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# An Integrative Formulation-Based Cognitive Treatment of Bipolar Disorders: Application and Illustration

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An integrative cognitive treatment for mood swings and bipolar disorders is summarized and then illustrated in a clinical case. In essence, it is proposed that multiple, extreme, and conflicting beliefs about changes in internal state, and the reciprocal impact of these beliefs on behavior, physiology, and the social environment, constitute the central mechanism that maintain and escalate bipolar symptoms. Using a case illustration with examples of therapy dialogue, several key aspects of cognitive-behavioral therapy are explained, including the assessment of mood, beliefs, distressing imagery, and recurrent thinking; case formulation; therapeutic techniques; self-awareness; interpersonal factors during therapy; and systemic issues. © 2007 Wiley Periodicals, Inc. *J Clin Psychol: In Session* 63: 447–461, 2007.

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A burgeoning of therapeutic approaches occurred within the treatment of psychosis throughout the 1990s (e.g., Haddock, Bentall, & Slade, 1993; Kuipers et al., 1997). The end of this period resulted in the formation of focused, cognitive treatments that were developed to enable collaborative formulation of clients' key problems (e.g., Morrison, 2001).

Bipolar disorders are becoming increasingly recognized, yet until comparatively recently, little has been offered in terms of psychological treatments. In the last decade, this gap has been filled by several therapeutic approaches, including cognitive therapy (e.g., Lam et al., 2003).

My recent aim, and that of many of my colleagues, has been to try to bring some integration and progression within bipolar disorders. This article describes an integrative

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formulation-based cognitive treatment (CT) for bipolar disorder with this aim in mind (Mansell, Morrison, Reid, Lowens, & Tai, in press). I then provide examples of how this treatment is clinically practiced.

### Cognitive Therapies of Psychological Disorders

The strong similarities among the multitudes of cognitive therapies for psychological disorders, alongside abundant research evidence, have led to the conclusion that certain cognitive processes that maintain symptoms are transdiagnostic; that is, they are shared across a wide range of different disorders (Harvey, Watkins, Mansell, & Shafran, 2004). An overview of these treatments suggests that they share at least six components: the current situation, intrusions, appraisals, safety behaviors, metacognitive beliefs, and previous life experiences. Within each treatment, entering certain situations triggers the intrusion into consciousness of perceptual experiences that capture attention. The individual may describe these as thoughts, feelings, images, or impulses. The treatments presume that the perceptual experience is relatively automatic—that it occurs suddenly and is not under deliberate control. The intrusion also is presumed to be normal to the extent that many other people without the disorder in question (but not necessarily everyone) could experience the same perceptions, yet not develop the disorder.

The following two processes are key to CTs: (a) an appraisal of the intrusion and (b) the behaviors that result from the appraisal. In most cases, the appraisal is of some kind of extreme personal threat [e.g., “This palpitation means I am having a heart attack!” in panic disorder; “This impulse to harm someone means I am an evil person!” in obsessive-compulsive disorder (OCD); Clark, 1999]. This leads the individual to try to prevent the extreme danger at all costs through the use of safety-seeking behaviors (Salkovskis, 1991). Safety behaviors are any acts carried out to try to avoid or reduce the severity of a perceived threat. Safety behaviors are extremely diverse in content and include escape and avoidance, mental strategies such as thought suppression, compulsive rituals, dieting, worry, self-critical thinking, and perfectionist goal-striving.

There are several problems with safety behaviors. First, they confirm the threat belief (e.g., “I managed to hide my trembling before other people ridiculed me for looking a nervous wreck!”). Second, they can often provoke further symptoms (e.g., thought suppression often leads to a rebound effect; Purdon, 1999). Third, they can contaminate the situation (e.g., avoiding attention from other people leads other people to believe that person is unfriendly). Because of these direct effects of safety behaviors, a vicious cycle is formed that confirms an individual’s beliefs in extreme danger and escalates symptoms. It has been proposed that underlying the individual’s use of these appraisals and safety behaviors are certain beliefs that they hold about themselves, others, and their own affective states and mental events (metacognitive beliefs; Wells, 2000). For example, individuals with OCD report high levels of thought–action fusion—the belief that thoughts inevitably result in action and are morally equivalent to acting on the thought (Shafran, Thordarson, & Rachman, 1996).

