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Cognitive Processing Therapy for PTSD and Bipolar Disorder Comorbidity: A Case Study

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There is a strong comorbidity between Posttraumatic Stress Disorder (PTSD) and bipolar disorder. Unfortunately, there is lack of dissemination regarding modifications of evidence-based therapies for PTSD among individuals with comorbid bipolar I disorder. Cognitive Processing Therapy (CPT) is one such evidence-based, gold-standard psychotherapy for PTSD that can be modified to address a wide-scope of symptoms either directly, or indirectly, related to traumatic events. This case study describes a female veteran with PTSD and comorbid bipolar I disorder who received CPT. Modifications of CPT were implemented during the later phase of therapy and were related to the management of hypomanic symptoms, medication adherence, and anxiety related to her self-trust and control regarding future manic episodes. The patient exhibited few symptoms of PTSD or depression at a 3-month follow-up and reported that CPT simultaneously helped her manage symptoms of bipolar disorder. A description the patient, necessary modifications, and strategies to address comorbid PTSD and bipolar I disorder are provided.

Posttraumatic stress disorder (PTSD) is characterized by intrusion symptoms, avoidance, persistent negative moods and cognitions, and hyperarousal following a traumatic event (American Psychiatric Association [APA], 2013). Active-duty service members and veterans of the military report rates of PTSD following combat deployments of 7–20% (Institute of Medicine, 2014; Richardson, Frueh, & Acierno, 2010). Emerging evidence suggests that patients with bipolar disorder also have elevated rates of PTSD when compared to the general population. In a review of eight studies, the estimated mean prevalence rate of PTSD in patients with bipolar disorder was 16% (Otto et al., 2004), compared to 6.9% in the general U.S. population (Koenen et al., 2017). Notably, in a sample of veterans at a Veterans Affairs hospital the prevalence rate of PTSD in patients with bipolar disorder was 38% (Thatcher, Marchand, Thatcher, Jacobs, & Jensen, 2007).

Although the literature indicates elevated rates of PTSD in patients with bipolar disorder, the etiology of this comorbidity is unclear. Patients with bipolar disorder may be at greater risk of trauma exposure during a manic episode, and subsequently developing PTSD, due to increased risk-taking behaviors (Otto et al., 2004). Moreover, researchers found a manic episode to be the most critical risk factor associated with new-onset PTSD due to intensification of anxiety sensitivity at the time of the trauma (Pollack et al., 2006). Additional vulnerabilities found to place patients with bipolar disorder at greater risk of developing PTSD include the following: being female (Reddy, Meyer, Wittlin, Miller, & Weinstock, 2017), childhood trauma (Assion et al., 2009), multiple comorbid psychiatric disorders (Otto et al., 2004; Reddy et al., 2017), neuroticism, lower levels of extroversion, lower social support, and lower socioeconomic status (Otto et al., 2004).

Research suggests that PTSD is associated with increased symptom severity of bipolar disorder (Thatcher et al., 2007). Patients with comorbid bipolar

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disorder and PTSD may have poorer quality of life, decreased likelihood of recovery (Otto et al., 2004; Simon et al., 2004), lower psychosocial functioning, more severe depression (Assion et al., 2009), increased likelihood of substance use disorder (Simon et al., 2004; Thatcher et al., 2007), and an elevated risk of suicide attempts (Otto et al., 2004; Reddy et al., 2017; Simon et al., 2004) when compared to patients with bipolar disorder only. Additionally, sleep disruption associated with PTSD may place patients with bipolar disorder at greater risk of manic episode onset (Malkoff-Schwartz et al., 1998).

Unfortunately, many randomized controlled trials that examine the efficacy of evidence-based therapies for PTSD exclude individuals with a diagnosis of bipolar I and/or bipolar II disorder (e.g., Foa et al., 2019; McLean et al., 2018; Resick et al., 2015, 2017b). Moreover, veterans with both disorders are less likely to receive evidence-based therapy for PTSD (Sripada, Pfeiffer, Rauch, Ganoczy, & Bohnert, 2018). Individuals with bipolar disorder, on average, receive only 7 sessions of psychotherapy, and patients with comorbid bipolar disorder and PTSD receive 14.6 sessions, compared to 20.7 sessions for individuals with only PTSD (Thatcher et al., 2007).

