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The Hypomanic Attitudes and Positive Predictions Inventory (HAPPI): A Pilot Study to Select Cognitions that are Elevated in Individuals with Bipolar Disorder Compared to Non-Clinical Controls

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Abstract. The development in science and practice of cognitive therapy for psychological disorders has benefited from coherent models that specify the key cognitions that can be targeted in therapy. A scale is required to identify the cognitions that characterize bipolar affective disorder and that may influence the development of mania or hypomania. In this pilot study, 104 items were generated within five theory-driven categories: Self-activation, Response style, Other-positive, Other-negative, and Self-catastrophic. The mean score for all items, and for each category of items, was significantly elevated in a group of individuals with a diagnosis of bipolar disorder ($n = 22$) relative to a group of non-clinical controls ($n = 22$). An exploratory analysis revealed the items that were significantly elevated in the bipolar group. Theoretical and clinical implications, limitations and plans for future research are discussed.

Keywords: Manic depression, information processing, dysfunctional attitudes, appraisals.

Introduction

The cognitive approach to bipolar disorder has developed significantly over recent years, as indicated by successful treatment trials (Lam et al., 2003; Scott, Garland, and Moorhead, 2001) and widely cited therapy manuals (Basco and Rush, 1996; Lam, Jones, Hayward and Bright, 1999; Newman, Leahy, Beck, Reilly-Harrington and Gyulai, 2002). Traditionally, cognitive therapy for psychological disorders has developed in tandem with empirical work investigating the key cognitive constructs that are associated with the condition (Harvey, Watkins, Mansell and Shafran, 2004; Salkovskis, 2002). For example, the cognitive model of panic disorder (Clark, 1986) proposes that the catastrophic interpretation of bodily sensations maintains the disorder. In this area of research, the Body Sensations Interpretation Questionnaire was developed to assess these interpretations and it can be used to help identify specific beliefs that are addressed during therapy (Clark, Salkovskis and Öst, 1997). In a similar vein, the Post-Traumatic Cognitions Inventory (PTCI; Foa, Ehlers, Clark, Tolin, and Orsillo, 1999) assesses appraisals of trauma and its sequelae in posttraumatic stress disorder, and the Metacognitions Questionnaire (MCQ; Wells and Cartwright-Hatton, 2004) assesses positive and negative beliefs about worry in generalized anxiety disorder. To date, there are no published scales

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developed specifically to assess the key cognitions of people with bipolar disorder (Mansell and Scott, 2006). The current pilot study is the first stage in the development of a new scale with this purpose in mind: the Hypomanic Attitudes and Positive Predictions Inventory (HAPPI).

Individuals at risk of mania experience isolated symptoms in between episodes of depression and mania (Judd et al., 2002). In many people with bipolar disorder, these isolated symptoms of mania can escalate into full-blown hypomania or mania. Arguably, it is these cognitions that are critical to target in cognitive therapy rather than those during clinical mania, which is typically treated acutely using medication. Although there is evidence that psychosocial factors such as goal-attainment events, events that disrupt circadian rhythms, and self-reported behavioural activation can predict increases in manic symptoms (Johnson, 2005), no measures of the specific beliefs, attitudes or appraisals that might influence the development of manic symptoms have been developed.

The measure piloted in the current study has been developed to test a recent cognitive model (Mansell, 2006) that specifies key cognitive and behavioural processes that are thought to contribute to the development of mania. In essence, it proposes several vicious cycles whereby existing fluctuations in internal state are appraised and responded to in a way that heightens the internal generation of behaviour, affect and cognition to the expense of the detailed processing of information that would have the capacity to regulate and de-escalate the cycles.

