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EFFICACY OF COGNITIVE BEHAVIORAL THERAPY IN MANAGING ANXIETY AMONG YOUNG ADULTS WITH BIPOLAR DISORDER

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ABSTRACT

*Although cognitive behavioural therapy (CBT) is considered a promising adjuvant to pharmacotherapy for treating bipolar disorder (BD), its efficacy is unproven. Cognitive behavioural therapy (CBT) refers to a popular therapeutic approach that has been applied to a variety of problems. But, in Pakistan ignored this area of research specifically CBT efficacy not explored through experimental study among bipolar patients for managing side syndrome like anxiety and depression. The present review experimental study evaluated the treatment outcomes of patients with Bipolar disorder (BD) treated with CBT plus behavioural psychotherapy and compared these data with the outcomes of those who received rational emotive behavioural therapy and other psychotherapies. This study is providing the systematic evidence for proving the efficacy of cognitive behaviour therapy (CBT) for anxiety reduction among bipolar patients. An exploratory research was conduct at Hazara division headquarter teaching hospital and other hospitals facilitating for psychological treatment. Time serious research design was utilized in experimental study. The purpose of the study was to measure the efficacy of cognitive behaviour therapy (CBT) in reducing the anxiety among patients with BD. There was assumed cognitive behaviour therapy is an effective intervention for anxiety reducing among bipolar disorder patients then other psychotherapies. There was found significant difference in efficacy of CBT among bipolar patients for reduction gender wise. Sample of study was comprised on (**N = *100) participants from different clinics' of KP Pakistan by using clinical sampling technique. Zung (1971) anxiety scale was used for identifying level of anxiety, whereas demographic information regarding their gender, psychotherapy type was recorded on separate sheet. Statistical analysis was evaluated by using repeated measure t-test. Repeated measure analysis revealed that CBT is more effective intervention than behavioural psychotherapy (M = 61.28, SD = 11.823; M = 78.20, SD = 10.70) t(198) = -7.58, p<.001. Rational emotive behaviour therapy is more effective intervention than other psychotherapies for reducing anxiety among bipolar patients (M = 68.52, SD = 5.45; M = 77.08, SD = 5.99) t(198) = 6.77, p<.001. Results revealed control group patients more suffering by anxiety than experimental group (M = 80.40, SD = 8.32; 59.62, SD = 12.42) t(198) = 10.16, p<.001 Males are more suffering by anxiety than female bipolar disorder patients (M = 85.28, SD = 7.77; M = 75.44, SD = 5.64) t(198) = 4.992, p<.001. There was observed cognitive behavioural therapy was effective for reducing the anxiety among bipolar disorder young adults patients than behavioural psychotherapy diagnostic techniques.*

Keywords: *Exploratory, cognitive behavioural therapy, bipolar disorder, purposive sampling, Anxiety, Psychotherapy, intervention, clinical.*

INTRODUCTION

People who have bipolar disorder can have periods in which they feel overly happy and energized and other periods of feeling very sad, hopeless, and sluggish. In between those periods, they usually feel normal. You

can think of the highs and the lows as two "poles" of mood, which is why it's called "bipolar" disorder (First et al., 2023).

Individually delivered cognitive behavioral therapy (CBT) as an adjunct to pharmacological treatment is feasible and associated with symptom improvement in adolescents with bipolar (William et al., 2002).

CBT strategies aim to manage and prevent cognitive, affective and behavioral symptoms associated with the depressive or mania phase with the patient's and, at times, the family's active cooperation (Basco & Rush, 1996; Newman, 2002).

CBT shows efficacy in several significant phases of the disorder and can improve the QoL of BD patients by maintaining their euthymic phase or reducing the frequency and intensity of mania or depressive episodes (24-32). (Gomes et al., 2008).