Cognitive therapy has been generally successful, yet no integrative approach of this kind has been developed for bipolar disorder. This is despite the publication of a number of useful therapy manuals (e.g., Newman, Leahy, Beck, Reilly-Harrington, & Gyulai, 2002) and specific techniques for bipolar disorder (e.g., Leahy, 2005). It would be surprising if bipolar disorder is very different from these other disorders, especially considering the high levels of comorbidity of bipolar disorder with these conditions (Kessler, Rubinow, Holmes, Abelson, & Zhao, 1997) and the established evidence that hypomanic symptoms, like other forms of psychopathology, occur on a continuum with normality

(Eckblad & Chapman, 1986). For this reason, together with several colleagues, I am pursuing an integrative cognitive formulation and treatment of bipolar disorders that incorporates these insights.

### An Integrative CT

The treatment is based on the six components that were described earlier, yet several elements have a unique content for individuals with mood swings and bipolar disorder (Mansell et al., in press).

First, we propose that the key intrusions that feed into mood swings are changes in *internal state*. This is conceptualized as the rate of change of cognition, mood, physiology, or behavior that is perceived by the individual. Examples include speeded-up versus slowed-down thinking and elevated versus reduced arousal levels.

Second, unlike within the cognitive therapies for other psychological disorders, the appraisals made of the perceptual changes by individuals with mood swings are not exclusively threatening nor are they always along a specific personal theme. We propose that what characterizes individuals with mood swings is that they have multiple, extreme, conflicting appraisals of their internal state that are unresolved with respect to one another. For example, a woman with bipolar I disorder may believe that her mind racing faster is both a sign that she will be supremely creative and successful, *and* a sign that she is about to have another breakdown, *and* a sign that she is acting in an arrogant and overbearing manner. Which appraisal is expressed at any one time will vary in a way that is a dynamic interplay of factors such as the current social situation and the current internal state.

The key element of the appraisal part, however, is that there is an *extreme personal appraisal* made of the change in internal state at any one time, and that this appraisal leads to behaviors that aim to control the internal state in some way—including attempts to suppress it, sustain it, or enhance it. The person with mood swings does *not* simply experience the change in internal state without trying to evaluate it and control it in some way. In our terms, behaviors that enhance the activation level of the internal state have been labeled *ascent behaviors*, and acts that reduce the level of activation have been termed *descent behaviors*. Just like safety behaviors, they have at least three counterproductive effects: They maintain the extreme personal appraisals (e.g., “I managed not to relapse this time when I felt high because I isolated myself from other people”), they contribute to changes in internal state (e.g., being active for longer during the day disrupts sleep rhythms, which leads to a neuropsychological state of increased activation; Healy & Williams, 1989), and they contaminate the social situation (e.g., increased autonomous activity entails rejecting potentially helpful advice and feedback from other people; Mansell & Lam, 2006).

We have found that people who experience mood swings have formed long-held beliefs about themselves and others, and how these relate to changes in their internal state. These beliefs can be accessed “offline,” for example, through Socratic questioning or through established questionnaires. One scale constructed for this purpose is the Hypomanic Attitudes and Positive Predictions Inventory (HAPPI; Mansell, 2006; Mansell & Jones, 2006), which has been validated in two bipolar versus nonclinical control samples. As in other cognitive models, these beliefs are thought to have formed from early life experiences that are associated in theme with the appraisals (Holmes & Hackmann, 2004). For example, people suffering from bipolar I disorder have been found to report recurrent memories of being regarded as a failure by other people (Mansell & Lam, 2004). Experiences also are seen to occur during the lifetime that further confirm these established beliefs. For example, ongoing experiences can confirm the belief

in extreme success during highly activated states of mind (e.g., producing one's most impressive work when in a hypomanic mood swing). Equally, past experiences of arguments and conflict with family members, friends, and health professionals can confirm beliefs that these activated states of mind inevitably result in being misunderstood, stigmatized, and controlled by others.

The relative importance of the different kinds of beliefs that contribute to mood swings is yet to be established; however, clinical experience suggests that two classes of beliefs are particularly pernicious: self-critical or shaming beliefs internal states (e.g., "Whenever I am feeling excited and restless, I end up telling myself I am being stupid for what I have done") and catastrophic appraisals of internal states (e.g., "When I feel agitated and restless it means that I am about to have a breakdown").

This integrative cognitive conceptualization leads to implications for therapeutic style, clinical assessment, treatment methods, and the overall approach to individuals with mood swings and bipolar disorders. Each of these will be described in turn and illustrated with an anonymized case example.

