Cognitive-Behavioral Therapy for Rapid Cycling Bipolar Disorder

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This article describes the application of cognitive-behavioral therapy (CBT) to the treatment of rapid cycling bipolar disorder. Between 10% and 24% of bipolar patients experience a rapid cycling course, with 4 or more mood episodes occurring per year. Characterized by nonresponse to standard mood-stabilizing medications, rapid cyclers are particularly in need of effective, adjunctive treatments. Adjunctive CBT has been shown to improve medication compliance and reduce relapse rates in patients with bipolar disorder. However, no published trials to date have examined the application of CBT to the treatment of rapid cyclers, with only a single case study existing in the literature. We address challenging clinical problems in the treatment of patients with rapid cycling bipolar disorder and include strategies for managing frequent mood fluctuations, medication compliance, sleep hygiene, lifestyle regularity, mood elevation, suicidality, and comorbidity. A case example is included to illustrate the treatment approach.

This article explores the application of cognitive-behavioral therapy to the treatment of rapid cycling bipolar disorder. Bipolar disorder is a serious and recurrent mental illness that affects 1% to 2% of the population (Kessler et al., 1994; Smith & Weissman, 1992). Bipolar patients with a rapid cycling course experience four or more depressive, manic, hypomanic, or mixed episodes per year, as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994). In fact, individuals with “ultra-rapid cycling” may experience dramatic mood shifts on a weekly or even daily basis (Kramlinger & Post, 1996). While Emil Kraepelin (1921) initially described the phenomenon of frequent cycling in his pioneering work on manic-depressive illness, the term “rapid cycling” was first coined by Dunner and Fieve (1974). Rapid cycling has since been validated as a distinct course modifier for bipolar disorder (Bauer et al., 1994; Maj, Maglino, Pirozzi, Marasco, & Guarneri, 1994). Rapid cycling occurs in 10% to 24% of patients with bipolar disorder (Dunner & Fieve, 1974; Kukopulos et al., 1980; Maj et al., 1994; Tondo, Baldessarini, Hennen, & Floris, 1998) and while bipolar disorder is equally common in males and females, rapid cycling is significantly more common in females (Leibenluft, 1997; Tondo & Baldessarini, 1998).

Pharmacotherapy has traditionally been the mainstay of treatment for bipolar disorder. However, limitations to medication alone are suggested by relapse rates as high as 73% over 5 years, even with adequate maintenance treatment (Gitlin, Swendsen, Heller, & Hammen, 1995). In particular, patients with rapid cycling bipolar disorder are considerably less responsive to standard mood-stabilizing medications for bipolar disorder, such as lithium and carbamazepine (Calabrese et al., 2001; Okuma, 1993). Furthermore, despite the frequent recurrence of depression in rapid cyclers (Calabrese et al., 2001), the use of antidepressant medication is discouraged due to the risk of inducing mood elevation or exacerbating cycling (Calabrese, Rapport, Kimmel, & Woysavlve, 1993; Kilzieh & Akiskal, 1999). Medication noncompliance further complicates treatment with bipolar patients, with at least 50% exhibiting poor medication compliance within the first year of treatment (Keck et al., 1996; Keck et al., 1998). Furthermore, within a sample of rapid cyclers, Calabrese et al. (2001) found that comorbid substance abuse and dependence adversely affected medication compliance. Thus, the pharmacological management of rapid cycling bipolar disorder is often complex and challenging. Effective, adjunctive treatments are needed to improve medication compliance and to augment pharmacotherapy in this population.

In the last several years, a growing number of controlled studies have provided encouraging data on the application of adjunctive cognitive-behavioral treatments for bipolar disorder. In an early study, Cochran (1984) randomized 28 bipolar patients to a 6-week adjunctive cognitive-behavioral therapy protocol or to standard pharmacotherapy alone. The therapy protocol was based on cognitive therapy principles and focused on modifying the behaviors and cognitions that interfered with medication compliance. Patients who received the intervention demonstrated better medication compliance both at post-treatment and at 6-month follow-up. In addition, patients in the cognitive-behavioral therapy condition were significantly less likely to discontinue medication, to be hospitalized during the study, and to have episodes associated with medication noncompliance.
At 6-month follow-up, patients who received cognitive-behavioral therapy for bipolar disorder. Analyses of data from the first 30 participants indicated that patients who completed the adjunctive group treatment had longer periods of euthymia and fewer new episodes than patients treated with standard pharmacotherapy alone. This result was maintained at 3-month follow-up.

