CHAPTER 1

Bipolar Disorder and Mindfulness

Bipolar disorder is a mood disorder characterized by periods of hypomania or mania, and most often includes episodes of depression, interspersed with times of recovery. In its various forms bipolar disorder affects approximately 5.7 million Americans (Kessler, Chiu, Demler, Merikangas, & Walters, 2005; U.S. Census Bureau, 2005) and takes a huge toll on the affected individuals, as well as their families and friends. As most people who suffer from bipolar disorder will tell you, bipolar disorder is a recurrent, chronic, and often debilitating illness. Despite taking "mood-stabilizing" medications, people with bipolar disorder typically experience many recurrences and are rarely symptom-free. They have trouble succeeding in school, holding jobs, maintaining relationships, and getting along with others. Psychological treatments for bipolar disorder such as cognitive-behavioral therapy, family therapy, or interpersonal and social rhythm therapy may help to ease the burden. With one or more of these treatments, patients can delay the onset of new mood episodes and shorten their duration. These therapies, adjunctive to medications, can help patients function better and improve their quality of life. Yet, despite these advances, many patients continue to struggle in all areas of life.

This book describes a mindfulness-based cognitive therapy (MBCT) for people with bipolar disorder. The 12-session group program coupled with individual therapy sessions is designed to treat those who have experienced many mood episodes; have struggled with chronic, pervasive depressive and manic residual symptoms; and who may also have concurrent disorders such as anxiety disorders. We felt mindfulness would be a meaningful addition to the menu of therapeutic choices available to individuals with bipolar disorder adjunctive to medication.

The practice of mindfulness has been reported to produce beneficial effects for a number of psychiatric, functional somatic, and stress-related symptoms, and therefore has been increasingly incorporated into psychotherapeutic programs (Baer, 2003; Grossman, Niemann, Schmidt, & Walach, 2004). "Mindfulness" refers to paying nonjudgmental attention to experiences in the present moment (Kabat-Zinn, 1990). It has been conceptualized as comprising two components. The first is regulating attention in order to maintain focus on the immediate experience. The second involves approaching one's experience with curiosity, openness, and acceptance toward the encountered experiences, regardless of their valence and desirability (Bishop et al., 2004). Much of the emphasis of established psychosocial treatments for bipolar disorder adjunctive to medication is on "doing." Patients learn to monitor their moods, adjust their lives, acquire skills that help them to take medication regularly, adjust their rhythms, and learn to communicate and problem-solve more effectively. Nonetheless, many patients continue to experience days with depression, mood elevation, anxiety, irritability, worry, and rumination. Mindfulness involves learning to relate to these experiences differently—being rather than doing, mindfully. As we will see, changing the way of "being" with unpleasant and upsetting experiences, as well as pleasant experiences, can have a profound impact on how these experiences unfold for a person who has bipolar disorder. That said, the purpose of this treatment program is not simply to learn to "get used to" unpleasant experiences, or to compete with well-established treatment approaches that have been successfully used by people with bipolar disorder. Rather, our approach integrates three areas of expertise: (1) clinical knowledge about bipolar disorder, (2) therapeutic knowledge in established treatments for bipolar disorder, and (3) experience in mindfulness. We look at mindfulness as an additional therapeutic avenue that supplements the options that are already available for individuals with bipolar disorder. For this reason, our treatment incorporates and adopts many tools that have already been developed and successfully used in the treatment for bipolar disorder, and combines them with mindfulness.

WHO IS THIS BOOK FOR?

This book is for clinicians who already have experience in treating patients with bipolar disorder using other treatment modalities, such as cognitive-behavioral therapy (CBT), family-focused therapy (FFT), interpersonal and social rhythm therapy (IPSRT), or dialectical behavior therapy (DBT), and who are familiar with bipolar disorder and would like to expand their repertoire of therapeutic avenues to mindfulness. This book is also

for experienced mindfulness teachers who would like to treat people with bipolar disorder. This book provides information about bipolar disorder, as well as guidance on how to adapt mindfulness to the signs and symptoms of bipolar disorder. The book also describes how to incorporate established cognitive-behavioral treatment strategies that we consider essential into the treatment of bipolar disorder.