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An exploratory research was conduct at Hazara division headquarter teaching hospital and other hospital facilitate for psychological diagnose and treatment by psychologist and psychiatrics from 1st Jan 2015 to July 2016. To explore, the efficacy of cognitive behaviour therapy (CBT) for reducing the anxiety among bipolar disorder patients as an intervention. There was assumed cognitive behaviour therapy is an effective intervention for anxiety reducing among bipolar disorder patients then other psychotherapies. Rational emotive psychotherapy was proved better intervention then others psychotherapies. There was found significant difference in efficacy of CBT among bipolar patients gender wise.

Sample of study was comprised on **(N =** 200) participants with an overall mean age (M = 29.60, SD = 16.563) years from different clinics' of KP Pakistan. There was equal representation of both sexes male and female in acquire study. Zung anxiety scale was used for identifying level of anxiety, whereas demographic information regarding their gender, psychotherapy type was recorded on separate sheet. Statistical analysis was evaluate by using repeated measure t-test.

Bipolar disorder is a chronic, impairing disorder that is characterized by significant disturbance in mood, as well as grandiosity or unstable self-esteem, hypersexual behavior, a decreased need for sleep, poor judgment, racing thoughts, and pressured speech (Kupfer, 2005).

Bipolar disorder, also known as manic depression, is a mental illness that brings severe high and low moods and changes in sleep, energy, thinking, and behavior (Stang et al., 2006).

Cognitive Behavioral Therapy (CBT), the dominant psychotherapy bipolar treatment available today, is based on the premise that many (but certainly not all) mood problems are based less on physical brain problems, and more on habitually dysfunctional ways that people learn to appraise and interpret stressful events occurring in their lives. The stressfulness of life events becomes magnified, and certain bipolar symptoms occur or become exaggerated as a byproduct of faulty judgments (Made & dombeck, 2009).

Bipolar 1 higher in males and bipolar II in females Prevalence of bipolar disorder 2.4 % internationally Year prevalence of rapid cycling among all bipolar patients ranges between 5-33.3%, while lifetime prevalence ranges between 25.8-43% (Baldesarini et al., 2003).

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CBT shows efficacy in several significant phases of the disorder and can improve the QoL of BD patients by maintaining their euthymic phase or reducing the frequency and intensity of mania or depressive episodes (24-32). (Zaretsky et sl,. 1999; Gomes et al., 2008).

Szentagotaj and David (2010) through quantitative meta-analysis investigated the role of cognitive behavior therapy as treatment to medication for patients diagnosed with bipolar disorder.

Yu ye et al. (2016) were investigated the effectiveness of the CBT in treating bipolar disorder. Short-term efficacy of CBT in reducing relapse rate of BD and improving the severity of mania was proved. But these effects could be weakened by time. In addition, there was no effect of CBT on level of depression in BD.

Stefan et al. (2012) were explored Cognitive-behavioral therapy (CBT) refers to a class of interventions that share the basic premise that mental disorders and psychological distress are maintained by cognitive factors.

A randomized controlled single-dazzle trial was directed with 50 patients with bipolar confusion composes I and II followed up for no less than a year in an outpatient benefit and whose infection was disappearing. An exploratory CBGT manual was produced and added to treatment of course (TAU), and results were contrasted and TAU alone (Kai et al., 2007).

Nine randomized controlled trials with 520 bipolar I or II disorder patients were reanalysed. Overall analysis showed that CBT did not significantly reduce the relapse rate of BD or improve the level of depression. However, significant efficacy of CBT in improving severity of mania was proved based on the YMRS (SMD = −0.54, 95%CI, −1.03 to −0.06, P = 0.03) but not based on MRS. Subgroup analyses showed that CBT had short-term efficacy in reducing relapse rate of BD (at 6 months' follow-up: relative risk = 0.49, 95%CI: 0.29–0.81, P = 0.006) and improving severity of mania based on YMRS score (post-treatment: SMD = −0.30, 95%CI, −0.59 to −0.01, P = 0.04) (Chiang et al., 2017).