### Case Illustration

#### *Presenting Problem/Client Description:*

Christine was a 37-year-old married mother of five who had a history of postpartum depression, social anxiety, and mood swings. She was referred for cognitive therapy because her elevated moods were leading to increasing problems. For example, for one period of 12 days over Christmas, she single-handedly redecorated several rooms in her house, taking few breaks. She and her family reported an increase in self-esteem, activity levels, and pace of speech that was out of character compared to her normal self. It led her to ignore her domestic activities and culminated in the onset of an episode of depression. She had experienced several other periods like this. Christine's history of symptoms was consistent with a diagnosis of bipolar II disorder. She was on a course of antidepressants prior to therapy and throughout the course of treatment, but had not received any other psychological therapy.

Christine reported a childhood growing up with her mother after her father left when she was 2 years of age. Throughout her childhood and adolescence, she had a fluctuating relationship with her father, whom she described as perfectionist and selfish. He had tried to deny Christine's existence to his new (remarried) family, leading to a key moment at a family wedding when she declared her identity by announcing who she was to the rest of the family.

Christine was always an independent person, working from the age of 12, and succeeded in a range of jobs. She described her first marriage as chaotic, with a man who did not value family life, whom she strived to notice her. She experienced two episodes of postpartum depression in this marriage. She found a new partner, who is her current husband, during a period of high mood when she "acted in a way she now regrets." Her current husband is a "family man" with whom she has had three further children, and she reports that they have a good marital relationship. Christine clearly linked her strive for perfection and fear of abandonment now to her beliefs about her father's view of her as a child and the meaning of his abandonment of her and her mother at that time.

The integrative CT is designed to apply to a range of goals that clients generate during therapy, which are summarized in Table 1. Thus, the therapy is applied in an ongoing cycle to assess, formulate, and aid in the client's discovery of what may be maintaining and enhancing their difficulties.

Table 1  
Christine's Goals and Corresponding Therapy Methods

Goals	Potential Assessments, Formulations, and Methods
"I want to understand what causes my mood swings and to manage them better."	Monitor mood swings regularly; formulate events triggering sudden change in mood; identify different appraisals and behaviors; suggest alternative appraisals to test for evidence
"I want to deal with depressed moods better."	Assess current symptoms; formulate model of depression maintenance; functional analysis of rumination or self-critical thinking; behavioral experiments; role play
"I want to try to understand how my hypomanic episodes came about."	Develop a chronology of the experiences leading up to the episode, asking about internal states, appraisals, behaviors, and responses by others; formulate links between these elements
"I want to get into less conflicts with my partner."	Assess symptoms of irritability and conflict; formulate model of conflict maintenance; identify appraisals of self and others during activated states; role play alternative behaviors
"I want to worry less."	Assess anxiety and worry; establish content of worry—if specific, see below as an example; if generalized, explore and test positive and negative beliefs about worry
"I am afraid of relapsing."	Assess anxiety and worry; formulate model of catastrophising over change in internal state; identify feared self-image; behavioral experiment—face feared change in internal state while dropping ascent and descent behaviors

### Assessment and Formulation

Integrative CT involves certain aspects of assessment that are shared with existing approaches to bipolar disorders; namely, risk assessment, history taking, and mood monitoring. These will not be covered in detail here. Yet, note that risk situations and past experiences both provide the opportunity for formulation later in therapy, for example, to aid relapse prevention. The therapist may select his or her own mood-monitoring measures, but the Internal State Scale (ISS; Bauer et al., 1991) uses a visual analogue scale and is particularly good at identifying daily changes in mood.

An early aid to engagement and socialization into the treatment is the Hypomanic Attitudes and Positive Predictions Inventory Scale (HAPPI; Mansell, 2006). Clients tend to identify their own beliefs readily and gain a sense of being understood and less isolated, from seeing their own beliefs described in a standardized questionnaire. The scale sets the aims of the therapy clearly: It is about changing attitudes toward moods rather than about controlling moods. It also can flag beliefs held with strong conviction for discussion of their origin, function, and how they impact on everyday life, which in turn guides formulation. Lastly and importantly, it raises awareness of the conflict between beliefs, which is a core aspect of the approach.

Christine completed the ISS twice per week. Her changes in internal state over the course of therapy are described later. At the start of therapy, Christine completed the HAPPI. The following excerpt from therapy illustrates how the HAPPI was used to help Christine articulate her beliefs and explain their impact:

THERAPIST (T): Were there any other ones of these [*items on the HAPPI*] that stood out for you, that you wanted to talk about?

