

RUNNING HEAD: CBT for Mania, Depression and Anxiety

Conceptualising a Cycle of Ascent into Mania and the Role of Comorbid Anxiety
in CBT for Bipolar Affective Disorder

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Bipolar affective disorder (BD), otherwise known as manic depression, affects up to 1-1.5% of the population (Robins et al., 1984; Bebbington & Ramana, 1995). It is a severe mental illness, which leads to high rates of hospitalisation and suicide (Goodwin & Jamison, 1990). It also appears to be highly comorbid with other diagnoses. A large general population study found that all individuals with bipolar I disorder demonstrated at least one other psychiatric disorder, and that in 60% of cases these predated the onset of the bipolar illness (Kessler et al., 1997).

Cognitive behaviour therapy for BD has developed considerably in recent years. Groups in the UK and US have produced treatment manuals and have begun to evaluate the effectiveness of their treatments (Basco & Rush, 1996; Lam et al., 1999, 2002; Newman et al., 2002; Scott, 1995; Scott, Garland, & Moorhead, 2001; Zaretsky, Segal, & Gemar, 1999). This paper describes the cognitive therapy of a client who had developed a high degree of insight into his condition, its possible aetiology and maintenance. This paper focuses on three main issues. First, it provides an example of how a model of the ascent into mania can be produced collaboratively with the client. Second, it provides an example of where comorbid anxiety symptoms can be formulated in relation to the bipolar disorder, and can thereby aid treatment. Third, it describes how many treatment elements can be combined in a complex case.

The introduction will begin with a short review of the evidence for psychological processes being involved in the condition. Next, the main themes of cognitive therapy for bipolar affective disorder will be described, and the issue of identifying and treating comorbidity in bipolar disorder will be discussed. Finally, the aims of the case study will be described.

Evidence for psychological processes

The majority of evidence for a role of psychological processes in bipolar disorder has emerged comparatively recently. Several studies have explored the 'cognitive style' in BD. An early content

analysis of the personality characteristics of a group of BD individuals (Peven & Shulman, 1983) found the presence of high ambition to achieve, the placement of a high value on excitement and a desire to impress others. This study also noted the presence of a covert rebellion against the obligation to achieve, emotional reasoning (placing excessive meaning on feelings) and dichotomous thinking (extremism). Earlier research also provided evidence that BD individuals display greater social desirability and self-deception (Winters & Neale, 1986). One more recent study (Scott, Stanton, Garland & Ferrier, 2000) suggested that remitted BD individuals show a similar cognitive vulnerability to people with unipolar depression; compared to controls they showed higher levels of dysfunctional attitudes (in particular perfectionism and need for approval), more overgeneral memory and poor problem solving. More recently, a more focused study has homed in on specific cognitive factors (Lam, Wright & Smith, 2002). They found that remitted BD individuals report more extreme and autonomous goal orientation than remitted unipolar controls.

Some recent investigations suggest that life events interact with BD patients' cognitive style to predict increases in manic symptoms (Reilly-Harrington, Alloy, Fresco, & Whitehouse, 1999). In particular, their responsiveness to reward (subscale of the Behavioural Activation Scale) and their striving for achievement-related goals (facet of Conscientiousness on the NEO Five factor Inventory) predict increases in manic symptoms over time (Lozano & Johnson, 2001; Meyer, Johnson & Winters, 2001).

To date, only two studies appear to have explored information processing biases in BD individuals. BD individuals in a current manic episode showed a stronger tendency to attend to positive stimuli, compared to unipolar depressed patients and controls (Murphy et al, 1999); they also demonstrated a greater attentional bias to positive stimuli when subject to a positive mood induction, compared to controls (Johnson et al., 2002).

In summary, convergent evidence to date suggests that BD individuals are characterised by a cognitive style that involves an emphasis on autonomous achievement, desire for approval, and reward-

seeking that may predispose them to manic episodes. Theoretical approaches to BD have recently highlighted possible mechanisms for the ascent into mania that relate to these findings. For example, it has been suggested that increased attention to rewarding stimuli in response to positive mood leads to increases in goal-directed behaviour, that could further escalate mood (Johnson et al., 2002; Lam et al., 1999). It has also been proposed that the information from internal sensations, such as feelings of high energy and agitation could be appraised as indications of an overly positive sense of self that may in turn lead to elevations in mood and goal-directed behaviour (Healy & Williams, 1989; Jones, 2001). Certain authors (Gardner, 1982; Stevens & Price, 1996) have conceptualised mania as an evolutionarily prepared expression of a 'winning routine', during which an individual perceives a swift rise in their social status. This ascent would reflect the opposite process from the drop in perceived social status that is associated with depression (e.g. Gilbert, 2000). It is possible that the cycle of cognitive distortions, behaviour and physiology described by the above authors mediate such as an ascent into mania. These processes were explored in detail in the current case.