The model is comprised of two elements. First, a primary vicious cycle is involved in heightening the core symptoms of mania: behavioural, cognitive, affective and physiological activation (e.g. increased activity, racing thoughts, elevated mood, and distractibility). This vicious cycle begins when the feelings of activation are appraised as indicating extreme personal success or personal triumph over adversity (self-activation appraisals; e.g. thoughts racing are appraised as a sign of inherent intelligence and wit; see also Healy and Williams, 1989; Jones, 2001). These appraisals immediately trigger a response style that further contributes to the symptoms of activation. For example, the individual may believe that continually generating new creative ideas will provide further personal success. The responses have been termed "ascent behaviours" (Mansell and Lam, 2003) and include increased rates of activity, seeking stimulating environments, and ingesting stimulating substances. Ascent behaviours are distinguished from normal goal-directed activity in that they lead to increased activation that is perceived by the individual as indicating personal success, yet these behaviours may not necessarily bring about success in the "real world" (and are often counterproductive). Some ascent behaviours may develop from safety behaviours (Salkovskis, 1991) that are associated with comorbid anxiety disorders. For example, an individual with comorbid social phobia may initially use alcohol to try to prevent social rejection, yet drinking excessively becomes an ascent behaviour owing to its activating and disinhibiting consequences.

The model suggests that the primary cycle alone can be sufficient to increase certain manic symptoms. However, most individuals (those without bipolar disorder) can circumvent the cycle by a change in processing style. For example, the individual may notice other people's negative responses towards them and therefore moderate their behaviour, or they may reappraise the symptoms of activation as less personally meaningful (e.g. "it is just a temporary result of poor sleep"). On the other hand, individuals with bipolar disorder are less likely to circumvent the vicious cycle because further secondary appraisals drive processes that prevent normal self-regulation. These are: (idealistic) positive and (extreme) negative appraisals of other people, catastrophic appraisals of manic symptoms and culturally unacceptable appraisals of manic symptoms (see also Morrison, 2001). The model predicts

that each set of appraisals is associated with specific symptom clusters that appear to occur during mania (e.g. Cassidy, Forest, Murry and Carroll, 1998). Negative appraisals of others are associated with irritability, aggression and paranoia; catastrophic appraisals are associated with panic, anxiety and dysphoria; and culturally unacceptable appraisals are associated with psychotic symptoms. These appraisals vary between individuals, alongside their symptom profile during mania, and they further heighten activation and contribute to further ascent behaviours. For example, the individual may ignore potentially helpful advice from close friends and relatives because these people are perceived as manipulative and overcontrolling (example of a negative belief about others).

It is proposed that each of the appraisals involved in the model are triggered during activated internal states, yet individuals are able to introspect on them when outside these states, and therefore report them during remission. During states of low activation, the flip side of these beliefs form the content of ruminations that reverse the cycle and contribute to depression (e.g. "now I have no energy, my life no longer has a purpose"; Mansell, Colom and Scott, 2005). A model that integrates these cycles to provide a generic formulation of bipolar disorder for treatment has also been produced (Mansell, Morrison, Reid, Lowens and Tai, 2006).

While many of the key processes in the model can be assessed using laboratory-based paradigms (e.g. Mansell and Lam, in press), self-report questionnaires provide a more accessible and clinically useful method to test the model. This paper reports on the initial selection of items for the questionnaire, the internal consistency of subscales, and their capacity to distinguish between individuals with bipolar disorder and healthy controls in a pilot study. It was predicted that the mean score on the scale and for each subscale would be significantly higher in the bipolar group. Further, in an exploratory test each item was analysed for its capacity to distinguish between the two groups.

Method

Item selection

Preliminary items were generated from three sources. First, the cognitive model of the ascent into mania described above provided the majority of items. Second, therapy manuals, chapters and journal articles were analysed for appropriate items. Third, clinical experience with earlier patients with bipolar disorder provided some items (e.g. Mansell and Lam, 2003). A total of 104 items were identified. All items were then labelled according to five themes that are specified in the cognitive model: overly positive appraisals of the self relating to feelings of activation and change in mood (self-activation; e.g. "When I feel more active I realise that I am a very important person"), beliefs about the cognitive and behavioural response to changes in feelings of activation and mood (response style; e.g. "If I notice something new when I am feeling good, I must make every effort to think about how it connects with everything else"); overly positive attitudes about how the self should ideally be regarded by other people (other-positive; e.g. "If I am very special to everyone around me then all my problems will disappear"); negative beliefs about other people and their relationship towards the self during states of activation (other-negative; e.g. "When I feel really good, people don't understand me"; see also Mansell and Lam, in press); and finally catastrophic beliefs involving the self relating to feelings of activation and change in mood (self-catastrophic; e.g. "When I feel agitated and restless it means that I am about to have a breakdown"). The scale did not include

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"culturally unacceptable" items because this component of the model was added at a later stage.

