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Chapter 8

Adaptation of Cognitive Behavioral Analysis System of Psychotherapy in a 29 Year Old Female Patient with Chronic Major Depression and Antecedent Dysthymic Disorder Who Switched Under Combined SSRI/CBASP Outpatient Treatment into Bipolarity: A Case Report

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Additional information is available at the end of the chapter

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1. Introduction

Affective disorders are among the main psychiatric illnesses reaching from **m**ajor **d**epressive **d**isorder (MDD) and **b**ipolar **d**isorder (BD) to schizoaffective disorder.

Under a historical perceptive, the beginning of the conceptualisation of affective disorders was done in 1854, when Jean-Pierre Falret named recurrent episodes of mania and depression as *folie circulaire* (Sedler & Falret, 1983). This was followed by Emil Kraepelin's definition as *manic-depressive psychosis*, which include the observation by Kraepelin that symptom-free intervals and acute illness episodes alternates in these patients (Kraepelin, 1921). A categorical distinction between two spectra with different diseases and different clinical courses, i.e. the *unipolar* spectrum and the *bipolar* spectrum, was first introduced by Karl Leonhard in 1957 (Beckmann, 1999).

With respect to the unipolar spectrum, MDD is among the most debilitating diseases worldwide with high disability compared with all human diseases (Falagas, Vardakas, & Vergidis, 2007). Lifetime prevalence of MDD is up to 20% once a life (Williams et al., 2007). In one third of the cases, the course of the illness is chronic, with often "difficult to treat" patients suffering from high social disturbances, resulting in a higher rate of mortality

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compared to pure MDD, higher economic costs and bad long-term prognoses compared to pure MDD (Schoepf et al., 2007). Chronicity is defined as unipolar depressive disorder lasting two or more years with less than a two-month period during which the individual reports no symptoms. The rating is contingent upon the density of symptoms at the time of assessment, every day in chronic MDD and more days than not in dysthymia. Manic, mixed or hypomanic episodes are listed as exclusion criteria (Schoepf & Neudeck, 2011). Studies assessing the course of unipolar depression (15 years range) indicate that approximately 15%-46% of the patients initially diagnosed with non-psychotic MDD or chronic MDD develop their symptoms into BD (Walden & Grunze, 2006). It is important to note, that 80% of initially unipolar diagnosed patients who suffer of a psychotic MD-episode develop their symptoms into the classic phenotype of manic-depressive illness within 5 years. This phenomenon is called *switch*. In general, the most obvious characteristic of BD are mood fluctuations and mental excitement those usually cause a marked change in the patient's baseline level of daily functioning (AACAP 1995). In paediatric BD, instability of mood in the early course of the disorder often interfere with the child's capacity to develop or maintain stable representations of self and others and results more often than not in difficulties to develop or maintain self-esteem. Bipolar children show co-morbidity rates of 13% with conduct disorder, 88% with oppositional defiant disorder, 98% with attention deficit hyperactivity disorder, and 11% with pervasive developmental disorders. In "older adolescent-onset" BD (aged 14-19 years) the symptom presentation, natural course of illness, phenomenology, and mental co-morbidity appear more similar to the classical symptoms described for adults in DSM-IV. In adult patients with manic depressive illness the life-time prevalence of concomitant occurrence of BD and other psychiatric disorders is 100% for one co-morbid axis-I disorder and 96% for > two co-morbid axis-I disorders with the highest co-morbidity rates for substance use disorders (alcoholism 30% -50%) and anxiety disorders (45%). Life-time prevalence rates of BD range from 5 % to 10% in the general population for all types and subtypes within the bipolar spectrum (Angst 1998). Further important public health issues are that BD (1) is a lifelong cyclical illness, (2) that the peak onset of BD is between 15–30 years, (3) that suicide is highest within 10 years of the onset of BD, (4) that frequent and repeated hospitalizations occur more often than not, (5) that the rate of promiscuity is increased compared to the general population, (6) that financial disasters, repeated job changes and/or losses are often associated with acute illness states, (7) that the coexistence of BD with other psychiatric disorders results in higher recurrence rates, higher suicide rates and a greater extent of psychosocial impairment, (8) that non-adherence to medication is common, and (9) that BD is associated with an increased risk of cardiovascular mortality on the long run of the illness. Commonly, a BD disorder needs approximately eight years to be correctly diagnosed (Wagner & Bräunig, 2000). One reason of the delay in correct diagnosis is that the disorder frequently starts with MD-episodes (60-80 % of all cases; (Wagner & Bräunig, 2000), so that primarily a MDD is diagnosed (Walden & Grunze, 2006). Further more, - clinical pathological - hypomanic or manic symptomatic states are often, mainly at the beginning of an episode, without psychological strain for the involved person (M. Hautzinger & Meyer, 2002). To be finished, the currently existing diagnostic instruments to validate manic or depressive symptoms might be impaired by self-evaluation (M. Hautzinger & Meyer, 2002).

With respect to disease classification within the bipolar spectrum, the current prominent psychiatric classification systems, which are used in clinical and research settings, are the *Diagnostic and Statistic Manual of Mental Disorders* (DSM-IV; American Psychiatric Association, 1994), and the *International Classification of Disease* (ICD-10; World Health Organization, 1992). In general, both don't differ in the descriptions of the symptomatology of BD, but there are differences regarding the definition of the subcategories: In the DSM-IV, the occurrence of depressed and hypomanic episodes during the course of the illness is subsumed under the diagnosis BD-II, whereas the occurrence of MD-episodes and manic or mixed episodes are classified as BD-I. In the longitudinal course of BD-I, mayor mood episodes are demarcated by either partial or full remission for at least 2 month or a switch to an episode of opposite polarity. The categorical approach of DSM-IV (Text Revision 2000) conceptualises four heterogeneous phenotypes of BD and works out two subtypes of BD-I and BD-II according to episode frequency:

