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Brief Clinical Reports

CONCEPTUALIZING A CYCLE OF ASCENT INTO MANIA: A CASE REPORT

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Abstract. This case study describes the collaborative development of an idiosyncratic cognitive model of the ascent into mania in a patient with bipolar affective disorder. The client held the belief that he could rise above his depression and feelings of low self-esteem through the pursuit of highly demanding goals and rewarding activity. While still depressed and anxious, small increases in positive mood and energy triggered hyper-positive thoughts about himself (e.g. ''I am back to my attractive, intelligent and outgoing self again''). Consequently, he engaged in a range of ''ascent'' behaviours that were consistent with the pursuit of this self-view. The direct effects of these behaviours and their effects on other people led to further increases in positive mood and physiological activation, which in turn triggered more hyper-positive self-relevant thoughts. The client reported that he found the model an extremely useful component of cognitive behavioural therapy.

Keywords: Bipolar disorder, formulation, treatment, cognitive bias, social feedback.

Introduction

An important component of cognitive therapy for depression involves identifying and challenging dysfunctional assumptions. Recent empirical findings (Lam, Wright, & Smith, in press) indicate that people with bipolar disorder are characterized by specific dysfunctional assumptions; they are particularly driven to achieve highly demanding personal goals. Furthermore, prospective studies have shown that striving for achievement-related goals (facet of Conscientiousness on the NEO 5-factor Inventory) predict increases in manic symptoms over time (Lozano & Johnson, 2001). Recent advances in cognitive therapy for anxiety disorders and depression have suggested that dysfunctional assumptions may be mediated by in-situation cognitive biases and behaviours (e.g. Clark, 1999). What are the cognitive biases and behaviours that could mediate the ascent into mania? It has been proposed that the information from internal sensations, such as feelings of high energy and agitation, could

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be appraised as indications of an overly positive sense of self that may in turn lead to elevations in mood and goal-directed behaviour (Healy & Williams, 1989). An alternative, but not mutually exclusive, suggestion is that mania is an exaggerated attempt to suppress feelings of low self-esteem (Lyon, Startup, & Bentall, 1999). This brief case study demonstrates a collaborative model of one client's experience of his ascent into mania that includes elements of the above theories, and helped the client (and therapist) gain a better understanding of his condition.

Client history

Stephen was a middle-aged man, who had a previously successful, but erratic, career in the arts. He reported a history of emotional abuse by his father and physical and emotional abuse by his brothers. He had experienced a 10-year history of intermittent episodes of depression, interspersed 6 years prior to therapy with episodes of mania, which had included social and sexual disinhibition, attempts to change his identity, grandiose delusions and occasional hallucinations. The episodes were associated with erratic use or cessation of antidepressants, and use of alcohol and drugs (in particular amphetamines). During depressive episodes, Stephen was often preoccupied by feelings of guilt and shame regarding his behaviour during manic periods, leading to suicidal intents and plans. He had made one suicide attempt. He had been taking Nefazodone 100 mg twice daily and Lithium Carbonate 600 mgs daily for 10 weeks before the start of therapy.

Assessment

A full history was taken and the areas of current difficulty were discussed. Stephen completed several standardized questionnaires including the Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) and the Internal State Scale (ISS; Bauer et al., 1991). At the start of therapy, he was severely depressed and he had thoughts of killing himself but would not carry them out. Stephen also avoided many social situations for fear that he would be ridiculed by other people. These included social gatherings, interviews and meeting previous work acquaintances. He thought that people would see him blush, stumble with his words, ''smell his fear'', and that he would look ''desperate for praise''. He received formulated cognitive therapy for social phobia (see Clark, 1999), depression, and the prevention of mania (Lam, Jones, Hayward, & Bright, 1999). After 16 sessions of therapy and a considerable improvement in symptoms, he wished to produce a model of his mania in order to further understand how he could prevent a relapse of mania. A model was produced collaboratively, basing the structure (i.e. a vicious cycle of mood, thoughts, behaviour, the environment and physiology) on what he had learned from the models of social phobia and depression.

Client's model of the ascent into mania

The formulation of the ascent into mania is displayed in Figure 1 and is described as follows. Stephen held a set of dysfunctional ''ascent'' beliefs. He believed that by going into a high mood, attaining difficult goals and rewarding himself he could rise above his current perceived low self-esteem. For example, he stated that, ''On an 'up', I can forget my anxiety and I no longer feel weak, bad and useless'' and ''During my high, I can hide behind a new identity''. While Stephen was still experiencing depression and anxiety, he would also start

