CHAPTER 1

Introduction to the Second Edition

Much has happened since the writing of the first edition of *Cognitive-Behavioral Therapy for Bipolar Disorder.* The scientific world has grasped what patients and therapists have known for some time—namely, that psychotherapy can be a helpful adjunct to pharmacotherapy in the treatment of bipolar disorder. Studies have demonstrated the efficacy of cognitive-behavioral interventions in the treatment of bipolar disorder for improving outcomes and reducing the risk of recurrence (e.g., Cochran, 1984; Lam et al., 2000; Scott, Garland, & Moorhead, 2001). And, time and practice have allowed for refinement of the methods presented in the first edition.

In this second edition we offer an elaboration of the methods presented previously along with new strategies for preventing relapse, adaptations to the treatment of children and adolescents, ways to tailor the intervention to the specific needs of patients, and interventions for coping with common comorbid psychiatric and psychological problems.

The Therapeutic Alliance

It has become clear that the efficacy of cognitive-behavioral therapy (CBT) rests on the strength of the therapeutic alliance. For the clinician's part, respect for patients' preferences and needs, even when counter to clinical judgment, is a cornerstone of a strong collaborative relationship. For patients, trust in therapists, even when the feedback

is not what the patient wants to hear, is critical to the task. Patients must feel comfortable telling therapists when symptoms are beginning to reemerge, and therapists must be able to give honest feedback to their patients when the warning signs are overlooked or when their actions place them at risk for relapse. Because of its pivotal role in the delivery of CBT, we begin this chapter with suggestions for building and maintaining a therapeutic alliance.

Commitment to Treatment

Unlike acute treatments for unipolar depression or anxiety disorders using CBT, the effective treatment of those who suffer from bipolar disorder requires a longer-term commitment. With its waxing and waning course, symptoms of bipolar disorder will remit spontaneously or with the aid of treatment and will recur with either precipitating events or on their own. The clinician's task is to not only help a person overcome the symptoms of the illness and recover from its psychosocial consequences but also to prepare for its inevitable return. This means that the course of therapy may follow an untraditional pattern. Visits usually occur weekly during the first phase of treatment when skills are taught and symptoms are reduced. As progress is made and patient distress decreases, the interval between visits is lengthened to biweekly and then again to monthly depending on the need of the patient. Once the patient is stable, therapy may take a pause for several months or perhaps years until the services of the therapist are once again needed. Cues to resuming therapy include a return of symptoms, stressful events, or life transitions. If therapy is discontinued for 6 months or more, it is helpful for continuity of care if the patient makes contact with the therapist to provide a progress update, either in writing or with a brief phone call. This helps the therapist to track the progress of the patient and stay aware of major life transitions. When and if therapy resumes, the therapist can help the patient pick up where he or she left off in the story. Rather than following the "no news is good news" rule, therapists should encourage their patients to call in when things are going well or when they have good news. This positive feedback provides positive reinforcement to the therapist for previous therapeutic efforts and communicates to the patient that he or she is of interest as a person not just as a disorder or problem. While in large practices this may seem impossible, a short note or brief phone mail message that takes only a small amount of clinician time will be returned with a better therapeutic bond that can be important when the patient is having difficulties with adherence to treatment or control of symptoms.

Stability and Structure

Psychotherapy is often a stabilizing force in the lives of patients. Therapy visits can provide a structure for marking the passage of time, for monitoring progress, and for achieving goals. Feedback from therapists on changes seen since the last visit or since beginning treatment can help patients gauge their progress and feel good about their accomplishments. Regularly scheduled visits where patients report on their progress between sessions provide opportunities for patients to be accountable, thereby increasing the chance that they will implement the plans made in therapy. Regardless of the time interval, anticipation of therapy visits cues patients to be self-observant and to identify difficulties they hope to address with the therapist. Most people who are not involved in psychotherapy do not regularly take the time to monitor their feelings and actions, nor do they make time to identify personal problems and set goals for improvement. Psychotherapy that focuses on symptom monitoring, goal setting, and relapse prevention provides a structure for self-improvement.