Cognitive therapy for bipolar affective disorder

Cognitive therapy for BD has several features. First, it involves methods to directly alleviate depression, which are similar to the treatment of unipolar depression, such as negative automatic thought diaries and activity scheduling. The same techniques can be used to tackle hypomanic and manic symptoms. For example, the activity schedule can help the client and therapist monitor changes in mood and activity, and identify a daily routine that minimises symptoms (e.g. having regular sleep and eating). The automatic thought diary can also be adapted for overly positive thoughts about the self (Beck, 1967; Chor, Mercier & Halper, 1988; Lam et al., 1999). The therapist and client identify thinking errors such as overgeneralisation, personalisation and emotional reasoning, and look for alternative, less overly positive, explanations for the client's experiences. A particularly important technique is for the client to learn to identify the prodromal signs of a relapse into mania, such as lack of sleep and feelings of high energy, and to identify coping strategies to reduce them. For some clients

in whom the hypomanic state is a positive experience, they are encouraged to identify and weigh up the pros and cons of becoming hypomanic.

Two case studies of individual cognitive behaviour therapy for bipolar disorder have described the use of many of these techniques (Chor, Mercier & Halper, 1988; Scott, 1996). Chor et al. (1988) used an adapted version of the automatic thought diary as described above. They noted some interesting distortions related to hypermania and mania: feeling she is totally responsible for everything in her world (“excessive responsibility”), she can do anything she attempts (“can” statements), without any error, and that anyone else must be incompetent or inferior for not reacting immediately to her (“assuming superiority”). Scott (1996) describes a case in which a more eclectic range of techniques were used, including goal setting, problem-solving, cost-benefit analyses of taking medication, self-esteem work, and monitoring the signs of relapse as described above. The current case study uses many of the same techniques, but the more innovative elements will be highlighted.

Comorbidity

A second key issue of relevance to the current case is that of comorbidity. Patients with BD have elevated rates of PTSD (Mueser et al., 1998) and drug and alcohol abuse (Goodwin & Jamison, 1990). Several recent studies have found rates of anxiety disorder to be between 33% and 45% in individuals with bipolar disorder (Cassano et al., 1999; Cosoff & Hafner, 1998; Perugi et al., 1999). Conversely, the risk of developing mania is greatly increased in individuals with anxiety disorder: social phobia holds a five-fold increased risk; agoraphobia an eight-fold increased risk, and specific phobia a ten-fold increased risk (Magee et al., 1996). The high prevalence of anxiety disorders in people who regularly experience mania, may seem counterintuitive considering that mania is often regarded as a state of high mood and reduced worry. However, it is important to note that one could provide the same argument about the state of depression. Furthermore, mania does share features with states of anxiety, such as increased irritability and distractibility. Indeed, a recent study showed that

people with anxiety disorders show more high moods than healthy controls (Bowen, Clark, & Baetz, 2003).

The relationship between social phobia and bipolar disorder is particularly intriguing. One study has reported that the majority of social phobia patients who improved following treatment with monoamine oxidase inhibitors became hypomanic (Himmelhoch, 1998). Data from the US National Comorbidity Survey found that 47% of their bipolar patients had comorbid social phobia, and that the risk of bipolar disorder increased with the number of social fears (Kessler et al., 1999). Indeed, it has been proposed that protracted social anxiety may represent the dimensional opposite of gregarious hypomania, in a significant minority (around 10%) of individuals with social phobia (Perugi et al., 2001). Interestingly, one of the the published case studies of bipolar disorder (Scott, 1996) highlights fear of negative evaluation by others (the key component of social anxiety, Stopa & Clark, 2001) as playing a critical factor in the maintenance of the clients' problems. Perugi et al. (1999) describe the case of a woman with a history of social phobia since childhood who left her employment at the age of 27 because of disabling social anxiety. Eighteen months later, her social anxiety gave way to 'impudence' and 'shamelessness' and a firm belief that she would reach 'enlightenment', culminating in hospitalisation for a manic episode. After successful treatment for mania, she became depressed and ashamed for everything she had said during the manic episode. Furthermore, recent evidence has suggested a connection between mania and later social anxiety, in that concerns about people's negative evaluations of the stigma of the bipolar disorder are associated with avoidance of social interactions with individuals outside the family (Perlick et al., 2001).

Little attention has been paid to the findings of comorbidity in bipolar disorder until recently, maybe because the bipolar disorder often 'trumps' the other diagnoses. But recently it has been stated that "multiple associations of panic disorder, OCD, and social phobia are not rare among individuals with affective psychoses, and are likely to be associated with more severe psychopathology than than is found in individuals without anxiety disorders" (Cassano et al., 1999). Although a cognitive model of

social anxiety has been used to treat schizophrenia (Good, 2002; Halperin, Nathan, Drummond & Castle, 2000), it does not appear to have been applied to bipolar disorder. The cognitive treatment and conceptualisation of the anxiety disorders used in this case study was based on earlier work in this area (Clark & Wells, 1995; Clark, 1999; Ehlers & Clark, 2000; Salkovskis, 1991)

Aims of the Study

1. To describe the example of the formulation of a client with bipolar affective disorder which incorporates comorbid anxiety symptoms.
2. To describe the elements of treatment that were used to treat this individual.
3. To demonstrate the effectiveness of the therapy and the perceived usefulness of different elements of treatment.
4. To describe a vicious cycle model of the ascent into mania that is clinically useful.