1. BD-I, the classic "phenotype" of manic-depressive illness, that is diagnosed when a patient experiences at least one full manic episode severe enough to require psychiatric hospitalisation or is accompanied by DSM-IV psychotic features of psychotic misperceptions of environmental stimuli. DSM-IV manic features can include elation, irritability, and increased energy with hyperactivity, racing thoughts, pressured rapid speech, a decreased need for sleep, and an increased involvement of pleasured activities. BD-I has a life-time prevalence of approximately 1% of the world's population.
2. The "softer" BD–II phenotype, defined as one or more MD-episodes and hypomania over lifetime. BD-II is more common in females, young patients and early-onset patients with a strong association to depressive mixed states, atypical features of depression, and rapid-cycling features.
3. Cyclothymic disorder, defined as a period of 1 year or more in which there are depressive and hypomanic symptoms that do not meet full criteria for either a MD-episode or a manic episode, but that do interfere with daily functioning.
4. BD **n**ot **o**therwise **s**pecified (BD-NOS): Patients, who have very brief (shorter than a week), although sometimes severe, episodes that do not fall within the DSM-IV definition of rapid-cycling but are classified as having BD not otherwise specified.
5. Rapid cycling (RC): The phenomena of rapid cycling (first introduced by Dunner 1974) in the long-term course of BD is defined as the occurrence of at least four episodes (MD, manic-, mixed-, or hypomanic episode) within a given year.
6. Ultra-RC and Ultradian-RC: Cycle lengths as short as 48 hours or even 24 hours are sometimes referred to as Ultra-RC (episodes occurring within the course of days to week) and Ultradian RC (moods shifts within a day), respectively (Kramlinger 1996).

At present, it is unclear whether RC, ultra-RC and ultradian-RC are distinct subtypes of BDs or just a clinical phenomenon toward one extreme on a continuum of episode frequencies (Bauer, 1996). Rapid cycling has been associated with female gender, BD-II, a longer duration of illness, a positive family history of mood disorders, the presence of clinical or subclinical hypothyroidism, non-response to prophylactic lithium treatment, and the use of

antidepressants (Shelton, 2000). In general, rapid-cycling is associated with increased resistance to standard pharmacological treatments and a poorer prognosis than classic BD (Calabrese, 2001). Some of the subcategories are not present in the ICD-10, but can be relevant for diagnostic and pharmacological considerations. Other subtypes which were conceptualized by clinical researchers include the BD-III1/2 (multiple substance abuse caused hypomanic- and manic episodes) and BD-IV (individuals who develop depression later in life from a lifelong background of hyperthymic temperament) concept. This concept was first introduced by Gerald Klerman in 1981 (Young & Klerman, 1992). Akiskal (Akistal, 1995), enlarged the concept by Gerald Klerman and defined six different types of bipolar disorders based on clinical features. However, in the current classification systems, these subtypes are not included. Nevertheless, current researchers dispute the use and the clinical relevance of these concepts. With respect to the classification of schizoaffective disorder as a mood disorder there is a worldwide controversy and a poor agreement rate, i.e. schizophrenia, schizoaffective disorder and BD with psychotic symptoms overlap in many dimensions as they involve as well psychotic as affective symptoms.

Current pathophysiological models of affective disorders imply that a large number of pathophysiological mechanisms which have been implicated in MDD and BD as well. Beside genetic and environmental risk factors, abnormal molecular factors, aberrant neuronal mechanisms and dysfunction of neuronal networks are known to have important implications for the disease progression, see Figure 1 (Schneider et al., 2011).

Common treatment models of BDs combine individual pharmacological and psychotherapeutic strategies (Grunze & Walden, 2003). The treatment of acute hypomanic or manic episodes is normally implemented during inpatient therapy. In exceptional cases, like if there is a good psychosocial network, a good compliance and only slight symptoms, it might be possible to treat acute hypomanic / manic symptoms with an outpatient form of therapy. Many recent studies have demonstrated benefits from the addition of psychotherapy to pharmacotherapy, especially when an individual is still in an acute episode (Frank et al. 2005). From a perspective of disorder-specific psychotherapy, several research groups have adapted revised behaviour theory approaches like cognitive therapy of Beck, interpersonal theory approaches like Klerman's interpersonal therapy and family-focused psycho educational treatment of BD. The most promising and best evaluated adaptation seems the **I**nterpersonal and **S**ocial **R**hythm **T**herapy (IPSRT) by Ellen Frank, a therapy which built on a model of aetiology that is widely accepted in the field. IPSRT strongly focuses on modulating both biological and psychosocial factors to mitigate the patient's circadian and sleep-wake cycle vulnerabilities, to improve overall functioning, and better manage the potential chaos of bipolar symptomatology (Frank et al. 2000).

1.1. Overview of chapter

In this chapter-article, we describe the adaptation of **C**ognitive **B**ehavioral **A**nalysis **S**ystem of **P**sychotherapy (CBASP), the only model of psychotherapy that is specifically developed for chronic MDD, to a female early-onset chronically depressed outpatient who switched