Symptoms and Therapy

There is interplay between a patient's symptoms and his or her experience in the therapy session. Cognitive and affective symptoms have the greatest impact on the therapy process. When concentration is poor or the person is easily distracted, it is hard to accomplish much in session. Sometimes it is necessary to shorten sessions, limit the agenda, or give the patient a mental break between topics of discussion. If the individual's outlook is colored by depression, efforts at reviving hope must be intertwined with other agenda items. Hypomania can begin with subtle cognitive changes. Increased optimism or desire to accomplish more may appear to be within normal limits, especially if it comes on the heels of a depressive episode. This enthusiasm can be very seductive for the therapist who wants the patient to feel better and achieve his or her goals. You might find yourself agreeing with the patient's numerous plans before realizing that the improvements in energy and optimism may be symptomatic.

If the patient has racing thoughts, it is possible that he or she will forget any plans made before the next session occurs. Note taking can help to cue the patient's memory between visits and can help the therapist to keep track of the number of plans made or homework assignments given within a session.

When a patient with bipolar disorder is hypomanic, therapy sessions can be quite enjoyable. There is often an injection of humor that

may have been missing when the patient was depressed. The rate of speech is usually faster, perhaps an improvement over psychomotor retardation that may have made prior sessions seem to drag on. The quicker thinking of the patient and fluidity of new ideas can give the impression that time is being used more efficiently. These sessions often leave the therapist feeling more optimistic and perhaps energized.

In contrast, when patients are depressed and demonstrate some psychomotor retardation, therapy sessions can be slow and difficult for both parties. The therapist may feel compelled to help the patient more, fill in the blanks when word-finding difficulties occur, or show more enthusiasm in hopes that it might brighten the mood of the patient. A clinic day with several patients in a depressed state can leave the therapist feeling drained, discouraged, and useless. It takes some self-monitoring on the therapist's part not to communicate the impotence they may feel in the face of the patient's severe depression. Students of CBT who are instructed to set an agenda and accomplish tasks within session often feel particularly compelled to push their depressed patients to accept interventions, may resort to giving advice when the collaboration is slow, or may feel the urge to give up on CBT altogether.

CBT methods work just as well for therapists as they do for their patients. Therefore, when feeling internal distress during therapy sessions, therapists should be mindful of their automatic thoughts, search for thinking errors, and correct their distortions in logic before they have a negative effect on the therapeutic process. A recent doctoral student was treating a middle-age woman with chronic depression. The student's internal monologue was something like, "This woman is so sick. I can't begin to help her. She probably needs to be in the hospital. I have no idea what I'm doing here. She is bringing me down with her negativity. How much longer do we have until I can get out of here?" While the therapist was able to maintain composure and not show the distress, this train of negative thinking kept the student from selecting a CBT strategy that might have been useful. Instead, there was an overreliance on reflective listening.

Seeing the Person Separate from the Illness

The phenomenon of bipolar disorder can be so overwhelming to the patient and to care providers that it dominates the focus of therapy. It is easy to depersonalize the conceptualization of the problem or to organize treatment around remediation of individual symptoms and lose sight, to some extent, of the impact on the person. People who

suffer from bipolar disorder have difficulty knowing where their symptoms end and their personality begins. As one patient put it, "Am I an impatient person and judgmental toward others or do I have an illness that makes me act that way?" Another asked, "I think I am a natural pessimist given all the tough times I went through as a kid. But on the other hand, could it be that I have been depressed for so long, that I'm just accustomed to thinking negatively?"

People try to understand themselves and their experiences. They want to know what is stable and permanent in their lives and what is likely to be transient or a product of their mental illness. They also want others to see them as people, not as patients, or a case of bipolar disorder, or an oddity. Attention to non-illness-related topics during therapy sessions is one way of communicating to patients that we are interested in them as people. During the first few minutes of most therapy sessions there is time for chitchat or storytelling—disclosures unrelated to illness that give clues to the happenings of patients' lives. Some patients are too verbose and allowing too much time for storytelling can detract from the work of therapy. However, eliminating such discourse altogether in the interest of time may send a message of disinterest in the nonpathological elements of the patient's life.

To keep the focus on the individual and not just the illness, inquire about patients' lives before the illness began, what they are like between episodes, and what stays the same in them regardless of how they feel. Characteristics such as intelligence, sense of humor, social comfort, interests, sources of pleasure, and preferences for activity are elements of the person that are independent of the illness. Other clues about the person behind the illness can be gleaned from knowing about the family of origin, how other members of the patient's family function, and what would have been expected from life had the illness not intervened. When a therapist takes the time to inquire about these things, he or she is showing interest in the person and communicates a value for the patient's personal life.

