Cognitive-Behavioral Therapy of Bipolar Depressive Disorder (Manic-depressive): A Case Study

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Abstract

Introduction: The usual treatments of the bipolar depressive disorder, such as medication and electroconvulsive therapy (ECT) have negative side effects on memory and cognition and the likelihood of recurrence. Researchers and clinical experts have been trying to design alternative psychotherapeutic methods for treating this disorder. For example, cognitive behavior therapy (CBT) has been shown to be an efficient treatment.. **Objective**: the purpose of the present case study is to examine the efficiency of CBT combined with medication in the treatment of bipolar depression. **Method**: Two participants with bipolar disorder were treated using CBT and medication. In this method, techniques such as self-monitoring, positivism, relaxation, cognitive re-construction, training problem solving and social skills were applied. **Result**: The results showed that the combination of CBT and medication can be effective in treating bipolar depression. **Conclusion**: The findings, which are congruent with those of previous investigations, indicating that unhealthy beliefs, attitudes and cognitive constructs may play an important role in the formation and continuation of this disorder, and therefore a proper way of treating it would be to work with those unhealthy cognitive constructs.

Key words: Mood disorders, bipolar disorder, manic depression, cognitive behavior therapy

Introduction

Bipolar disorders include type I bipolar disorders, type II bipolar disorder, cyclothymiacs and the bipolar disorders which have not been specified in other ways. In type I bipolar disorder, the patients have completely maniac syndrome or mixed episodes while, in type II bipolar disorder, in contrast to the patients with type I bipolar disorder, they have only mild mania episodes Hypomania cycles and experience one major depression episode (Barlow, 2001). Type II bipolar disorder or recurrent major depressive episodes with hypomania episodes with the prevalence rate of 0.5% in society is one of the most prevalent psychiatric disorders. The important specifications of bipolar depression disorder include severe emotional irregularities and mood fluctuations ranging from major depression to severe mania. This disorder is usually accompanied by committing suicide and results in escape from school, educational dropout, occupational failure and divorce in the patients. Goodwin and Jarnison, 1990; quoted from Zaretsky, Segal and Gemar, 1999).

Although recognition and knowledge about depressive-maniac disorder are growing, there are limited studies on bipolar depression therapy. In addition, although medication are common therapies for this disorder, almost all medication have some limitations. For instance, it has been observed that therapy with lithium reduces risk of suicide in the patients with bipolar disorder to 1.6 (Tondol, Jamison and Baldessarini); however, in a long run, lithium protects only 1.2 of the patients with bipolar disorder from the risk of remission. Even in optimal conditions, syndromes of the disorder recur after 2 years (Goldberg, Harrow and Grossman, 1995). Many patients suffering from bipolar depression disorder are resistant to lithium and other medication (Calabrese and Post, 1999; quoted from Williams, 2001) and some cannot tolerate their side effects (Ketler and Post, 1994, quoted from Joffe, 2002). It has been also observed that therapy with lithium leads to more reduction of mania in the patients than reduction of their depression. On the other hand, use of the anti-depressants leads to mood instability in the patients suffering from bipolar disorder (Bowden et al., 1994). Although electroshock therapy is effective for the treatment of most major and resistant depressions, it has adverse and undesirable effects on memory and cognition (Hollon, Thase and Markowitz, 2002). For this reason, clinical specialists and researchers have been interested in different psychotherapeutic approaches for treating bipolar disorder which include dynamic psychotherapy, interpersonal psychotherapy and cognitive-behavioral therapy. Moreover, research results have shown that cognitive-behavioral therapy by itself or combined with medication is a more efficient treatment than medication alone, which may not only reduce acute disorders but also prevent from remission of the disorder symptoms and recurrence of the disease in a long run and after stopping medication (Carolyn, 2002, Hollon, Thase and Markowitz, 2002). Most studies which have been conducted so far in this field have concentrated on studying the efficiency of cognitive–behavioral techniques for the treatment of unipolar depression and a limited number of the

studies have evaluated usefulness and effectiveness of cognitive–behavioral therapy in the treatment of bipolar depression. Considering what was said before, the main goal of the present research was to report two successful cases of treating bipolar depression disorder using the cognitive–behavioral therapy techniques combined with psychotherapy.

Review of the Literature

The results of some studies have demonstrated that the cognitive–behavioral therapy approach not only is an efficient therapy for mood disorders but also leads to the creation of some stable skills in the participants, which reduces the possibility of the diseases remission after the therapy (Hollon and Thase, 1983). Some results of these studies are referred to in the rest of this research.