Co morbidity among the tension issue is normal and may contrarily affect treatment result. Possibly, trans diagnostic psychological behavioural medications (CBT) bargain more viably with co morbidity than standard CBT. The present investigation tried the adequacy of The Unified Protocol (UP) connected to Mental Health Services (Morris et al., 2016).

Granath et al., (2007) in one research a stress management program based on CBT rules was evaluate with yoga program. Study was comprised on 26 ladies and 7 men from a big firm of Swedish company divide in two groups for different forms of intervention. There were four groups all instructed by trained leaders and ten sessions were held. Results exposed both cognitive behaviour therapy and Yoga are shows potential management techniques.

Priyamvada et al., (2009) Social phobia consists of a marked and persistent fear of encountering other people, usually in small groups; or doing certain acts in a public place, like eating in public toilets, public speaking or encounters with persons of the opposite sex. Affected individuals fear that they will be evaluated negatively or that they will act in a manner that resulting in their humiliation or embarrassment whenever they are expected to go into the phobic situations; they develop severe anticipatory anxiety. They utilize various excuses to avoid phobic situations. This avoidance usually affects their lives quite adversely. Many of these patients exhibit psychological symptoms of poor self-confidence, show anxiety on trifles and may be very conscious of some physical or psychological defect in them; as a result, they may develop secondary depression. Exposure to social situations can produce physical symptoms such as sweating, blushing, muscle tension, pounding heart, dry mouth, nausea, urgency of masturbation, shaky voice or trembling. Social phobia is the third most common mental disorder in adults worldwide, with a lifetime prevalence of at least 5% (depending on the threshold for distress and impairment). There is an equal gender ratio in treatment settings; but in catchment area surveys, there is a female preponderance of 3:2. Affected individuals are more likely to be unmarried and have a low socioeconomic status. Although common, social phobia is often not diagnosed or effectively treated. There have however been a number of developments in our understanding and treatment of social phobia over the past decade. Cognitive and behavioural interventions for social phobia appear to be more effective than wait-list controls and supportive therapy. Cognitive behavioural treatment involving cognitive restructuring plus exposure appears to be an effective treatment and exhibits a larger effect than either exposure or social skills

training or cognitive restructuring alone. The sessions of CBT for social phobia are devoted to training clients in the basic tenets of cognitive therapy, especially the link between faulty assumptions or irrational thinking about social situations and anxiety experienced in those situations.

De Castella et al., (2015) Despite strong support for the efficacy of cognitive behavioural therapy (CBT) for social anxiety disorder (SAD), little is known about mechanisms of change in treatment. Within the context of a randomized controlled trial of CBT, this study examined patients' beliefs about the fixed versus malleable nature of anxiety—their 'implicit theories'—as a key variable in CBT for SAD. Compared to waitlist (n = 29; 58% female), CBT (n = 24; 52% female) led to significantly lower levels of fixed beliefs about anxiety ($M_{baseline}$ = 11.70 vs. M_{Post} = 7.08, d = 1.27). These implicit beliefs indirectly explained CBT-related changes in social anxiety symptoms (κ^2 = .28, [95% CI = 0.12, 0.46).

Clients' resistance relates negatively to their retention and outcomes in psychotherapy; thus, it has been increasingly identified as a key process marker in both research and practice. This study compared therapists' post session ratings of resistance with those of trained observers in the context of 40 therapist–client dyads receiving 15 sessions of cognitive-behavioural therapy for generalized anxiety disorder. Therapist and observer ratings were then examined as correlates of proximal (therapeutic alliance quality and homework compliance) and distal (post treatment worry severity) outcomes. Although there was reasonable concordance between ratters perspectives, observer ratings were highly and consistently related to both proximal and distal outcomes, while therapist ratings were not. These findings underscore the need to enhance therapists' proficiency in identifying important and often covert in-session clinical phenomena such as the cues reflecting resistance and non-collaboration (Hara et al., 2016).