THE ORGANIZATION OF THIS BOOK

We start this book by reviewing the most important clinical aspects of bipolar disorder. What are the symptoms of bipolar disorder? What are the different forms of bipolar disorder and how common are they? Clinicians also want to develop an appreciation for bipolar disorder as a recurring, chronic disorder, which despite interspersed periods of "recovery," often dramatically impacts people's functioning and quality of life. As mood-stabilizing medications remain the first line of treatment, we cover the most common medications and pharmacological treatment approaches, as well as their challenges. Our mindfulness-based program adopts treatment elements from other, already established treatments for bipolar disorder, and blends those with elements of mindfulness. Therefore, we also briefly describe the most commonly available adjunctive psychotherapies for bipolar disorder, their techniques, and what is known about their efficacy. This leads us to our rationale that mindfulness may be a meaningful addition to the portfolio of approaches to bipolar disorder. In this context we will review already established mindfulness-based treatments (mindfulness-based stress reduction, mindfulness-based cognitive therapy for depression), and what we know about the benefits of regular mindfulness practice (e.g., increased concentration abilities, more mood stability). We also review pilot studies that have been done in groups of people with bipolar disorder, including our own pilot studies at the Bipolar Clinic and Research Program at Massachusetts General Hospital in Boston. This MBCT program is designed to treat people with bipolar disorder who have experienced many mood episodes; have struggled with chronic, pervasive depressive and manic residual symptoms; and who may also have concurrent disorders such as anxiety disorders. As described in more detail in Chapter 2, it is a 12-session group program coupled with individual sessions. In Chapter 3, we provide helpful information about how to diagnose bipolar disorder and its associated problems. Chapter 4 covers the format and content of individual sessions supplementing group meetings. The remainder of the book includes a session-by-session description on how to implement the group part of this program and the handouts. This includes treatment elements such as how

to conduct mood monitoring (Session 1), detect warning signs for mood episodes (Session 2), and design behavioral emergency plans for mood elevation (Session 3). Instructors will also learn how to teach yoga exercises (Sessions 1 and 2), sitting meditations, and body scans (Sessions 2–8), as well as how to transfer mindfulness into daily life (Sessions 1 and forward) and how to apply mindfulness to symptoms of depression or mania when they arise (Session 3 and forward). Increasing self-compassion, well-being, and mindfulness toward pleasurable experiences becomes a topic midtreatment, once basic mindfulness exercises have been introduced (Session 9 and forward). Instructors will also learn how to implement loving-kindness meditations and translate those into participants' daily lives. Group sessions are coupled with regular individual sessions (see Chapter 4) that are used to tailor mindfulness to participants' special needs and to provide help with crisis situations that often occur over the course of the treatment. In this book we have included scripts for the guided meditations we use in this treatment. Most participants find it helpful to have audio recordings of these meditation instructions to use in their home practice. We have created recordings of these instructions that can be downloaded for participants (see p. viii for details).

BIPOLAR DISORDER: THE BASICS

Symptoms

In this book, we concentrate on two of the most common forms of bipolar disorder: bipolar I disorder and bipolar II disorder (for a full list of bipolar disorders, see DSM-5, the latest edition of the *Diagnostic and Statistical Manual of Mental Disorders*). Both forms of bipolar disorder require a period of abnormally elevated or irritable mood (American Psychiatric Association, 2013). This includes symptoms such as elevated, expansive, or irritable mood coupled with being overconfident and more talkative than usual, having grandiose ideas, thoughts being more fluent and speeded, as well as being distractible, experiencing flight of ideas and decreased need for sleep associated with increased levels of activity often involving pleasurable and/or risky activities (e.g., overspending or gambling). The critical distinction between bipolar I and II disorder is the duration and severity of the mood elevation episode. People who experience expansive or irritable mood and the associated symptoms for at least 4 days, but not severe enough so that they markedly impair functioning (e.g., at work, in relationships), have a hypomanic episode (not a manic episode). If they have also experienced one or more episodes of major depression (see below), they meet criteria for bipolar II disorder.

Grandiose ideas and paranoia coupled with a lack of recognition of how unrealistic those ideas are (lack of insight) are examples of mood-congruent psychotic features consistent with a manic episode, provided mood elevation and the associated mania symptoms have lasted for at least a week. The presence of psychotic symptoms can easily be mistaken as signs of a non-mood psychotic disorder (Meyer & Meyer, 2009). As a sign of mania, psychotic features need to be congruent with the mood (e.g., grandiose) and only occur during the manic episode. The manic episode cannot be drug-induced or due to any other medical factors; otherwise it would yield a diagnosis of substance/medication-induced bipolar disorder (American Psychiatric Association, 2013). The presence of a manic episode leads to a diagnosis of bipolar I disorder. A history of depression is not a requirement for a diagnosis of bipolar I disorder, unlike bipolar II disorder. An episode of a major depression consists of depressed mood, and/or loss of interest or pleasure for most days over 2 weeks. Symptoms may include loss of energy, oversleeping, difficulties concentrating, being slow, lack of activity, and feeling completely worthless. The experience of depression may vary over time—for example, symptoms include becoming more anxious and irritable, ruminating, feeling restless, having difficulties falling and staying asleep, concentration difficulties, lack of appetite, and contemplation of suicide. When both manic and depressive symptoms are present at the same time, a person experiences what is called a mixed state. Mixed features (the simultaneous presence of symptoms of both depression and mania) are quite common. Also, full-blown mania and depression typically do not appear suddenly. Usually, there is a ramping up in symptom severity (called "prodromal signs") that can be used as warning signs that foreshadow the onset or worsening of hypomanic or depressive symptoms (Carlson & Goodwin, 1973). As we will later see, these warning signs, particularly for mood elevation, open a small window of time where one can intervene both medically and behaviorally in order to prevent their spiraling into hypomania or mania.