Williams (2001) presented a cognitive–behavioral model for the evaluation and treatment of bipolar disorders and reported a successful therapy case of an adult suffering from bipolar depression disorder using the cognitive–behavioral model. The participant of this research was 43 years old suffering from bipolar disorders who improved within 38 weekly sessions of cognitive–behavioral therapy and had no sign of disorder remission one year after stopping the therapy. This researcher mentioned a five-part evaluation for bipolar disorders in the present cognitive–behavioral approach which included: 1- determining position, conditions, relations and practical problems by the participant, 2- influential thinking, 3- influential feelings, 4- influential physical symptoms and 5- influential behavior.

In the research entitled "treatment and prevention from depression", Hollon, Thase and Markowitz (2002) introduced different efficient therapy methods of depression and bipolar disorders and found that cognitive–behavioral therapy alone or combined with medication was the most efficient therapeutic technique for treating and preventing from the syndrome remission of type I and II bipolar disorder in the patients suffering from these disorders.

Research Method

In this research, two participants (one male and one female) who were suffering from type II bipolar disorders based on the results of clinical interviews, psychiatrist's diagnosis, reference to medical files and diagnostic criteria (DSM-IV-TR) for bipolar disorders were investigated. During the therapy sessions, both participants received therapy using the combined technique of cognitive–behavior therapy and medication. After terminating and stopping therapy sessions, they were followed-up for two years.

The therapy method used in this research was cognitive–behavioral therapy based on the techniques mentioned by Beck (1964). This therapeutic method was first used by Beck (1952) for treating depression. In Beck's cognitive model (1964) on depression, three kinds of cognition were assumed: 1) automatic thoughts, 2) schemas (or influential presuppositions) and 3) cognitive distortions. According to this theory,

influential false beliefs or the schemas which are formed during life of the person result in changes of thoughts, emotions and behavior. Automatic thoughts include the thoughts and imaginations which result from cognitive schemas of people and help in the formation of feelings of uselessness, compunction, incompetence, inadequacy, loneliness and despair in the person. Cognitive distortions also result in negative construction and interpretation of the world, self and ability for effective dealing with future events and adversely affect emotional and behavioral responses of the person. Schemas may remain immobile or stagnant until they are activated by an external event and result in abnormal behaviors and emotional states in people. On this basis, Beck et al. (1979) believed that intervention is an effective strategy at false and useless cognitions level. For this purpose, false beliefs and attitudes of the person should be restructured. Goal of the therapy is to facilitate this change and restructuring which is a kind of participatory empiricism combined with cooperation of the patient and therapist. The patient is conducted toward self-exploration using Socratic Questioning and takes action regarding his/her cognitive restructuring using self-monitoring, positive thinking and problem solving techniques. On the other hand, the results of studies have shown that bipolar depression (BD) disorder is both genetic disposition and results from stresses (Simos, 2001, quoted from Caroline, 2002). In other words, studies have demonstrated that genetic disposition components result in biochemical abnormalities which endanger the patients for showing complete disorder states but genetic problems and factors cannot indicate cause of bipolar disorder by themselves because environmental factors such as stressful ones play an important role in affliction with this disorder. On this basis, clinical specialists and authorities of mental health centers seek to design and develop psychological therapies with the main purpose of reducing stress levels in the people with bipolar depression disorder (Newman et al., 2001). As was mentioned above, cognitive-behavioral therapy of emotional disorders believes that those people who have systematic and regular biases in their thinking processes are at the risk of emergence and intensification of negative and extreme emotions such as anxiety, anger and irritation. This in turn increases their risk of experiencing clinical depression and continuation of these states over time makes the person's attitude negative toward him/herself, others and the world (cognitive triangle of Beck et al., 1979) which exactly indicates depression episode in bipolar depression disorder. On the other hand, extreme negative thoughts become problematic as they are seen in the people with mania. Such thoughts can cause people to do uncontrolled activities such as extravagance, incorrect and unwise sexual behaviors and impulsive decision-making which are problematic. These problematic activities have negative and accumulative consequences which require advanced problem solving and high abilities to cope with the problems, which in turn results in major depression episodes in the people with bipolar depression disorder. Therefore, one of the important goals of cognitive therapy is to reduce psychological stress level in people with this disorder and, as a result, to decrease the probability of experiencing uncontrolled emotional cycles via instructing some skills such as problem solving, positive thinking, self-monitoring and stress relieving. On this basis,

Newman (1999, quoted from Caroline, 2002) mentioned goals and stages of cognitive therapy for bipolar depression disorder as follows:

1- Instructing the patients in order to help them understand stylistics, causes, stages of disorder and its therapy methods.

