Adapting Tele- CBT for an adult with Bipolar Disorder, Type II: Case study

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Abstract: Bipolar disorder II is a highly prevalent psychiatric condition that can significantly impact every aspect of an individual's life if left untreated. The present case study describes the application of tele-cognitive behaviour therapy (CBT) to the treatment of a 44 year old adult diagnosed with Bipolar Disorder, type II. During his 12-week treatment period, his maladaptive thought and behavioral patterns significantly decreased and improvement in his cognitive skills was reported. The single case study has implications for the treatment of BPAD and other mental health problems due to lack of generalization. However, it focuses on the need for interventions addressing mental health problems in individuals with maladaptive behavioral patterns. This case study suggests that tele-CBT as a promising primary and secondary prevention treatment for adults with Bipolar II disorder.

Index terms: **Bipolar disorder II, tele cognitive behaviour therapy, case study, psychiatric condition**

I. INTRODUCTION

Bipolar disorder (BD) is a highly prevalent affective psychiatric characterized by periodic, intense emotional states affecting a person's mood, energy, and ability to function. These periods, lasting from days to weeks, are called mood episodes. Mood episodes are categorized as manic/hypomanic episodes when the predominant mood is intensely happy or irritable, or depressive episodes, when there is an intensely sad mood or the ability to experience joy or pleasure disappears.

Overall, people with BD experience significant impairment in functioning in multiple domains of their life, including work, social and family life, both during the acute episodes and during the clinical remission (Baune et al., 2015; Sanchez-Moreno et al., 2017). Individuals with BD-II tend to experience longer and more persistent depressive episodes, sometimes with residual depressive symptoms, which are further exacerbated by the negative consequences of their hypomanic episodes (McMurrich, Grandin, Harrington, 2013).

World Mental Health (WMH) Survey by the World Health Organization (WHO), which estimated the prevalence of BPAD as 0.8% globally (0.4% in low-income, 0.6% in medium-income, and 1.1% in high-income countries) (Merikangas etal, 2011). The National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) has reported a substantially greater lifetime prevalence of Bipolar I disorder of 3.3% and Bipolar II of 1.1% (Hasin & Grant, 2015) The Global Burden of Disease Study (GBDS) estimated the prevalence of BPAD to be 0.7% overall, 0.6% among males, and 0.8% among females worldwide (Ferrari etal, 2016). The prevalence of BPAD as per GBDS in India is 0.6% (for both males and females) (India State-Level Disease Burden Initiative Mental Disorders Collaborators, 2020)

BPAD is also one of the top 20 leading causes of disability worldwide. Unfortunately, despite the availability of effective treatment, BPAD continues to be an illness that is underdiagnosed, misdiagnosed, or diagnosed after a substantial delay(Lublóy, Keresztúri, Németh, Mihalicza, 2020)

Although mood-stabilizing medication remains the first line of treatment for BD, the beneficial effects of psychosocial treatments, particularly cognitive behavioral therapy (CBT), are now widely recognized (Abreu, 2016). Furthermore, the use of psychotherapy for the management of BD-II has evolved significantly over the past few decades. CBT targets negative or dysfunctional thought patterns and behaviors through cognitive and behavioral restructuring techniques. These techniques aim to help the individual develop healthier or more balanced thought patterns (cognitive restructuration), which can then be applied in day-to-day life (behavioral restructuration). This can help with reducing psychiatric symptomatology and

decreasing depressive episode duration along with increasing euthymic periods and improving global functioning and quality of life (Alavi & Omrani, 2019; McMain, Newman, Segal, DeRubeis, 2015). Furthermore, CBT specific for BD-II often includes techniques to practice acceptance, recognize warning signs of an upcoming mood episode, recognize potentially triggering stimuli, and develop an action plan with helpful steps and considerations to follow before, during, and after a mood episode.