Prevalence and Course

Together, bipolar I and II disorder affect 2.1% of the U.S. population (Merikangas, Akiskal, et al., 2007). One percent of Americans have bipolar I disorder and 1.1% have bipolar II disorder. Another 2.4% of Americans suffer from less severe forms of bipolar disorder characterized by subthreshold hypomania with major depressive episodes, or recurrent hypomanic or subthreshold hypomanic episodes without major depression (Merikangas, Akiskal, et al., 2007). Bipolar disorder affects men and women equally. Most individuals (50–67%) experience their first episode before the age of

18 (Perlis et al., 2004). Between 15 and 28% develop the disorder before the age of 13 (Perlis et al., 2004). Bipolar disorder rarely occurs by itself. Ninety-eight percent of individuals with bipolar disorder have another lifetime psychiatric disorder that warrants treatment (Merikangas, Ames, et al., 2007). The most common include lifetime alcohol and substance dependence (60%) and anxiety disorders (50%) (Simon et al., 2004).

Nearly everyone experiences multiple episodes of mania and depression over their lifetime, but depression and ongoing chronic, pervasive depressive symptoms are the most difficult aspects of bipolar disorder to treat. The Collaborative Depression Study, a study that followed patients with unipolar and bipolar disorder, found that patients with bipolar disorder changed their symptom status an average of six times per year (Judd et al., 2002). Over the 13-year follow-up period, patients with bipolar disorder spent almost half of their time symptomatic, and depression accounted for three times as many weeks as mania or hypomania (Judd et al., 2002).

Findings from clinical and large-scale epidemiological studies also challenge the traditional view of bipolar disorder as an illness where mood episodes are interspersed with periods of full symptomatic and functional recovery (Judd et al., 2002; Kessler et al., 2006; Trede et al., 2005). Problems at work and with social and family functioning occur in 90% of individuals with bipolar disorder (Merikangas, Ames, et al., 2007). Tohen and colleagues (Tohen et al., 2003) followed people with bipolar disorder who had been hospitalized with their first manic episode for 2 years after discharge from the McLean Hospital near Boston. While nearly all of them (98%) reached a point during those 2 years when they did not meet criteria for mania anymore, only 72% reached a level where they had few or no symptoms. Only 43% within those 2 years returned to their level of functioning as it was the year before their manic episode. Similar results were reported by Keck et al. (1998) who found that in the 12 months following hospitalization for a manic or mixed episode, only 24% of patients were able to go back to work and socialize at their pre-episode levels of functioning (Keck et al., 1998).

Work-performing difficulties are common in individuals with bipolar disorder. In the National Comorbidity Survey Replication (NCS-R) study, a large nationwide epidemiological study of 9,282 people, individuals with bipolar disorder on average missed the equivalent of 65 days at work in a year (Kessler et al., 2006). This translates into the equivalent of 1 week of work missed every month. Depressive symptoms greatly contribute to people's ongoing functioning difficulties. In the NCS-R study, the number of workdays missed doubled for people who had a depressive episode in the past 12 months (Kessler et al., 2006). In the Collaborative Depression Study, when followed over time, functioning was worst when people were

depressed (Judd et al., 2005). Changes in functioning over time mirrored changes in depressive severity (Judd et al., 2005), but people's functioning remained impaired even when patients remitted from a previous mood episode (Judd et al., 2008). At times, patients achieved restored levels of functioning in most areas (relationships, etc.), with the exception of work performance, where patients remained impaired a significant percentage of the time (Judd et al., 2005, 2008). With recurrent episodes and poor interepisode functioning, many patients with bipolar disorder have difficulties holding onto a job. In the Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD), a large, multisite study funded by the National Institute of Mental Health and conducted at medical centers and universities in the United States, 15% of patients were disabled and 20% were unemployed (Kogan et al., 2004). Similar results have been obtained by the Stanley Foundation network: of 253 patients with bipolar I or II disorder, only one in three worked full time outside the home. More than half were unable to work or worked only in sheltered settings (Suppes et al., 2001).

Treatment

Medications

Bipolar disorder presents unique challenges for medication treatment, one of which is how to treat the multiple phases of the disorder: acute mania or hypomania, acute depression, maintenance preventative treatment, and the management of subsyndromal symptoms and comorbid conditions (Bersudsky & Belmaker, 2009). Few patients respond to monotherapy, and most require multiple medications to relieve their symptoms and distress (Ghaemi et al., 2006).

