

Management of Bipolar I Disorder through CBT (Cognitive Behaviour Therapy): A Case Report

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Abstract

Bipolar disorder is considered a treatable medical condition marked by extreme changes in mood, thought, behavior and energy. Bipolar disorder is also known as manic depression because a person's mood can alternate between manic state and depressive state. This study presents a case of MR. X of 57 years of age. He was brought Fouji Foundation hospital with the symptoms insomnia, distractibility, racing thoughts and poor judgement and rapid ups and down in mood. Diagnosed was made according to DSM-5. Through detail examination it was concluded that his sign and symptoms are due to his circumstances not due to any biological or neurological deficits. Client was successfully treated cognitive and behavioural therapies. The client showed significant improvement in his condition.

Keywords: Insomnia; Racing thought; Cognitive and behavioural therapies

Abbreviations: BDI: Beck Depression Inventory; RISB: Rotter Incomplete Sentence Blank; HFD: Human Figure Drawing

Introduction

Bipolar disorder is turning a major global health issue which causes lifetime mortality and morbidity. Youth phase of life is generally associated with the onset of mood disorders including bipolar disorder, there are frequently significant delays before the diagnosis is made and effective management initiated.

Bipolar disorder is related with increased mortality. Many research studies argued that mortality rate is high among people admitted to hospitals with bipolar disorder. High risk for suicidality is not only limited to those diagnosed with bipolar I disorder rather a meta-analysis of 15 studies by Novick and Swartz [1] suggested that bipolar I and bipolar II disorder did not differ with regard to rates of attempted suicide. Approximately 2% lifetime prevalence of bipolar I disorder is [2]. Gender differences are rarely found in bipolar disorders and it is estimated that developing countries have more incidence and prevalence of bipolar disorder [3].

Some studies have also suggested that personality disorder also pose an important comorbidity with bipolar disorder [4]. Emotional instability in borderline personality disorder can be viewed as a differential diagnosis of BD. Many patients with the diagnoses of borderline personality disorder also meet diagnostic criteria for BD [5].

It has been reported that early-onset manic-depressive illness is associated with more chronic outcome, including a high rate of suicide and repeatedly recurring mood swings associated with uncontrollable fluctuations in affective state [6].

Many factors contribute to the development of bipolar disorder some of them are biochemical imbalances, hereditary factors, stressful life events, and faulty cognitive. Thus genes and environment interaction plays important role in the development of bipolar disorder. It has been reported that relatives of those with the bipolar disorder have higher chances for having bipolar disorder as compared to the relatives of those with unipolar depression or no disorder at all [7]. Twin studies have explored 70% risk rate for bipolar disorder, which indicate hereditary component [8].

Many times biochemical imbalances create bipolar symptoms.

Chemical abnormalities in brain system containing a class of transmitters known as monoamines cause depression. The specific monoamines implicated in this biogenic amine theory of depression are serotonin, dopamine and nor-epinephrine [8]. Goodwin and Jamison [9] explored that instabilities in the levels of serotonin may become a major cause of wide range of mood and activity states of manic-depressive illness.

Stressful life events also trigger bipolar disorder. Any recent loss of someone, separation, breakup, frustration due to not fulfilling goals and failures many predict depression. Study by Johnson and colleagues proposed that negative life events serve as a predictor of bipolar depression, but that in combination with a high behavioral activation system, they can trigger mania [10]. Furthermore lack of social support and low or negative self-concept play more important role in triggering bipolar depression than mania and excessive focus on goal attaining activities can stimulate the onset of a manic episode.

Vulnerability factor toward bipolar disorder also play significant role in developing bipolar disorder, vulnerability factor is a person's cognitive style. Some people have specific vulnerability towards developing certain psychiatric disorders. Some attribution styles along with negative life events can also act as predictor or indicator of hypomanic mood shifts [11].

Diagnostic Criteria of Bipolar I Disorder

In Bipolar I disorder there is at least one episode of mania or mixed depressive and manic symptoms. The sign and symptoms must cause social or occupational distress. Symptoms of Bipolar I disorder should not be better accounted for by schizoaffective disorder. The manic or mixed episodes must not be superimposed on schizoaffective disorder, schizophrenia, delusional disorder or other psychotic condition [12].

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Manic episodes are characterized by expansive, elevated or irritable mood and increased activity and energy level, which last for a week or more, accompanied by 3 of the following (4 if the mood is irritable), psychomotor agitation or increased goal-directed activities or behavior, inflated self-esteem or grandiosity, decreased need for sleep, flight of ideas, distractibility, increased talkativeness or increased risky behavior. These signs and symptoms must be severe enough to cause social impairment, hospitalization and should not be better accounted by the medical condition or substance abuse [12].