Questionnaire structure

The questionnaire was headed with the following paragraph: "Please read each of the statements below and make a rating in the right hand column to indicate how much you believe each one. Make your rating by intersecting the line between 0% (don't believe this at all) to 100% (believe this completely). For example, 50% means that the statement is 50:50, equally likely to be true or false for you. Try not to think too much about each item. There are no right or wrong answers to this questionnaire and only your own opinion counts".

The first page of the questionnaire asked participants to answer "yes" or "no" to whether they had ever received a diagnosis of bipolar disorder (manic depression) and whether they had ever had clinical depression. They were asked to provide their age and gender, and to rate their current mood on a line scale with 10 point intervals from −100 (extremely low/depressed) through 0 (neutral) to +100 (extremely high/happy) and their current level of energy from −100 (extremely tired/slowed down) through 0 (neutral) to +100 (extremely energized/speeded up). The following pages listed the 104 preliminary items. Each item was printed alongside a line with 11 divisions and marked with 0 and 100 at the extremes. The questionnaire took approximately 20 minutes to complete.

Participants

Twenty-two individuals (14 females and 8 males) who had received a diagnosis of bipolar affective disorder were recruited through clinical practice (6 individuals) and the remaining participants via one local and one national event organized by the Manic Depression Fellowship, after consultation with the organizers involved. Approximately 40 questionnaires were distributed, entailing a response rate of around 40%. Twenty-two healthy controls (15 females and 7 males) were recruited via personal contacts. None of the healthy controls reported a history of depression or bipolar disorder. The ages of the two groups did not differ, $t\,(42) = 0.94$, $M\ (SD) = 43.4\ (11.1)$ for the bipolar group, and $M\ (SD) = 39.8\ (14.0)$ for the controls.

Results

Mood and energy levels

The bipolar group reported a significantly lower mood than the controls, $t\,(35) = 4.87$, $p < .001$, *Ms (SDs)* = −2.2 (22.3) and 38.4 (28.3), respectively, but there was no significant difference in self-reported energy levels, *Ms (SDs)* = 1.5 (25.2) and 9.7 (23.5), in the bipolar and control groups respectively, $t\,(34) = 1.01$, *ns*.

HAPPI

The internal consistency of the subscales was first assessed. Table 1 shows that the overall scale and each subscale had a high level of internal consistency; only one subscale had an

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Table 1. Group differences in mean score for all items and each subscale of the preliminary version of the HAPPI

Mean scores	Alpha	Bipolar *M (SD)*	Control *M (SD)*	*t*	*D*
All items	.98	36.3 (17.9)	14.6 (7.6)	5.25	1.58
Self-activation	.94	40.1 (19.2)	18.1 (9.3)	4.85	1.46
Response style	.96	34.8 (18.6)	14.5 (8.7)	4.63	1.40
Other-positive	.75	36.9 (25.3)	8.3 (8.5)	5.03	1.52
Other-negative	.93	33.6 (21.3)	8.5 (6.0)	5.31	1.33
Self-catastrophic	.87	33.9 (17.3)	15.4 (8.9)	4.46	1.34

alpha coefficient of below .8 (other positive = .75). Second, subscale scores were calculated from the mean belief rating for all items in that category, to establish whether the scores distinguished between the two groups. A mean score for all questionnaire items was also calculated. Independent-samples *t*-test revealed a significant difference between the two groups in mean score for each subscale and the whole inventory. The means, standard deviations and *t*-values are displayed in Table 1. All differences were significant to the $p < .001$ level. In addition, each analysis was repeated as a one-way Group ANOVA using mood as a covariate. All differences remained significant to the $p < .01$ level.