The overarching principle of pharmacological treatment of bipolar disorder considers multiple spheres of dysregulation including mood, energy, sleep, anxiety, and cognition, each of which can change depending on episode status, and each of which can be the target of pharmacotherapy. Acute manic and hypomanic episodes are the hallmark of bipolar disorder and are usually responsive to available treatments (Bersudsky & Belmaker, 2009). Broadly, the categories of medications effective for these episodes include the classic "mood stabilizers": lithium, valproate, carbamazepine, and the antipsychotics (first and second generation, including haloperidol, perphenazine, risperidone, aripiprazole, olanzapine, quetiapine, ziprasidone, asenapine, and lurasidone), either alone or in combination. Lamotrigine, a repurposed anticonvulsant (as are valproate and carbamazepine), appears to have unique preventative antidepressant properties, but weaker acute

antidepressant effectiveness and maintenance antimanic effects (Geddes, Calabrese, & Goodwin, 2009).

Acute bipolar depressive episodes and depressive symptoms present the biggest challenge for patients with the fewest options (Belmaker, 2007). Treatments approved by the U.S. Food and Drug Administration (FDA) include the combination of olanzapine and fluoxetine and quetiapine monotherapy. Antidepressants have not been shown to be effective for bipolar depression in rigorous studies (Nierenberg, 2010), although the field continues to struggle with the discrepancy between the research data and practice. Clinicians prescribe antidepressants along with antimanic agents as the most common response to bipolar depression (Frye, 2011). A key randomized placebo-controlled trial from the STEP-BD study failed to find an advantage of antidepressants over placebo when added to a mood stabilizer (Sachs et al., 2007). Nonrandomized observational data from the same study found no difference between those who had a bipolar depressive episode and subsyndromal hypomanic symptoms and those who were or were not treated with antidepressants (Goldberg et al., 2007). Lamotrigine monotherapy showed acute antidepressant efficacy in a key trial in 1999, but subsequent studies failed to replicate this finding (Calabrese et al., 1999). A meta-analysis of all randomized studies of lamotrigine monotherapy found that, in aggregate, the studies found a modest effect of lamotrigine monotherapy (Geddes et al., 2009). But a key study of lamotrigine or placebo added to lithium found a statistically and clinically significant effect for lamotrigine (van der Loos et al., 2009). Thus, even though lamotrigine is approved by the FDA for the prevention of mood episodes, based on innovative prevention studies, many clinicians prescribe lamotrigine for the management of acute bipolar depressive episodes.

Even with state-of-the-art guideline concordant treatment, the outcomes of many bipolar patients remain suboptimal. Anxiety occurs frequently, and although some secondary analyses have found that medications such as quetiapine can have a beneficial effect on anxiety, no targeted studies have examined this important question. Many clinicians turn to benzodiazepines to help. Fatigue, too, persists in many and can either be a symptom or a side effect from other medications. Stimulants such as methylphenidate and awake-promoting agents such as modafinil are frequently prescribed, although with a risk, albeit uncertain, of exacerbating mania. Insomnia can also persist and cause problems with the rhythms of daily living and predispose bipolar patients to become manic. No specific pharmacological treatments have been studied, but hypnotics (e.g., zolpidem, eszopiclone, or benzodiazepines such as lorazepam) are used for insomnia. Finally, cognitive and executive dysfunction impairs bipolar patients

even when they are outside of acute episodes, although there are no FDA-approved medications for cognitive impairments in bipolar disorder.

Despite pharmacotherapy, most patients will experience recurrence of mood episodes (Gitlin, Swendsen, Heller, & Hammen, 1995). Further complicating the picture, less than half of the patients who are prescribed medications are fully adherent to their medication regimen (Colom, Veita, Tacchi, Sanchez-Moreno, & Scott, 2005). Within 1 year after being hospitalized for a mixed or manic episode, up to 60% of patients discontinue their medications or do not take them regularly (Keck et al., 1998). A large community study found that the average length of adherence to mood-stabilizing medication was a little over 2 months (Johnson & McFarland, 1996). Not taking prescribed medications, or only taking them irregularly, dramatically increases the risk for relapse and rehospitalization (Keck et al., 1998; Scott & Pope, 2002).

Psychotherapies

Among other issues, psychological treatments have addressed the reasons for patient nonadherence to their medications. In the first study of CBT for bipolar disorder, Susan Cochran, at the University of California, Los Angeles, worked with bipolar patients for 6 weeks to address reasons for medication nonadherence (Cochran, 1984). Medications are disliked for multiple reasons, with medication side effects (sedation, weight gain, etc.) being just one of many. Not surprisingly, if side effects are experienced as intolerable, patients often do not take the medications for very long. However, in a Europe-wide survey of patients, side effects were ranked low (3%) on a list of reasons why patients felt bothered by taking medication (Morselli & Elgie, 2003). If severe side effects are not the reason, why then do patients discontinue medications? Reasons include the lack of insight into the chronic nature of bipolar disorder, lack of understanding of the need for medication treatment (Peralta & Cuesta, 1998), denial of the severity of the disorder, and fear of dependence (Morselli & Elgie, 2003). People are also ashamed about the need to take psychiatric medications, may see medications as unnatural, and don't want their feelings controlled by the medications. Others believe that if they just try hard, they can control mood without medications (Scott & Tacchi, 2002). Discontinuing medication can also be a prodromal sign of mood elevation (Keck et al., 1998), leading patients to believe that they do not need medication. Addressing these issues can increase patient medication adherence. At the end of the treatment (as well as at the 6-month follow-up) in Susan Cochran's 1984 study, patients were taking their medication (in this case lithium) more

regularly, discontinued it less against medical advice, and had fewer mood episodes caused by nonadherence than patients who had received regular clinical care (Cochran, 1984).