The objective of the present examination was to lead a quantitative meta-examination exploring the part of subjective behavioural treatment (CBT) as adjunctive treatment to pharmaceutical for patients determined to have bipolar turmoil. These consequences for result classes were more obvious at post treatment contrasted with development. Subjective behavioural treatment can be utilized as an adjunctive treatment to medicine for patients with bipolar confusion, yet new CBT systems are expected to increment and advance the effect of CBT at post treatment and to keep up its advantages amid development (Szentagotai et al., 2010).

Past investigations have upheld acknowledgment and duty treatment (ACT) for decreasing disability identified with different incessant conditions. ACT may potentially be advantageous for bipolar confusion (BD) with existing together tension, which is related with a poorer treatment result. Endeavours are expected to recognize reasonable mental mediations for BD and existing together uneasiness. In this open clinical trial, we included 26 patients with BD compose 1 or 2 at an outpatient mental unit spend significant time in emotional scatters. The mediation comprised of a 12-session assemble treatment that included psycho education, care, taking part in values-based conduct, subjective diffusion, acknowledgment and backslide avoidance modules. Members finished four self-report polls covering nervousness side effects (Beck Anxiety Inventory - BAI), depressive indications (Beck Depression Inventory - BDI-II), personal satisfaction (Quality of Life Inventory - QOLI) and mental adaptability (Acceptance and Action Questionnaire - AAQ-2) preceding, amid and after the treatment. At post-treatment, the members revealed noteworthy upgrades in all result measures, with extensive impacts (Cohen's d in the vicinity of 0.73 and 1.98). The mean diminishment in tension side effects was 45%. At post-treatment, 96% of the patients were delegated responders on no less than one of the result measures. A constraint is that the trial is uncontrolled. The outcomes recommend that ACT can possibly be a viable treatment for BD patients with existing together uneasiness. Additionally randomized examinations are justified (Pankowski et al., 2016).

Bipolar confusion is a standout amongst the most genuine and predominant mental issue. The point of the present article is to audit the proficiency of intellectual behavioural treatment (CBT) for bipolar patients. A few investigations demonstrate predictable proof that intellectual treatment, associative to psycho-training and pharmacological treatment, offers viability in various periods of the illness. In the vast majority of the examinations, patients experiencing CBT demonstrated changes in personal satisfaction, with a decrease in both recurrence and span of state of mind scenes, and higher degrees of consistence and less hospitalization. More investigations are required to demonstrate the

adequacy of CBT for bipolar turmoil with regards to institutionalizing analytic criteria and estimating instruments to assess the confusion's diverse stages and seriousness (Da Costa et al., 2010).

Methods

The study was conducted at the University of Haripur, Pakistan, from 1st Jan 2015 to July 2016, and was comprised on clinical sample. This study was approved by the university ethical board. The participants' were selected to KP Hazara division hospitals clinical sampling technique was used, because for concerned study just was recruited diagnosed bipolar patients as participants of the study. Those were not diagnosed cases and were getting the psychotherapy excluded from the study. Only those bipolar patients were choosing for data collection whose were diagnose by expert psychiatric to last 6 months. Whose could comprehend urdu translated scale whose have urdu reading and writing skills. Hamilton anxiety was in foreign language English which empirically with the help of psychologist, psychiatrist and bi language experts was translated in urdu by committee approach through back translation method thrice time. This experimental study was consisted on bipolar clinical patients of Hazara division hospitals. Hamilton anxiety scale was used to measure level of anxiety among clinical sample after getting consents from hospitals authority bodies and respondents. For cognitive behaviour therapy CBT utilized (Gratituding), Behaviour therapy utilized (appreciation as positive incentive on modification), in rational emotive therapy applied (exercise dig breathing) and for psychoanalysis utilized (free flowing conversation) psychotherapy for reducing anxiety as intervention for bipolar disorder patients. Anxiety scale was comprised on 14 items scale rated on a size of 0 (not present) to 4 (extreme), with an aggregate score scope of 0– 56, where <17 shows gentle seriousness, 18– 24 melodious to direct seriousness and 25– 30 direct to extreme. All participants participated in the study voluntarily and no one paid for their cooperation. There had taken 100 patients those patients were under treatment with CBT and 100 those patients were under treatment with other therapies. They were instructed how to answer the questions, and were assured about the confidentiality of their responses. For statistical analysis applied descriptive statistics, Pearson correlation, ANOVAs and liner regression.