CHRISTINE (C): That one [pointing at “*My high moods are outside my own control*”], ‘cause I don’t have any control. Once I get whatever in my head, that’s it, I do it until I stop, until it’s finished, like painting the room. I very rarely stop, unless my husband says come on you’ve got to have something to eat now . . . and then I stop, because he’s told me to have something to eat . . . and then I’ll just . . . straight back. All the rooms are done at the minute and it’s killing me. Cause’ they’re all done and I’m not allowed to do any more.

T: Yeah, there’s nothing more to do.

C: Yeah.

T: But you really want to get involved and do another one.

C: Yeah.

T: And you say when you’re into it, feels like you’ve got no control about doing anything else?

C: No, because I’m focused on it. I want to do it, get it done. But then it’s done.

T: Is that a good thing or a bad thing that you have no control over this?

C: Well, it’s the high I get from doing whatever that is good . . . but it’s the big drop once I’ve done it. I need to be able to . . . I’ve got to be able to slow down what I’m doing, like go paint for half an hour . . . come out and do something else. Then go back and paint for half an hour, then come out. I’ve got to be able to do that, rather than go paint for four hours, finish it and then have the big drop. I managed that with a wardrobe.

T: Oh right?

C: Because she talked me through it . . . my mother-in-law and Kate [*Care-coordinator*] were with me at the same time . . . and she says I’m not allowed to do the wardrobe, I’ve got to take my time, so my mother-in-law kept stopping me after 15 min and making me come out. I was horrible until it was done, if you understand what I mean, because I couldn’t concentrate, because I wanted to finish making this wardrobe.

T: So you really wanted to go on and do things without a break then?

C: Yeah.

T: And how did it feel that you come to this agreement where you had to take it slowly?

C: Horrible.

T: When you say horrible . . .

C: It was just . . . I was like sitting . . . I couldn’t relax . . . there was no relaxing. I couldn’t sit down or enjoy something on the telly. I was just sort of wanting to . . .

T: So you weren’t really having a break, you were still moving around and were still quite active . . . you were still moving a fair bit.

C: I just wanted to carry on . . . so I did it and instead of taking half an hour to make this wardrobe, it took me 4 or 5 hours because I still wanted to have it done.

T: So how did you feel at the end of it?

C: Great that I’d done it but then I’d done it . . . it’s the fact that I had nothing else. It’s like projects. I need something to keep my mind . . .

T: So you’ve got this feeling when you’re doing something that you need to keep going. And when you’ve done something you get this . . . what is it?

C: It’s like a drop, its just feels like a drop.

T: Is there any other way you can describe this drop feeling?

C: Like an empty drop . . . I don’t know. It’s just an empty drop.

T: An emptiness?

C: Yeah.

T: Is that pretty distressing?

C: It just makes me very down.

- T: When you say it makes you feel very down, is it a down that you can't tolerate?  
C: Well it's not good for other people around you, is it? It's not good for me.  
T: What happens to people around you when you get that empty drop feeling?  
C: I just don't want to do anything or go anywhere.  
T: So when you get that empty drop feeling you think, "I don't want to . . ."  
C: Just don't want to go anywhere or do anything . . . just . . . not bothered.

The time spent discussing the HAPPI items provided an opportunity for Christine to discuss the situations in which they arose. They also provided the opportunity to talk about the dilemma of having conflicted beliefs about the same internal states (e.g., "My high moods are completely outside my own control" and "I must have complete control over my moods to prevent myself from having a breakdown"). How is it possible for both of these to be true? Could she have some control already? Maybe it is okay not to have complete control over your moods? The therapist was then able to help her build a formulation based in these discussions.

We propose that it is important to assess and raise awareness of certain aspects of cognition, in particular intrusive imagery and memories, and recurrent evaluative thinking. Thus, the therapist asks about these perceptual experiences when a client is discussing a problematic situation: "What was going through your mind at the time?" "Did you get any mental images, pictures in your mind?" "What was going on in this image?" "Can you play it through to the end?" When the client has described these cognitions in detail, the therapist may inquire whether he or she wants to discuss where these images could have come from. When was the first time you remember feeling like this? Often, these questions can reveal that the clients respond to these images as though they reflected current reality, yet they are actually formed from memories of past events. This provides further information for the formulation and possible avenues for intervention such as imagery reappraisal or rescripting (cf. Grey, Young, & Holmes, 2002).