In a third stage, the *t*-tests were repeated for each test item separately, in order to identify the most effective items and to allow the elimination of items that did not distinguish between groups for later versions of the scale. Twenty-nine items differed to less than the $p < .001$ level (the highest level of significance displayed by SPSS statistical software) and are listed in Table 2 along with the group means, standard deviations and *t*-values. Considering that there were just over 100 items, the $p < .001$ level of significance would reflect a statistically significant finding even when incorporating a Bonferroni correction for a one-tailed test of significance at the $p < .05$ level. The items that differed to the $p < .01$ level of significance are listed in Table 3; the group differences were also large but these items would not survive a Bonferroni correction.

Discussion

The HAPPI was easily completed by participants and showed a high internal validity both of the overall scale and the subscales. As predicted, the mean of all items and each subscale distinguished between individuals who had received a diagnosis of bipolar disorder from healthy controls. These findings remained significant even when accounting for the finding that the bipolar group reported a lower subjective mood than the controls. These results are consistent with the view that cognitive factors can distinguish individuals with bipolar disorder.

The items that were found to most clearly distinguish between the groups deserve some mention in relation to the model; many showed a group difference of more than 30 percentage points. A proportion of the items involved self-activation. These appraisals contribute to the primary vicious cycle of the model and bear the closest resemblance to previous accounts of mania (e.g. Healy and Williams, 1989; Jones, 2001). Several items related to appraisals of response style. In particular, the bipolar group reported that they have little control over, or

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Table 2. Items that distinguish between the bipolar and control groups at $p < .001$, ordered in decreasing size of *t*-value

Items	Bipolar *M (SD)*	Control *M (SD)*	*t*
I have no control over whether I get excited when something good happens to me (R)	47.1 (29.4)	9.1 (15.2)	5.38
When I feel agitated and restless it means that I am about to have a breakdown (SC)	47.4 (30.9)	7.3 (15.2)	5.31
When I feel restless, what happens to me is more important than what happens to other people (ON)	46.9 (34.3)	8.0 (12.4)	4.90
When my mood reaches a certain extreme, I have no responsibility over dealing with it (R)	52.1 (38.6)	5.3 (10.7)	4.84
When I feel good, I know that whatever I do, I could do no wrong (SA)	45.6 (32.6)	7.1 (12.2)	4.59
When I feel really good, people don't understand me (ON)	39.3 (32.5)	7.3 (11.9)	4.35
When I get excited about something I have no control over my thoughts (R)	40.7 (35.9)	6.6 (8.2)	4.34
When I feel agitated and restless, I can fight against other people's attempts to control me (ON)	40.2 (31.1)	9.6 (12.3)	4.30
I need to be the centre of attention to enjoy myself (R)	34.3 (31.4)	5.2 (6.6)	4.25
When I feel more active I realize that I am a very important person (SA)	43.0 (31.9)	11.6 (14.2)	4.21
I need to have complete control over my moods in order to prevent myself from having a breakdown (R)	43.2 (34.3)	10.0 (13.8)	4.21
If I am very special to everyone around me then all my problems will disappear (OP)	36.8 (35.6)	4.1 (8.8)	4.18
When I get very agitated about something I have no control over my behaviour (R)	40.5 (35.5)	8.0 (8.7)	4.17
When I try hard to get what I want, other people try to stop me (ON)	32.3 (33.4)	2.7 (4.6)	4.11
I have all my best ideas when I feel extremely good about myself (SA)	62.1 (28.6)	30.0 (23.1)	4.09
When I am with other people it is most important that they admire me (OP)	38.4 (32.3)	8.4 (12.1)	4.08
If I have a bad night's sleep it means that I am about to have a breakdown (SC)	30.0 (31.6)	2.3 (5.3)	4.06
If I notice something new when I am feeling good, I must make every effort to think about how it connects with everything else (R)	60.3 (35.8)	17.9 (21.3)	4.06
When I feel full of energy I am extremely funny and witty (SA)	61.1 (28.7)	31.1 (21.7)	3.91
Doing anything very active can lead me to have a breakdown (SC)	22.7 (25.9)	1.4 (3.5)	3.84
The better I feel about myself, the worse other people react towards me (ON)	33.6 (33.7)	5.5 (8.3)	3.81
When I feel that I am right, I must keep on generating lots more new ideas and solutions (R)	56.3 (37.5)	15.8 (19.5)	3.79
My feelings need to be very intense to feel real to me (SA)	44.4 (37.9)	7.9 (12.8)	3.78
When I have a lot of energy, I don't need support from anyone or anything (ON)	51.1 (34.2)	19.8 (19.0)	3.76
When I feel restless, the world becomes full of unlimited opportunities for me (SA)	44.6 (34.0)	14.6 (17.8)	3.66
When I get new ideas I must tell people at once and at length so that they admire me (R)	33.2 (35.0)	5.0 (9.1)	3.66
If I sleep much less each night it means that I can get a lot more done during the day (R)	30.2 (33.7)	3.6 (6.9)	3.63
I must act on a good feeling as soon as I experience it (R)	39.4 (26.3)	14.0 (13.0)	3.61
What happens right now is more important to me than what things are like in a few days time (SA)	40.0 (32.3)	13.2 (14.5)	3.55