Results

Table 1

Intervention Sessions Wise level of Anxiety among Bipolar Disorder Patients

	Baseline		**After 5 Sessions**				
Variable	*M*	*SD*	*M*	*SD*	*t(49)*	*p*	*Cohen's d*
Anxiety	88.60	6.896	78.60	5.775	7.088	.000	0.1794
	After 10 Sessions		**After 15 Sessions**				
Anxiety	69.42	4.941	42.56	7.080	27.698	.000	4.400

Note. M = Mean, SD = Standard Deviation

Table 1 is depicting the level of anxiety among bipolar disorder patients intervention level wise. Before starting intervention at base line anxiety level of target population was higher after five sessions of intervention level of anxiety reduced with these numerical values (M = 88.60, SD = 6.896 & M = 78.60, SD = 5.775) respectively. After ten and fifteen psychotherapy sessions anxiety more reduction among bipolar disorder patients means values (M = 69.42, SD = 4.941& M = 42.56, SD = 7.080) accordingly.

Table 2

Level of Anxiety among Bipolar Disorder Patients in regard of psychotherapies

	CBT Therapy		***Behaviour Therapy***				
Variable	*M Graduation*	*SD*	*M Apprication*	*SD*	*t(49)*	*p*	*Cohen's d*
Anxiety	56.98	11.876	77.94	10.458	-10.356	.000	0.1794
	REBT *Therapy Relaxation Exercise*		**Psychoanalysis Free Flowing Conversation**				
Anxiety	67.94	5.780	74.74	7.655	5.636	.000	4.400

Note. M = Mean, SD = Standard Deviation

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Table 3

Level of Anxiety among Bipolar Disorder Patients in control group and experimental group and Gender Wise

	Control Group		**Experimental Group**				
Variable	*M*	*SD*	*M*	*SD*	*t(49)*	*p*	*Cohen's d*
Anxiety	80.40	8.327	59.62	12.428	10.426	.000	0.1794
	Female		**Male**				
Variable	*M*	*SD*	*M*	*SD*	*t(24)*	*p*	*Cohen's d*
	85.28	7.77	75.44	5.64	-4.992	.000	

Note. M = Mean, SD = Standard Deviation

Table 1 is depicting the level of anxiety among bipolar disorder patients grouping wise. Control group participants anxiety level of target population was higher than experimental group with these numerical values (M = 80.40, SD = 8.327& M = 59.62, SD = 12.428) respectively.

Cohen's d is showing the less effect size. Results also revealing the gender difference in level of anxiety among bipolar disorder patients female patients anxiety overall was observed higher then male bipolar disorder patients with mean values (M = 85.28, SD = 7.77 & M = 75.44, SD = 5.64) respectively.

