



Preliminary communication

Schema therapy for bipolar disorder: A conceptual model and future directions



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ABSTRACT

Schema therapy (ST) is an integrative form of psychotherapy developed for complex, chronic psychological disorders with a characterological underpinning. Bipolar disorder is just such a disorder—complex and often comorbid, with demonstrated stable cognitive and personality features that complicate the course of illness. This article presents the reasons justifying the application of ST to bipolar disorder and proposes a treatment rationale and future directions for treatment and research. If well adapted to the characteristics of bipolar disorder, ST might prove to be an effective adjunctive psychotherapy option that attenuates emotional reactivity, reduces symptoms and improves quality of life.

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1. Introduction

Bipolar disorder (BD) is a chronic disorder characterized by frequent relapses of depressive or (hypo)manic episodes. Patients also face substantial residual or interepisodic symptoms (Benazzi, 2004; Paykel et al., 2006), complex comorbidity (Schaffer et al., 2006; Sublette et al., 2009), high suicidality (Judd and Akiskal, 2003), and reduced quality of life (Brissos et al., 2008). While the first line of treatment is pharmacotherapy, adjunctive psychotherapy has also shown promise in improving the course of illness, including psychoeducation, cognitive-behavioral therapy (CBT), interpersonal and social rhythm therapy and family-focused therapy (Basco and Rush, 2005; Colom and Lam, 2005; Frank, 2005; Miklowitz, 2004a; Parikh et al., 2012; Provencher et al., 2010). Although psychosocial treatments have provided benefits, effect sizes have been small to moderate, leaving some room for improvement. Given the complexity of the disorder, Leboyer and Kupfer (2010) have suggested reframing BD to account for its chronic course and impacts across the phases of illness, including acute episodes and nonsyndromal periods. Placing greater focus on the interepisodic phase, this model calls for new treatments that target the chronic disease characteristics and risk factors to prevent affective episodes and improve long-

term disease management. Schema therapy offers considerable potential as just such a treatment.

2. Schema therapy

Schema therapy (ST) is an integrative form of psychotherapy developed for patients resistant to CBT, who have a chronic course of illness (Young, 1990; Young et al., 2003). Drawing on concepts and techniques from a variety of schools of psychology, schema theory takes a developmental approach to the character traits that often underlie severe psychopathology. Although the majority of work on schema theory and schema therapy has focused on personality disorders, research has shown that it also applies to the mood and anxiety disorders (Hawke and Provencher, 2011).

Central to schema therapy are “Early Maladaptive Schemas” (EMSs). EMSs are broad, pervasive themes or patterns relating to the individual and his or her relationships with others, developed during childhood and adolescence and affecting the individual throughout adulthood. EMSs have been shown to mediate the relationship between adverse childhood experiences and adult psychopathology (Carr and Francis, 2010). Because EMSs are considered egosyntonic, clients with chronic difficulties are believed to lack the motivation to change them—a motivation essential to CBT. To target EMSs more effectively, schema therapy integrates techniques from CBT, object relations and Gestalt therapies, transactional analysis, and more (Edwards and Arntz, 2012). Techniques include education about EMSs; cognitive strategies such as validity testing, reframing and evaluating

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coping responses; and experiential techniques, such as imagery dialogues and psychodrama.

ST has proven effective for personality disorders (Giesen-Bloo et al., 2006; Gude and Hoffart, 2008), while the degree of EMS change over a course of ST predicts symptom relief (Nordahl et al., 2005). The feasibility of implementation in general mental health settings has been demonstrated (Nadort et al., 2009), as has its cost-effectiveness (van Asselt et al., 2008). Although its application to mood disorders is only just beginning, ST is being applied to a lengthening list of patient groups with positive results (Cockram et al., 2010; Giesen-Bloo et al., 2006; Gude and Hoffart, 2008; Heilemann et al., 2011).

3. Why apply schema therapy to bipolar disorders?

The growing success of ST with personality disorders raises hope that it may be useful for other complex, chronic disorders, such as BD. Several domains of evidence point to the relevance of ST for BD: (1) early adversity in BD; (2) the role of life events and cognitive appraisals in triggering affective symptoms; (3) similarities between BD and BPD.

1) Early environment in bipolar disorders

ST focuses on attenuating the impact of toxic childhood experiences. Indeed, childhood adversity is extremely common in BD. As many as half of all patients report severe childhood trauma, which is associated with a more complex presentation of BD (Garno et al., 2005). Negative childhood experiences like abuse predict the development of BD and are associated with severity indicators such as an earlier age of onset and greater suicidality (Carballo et al., 2008; Grandin et al., 2007). Many other negative environmental factors have been found in the developmental histories of people with BD: low maternal affection and less secure attachment (Alloy et al., 2005), a family history of substance abuse and psychiatric disorders (Sbrana et al., 2007), early parental loss (Agid et al., 1999), and negative expressed emotion or criticism in the family of origin (Miklowitz, 2004b). Given these high rates of early adversity, ST might be useful in alleviating its long-term impacts for individuals with BD.