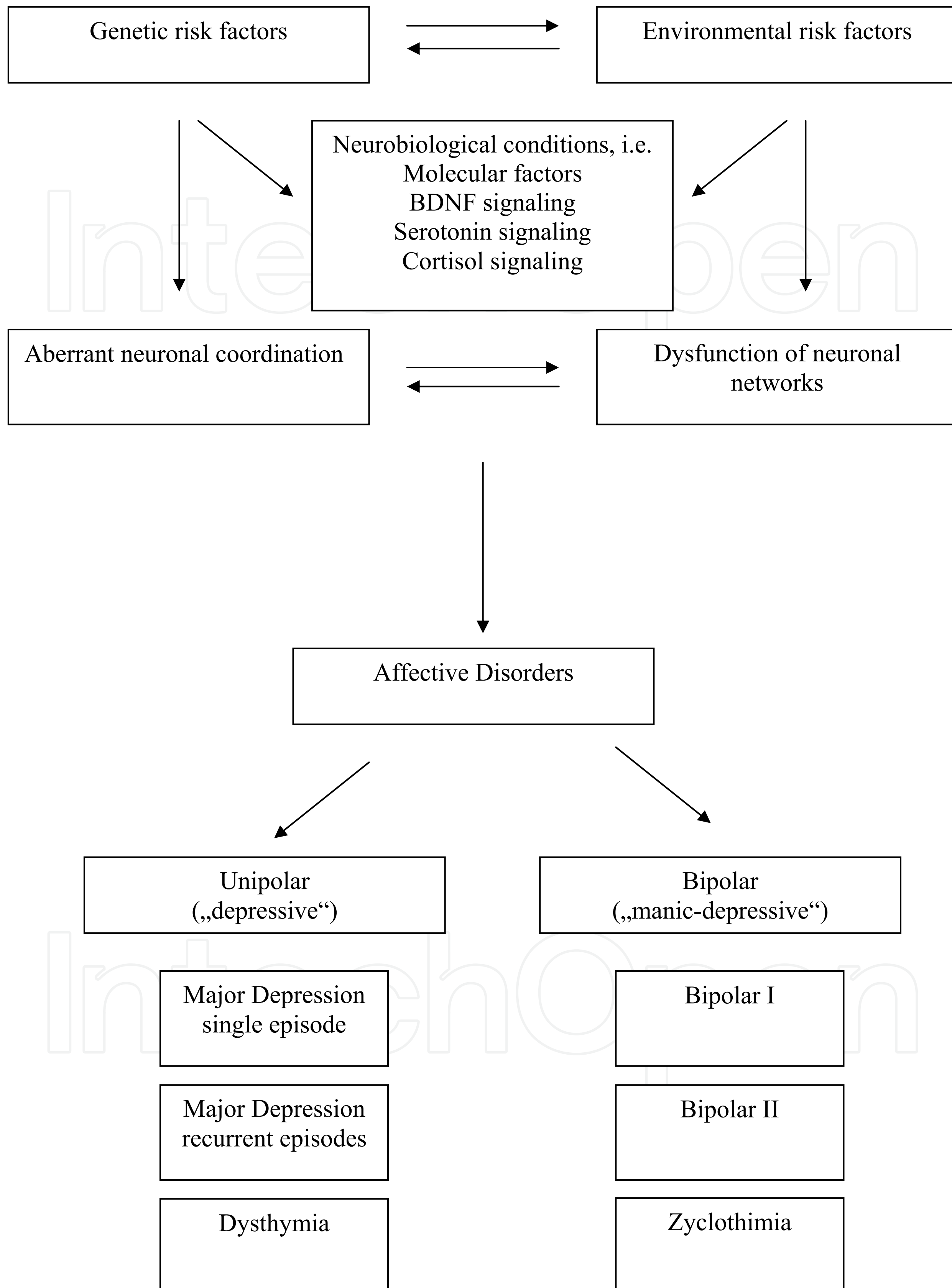

Figure 1. Pathophysiological mechanisms of affective disorders and dimensional classification of affective disorders spectrum.

into a first hypomanic episode during the outpatient treatment course. The reported case is a 29-years aged female patient, who was initially diagnosed as chronic MDD with antecedent dysthymic disorder during inpatient treatment in University Frankfurt, at that time suffering from a moderate(-to severe) MD-episode. There was no direct or indirect evidence for an earlier manic, mixed or hypomanic episode. After 27 sessions of CBASP – that included a prolonged SOH procedure according to a modified protocol - she reached a stable state of full syndromal remission and achieved in-session two-way circular functioning. She switched under combined SSRI/CBASP outpatient treatment for 6 months, without any obvious forewarning or stressful encounter, into a first hypomanic episode (Type II) (ICD-10 F 31 [WHO, 1992]). The hypomanic episode was followed by a prolonged phase of mood instability before another hypomanic episode occurred one year later. The applied psychotherapy from session 28-50 faithfully followed the conception of CBASP in an adapted way. We attempt to illustrate which part of the CBASP concepts might be useful in acute hypomanic/manic episodes of BDs. We suggest that the presented strategies here might be implemented in an advanced form of BD treatment strategies.

2. CBASP

CBASP was originally developed by James McCullough for the specific treatment of chronic depression as an outpatient protocol that is not yet evaluated for the treatment of BD (McCullough, 2000, 2006). CBASP`s interventions include elements from both classical and cognitive behaviour therapies as important elements of "third generation" psychotherapy methods that deal with models of self-regulation with respect to motivational and perceptual factors in meta-cognitive processing. In contrast to any other psychotherapy model the therapist is viewed as the primary choreographer of behaviour change using a disciplined personal involvement role that stands in contrast to the relationships the early-onset chronic depressed patient has experienced with his **S**ignificant **O**ther's (SOs) during childhood (Schoepf & Neudeck, 2011). CBASP demonstrated significant therapeutic effects for treatment patients with chronic MDD with antecedent dysthymic disorder as well as chronic MDD without antecedent dysthymic disorder. Especially, CBASP has demonstrated greater efficacy than antidepressant medication for patients with histories of childhood trauma ranging from childhood maltreatment (sexual abuse, physical abuse or emotional abuse) to experiencing neglect to witnessing domestic violence or to having a life-threatening injury (Schoepf et al., 2007; Schoepf & McCullough, 2009; McCullough et al., 2010; Schoepf & Penberthy, 2010; Schoepf & Neudeck, 2011; McCullough, 2012; Schoepf, in this book).

Treatment resistance or chronic MDD is quickly becoming a clinical reality, with up to 15% of patients not responding to intensified pharmacological and psychotherapeutic approaches. McCullough suggests that chronically depressed individuals have a primitive cognitive functioning that is unaffected by the logical reasoning and reality-based views of others. In addition, these patients most often perceive that the causal influences in their life are beyond their personal control. They have a poor ability to use a problem-focused coping style and problems are described in a global way, resulting in feelings of hopelessness and

helplessness. This results in a pervasive degree of social isolation, which worsens the depressive mood. CBASP specifically focuses on central mechanisms of affective and motivational regulation via an interpersonal contemporary learning acquisition model, utilizing disciplined personal involvement to aid acquisition of perceived functionality in the patient. For example, a basic CBASP technique is to enable the patient to recognize his own impact on the therapist's behaviour (adapted and modified from the 2010 proposal written by K.Penberthy: "CBASP: New applications and Neurocognitive mechanisms").