More recently, Lam et al. (2000) randomized 25 bipolar patients to adjunctive cognitive-behavioral therapy or to routine clinical care. Patients in the cognitive-behavioral therapy condition received up to 20 sessions of cognitive-behavioral therapy over a 6-month period. Ratings completed at 6- and 12-month follow-up indicated that patients receiving cognitive-behavioral therapy had significantly fewer mood episodes, better general social functioning, better ability to respond to early warning signs of episodes, less hopelessness, and better medication compliance than patients receiving routine clinical care.

Finally, Scott, Garland, and Moorhead (2001) conducted a randomized, controlled trial in 42 patients with bipolar disorder who were assigned to either immediate cognitive therapy for bipolar disorder or to a 6-month wait-list control condition followed by cognitive therapy. At 6-month follow-up, patients who received cognitive therapy showed significantly greater improvements in symptoms and functioning. In addition, relapse rates were 60% lower in the 18 months after initiating cognitive therapy, as compared to the 18 months prior to receiving cognitive therapy, in the 29 patients who eventually received cognitive therapy. Twenty-six patients reported that cognitive therapy was "highly acceptable" and 23 patients stated that they would recommend it to others with bipolar disorder.

In addition to the studies detailed above, several other recent pilot studies and open trials have also shown promising data on the role of adjunctive cognitive and cognitive-behavioral therapy for bipolar disorder (Fava, Bartolucci, Rafanelli, & Mangelli, 2001; Palmer, Williams, & Adams, 1995; Patelis-Siotis et al., 2001; Zaretsky, Segal, & Gemar, 1999). Despite all of these encouraging findings, no trials to date have specifically examined the application of cognitive-behavioral therapy to the treatment of rapid cycling bipolar disorder. Only one published case report of cognitive-behavioral therapy in a rapid-cycling patient currently exists in the literature (Satterfield, 1999).

Using an empirical, single-case study design, Satterfield (1999) conducted 12 months of adjunctive cognitive-behavioral therapy with a rapid-cycling patient, focusing on the prediction, prevention, and treatment of affective episodes. He reported a significant reduction in the frequency and intensity of mood episodes during the 12 months of treatment as compared to the preceding 14 months prior to cognitive-behavioral treatment. Parallel decreases in hopelessness and anxiety and improvements in global functioning were also reported. Many of the targets for treatment described by Satterfield, such as psychoeducation, mood monitoring, early detection of episodes, stress management, activity scheduling, medication compliance, and cognitive restructuring, are consistent with current treatment manuals and protocols for bipolar disorder (Basco & Rush, 1996; Newman, Leahy, Beck, Reilly-Harrington, & Gyulai, 2001; Otto, Reilly-Harrington, Kogan, Henin, & Knauz, 1999). This is encouraging and fits with our own pilot work on the treatment of rapid cycling bipolar disorder (Reilly-Harrington & Knauz, 2000). In this article, we will elaborate on the specific applications of cognitive-behavioral strategies to the treatment of rapid cycling bipolar disorder.

**Interventions for Rapid Cycling**

Characterized by nonresponse to traditional pharmacotherapy and frequent, unpredictable fluctuations in mood, rapid cyclers are often considered to be the most challenging type of bipolar patient (Kilzieh & Akiskal, 1999). Therapists must be particularly flexible, creative, and adept at detecting and responding to rapidly shifting moods. While many of the cognitive-behavioral interventions used to treat rapid cyclers overlap with those used to treat non-rapid-cycling bipolar patients (Newman et al., 2001; Otto et al., 1999; Otto, Reilly-Harrington, & Sachs, 2003), we will discuss the specific obstacles and considerations in treating this population. In addition to describing the rationale for these recommended interventions, we will illustrate their use in a case example.

**Psychoeducation and Medication Compliance**

It is vitally important for patients to fully understand the nature of their bipolar illness and its treatment. Therefore, initial sessions should include information about rapid cycling bipolar disorder, the role of medications, and the collaborative nature of cognitive-behavioral therapy. While some patients may be highly informed about their diagnosis, others may benefit from even basic discussions of how to recognize the symptoms of mania and depression. Education is essential regarding factors that may worsen the course of rapid cycling, such as sleep loss, substance abuse, and caffeine. Coming to terms with the idea of having a recurrent, chronic illness is often an ongoing issue in treatment, particularly for patients who are relatively new to diagnosis and treatment.

Structure within treatment sessions is particularly important, given the memory and attention deficits reported in both euthymic and symptomatic bipolar patients (Deckersbach et al., 2002; Deckersbach, Reilly-Harrington, & Sachs, 2001). Asking patients to take notes in session and...
to review audiotaped sessions may enhance the organization and learning of session content. Likewise, therapists may keep sessions on track by regularly setting agendas, collaboratively prioritizing goals, and providing summary statements. While such strategies are recommended for the treatment of all bipolar patients (Newman et al., 2001), patients with a rapid cycling course may be particularly in need of such organizational tools.