Enhancing medication adherence was not the only reason why psychological treatments for bipolar disorder began to gain traction. Monitoring and detecting prodromal signs, especially those signaling mania, provides a window for early intervention (e.g., boosting or changing medication). It had also become increasingly clear that for many people psychosocial stress greatly increases the risk of recurrence of mood episodes (Ellicott, Hammen, Gitlin, Brown, & Jamison, 1990). Psychosocial treatment researchers felt that if they could work with people with bipolar disorder to learn more about their illness, monitor symptoms, help them to become more adherent, and adjust their behavior and their environment in ways that would minimize risk factors (irregular medication adherence, lack of sleep, alcohol and substance abuse, family criticism, stress) and maximize protective factors (regular schedules, etc.), that this would have beneficial effects on the course of the illness and ultimately improve people's quality of life (Miklowitz & Johnson, 2006). To date, psychological treatments have utilized an array of interventions. These include psychoeducation about bipolar disorder, mood monitoring and relapse prevention, communication and problem-solving training, cognitive restructuring (a technique to challenge maladaptive thoughts), activity scheduling, social rhythm adjustments, and interpersonal techniques. These have been combined in various forms in individual, group, or family treatments that were implemented at different stages of this illness (acutely ill, stable, etc.).

Free-standing psychoeducation programs for remitted, stable patients with bipolar disorder in conjunction with medication have been shown to lower the rate of manic recurrences (Perry, Tarrier, Morriss, McCarthy, & Limb, 1999) or both manic and depressive recurrences (Colom et al., 2009). Other treatment programs have combined psychoeducation with additional treatment modules (Bauer et al., 2006a, 2006b; Frank et al., 2005; Lam, Hayward, Watkins, Wright, & Sham, 2005; Lam et al., 2003; Miklowitz, George, Richards, Simoneau, & Suddath, 2003; Miklowitz et al., 2007; Simon et al., 2006). For example, Lam et al. (2003, 2005), who investigated a cognitive-behavioral approach for preventing relapse, combined psychoeducation with active mood monitoring, relapse prevention, modification of behaviors that could trigger mood symptoms (prodromes), and emphasis on regular routines and sleep (Lam et al., 2005; Lam et al., 2003). Lam et al. (2003, 2005), who compared their CBT relapse prevention program against treatment as usual, found that within the first year participants had fewer mood episodes, and within the first 2 years of follow-up experienced shorter mood episodes, fewer overall mood symptoms,

better coping with prodromal manic symptoms, and fewer admissions to the hospital (Lam et al., 2005; Lam et al., 2003). In the two largest randomized studies conducted to date, Bauer et al. (2006a, 2006b) and Simon et al. (2006) combined group psychoeducation (recognizing triggers for episodes, monitoring warning signs, developing relapse prevention strategies, and increasing medication adherence) with sessions that focused on increasing functioning through achieving goals in life (Bauer et al., 2006a, 2006b; Simon et al., 2006). Patients were also assigned a nurse coordinator who would facilitate access, coordinate care, and reach out to patients (e.g., when they missed appointments, a sign that things may not be well). Both programs observed beneficial effects for shortening manic episodes (Bauer et al., 2006a; Simon et al., 2006) and lowering risk of manic episodes (Simon et al., 2006), although there were no effects on depression severity, weeks depressed, or depressive recurrences (Simon et al., 2006), confirming a growing realization that depression for people with bipolar disorder is more difficult to treat than mania.

David Miklowitz's (2008b) FFT for bipolar disorder educates families about the elements of bipolar disorder and teaches them to communicate more effectively and problem-solve together around the issues bipolar disorder creates for them. Miklowitz and colleagues who tested this program found that FFT participants had fewer relapses than patients who just received psychoeducation (Miklowitz et al., 2003; Rea et al., 2003). The role of interpersonal factors as well as that of the regularity of one's daily schedule (social rhythms) on the course of bipolar disorder have also been highlighted by Ellen Frank (Frank, Hlastala, Ritenour, & Houck, 1997; Frank et al., 2005). IPSRT was developed as both an acute and maintenance treatment for bipolar disorder to target nonadherence to medications, stressful life events, and disruptions in routines and social rhythms. IPSRT combines interpersonal psychotherapy with the social zeitgeber hypothesis. The social zeitgeber hypothesis states that disruption in daily routines can lead to instability of circadian rhythms, which, in vulnerable individuals, can lead to mood episodes (Frank et al., 2005). The treatment addresses the importance of maintaining regular routines and managing potential disruptions in that routine. Interpersonal aspects are drawn from interpersonal psychotherapy and focus on unresolved grief, interpersonal disputes, role transitions, and interpersonal deficits (Frank, Swartz, & Kupfer, 2000). In addition, the treatment addresses "grief for the lost healthy self," assisting the patient in mourning the life the patient may have lost because of the diagnosis and its accompanying limitations. IPSRT has helped individuals with bipolar disorder regulate their daily routines and sleep–wake cycles (Frank et al., 1997). Maintenance IPSRT, in combination with medications, also helps individuals maintain mood stability (Frank, 1999).