Client History

Stephen was a middle-aged man, who had a previously successful, but erratic, career in the arts. He experienced a ten-year history of intermittent episodes of depression, interspersed six years prior to therapy with episodes of mania, which had included social and sexual disinhibition, attempts to change his identity, grandiose delusions and occasional hallucinations. His manic episodes appeared to coincide with his work, thereby making it increasingly difficult for him to get employment. The episodes were associated with erratic use or cessation of antidepressants, and use of alcohol and drugs (in particular amphetamines). During depressive episodes, Stephen was often preoccupied by feelings of guilt and shame regarding his behaviour during manic periods, leading to suicidal intents and plans. He had made one suicide attempt.

Stephen articulated a willingness to both overcome his depression and prevent future manic episodes. He was very concerned about the stigma of his illness but he showed good insight that he was suffering from bipolar affective disorder, and was keen to commence cognitive-behaviour therapy. He

had been taking Nefazodone 100mg twice daily and Lithium Carbonate 600mgs daily for ten weeks before the start of therapy.

Stephen reported having a highly critical father who had been treated by ECT for a ‘nervous breakdown’, and a loving but ‘emotionally smothering’ mother. His mother was devoted to Stephen pursuing a career in the arts, a vocation which his father apparently despised. Stephen was emotionally and physically abused by his elder brothers, but maintained good relations with his peers at school. Owing to his experience with his brothers and father, he found it difficult to relate to other men. Stephen’s mother died when he was still a teenager, and his father died eight years prior to therapy, which appeared to trigger an earlier hypomanic episode. Two years later, Stephen was attacked by a group of adolescents, which led to increased anxiety and hypervigilance, and he could not leave the house unaccompanied for several months after this event owing to a fear of being assaulted again.

Assessment

Assessment and Questionnaires

A full history was taken and the areas of current difficulty were discussed. Stephen completed several standardised questionnaires to assess depressive and manic symptoms: the Beck Depression Inventory (Beck, Ward, Mendelson, Mock., & Erbaugh, 1961); the Hopelessness Scale (Beck et al., 1974); the Internal State Scale (ISS; Bauer et al., 1991) and the Dysfunctional Attitudes Scale (DAS; Weissman, 1979). Following from his history, which emphasised fear of criticism and harm from others, several further measures were administered to assess important components of the client’s anxiety: Liebowitz Social Anxiety Scale (Baker, Heinrichs, Kim & Hofmann, 2002; Liebowitz, 1987) and the Post Traumatic Cognitions Inventory (PTCI; Foa et al., 1999). Each of these scales was completed within the first month of therapy, with the exception of the Liebowitz, which was a retrospective rating of the first month, completed at six-month follow-up. He also completed a life review to show his change in mood over time and its precipitating events. During the early assessment stages, it became more clear that shame and fear of embarrassment and assault were Stephen’s key

concerns, and several of his statements on the subject are cited to show their relevance to the formulation.

Results of the Assessment

Stephen presented as articulate, engaging and conscientious. At the start of therapy, he was severely depressed and hopeless (see Table 1), and he had thoughts of killing himself but would not carry them out. Stephen engaged in little pleasurable or achievement-oriented behaviour, and reported spending considerable amounts of time ruminating and blaming himself for behaviours he regarded as signs of his inadequacy and incompetence. He fulfilled the DSM-IV criteria (APA, 1994) for a major depressive episode at the time of assessment.

Stephen avoided many social situations for fear that he would be ridiculed by other people. These included social gatherings, interviews and meeting previous work acquaintances. He thought that people would see him blush, stumble with his words, “smell his fear”, and that he would look “desperate for praise”. He described a mental image at these times (elicited during session 8) of “sitting, full of energy and my face being red, blushing. I want to move my head and duck. I have this overgratitude and I’m trying not to show it”. He linked this to a memory from when he was between 8 and 11 years old and his father had reacted with criticism and contempt at his desire for praise. At the time of assessment, Stephen fulfilled the DSM-IV criteria (APA, 1994) of social phobia. He reported that he had always been socially anxious and that he had experienced debilitating anxiety long before his experience of mania.

Stephen reported a range of thoughts during social situations: “I am unlikeable”, “I am foolish”, “I am inadequate”, “I am inferior”, “People won’t be interested in me”, “People won’t like me”, “I am weird/different”, and “People will see I am nervous”. He rated his belief in each of these thoughts at between 80-100%. He reported a range of safety behaviours. Safety behaviours are acts that are carried out with the aim of preventing or ameliorating a perceived catastrophic outcome (Salkovskis, 1991). The safety behaviours which he would carry out often or always were: (1) trying not to attract attention;

(2) hiding the symptoms of anxiety (3) monitoring and censoring his speech and (4) trying to act normal and control his behaviour.