Therapists working with bipolar patients should familiarize themselves with the mood stabilizing, antidepressant, and antipsychotic medications commonly prescribed for rapid cycling bipolar disorder (see Newman et al., 2001, for an overview). In order to facilitate medication compliance, patients should be encouraged to discuss their beliefs about medication and their concerns about side effects, such as weight gain. Strategies such as cognitive restructuring and daily thought records (J. S. Beck, 1995) are often useful in modifying negative beliefs (e.g., “Taking this medicine means I’m crazy”) that may interfere with compliance. Behavioral strategies and reminders, such as Post-It notes, watch alarms, and pill boxes may be useful in improving adherence. Rapid communication between care providers and prompt medical and psychosocial intervention are warranted when the early warning signs of a mood episode are detected. Such swift collaboration among care providers is particularly important when treating bipolar patients with rapidly shifting mood states.

Mood Monitoring

Daily mood monitoring (Sachs, 1996) ideally enables rapid cycling patients to increase their awareness of early shifts in mood that may serve as precursors of episodes. This strategy involves daily graphing of both depressed and elevated moods, with the goal being to initiate prompt pharmacological and psychosocial intervention prior to severe episodes. The mood chart also tracks daily compliance with medications, hours slept, and psychosocial stressors that may serve as triggers for mood symptoms. Patients frequently report a greater understanding of the connections between stressors, sleep, medication use, and mood through using the mood chart. The mood chart also provides an invaluable snapshot of the patient’s week and review of it should be included as a regular agenda item at each session (Otto et al., 1999). Longitudinally, the mood chart can provide valuable information about the impact of menstrual cycles and seasonality on mood changes. The mood chart can be downloaded from the Web site of the Harvard Bipolar Research Program at Massachusetts General Hospital (www.manicdepressive.org).

Activity Scheduling and Lifestyle Regularity

The instability of sleep, circadian rhythms, and daily routines has been linked to mood disturbance in theories of affective disorder (Ehlers, Frank, & Kupfer, 1988; Ehlers, Kupfer, Frank, & Monk, 1993; Healy & Williams, 1988). Several studies have examined the effects of sleep-wake cycles and daily routines or “social rhythms” on mood in patients with rapid cycling bipolar disorder (Ashman et al., 1999; Leibenluft, Albert, Rosenthal, & Wehr, 1996). Leibenluft et al. longitudinally followed 11 rapid cycling patients over the course of 18 months, with patients completing daily mood and sleep ratings. In their sample of rapid cyclers, decreased sleep duration was the best predictor of mania or hypomania. Consistent with these findings, Wehr, Sack, and Rosenthal (1987) have proposed that sleep loss may be a common causal pathway in the development of mania. Given the connection between sleep loss and mania, several investigators (Wehr et al., 1998; Wirz-Justice, Quinto, Cajochen, Werth, & Hock, 1999) have examined the effects of sleep-related interventions in case studies with rapid cycling patients. Such reports suggest that regularly scheduled periods of nightly darkness and bed rest may be helpful in stabilizing mood fluctuations in patients with rapid cycling.

While the stabilization of sleep patterns is an important goal for all individuals with bipolar disorder, it may be particularly challenging for rapid cyclers, whose daily routines, including sleep, may be highly irregular. Not surprisingly, Ashman et al. (1999) found that patients with rapid cycling bipolar disorder had daily routines or “social rhythms” that were significantly less rhythmic (i.e., regular), than normal controls.

Cognitive-behavioral interventions targeting the regulation of sleep and activity levels are especially important for rapid cycling patients. While decreased sleep is typically associated with mania, hypersomnia is typically associated with depression in patients with bipolar disorder (Detre et al., 1972). Thus, patients who rapidly cycle between mood states may exhibit particularly erratic sleep patterns. In order to stabilize these sleep patterns, patients are encouraged to adopt good sleep hygiene by establishing regular sleep and wake times, even on weekends, avoiding caffeine, and keeping stressful activities, such as working or paying bills, out of the bedroom. Sudden sleep disruptions, such as switching to a night shift or staying up all night to study for exams, should be avoided. Daytime napping should also be avoided if it interferes with nightly sleep. Relaxation strategies, such as diaphragmatic breathing and progressive muscle relaxation, can be used prior to bedtime to ease the transition to sleep. Since changes in sleep patterns may serve as either triggers to episodes or as early warning symptoms, they should be addressed immediately both pharmacologically and behaviorally.