Preexisting Coping Skills

CBT is a skills-oriented form of psychotherapy. Therapists are equipped with a number of tools for helping patients to manage their moods, restructure their thinking, and cope with their problems. It is easy to assume that the patient is a blank slate and that the skills to be introduced are not part of the individual's behavioral repertoire. As clinicians, we sometimes forget that the people we treat have managed to get along in life long before therapy came along. They may not have managed in an optimal manner, but chances are they possess some

skills and have learned from their experiences along the way. When we assume that people have preexisting coping skills and we communicate that either verbally or through our actions, they get the message that we think they are competent, able to solve problems, and smart enough to know when to ask for help. Validation of this type enhances the collaborative nature of the therapeutic bond—an essential in CBT.

People who are distressed probably coped better with life at times when they were not distressed. Skills do not disappear when the symptoms of bipolar disorder emerge. However, the emotional upheavals, confusion, and loss of motivation and energy can make it difficult for people to access their skills. Many, in fact, forget they even possess coping skills. Their distress coupled with an eagerness to help can lead the therapist to introduce CBT methods before assessing the patient's existing coping skills. Some suggested questions for tapping into patients' skills include the following:

- "If you were not so distressed, how might you handle this problem?"
- "Have you run into this problem/symptom before? What has been helpful to you in coping with it in the past?"
- "What do you think would be a good way to deal with this?"
- "How do you imagine other people cope with things like this? Would that work for you?"
- "What advice would you normally give to a friend if they had a similar problem?"

As will be discussed in Chapter 7, one of the first steps in CBT for bipolar disorder is to get patients to avoid doing things that will make them feel worse. Interestingly, most patients quickly respond with a list of actions, thoughts, and situations that would likely made them more depressed or more manic. They have figured these things out from their experiences with the illness. Likewise, if the clinician inquires about things that might make their situation better, they will very likely come up with at least a few ideas. If reasonable, the clinician should go with their ideas first (e.g., visit with a friend instead of being alone), and then work on adding to their existing coping skills. If their coping ideas sound unreasonable (e.g., take sleeping pills in the early evening and sleep rather than face the loneliness of the evening), get patients to elaborate on their reasons for choosing such an

intervention and then ask them to consider the disadvantages. Often there are short-term advantages for coping choices, such as allowing avoidance of stressful situations, but longer-term disadvantages (i.e., the problem never really gets solved).

If time in psychotherapy is limited, never sacrifice attention to the therapeutic alliance in order to teach another CBT skill. In the long run, if the patient does not feel respected or doubts the compassion of the therapist, he or she will not use the skills outside the therapy session.

A Reformulation of CBT for Bipolar Disorder

The first edition of *Cognitive-Behavioral Therapy for Bipolar Disorder* provided a 20-session protocol including session procedures and homework assignments. That structure was omitted in this second edition to make the intervention applicable to a broader range of individuals with bipolar disorder. Instead, we present and discuss cognitive and behavioral skills for management of the symptoms and problems associated with bipolar as well as some guidelines for selecting the interventions that best meet the patient's needs. When we originally developed the CBT protocol for bipolar disorder we wanted to define the procedures of the protocol in such a way that they could be tested empirically. In the world of clinical research, procedures must be specified with enough detail to be easily replicated across clinicians with varying levels of training and skill. Therefore, it seemed necessary to provide session-by-session instructions. The first edition accomplished this goal. These session-by-session instructions are provided in the Appendix for anyone interested in using the standardized treatment protocol. With that goal accomplished, we now turn our sights toward providing an intervention that is flexible enough and complete enough to be useful with a broader range of patients, including those who have been recently diagnosed, those who have mastered the management of the illness, and those who struggle day to day to achieve symptom remission.

Patients' therapeutic needs will vary depending on their level of acceptance of the illness, experience with symptom management, and degree of symptom control. For example, basic education will be necessary for the patient who is unfamiliar with the illness but may be unnecessary for those who have dealt with it for many years. CBT techniques may be helpful to someone who realizes that his or her

thoughts and feelings vary with the course of the illness but may be too complex for a person who is still questioning the accuracy of the diagnosis. In the sections that follow, suggestions for treatment are provided for three patient groups, those who are newly diagnosed, those who are experienced with the illness but have not yet reached stability, and those who are in sustained remission. Table 1.1 provides an overview of suggested interventions for these three groups of patients.