3. Main treatment concepts of bipolar disorders

There are the following recommended practices for a positive prognosis of the long-term course of BD: Good responses to the pharmacological treatment, avoidance of misuse of drugs and alcohol, early detection of acute episodes, social capabilities and a good relationship to attachment figures. Current BD treatment models combine individual pharmacological and psychotherapeutic strategies (Grunze & Walden, 2003). The pharmacological treatment includes mood stabilizer, antidepressant, benzodiazepine and neuroleptic medication (Wagner & Bräunig, 2000) in dependence of the respective illness state. Psychotherapy has to be seen as supplementary to the pharmacological treatment, not instead of. The psychotherapeutic measures are divided into different stages, acute (manic / depressive) treatment, maintenance (inter-episodic) treatment and prophylaxis. But it is important to see the whole spectrum of illness states, not only single stages. The best suitable starting time to begin an outpatient psychotherapy is after the retreat of acute symptoms (M. Hautzinger & Meyer, 2011). There are a number of classical psychotherapeutic methods used in the treatment of BD.

In general, the psychotherapeutic concepts set the focus on improvement of compliance for medication, psycho education, relapse prevention, prophylaxis and social rhythms strategies (Meyer & Hautzinger, 2000). Examples of approaches focusing on those subjects are the *cognitive-behavioral therapy* (CBT; (Basco & Rush, 2005), the IPSRT, (Frank, 2005)), the *family-focused treatment approach* (FFT; (Miklowitz & Goldstein, 1997)) and the *psychoeducation-based group therapy (PEG)*(Schaub, Bernhard, & Gauck, 2004).

The FFT is a cognitive-behavioral-based method that focuses on the integration of attachment figures into the therapy. The goal is to modify dysfunctional thoughts of the attachment figures, to modify social skills and to identify early symptoms.

The IPSRT (Frank, 2005) consists of three modules, including compliance for medication, social rhythms and reduction of interpersonal difficulties. Interpersonal psychotherapy (IPT) including maintenance IPT, brief IPT, and interpersonal and social rhythm therapy for the treatment of BD have recently adapted for both group and individual treatment of both BD and unipolar disorders. In addition, Frank recently completed a study with Italian researchers (University Pisa) that aims to achieve a better understanding of the clinical importance of sub-syndromal mood and anxiety conditions and their impact on the outcome of interpersonal psychotherapy and SSRI for depression.

In Germany, the most established cognitive-behavioral program for the therapy of BD is the CBT approach of Meyer and Hautzinger (2004), which contains four modules, including psycho education, prophylaxis, and relapse prevention, modification of dysfunctional cognitive beliefs and formatting of additional interpersonal and social skills. The module psycho- education has the aim of training the patient about the cause of the illness and treatment possibilities. During prophylaxis, patients are trained to identify and modify early symptoms through the keeping of a daily diary. Also, they are taught to improve social rhythms. During acute hypomanic / manic episodes, the program tries to reduce acute symptoms, e.g., sleep disturbances, blowing money, agitation and distractibility. To reduce such symptoms, the manual shows strategies to reduce the activity level, to reduce social contacts and to introduce breaks and calm activities.

4. Case history

In the following sections, we describe the psychotherapeutic treatment of a 29-years-aged female patient, who was initially diagnosed with “difficult to treat” chronic MDD with antecedent dysthymic disorder during inpatient treatment in the University Frankfurt, at that time suffering from a moderate (-to severe) non-psychotic MD-episode. The inpatient treatment lasted 6 weeks, followed by an outpatient treatment, lasting 25 months, using an adaptation of the CBASP. This was the first in- and outpatient psychiatric and psychotherapeutic treatment for the affected patient. After six months of combined SSRI/CBASP outpatient treatment, the patient switched from a state of syndromal remission, without any obvious forewarning or stressful encounter, into a hypomanic episode (Type II) (ICD-10 F 31 (WHO, 1992)). This was followed by a prolonged phase of mood instability before another hypomanic episode occurred one year later.

4.1. Psychiatric and medical history

Clinically, the patient suffered from “double depression”, made obvious by social withdrawal, loss of energy and drive since the age of 17 years with superimposed MD-episodes. Eight weeks in advance of the inpatient treatment, worsening of depressive symptoms had led to the onset of a new MD-episode: Mood changed for the worse, she cried a lot. In addition, there was also a loss of concentration and a loss of social, domestic and job-related capacities. This was followed by sleep disorders, undifferentiated anxiety and uneasiness. Just before she wanted to start outpatient treatment, she felt like wishing to commit suicide and told this to her sister. The operationalized diagnosis of a recurrent depressive disorder, moderately (-to severe) episode (ICD-10 (WHO, 1992), F 33.1) together with an antecedent dysthymic disorder (F 34.1) (”double depression”) was ensured using the Structured Clinical Interview for DSM-IV (SKID-I and SKID-II, (Wittchen, Zhao, Abelson, Abelson, & Kessler, 1996). There was neither any direct or indirect sign for a prior hypomanic episode nor of hypomanic features (irritability, mood swings, crowded thoughts, sexual arousal, psychomotor acceleration, increased talkativeness) during the current MD-episode. There was no significant somatic history. The patient stated to smoke 20 cigarettes / daily; no other drugs were consumed.

4.2. Autobiographical history

The female patient was born and raised in a family with father, mother and a younger sister (- 2 years). The father worked as a teacher, the mother was a housewife. There was no family history of psychiatric disorders according to DSM-IV criteria (American Psychiatric Association, 1994). She reported a close relationship to the other family members, but, the patient noted that, beside this close relationship, there was a lot of pressure to perform. During her childhood, the patient was a successful athlete of track and fields athletics. This was very important for her relationship to her father, because he joined every training and competition session and assisted her a lot. At the age of 17 years, her performance decreased due to a lack of body height. She called this event as a personal "trauma", because this was a break in the close relationship to her father. Since then, she refused to do any sports. The patient finished school at the age of 19 years, and then she began a formation in the field of advertising. She broke off the education after one year due to conflicts with her boss. After a few months of unemployment, she began to work in shifts work as an employee in a company. Further, she married in the age of 30 years and is living together with her husband, without a child.