2) Life events and cognitive appraisals

Since EMSs are believed to influence the way individuals appraise and interpret life events, ST might lead to healthier cognitive appraisals, thereby attenuating emotional and behavioral reactivity and reducing the risk of symptoms emerging. Life events have been shown to play a precipitating role in depressive and (hypo)manic symptoms (Johnson, 2005). A full 90% of BD respondents have reported stressful events in the three months prior to onset, and 82% prior to their most recent relapse (Bidzińska, 1984). Failure to achieve goals, family conflict, physical health problems, death of a family member and general negative life events have all been implicated in depression (Bidzińska, 1984; Christensen et al., 2003; Johnson et al., 2008), while goal-attainment events have been implicated in (hypo)mania (Johnson et al., 2008, 2000). Several models have been proposed to explain the link between affective states and life events in BD (Mansell et al., 2007; Reilly-Harrington et al., 1999; Urošević et al., 2008). While each model takes a slightly different approach, focusing on concepts such as a dysregulation of the Behavioral Activation System (BAS) and extreme interpretations of changes in internal state, all converge on the notion that cognitive appraisals play a key role in determining whether a life event triggers affective symptoms. With its focus on cognitive appraisals in the form of EMSs, ST is consistent with emerging models of life events in BD.

3) Similarities between bipolar disorder and borderline personality disorder

Many similarities are observed between BD and borderline personality disorder (BPD) (Benazzi, 2006), for which ST has been demonstrated effective (Giesen-Bloo et al., 2006). Both disorders are characterized by affective instability (2001). Bipolar mixed states bear a striking resemblance to BPD, with symptoms such as dysphoria, impulsivity, suicidal ideation and irritability (2001). Residual symptoms frequent among euthymic BD patients resemble the chronic instability of BPD (Benazzi, 2006), while both disorders have a high risk of substance abuse and interpersonal difficulties (Bowden and Maier, 2003). BD and BPD are frequently comorbid, which compromises outcome (Gunderson et al., 2006; Swartz et al., 2005).

BD and BPD are also similar in terms of treatment. Many medications used for BD have some efficacy in BPD, i.e., antidepressants and mood stabilizers (Paris et al., 2007). They also share psychological treatments. Dialectical behavioral therapy (DBT) is among the top for BPD (Bohus et al., 2004) and has been adapted for BD (Goldstein et al., 2007). DBT combines cognitive-behavioral strategies and psychoeducation, both among the treatment arsenal for BD (Basco and Rush, 2005; Bauer and McBride, 2003). It also includes training in mindfulness skills, like the mindfulness-based cognitive therapy that has shown promise for BD (Williams et al., 2008). Since BPD and BD share many characteristics and treatments, they may also share treatment success with ST.

4. Evidence for the application of schema theory to bipolar disorder

Some have discussed the possibility of applying ST to BD, suggesting that EMSs might interact with life events to trigger symptoms and complicate the course of illness (Ball et al., 2003; Newman et al., 2002). Ball et al. (2006) inserted a brief introduction to the schema model into a CBT group for bipolar patients, which produced better results than treatment as usual. However, the treatment was not full schema therapy and the report makes no mention of EMS scores, limiting the conclusions that can be drawn.

New research supports the applicability of schema theory to BD. One study compared the EMSs of patients with BD to those with BPD and controls (Nilsson et al., 2010). Although BPD was associated with significantly higher scores on most EMSs, participants with BD had significantly higher scores than controls on *Insufficient Self-Control* and a trend toward higher scores on nine more EMSs. Another study examined the EMSs of individuals at risk of BD, finding elevated scores on most EMSs, with a particular risk profile consisting of *Entitlement/Grandiosity* and *Insufficient Self-Control/Self-Discipline*, together with the absence of *Emotional Inhibition* (Hawke et al., 2011). In a subsequent study in a clinical sample, *Entitlement/Grandiosity* and *Insufficient Self-Control/Self-Discipline* were again found to be high in BD, along with *Approval-Seeking/Recognition-Seeking*, while *Emotional Inhibition* remained typically low (Hawke and Provencher, 2012).

These core EMSs can be interpreted in the context of the cognitive and behavioral characteristics of BD. People with the *Entitlement/Grandiosity* EMS are considered competitive, dominant and selfish (Young et al., 2003; Zeigler-Hill et al., 2011). Feelings of grandiosity are a diagnostic criteria of (hypo)mania (American Psychiatric Association, 2001), while signs of grandiosity, high success-oriented cognitions and elevated confidence have been found in the cognitive profile of BD independent of symptoms (Eisner et al., 2008; Johnson et al., 2005; Lam et al., 2004). The *Insufficient Self-Control/Self-Discipline* EMS is characterized by difficulty restraining emotions,

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