Overall, IPSRT may be most helpful when patients are experiencing acute episodes and is not recommended for individuals with bipolar disorder and comorbid anxiety disorders or high medical burden (Miklowitz, 2008a).

Finally, in the STEP-BD study, psychosocial researchers also turned their attention to treating acute depressive episodes. Depressed patients with bipolar disorder were randomized to either IPSRT, FFT, or CBT (consisting of mood monitoring, relapse prevention, and Beckian style CBT) (Miklowitz et al., 2007). All three treatments were equally successful in decreasing the length of the depressive episodes over the course of a year, compared to a low-level treatment condition that provided patients with a workbook with information about bipolar disorder and the opportunity to meet with a professional up to three times. Not only did the three treatments decrease the length of the depressive episode, but they also translated into more days well over the study year, and improved relationship functioning and life satisfaction (Miklowitz et al., 2007). With this array of impressive accomplishments of the existing psychotherapies for bipolar disorder, why was there a need for incorporating mindfulness?

MBCT FOR MAJOR DEPRESSION

When we started to think about additional therapeutic options for the patients in our clinic, mindfulness-based cognitive therapy for people with recurrent depressive episodes had already gained empirical support and had received much publicity. As they described it in their book *Mindfulness-Based Cognitive Therapy for Depression*, Zindel Segal, Mark Williams, and John Teasdale had looked for a psychological treatment that could help prevent future major depressive episodes in people with recurrent major depression (Segal, Williams, & Teasdale, 2002, 2013). They and many others had found that depressed people experience high levels of negative, self-critical thinking. Once recovered, however, negative thinking would normalize such that it could not be distinguished from that of never-depressed people. Likewise, decreased activity levels also tend to return to the normal range when people are no longer depressed. This removed pivotal targets for CBT as a treatment for the prevention of major depressive episodes.

Segal et al. (2002, 2013) were also aware of research done by Robert Post at the National Institute of Mental Health who had found that while life events often play a role early in the occurrence of major depressive episodes, they tend to lose their importance as precipitants as patients continue to experience major depressive episodes (Post, 1992). With unbiased thoughts, normal activity levels, and no life events to alter, Segal and

colleagues turned their attention to mindfulness as a way to prevent the recurrence of major depressive episodes. They hypothesized that relapse, at a time of sad or lowering mood, involves the automatic reactivation of negative thinking, similar to the thought patterns that were active during people's previous episodes of depression (Segal et al., 2002, 2013). The more episodes of depression someone has experienced, the more the brain would be "trained" in this mode of responding, and the more automatic this mode of responding to sad or lowering mood would become (thereby also increasing the risk of future depressive episodes). More broadly, any thoughts and feelings associated with stored memories of depressed mood could serve as an internal context (a retrieval cue) that automatically reactivates depressed mood and its associated patterns of thinking and feeling (Segal et al., 2002, 2013; Williams, Teasdale, Segal, & Kabat-Zinn, 2007).

Part of this automatic pattern is a tendency to ruminate in response to negative affect (Johnson, McKenzie, & McMurrich, 2008). Rumination refers to behaviors and thoughts that focus one's attention on one's depressive symptoms and on the implications of those symptoms (Nolen-Hoeksema, 1991). This appears to create an automatic self-perpetuating cycle of ruminative, negative thinking; loss of positive affect; coupled with reduced motivation and goal-directed behavior leading back into depressive episodes. Segal et al. (2002, 2013) looked for a treatment that could help people to disengage from mind states characterized by self-perpetuating patterns of ruminative, negative thought. They turned to a treatment called mindfulness-based stress reduction (MBSR), developed by Jon Kabat-Zinn in the late 1970s (Kabat-Zinn, 1990). MBSR is typically taught to mixed groups of patients that present with a wide variety of problems ranging from stress-related health issues to chronic pain. This program is designed as an 8-week course for groups. The capacity for mindfulness is developed through multiple mindfulness meditation exercises, such as sitting meditation, walking meditation, mindful yoga, and the body scan. Participants are also taught to practice mindfulness in everyday activities, such as eating, cleaning the dishes, or taking a shower in order to facilitate the integration of mindfulness into daily life. Segal and colleagues adapted many of these exercises (e.g., body scans, sitting meditations) and coupled them with education about depression, mood, and thoughts (Segal et al., 2002, 2013). They tested the efficacy of their mindfulness-based cognitive therapy program in several clinical trials (Segal et al., 2010; Teasdale, Segal, & Williams, 1995; Teasdale et al., 2000). It turned out that for patients who had three or more episodes of major depression, MBCT reduced the recurrence of future episodes compared to people who had had only two or fewer major depressive episodes (Teasdale et al., 2000). More recently, Segal et al. (2010) found that among patients with unstable remission, MBCT

substantially reduced the risk of occurrence, but there was no difference between MBCT and placebo for patients with stable remission (Segal et al., 2010).