5. Progress of therapy

During the six-week combined pharmacologic and psychotherapeutic inpatient treatment, the course of the symptoms was measured weekly using the Beck Depression Inventar (BDI-II, (M. Hautzinger, Keller, & Kühner, 2006)). The BDI-II is a 21 item multiple-choice self-report questionnaire. It is one of the most widely used instruments for measuring the severity of depression. The applied psychotherapy during this phase mainly included basic psychotherapeutic strategies with an emphasis on supportive elements in order to relieve the patient from symptom pressure. This was followed by 50 outpatient psychotherapeutic sessions (each lasting 45 minutes), during a time span of 25 months. An adaptation of CBASP was used after the switch into bipolarity. The frequency of the sessions differed between weekly during acute episodes and monthly during symptom-free episodes. The psychotherapy was complemented by pharmacological treatment prescribed from a psychiatrist.

5.1. Progress of medical treatment

During the inpatient stay, a pharmacological treatment with Citalopram (40 mg / d) to reduce the acute depressive symptoms was initiated. This resulted in a reduced score of the BDI-II: Week 1: 41 points, week 6: 35 points; view Figure 1). The following progress of medical treatment reflects the clinical perspective of the responsible psychiatrist, showing a changed symptomatology including hypomanic symptoms according to the operationalized criteria. The antidepressant therapy was reduced during the first hypomanic episode six months after the start of the outpatient therapy (Citalopram 30 mg/d), and a neuroleptic treatment (Aripiprazol) was initiated. Under this medical treatment, the patient gained 10

kg of weight during a time span of 3 months most likely due to unrestrained eating behaviour. This was the reason to change the pharmacological therapy to the mood stabilizer Lithium. The following combined antidepressant and mood-stabilizing therapy was continuously kept up until the patient stopped it rapidly without consultation. This was followed by a second hypomanic episode. The treatment was then changed to Valproat going on through the whole following therapy time span without any further problems. The progress of medical treatment after the switch reflects the diagnostic dilemma in a switch situation. Although - according to the operationalized criteria - definitely a switch into BD-II is described, it has to be indirectly assumed that the responsible psychiatrist has done his clinical decisions from a clinical perspective of a transition from early-onset chronic MDD to BD-I.

5.2. Outpatient CBASP therapy before switch into bipolarity

At the beginning of outpatient therapy the symptom-severity was reduced to a slight characteristic (BDI-II sum score: 25 points). The patient mainly reported social withdrawal, undifferentiated anxiety and bad social skills as core symptoms at this state. Interestingly, during the whole time span of therapy, the outside appearance of the patient was eye-catching, with multi-coloured clothes and hair. The psychotherapy faithfully followed the conception of CBASP in an adapted way including two treatment phases.

5.2.1. Sessions 1-10: First out-patient treatment phase (pre-SA phase)

The major therapeutic goals of the early treatment phase (pre-SA phase) are summarized in the Schoepf chapter in this book. Here, the major treatment goals were:

1. That she learned to self-monitor the intensity of her depression and to work through the results of the BDI II from a behavioral perspective together with the therapist.
2. To shape a sensitive patient-therapist relationship in the early treatment phase. The patient’s stimulus value was initially hostile-submissive, i.e. the patient had always a jacket and a cap on at the beginning of out-patient therapy, evoking *hostile-dominant* responses in the therapist. For enhancing and accelerating the up-coming tasks, the therapist always responded to the patient in a non-dominant and friendly way. In addition, the SOs (parents, husband, sister) of the patient were asked by the patient to fill out the ***I**mpact **M**essage **I**nventory* (IMI-R; (Kiesler, 1987). The feedback was positive (friendly, adorable, interesting person) so that the patient was very impressed. The resulting changes in her hostile-submissive interpersonal messages, as perceived by the therapist and the supervisor, were associated with decreased anxiety and approaching behaviour. After six therapeutic sessions, the patient appeared, for the first time, without her cap. Additional elements comprised fundamental and additional CBASP specific therapeutic interventions that are described elsewhere (Schoepf & Neudeck, 2011).
3. The reconstruction of the patient`s *emotional learning history* in antecedent consequent way. This was achieved by applying the SOH procedure over a prolonged time interval of up-to 8 sessions of therapy with eliciting the *causal theory conclusions* of the patient,

continued by setting up the ***t**herapy **h**ypothesis* (TH). Key past encounters with her SOs were characterized by a lot of pressure for performance, strong devaluation, ignoring the feelings of the patient and a lot of dominant behaviours. As described in 4.2, there was a meaningful personal trauma at the age of 17 years, when she was refused to do any further track and fields athletics. Beyond this age, the father did no longer support her and he stopped to give her any heed. The father was one of her SOs who had exerted a negative formative influence with high impact on her life. Additionally, shortly after the end of the track and fields athletics, her mother asked the patient to leave her parents' home. The patient remembered that "the mother's motivation was the wish for her daughter to be autonomous". However, in the view of the patient, this was a meaningful refusal by one of her SOs. The reconstruction of the emotional learning history resulted in the identification of the dominant interpersonal-emotional theme domain that she had to "perform well all the time" as she "always under-achieved the expectations of others". According to CBASP`s TH construct, in this patient in-session events during which she makes mistakes towards the therapist (i.e. not doing her homework or coming late) evoke in her (Pavlovian) fear of punishment (mistake and failure area). The TH includes the hypothesized core content of the patient`s in-session interpersonal fear that most likely reflects the patient's expectancy of the therapist's reactions toward the individual (McCullough et al., 2010). The TH *was*: "If I make a mistake during the session, Ms. Oertel will punish me in some way".

Altogether, the first treatment phase lasted 10 therapeutic sessions. This was uncommonly long compared to McCullough's original outpatient protocol due to the generalization of the heavy personal trauma (sports) into all other social and performance situations.

5.2.2. Sessions 11-27: Second out-patient treatment phase (SA/IDE phase)

The SA/IDE phase of treatment started with introducing the technique of ***S**ituational **A**nalysis* (SA) with the major treatment goal to help her to start thinking and acting more according to formal operational criteria (Schoepf *et al.*, 2007).