Note: SA = Self-activation: beliefs about the self relating to feelings of activation and elevated mood; SC = Self-catastrophic: catastrophic beliefs about the self relating to feelings of activation and elevated mood; OP = Other-positive: beliefs relating to needing positive responses from other people; ON = Other negative: beliefs relating to negative responses from other people when activated or in an elevated mood; R = Response style: beliefs concerning response style when activated or in an elevated mood.

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Table 3. Items that distinguish between the bipolar and control groups at $p < .01$, ordered in decreasing size of *t*-value

Items	Bipolar *M (SD)*	Control *M (SD)*	*t*
When people criticize my enthusiastic behaviour they are being deliberately malicious and nasty (ON)	28.4 (30.6)	4.6 (6.7)	3.57
When I feel good, I am sure that everything will work out perfectly (SA)	50.9 (32.7)	17.9 (22.4)	3.50
When I am more active than usual, other people dislike me (ON)	25.3 (28.3)	2.9 (4.5)	3.49
When I feel good, I must keep "on the go" all the time or things will fall apart around me (R)	38.2 (37.0)	6.1 (9.5)	3.49
When my moods drive upwards there is nothing I can do about it (R)	44.1 (35.0)	12.1 (16.6)	3.44
When I feel excited, my fears and worries are no longer real (SA)	45.8 (39.0)	12.4 (19.2)	3.42
When other people around me are upset it is an over-reaction to the situation (ON)	31.6 (31.6)	7.5 (11.7)	3.35
If I let other people do things at their own pace, I will not get what I want (ON)	36.1 (36.0)	9.3 (12.5)	3.30
I must be decisive about everything (R)	36.4 (27.5)	13.9 (16.8)	3.27
On the surface I may often appear ambitious and independent but underneath I am very dependent on other people (ON)	47.1 (35.2)	18.2 (22.3)	3.25
When my energy levels increase I can bring about a large rise in my social status (SA)	39.3 (30.9)	14.3 (18.9)	3.24
When I am feeling restless and agitated, there is no point in eating regularly (R)	26.3 (25.9)	6.6 (7.5)	3.19
My high moods are outside my own control (R)	48.6 (38.8)	19.3 (19.0)	3.12
I cannot cope with feeling sad for a short while (SC)	38.7 (32.6)	9.7 (16.9)	3.12
When I feel excited I know that other people desire me (OP)	35.5 (31.5)	12.3 (17.4)	3.02
Unless I am active all the time, I will end up a failure (SC)	28.9 (30.9)	7.5 (12.6)	3.01
I sometimes do something risky just for the sake of stirring things up (R)	27.4 (28.8)	6.1 (7.2)	2.96
If I choose to follow other people's advice, they will control me (ON)	20.6 (22.4)	4.0 (11.7)	2.96
I am only worth knowing when I am full of energy (SA)	27.7 (27.5)	8.7 (13.1)	2.94
When I get an idea, it always turns out to be the best solution (SA)	38.6 (29.2)	17.1 (19.4)	2.89
If I fall behind in my goals for a short while, I will end up a failure (SC)	30.9 (29.7)	10.5 (15.8)	2.85