In addition to careful monitoring of sleep regularity, it is highly advisable for rapid cycling patients to establish and maintain a regular pattern of activities. Ideally, this
routine should include a balance of work, social interaction, leisure, and exercise. There is often the tendency for depressed patients to withdraw and do less, while patients in the manic phase may become overly committed, starting many new projects and activities. Cognitive-behavioral interventions involving activity scheduling (J. S. Beck, 1995) may be helpful in establishing a regular routine of activities that are associated with mastery—a sense of accomplishment and pleasure. In non-rapid-cycling bipolar patients, there is some evidence that engaging in consistent psychosocial treatment may create structure and be mood stabilizing in and of itself, regardless of the modality (Frank et al., 1999). It is probable, then, that rapid cycling patients may also benefit from the consistency that regular psychosocial treatment may provide.

Management of Life Stressors

A growing number of studies suggest that negative life events and environmental stressors contribute to relapse in patients with bipolar disorder (see Johnson & Roberts, 1995, for a review). Stressors may provoke bipolar mood episodes through the destabilizing effects of stress on daily routines of sleep and activity, thus disrupting critical biological rhythms (Ehlers et al., 1988; Healy & Williams, 1988). Stressors leading to sleep disruption may be more likely to induce mania than depression. Consistent with this, Malkoff-Schwartz et al. (1998) found that manic patients had significantly more pre-onset life events leading to sleep disruption than did depressed bipolar. Thus, as discussed above, one of the goals of cognitive-behavioral therapy for rapid cycling is to stabilize patterns of sleep and activity. Activity management is a particularly important focus when patients are confronted with stressful events. For example, it is vitally important for the patient who is laid off from his job to maintain a consistent sleep-wake cycle and pattern of daily activity.

Problem-solving is also an important component of CBT for rapid cycling bipolar disorder and patients are encouraged to develop and evaluate potential alternatives for managing stressful life situations. It is highly advisable for patients to evaluate the types of stressors that characteristically provoke episodes and to problem solve in advance regarding potential solutions and alternative coping mechanisms. For example, a patient who characteristically becomes depressed following criticism from her boss can plan in advance that she will take specific steps to buffer herself against the effects of this criticism in the future: increase assertive communication with boss, evaluate negative automatic thoughts using thought record, call a friend to discuss concerns, take a brisk walk, utilize relaxation strategies, treat self to something special (e.g., a movie) to distract self from ruminative thoughts. Such advance problem-solving may help to reduce the impact of stressors, lessen the likelihood of full-blown episodes, and interrupt a rapid cycling course of bipolar disorder.

Family stress also appears to affect relapse in patients with bipolar disorder. Specifically, high levels of expressed emotion (criticism, hostility, or emotional overinvolvement) on the part of family members have been shown to increase vulnerability to episodes. For example, Miklowitz, Goldstein, Nuechterlein, Snyder, and Mintz (1988) reported that bipolar patients who were discharged from the hospital into family environments characterized by high levels of expressed emotion were five times more likely to relapse within 9 months of discharge than patients discharged into environments characterized by low expressed emotion. Thus, interventions geared toward improving communication patterns among family members may be incorporated into the context of cognitive-behavioral therapy for rapid cycling bipolar disorder. We typically invite family members to attend several therapy sessions, with the goal of providing information about bipolar disorder, problem-solving regarding current stressors, and involving the family in the patient's treatment contract, which will be described below.

Cognitive Restructuring and Core Belief Work

Several studies have found that cognitive styles interact with intervening life events to prospectively predict manic and depressive symptom changes in patients with bipolar spectrum disorders (Alloy, Reilly-Harrington, Fresco, Whitehouse, & Zechmeister, 1999; Reilly-Harrington, Alloy, Fresco, & Whitehouse, 1999). These studies have provided support for the applicability of the cognitive vulnerability stress theories of unipolar depression (e.g., Beck's Theory—A. T. Beck, 1967; Hopelessness Theory—Abramson, Metalsky, & Alloy, 1989), in which maladaptive cognitive styles act as risk factors for affective episodes in combination with negative life events, to the bipolar spectrum. Therefore, one of the goals of cognitive-behavioral therapy for rapid cycling bipolar disorder is to modify maladaptive cognitive styles and dysfunctional attitudes that provide risk for relapse. Standard cognitive restructuring techniques, such as thought records (J. S. Beck, 1995), are utilized to teach bipolar patients to respond more adaptively to negative thoughts. Most importantly, patients and therapists work together to identify recurrent themes and core beliefs, such as "I'm unlovable" or "I'm incompetent," that are formed early in life, may be triggered by negative events, and serve to prolong or worsen episodes.

Rapid cycling patients and their therapists may find themselves shifting gears on a weekly basis from responding to depressive thoughts to restructuring hyperpositive, hypomanic thoughts. Similar techniques, such as thought records, can be used to respond to elevated thoughts, such as "I can afford it" or "Everybody finds me attractive."
As described below, cognitive-behavioral interventions for managing mood elevation are often geared at preventing the damage and embarrassment that can result from manic behavior.