The Newly Diagnosed Patient

It is not unusual for a patient to have suffered through several episodes of depression or mania before the illness is diagnosed (Suppes 2001). Unless they are severe enough to include psychosis, a dramatic decline in functioning, or behaviors that draw the attention of law enforcement or health care providers, the first few episodes of depression and mania often go undetected or are misdiagnosed as stress reactions or medical conditions, such as the flu. This underestimate of the severity of the situation may be reinforced by the presence of stressful life

TABLE 1.1. Suggested Interventions by Patient Group

Newly diagnosed
Education
Instructions on lifestyle management
Symptom Summary Worksheet
Experienced, but not yet stable
Mood Graphs
Symptom Summary Worksheet
Controlling triggers
Management of cognitive symptoms
Management of behavioral symptoms
Compliance training
Symptomatically stable
Relapse prevention
Maintenance of adherence
Achievement of life goals

events, which is often associated with the first few episodes of depression or mania (Brown & Harris, 1978). In children, the symptoms of mania can be easily mistaken for conduct or attention problems, while depressive symptoms may be attributed to the child's temperament.

Although it may not always coincide with the first episode of illness, a new diagnosis of bipolar disorder is still often received with alarm and disbelief. The patient and his or her significant others may know very little about the illness but often fear the worst. In addition to feeling badly and having difficulty with attention and concentration, the newly diagnosed patient experiences confusion about the treatment, can have misconceptions about the nature or cause of the illness, and is usually uncertain about what to do next. As the reality of the illness begins to settle in, there are usually questions about the impact of bipolar disorder on the patient's life, such as the ability to work or care for family and the prospect of regaining stability. A reasonable reaction to receiving a lifetime diagnosis of a chronic and severe psychiatric illness is denial of its severity, chronicity, or the need for intervention (Dell'Osso et al., 2002; Swanson et al., 1995).

The therapist can be most helpful to the newly diagnosed patient by addressing patient and family member concerns and questions about the illness, the treatment, and the long-term consequences. As the patient and his or her loved ones begin to grasp what has happened, the therapist can help them to connect their observations and experience with the onset and symptoms of the disorder.

> John's wife, for example, knew that something was wrong with her husband, but could not get John or anyone else to listen to her. She knew that he was not acting like his normal self, not treating others with his usual kindness, and even physically changing from lack of sleep and appetite. When he was finally diagnosed with depression, she was relieved that he was getting the care he needed and furious that it had to reach the point of attempting suicide before she could get him the help he needed. John, though clearly depressed for several months, thought it was just work stress. Now that he had a diagnosis, he tried to rethink the past few months to connect what he had been through with what he was being told about depression.

The Experienced but Not Yet Stable Patient

Sandra, like many people who suffer from bipolar disorder, was compliant with her medication on an intermittent basis. People do not usually fluctuate between full adherence to their medication regimens and discontinuation altogether. Studies assessing compliance rates among

people who suffer from bipolar disorder have shown that the majority of individuals periodically skip or alter doses, omit some but not all types of medications, or discontinue use for short periods (Keck et al, 1996; Scott & Pope, 2002a, 2002b; Weiss et al., 1998). Because noncompliance appears to be the rule rather than the exception (Basco & Rush, 1995; Svarstad, Shireman, & Sweeney, 2001), clinicians working with those who have not yet achieved consistent stability of remission should raise the issue for discussion.

> In Sandra's case, her extraordinarily busy home life did not follow a daily routine with regular work hours, meal breaks, or a set bedtime. She was a "soccer mom" with three young children whom she drove to school, piano lessons, sporting events, and tutoring in varying combinations each day. Because she was so intelligent, well organized, and compulsive with her kids and home life, it was easy to assume that she also was organized about taking medications. But her evening schedule varied from day to day, and she often did household chores long into the night. By the time she went to bed she was exhausted and would forget to take her medications. When Sandra reported continued problems with racing thoughts, distractibility, anxiety, and insomnia, her psychiatrist reevaluated her medication regimen and started her on a new mood stabilizer before assessing her degree of adherence with the old treatment plan. When she would not respond to treatment, more changes were made in the regimen. To improve her symptomatic control, Sandra would need to make modifications in her adherence to treatment.

CBT can help this type of patient in a variety of ways. Early goals might include improving adherence to treatment by helping Sandra apply her existing organizational skills to herself. Finding cues to remind her to take medications more consistently might be a start. Chapters 4 and 5 provide a number of interventions for managing treatment compliance.