At a glance, SA has the aim to train the patient in a highly structured sequence to perform in a goal-orientated way. However, SA can also be seen as a top-down intervention that strengthens the executive functions by: (1) reinforcing and sensitizing the perceptive and interpretative performance by means of attention-focused interventions under aspects of awareness; (2) building-up the ability to control and perform with competence in a given situation, by means of contrasting past behaviour with the desired goal behaviour; and (3) shaping mental functions to think and act according to formal operational criteria. In this patient, SA work predominantly focussed on the counter-conditioning of fear reactions those occurred during the practising of realistic and goal-oriented behaviour in the elicitation phase of SA work.

Second, the core content of the patient's interpersonal fear was counter-conditioned due to ***I**nterpersonal **D**iscrimination **E**xercise* (IDE) work. IDE work helped this patient to perceive how the patient-therapist relationship differed from her past relationships with her SOs due

to the various forms of the IDE - that were employed in relation to the progress of therapy (Schoepf, this book). The technique of IDE was formerly described by us as a bottom-up technique that is assumed to be the major CBASP technique of (explicit) in-session acquisition learning (Schoepf et al. 2007; Schoepf & McCullough, 2009; Schoepf et al., 2011; Schoepf & Neudeck, 2011). For a further description of the use of the various forms of the IDE see the I-SOH chapter in this book (Schoepf).

Learning context: The patient usually brings into therapy a completed SA worksheet of either a distressing or pleasant daily living encounter that happened during the last week. The review of the worksheet is usually carried out in two consecutively phases on the flip-chart (some therapists additionally distinguish a learning and transfer phase for didactic reasons).
Elicitation phase: In the first step the interactional (social) event has to be described by the patient from an observational-describing focus. The beginning and the end point have to be clearly addressed. During the second step the patient's cognitive-emotional attribution is elicited. Relevant and accurate forms represent self-referential emotional or self-referential cognitive interpretations, as well as describing (interactional) interpretations and action interpretations. In the following three steps the verbal and nonverbal interactional responses, the actual outcome (AO) in behavioural terms, and the way the patient wanted to behave in the situation – his desired outcome (DO) - are elicited. In the case of a distressing event a clear discrepancy appears between the patient's AO and DO. At this point a condition of negative-reinforcement is created by the therapist. The induced cognitive dissonance is later reduced by the finding of more adaptive strategies. The last two steps are important for the patient in order to become aware of the discrepancy between his AO and DO. The patient has first to decide if he got what he wanted by comparing his AO with his DO. Then he is gently asked to explain why he did not behave in the way he wanted to behave.
Remediation phase: In this phase, the therapist and patient work together on solutions for the patient, to behave in a way that is efficient with respect to his DO. Shaping of functional interpretations (first step) as well as shaping of missing behavioural aspects of the DO (second step), learning summary (third step), transfer to a future situation and skill training (fourth step) amplifies both the new element of reaction and experience as the conditional relationship between positive efficacy beliefs and positive outcome expectancies. Transfer is maximized because the target situations come out of the daily living experiences of the patient.

Table 1. SA: Description of learning context, elicitation phase and remediation phase (adapted from Schoepf & Neudeck, 2011).

In the course of this phase, the patient initially showed an increase in interpersonal anxiety, e.g. through short-term cancellation of the sessions. The patient needed exercising several SA exercises and IDE`s with positive feedback in a friendly manner by the therapist to

perceive that the relationship to the therapist did not depend on her performance during the tasks. This was visible in the following obvious signs: After 13 therapeutic sessions she appeared without her jacket. Also, during the 13th session, the patient asked the therapist, for the first time, a personal question (about clothes). This was interpreted as reduced interpersonal distance. The IDE showed that the patient felt to be closer to the therapist than before. Simultaneously, the BDI-II sum score was reduced to 9 points. From then on, the patient always participated without the cap and the jacket. To receive positive feedback of a social interaction partner was a new and unexpected experience of the patient with respect to her interpersonal history. The positive feedback together with the IDE by the therapist helped the patient to reduce interpersonal anxiety and was therefore useful in this case although this is not common in early-onset chronically depressed patients. In the following sessions, a marked reduction of interpersonal anxiety developed, which the patient was able to keep up outside the therapy. With respect to CBASP`s skills teaching dimension the patient started to keep a diary of the relationship between behaviour and consequences ("effective diary"). For example, the patient was asked to test the consequences of doing any kind of sports (which she had been refused to do for years, see above). Through this exercise, she learned that physical training improves mood. Since that moment, the patient reintegrated sports into her leisure time. At the end of the SA/IDE phase she reached a stable state of full syndromal remission, i.e. here defined as a BDI-II sum score <=10. As described in the I-SOH chapter by Schoepf, the course of treatment in this young female patient demonstrates that under out-patient conditions an adapted CBASP protocol with a prolonged SOH procedure works best with a dosage of up-to 35 sessions in patients with chronic MDD and antecedent dysthymic disorder.

5.3. Sessions 28-50: Adapted CBASP out-patient therapy after switch into bipolarity (adapted phase)

5.3.1. First hypomanic episode

Starting at session 28, the patient switched, without any obvious forewarning or stressful encounter, into a hypomanic episode (Type II) (ICD-10 F 31 (WHO, 1992)). She had less need for sleep, elevated mood and energy level, extravagant style, expanded self-esteem, increased consumption of nicotine and alcohol, she talked more often and had higher mood. The pharmacological treatment was changed as described in 5.1. The hypomanic state lasted 14 days.

Behaviour-related strategies were adopted to reduce acute symptoms, i.e. calm activities, more breaks between activities, quiet environment. Another weekly inventory (beside the BDI-II), the *Bech Rafaelsen Mania Scale* (BRMAS)(Bech, Rafaelsen, Kramp, & Bolwig, 1978), asking for hypomanic / manic behaviour, was introduced into the therapeutic sessions. The scores of the BRMAS increased between the 28th and the 30th session (up to 41 points), but decreased in the following weeks. In addition, the technique of ***C**ontingent **P**ersonal **R**esponsivity* (CPR) was applied more frequently than before in a "here to now" way to consequate "difficult to treat" inpatient behaviour by disclosing personal responses and

feelings produced by the "chaotic" behaviour of the patient in order to help her constructive solutions to emerging interpersonal and social dilemmas. For a further description of the CPR exercise the interested reader may refer to the Schoepf I-SOH chapter in this book.