**Management of Mood Elevation**

Detection of the earliest warning signs of mania/hypomania is critical in breaking the pattern of repeated episodes in rapid cycling patients. While it is often quite difficult to engage a severely manic patient in cognitive restructuring, it is certainly possible to intervene with a patient whose mood is mildly elevated. Thus, it is vitally important for patients to be aware of their subtle, early symptoms indicative of elevated mood (e.g., feeling slightly more verbose, awakening an hour earlier than usual, thinking about making new plans, feeling slightly flirtatious, etc.). In a phase of mild mood elevation, patients can take several precautionary steps to ensure that their mood does not launch into mania. These steps include: maintaining compliance with medication, maintaining regular sleep/wake cycle, contacting psychiatrist for pharmacological assistance in the event that falling or staying asleep is difficult, avoiding alcohol and drugs, reducing stimulation, and avoiding highly stressful or confrontative situations. In order to reduce the impulsive risk associated with elevated mood, we recommend that patients leave credit cards at home, resist engaging in conversations with strangers, and avoid driving if speeding or “road rage” have occurred during previous episodes. Newman et al. (2001) outline several rules for bipolar patients that are particularly useful in interrupting impulsive decision-making. These include a “Two Person Feedback” rule, in which patients are instructed to check new plans or ideas with two trusted friends before acting on them, and a “48 Hours Before Acting” rule, in which patients are instructed to wait 2 full days and get 2 full nights of sleep before making major decisions. Many of these strategies are described in further detail in Newman et al. (2001) and are particularly appealing to patients who have suffered devastating consequences from previous manic episodes. It is important to recognize that mania can be quite seductive and patients new to a bipolar diagnosis may have greater difficulty accepting the premise that mania is harmful. With patients such as this, it is vitally important to avoid lecturing on the costs of mania. Rather, it is much more powerful to utilize Socratic questioning and to guide patients in evaluating the advantages and disadvantages of mood episodes. We have also found it helpful for patients to attend bipolar support group meetings and to hear about the downsides of mania from other patients.

**Management of Depression and Suicidality**

Frequent, severe depression has been described as the “hallmark” of rapid cycling and the primary unmet treatment need for rapid cycling patients (Calabrese et al., 2001). From a pharmacological perspective, patients with rapid cycling bipolar disorder are considerably less responsive to standard mood stabilizers, and antidepressant use is discouraged due to the risk of inducing mood elevation.

Furthermore, the rates of suicide in patients with bipolar disorder are astounding. Goodwin and Jamison (1990) report that lifetime completed suicide rates for patients with bipolar disorder are 19%, with 25% to 50% of bipolar patients attempting suicide at least once. Brown, Beck, Steer, and Grisham (2000) report that the diagnosis of bipolar disorder carries the highest risk of completed suicide, with four times the risk of suicide as compared to other psychiatric diagnoses. Little research has directly compared the suicide rates of rapid cycling and non-rapid-cycling patients, with one study finding no significant difference in suicide attempts in rapid cycling versus non-rapid-cycling patients (Wu & Dunner, 1993).

Clearly there is the need for effective, adjunctive treatment for depression and suicide prevention in bipolar disorder, particularly in patients with rapid cycling bipolar disorder. Cognitive and behavioral interventions described in detail by Newman et al. (2001) and J. S. Beck (1995) are recommended to treat depressive symptoms and reduce suicidal risk. The treatment contract described below may also be used to reduce the risk of suicide by involving the patient’s support network.

**Treatment Contracting**

Our treatment of rapid cycling bipolar disorder involves the use of a written treatment contract in which the patient, while euthymic, formulates a plan for detecting, coping with, and preventing future episodes of mania and depression (Otto, Reilly-Harrington, Kogan, & Winett, 2003; Reilly-Harrington, Kogan, Otto, & Sachs, 2002). First, the patient selects a support network to include in the treatment contract. The support network may consist of treatment providers, trusted family members, friends, or even coworkers, with whom the patient has regular contact. In the contract, the patient specifies the early warning signs of mood episodes and instructs their support network to take specific actions in the event of noting mood symptoms. The following are some examples of directions that a patient might give their support network:

- **Encourage me to contact my doctor if you notice that I am becoming manic.**
- **Remove my credit cards if I am spending impulsively.**
- **Keep in touch with me if I appear hopeless and suicidal.**

Support members are typically asked to attend several therapy sessions in which the contract is reviewed and questions are answered about bipolar disorder and its
treatment. Finally, the contract is signed by all parties and the support members become agents of the patient’s plan, not people imposing restrictions on the patient. The contract ideally enables patients to maintain control over their illness during episodes in which their judgment or functioning might be compromised. The likelihood of swift attention to early warning signs of episodes is also likely to increase when open communication exists among patient, treatment providers, and support network.