However, several barriers prevent the broader uptake of CBT and other in-person psychotherapy options, including high costs, low availability, long waitlists, stigma against psychiatric interventions, and geographical and physical limitations (Musiat, Goldstone & Tarrier, 2014). Thus, web-based adaptations of traditional in-person CBT (e-CBT) have become promising alternatives due to their lowered cost, time effectiveness, flexibility, privacy, and convenience (Ruwaard, Lange, Schrieken, Dolan, Emmelkamp, 2012). Additionally, e-CBT has been shown to increase help-seeking behaviors among patients and to have similar effectiveness at reducing psychiatric symptomatology as in-person CBT (Musiat, Goldstone & Tarrier, 2014). E-CBT programs often include weekly assignments for the participants and may be either fully self-guided or guided with asynchronous support from an assigned therapist (Ruwaard, Lange, Schrieken, Dolan, Emmelkamp, 2012). Despite these benefits over in-person CBT, e-CBT options specific to BD remain significantly understudied and underdeveloped, and very few e-CBT programs have focused on BD-II (Holländare, Eriksson, Lövgren, Humble, Boersma, 2015).

To supplement this gap in the literature and guide clinical practice, the primary objective of this case study will be to determine the changes in BD symptomatology (hypomanic and depressive symptoms) of an adult receiving Tele-CBT. The secondary objective will be to assess the effects of this tele-CBT program on quality of life and resilience.

Case Report

The patient is a 44-year-old self-employed gentleman, presenting with ten year history of depression and mood instability. The depression was exacerbated four years ago, after having an episode with an escort after which he repeatedly had thoughts of contacting HIV in spite of multiple blood investigations to rule out HIV. Symptoms described included persistent low mood, and feeling like he wants to "die". He lost motivation to work and lack of interest in other activities which earlier he used to do. He was also noticed to become increasingly socially withdrawn. Somatic symptoms include sleep-onset insomnia; loss of appetite and weight. He visited a psychiatrist and was diagnosed as Bipolar Disorder type II.

Further psychiatric consultation over the course of one year elicited periods of elevated mood. These included overspending money; inappropriate health behaviour, such as phoning doctors now and then, getting blood investigations after every 15 days. He also described staying awake for up to 48 hours due to constant thoughts running through his mind. These elevated moods can last up to 10 days in duration. In between the high and low moods, he described the feelings of intense irritation, frustration and anxiety. The psychiatrist referred him to a psychologist for psychotherapy. Due to time and transportation constraints the patient chose an online platform, Medibuddy vHealth to seek therapy from a trained psychotherapist.

He started with his Tele- Cognitive Behaviour therapy (CBT) in the month of March, which involved twelve (12) psycho therapeutic sessions. The sessions aided the patient to learn ways he can utilize to cope with fluctuating mood episodes and find out how to change his distorted cognition's. During the first few sessions, the therapist created a rapport with the patient and guaranteed him that maximum confidentiality is maintainable throughout the sessions. The next few sessions were spent to identify the problematic thought patterns, and discuss the patterns with the patient. He was psycho educated about the cognitive distortions and asked to maintain a journal to be aware of the same. It was noticed through his journal that he blamed himself for the instances that occurred in his life. For instance he felt guilty for seeing an escort in spite of being married for 14 years due to which his mood disorder got aggravated. He also blamed himself for the reckless behaviour of playing tennis for over 2 hours due to which he had a knee injury. These patterns were so repetitive that they had to be worked on. The sessions also focused on the cognitive restructuring, which involved a systematic identification of his problematic thought patterns. It contributes to the maintenance and onset of symptoms.

There was an importance and need for the patient to understand that his negative thoughts are affecting and enhancing problems such as depression, stress, and manic symptoms. The problematic thoughts were addressed one after the other. This process took 6 sessions as the problematic thoughts were deep rooted and repetitive. Once the patient started to show positive changes in his thought patterns, other techniques of CBT were introduced. These techniques foccused on changing his maladaptive behaviors. For instance he was introduced with muscle relaxant techniques so he may cope well with stress. During the same sessions, the patient was made familiar with anger and stress management. The advantage of tension control was helpful for the patient in handling stress in the future through problem solving, cognitive restructuring and communication skills. The patient was also made sensitive to the relationship between physical feelings and mood swings. It is imperious for the patient to undergo training and be able to detect and scrutinize early warning symptoms. Subsequently, he gained knowledge of using techniques that control anxiety. Such anxiety-control practices include self-instructions, cognitive distraction, and relaxation and breathing.

