Other problems commonly treated by C.B.T.

SPECIFIC PHOBIAS

SOCIAL PHOBIA

OBSESSIVE COMPULSIVE DISORDER

IMPULSE CONTROL DISORDERS

GENERALISED ANXIETY DISORDER

PANIC DISORDER

PANIC ATTACKS

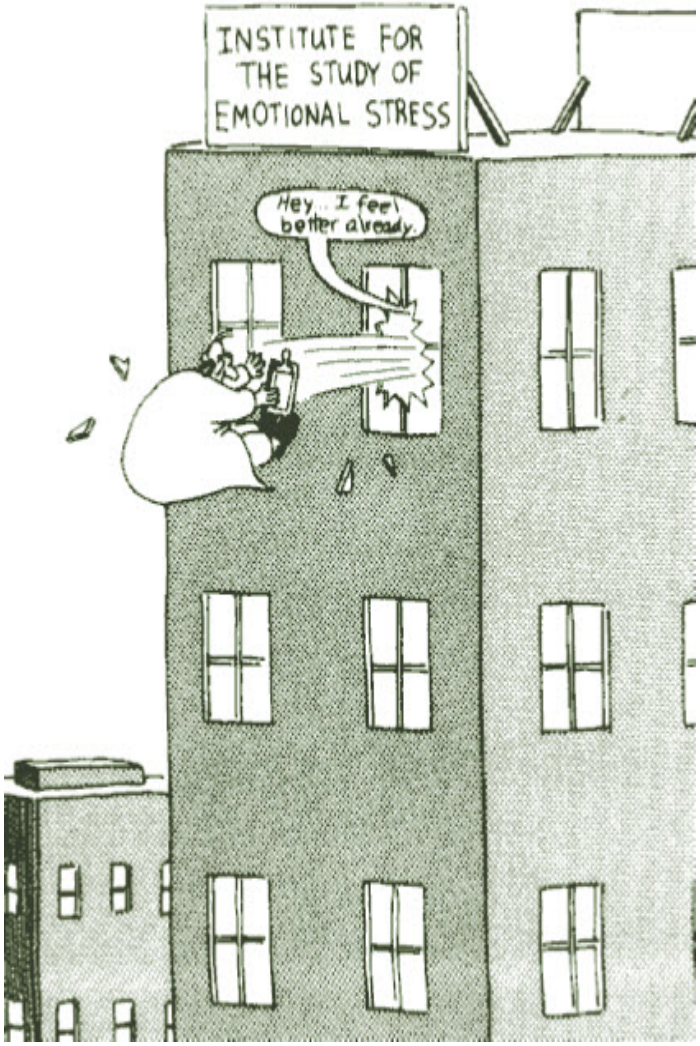
HEALTH ANXIETY

POST TRAUMATIC STRESS DISORDER

SEXUAL DYSFUNCTION

MARITAL & RELATIONSHIP THERAPY

DEPRESSION



A.S.T Consultancy

Bi-Polar Disorder

"Cognitive Behavioural Therapy can empower an individual to manage and transform their feelings -and thus their life"

Professor Lord Richard Layard
"Mental Health–Britain's Biggest Social Problem?"

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COGNITIVE BEHAVIOURAL PSYCHOTHERAPY

Bi-Polar Disorder

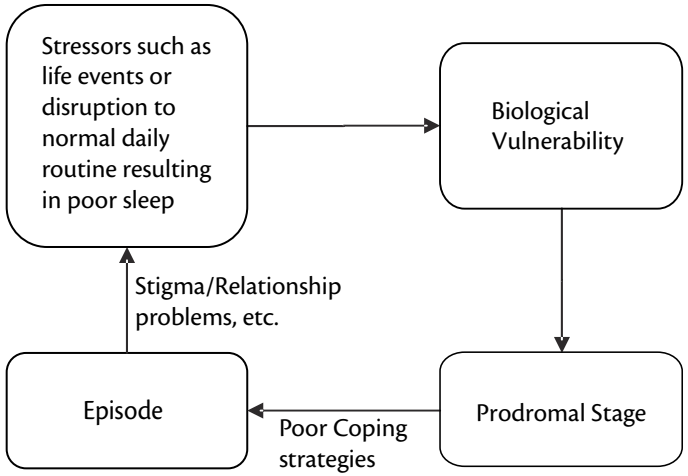
Bi-polar disorder is a common disorder that, despite aggressive pharmacotherapy, results in a substantial impairment in psychological, social, and physiological functioning. The heredity of bi-polar disorder has contributed to a focus on pharmacological treatments, which have demonstrated that lithium and other mediators are effective for many patients. Nevertheless, the high rates of noncompliance and relapse with pharmacological treatment alone suggest that other therapies be explored. Up to 69% of individuals relapse within 2 years and up to 59% of patients relapse within 5 years.

Psychosocial variables appear to important precursors of episodes. Both expressed emotion and life events plays influential roles in relapse which are not cushioned by medication alone.

Bi-polar disorder is classified as bi-polar I illness and is characterised by distinct episodes of mania contrasting with episodes of severe depression.

Bi-polar II illness is a less severe form of the condition with depression alternating with periods of hypomania. Hypomania differs from 'true' mania in that this state does not include psychotic symptoms (such as hallucinations) or lead to severe social and occupational dysfunction.

Cyclothymia is a condition in which the person experiences numerous brief episodes of hypomania and minor depression.



A basic model of Bi-Polar Disorder

Manic episodes are characterised by at least one week of profound mood disturbance with elation, irritability, or expansiveness and include three or more of the following symptoms:

Grandiosity; diminished need for sleep; excessive talking/pressure of speech; excessive engagement in pleasurable activities, often with painful consequences; distractibility; increased activity (including sexual); racing thoughts/flights of ideas. Such mood disturbances will cause impairment at work, or danger to the patient or others. Hypo-mania is characterised by the above symptoms but to a lesser degree.

Major depressive episodes are characterised by five or more of the following symptoms, with at least one being a depressed mood lasting two weeks or more:

Depressed mood; weight loss or gain; hyper-somnia or insomnia; preoccupation with death or suicide; psychomotor retardation or agitation; diminished pleasure or interest; decreased concentration or marked indecisiveness and loss of energy.

Formulation

The Cognitive Behavioural Psychotherapist will collaborate with the patient and assess all maintaining factors; including thoughts, behaviours, emotions and physical symptoms associated with the problem and develop a working formulation which will be utilised to guide the course of therapy.

Treatment

Therapy will include the identification of all prodromes and other relapse signatures. Treatment will then depend upon whether depressed or elated but will include behavioural reactivation, challenging of dysfunctional assumptions and relapse prevention strategies.

A Professional and Confidential service, provided by a fully Qualified and Experienced Psychotherapist.

Adrian Soden.
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Adult Behavioural Psychotherapist

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