Another way in which CBT can help the experienced yet still symptomatic patient is to help him or her become familiar with the factors that influence mood swings through "mood graphs," as described in Chapter 6. Once becoming sensitized to these changes, cognitive and behavioral interventions can be taught to help improve coping, regulate sleep, achieve goals, and eliminate distorted thinking patterns. Chapters 7 through 10 cover these interventions.

Work with the symptomatic patient most closely resembles cognitive therapy for acute depression in that skills are systematically taught to help control symptoms and homework is assigned to generalize skills outside the therapy session. Skills are presented in order of complexity

beginning with simple mood, cognitive, and/or behavioral monitoring. Their effect on symptom reduction is closely monitored and success is reinforced. As skills are gained and symptoms remit, the frequency of visits can decrease perhaps from weekly to biweekly to monthly and so on. If symptoms begin to return, the frequency of visits can increase until the patient feels more confident in his or her newfound abilities in symptom management.

The Patient in Sustained Remission

Once the illness is under control, the focus of treatment is the maintenance of gains and improvement in quality of life. Continued psychotherapy can be useful to aid the patient in the surveillance of the illness and prevention of relapse. The content of therapy for the symptomatically stable patient, however, may shift away from symptom resolution to stress management, relationship problems, life decisions, and existential issues as well as relapse prevention.

Patients in sustained remission will usually come to treatment following a psychosocial stressor or present with some life management problem such as marital or job difficulties. In those situations, the illness may not be the initial focus of treatment. However, such a presenting problem does pose an opportunity to inquire about the person's management of his or her illness. Should information or training in relapse prevention be needed, it can be incorporated into the ongoing treatment.

Those who "graduate" from the skills training phase of treatment can be followed at less frequent intervals to help sustain remission and to facilitate their adaptation to the illness, once remission has been achieved. It is not unusual for patients to visit their therapist a few times each year to review progress, set goals for the future, assess symptoms, or seek support for life decisions or changes. Sometimes they use therapy to help themselves stay well when they fear a return of symptoms.

Regardless of the phase of adjustment to the illness and control of symptomatology, the primary focus of CBT is relapse prevention. The hope is that in augmenting medication treatment with CBT, recurrences of mania and depression will occur less frequently, will be controlled earlier in their course, and will remit more rapidly. Adjustment to the illness should mean more time feeling well, less time feeling ill, fewer disruptions in normal routines, and improved quality of life. To achieve these goals, we present various strategies, exercises, and methods throughout the book for (1) helping patients to better understand the nature of the illness; (2) developing an early warning system that symptoms are returning; (3) control of the cognitive, behavioral, and

affective symptoms of depression and mania; (4) enhancement of treatment adherence; and (5) management of stress and resolution of psychosocial problems.

While the sequence of presentation of each component of CBT may vary across patients depending on their needs and abilities, a new patient might find it most helpful to begin with education and symptom detection before moving on to the other areas. Skills for symptom management can be combined with interventions for solving psychosocial problems. It is best to inquire early in treatment about medication adherence problems, as inconsistencies in dosing could preclude control of symptoms with psychotherapeutic methods.

Clinical judgment is needed to help the patient set and prioritize treatment goals. In the interest of developing a collaborative therapeutic alliance, it is generally best to begin therapy by addressing the most pressing problem identified by the patient. In this way, the patient will get the clear message that he or she will play an active role in the therapeutic process and that the therapist is taking his or her concerns seriously.

Table 1.2 gives the reader a preview of interventions to be covered in this book. It can be used to select interventions to address specific patient concerns. Although we suggest a structure for sequencing interventions, it is acceptable to pick and choose interventions that meet the needs of patients at the time of intervention and/or are possible to teach within the time constraints of the therapy. Even if clinicians can spend only a short time with patients at each visit, such as a medication visit, introduction of a few interventions at a time still can add up to a relapse prevention program.