MBCT FOR BIPOLAR DISORDER?

"Unstable remission"? Intermittent days, with lowered mood and negative self-critical thinking? This sounded familiar to us. As Michael, one of the bipolar patients who participated in our program described, "I may have a few good days, but then one morning I wake up and feel down, blah, just not right, with no energy. Or, there would be those days when I could not do anything right, no matter what I tried. Just a lot of self-critical, negative thinking, and being very irritable." Like Michael, even those patients with bipolar disorder who have infrequent recurrences experience ongoing, mostly depressive mood symptoms in between major mood episodes (Judd et al., 2002). In the STEP-BD program, most patients who were recovered at the time when they joined the study still experienced noticeable mood symptoms, among them difficulties sleeping, concentration issues, low energy, and self-critical thinking (Rodman et al., 2011). For patients who recovered in their first 2 years of the STEP-BD program, residual depressive or manic symptoms at recovery and proportion of days depressed or anxious in the preceding year shortened the time to depressive recurrence. Residual manic symptoms at recovery and proportion of days of elevated mood in the preceding year significantly shortened the time to manic, hypomanic, or mixed episode recurrence (Perlis et al., 2006). To us, these findings emphasized the need to treat ongoing depressive and manic mood symptoms.

Besides unstable remission and residual symptoms, people with bipolar disorder also seemed to share a tendency to ruminate about negative feelings and events (Kim, Yu, Lee, & Kim, 2012). Unlike people with major depression, however, people with bipolar disorder seemed to have a vulnerability to also ruminate about positive feelings (Johnson et al., 2008), suggesting self-perpetuating, ruminative responses as a potential avenue not only into depression, but also into mania. In healthy individuals mindfulness meditation decreases negative mood states (Jha, Stanley, Kiyonaga, Wong, & Gelfand, 2010) and reduces distractive and ruminative thoughts (Jain et al., 2007). Therefore, we could not help but wonder whether the practice of mindfulness could help people with bipolar disorder to treat their thoughts and feelings as transient mental events rather than reflections of reality, and whether this could help prevent the escalation of negative or positive ruminative patterns into depression or mania.

Mindfulness in Other Treatment Programs

Besides being effective in preventing depressive recurrences and rumination (Hofmann, Sawyer, Witt, & Oh; Segal et al., 2002, 2013), mindfulness has also been an integral part of other treatment programs. Among them, DBT for borderline personality disorder, a program for patients with intense emotions and severe emotion dysregulation difficulties (Linehan, 1993; Neacsiu, Rizvi, & Linehan, 2010), mindfulness-based relapse prevention for addictive behaviors (Bowen et al., 2006; Marlatt & Gordon, 2007), and mindfulness- and acceptance-based behavioral therapy for anxiety (Hofmann, Sawyer, Witt, & Oh, 2010; Roemer & Orsillo, 2009; Roemer, Orsillo, & Salters-Pedneault, 2008). Fifty percent of patients with bipolar disorder have a lifetime anxiety disorder (Simon et al., 2004). "Worry is a daily part of my life," said Holly, one of our patients, in a first meeting at the Bipolar Clinic. "It is particularly hard when I am depressed, but it still does not go away when things are better." Other people with bipolar disorder experience panic attacks and worry about their occurrence; yet other patients fear and/or avoid social situations or experience anxiety-provoking memories about traumatic events.

During mindfulness, practitioners expose themselves to whatever is present in the field of awareness, including thoughts, body sensations, and emotional experiences. They let themselves be affected by the experience, refrain from taking countermeasures, and instead bring an attitude of acceptance to bodily and affective responses (Hart, 1987). Practitioners are instructed to meet unpleasant emotions (such as fear, sadness, anger, aversion) by "turning towards them, rather than turning away" (Santorelli, 2000). Although this may be counterintuitive, novice practitioners soon discover that the unpleasant emotions pass away and a sense of safety or well-being can be experienced in their place—a process that is called "extinction," which underlies the highly effective exposure-based treatment for anxiety disorders (Chambless & Ollendick, 2001). Mark Williams and colleagues (2008) who employed the Segal et al. (2002, 2013) MBCT treatment in remitted patients with bipolar disorder, with a focus on in-between episode anxiety and depression symptoms, found that compared to a waiting-list group (no treatment), patients with bipolar disorder following 8 weeks of MBCT indeed showed reduced anxiety as well as depression symptoms (Williams et al., 2008).