Literature on the Use of Psychotherapy for Bipolar Disorder

Despite of the fact that genetic, psychopharmacological and biological factors involved in the treatment of symptoms of bipolar disorder are considered, approximately 40% of bipolar patients do not respond well to lithium or other mood stabilizers [13]. Solomon [14] reported that in spite of receiving the required medication dose, these bipolar patients remain free of relapses for a maximum of only two- to three-year follow-up periods. Moreover many researchers supported that psychotherapy used in combination with pharmacotherapy has best outcome in treating patients diagnosed with bipolar disorder [15].

According to the literature in recent years structured psychological therapies which combine both kind of methods including psycho education and cognitive behavioral therapy are being increasingly used in the treatment of bipolar disorders [16-18]. While psycho educational programs have been shown effective on bipolar disorder both for preventing manic and depressive episodes, research has suggested that cognitive-behavioral therapy is particularly useful in the treatment and prevention of depression [19,20]. So the combination of both therapies has been shown equally effective in treating bipolar disorders. Psycho education programs have also been reported very effective for several other mental health disorders including schizophrenia, etc. [21]. Long term studies conducted on the bipolar patients also showed that participants who received cognitive-behavioral therapy in addition to psycho education experienced 50% fewer days of depressed mood over the course of 1 year and less antidepressant increases comparatively with those who only received psycho education [22].

In a comparative study by Colom [23], a group of patients receiving standard treatment for bipolar disorder was compared with a group receiving psycho education additionally as an adjunctive therapy, for a 5 year follow-up period. It was reported that patients receiving adjunctive psycho-education therapy experienced fewer relapse and shorter periods with acute symptoms, and needed shorter hospital stay [23]. It has been suggested that psychological adjunctive therapy is more effective and cost effective as compared to conventional therapy [24].

Lam and Jones in 1999 [25] reported in their study that cognitive behaviour therapy techniques aim at managing and preventing cognitive, affective and behavioral symptoms which are associated with bipolar disorder sign and symptoms. These techniques try to reduce negative impacts of BD in the psychosocial and interpersonal domains and improve quality of life of individuals suffering from Bipolar disorder [25].

Newman [26] suggested the efficacy of applying Cognitive Behaviour Therapy for Bipolar disorder in his study and reported that Cognitive behaviour therapy for bipolar disorder has following aims:

- Make client aware and his or her family about the treatment process and common difficulties associated with the bipolar disorder

- Teach clients how to manage depressive symptoms or manic sign and symptoms using a mood chart, and to assess their severity
- Encourage and enhance compliance with pharmacological treatment (i.e., psycho-education and reality test of thoughts and beliefs)
- Teach clients psychological strategies, especially in terms of cognitive-behavioral skills, that will make them to manage stress factors associated with bipolar disorder
- Decrease the trauma and stigma associated with the diagnosis of bipolar disorder [26].

Objectives of the Case Report

The main objective was to treat client mainly with talk therapy or psychotherapy rather than medication. Psychotherapy is considered an important part of treatment for many people diagnosed with bipolar disorder. In psychotherapy therapist helps the client in modifying behavioral or emotional patterns that contribute in the development of bipolar disorder. People with bipolar disorder usually benefit from a combination of medication and psychotherapy. Past research has supported that bipolar disorder can be best treated by a combination of pharmacotherapy, cognitive therapy, social support and family interventions. Although antidepressants have been suggested to be effective in treating bipolar disorder but they have also been reported to provoke manic switch and rapid cycling [27].

Case Report

Presenting complaints

Mr. X was presented with having complaints like insomnia, distractibility, racing thoughts and depressive mood and at times euphoric mood, poor judgement, and ups and down in mood. According to him, his mood changes quickly from being sad to extremely pleasurable. He reported to having these symptoms since 1 month. He also reported to have episode of manic and depressive symptoms before. But he did not take any medical or psychological help for his symptoms and he also reported that prior episodes were not very severe. No alcohol or substance use related history was reported by the client.

Mr. X was 52 year old married man. He belonged to a religious family and lived with his wife and daughter. He was the resident of Multan. He got only high school education from government school. He was good in education but cannot continue his education due to his poor socioeconomic circumstances. His father died due to typhoid when he was 17 years old. As he was the only child of his parents so after the death of his father he took the responsibility of his family and stops education and started working. His mother died 7 years ago at the age of 70.

History of the patient

When investigated about his past illness he reported that he was operated for appendix at the age of 30 and was hospitalized for 3 days after his operation and he use 2 week medications after his operation. After that he did not have any serious kind of physical and mental illness.

Mr. X reported that he was good in studies in her childhood but cannot continue his education due to his father death. Apart from studies he was also good in extracurricular activities.