responsibility for, dealing with their changes in mood, thinking and behaviour, yet at the same time demanding of themselves a high level of control over these factors. The bipolar group also believed that they should respond to positive moods by searching for connections between events, generating more ideas, responding quickly, and talking at length to other people; these are examples of ascent behaviours within the model. The bipolar group reported a strong desire to be seen positively by other people (e.g. "When I am with other people it is most important that they admire me"); excessive need for approval has been identified in earlier psychodynamic accounts (e.g. Cohen, Baker, Cohen, Fromm-Reichmann and Weigert, 1954) and also identified in cognitive studies (e.g. Scott, Stanton, Garland and Ferrier, 2000). Within the model, these beliefs contribute to the perception that other people's actual responses fall far below the individual's high expectations and therefore contribute to negative appraisals of

others. Six of the items related to the negative beliefs. The bipolar group reported an inverse relationship between how good they feel and how well they think other people understand them, with some items referring to others trying to control them or trying to stop them getting what they want. According to the model, owing to these appraisals of other people, individuals who are developing manic symptoms resist people's attempts to provide advice or to try to slow them down, and this is reflected in their increased irritability and sometimes paranoia and aggression. Several items relating to feared catastrophes were elevated in the bipolar group. The bipolar group reported more beliefs that they may have a breakdown (i.e. relapse). To a certain degree these fears may be realistic, but the model proposes that these fears are often exaggerated and may contribute to excessive worry and anxiety (e.g. "If I have a bad night's sleep it means that I am about to have a breakdown"; see also Harvey, Schmidt, Scarnà, Neitzert Semler and Goodwin, 2005). In addition to fears of a breakdown, the bipolar group reported fears of personal failure (e.g. "Unless I am active all the time, I will end up a failure"). Fears of failure have also been articulated within contemporary psychodynamic accounts (Neale, 1988). In a recent study of autobiographical memory, Mansell and Lam (2004) found that a group of remitted bipolar patients reported frequent past memories related to experiences of personal failure. Within the model, perceived failure represents an adverse outcome over which the individual attempts to triumph through their increased personal success. During states of low activation, it is proposed that rumination on themes of failure predominates and contributes to bipolar depression (Mansell et al., 2006).

The principal aim of the HAPPI scale is as a therapeutic tool. The findings highlight the importance of addressing catastrophic cognitions such as fear of relapse and failure and negative cognitions about other people, as well as positive cognitions, in cognitive behaviour therapy for bipolar disorder (Mansell and Lam, 2003). Cognitive therapy for bipolar disorder is also aimed at targeting beliefs using behavioural experiments (e.g. Dent, Close and Ryder, 2004). The HAPPI scale is designed so that the majority of items set up predictions that can be tested in therapy, and change evaluated (see Mansell et al., 2006). A future aim of the HAPPI is therefore to aid therapeutic developments in this area.

Despite the potential benefits of using this scale, it is critical to state to limitations of the investigation. The participants were not diagnosed independently by the experimenter using standardized criteria. Their current state was not directly assessed using standardized criteria, although to the author's knowledge no scales were completed by patients currently undergoing acute treatment for either mania or depression. There was no psychiatric control group to confirm that the items that distinguish between bipolar patients and healthy controls are specific to bipolar disorder. Also, one can not rule out the possibility that some of these items reflect constructive ways of coping with bipolar disorder, although given their content, it seems unlikely.

The scale has recently received further validation. The findings have been replicated using a brief 30-item version of the HAPPI, including reverse and filler items, in a sample of 56 individuals with bipolar disorder and 39 healthy controls (Mansell and Jones, in press). In this study, the Brief-HAPPI was also cross-validated with second measure of cognitions in bipolar disorder: the Hypomanic Interpretations Questionnaire (HIQ; Jones, Mansell and Waller, in press). The HAPPI scale now requires further investigation using independently diagnosed samples, including a psychiatric control group. The subscales require validation in a factor analysis, and the predicted associations between subscales and symptom clusters also need to be investigated.

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