Key Points for the Therapist to Remember

- The efficacy of CBT rests on the strength of the therapeutic alliance.
- The clinician's task is not only to help a person overcome the symptoms of the illness and recover from its psychosocial consequences but also to prepare for its inevitable return.
- Psychotherapy is often a stabilizing force in the lives of patients. Therapy visits can provide a structure for marking the passage of time, for monitoring progress, and for achieving goals.
- Psychotherapy that focuses on symptom monitoring, goal setting, and relapse prevention provides a structure for self-improvement.
- CBT methods work just as well for therapists as they do for their patients. Therefore, when feeling internal distress during therapy sessions, therapists should be mindful of their automatic thoughts, search

TABLE 1.2. Summary of Common Problems and Interventions

Problem	Suggested intervention	Chapter(s)
Does the patient understand the nature of bipolar disorder and its treatment?	Provide education. Complete Life Chart	1, 2, and 6
Does the patient need more information about his or her medication?	Provide information	3
Is the patient in denial?	Provide information. Challenge inaccurate views with Socratic questioning.	4
Is the patient having difficulty accepting the illness and treatment?	Identify stage of adjustment to having the illness, address automatic thoughts, facilitate grieving the loss of mental health.	4
Is the patient angry about having the illness?	Validate feelings. Do not move too quickly to intervention.	4
Is the patient engaging in a bargaining process by self-adjusting medications?	Explain process of adjustment that includes bargaining. Normalize the process. Allow patient to have input in regimen planning.	4
Is the patient's adherence to treatment inconsistent?	Provide education about adherence. Complete compliance contract.	4 and 5
Does the patient know his or her symptoms of depression, mania, hypomania, and mixed states?	Complete Symptom Summary Worksheet	6
Is the patient aware of when his or her mood is climbing or dropping and the factors that influences mood swings?	Complete Mood Graphs	6
Is the patient unsure if symptoms are returning?	Review the Symptom Summary Worksheet.	6
Does the patient engage in activities that seem to worsen mood or other symptoms?	Identify mood triggers and make plan to avoid them.	7
Has the patient stopped engaging in healthy habits?	Increase one positive and decrease one negative.	7
Does the patient have poor sleep habits?	Teach sleep hygiene	7
Is the patient isolated from others?	Increase social contact.	7 and 12

cont.

TABLE 1.2. *cont.*

Problem	Suggested intervention	Chapter
Does the patient engage in any enjoyable activities?	Use activity scheduling to add positive activities.	7
Does the patient feel overwhelmed and unable to take effective action?	Increase activity with graded task assignment or A list/B list.	8
Does overstimulation affect the patient's behavior?	Reduce or control hyperactivity with goal setting or A list/B list.	8
Is the patient's attitude overly negative or is he or she overlself-critical or pessimistic?	Teach Catch, Control, Correct interventions.	9
Does the patient fail to see his or her strengths or fail to see risks of his or her actions?	Address Tunnel Vision by examining the evidence and generating alternative explanations	9
Does the patient seem to be jumping to conclusions or making assumptions?	Address Making Guesses by examining the evidence and generating alternative explanations	9
Is the patient blowing things out of proportion or minimizing?	Address Misperceptions by getting feedback from others and monitoring symptoms.	9
Is the patient overly rigid in his or her thinking?	Address Absolutes with the cognitive continuum, weighing advantages and disadvantages, or problem solving.	9
Is the patient depressed about having bipolar disorder?	Use the Catch, Control, and Correct methods to cope with negative thinking.	9
Does the patient have difficulty coping with psychosocial problems?	Teach problem-solving, decision-making, and coping skills.	10
Is the patient having difficulty concentrating, organizing thoughts, or making decisions?	Teach the Slow It, Focus It, Structure It interventions.	10
Is the patient stressed?	Teach stress management skills.	11
Is the patient having problems with his or her relationships?	Teach CBT skills for improving interpersonal communication.	12

for thinking errors, and correct their distortions in logic before they have a negative effect on the therapeutic process.

- When the clinician assumes that people have preexisting coping skills and communicates that either verbally or through actions, they get the message that the clinician thinks they are competent, able to solve problems, and smart enough to know when to ask for help. Validation of this type enhances the collaborative nature of the therapeutic bond—an essential in CBT.

Points to Discuss with Patients

- For patients, trust in therapists, even when the feedback is not what the patient wants to hear, is critical to the task. Patients must feel comfortable telling therapists when symptoms are beginning to reemerge and therapists must be able to give honest feedback to their patients when the warning signs are overlooked or when their actions place them at risk for relapse.
- People who are distressed probably coped better with life at times when they were not as distressed. Skills do not disappear when the symptoms of bipolar disorder emerge. However, the emotional upheavals, confusion, and loss of motivation and energy can make it difficult for people to access their skills.

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