition to having a negative impact on patient quality of life. A significant percentage of BD patients do not respond well to current treatments, even when adhering to their treatment regimens, and continue to present phases, not to mention other problems such as stigma, demoralization and family problems, as well as the difficulties and psychodynamic conflicts we all face. There is a wide-open field for treatment with psychotherapy.<sup>1</sup>

The aims of cognitive behavior therapy (CBT) for BD patients:

- 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.

There are differences between CBT and traditional psychotherapy,

most related to the fact that, in CBT, patients are usually not in the acute phase of the disease. It is quite difficult for a patient to undergo therapy during mania. A more instructive form is presented through CBT, some techniques are simply taught and the schedule for each session may or may not be determined by a protocol. However, in no way is traditional therapy disregarded.

### Phases of treatment

For BD patients, CBT 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. Psychosocial and interpersonal problems are discussed and techniques for better dealing with such problems are taught. For examples, see "Problemas e Treino de Habilidades Sociais" ("Problems and Social Skill Training") by Hawton & Kirk.<sup>2</sup>

It is important to create a therapeutic alliance and to promote the active participation of the client in the treatment. Therefore, it is essential to share the philosophy or logic on which the established treatment is based, discuss any concerns regarding the treatment, negotiate therapeutic plans and initiate the treatment chosen by the patient.

The attention given to the family is an important element of the therapeutic alliance. The therapist should discuss symptoms and forms of treatment, as well as expectations for the future, with the family. It should be taken into consideration that the family also needs to deal with pain and suffering, and the therapist should create an atmosphere that is propitious for that. In addition, attention should be paid to small children since, in a crisis, they may be forgotten and may be scared or even neglected.

It is essential for the patient to decide who should be involved in the treatment. This will be useful if the patient is eventually hospitalized, or for deciding who should keep the credit cards and checkbook and take care of other important details.

When an individual is advised of having a chronic disorder, the significance of this revelation may vary from individual to individual.

The therapist should always remember to discuss this matter, at the onset and over the course of the treatment. The patient may be worried about chronic incapacity; the role of life events and stress in triggering new episodes, the lifetime use of medication, the hereditary issue (getting married and having children), pregnancy and breast feeding.

Adherence to drug treatment should be discussed in therapy, since patients are typically uncooperative. Nonadherence may be caused by prejudice, erroneous concepts, problems in the therapeutic alliance, side effects, wrong dose levels, forgetting to take medication, taking more than the prescribed dosage, taking medication prescribed for family or friends, confusing the medication schedule, use of alcohol or drugs, taking other medication that interferes with mood stabilizers (diuretics, anti-inflammatory drugs), or lack of resources to pay for the treatment. Severe psychopathology and personality disorders are predictive of nonadherence to treatment.<sup>3</sup>

### Techniques for monitoring symptoms

Another important element of psychotherapy is the early identification of the onset of a phase, so that it can be effectively controlled through intervention, thereby preventing problems and hospitalization. This is done through teaching patients and families to identify and monitor the symptoms of the disorder. A number of techniques may help in this process.<sup>3</sup>

Life mapping is a technique widely used in psychotherapy. In this technique, the patient draws a line on a piece of paper, identifying with ups, downs and colors the course of his life and illness. The patient may write down the number, sequence, intensity and duration of depressive and manic phases, the impact of treatment and important events. This provides the patient with a broader view of the course of the disease, stress factors and the influence of the treatment.

Identifying the symptoms is intended to help the person and family identify specific symptoms of the depressive and manic phases, differentiate between normal and pathological mood states, be aware of the clinical situation and deal with family conflicts, in which the problem is often attributed to the illness of the patient. In addition, the therapist will help the patient understand what life changes to expect during depression and mania, as well as how the way he sees himself, others and the future may change. Will others notice or realize what is happening? What will people say? Manic and depressive symptoms are reviewed, identifying which occurred at onset of the phase. Finally, the therapist asks the family for assistance (describing the difference between when the patient is in a normal state and when he or she begins to feel ill).

Indicators of normal behavior include the following abilities: sitting and read a book or newspaper for an extended period without feeling bored; being a good listener in a social conversation; not testing social boundaries or taking risks; completing tasks without becoming distracted; not becoming overly anxious or concerned about daily demands (responsibilities, financial obligations, etc); taking pleasure in moments of quietness and serenity; sleeping well at night and accepting constructive criticism without becoming annoyed.

The following are typical initial symptoms of mania or hypomania:<sup>4</sup>

- 1) Decreased need for sleep
- 2) Sharp decrease in anxiety
- 3) High levels of optimism, with little planning
- 4) Urge to relate to people, but with little ability to listen
- 5) Decreased concentration

6) Increased libido with diminished rationality and capacity for embarrassment

7) More ambitious objectives, but with low systematization of tasks

Another instrument is the mood graph. It allows the patient to monitor daily changes in mood, thought and behavior, as well as aiding in the identification of mood or activity fluctuations and subsyndromal symptoms, in order to seek help and counseling when appropriate. The graph should be adapted to the peculiarities of the clinical profile of the patient.

### Problems encountered in the manic phases

Some problems are common in the manic phase and the patient may benefit from learning a few techniques to better deal with them.<sup>3-4</sup> For example, in order to increase interest and improve ideas and activities, the mood graph could be used to identify the onset of the phase while it can still be controlled, guide the person in choosing activities that are likely to be successful (the aim may also be to limit the activities), establish a schedule of activities (including sleeping and eating), determine priorities and assess energy expenditure. Another problem of crucial importance is sleep loss. It is known that a sleepless night may initiate a manic phase. This problem requires the creation of a sleep hygiene program that encourages appropriate habits, avoiding excessive stimuli (exercise, caffeine, etc.) and including techniques and strategies for relaxation and for dealing with concerns (for example: making lists and schedules and reviewing them).