Cognitive Processing Therapy (CPT; Resick et al., 2017a) has been shown effective in reducing PTSD symptoms in civilian and military populations (e.g., Chard, 2005; Galovski, Blain, Mott, Elwood, & Houle, 2012; Monson et al., 2006; Resick et al., 2017b; Rosner et al., 2019). Although these therapies have demonstrated efficacy in the treatment of PTSD, limited research exists on the efficacy of such treatments for patients with comorbid PTSD and bipolar disorder (Otto et al., 2004). However, there is growing evidence to support the use of Cognitive Behavior Therapy for PTSD (Provencher, Hawke, & Thienot, 2011), Prolonged Exposure (Grubaugh et al., 2016), and Eye Movement Desensitization and Reprocessing (Moreno-Alcázar et al., 2017; Novo et al., 2014) to treat comorbid PTSD and severe mental illness, including bipolar disorder. In a review of the literature, we were unable to find clearly defined guidelines for when it is and is not appropriate for someone with a bipolar I disorder diagnosis to receive PTSD treatment. However, research on treating PTSD in patients with comorbid bipolar disorder used fairly consistent inclusion/exclusion criteria: requiring that patients either be on stable doses of mood stabilizers (Novo et al., 2014), be currently euthymic (Moreno-Alcázar et al., 2017; Novo et al., 2014), or have no psychiatric hospitalizations within the past 1 to 3 months (Grubaugh et al., 2016; Mueser et al., 2007, 2008; Rosenberg, Mueser, Jankowski, Salyers, & Acker, 2004). Thus, there is a consensus that patients currently endorsing mania should be stabilized prior to receiving PTSD treatment.

Modifications to CPT for individuals with comorbid PTSD and bipolar disorder have not been disseminated. The purpose of this case study is to describe the necessary modifications made to CPT for a female veteran who experienced multiple traumatic events, including childhood sexual abuse and military sexual assault. The flexible nature of CPT allowed the therapist to adequately address unique symptoms and treatment-interfering behaviors related to comorbid bipolar disorder. Moreover, this case study demonstrates the effectiveness of such modifications, demonstrated by excellent end-state outcomes.

The Patient

The patient in this case study provided her written informed consent for the publication of the case study. The pseudonym "Margaret" is used in this paper to protect her privacy. Details of her military background and family history have been changed to ensure patient confidentiality. Margaret was a White female veteran of the U.S. Navy with PTSD from childhood sexual abuse and military sexual trauma. She was 50 years of age at the time treatment started, served 8 years on active duty, and self-identified as a lesbian.

Margaret reported early childhood sexual abuse by a family friend, starting at the age of 3 and continuing until the age of 9. Margaret stated that intercourse began at the age of 6, at which time she told her mother about the abuse. Her mother reacted violently, hitting Margaret and screaming. The family friend continued to rape her for 3 additional years after she informed her mother of the abuse and multiple perpetrators became involved in the sexual abuse.

Margaret enlisted in the military at the age of 18. During her 8-year service, she was deployed three times to the Persian Gulf. During one deployment to the Persian Gulf, she reported that a superior officer raped her. She explained that she was in shock and froze during the rape. While discussing this incident during the beginning phases of therapy, Margaret stated, "he didn't know" that he was violating her.

Margaret identified her early childhood sexual abuse and rape as her index event or events that were causing her the most distress and impairment. More specifically, she identified the first time that the family friend had raped her, including her response of running back to her house and hiding. She remembered that her mother found her crying and reported thoughts of self-blame, including that it was her fault that he had raped her. She also had the belief that she should have told someone else about the abuse,

rather than disclosing the incident to her mother. She stated that she should have told her teachers or her father. She had three reported suicide attempts in her life, at 18, 26, and 49 years of age. Additionally, she endorsed nonsuicidal self-injury and indicated she cut her legs with a knife 3 years prior to starting treatment.