In addition to cognitions relating to shame and embarrassment, Stephen also post-traumatic stress symptoms. He was afraid that he would be attacked other men, and therefore he avoided a range of situations including public transport, pubs, markets, and other situations involving young ‘macho’ men, such as small DIY stores, and garages. Exposure to these situations provoked intense distress and physiological arousal. He scored 197 on the PTCI, where the mean for PTSD patients is 133 (s.d. = 44.17) (see Table 1). The items on which he scored at the maximum possible level (‘Strongly agree’) were, “I have to be on guard all the time”, “You can never know who will harm you”, “The world is a dangerous place”, “I feel isolated and set apart from others”, “I feel like I don’t know myself anymore” and “You can never know when something terrible will happen.”

The relationship between Stephen’s anxiety, depression and his manic episodes was reflected by his own statements. The social anxiety appeared to feed the mania: “I used to get panic attacks and social anxiety before I ever experienced mania, and I used alcohol to try to cope”; “On an ‘up’, I can forget my anxiety and I no longer feel weak, bad and useless”; “During my high, I wanted to hide behind a new identity”. In turn, the mania tended to feed into the social anxiety: “I monitor myself for not telling the truth because I lied a lot during my highs”; “I have avoided the people who knew me during my manic episode”; “I am frightened to show excitement or pleasure, and frightened about making other people feel bad”. He was also naturally concerned about the stigma of bipolar illness, and was worried about how his friends and acquaintances would view him if he told them the diagnosis. The depression and feelings of failure also appeared to feed into the mania: “I was so relieved to feel good that I would want to do all the things that I couldn’t do when I had been depressed”.

Formulation

In summary, Stephen was suffering from bipolar affective disorder, social phobia, post-traumatic stress symptoms, and was currently in a major depressive episode. The formulation of his

comorbid conditions at assessment is shown in Figure 1. In summary, Stephen had a history of being humiliated and assaulted as a child which made him vulnerable to anxiety in social situations. In response, he used safety behaviours such as avoiding social situations, hiding his anxiety, monitoring his speech, and trying to act normal to try to prevent being humiliated, rejected or attacked. These safety behaviours were used regularly, but they were interspersed, and later gave way to a set of behaviours that fed the ascent into mania. They included the pursuit of extremely difficult goals, cessation of antidepressants, the use of alcohol and other drugs, reduction in sleep, and increased social and work activity. These behaviours appeared to be aimed at rising above the depression, ignoring any of his problems and re-emerging as a new, highly creative and intelligent self. These behaviours could be called 'ascent behaviours' because they feed the ascent into mania. The behaviours may have had their origins in Stephen's biological vulnerability, in his early experiences, and/or in the current environment (e.g. the availability of drink and drugs).

When the ascent behaviours were employed they may have led to hypomanic or manic episodes (the details of this process will be described later), which, when the mania or hypomania had abated, served to trigger later experiences of shame and embarrassment which in turn triggered another depressive episode. The depression and the concomitant fear and anxiety, were then maintained by self-blame, overgeneralisation and safety behaviours, until another cycle of ascent behaviours began.

Treatment

Techniques

Considering the complexity of Stephen's condition, a range of treatment techniques were adopted at different times. The key root of Stephen's difficulties was conceptualised by both client and therapist as being his fear of negative evaluation and assault that had preceded the manic symptoms in the client's history, yet the overlay of depression and mania served to maintain and exacerbate the fear and anxiety. The client listened to an audiotaped recording of each session in between appointments.

He chose to listen to them with his partner. The client engaged in a total of 20 sessions of cognitive therapy, including two initial assessment sessions, each lasting between 60 and 90 minutes.

Depression. Stephen completed an activity schedule for every hour every week, with the aim of increasing the number of activities that provided either sense of pleasure or achievement. They also provided information on what activities Stephen was avoiding owing to anxiety, leading on to discussions about how to begin to gradually face them. Negative automatic thought diaries were used to identify the evidence for alternative explanations of problem situations. A vicious cycle of self-blaming behaviour was identified, leading to a key insight that Stephen often felt deeply inadequate partly because he was deliberately engaging in self-blaming behaviours, such as curling up in a ball and cursing at himself. Stephen had strong beliefs that the world was an extremely competitive place, which had no tolerance of depressed people (an 'agonic' mode; Trower & Guilbert, 1989). To explore evidence for this, the psychologist conducted a tape-recorded survey of three of his acquaintances to see whether other people shared the client's view, and how they dealt with it. Stephen also found it particularly helpful to listen to other peoples' experiences of depression and how they had received both negative and positive reactions from others. Towards the end of therapy, we worked on setting goals for the future (e.g. work) and used negative thought diaries and problem-solving techniques to anticipate future obstacles and risks. He also identified, described and wrote down his early, middle and late prodromal signs of depressive episodes, along with suitable coping strategies.