Another problem is irritability, which could transform into aggressiveness. The therapist should teach the patient to recognize irritability as a manic or depressive symptom and help the person develop alternative responses, rather than reactions. For example, a therapist could suggest that, when confronted with a potentially irritating situation, the patient try to recognize the irritability before it increases, not saying anything and leaving the place for a while, or (if unable to resist expressing irritation) express empathy for the feelings of others and make apologies.

An additional problem is hypersensitivity to rejection and criticism. The family should notice when the patient is annoyed and should react, taking into consideration the perspective of the patient. When there is extravagant spending, the nature of such an act and whether the patient is able to control it should be investigated, and the patient should be checked for other manic symptoms.

A series of cognitive changes occur during mania. These include exaggerated optimism, delusions of grandeur, paranoid thoughts, pressure to speak, racing and disorganized thoughts, quantitative changes in perception, resentment due to lack of confidence that the therapist and the family have a real interest in the well-being of the patient. Other negative distortions are common and lead to inappropriate behaviors:

- 1) Increased sexual drive and the idea that sexual interest is reciprocated by others
- 2) Believing that others are too slow
- 3) Prematurely moving to the top of the chain of command
- 4) Having a sarcastic attitude and making inappropriate comments
- 5) Overestimating the appreciation that others have for his or her ideas
- 6) Considering those who do not accept his or her ideas as stupid or uninterested
- 7) Thinking that he or she does not need medication in order to feel well
- 8) Thinking that he or she is always right, not taking the opinions of others into consideration, and making unnecessary demands
- 9) Living in the present, because "tomorrow will be even better"

These cognitive distortions in mania lead the individual to underestimate risks, as well as exaggerating possibilities of gains and getting things right. Moreover, the patient is likely to believe he is luckier, to overestimate abilities, to minimize life problems and to value immediate gratification.

#### Dealing with stress factors

Another important aspect is to teach the patient to deal better with stressful life events. Several of these problems are well described in interpersonal therapy. This type of therapy addresses issues such as mourning the death of someone, conflicts with close acquaintances, changes in the existential role, social ability deficits, loss of the notion that he or she is a healthy individuals, and relationship problems between adolescents and divorced parents regarding the new families.

These problems may contribute to the worsening and maintenance of depression and are usually present at, or are worsened by, the onset of manic phases. The patient should learn to define and evaluate priorities and think about how past problems were resolved. The therapist should suggest interventions that have not previously been tried, respect the intelligence and resourcefulness of the patient, as well as to analyze obstacles to changes. Problem-solving techniques are very useful and should also be taught. Social ability training is an essential instrument, teaching self-affirmation and basic behavioral strategies to patients with severe profiles and greatly compromised social lives.

#### Problems in depressive phases

Characteristic problems are also presented in depressive phases.<sup>4-5</sup> In cases of guilt combined with inertia and lethargic behavior, it is important to analyze personal distorted explanations for the inertia, see it as a symptom and not a character flaw, and direct the available patient energy toward the possible and the most important.

Here are some helpful techniques: making a schedule of activities; focusing on essential tasks (bill paying, housecleaning, making important phone calls, etc.); splitting tasks into smaller steps and starting with those that are more likely to be successful; setting realistic goals; making a list of pleasurable activities and engaging in those activities.

Some depressive patients set unrealistic goals. These patients may benefit from evaluating their own self-established patterns, determining the time needed to complete a given task, planning realistic tasks, and analyzing cognitive schemes for dealing with perfectionism and incompetence.

Many patients lose the ability to experience pleasure and do not engage in leisure activities. Such activity increases the possibility of remediation. Therefore, entertainment should be prescribed, and the patient should be encouraged to make a list of pleasurable activities, learn to deal with negative thoughts that hinder the perception of positive aspects, and learn to manage rejection, anxiety and failure.

Many patients have difficulty in concentrating or making decisions. Such patients usually present lack of mental ability to organize the perceived abundance of options; inability to generate ideas (drawing a blank) and the habit of weighing the advantages and consequences of each option without reaching a conclusion. In more severe cases, patients may find it helpful to ask someone else to make the decision for them, or to make the decision in advance. Such patients may benefit from relaxing and reducing environment distractions, as well as from doing only part of the task, learning to analyze advantages and disadvantages, and analyzing their anticipation of catastrophic consequences of their choices.

Depressive patients present automatic thoughts, as well as distorted rules and beliefs, which lead to helplessness and suicidal ideation. The following are some examples:<sup>4</sup>

- 1) My problems are enormous and the only way to solve them is to end my life.
- 2) I'm a burden to everyone; it would be better if I moved away.
- 3) I hate myself; I deserve to die.
- 4) Only death can alleviate my pain.
- 5) I'm so mad at everyone that I'm going to kill myself just to teach them a lesson.

Suicidal ideation is always a treatment priority. This should be discussed and the lethality evaluated. The therapist should help the patient reconstruct his thoughts, assisting the patient in evaluating options in a specific way, rather than in a radically negative way.

Individuals with bipolar disorder may present various communication problems. One of these is caused by hypersensitivity, in which patient feelings are easily hurt, and criticism and rejection are anticipated. When such patients sense or expect rejection, their reactions (sadness, anger, guilt or embarrassment) are disproportional. The therapist should teach strategies for dealing with anger and evaluating the validity of the thoughts had and assumptions made by the patient. It is also important to teach the family to understand the problem from the perspective of the patient, rather than reacting to it.

Simple methods, such as teaching patients how to listen, repeat what was understood, ask for confirmation and speak clearly and specifically, may be very valuable.

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