2- Identifying and testing thoughts of patients and showing them how to monitor their thoughts and convert their illogical thinking patterns to logical ones.

3- Instructing the patients to learn problem-solving principles and methods and to efficiently and effectively solve the problems which they may face.

4- Controlling the tendency of patients to be impulsive at the time of maniac episodes.

5- Adjusting emotional states of patients by pattern forming, role-playing, stress relieving and other skills such as mental training.

6- Emphasizing the mutual effect of distraction and disorganization of patients using strategies which maximize planning, focus and repetition.

Specifications of the first participant: Mr. M. Sh., 50 years old, holding a Ph.D. degree, university professor, married and having three children: a 25 year old son holding Bachelor's degree and two daughters of 20 years old and student and 17 years old and high school student.

Therapy period: 72 sessions, once per week

The participant declared in the first session, "It is 20 years that I am suffering from bipolar depression and experiencing depressive-maniac episodes. I have referred to psychiatrists several times, all of whom agreed on the depression–mania diagnosis and I have always taken their prescribed medicines regularly. But, unfortunately, my depressive–maniac episodes recur after stopping medication which is what bothers me. Now, I am manic for 3 months and I commit activities which I really do not know if they are normal or no. Before this time, I was severely depressed. I feel absurdity, uselessness and hopelessness, my activity level is reduced and I get angry and irritable and I sleep most of the time of the day so that I even have meals in my bed. My father also suffers from this disorder and always experiences depressive-maniac episodes. However, when I am depressed, he is in the manic state and vice versa. I take the medicine prescribed by the physician."

Therapeutic Measures: During the first therapeutic session, first, type of disorder, its causes and therapeutic methods were elaborated on for the patient. Then, the therapist asked the participant to specify his work and practical problems, relations, conditions and situations and describe his daily important emotional events during the therapeutic sessions. The participant declared: "my father's behaviors and beliefs have considerable negative effects on me and intensify my mania. My farther does not accept anyone and is very hard-working; he expects me to only deal with my

occupational position, like him, and believes that I am henpecked. He sometimes admires me and sometimes reproaches me severely. His thoughts and actions make me extremely anxious, angry and hopeless." On this basis, the therapist spoke about illogical and false thoughts and imaginations and effect of these false thoughts and beliefs on emotional behavior and states while making an emphasis on the regular consumption of medication prescribed by the psychiatrist and asked the participant to revise his thoughts, attitudes and beliefs, specify negative and illogical thoughts and try to replace them with logical and correct ones (recognizing negative and illogical thoughts). In the following sessions, the participant stated that he was severely affected by his father's hard working and this has led to his extreme activities and that he still has maniac states. In this stage, the therapist instructed the participant to solve problems and asked him to utilize this method while coping with daily problems and consider positive and negative aspects and possible solutions before making a decision and taking any action and then to select the best possible solution. In the next sessions, the participant declared that he was out of the manic state and was severely depressed, bored and isolated so that he did not like to answer his mobile phone and turned it off. He was asleep most of the time and felts hopeless and helpless. In this stage, the therapist took action regarding the use of personal and family positive thinking for the patient and asked him to think about his strengths and fill out the Positive Points Form on a weekly basis. Also, he was asked to have sport activities such as swimming and walking in his routine plans. After several positive thinking sessions, he declared that he was getting better and did not feel distressed; he was doing his routine activities and his isolation and sleepiness were reduced. In this session, the therapist emphasized the role of automatic thoughts and imaginations and asked him to monitor his illogical and false thoughts and to take action regarding the preparation of illogical thoughts chart (self-monitoring) on a weekly basis. In the next sessions, the participant declared: "although my depression has reduced considerably and the psychiatrist has reduced my medicines by half, I still think that the only cause of my depression is my relationship with my father and occupational partnership with him. My father cannot tolerate any independent success of me and tries to make me dependent on him. This issue makes me severely anxious because I am a religious person and believe that my religious duty is to obey my father and fulfill his requirements and, if not, I will feel anxious and guilty and I will feel that I have not performed my religious duties." In this session, the therapist instructed the participant how to relieve stress and asked him to practice stress relieving for 30 min on a daily basis while filling out the Positive Points Form and self-monitoring chart every week. He was also asked to attempt to use problem solving method in coping with his problems and select the best solution for the problem and cope with the problem because problem solving logically reduces negative and distressing emotions such as compunction and anxiety (in this stage, the therapist instructed him to solve problems by pattern forming). In the final sessions, the participant said that his dependence on his father has been reduced and he is less affected by his illogical thoughts; as a result, he feels hopeless, valueless and guilty to a less extent. He was improved completely and performed his routine activities normally, he did not feel hopeless and normally

slept so that the psychiatrist completely stopped his medicines. Although he was not taking any medication, his work and routine activities were satisfactory and successful and he could make decisions and take actions independently and without reliance on his father.