Anxiety. Treating Stephen's social anxiety involved introducing the cognitive model of social phobia and carrying out behavioural experiments in the session to test his specific fears (see Clark & Wells, 1995, for a detailed description of the model). People with social phobia appear to use feelings of anxiety, distorted images of themselves and negative thoughts to judge how they appear to others. They use safety behaviours, such as avoiding attention, to try to prevent being rejected or ridiculed by others. During therapy, Stephen was able to drop his safety behaviours and receive feedback from his conversation partners, and from listening to tapes of the interaction. For example, he dropped the safety

behaviour of sitting far away from the other person in case they could 'smell his fear'. In doing so, he realised that the internal information was not an accurate reflection of how he appeared to others. With respect to the post-traumatic stress symptoms, Stephen engaged in homework in which he would face his feared situations, such as crowded markets or public houses. During discussion of specific past feared situations, it became clear that he would make a judgement of danger on the basis of very little information, such as the colour of the furniture in a pub or on his internal feelings that he was being stared at. He would then immediately attempt to escape the environment without testing out his fears. Therefore, he was encouraged to face the feared situations gradually, and to sample the external environment fully before allowing himself to conclude that the situation was dangerous. These behavioural experiments demonstrated that to him that the situations were less dangerous than he had feared.

Mania. Stephen carried out a life review to show his change in mood over time and its precipitating events (Lam et al., 1999). He identified, described and wrote down his early, middle and late prodromal signs of manic episodes, along with suitable coping strategies (Lam et al., 1999). The signs and strategies are displayed in Table 2. We discussed and specified the distinction between happy mood and prodromal signs of mania. He also identified key individuals to support him through times of distress, using the Significant Others Scale (Power et al., 1988). We also discussed and reappraised the meaning of his bipolar illness using the Views on Manic Depression Questionnaire (Hayward et al., 1999; Lam et al., 1999). The key prevention of mania also involved producing a cognitive model of the ascent into mania. The model was produced collaboratively, basing the structure (i.e. a vicious cycle of mood, thoughts, behaviour, the environment and physiology) on what he had learned from the models of social phobia and depression. The model is described in the Results section.

Assessment of Change in Symptoms. Stephen completed the BDI, ISS, and Hopelessness scales for every session. He also recorded each of the activities that gave him a sense of pleasure or achievement in the activity schedule, on a scale of 0 to 10. These data provided a measure of the

number of pleasurable or achievement-oriented activities in which he engaged every week, and the mean ratings of both pleasure and achievement per week. The regular recording of these measures allowed a statistical analysis of their degree of change over time, and whether any specific points in therapy led to significant improvements. Each of the clinical measures obtained at assessment were repeated at the end of treatment and at six- and ten-month follow-up in order to evaluate the change in symptoms.

Cognitive Formulation of the Ascent into Mania. The model is displayed in Figure 2 and can be summarised as follows. Stephen held a set of dysfunctional 'ascent' beliefs. He believed that by going into a high mood, attaining difficult goals and rewarding himself he could rise above his current perceived low self esteem. For example, he stated that, "On an 'up', I can forget my anxiety and I no longer feel weak, bad and useless" and "During my high, I can hide behind a new identity". While Stephen was still experiencing depression and anxiety, he would also start to notice increases in energy and positive mood. The increases in mood would activate thoughts such as "I'm back to my attractive, intelligent and outgoing self again" and "The depression is dead, never to return!". In response to these thoughts, he would begin to engage in a range of 'ascent' behaviours relating to the ascent beliefs, i.e. aimed at rising above the depression, ignoring any of his problems and re-emerging as a new, highly creative and intelligent self. The behaviours included stopping antidepressants, reducing his sleep, drinking more, taking drugs, looking for social opportunities, adopting highly challenging goals and ignoring his problems. Many of these behaviours would lead to direct increases in positive mood. Stephen's social environment would react in two different ways to these behaviours. People who did not know him would encourage them, being drawn to his optimism. This would lead to further increases in ascent behaviour. People who did know him would become worried and concerned. In response to this concern, Stephen would become irritable at being controlled, and would try to persuade and reassure people that nothing was wrong. They would often capitulate and this led to further thoughts of being supremely intelligent and capable. If the negative feedback from his friends continued

he would avoid these people, which further prevented a drop in mood. Throughout this cycle, the ascent behaviours would have direct effects on his physiology (e.g. sleep cycle, arousal), yet these experiences would be interpreted in a positive rather than negative manner, further feeding into the cycle. The cycle served to increase mood, grandiose thoughts and ascent behaviour, reflecting the pathway from high mood to hypomania to mania. Only a catastrophic incident or medication would normally stop the cycle at this point. Stephen found this conceptualisation very useful in understanding his vulnerability to another manic episode.

Results of Treatment

Pre-, post- and follow-up measures. The measures of symptoms following therapy, and after six and ten month follow-up, are shown in Table 1. Measures of depression, hopelessness and self-reported prodromal manic symptoms fell to a level within the non-clinical range after therapy and at three, six and ten month follow-up. Social anxiety (Leibowitz Scale) also dropped from clinical to non-clinical levels. The PTCI scores dropped from a level before therapy that was at least one standard deviation higher than a population of individuals with PTSD, to a level intermediate between PTSD patients and non-clinical controls.