In last sessions, the patient became proficient in perceiving distorted thoughts and utilization of cognitive restructuring. Improving self-esteem as a technique helps restrain from future relapses. In addition to the self-esteem recognition, it is equally important for the patient to understand social skills so he can easily relate to other people and friends. For the final session, the therapist noted the progress concerning mood changes and general improvement with his life. Follow-up checkups were recommended in scrutinizing his recovery progress.

DISCUSSION

According to Björgvinsson et al. (2014), bipolar disorder has become a chronic and debilitating psychiatric condition and the treatment needs to be earnest and comprehensive, thus the application of the Cognitive Behavior Therapy. This case study encompassed the process of applying the Tele- CBT along with the use of medication. From the diagnosis and treatment procedure, the expectation is for CBT to be successful. As illustrated by Freeman (2016), CBT uses cognitive restructuring where negative thoughts are transformable into more realistic and healthier thought patterns. Many thoughts in the patient were identifiable, which then abetted him in becoming aware of his thoughts with the aim of preventing future bipolar episodes. As per Krucik (2015), the other important part of the CBT is behavior modification whereby maladaptive and destructive behaviors are removable and replaceable with positive reactions. The therapist management were helpful for the patient to learn anger and stress management techniques.

During the entire treatment process, the purposes of all psychotherapeutic methods were meant to assist the patient to learn and understand his signs and symptoms, hence reduce his levels of anxiety, improve her social skills, and enhance her gain greater control of his moods.

The strengths tele-CBT program for this study include the use of a validated approach for the delivery of interactive, predesigned web-based modules with the asynchronous guidance of a therapist. Also, by taking advantage of the web-based medium, this program has the potential to improve accessibility, cost, time effectiveness, flexibility, privacy, and convenience. Furthermore, using the online platform, this study was able to reliably collect user analytics, which allows for the improvement and continuous optimization of tele-CBT program delivery. Additionally, by comparing this proposed program to a validated therapeutic approach (face-to-face CBT for the management of BD-II), the design of this study should provide helpful evidence for the validation of tele-CBT for the management of BD-II. However this study comes with limitations as well, the first limitation is that this study cannot be generalized due to its sample size. Secondly, due to tele CBT, the network issues at times couldn't be controlled and twice the sessions had to be rescheduled. Lastly, since the therapy was administered online, some screening tests that could have been conducted in person, couldn’t be conducted.

CONCLUSION

In conclusion, this study recognizes the significant potential of tele-based psychotherapy as a tool that can lower costs and increase capacity and accessibility in mental health care, as well as the lack of available tele-based psychotherapy options for individuals with BD-II. Therefore, the results of this study aim to fill an important gap in the literature through the

development, implementation, and validation of a novel tele-CBT program for the management of BD-II. Additionally, these results aim to inform clinical practice and health care policy to support the widespread implementation of tele-based psychotherapy, with potential benefits to the care capacity and performance of the health care system.

REFERENCES

[1] Baune, Bernhard & Malhi, Gin. (2015). A review on the impact of cognitive dysfunction on social, occupational, and general functional outcomes in bipolar disorder. *Bipolar Disorders.* 17. 41-55. 10.1111/bdi.12341.
Sánchez-Moreno, Jose & Martínez-Arán, Anabel & Vieta, Eduard. (2017). Treatment of Functional Impairment in Patients with Bipolar Disorder. *Current Psychiatry Reports.* 19. 10.1007/s11920-017-0752-3.

[2] McMurrich S., Grandin. L., Reilly-Harrington. N. (2013). *The Bipolar II Disorder Workbook.* Oakland, CA: New Harbringer Publications, Inc; p. 254.