There were several situations in which Christine described experiencing distressing mental imagery. In this excerpt, she describes one recurring scenario that she played through in her mind during situations in which she met with new people or a group of familiar people. In this dialogue, she spontaneously describes the imagery when she is asked to focus on the thought about going back to playgroup with her daughter:

- C: That's my aim, to go back to playgroup.  
T: And that's something that you do want to do but your anxiety is holding you back.  
C: Yeah.  
T: So bearing in mind that's still then our focus . . . what's the key thing that's holding you back at the moment?  
C: It's just the thought of going in.  
T: The thought of going in? Are you saying it's not actually going in but the thought of going in?  
C: And talking . . . and it all going wrong . . . because in my head I see myself going in, sitting down and jabbering away, and getting too carried away, and getting to the point where I think "oh my God" . . . and then think I've embarrassed myself, I can't go back again . . . because I haven't embarrassed myself, so there's no reason . . .  
T: But you've got this very vivid image in your head of going in there, jabbering away?  
C: Jabbering away.  
T: Can you actually see yourself in the image?

- c: Yeah . . . jabbering away, and all of a sudden you get that sinking . . . gut, horrible feeling that I've said too much . . . I've embarrassed myself . . . what am I going to do now? . . . I don't go back.
- T: So in the image, when you're looking at yourself jabbering away, as you put it, what else can you see in the image?
- c: These other people going . . . [*demonstrates avoiding eye contact and talking to a person next to her*]
- T: These other people just kind of getting all . . .
- c: Sort of like trying to talk to other people.
- T: Trying to ignore you or pretending you're not there . . .
- c: Yeah.
- T: And is that when the embarrassment . . .
- c: Embarrassment yeah . . .
- T: And in that image, when you're embarrassed and think you've said too much, what . . . are you looking in on yourself or looking out into the room?
- c: I can see myself leaving the room.
- T: So you've got an image of yourself leaving the room?
- c: Yeah. I've got an image of myself going in, doing all this jabbering . . . then walking away thinking . . . can't talk to them again.
- T: And do you run out or just make excuses?
- c: Just make a swift exit.
- T: And do you have an image of what happens afterwards?
- c: Just don't go back.
- T: Do you have an image of what's going on in the room once you've left?
- c: They're all . . . [*pulls a laughing expression*].
- T: Laughing at you?
- c: Hmm.
- T: Does it go any further than that?
- c: Just talking about me . . . badly.
- T: What kind of things are they saying?
- c: She's weird, mad . . . stupid.
- T: So at the end of the image you've got worry that they think you're stupid or mad or weird.
- c: Hmm, Yes.
- T: Do you want to talk about this scene in your mind a bit more, like where it might have come from?

Following this discussion, Christine talked about the origins of this image—it seemed to represent an amalgam of embarrassing and humiliating experiences that she had either personally experienced or witnessed happening to other people. Similar findings along other themes have emerged when individuals with other psychological disorders have discussed the origins of their imagery (cf. Holmes & Hackmann, 2004). Christine found it helpful to talk about these images, and she and the therapist worked on drawing distinctions between these images and what was *really* going on in the current situation. In light of this, Christine was able to face the playgroup on later occasions as she could de-center from these images and start to better distinguish them from the real outcome of the situation.

The engine that drives appraisals of extreme personal meaning is recurrent thinking, or rumination. Rumination is elevated in people with bipolar disorder and those at risk of bipolar spectrum symptoms (Jones, Tai, Evershed, Knowles, & Bentall, 2006). The process

of attaching extreme personal meaning to current experience is regarded as very similar whether the theme of the thinking involves threat (i.e., worry; Engström, Brandström, Sigvardsson, Cloninger, & Nylander, 2004), self-criticism (Gilbert & Irons, 2005), criticism of others (Mansell, 2006), or extreme positive appraisals of the self (Lam, Wright, & Sham, 2005). Thus, worry, rumination, self-attacking, and positive ideation are conceptualized as similar processes with differing content. The aim of the assessment is to establish the forms and functions of this recurrent thinking and allow the clients to start to de-center from this process to begin to regard it as a controllable behavior that they can choose whether to carry out.

Christine described periods of worry, positive ideation, and self-attacking. She would spend time worrying about how she was seen by others and whether they would reject or abandon her for not being the “perfect mother.” Her positive rumination would come as a protective response to these underlying fears. She believed that if, when she got a new idea, she spent time thinking about how good it would turn out and planning every detail in her own mind, this would keep her positive, demonstrating how she was autonomous and efficient as a mother. Unfortunately, when the plan was finished, or it did not go exactly as she had envisaged (either because her family was unaware of the plan or she acted in a way that she concerned other people), she would experience a low feeling, which she had described as “an empty drop.” In turn, the self-attacking thinking style came into action, and she would tell herself that she was over the top, stupid, and weird for things turning out this way. This had the effect of driving her mood down further. Christine was asked about what she achieved from her time spent thinking and telling herself things in these situations. Their functions included being a distraction from painful feelings and being prepared for the worst.