Treatment of Comorbidity

High rates of comorbid substance abuse and anxiety disorders have been reported in patients with bipolar disorder (Perugi, Toni, & Akiskal, 1999). McElroy et al. (2001) reported that 42% of their bipolar sample met criteria for a comorbid anxiety disorder and 42% met criteria for a comorbid substance use disorder. The presence of comorbid anxiety has been associated with poorer outcomes and longer times to remission in patients with bipolar disorder (Feske et al., 2000). Moreover, comorbid substance abuse and dependence has been shown to adversely affect medication compliance in patients with rapid cycling bipolar disorder (Calabrese et al., 2001). Therefore, the treatment of comorbidity is an important area of focus in our treatment of rapid cycling. In our small, ongoing, open pilot study of rapid cycling bipolar disorder, we have found particularly high rates of comorbid anxiety disorders, with 7 out of 9 patients currently meeting criteria for a comorbid anxiety disorder, including panic disorder, generalized anxiety disorder, and obsessive-compulsive disorder.

Structure of Treatment

The treatment utilized in our ongoing open pilot study of rapid cycling bipolar disorder is based on Newman et al. (2001) and Otto et al. (1999) and consists of four flexible core modules. The first module focuses on medication compliance and psychoeducation about rapid cycling bipolar disorder. In this module, patients are taught to monitor and respond to daily mood fluctuations, manage medication side effects, and maintain adequate sleep hygiene. The second module targets crisis-management skills and coping strategies for dealing with depressive and manic mood shifts, including suicidal and high-risk manic behaviors. In this module, patients construct the treatment contract, in which they specify a plan for detecting, coping with, and preventing future episodes. The third module targets specific cognitive restructuring skills for identifying and responding to depressive and manic thoughts and beliefs. Finally, a fourth module focuses on cognitive-behavioral skills for managing comorbid disorders, including anxiety disorders and substance abuse.

In summary, therapists working with rapid cycling patients must be particularly flexible, creative, and adept at detecting and responding to rapidly shifting moods. Thus, these modules represent core areas of focus, but may be adapted flexibly for each patient.

Case Example

Jason is a 42-year-old disabled professional who is separated from his wife and has no children. Upon intake evaluation, he was diagnosed with bipolar I disorder, most recent episode depressed, rapid cycling type; alcohol dependence in sustained partial remission; and opioid dependence in sustained full remission. Further elucidation of the diagnoses revealed that he had had six mood episodes in the previous 12 months consisting of two major depressive episodes and four hypomanic episodes. Jason had not had a full-blown manic episode in over 15 years, but described previous episodes in which he had destroyed property in fits of irritable mania. His recent bouts of depression included hypersomnia, decreased interest, feelings of worthlessness, low energy, decreased concentration, and passive suicidal ideation with no plan or intent. Behaviorally, Jason stated that his depressive episodes included spending “long periods of time in bed, feeling miserable about myself and about how little I am achieving.” His hypomanic symptoms included increased irritability, increased distractibility, mild racing thoughts, increased activity, increased spending, and decreased need for sleep. Jason stated that his hypomanic episodes were rarely pleasurable as he engaged in more arguments with his friends and family and felt wired but could accomplish little.

Jason also had comorbid Axis I diagnoses of alcohol and opioid dependence. Both were in various stages of remission upon intake. He had a 13-year history of drug and alcohol dependence with increasingly greater lengths of sobriety after each relapse. He had not used alcohol for 9 months and had not used opioids in 3 years. Largely, his substance use coincided with his mood episodes. He often would use opioids to control his sleep-wake cycle, and he would use alcohol to modulate his feelings of low self-esteem and poor self-image. His last relapse consisted of a 2-week binge on alcohol during a major depressive episode. He subsequently checked himself into a 28-day rehab and then moved to a sober halfway house. He moved to his own apartment about 3 months prior to our intake evaluation.

Jason also had several psychosocial stressors, or “loose ends,” as he often described them. The first involved his marriage of the past 5 years. This was Jason’s third marriage, and he and his wife had been separated for the past 3 years after a relapse on opioids. They had a contentious relationship with long periods of no communication.
punctuated by high levels of negative emotions. Overall, Jason stated this his wife “blamed him for everything that went wrong” and he spent his time “acting as if she is right and doing what [he] can to get her forgiveness.” Jason also had a second significant stressor. He had been deemed disabled for the past 3 years, yet he wanted to return to his previous career. He had lost the ability to perform his job due to his use of substances on his job and the suspension of his license. As he stated, “I just don’t see how I can be anyone unless I get my job and my wife back just like it was before.”