5.3.2. Inter-episode

The acute hypomanic episode was followed by a prolonged phase of mood instability (beginning at the 34th session, end at the 44th session), lasting approximately one year. In the inter-episodic phase, we added psycho educative elements that included the concept of "time disturbers" to reduce disease risk and fall-back and to increase the compliance of the patient. Other important motivational elements of this therapy phase included abbreviated forms of SAs to improve goal-orientated (action-outcome) behaviour in order to improve (1) self-efficacy, (2) to adapt action-outcome expectancies, (3) and to help the patient to better perceive that a specific situational behaviour (desired outcome) leads to a positive emotional state. To improve the social rhythms, the patient filled in weekly the "so-called" effective diary. Topics of this diary were to improve shift work, to continue the physical trainings and to improve social rhythms. Every session began with the request of potential hypomanic / manic or depressive symptoms, using the BDI-II and the BRMAS inventories. During the inter-episodic phase, the BDI-II scores ranged between 8 and 12 points, the BRMAS scores ranged between 18- 22 points. The frequency of the therapeutic sessions was changed to monthly sessions.

5.3.3. Second hypomanic episode

After one year of inter-episodic phase, another hypomanic episode (ICD-10 F 31 (WHO, 1992)) came up. The patient reported that she had reduced the psychiatric medication four weeks ago without any consultation. The symptoms were similar to that one year before, starting with less need for sleep, elevated mood and energy level, extravagant style, expanded self-esteem and increased consumption of nicotine and alcohol. The hypomanic state of this episode lasted 18 days. The most important therapeutic step was to prove the pharmacological treatment as described in 5.1. This was followed by behavioural strategies, e.g. reduced social contacts, reduced activities and introducing of breaks and calm behaviour. Interestingly, IDEs were helpful to increase the compliance of the patient: the patient reported that, based on her close relationship, she wanted to follow the track of the therapist, independently of her opinion that she did not need any therapeutic elements at that moment of subjective "well-being".

6. Discussion

In this chapter-article, we described the successful outpatient treatment of a 29-years aged female patient who was initially diagnosed with chronic MDD and antecedent dysthymic disorder, who switched during combined pharmacologic and CBASP out-patient therapy after six months into a hypomanic episode. After a prolonged phase of mood instability, another hypomanic episode came up one year later.

Symptomatology during the treatment

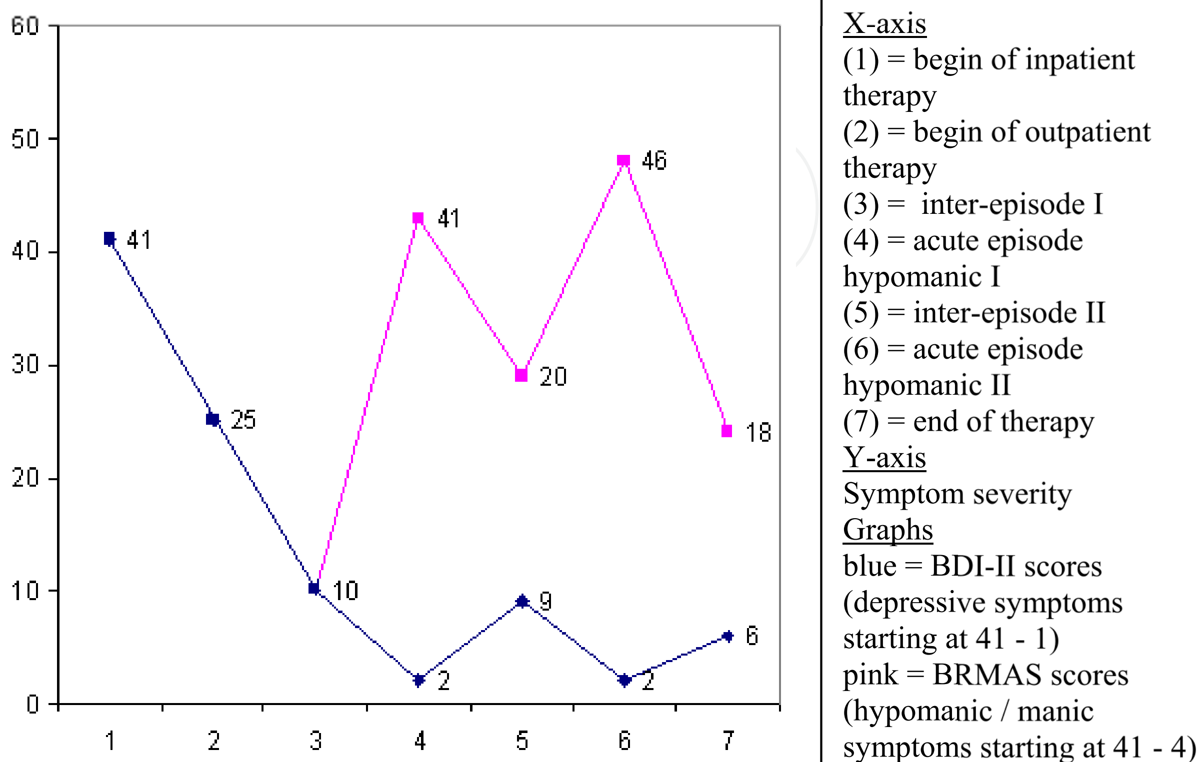

Figure 2. Course of the scores of the scale for depressive (BDI II) and hypomanic / manic (BRMAS) symptoms across the different episodic stages.

6.1. Resume of specific CBASP therapeutic strategies

The psychotherapeutic treatment followed an adaptation of CBASP. Therapeutic elements of this case report included a number of treatment steps, including diagnostic stage, the evaluation of emotional cognitive and behavioural attitudes, the reconstruction of the emotional learning history in antecedent-consequent way, setting up the TH, SAs and cognitive-behavioural strategies, IDE`s using the person's individual *Hot-spot*, and CPR (see Table 2).