As in most forms of cognitive-behavioral therapy (CBT), the formulation guides treatment. The formulation can follow the model exactly or can be adapted for the client. The critical aspects are the key role of appraisals and the cyclical nature of the formulation that emphasizes the self-maintaining features of the thinking style and behavior. Christine’s formulation is summarized in Figure 1. It brings together many of the elements covered thus far into a coherent whole. At this stage, it did not include every element of the model (e.g., the latent beliefs), yet it is more important to develop a simple formulation that is a reflection of the current understanding of the problems than to require a complete working of the model in every detail. The model provides exit points and suggests possible behavioral experiments.

### *Course of Treatment*

Christine has been seen for 25 individual psychotherapy sessions to date over a 12-month period. The therapist and client worked together to find adaptive ways of appraising and responding, such as testing ideas at an early stage. There were many occasions in which she was now able to step outside a vicious cycle of high mood that she believed she would not have done in the past. For example, she experimented with delegating responsibility for many of her duties, predicting that her family members would not be able to cope, yet she discovered that they were very able to take on these tasks. She also experimented with just accepting low mood states for a while without trying to explain them or rise above them. It soon became apparent, however, that Christine not only needed exits but also entry points. How was she going to build helpful ways of thinking and behaving for the future into a “self” that she would be happy with?

Many people with bipolar disorder spend their time switching between different states of mind depending on their mood. During psychotherapy, with monitoring of moods,

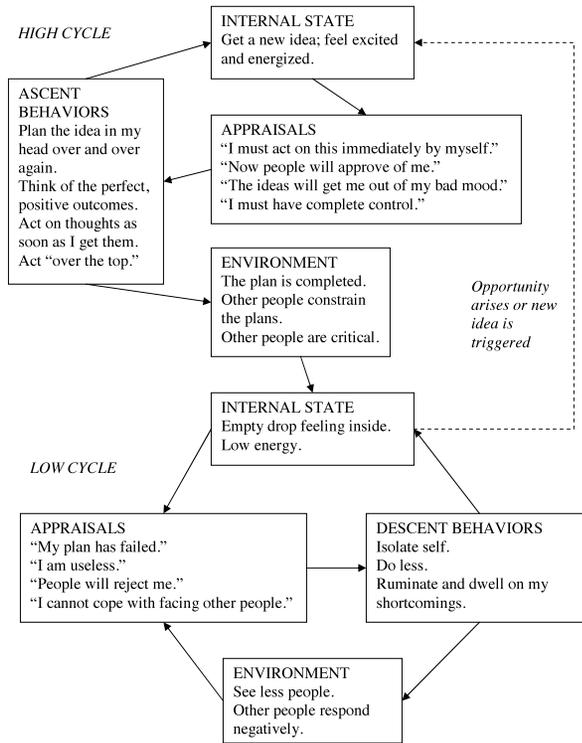


Figure 1. A formulation of Christine's high and low moods.

thinking, behaviors, and social situations, these different states become more evident. We believe they emerge from the conflicting extreme personal beliefs that become activated in different internal states and social contexts. In therapy, the client and therapist work on developing this higher level understanding, and in tandem they can work on building a positive, healthy self that can be added to the repertoire. So, the aim is not to eliminate the other states of mind, but to notice when they are occurring and therefore provide the client with the choice whether to maintain that state. This is clearly easier to do once the finer grained formulation of each state has occurred, but can feasibly occur earlier in therapy depending on the goals of the client. This part of the therapy draws on the "mood profile" used in other forms of CBT for bipolar disorder (e.g., Lam et al., 2003).

In the following example, the therapist works with the client to try to draw out the different states. The dialogue begins by elucidating a key conflict in appraisals: the coexisting beliefs that high mood states are both a very positive and a very negative experience.

[Christine describes how energized she was putting together her new bed and how she is getting very excitable in the moment at home.]

T: Do you think that your need to do things right now has an impact on other people?

C: Quite a bit actually because I am being very . . . you know. If I ask them to do something, I say "Oh can we?" . . . with this big stupid smile on my face!

T: So you are smiling at people to try to persuade them to do things?