When investigated about his personal history he reported that he was born with full time pregnancy and his delivery was vaginal. He did not face any kind of birth complication at the time of his birth. His mother was not having any kind of disease at the time of her delivery. His both parents were very caring and he did not have any conflicting relationships with his parents or anyone else.

Pre morbid personality

Before the onset of the signs and symptoms he reported himself to be slightly social and have only few friends. He reported himself of friendly nature and cooperative. His relationships with his neighbours were also good.

Family history of the patients

No family history of his disease was found. According to his he belongs to a very religious family and all the religious traditions are strictly followed by his family. He is the dominant member of his family and he sets the rules and regulation for his family.

Mental status examination

The client was alert and fully oriented. Attention was intact. His speech was pressured, loud and rapid and it was difficult to interrupt his speech. He was looking decent man. He was tall and smart and well dressed. He was not maintaining proper eye contact with the therapist during the session. During the sessions he said many times that he is the perfect and energetic man. He was not suffering from any hallucination. His abstract thinking was not quite developed due to lack of education.

Behavioural observation

Client appeared in a very sad mood. His speech was not normal as he was speaking very fast, loud and he was changing topic of conversation very rapidly. He reported that he was not having proper sleep for many previous nights but he was looking very energetic.

Treatment process

His score on the BDI was 23 which indicate moderate level of depression in him. Client score on the mania rating scale is above cut off score which show the high level of mania in client. His RISB score also indicate that he is not well socially adjusted. The overall HFD test shows that person is having inflated self-esteem and feelings of grandiosity. There are many emotional indicators in his drawing. There are many indicators in his drawing which shows his trends towards impulsive sexual behaviour. The symptoms of mania and depression are prominent in client drawing. The patient seems to have the feelings of insecurity. Several features indicate his depressive behavior. He seems to have confused thinking and distorted self-image. The patient seems to have difficulty in interpersonal relationship. In drawing the person, feelings of inadequacy inferiority of social intellectualization, aggressive tendency, need for increase in physical power. There is no evidence of neurological impairment including eye hand co-ordination and perceptual organization.

Psychotherapies

After the administration of different psychological tests Mr. X was given proper psychotherapeutic sessions. Mr. X was coped with 12 psychotherapeutic sessions. Cognitive behavioural therapy was applied to Mr. X. As he was suffering from mood swings, by using CBT he was able to learn how to change his distorted cognitions. As being a psychotherapist I help him to identify which negative behavior patterns he would like to work on. Through CBT I taught him coping skills

to handle the problem correctly. CBT focus on both behaviour and cognition and client was taught to improve his maladaptive behaviour by behavioural techniques.

Psychotherapy was started after Mr. X achieved remission phase. During first few sessions, therapist builds rapport with the client and ensures him that maximum level of confidentiality will be maintained throughout sessions. In next few sessions I identified with his help that which thought patterns are problematic for him. According to him, he really wanted to get rid of his problematic thoughts and associated behaviours like he told during sessions that he is the victim of bad luck and all that is happening to him is the result of bad circumstances and he often thought to commit suicide to get rid from this bad world. Through a thorough investigations it was revealed that his poor socio economic condition has played significant role in his thought pattern. During sessions I identified more stressors in his life which were creating troubles for him. After identifying negative thought patterns from which he wanted to get rid, I discussed with him that how we will work on them mutually.

In next few sessions focus of the therapeutic session was on the cognitive restructuring of the client. Cognitive restructuring involves systematic identification of the problematic thought patterns which contribute to the onset and maintenance of the symptoms. Mr. X was made aware how negative thought patterns and their associated behaviours like aggression in his case were enhancing his problems like stress, depression and mania symptoms. I started to work with him on his negative thought pattern and problem behaviours one by one. We set our targets of psychotherapy priority wise. First of all we identified problem thoughts and behaviours then decided strategies to work on them. His main problems include sleep deprivation, stress, anger and racing thoughts. Follow up session were also conducted for accessing his level of achievement for achieving targets of psycho-therapy.

For sleep management the client was educated about the role of disruptions in the sleep/wake cycle in heralding new episodes and it was discussed with the client what level of activity and sleep seems most reasonable for the client. After identifying desired hours of sleep client was asked to calculate a regular bed time relative to daily demands and waking times. After knowing all the client activities before sleep time, he was asked to avoid thinking hard and doing all kinds of behaviours which divert the attention before sleep.

Behavioural therapies were applied on Mr. X in latter sessions to change his maladaptive behaviours. He was taught muscle relaxant techniques to cope with stress. During sessions he was also taught stress management and anger management techniques. Stress management techniques were applied on the client to cope with stress in future by problem solving, communication skills and cognitive-restructuring.