Specifications of the second participant: Ms. N. Sh., 25 years old, holding high school diploma, housewife, married and having one 4 year old son

Therapy period: 35 sessions with the reference of once a week

The participant said in the first session: "I have got married for 6 years and my major problem is myself; that I am very pessimistic and quarrelsome. I have decided to get a divorce from my husband. My husband did not hold a wedding party due to financial problems; but, he purchased a house for his mother immediately after our marriage. Now, he fulfills all my needs but I am irritated by his relationship with his family. My husband says that he cannot tolerate my pessimism. I am severely depressed and referred to the psychiatrist many times; they diagnosed my bipolar depression and prescribed medication. I regularly take my medication but I never get better. I have quarrelsome state; I am anxious and act aggressively toward others. Even I cannot have a good relationship with my son (crying). Recently, there was a struggle between my mother and husband which aggravated the situation. Before marriage, I was very happy. I was a student of chemistry but I stopped my study after 2 years. Another issue which bothers me a lot is my overweight. After marriage, I gained 35 kilogram and now I am 105 kilogram. My husband only asks me not to cry out and not to curse him and our son but I cannot be like that, especially in the manic state; I hit my husband and I always insult his family. I am always thinking about suicide and once I committed suicide by taking many tablets (sobbing). I have intensive and strange hostility toward my husband's family because I blame them for the death of my child last year. I have come at my husband with a knife in the manic state several times and once I threw a vase on his head when we fought together. But he only curled up in a corner and did not show any reactions. His inattention and indifference drive me crazy. Now, I am experiencing depression episode. I do abnormal things in the manic state and strongly bother my husband."

Therapeutic methods and measures: in the primary sessions, the therapist elaborated on the type of disorder and its therapeutic ways and, considering her major depression, the therapist specified illogical and false beliefs, attitudes and thoughts of the participant and asked her to monitor her illogical thoughts and beliefs while making an emphasis on the role of negative thoughts in the expression of false behaviors and trying to replace them with logical and correct thoughts (recognizing negative and illogical beliefs and thoughts). The participant was also asked to complete her illogical thought self-reporting chart on a weekly basis (self monitoring). In the following sessions, the participant stated: "my excessive pessimism toward my husband's family is the origin of all of my distresses. My pessimism has family origins. My mother is severely pessimistic which aggravates my pessimism. My sister

and brother are also affected by my mother's pessimistic thoughts, like me, and they are also pessimistic. They also have an excessive and illogical dependence on my mother, just like me. On the other hand, I consult with my mother in all of my affairs due to my excessive dependence on her; however, both my husband and I are annoyed with this work. My husband has false and negative thoughts about my mother and this bothers me. He believes that there is matriarchy in our family. On the one hand, I am interested in and dependent on my mother and, on the other, I am bothered by her improper effects on me and my married life. This makes me angry and generates compunction in me." In this stage, the therapist instructed problem-solving method and asked the participant to consider all the possible solutions and hypotheses and select the best solution and apply this method for all social and family problems. In this session, the therapist perceived that she should reduce her illogical and excessive dependence on her mother. The participant was asked to do exercises such as walking and swimming on a daily basis. Moreover, during separate sessions, her mother was treated. In the next sessions, the participant declared that she got better using the methods mentioned in the previous sessions and had better relations with her husband. But, she was feeling useless and hopeless and was desperate. In this stage, the therapist took action regarding personal and family positive thinking and asked the participant to complete the Positive Points Form every week. In the next session, she declared that she was getting better so that her medicine dose was reduced by the psychologist and the medication were reduced almost by half. She was trying to contact her mother only once a week and not to be affected by her pessimism and illogical thoughts. Nevertheless, she got angry and cried. In fact, when her demands were not fulfilled, she suffered from anxiety, worries and could not control her anger. In this session, the therapist asked the participant to exercise stress relieving for 20 to 30 min after instructing how to relieve stress. In the individual and separate sessions, her husband was interviewed and asked not to intensify excessive dependence of his wife on her mother and facilitate her treatment. In a common session, the couple was instructed to solve problems through pattern forming in order to use this method at the time of marital disputes. Also, false and illogical attitudes toward each other were corrected and adjusted using cognitive restructuring technique. After several sessions, the participant declared that she did not feel useless and hopeless, her pessimistic thoughts were reduced and her relations with her husband and his family were very good and satisfactory. The only concern was his overweight which would be controlled by physical exercises, walking and going on a diet. The participant also stated that: "my mother ruled over our family all the time and I also liked to be like her because I was dependent on her. Although I love her, my excessive dependence on my mother bothers me which causes conflict and compunction in me. My mother has committed suicide in my presence several times. She is always depressed and I think that I am affected by her false and illogical behaviors and thoughts and these false thoughts cause pessimism, hate and false behaviors." In this stage, the therapist spoke about negative and illogical thoughts and their effect on behaviors and emotional states and asked the participant to replace negative and illogical thoughts with the positive ones. For this purpose, she was asked to prepare a thought self-