C: With the girls, yes. They call it OTT. I don't seem to have come up to the level I was at before. I seem to have come up to this stupid level where I am really silly. I'll be

- talking to Anita's boyfriend in a really smiley and over the top way. The girls say "You're not like this usually!"
- T: And what do you think is the impact on them?
- C: Since I got better I notice that I am doing it, and I hate it.
- T: So it sounds that you are doing things to make you think you are fine, and people think that you are not your normal self?
- C: I think I am being quite funny, but they want me to get away because of how I am acting.
- T: So do you have choice?
- C: Well, I don't want them to think I am this really depressed mum, because I was ill for nearly a year and a half. So I am trying to be this really happy mum.
- T: So, what would you like to do to let go of this? Is there an alternative? A mid-ground?
- C: There is but I can't find it.
- T: So are you finding it difficult to let go of this OTT, you still attached to it?
- C: No, because it's horrid!
- T: So are you saying you are in two minds about it—it feels really good at times and on the other hand it is horrid?
- C: I guess so. My daughters walk round with this negative face on . . .
- T: That's what it's like at the moment? How do you want things to be?
- C: Just to be normal.
- T: What's that like?
- C: Being normal, ratty, horrid, boring.
- T: So normal is the same as ratty and boring? Or can it be different? Is it possible to find something that is positive enough to not be boring and ratty, but not so extreme that it's over the top?
- C: Maybe.
- T: So [*Therapist and client draw diagram of the different self states; see Table 2.*] So, we have the way things are when you are depressed, when you are "anxious and ratty" and when you are "OTT." Is there space for something in the middle here?
- C: Happy.
- T: OK, great, what other things?
- C: Positive.
- T: Positive, good. What other things, that you might do?
- C: It's like when I was in Australia, but I can't do that all the time.
- T: But you have memories of what you did then?
- C: Yes, doing things together with other people. People liking me for who I am. I like that one [*pointing at the diagram*].
- T: So we can work on trying to plot out this side of you [*points to happy and positive section*], and notice when you go between these different sides.

Christine used the new diagram to notice when she was in a particular self-state, providing her with a choice to continue in that state or attempt to try another one. Her goal was to build the positive, real self by trying it in different situations. For example, when meeting new mothers at a party, she took the risk of being herself rather than either trying not to attract attention or overcompensating by hyping herself up and talking more than usual.

It is almost inevitable that a therapist will see clients during different mood states, and during these they will present quite differently. Therefore, a therapist with a depressed client may need to provide more space and time to let the client speak, and a therapist with a hypomanic client may need to interrupt more often than is usual; however, inter-

Table 2  
*Christine's Table of Her Multiple Self-States*

Client's Name of State	Client's Description
OTT; High	Feeling agitated and restless; looking for the next big idea all the time; smiling too much; other people say I am not my normal self; not allowing any negative feelings
Happy	Feeling happy and optimistic; like when I was on holiday in Australia with family; sharing positive experiences with other people; "real self"
Normal & Boring	Doing everyday tasks; feeling irritable and frustrated with family; anxious and worried
Depressed	Very low; no energy; want to avoid people; do very little; very self-critical thoughts

rupting during "highs" is best done after a prior agreement with the client that he or she finds this acceptable. An interruption is more likely to be acceptable to the client if it is genuinely directed at discovering what the client is experiencing and in clarifying what the client is trying to say. In each case, sessions where clients are in significant mood states can provide important tests of the approach. Not only does the therapist need to remain unconditionally validating toward the client, validating the constancy of their relationship despite the mood changes, but there also can be an opportunity for the therapist to help the client gain insight into their current state of mind, describing it in detail to the therapist, and they can weigh together the essence of this state of mind, how it differs from other states of mind, and the client's conflicted beliefs about it.

In the previous dialogue, Christine had initially presented as activated and irritable, but the therapist attempted to talk *about* this state rather than struggle with it, leading to the useful information and insight that arose. Note that this approach is appropriate for many different mood states, but it has not been explored within clients who are experiencing clinical mania during the session.

A key component of the integrative CT of bipolar disorders is the environment; a major part of which is how other people respond to the individual's behavior. It may sometimes appear difficult to discern whether these responses are a major contribution to the cycle of escalating symptoms; however, closer questioning usually will reveal if this is indeed the case. For example, in one session the therapist noted that Christine did not look him in the eyes. She explained that she did not want to look at anyone with a neutral face because they would bring her down and lead her to face her low feelings. In this example, it appears to be the appraisals of the social environment that seem most relevant. However, there also were many examples in which other people had been overtly critical or excessively worried about her relapsing imminently. In these examples, it is the appraisals of other members of the system that may need to be understood and formulated. The therapist and client may agree to meet with other family members, they may be offered their own support, and/or the client and therapist can work together to problem solve ways of managing situations in which other people are behaving in counterproductive ways.