Session-by-session change. The scores on the BDI & HS and ISS subscales at the beginning of each therapy session are shown in Figures 3 and 4, including one, three, six and ten month follow-up. The scores during the first ten sessions of therapy were compared to the scores in the last ten sessions of therapy plus the follow-up period. Independent-samples t-tests indicated that there was a significant drop in BDI, $t(22) = 7.2, p < .001$; Hopelessness, $t(21) = 8.5, p < .001$; ISS-Activation, $t(21) = 2.7, p < .05$; ISS-Depression, $t(21) = 5.4, p < .001$; and ISS-Conflict, $t(21) = 6.2, p < .001$; and a significant increase in ISS-Well being, $t(21) = 5.1, p < .001$. Thus, there was a significant improvement in all of these measures over time. Inspection of the Figure 3 shows a moderate drop in depressive symptoms from the start of therapy, accompanied by a much slower decline in hopelessness, until sessions 12, 13,

and 14, which showed steep drops in hopelessness, symptoms of depression, and the scores on the ISS scale. The treatment gains appear to be maintained from this point onwards.

Stephen was shown the graph and asked to explain why he thought the graph had showed this pattern. He said that from the beginning of therapy, his feeling of being understood had an immediate effect on reducing his depression, as did the activity schedule and the therapy for his anxiety symptoms. On Session 14, Stephen had returned from a trip from his home city with his partner to pick up some of his possessions from a town at the other end of the country; it was at this town where he had experienced his last manic episode. To Stephen, the trip represented an extremely anxiety-provoking exposure exercise, for him to face the place where he had last broken down, and indeed to face ‘the person that he had been’ while he was there. He had coped with the experience, and he felt that this had both given him a sense of accomplishment and resolved past issues. He felt that he would not have been able to do this without the previous weeks for cognitive therapy. During the same trip, he also visited his mother’s grave, which he had not seen for over 20 years. This triggered memories of his difficult family experiences, which he felt that he was able to process and put into place.

Activities over time. The weekly (not session-by-session as above) change in the number and quality (1 to 10 ratings) of pleasurable and achievement-related activities are shown in Figures 5 and 6. There was a significant increase in the mean ratings of both pleasurable and achievement-related activities over time, $t(17) = 3.8$, $p < .001$, and $t(17) = 3.5$, $p < .01$, respectively, and in the number of achievement-related activities per week, $t(17) = 2.3$, $p < .05$, but no significant change over time in the number of pleasurable activities, $t(17) = 0.6$, ns. Inspection of the graphs showed a progressive increase in the ratings of activity over time, with a clear peak at 16 weeks, which corresponded to Session 14 described earlier. There was a wide fluctuation in the degree of activity over the weeks of therapy, with no obvious relationship between number of pleasurable activities and number mastery-related activities.

Exit questionnaire. Table 3 shows Stephen's ratings of how useful he found each component of therapy. All components received ratings that were either 'particularly', 'very' or 'extremely' helpful. The most useful components included modelling his social anxiety, identifying prodromes, modelling the ascent into mania, and the behavioural experiments to test his fears. After reading an earlier draft of this paper, he was also particularly keen to state the importance of what he believed was a crucial factor in his treatment: the absolute importance for him to be able to trust and believe in his therapist's concern and care for his condition.

Global outcomes. Stephen continued to keep a brief account of his daily activities, along with a rating of his mood. He remained completely compliant with his medication throughout therapy and follow-up. This is in itself an accomplishment, although at the start of therapy he had already made a commitment with his psychiatrist to maintain his medication. He maintained his relationship with his partner, completed a training course, after which he found regular employment. He also regularly spent time working with a friend on a long term project.

Discussion

Outcome

The client's bipolar affective disorder was successfully treated using many of the traditional and more recent innovations in CBT (e.g. Basco & Rush, 1996; Lam et al., 1999, 2000; Scott, 1995, 2001), including activity scheduling, negative automatic thought diaries, life reviews and the identification of prodromal signs and coping strategies. Many of these components were viewed very favourably by the client. The client's ratings of the usefulness of the different elements of therapy may have been affected by implicit demand from the therapist, but it would be difficult to tease out whether this was the case. The client was asked to comment on an early draft of the paper, which may seem unorthodox and would not be recommended for all clients, but the client's comments proved to be valuable and constructive in this case. The case provides a detailed example of the application of multiple techniques within an individual and the detailed outcome measures used in this study show the course of recovery

in terms of symptoms of depression, hopelessness, internal states associated with mania, number of activities and levels of pleasure and achievement derived from these activities.

Conceptualisation of Mania

The therapy further provided an example of the production of a collaborative individualised cognitive model of the ascent into mania. This model incorporated elements from current theory and evidence. For example, he appraised small increases in energy and positive mood in an overly positive, personalised and overgeneral manner at the early stage of the prodrome (c.f. Healy & Williams, 1989; Jones, 2001). He felt that he would set highly autonomous goals for himself that were challenging but extremely difficult to achieve (c.f. Scott et al., 2000; Lam, Wright & Smith, 2002) and he also appeared to use the goal-oriented behaviour as a way to rise above his depression. The client found that producing a model of ascent into mania helped him understand, to a better degree, why he had relapsed in the past.