At the start of treatment, Jason was recovering from a major depressive episode and was beginning to cycle into a hypomanic episode. He noted that his sleep was becoming increasingly erratic, going from hypersomnia to a decreased need for sleep followed by another period of hypersomnia. During the periods of decreased sleep, Jason would notice that he was irritable and would become more easily distracted.

From the onset of treatment, his symptoms were compelling and needed immediate attention. After the intake evaluation, it was apparent that the first session needed to include a psychoeducational approach regarding his sleep patterns and an immediate discussion about the role of sleep loss and hypomanic symptoms. The first step involved discussing his sleep problems with his psychopharmacologist. It was apparent that one of his sleep aids, a tricyclic antidepressant, may have been putting him to sleep in the short-run, but may have been exacerbating his mood cycling in the long run, contributing to a decreased need for sleep the following night. He was immediately switched to a sleep aid that was less likely to exacerbate his mood cycling. During the first session, we discussed proper sleep hygiene and immediately employed several behavioral changes to regulate his sleep cycle. These strategies included avoiding daytime napping, waking and sleeping at regular times, decreasing the amount of stimuli just before bedtime (e.g., avoiding reading horror novels in bed), avoiding caffeine after 12:00 noon (ideally, rapid cycling patients should avoid caffeine use entirely), and buying a second alarm to help him arise in the morning. Though it is difficult to determine which of the pharmacological or behavioral interventions was the most important, it was apparent that by the second session Jason’s sleep was more regular and, subsequently, his mood had stabilized.

Sessions 2 to 6 continued with a psychoeducational and behavioral focus. We began with the use of mood charting, which involved having Jason chart his highest and lowest mood each day. He was also asked to mark how many hours he had slept on a nightly basis and what medications he had taken for his symptoms. Using a daily mood chart allowed Jason to take a step back from his mood symptoms in order to identify patterns of behavior, to begin a general discussion of the connection between events in his life and his feelings, and to feel more in control of his illness.

The use of mood charting also segued into more specific discussions around his bipolar disorder. It is important to note that the use of psychoeducation was geared toward Jason’s level of understanding around his illness. He was a highly intelligent person who was well read on his psychiatric diagnoses. Simply going over the symptoms of bipolar disorder would have likely belittled his intelligence and damaged the therapeutic alliance. Instead, the focus was on his knowledge of his mood symptoms and any gaps in understanding that he may have had. In fact, given his intelligence, he was given journal articles describing behavioral and cognitive approaches to his mood symptoms. We had many active discussions around these articles that seemed to make him feel more in charge of his treatment and more on the “cutting edge” of research. It seemed more important to make Jason feel engaged in his treatment than to simply lecture him on the signs and symptoms of his disorder.

In addition to psychoeducation, activity scheduling became a key behavioral intervention during the first six sessions. Jason often oscillated between trying to do too much during his hypomanias and then “crashing and burning.” During depressive episodes, he would ruminate about how he was a failure because he was unable to “do anything.” The goal was to find a manageable pattern of activities. However, it was clear that activity scheduling was stirring up automatic thoughts of being a “failure” and that “everything was his fault.” It was apparent that these interfering thoughts needed to be addressed more thoroughly. Otherwise, for all its good intentions, therapy would simply be a repetition of his life—scheduling too many activities to avoid feelings of failure and incompetence and then “crashing and burning” and confirming his beliefs about himself by doing no activities. The pace of his activity scheduling also seemed to mimic his rapid cycling mood symptoms; too many activities one week and then too little or none the following week. We decided to use the “one” rule. He agreed to do one thing well over the next week instead of focusing on all his activities at once. In this case, Jason agreed to get back to a regular exercise routine but to do only one exercise, running. We also began to challenge his automatic thoughts. However, it was apparent that Jason was employing the same zeal in our discussions of cognitive strategies as he had with his activity scheduling—for example, needing to complete the thought record perfectly or it (or he) would be worthless. Therefore, we began modifying these perfectionistic beliefs regarding homework assignments.

From Session 6 until the end of our 12 months of treatment, we examined Jason’s mood symptoms from both behavioral and cognitive perspectives. It became
clear that his automatic thoughts were driven around a strong desire to correct his life's problems due to his bipolar disorder and his substance dependence. In both cases, the patient described horrific journeys on the “roller coaster” of his symptoms. He described periods of extreme lows sometimes immediately followed by irritable highs, and he also discussed long stretches of substance use and then periods of sobriety. In all instances, it was a persistent battle of extreme illness and disability followed by a return to a high level of functioning. Each subsequent downturn resurrected his beliefs that he was a failure and a loser because he could not keep his moods stable and he could not maintain sobriety.