Another key principle is that the client and the therapist work collaboratively while the therapist tries to identify and help facilitate the conditions to modify the extreme, conflicting personal appraisals of internal states that may be maintaining and exacerbating problems through their effects on behavior, physiology, and environment. Beyond

that, therapists are encouraged to bring their own skills and specialties to their methods, in the same spirit that clients are encouraged to draw on their own strengths and capacities. Some therapists may have a particular propensity of imagery reappraisal and restructuring whereas others may have a propensity for testing metacognitive beliefs, employing mindfulness strategies, or using a compassionate mind approach. Each can be used within the model.

For example, some therapists like to use metaphor in therapy. In Christine's case, the therapist provided the metaphor of a "barrier" that Christine puts up to shield herself from people she cannot trust, and when the barrier is down, the therapist and client realized that she used another form of defense: the "weapons" of great ideas and plans. So what happens if you lower the barrier and drop your weapons? This metaphor revealed the vulnerability she feels, but may ultimately need to endure if she is to let other people know her "real" self.

### Outcome and Prognosis

Figure 2 illustrates Christine's fluctuations in internal state throughout the course of therapy. She completed the ISS twice weekly. Soon after the start of therapy when she formulated her high cycle (her initial goal), Christine developed depressive symptoms. These are manifested in her peaks of conflict (irritability, argumentativeness) and depression in the early stages of the graph. These symptoms abated after direct work on formulating the cycle of feelings, thoughts, and behaviors that were seen to be maintaining her low moods, aided by an activity schedule for timetabling activities that displaced rumination. For a while, she reported reasonably stable mood, preceding and during a holiday (up to Timepoint 30 in Figure 2); however, after she returned, she experienced a strong urge to regain the high feelings she had experienced, demonstrated by the periods of high activation (thoughts racing, restlessness) and conflict midway through therapy. The latter third of therapy began with her reformulation of four different self-states and the development and testing of her real self, during which time her mood gradually stabilized, combined with a gradual increase in well-being (capable, great inside).

At the time of writing, Christine had just completed the main course of therapy of around 25 sessions, but will be receiving regular follow-up sessions to assess her progress and help her to maintain gains. In terms of global outcomes, Christine continued to look

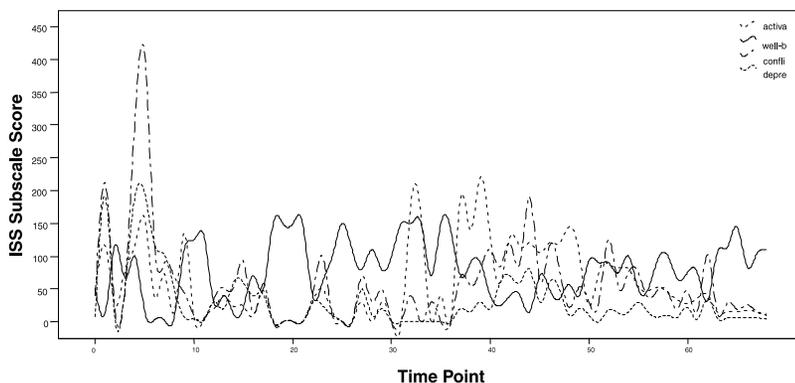


Figure 2. Hypomania symptoms and well-being as assessed by the Internal State Scale completed twice weekly over the course of therapy.

after her children during this period and coped with two family funerals. She started to broaden her social circle, talking more to other mothers and gradually built up her confidence. She also returned to a part-time job. She feels that when this real side of her is stronger, she will be able to give up periods of hyping herself up with new ideas and be more able to cope with periods of low mood.

### Clinical Issues and Summary

This article has attempted to elucidate and illustrate the use of a new integrative CT for mood swings and bipolar disorders. The treatment is designed to be both empirically testable and easily understood, and used by therapist and client in collaboration. Most of the treatment methods draw on the broad range of techniques developed within contemporary CBT, but several treatment methods and assessment instruments are unique.

The scientific foundations of the model are currently being evaluated. It will be several years before the approach is fully refined and evaluated in a controlled manner. Nevertheless, this article has attempted to encourage clinicians to begin to explore this approach to working with people on the bipolar spectrum. It is not that different from the way that other conditions are treated with contemporary CBT, yet the model helps set these interventions on the right path. The treatment approach is designed to be normalizing, empowering, and consistent with existing evidence on the psychology of bipolar disorders. As such, it has the capacity to push forward the development of psychological treatments for bipolar disorders, following on from the pioneering work on a range of other psychological conditions that are now better understood and treated.

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