Discussion

The efficacy of CBT on bipolar young adults patients, they were assessed to different hospitals and from their residential areas in this exploratory study. The most known influence of CBT on bipolar disorder clients declared by the findings in table I, anxiety was measured less in those clinical participants whose were getting intervention of CBT then counterparts in both assessment after 5 sessions and after 15 sessions. Results revealed in earlier sessions anxiety was higher among BD patients, while with increasing number of sessions anxiety was reducing and at psychotherapy maturation stage was a obvious difference in anxiety prevalence at base line and after

intervention completion. Implicit beliefs also uniquely predicted treatment outcomes when controlling for baseline social anxiety and other kinds of maladaptive beliefs (perceived social costs, perceived social self-efficacy, and maladaptive interpersonal beliefs). Finally, implicit beliefs continued to predict social anxiety symptoms at 12 months post-treatment. These findings suggest that changes in patients' beliefs about their emotions may play an important role in CBT for SAD. The more anxiety scores were reported among non-intervention received bipolar patients then intervention received participants and measuring anxiety was less among CBT psychotherapy intervention receiver bipolar disorders patients rather than other psychotherapies intervention participants. There repeated measure t test results exposed CBT more effective intervention for reducing anxiety among bipolar disorders clients then those bipolar disorders patients getting any other type intervention to their consultant psychologist. Yu ye et al (2015) were investigated the effectiveness of the CBT in treating bipolar disorder. Short-term efficacy of CBT in reducing relapse rate of BD and improving the severity of mania was proved. But these effects could be weakened by time. In addition, there was no effect of CBT on level of depression in Bipolar disorder (BD). CBT is powerful in diminishing the anxiety rate and enhancing depressive indications, insanity seriousness, and psychosocial working, with a mellow to-direct impact estimate. Subgroup investigations demonstrated that enhancements in sorrow or craziness are more intense with a CBT treatment span of ≥90 min per session, and the depression rate is much lower among patients with type I BD (Castella et al., 2014).

CBT was proved more effective for reducing the anxiety rather than counterparts; anxiety was higher with behavior therapy than CBT by finding of table II and Rational emotive therapy was proven more effective in anxiety reduction than other Psychotherapies. Stefan et al. (2012) were explored Cognitive-behavioral therapy (CBT) refers to a class of interventions that share the basic premise that mental disorders and psychological distress are maintained by cognitive factors. The core premise of this treatment approach was, as pioneered. CBT is powerful in declining the anxiety rate and enhancing depressive manifestations, madness seriousness, and psychosocial working, with a mellow to-direct impact estimate. Subgroup investigations showed that enhancements in discouragement or craziness are more intense with a CBT treatment span of ≥90 min per session, and the anxiety rate is much lower among patients with type (Strassler et al., 2017).

In present study was evaluated by table III women were more affected by anxiety then men's bipolar disorder patients. Previous study also agrees with research objectives and findings in this regard. The introduction and course of bipolar issues contrasts amongst ladies more than men. The beginning of bipolar issue has a tendency to happen later in women than men, and ladies all the more regularly have an occasional example of the state of mind unsettling influence. Ladies encounter depressive scenes, blended craziness, and fast cycling more regularly than men. Bipolar II issue, which is prevailed by depressive scenes, additionally gives off an impression of being more typical in ladies than men. Co morbidity of medicinal and mental issue is more typical in ladies than men and unfavourably influences recuperation from bipolar confusion all the more frequently in ladies (Altshuler et al., 2010). For bipolar confusion, course of sickness factors, for example, age at beginning and number of emotional scenes of every extremity don't appear to vary crosswise over sexual orientations. Ladies, be that as it may, might be more probable than men to be hospitalized for hyper scenes. While the two men and ladies with the disease have high rates of co morbidity with liquor and other substance utilize disarranges, ladies with bipolar turmoil are at an especially high hazard for co morbidity with these conditions (Diflorio, & Jones, 2010). In unipolar mood syndrome with solid proves depression is approximately double in ladies than men. Most investigations, however not all, report a relatively parallel sexual orientation proportion in the pervasiveness of bipolar issue yet the lion's share of studies do report an expanded hazard in ladies of bipolar II/hypomania, quick cycling and blended scenes. For bipolar turmoil, course of sickness factors, for example, age at beginning and number of emotional scenes of every extremity don't appear to contrast crosswise over sexual orientations (Diflorio, & Jones, 2010). Ladies, in any case, might be more probable than men to be hospitalized for hyper scenes. While the two men and ladies with the ailment have high rates of co morbidity with liquor and other substance utilizes clutters, ladies with bipolar confusion are at an especially high hazard for co

morbidity with these conditions (Hendrick et al., 2000). Experimental group bipolar patients exhibited more anxiety then control group patients, table III results had proved the study, intervention possess the potential for anxiety reducing among BD. CBT proved effective intervention for reducing anxiety among bipolar patients then other interventions.