The Role of Anxiety

The current case study also provided a formulation of the two-way interaction between between comorbid social anxiety and bipolar disorder. Although epidemiological studies have identified the association, this case appears to be the first to identify a functional relationship. The history indicated that social anxiety preceded and exacerbated the depression and mania in this case, and it was identified by the client as a main goal of therapy. The treatment rationale followed the cognitive model of social phobia (Clark & Wells, 1995), and its main components were rated as very useful by the client. He showed a substantial drop in his social anxiety symptoms, and in the frequency and degree of belief in negative social cognitions. The use of safety behaviours also dropped with time.

In addition to social anxiety symptoms, this client also demonstrated extremely high scores on the negative cognitions normally associated with PTSD, combined with a history of trauma and the triggering of distress and physiological reactions to reminders of the original incidents. The symptoms dropped during treatment, as the client began to test out his fears. He perceived this treatment to be

extremely useful. The client showed a decrease to non-clinical levels in his negative beliefs about himself and the world, but scored in the clinical range for self-blame cognitions concerning the cause of the assault he experienced. This may not be surprising because the client's responsibility for the trauma had not been selected as a treatment goal.

Views on Complex Treatment Protocols

The therapy clearly involved many components. This may be perceived as a weakness for several reasons. First, it is very likely that many clients would not respond to this diverse and intense form of therapy; this client was a highly conscientious and able individual. Second, it appears that under half of the clients with bipolar disorder report clinical levels of anxiety symptoms, according to past surveys. So this form of treatment may only apply to a (large) minority. Third, it could be conceived that introducing many components into therapy could be more confusing than useful, because no one strategy may be learned well.

Despite the above concerns, it appears that the application of many components were regarded as useful in this case. Moreover, the identification of the appropriate components of therapy was led by the formulation. The choice of when to introduce them was dependent on several other factors. First, the activity schedule provided an excellent base from which to explore avoidance behaviour, leading to cognitive modelling of anxiety, and exposure homework. Second, the content of therapy was determined collaboratively between the therapist and client according to the client's current priorities and concerns. Third, certain features of the therapy, such as the life review and activity schedule, were more appropriate at the beginning, and others, such as the identification of prodromal signs and modelling of the manic episodes, were more appropriate towards the end of therapy.

Limitations and Conclusions

The approach of this case study is a psychosocial approach rather than a bio-psychosocial approach, and therefore it is not designed to provide an all-encompassing view of the client's disorder that would include neurochemical and hereditary factors. Furthermore, although the client's anxiety

disorders were seen to precede the mania, and the client and therapist could explain a link between the two conditions, it would not be possible to provide empirical evidence that the functional relationship exists without carrying out a longitudinal experimental (e.g. ABA) design within the treatment of this client. This could not be carried out over the time interval of therapy.

The client had already been stabilised on ten weeks of psychotropic medication prior to therapy (which he perceived as a necessary component to help him cope with coming to therapy), but nevertheless was experiencing a current depressive episode. This remitted over the course of psychological treatment, as did his social anxiety and his traumatic stress symptoms. Clearly the operation of factors other than cognitive therapy (e.g. long-term effects of medicine, life events) in the improvement of symptoms cannot be ruled out. Indeed, the client identified the fact that he could trust and believe in his therapist's care and concern, as a crucial factor in the therapy. It is also interesting that the most clinically significant change in symptoms did not appear to be a direct result of in-session procedures of therapy. It involved meeting and confronting the environment, people and the 'self' associated with the last manic episode, and the return to his mother's grave coupled with the flux of childhood memories. Several speculations for the role of this experience could be suggested. Perhaps, the exposure to the environment associated with a past episode was a behavioural experiment. The fact that he was able to deal with his anxiety and not relapse in this environment provided him with evidence that he was not at immediate risk of relapse and its consequent shame and humiliation. Maybe part of the client's problems represented an unresolved grief reaction to the untimely death of his mother, who had supported him through the abusive experiences from the males in his family. Only after building his own self-confidence through therapy could he feel able to confront and process these beliefs and memories.

In summary, this paper reports on the successful treatment of a client with bipolar affective disorder and comorbid anxiety using a treatment package combining elements of CBT for both forms of disorder, which was organised within a collaborative, functional framework. Future studies could test

the specific components of this kind of treatment package, such as the ascent into mania and the role of comorbid anxiety, in order to ultimately help develop more focused treatments for a potentially significant proportion of people with bipolar affective disorder.

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Table 1. Measures of psychopathology, taken at pre-treatment, post-treatment and at six- and ten-month follow-up, and clinical and non-clinical means (and standard deviations) where available.