to notice increases in energy and positive mood. The increases in mood would activate thoughts such as ''I'm back to my attractive, intelligent and outgoing self again'' and ''The depression is dead, never to return!''. In response to these thoughts, he would begin to engage in a range of ''ascent'' behaviours relating to the ascent beliefs, i.e. aimed at rising above the depression, ignoring any of his problems and re-emerging as a new, highly creative and intelligent self. The behaviours included stopping antidepressants, reducing his sleep, drinking more, taking drugs, looking for social opportunities, adopting highly challenging goals and ignoring his problems. Many of these behaviours would lead to direct increases in positive mood. In addition, Stephen's social environment would react in two different ways to these behaviours. People who did not know him would encourage them, being drawn to his optimism. This would lead to further increases in mood and ascent behaviour. People who did know him would become worried and concerned. In response to their concern, Stephen would become irritable at being controlled, and would try to persuade and reassure people that nothing was wrong. They would often capitulate and this led to further thoughts of being supremely intelligent and capable. If the negative feedback from his friends continued he would avoid these people, which further prevented a drop in mood. Throughout this cycle, the ascent behaviours would have direct effects on his physiology (e.g. sleep cycle, arousal), yet these experiences would be interpreted in a positive rather than negative manner, further feeding into the cycle. The cycle served to increase mood, grandiose thoughts and ascent behaviour, reflecting the pathway from high mood to hypomania to mania. Only a catastrophic incident or medication would normally stop the cycle at this point.

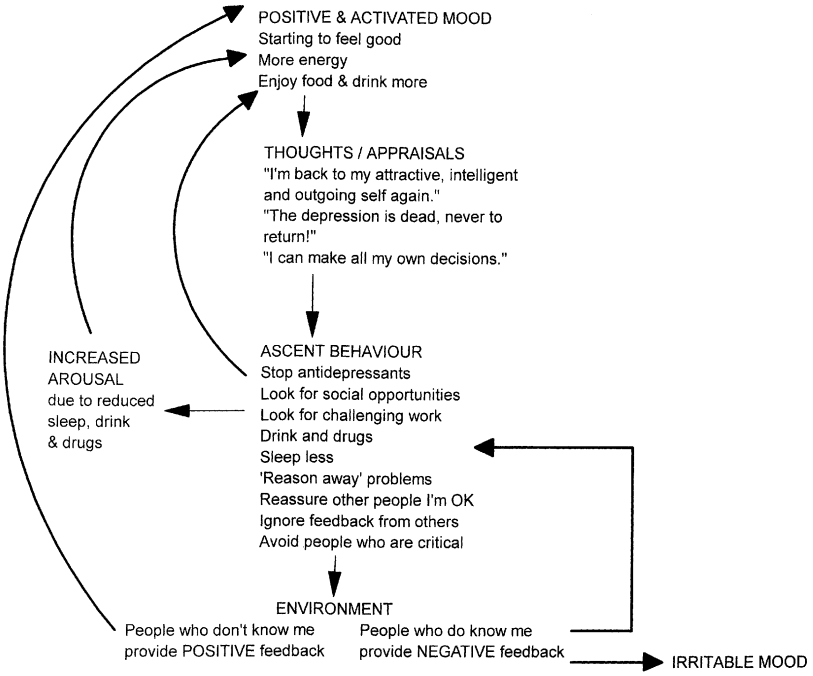

Figure 1. Idiosyncratic model of the ascent into mania

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Outcomes

Stephen filled in an exit questionnaire about each of the elements of therapy and reported that he found the idiosyncratic mania model an ''extremely useful'' component of the treatment. At the end of the complete programme of therapy, measures of depression and self-reported prodromal manic symptoms (ISS) fell to a level within the non-clinical range after therapy and at 3, 6 and 10-month follow-ups (see Table 1). Stephen did not experience the annual relapse he had experienced over previous years during the follow-up period. He continued to keep a brief account of his daily activities, along with a rating of his mood. He reported remaining compliant with his medication throughout therapy and follow-up. He maintained his relationship with his partner, completed a training course, after which he found regular employment. He also regularly spent time working with a friend on a long term project.

Discussion

This case provides an example of the production of a collaborative individualized cognitive model of the ascent into mania. This model incorporated elements from current theories. For example, the client appraised small increases in energy and positive mood in an overly positive, personalized and over general manner at the early stage of the prodrome (cf. Healy & Williams, 1989). He felt that he would set highly autonomous goals for himself that were challenging but extremely difficult to achieve (Lam et al., in press) and he also appeared to use the goal-oriented behaviour as a way to rise above his depression and his feelings of low self esteem. The formulation further identified interpersonal processes such as ignoring negative feedback from significant others, and searching for positive social feedback. Future research could explore these cognitive processes.

Naturally, the client's improvement would be explained largely by the initial programme of therapy that targeted his social anxiety, depression and mania. Also, the model of mania included elements that had been explored in earlier stages of therapy, such as early warning signs of relapse, and may have reflected the result of effective therapy rather than the cause. Furthermore, the model does not involve the hereditary and neurochemical factors that are thought to play a role in bipolar affective disorder. Nevertheless, the client found this formulation extremely useful and it may be possible to use this model-building approach with

Table 1. Measures of psychopathology, taken at pre-treatment, post-treatment and at 6- and 10-month follow-up

Measure	Pre	Post	6m FU	10m FU
BDI	37	1	0	1
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Activation	50	20	22	35
Depression	129	8	6	20
Well-being	21	92	189	219
Perceived conflict	266	18	12	47

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other clients earlier on in therapy in a way that allows them to test its efficacy, and thereby learn how to help prevent a future relapse.

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