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REFERENCES

Altshuler, L. L., Kupka, R. W., Hellemann, G., Frye, M. A., Sugar, C. A., McElroy, S. L., ... & Suppes, T. (2010). Gender and depressive symptoms in 711 patients with bipolar disorder evaluated prospectively in the Stanley Foundation bipolar treatment outcome network. *American Journal of Psychiatry*, *167*(6), 708-715.

Baldessarini, R. J., Tondo, L., & Hennen, J. (2003). Lithium treatment and suicide risk in major affective disorders: update and new findings. *Journal of Clinical Psychiatry*, *64*, 44-52.

Basco, M. R., & Rush, A. J. (2005). *Cognitive-behavioral therapy for bipolar disorder*. Guilford Press.

Chiang, K. J., Tsai, J. C., Liu, D., Lin, C. H., Chiu, H. L., & Chou, K. R. (2017). Efficacy of cognitive-behavioral therapy in patients with bipolar disorder: A meta-analysis of randomized controlled trials. *PloS one*, *12*(5), e0176849.

Costa, R. T. D., Range, B. P., Malagris, L. E. N., Sardinha, A., Carvalho, M. R. D., & Nardi, A. E. (2010). Cognitive–behavioral therapy for bipolar disorder. *Expert review of neurotherapeutics*, *10*(7), 1089-1099.

De Castella, K., Goldin, P., Jazaieri, H., Heimberg, R. G., Dweck, C. S., & Gross, J. J. (2015). Emotion beliefs and cognitive behavioural therapy for social anxiety disorder. *Cognitive behaviour therapy*, *44*(2), 128-141.

De Castella, K., Goldin, P., Jazaieri, H., Heimberg, R. G., Dweck, C. S., & Gross, J. J. (2015). Emotion beliefs and cognitive behavioural therapy for social anxiety disorder. *Cognitive behaviour therapy*, *44*(2), 128-141.

Diflorio, A., & Jones, I. (2010). Is sex important? Gender differences in bipolar disorder. *International review of psychiatry*, *22*(5), 437-452.

Feeny, N. C., Danielson, C. K., Schwartz, L., Youngstrom, E. A., & Findling, R. L. (2006). Cognitive-behavioral therapy for bipolar disorders in adolescents: a pilot study. *Bipolar disorders*, *8*(5p1), 508-515.

First, M. B., Clarke, D. E., Yousif, L., Eng, A. M., Gogtay, N., & Appelbaum, P. S. (2023). DSM-5-TR: rationale, process, and overview of changes. *Psychiatric Services*, *74*(8), 869-875.

Gomes, B. C., Abreu, L. N., Brietzke, E., Caetano, S. C., Kleinman, A., Nery, F. G., & Lafer, B. (2011). A randomized controlled trial of cognitive behavioral group therapy for bipolar disorder. *Psychotherapy and psychosomatics*, *80*(3), 144-150.

Granath, J., Ingvarsson, S., von Thiele, U., & Lundberg, U. (2006). Stress management: a randomized study of cognitive behavioural therapy and yoga. *Cognitive behaviour therapy*, *35*(1), 3-10.

Hamilton, M. A. X. (1959). The assessment of anxiety states by rating. *British journal of medical psychology*.

Hara, K. M., Westra, H. A., Aviram, A., Button, M. L., Constantino, M. J., & Antony, M. M. (2015). Therapist awareness of client resistance in cognitive-behavioral therapy for generalized anxiety disorder. *Cognitive Behaviour Therapy*, *44*(2), 162-174.