Psycho-education program was given to Mr. X about his disorder. In psycho-education session client was made aware about the relationship between activities, physical feelings and mood. He was given training about how to identify and monitor the early warning symptoms in order to deal with them in future and in present. Subsequently he was trained in the use of anxiety-control techniques (relaxation and breathing, self-instructions and cognitive distraction), sleep hygiene habits and planning gratifying activities.

In latter sessions he was trained in detecting distorted thoughts and using the process of cognitive restructuring. Problem solving and improvement of self-esteem techniques were taught to the client in order to prevent relapses. During psychotherapy Mr. X was also taught social skills (assertiveness, non-verbal communication, conversational

skills, giving and receiving compliments, giving and receiving criticism and asking for favors).

In the final session Mr. X reported of having less frequency of his sign and symptoms. He was in happy mood and was determined to improve his life. He was recommended the follow up session to check his progress of recovering.

Results

Psychotherapeutic sessions were started after Mr. X achieved remission phase. Diagnosis was made after having structured diagnostic interview with client. Monitoring of the client problematic thoughts and behaviours was made throughout the therapeutic session. BDI scoring on the baseline was 23 and after the course of treatment was 7 which indicate that depressive symptoms were almost gone. Mood disorder questionnaire also showed mania sign and symptoms at the baseline of therapy but after therapy MDQ also shown significant decrease in sign and symptoms of bipolar disorder. After therapy client was recommended for follow-up session.

Discussion

Bipolar disorder is turning out as a chronic, debilitating psychiatric condition, which affects about 1% of the population. Bipolar disorder is related with many comorbid psychiatric illness and substance abuse problems [28]. In fact, Bipolar disorder is ranked as the world's eighth greatest cause of medical disability [29]. Additionally, high mortality rates are found in Bipolar disorder, research has suggested that about one third of patients diagnosed with bipolar disorder have attempted suicide at least once in their lives [29]. Given the chronicity and severity of bipolar disorder, along with its long lasting impact on society, it is imperative that adequate, empirically supported interventions are available for patients diagnosed with bipolar disorder. Growing body of literature exist which suggest that combined psychosocial interventions and psychopharmacological are best for treatment of adults having Bipolar disorder [30].

This study presents the case of Mr. X who was diagnosed having bipolar disorder. The root cause of his disease was found his disturbing circumstances. He was having sign and symptoms of insomnia, distractibility, racing thoughts and poor judgement and ups and down in mood. He was not involved any kind of substance abuse. Mr. X was treated by psychotherapies rather than medication. Cognitive behaviour therapy was applied on him successfully.

Cognitive restructuring is an important part of cognitive behaviour therapy. In cognitive restricting negative thoughts patterns are turned into more realistic and healthy thought patterns. Many themes in Mr. X thoughts patterns were identified like according to him he is of no more value and life has no meaning for him etc. As being a psychotherapist I taught him new alternative thought patterns and made him aware the association between negative thought patterns and maladaptive behaviours.

Another important part of the cognitive behaviour therapy is behaviour modification. In behaviour modification maladaptive and harmful behaviours are removed and replaced with positive behaviours. I taught him stress and anger management techniques. As client was not social, I taught him techniques to enhance social network and taught him problem solving techniques for effectively managing problems which arise in day to day interaction with others.

The psycho-educational nature of cognitive therapy increases its efficacy in treating patients with bipolar disorder and prevents chances

of relapse. Results suggest for treating bipolar disorder cognitive therapy may be very effective. Cognitive therapy is specifically useful in improving life quality and functioning, increasing compliance, helping early symptom recognition, decrease relapse and decrease depressive and maniac symptomatology.

During the whole course of treatment the purpose of all the psychotherapeutic techniques applied to him to enhance Mr. X's understanding of his sign and symptoms, reducing his level of anxiety, improving his repertoire of social skills and assertiveness control, helping him in gaining greater control on his mood by shifting thoughts and getting him involved in enjoyable activities, enhancing his self-esteem, teaching him constructive and healthy taught patterns and teach him problem-solving strategies.

Current CBT protocols [31,32] emphasize on the early-intervention strategies to overcome the impact of hypomanic or manic episodes. For overcoming the likelihood of poor financial, social and sexual decisions that may occur in the context of an episode, these interventions are made.

Conclusion

The aim of the present study was to treat Mr. X who was diagnosed with Bipolar I disorder by psychotherapy more specifically with CBT rather than medications. Client was given proper psychotherapeutic sessions by the psychotherapist and it was shown that client successfully recover from his disease. So it is concluded that psychotherapy is very effective for the bipolar disorders and those patients who do not respond to medication can be best treated by psychotherapy. All the ethics of psychotherapy and counselling were maintained.

Limitations

Following are the limitations of the study:

- This is a clinical case study and case studies always have limited generalizability.
- Longitudinal research is needed for examining the development of bipolar disorder in whole life span.
- Only cognitive behavior therapy was applied in this case according to the need of client.

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