Though it was obvious that his feelings of failure and incompetence were there long before his first mood episode, we decided to remain focused on the here-and-now, and we began to challenge his beliefs about his illness and his sobriety. We examined what researchers know about the course of his disorders, but we also began to challenge his beliefs about himself and what he was capable of controlling. We discussed the dilemma that was inherent with both disorders (i.e., your mood episodes or urges to use may be completely out of your control, but it is your obligation to do anything in your power to maintain as much control as possible). We reviewed his past experiences, at times with painful emotions tied to his numerous low points. We also examined and challenged his automatic thoughts around daily activities and current experiences. Thought records proved useful for examining his daily life, and these usually led to deeper discussions about his past experiences and his beliefs.

Deeper discussions often led to another erroneous belief about his illness. He believed that if he could maintain his sobriety and stay out of a mood episode, then he would be “cured.” It was apparent that Jason had a difficult time accepting his diagnoses of bipolar disorder and substance dependence. Given the course of his illnesses, he was able, many times, to return to a stable, euthymic period of high functioning. His strong desire to return to his separated wife and his desire to return to his career were indicative of this wish to make it all better and be “cured.” Instead of going after this erroneous wish to be cured of his bipolar disorder through a rational discourse of the chronicity of the illness, we decided to dig deeper and began introducing the notion of core beliefs. It was apparent from his discussion of his early childhood that he was raised in a rather harsh, hypercritical environment. He described difficult experiences, for example, showing his parents a nearly straight-A report card only to be questioned about the “one A-minus.” Currently, his parents barely spoke to him but disclosed that when he returned to a “normal life” of a career and a wife, they would come back into his life. Again, we began to make frequent painful connections of this style of parenting and how it may have contributed to a core belief of feeling unlovable and how those tentacles reached to his feelings of failure, his bipolar disorder, and his current functioning. His bipolar disorder and his substance dependence fit too well into this belief system and often fueled depressive episodes and urges to use. (During one session, Jason connected that his nightly urges to use were related to his ruminative thinking around his daily activities and his self-deprecating list of everything he did not finish that day.)

Cognitive behavioral therapy with Jason was phased out after 12 months of weekly visits. His desire not to have a chronic illness was normalized, and though this wish never faded, we discussed how he could manage this yearning to “be normal.” We agreed to suspend treatment when it became apparent that his symptoms had stabilized and he was no longer “rapid cycling” (i.e., had dropped to two mood episodes in the previous 12 months). We agreed to suspend treatment to solidify his gains and to have a sense of success in treatment. He did believe upon termination that he still had bipolar disorder, but felt proud that he was controlling what he could of his mood symptoms and that he was “taking away the label of rapid cycling.” He also asked if he could return to treatment when he decided to return to work or if his mood symptoms became more severe. He predicted, probably accurately, that his core beliefs “would roar loudly” when he decided to reenter the workforce.

Of note, Jason did have one hypomanic episode and one brief, mild depressive episode during our 12 months of treatment. In both instances, we utilized a behavioral, “crisis mode” of treatment, focusing on safety, problem solving, and risk management. After these two mood episodes had ended, we then used these experiences to further our discussion of the interface of his cognitions, his feelings, and his mood episodes. Also of note is our intermittent discussion of his substance use and his attendance at AA support group meetings. Though we did not conduct outright substance abuse counseling, to ignore that potentially devastating comorbid condition would have been fatal to the treatment outcome. We focused on his urges to use and continually returned to behavioral interventions and cognitive restructuring. We also had several discussions on how to handle his relationship with his wife and his parents without further exacerbating the situation. We used crisis management techniques such as distraction, behavioral rehearsal, and self-soothing skills. The key point was to make the situations less stressful if they could not be avoided.

Given the nature of rapid cycling bipolar disorder, it would be difficult to review every intervention that was used with Jason. However, the key point is that a therapist needs to be flexible, creative, and empathetic to guide their patients to greater control of their mood symptoms.
A vast arsenal of behavioral and cognitive strategies is needed to help tame the mood episodes.

Conclusions

While nearly a quarter of bipolar patients may meet criteria for rapid cycling, this challenging population has been excluded from previous trials of cognitive-behavioral therapy for bipolar disorder. However, CBT offers numerous strategies to improve functioning and reduce relapse in these patients. We are in the process of conducting a small, open trial of CBT for rapid cyclers and plan to conduct a larger randomized controlled trial in the near future. We are hopeful that this article will generate a greater clinical and research interest in treating patients with a rapid cycling course of bipolar disorder.

References


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