monitoring chart every day and continue stress relieving exercises. In a common session, the couple was recommended to have positive thinking and they were asked to fill out the Positive Points Form about each other and their families in the following weeks. In the next sessions, the participant declared that she was well and had no problem and was satisfied with her life and the psychiatrist completely stopped her medication. It is necessary to note that none of the participants of the present research showed sign of disorder recurrence and no depressive-manic episodes started after the treatment in the one-year follow-up stage.

Discussion and Conclusion:

Findings of the present research showed that CBT combined with medication is an effective therapy for the people suffering from bipolar depressive disorder. As mentioned before, both participants of the present research received long-term medical treatment before participation in the psychotherapy sessions, but once their medication stopped, their symptoms recurred and they were in manic-depressive states again. However, when they participated in the weekly psychotherapy sessions based on cognitive–behavioral techniques combined with medication, they not only improved, but also did not show any symptoms in a one-year follow-up, even though their medication had been stopped for one year. This indicates high efficacy of CBT in the treatment of people suffering from bipolar disorders. Moreover, the findings of the present research were in line with those of Beck's cognitive model (1964) and demonstrated that irrational and non-realistic beliefs, attitudes and thoughts play an important role in the formation and continuation of the syndrome of this disorder. As was evident in the comments of the first participant, an important and critical illogical belief of this participant was related to her dependence on the father and responsibility toward his demands and even his illogical demands. This false belief that he was religiously bound to act according to his father's illogical words and demands led to the formation of negative emotions and behaviors in him. Concurrent with the participant's insight in this regard that this belief was a negative and illogical one and after replacing illogical and negative beliefs, his treatment trend was accelerated and facilitated. In the second participant, mutual dependence of her and her mother on each other and her conflict in this regard, i.e. her interest in her mother, very supportive role of the mother and the mother's interferences, illogical thoughts and beliefs, affected the participant and resulted in her pessimism, which had a very important role in the formation and continuation of the disorder syndrome. After specifying and solving this conflicting and illogical belief, the participant rapidly recovered. It is necessary to note that the reason for longer trend of treatment in the first participant was his long record of affliction with this disease. As mentioned above, the first participant was suffering from this disorder for 20 years while the second one suffered from the disorder for 6 years, which resulted in more complexity of the disorder and length of treatment in the first case.

It is necessary to note that one of the reasons which facilitated the treatment of participants in this study was active and useful cooperation of their families in the therapy process.

Results of this research were congruent with results of Hollon and Tesson (1983), Hollon, Thase and Markowitz (2002) and Williams (2001).

The results of the research by Hollon and Tesson (1983) showed that cognitive–behavioral therapy techniques resulted in the generation of stability skills in the patients which prevented from the remission of the disease. On the other hand, Hollon, Thase and Markowitz (2002) demonstrated that cognitive–behavioral therapy techniques alone or along with medication therapy were more efficient in the treatment of bipolar disorders. Findings of the research conducted by Williams (2001) and Zaretsky, Segal and Gemar (1999) indicated high efficiency of cognitive–behavioral therapy techniques in the treatment of bipolar disorders.

One of the limitations of this research was using a limited number of participants (two participants) and absence of a control group. It is recommended for future studies to compare cognitive–behavioral therapy techniques alone, or cognitive–behavioral therapy techniques along with medication therapy and medication alone with each other with the cooperation of more participants in order to obtain more accurate and reliable results.

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