Other Benefits of MBCT

Mindfulness also seems to have a beneficial effect on people's abilities to regulate strong emotions (Linehan, 1993; Neacsiu et al., 2010). "Don't tell me you know what I feel," Daniel, another participant in our program,

complained. "I hate when people do this. I absolutely, absolutely hate it. When someone does this, I get so angry that I can barely think anymore," he says as he describes one of his many situations where strong emotional reactions get in the way of his getting along with others. Meditation training has been shown to lead to decreased emotional reactivity (the tendency to react strongly) and facilitates a return to emotional baseline (Goleman & Schwartz, 1976; Zeidler, 2007). Experimental work has shown that mindfulness training leads to a reduction in emotional interference (as assessed by the delay in reaction time after being presented with affective as compared to neutral pictures) (Ortner, Kilner, & Zelazo, 2007).

Another area that benefits from mindfulness practice is cognitive functioning. Once thought of as being a part of mood episodes, it has been recognized that for many individuals with bipolar disorder, cognitive problems persist even when they are not in mood episodes (Altshuler, 1993). Difficulties with attention (concentration), memory, and the organization of behaviors (often called executive functioning) extending beyond mood episodes affect approximately 30–40% of individuals with bipolar disorder (Cavanagh, Van Beck, Muir, & Blackwood, 2002; Clark, Iversen, & Goodwin, 2002; Deckersbach et al., 2004; Martinez-Aran et al., 2004). The reasons for this are likely multifaceted and may include medications, lack of sleep, and other factors. These difficulties can greatly impair one's ability to function in the workplace and at home (Altshuler, Bearden, Green, van Gorp, & Mintz, 2008; Atre-Vaidya et al., 1998; Dickerson et al., 2004; Dittmann et al., 2007; Gildengers et al., 2007; Harvey, Twamley, Vella, Patterson, & Heaton, 2010; Jaeger, Berns, Loftus, Gonzalez, & Czobor, 2007; Martinez-Aran et al., 2004, 2007). Regular meditators have enhanced attentional performance (Jha, Krompinger, & Baime, 2007; Slagter et al., 2007; Valentine & Sweet, 1999; van den Hurk, Giommi, Gielen, Speckens, & Barendregt, 2010) and mindfulness practice has been shown to positively impact attention, or conflict monitoring, such as the ability to disregard distractions in order to maintain an attentional focus (Chan & Woollacott, 2007; Jha et al., 2007; Moore & Malinowski, 2009; van den Hurk et al., 2010). Even brief meditation interventions can lead to improvements on attention tasks (Tang et al., 2007; Wenk-Sormaz, 2005) and increased activation in brain regions involved in the regulation of attentional processes in the brain.

Psychotherapy for Relapse Prevention and Acute Depression Revisited

Finally, some recent data from a clinical trial looking at relapse prevention for patients with bipolar disorder also encouraged us to look for an

additional psychological treatment for patients with bipolar disorder. Jan Scott from the University of Newcastle had conducted a clinical trial in which she compared the effectiveness of cognitive behavior therapy with treatment as usual (TAU) for preventing the recurrence of mood episodes. Unlike other studies (Lam et al., 2003, 2005), she did not find any overall advantage of CBT over TAU in the ability to prevent recurrence. However, in a post-hoc analysis she discovered something interesting. For patients with 12 lifetime mood episodes, CBT and TAU were roughly equally effective in preventing relapse. For patients with fewer than 12 lifetime mood episodes CBT was more effective, whereas patients with more than 12 lifetime mood episodes, TAU seemed to be the better option. In fact, this effect became much more pronounced for patients with 20 or 30 lifetime mood episodes, suggesting that CBT may not be the best treatment for people with particularly severe and recurrent bipolar disorder.

We also wondered whether the beneficial effect of psychotherapy for recovery from acute depression in the STEP-BD program was dependent on the chronicity of bipolar disorder, and we looked at the number of lifetime depressive mood episodes as a potential moderator (Peters et al., in press). We found that psychotherapy (CBT, FFT, IPSRT), compared to three sessions of education about bipolar disorder (called "collaborative care") had its biggest impact on recovery rates for patients with 10–20 lifetime depressive episodes (psychotherapy: 79%; collaborative care: 27%), whereas it did not make a difference for patients with 1–9 lifetime depressive episodes (psychotherapy: 76%; collaborative care: 73%) or for patients with more than 20 lifetime episodes (psychotherapy: 63%; collaborative care: 52%) (Peters et al., in press).

Taken together, these findings suggested that MBCT might be a treatment option particularly for more chronic patients with bipolar disorder, who experience other concurrent psychiatric disorders (e.g., anxiety disorders) and deal with emotion regulation issues, and cognitive problems. In the next chapter we discuss why we decided to modify MBCT for depression.

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