[3] Merikangas, K.R., Jin, R., He, J.P., Kessler, R.C., Lee, S., Sampson, N.A., Viana, M.C., Andrade, L.H., Hu, C., Karam, E.G., Ladea, M., Medina-Mora, M.E., Ono, Y., Posada-Villa, J., Sagar, R., Wells, J.E., Zarkov, Z. (2011). Prevalence and correlates of bipolar spectrum disorder in the world mental health survey initiative. *Archives of General Psychiatry*;68(3):241-51. doi: 10.1001/archgenpsychiatry.

[4] Hasin, D.S., Grant, B.F. (2015) The National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) Waves 1 and 2: Review and summary of findings. *Social Psychiatry and Psychiatric Epidemiology*;50:1609–40.

[5] Ferrari, Alize & Stockings, Emily & Khoo, Jon-Paul & Erskine, Holly & Degenhardt, Louisa & Vos, Theo & Whiteford, Harvey. (2016). The prevalence and burden of bipolar disorder: findings from the Global Burden of Disease Study 2013. *Bipolar Disorders.* 18. 440-450. 10.1111/bdi.12423.

[6] India State-Level Disease Burden Initiative Mental Disorders Collaborators The burden of mental disorders across the states of India: The Global Burden of Disease Study 1990-2017. (2020). *Lancet Psychiatry*;7:148–61.

[7] Lublóy, Ágnes & Keresztúri, Judit Lilla & Németh, Attila & Mihalicza, Peter. (2020). Exploring factors of diagnostic delay for patients with bipolar disorder: a population-based cohort study. *BMC Psychiatry.* 20. 10.1186/s12888-020-2483-y.

[8] Abreu, Tânia. (2016). A review on the effectiveness of cognitive-behavioural therapy for bipolar affective disorder. *International Journal of Clinical Neurosciences and Mental Health.* 6. 10.21035/ijcnmh.2016.3.6.

[9] Alavi N, Omrani M. (2019). *Online Cognitive Behavioral Therapy: An e-Mental Health Approach to Depression and Anxiety.* Cham: Springer.

[10] McMain, S., Newman, M.G., Segal, Z.V., DeRubeis, R.J. (2015). Cognitive behavioral therapy: current status and future research directions. *Psychotherapy Research*;25(3):321–329. doi:10.1080/10503307.2014.1002440.

[11] Musiat, Peter & Goldstone, Phil & Tarrier, Nicholas. (2014). Understanding the acceptability of e-mental health—Attitudes and expectations towards computerised self-help treatments for mental health problems. *BMC psychiatry.* 14. 109. 10.1186/1471-244X-14-109.

[12] Ruwaard, J., Lange, A., Schrieken, B., Dolan, C. V., & Emmelkamp, P. (2012). The effectiveness of online cognitive behavioral treatment in routine clinical practice. PLoS ONE, 7(7),40089. https://doi.org/10.1371/journal.pone.0040089

[13] Holländare, Fredrik & Eriksson, Annsofi & Lövgren, Lisa & Humble, Mats & Boersma, Katja. (2015). Internet-Based Cognitive Behavioral Therapy for Residual Symptoms in Bipolar Disorder Type II: A Single-Subject Design Pilot Study. JMIR research protocols. 4. e44. 10.2196/resprot.3910.

[14] Björgvinsson ,T., Kertz, S., Bigda-Peyton, J., Rosmarin, D., Aderka, I., Neuhaus, E. (2014). Effectiveness of Cognitive Behavior Therapy for Severe Mood Disorders in an Acute Psychiatric Naturalistic Setting: A Benchmarking Study. *Cognitive Behaviour Therapy*;43(3):209–220. https://goo.gl/rFVsLM

[15] Freeman, D. (2016). *Cognitive-Behavioral Therapy for Psychotic Disorders | Psychiatric Times*. *Psychiatrictimes.com*. Retrieved from https://goo.gl/0YCMgE
[16] Krucik, G. (2015). *Cognitive Behavioral Therapy*. *Healthline*. Retrieved from https://goo.gl/brc8yX