Margaret stated that she experienced episodes of mania and hypomania 7 years prior to treatment. The onset of her bipolar I symptoms at mid-life (over the age of 40 years) is uncommon, given that most initial manic episodes occur in late adolescence and early adulthood. Thus, the expression of symptoms related to PTSD and bipolar I disorder may be atypical. Margaret was able to remain functional in her personal and professional life, and therefore did not seek treatment for these symptoms. She stated that during these episodes, she felt "good" and "productive." She reported a more severe and debilitating manic episode 6 months prior to treatment, in which she was not sleeping, had increased energy, and rapid and tangential thought processes. At this time, she went to work and demonstrated erratic behavior, as indicated by incoherent and loud speech, as well as property damage. She was subsequently hospitalized because of this behavior and was formally diagnosed with bipolar I disorder. At the baseline assessment, Margaret had been stable on psychotropic medications for more than 6 months. Her medications included aripiprazole, tramadol, and diazepam. Despite the impairment caused by bipolar I disorder and PTSD, she obtained her associates degree. Margaret had not received previous treatment for her traumas.

Baseline Assessment

Margaret's assessment scores are presented in Table 1. She was evaluated at baseline by an independent evaluator using the Clinician Administered PTSD Scale for the DSM-5 (CAPS-5; Weathers et al., 2013a). The CAPS-5 assesses the severity and frequency of each PTSD symptom associated with the index trauma, ranging from absent to extreme. Margaret endorsed symptoms of intrusion, avoidance, negative alterations in cognition and mood, and alterations in arousal and reactivity, with a total CAPS-5 score of 58. She also completed the PTSD Checklist for DSM-5 (PCL-5; Weathers et al., 2013b), a self-report measure of PTSD symptoms, with a total score of 78. The PCL-5 has good psychometric properties (Blevins, Weathers, Davis, Witte, & Domino, 2015), and scores greater than 30–34 indicate a possible PTSD diagnosis (Bovin et al., 2016). Together, results from the clinical diagnostic interview using the CAPS-5 and PCL-5 warranted the diagnosis of PTSD, based on DSM-5 criteria (APA, 2013). She also completed the Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996), a self-report measure of depression, with a total score of 53, suggesting severe depression. It is unlikely that her depression at the time of her baseline assessment was a residual effect of a manic episode, given her last reported manic episode was 6 months prior to this meeting. Margaret reported past suicidality, with three prior attempts, and passive suicidal ideation at the time of the baseline assessment on the Columbia-Suicide Severity Rating Scale (C-SSRS; Posner et al., 2011). Margaret and the independent evaluator affiliated with the research study collaboratively developed a Crisis Response Plan (Bryan et al., 2017) to determine strategies that Margaret could implement if she experienced significant emotional distress. These strategies included identifying her warning signs, using self-management strategies, considering her reasons for living, reaching out to her social support system, and, if needed, contacting professional help. Margaret's suicidal ideation was monitored throughout treatment. Her symptoms of bipolar disorder were not formally assessed. Throughout treatment, changes in symptoms and medication adherence were assessed and recorded by the therapist using a standard adverse event monitoring log (Peterson et al., 2013).

Table 1
Assessment Measures at Baseline, Session 12, and Follow-up Periods.

	Baseline	Session 11 (BDI-II) Session 12 (PCL-5)	3-Month Follow-Up
CAPS-5	58	-	0
PCL-5	78	3	0
BDI-II	53	0	0

Note. CAPS-5 is the Clinician Administered PTSD Scale for the DSM-5; PCL-5 is the PTSD Checklist-5; BDI-II is the Beck Depression Inventory-II.

Treatment Plan

After completion of the baseline assessment, Margaret was deemed eligible to participate in a study comparing the effectiveness of CPT delivered either in patients' homes, via telebehavioral health, or in office. Please see Peterson and colleagues (2018) for a description of the equipoise stratified randomized design of the clinical trial. Margaret was randomized to receive CPT via telebehavioral health. She was provided a laptop computer, a hotspot for connecting to the Internet, a video camera, and a scanner to send in practice assignments and measures. She was scheduled to receive CPT twice weekly and completed therapy within 45 days.