Hendrick, V., Altshuler, L. L., Gitlin, M. J., & Hammen, C. (2000). Gender and bipolar illness. *The Journal of clinical psychiatry*, *61*(5), 7623.

Hofmann, S. G., Asnaani, A., Vonk, I. J., Sawyer, A. T., & Fang, A. (2012). The efficacy of cognitive behavioral therapy: A review of meta-analyses. *Cognitive therapy and research*, *36*, 427-440.

Jones, S. (2003). Bipolar Disorder: A Cognitive Therapy Approach C. Newman, RL Leahy, AT Beck, NA Reilly-Harrington & L. Gyulai Washington, DC: American Psychological Association, 2002. pp. 260.£ 39.95 (hardback). ISBN: 1-55798-789-

0. *Behavioural and Cognitive Psychotherapy*, *31*(1), 113-122.

Kupfer, D. J. (2005). The increasing medical burden in bipolar disorder. *Jama*, *293*(20), 2528-2530.

López-Zurbano, S., & González-Pinto, A. (2019). Gender differences in bipolar disorder. *Psychopathology in women: Incorporating gender perspective into descriptive psychopathology*, 739-764.

Made, R. & Dombeck, M. (2009). Bipolar Disorder Treatment – Psychotherapy And Cognitive Behavioral Therapy. Bipo Treat Psycho 2009;

Morris, J., Firkins, A., Millings, A., Mohr, C., Redford, P., & Rowe, A. (2016). Internet-delivered cognitive behavior therapy for anxiety and insomnia in a higher education context. *Anxiety, Stress, & Coping*, *29*(4), 415-431.

Newman, C. F., Leahy, R. L., Beck, A. T., Reilly-Harrington, N. A., & Gyulai, L. (2002). *Bipolar disorder and the family*. American Psychological Association.

Pankowski, S., Adler, M., Andersson, G., Lindefors, N., & Svanborg, C. (2017). Group acceptance and commitment therapy (ACT) for bipolar disorder and co-existing anxiety–an open pilot study. *Cognitive behaviour therapy*, *46*(2), 114-128.

Priyamvada, R., Kumari, S., Prakash, J., & Chaudhury, S. (2009). Cognitive behavioral therapy in the treatment of social phobia. *Industrial psychiatry journal*, *18*(1), 60-63.

Stang, P. E., Frank, C., Kalsekar, A., Yood, M. U., Wells, K., & Burch, S. (2006). The clinical history and costs associated with delayed diagnosis of bipolar disorder. *Medscape General Medicine*, *8*(2), 18.

Strassler D. Bipolar Disorder Symptoms Lessened by Cognitive-Behavioral Therapy, Psychiatry Advisor 2017; May 4;12(5).

Szentagotai, A., & David, D. (2009). The efficacy of cognitive-behavioral therapy in bipolar disorder: a quantitative meta-analysis. *The Journal of clinical psychiatry*, *70*(1), 5997.William, E., Narrow, M. D., Donald, S., Rae, M. A, Lee, N., Robins, Darrel, A., Regier, M.D. (2002). Revised Prevalence Estimates of Mental Disorders in the United States. Archive General Psychiatry, 59:115-123

Ye, B. Y., Jiang, Z. Y., Li, X., Cao, B., Cao, L. P., Lin, Y., ... & Miao, G. D. (2016). Effectiveness of cognitive behavioral therapy in treating bipolar disorder: A n updated meta-analysis with randomized controlled trials. *Psychiatry and clinical neurosciences*, *70*(8), 351-361.

Zaretsky, A. E., Segal, Z. V., & Gemar, M. (1999). Cognitive therapy for bipolar depression: a pilot study. *The Canadian Journal of Psychiatry*, *44*(5), 491-494.