The outpatient treatment of the chronically depressed state included three treatment phases based on CBASP elements. During the first phase of treatment, the emotional learning history was determined over a prolonged time interval with eliciting the causal theory conclusions of the patient, continued by setting up the TH. The TH was set up in absence of the patient. Further elements comprised fundamental and additional CBASP specific therapeutic interventions that are described elsewhere (Schoepf & Neudeck, 2011). During the SA/IDE phase of treatment, we started to conduct SA with the goal to help the patient to start thinking and acting more according to formal operational criteria (Schoepf et al, 2007), as well as IDEs to integrate painful experiences with her Significant Other's early in her life

into her self-concept (Schoepf & Neudeck, 2011). Additionally, the personal style of the patient changed from hostile-submissive into friendly-dominant. From a perspective of psychosocial functioning, she was upgraded in her position (job) and the relationship to Significant Others (father, sister) was improved. The cognitive type has the aim to contrast different attitudes. In this case, the cognitive type leads to an increase in the compliance and motivation of the patient. Also, the patient renewed healthy behaviour, like doing sports.

Element	**Session Nr.**	**Notes**	**Stage of Treatment**
Emotional history	1-10	High level of pressure, lot of pressure to perform, strong devaluation, ignoring the feelings of the patient and a lot of dominant characters in the family	1st treatment phase
Core causal theory conclusions	10	Example: „ I cannot fulfil the expectations of others“.	1st treatment phase
Interpersonal theme domain	10	Making Mistakes	In between phases
TH	10	„If I do a mistake during the session, Ms Oertel will punish me in some way”	In between phases
Evaluation of Significant Others	3-10		1st treatment phase
Interpersonal discrimination exercises (IDEs)	11-50		2nd treatment phase And after switch
Controlled personal involvement	11-50		2nd treatment phase and after switch
Situational Analysis	11-27		2nd treatment phase
Learning of specific interpersonal behaviours	11-27		2nd treatment phase
Effective diary	11-27		SA
Reduction of activites,	28-30		Acute hypomanic state treatment
Psychoeducation	31-34		Acute hypomanic state treatment
- relapse prevention - behavior effect training - Training of learned strategies	34-44		Inter-episode treatment
Compliance for medication	44		Acute hypomanic state treatment

Element	Session Nr.	Notes	Stage of Treatment
Reduction of activities, keeping a diary, reduction of social contacts, behavior rules, IDE (cognitive type)	44-46		Acute hypomanic state treatment
Repition of relevant topics of the psychotherapy End of therapy	47-50		End of the outpatient treatment

Table 2. Therapeutic elements of the outpatient treatment.

After the switch into bipolarity, especially during the treatment of the two acute hypomanic episodes, the technique of CPR predominated in a “here to now” way to consequate “difficult to treat” in-session behaviour by disclosing personal responses and feelings produced by the “chaotic” behaviour of the patient in order to help her constructive solutions to emerging interpersonal and social dilemmas. In the inter-episodic phase we added psycho-educative elements that included the concept of “time disturbers” to reduce disease risk and fall-back and to increase the compliance of the patient.

Situation	Session Nr.	Topic	Notes
Strip of the cap	6	Closeness	Remarkable reduction of BDI II score (9 points)
Open the jacket	10 - 13	Reduction of interpersonal anxiety	
Strip of the jacket	13	Reduction of interpersonal anxiety	
Short-term cancellation of sessions	13-16	Increase in interpersonal anxiety, anxiety to fail	
To give an opinion	11 -27	Reduction of interpersonal anxiety	To bring forward outside the therapeutic sessions
Improvement of Compliance, cognitive type of IDÜ	28-31 44-47	- interpersonal relationship - closeness	Acute hypomanic state

Table 3. Changes of the interpersonal behavior of the patient during the course of the outpatient treatment.

However, in contrast to classical cognitive-behavioural therapy, CBASP works predominantly goal-directed and interpersonal. Specific CBASP elements were used to improve behaviour-related and interpersonal-related attitudes. There was no need for assessing and restructuring dysfunctional cognitions or related cognitive interventions in addition to the SA remediation phase work, because of the aim to lay the focus of the therapy on behavioural induced changes. The success of the presented case report is visible

through the fact that the patient did not need any inpatient treatment during a time-span of 25 months, which is – in our opinion - very impressive for that kind of serious mental illness. Despite the two acute hypomanic episodes during the treatment, the psychotherapeutic and pharmacological treatment was able to successfully reduce the acute symptoms both in the depressive and the hypomanic pole. The patient also improved directly important aspects: She renewed her sports activity during the chronically depressed state, she was upgraded in her working position at the end of the second treatment phase, and she improved her social skills and her interpersonal behaviour which resulted in better relationships to Significant Others. A critical point, which could not yet change, was the shift work which is inappropriate for patients with BD disorders. This might be important for the long-term prognosis of the patient. The positive course of the treatment over the long run leads to the assumption that the implementation of specific CBASP interventions in BD patients might be successful in the adaptation of emotional and motivational processes, and might help to develop a new treatment option for BD patients.

6.2. Conclusions

The represented case report demonstrates that interpersonal and behaviour-related CBASP strategies that include the disciplined personal involvement of the therapist were successful in reducing acute symptoms and maladjusted interpersonal behaviour, increasing over the long run the compliance and reducing disease risk and fall-back into maladapted depressive behaviour in this patient who switched into Bipolarity during the course of out-patient treatment. The main change in the core belief system of the patient was, in our opinion, connected to her belief of SOs. The restructuring of helplessness memories in antecedent-consequent way during the early treatment phase on the one hand, and the addressing, training, and thereby repairing of developmental trauma memories through IDE work in the SA/IDE treatment phase on the other hand, resulted in a high safety impact of the therapist on the hypothesized core content of the patient`s in-sessions fear that later generalized outside the therapy room. The resulting change in maladjusted interpersonal behaviour was clearly marked in (1) a change of the personal style from hostile-submissive into friendly-dominant, (2) and a positive adaptation of beliefs and predictions concerning self-efficacy and action-outcome learning. In addition, (3) the carefully timed self-disclosures during CPR interventions inhibited maladjusted rule-guided behaviour and counteracted the patient’s maladaptive interpersonal assumptions in both hypomanic episodes and the inter-episodic phase, which was characterized by on-going symptom fluctuations in both the depressive and the hypomanic pole.

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