Measure	Client's Scores				Comparison Scores	
	Pre	Post	6m FU	10m FU	Clinical	Controls
BDI	37	1	0	1	Unipolar 24.4 (8.4) ¹	Non-clinical 1.6 (1.7) ¹
Hopelessness Scale	19	3	1	1	12.2 (5.7) ²	3.0 (3.4) ³
DAS†	184	95	-	-	166.7 (38.1) ⁴	119.4 (27.2) ⁵
ISS					Bipolar ⁶	Non-clinical ⁶
Activation	50	20	22	35	300 (100)	115 (55)
Depression	129	8	6	20	135 (50)	20 (20)
Well-being	21	92	189	219	65 (35)	210 (40)
Perceived Conflict	266	18	12	47	150 (100)	65 (30)
Liebowitz††					Social Phobia ⁷	Non-clinical ⁷
Fear	67	-	16	18.5	37.4 (12.4)	6.5 (5.8)
Avoidance	66	-	8	9	28.9 (12.0)	3.5 (4.0)
PTCI†					PTSD ⁸	Non-clinical ⁸
Negative Self	5.0	2.0	1.5	-	3.6 (1.5)	1.1 (0.8)
Negative World	6.4	3.9	2.7	-	5.0 (1.3)	2.4 (1.4)
Self-blame	6.0	2.6	2.8	-	3.2 (1.7)	1.0 (1.0)
Total	197	89	71	-	133 (44)	49 (24)

¹Sackeim & Wegner (1986)

²Niméus, Traskman, & Alsen (1997)

³Velting (1999)

⁴Robins, Block, & Peselow (1990)

⁵Weissman (1979)

⁶Bauer et al. (1991)

⁷Fahlen (1995)

⁸Foa et al. (1999)

† This measure was taken within the first four weeks of therapy.

†† This measure was assessed retrospectively at six month follow-up.

Table 2. Prodromal warning signs and coping strategies

<u>Time Period</u>	<u>Prodromal Warning Signs</u>	<u>Coping Strategies</u>
Early	1. Feelings of being energised in the early morning or late at night	Use energy during the day, both physically and mentally. Stay in bed until normal getting up time. Ask partner to remind me about my responsibilities and joint needs.
	2. The thought "I will do what I want" in everyday things	Negotiate issues in a reasonable way.
	3. Regularly drinking the equivalent of more than one bottle of wine per night	Check desire to drink more. Remind myself that going to bed before 12am is better for me and partner.
	4. Progressively and consistently wanting to stay up later	
Middle	5. Enjoy memories of early manic experiences	Note down unusual thoughts in diary and challenge them. Become aware that these signs are serious, so challenge and stop the behaviours and discuss them with my partner and psychiatrist. Avoid going to clubs and bars on my own and behaving as if single.
	6. Saying to myself "I'll never get depressed again"	
	7. Feeling compelled to seek situations so as to flirt and meet other women	
Late	8. Buying unusual things when I don't need them, e.g. flamboyant clothes	
	9. Contacting people I have known when high	
	10. Only sleeping less than 4 to 5 hours every night	Allow partner to take control of income.
	11. Thinking "I have a right to spend my own money" without considering debts to others	Talk to partner and psychiatrist about pharmaceutical methods to help reduce the energy. Bring in the contract with partner and friends so that they decide the appropriate action to be taken.
	12. Behaving cruelly and thoughtlessly towards partner	
	13. Decide to leave relationship and home	
	14. Verbally aggressive, confrontational, emoting, slamming doors, etc	

Table 3. Client's ratings of helpfulness of each element of the treatment (where 1 = Not at all helpful and 7 =

Extremely helpful)

Element of Therapy

Rating (1-7)

Producing a cognitive model of my social anxiety	7
Engaging in experiences outside the session which further tested my fears, e.g. going to a crowded market	7
Identifying, describing and writing down prodromal signs of manic and depressive episodes, along with suitable coping strategies	7
Mapping out the cycle of mood, thoughts, and behaviour that may lead to future manic episodes	7
Recording each session on tape	7
Carrying out experiments to test out other peoples' evaluations of me	6
Listening to my voice on tape and comparing it to other peoples' speech	6
Understanding my tendency to get into vicious cycles of self-blame	6
Completing the activity schedule	6
Carrying out a life review to show change in mood over time and its precipitating events	6
Discussing and understanding the meaning of bipolar illness	6
Setting goals for the future (e.g. work)	6
Using problem-solving strategies to anticipate future obstacles and risks	6
Using negative automatic thought diaries to identify evidence of alternative explanations for problem situations	5
Carrying out a survey to find out what other people think of the social world	5

Figure 1. Formulation of Mania, Depression and Comorbid Anxiety

Figure 2. Conceptualisation of the Ascent into Mania

Figure 3. Changes in Levels of Depression and Hopelessness by Therapy Session and at Follow-Up

Figure 4. Changes in the Factors of the Internal State Scale by Therapy Session and at Follow-Up

Figure 5. Week-by-week Changes in the Number of Pleasurable and Achievement-Related Activities During Therapy

Figure 6. Week-by-week Changes in the Quality of Pleasurable and Achievement-Related Activities During Therapy