Cognitive Processing Therapy

CPT (Resick et al., 2017a) is an evidence-based therapy for PTSD that targets negative and erroneous trauma-related cognitions. CPT is a gold-standard therapy for PTSD among active-duty service members (Resick et al., 2015, 2017b) and veteran populations (Chard, Schumm, Owens, & Cottingham, 2010; Monson et al., 2006). The first several sessions of CPT are focused on providing psychoeducation about PTSD and helping the patient identify trauma-related thoughts (i.e., "stuck points") and related emotional responses. During the middle phase of therapy, patients begin to process the index event using progressive worksheets and weekly practice. In doing so, CPT fosters the patient's ability to (a) accept the traumatic event as it really occurred in context, (b) feel the natural emotions associated with the event, and (c) develop new and more balanced ways of thinking about the event through Socratic dialogue. As a result, the patient is able to (a) decrease negative emotions that derive from maladaptive cognitions, and (b) improve the quality of their life. The later phase of therapy assists the patient in recognizing and modifying stuck points related to present-day functioning in five different cognitive domains: safety, trust, power/-control, esteem, and intimacy. Patients with PTSD are able to use their previously learned skills to question these stuck points and develop more realistic alternative thoughts that lead to emotional relief.

Course of Treatment

Psychoeducation, Stuck Points, and the Relationship Between Events, Thoughts, and Feelings

In the first three sessions, Margaret learned that PTSD is an interruption in the natural recovery process that occurs after experiencing a traumatic event and that avoidance and maladaptive beliefs about the traumatic event serve to maintain PTSD. Margaret wrote her Impact Statement: a page on why she thought the child sexual abuse happened, focusing mainly on the first time she was raped, and how it affected her beliefs about herself, others, and the world in the domains of safety, trust, power and control, esteem, and intimacy. Her dysfunctional beliefs were labeled as "stuck points," and were related to the traumatic event itself (assimilated stuck points), as well as how the trauma currently impacted her (overaccommodated stuck points). She also learned that natural emotions associated with the trauma (e.g., fear, sadness, and anger) dissipate more quickly if they are felt, compared to manufactured emotions (e.g., guilt, shame, disgust), which are a result of stuck points. She completed practice assignments that encouraged her to identify the connection between events, thoughts, and emotions, recognized the role of hindsight bias to challenge assimilated stuck points (e.g., "I should have waited to tell my father"). Through the use of Socratic dialogue, she realized that her mind was racing, she felt terrified and nauseous, and that she was bleeding and crying in a closet when her mother found her. Therefore, waiting to tell her father was not an option, and instead Margaret identified that, "I wish my father knew," which was associated with sadness. Modification of the first phase of therapy was unnecessary; however, Margaret was often redirected to remain focused on challenging and processing one stuck point at a time. Questions and statements that were helpful to limit avoidance included, "How is this related to the stuck point?" and, "Let's go back to the original stuck point we were working on."

Processing the Index Event

Sessions 4 through 7 focused primarily on assisting Margaret process her experience of sexual abuse by addressing her assimilated stuck points. Self-blame was identified as a common theme for many of her assimilated stuck points (e.g., "I should not have followed him," "I let myself get into that situation"). The underlying cognition, "It was my fault this happened," was targeted through Socratic questioning and examination of the "Levels of Responsibility Handout." Margaret was able to identify that at the age of 6, even though she had been sexually assaulted by the perpetrator, there was no way for her to predict the rape. The unforeseeable event naturally leads to grief and sadness. She had previously felt guilt and regret, an inappropriate emotional response given she did not intend for the rape to happen and was not responsible for the actions of the family friend. A responsibility pie chart helped her place the responsibility of the rape fully on the perpetrator. She was able to identify that her "freeze" response to the event was natural, and possibly a result of previous trauma. Other assimilated stuck points that were addressed included, "If my dad knew, he would be able to protect me," and, "I should have told my teachers." She developed alternative thoughts, such as, "I wish I told my father," and, "I was a child and it was wrong for him to molest me and rape me." The concept of responsibility and blame was also applied to her military sexual trauma while deployed in the Persian Gulf. She previously thought that, "He didn't know, because I froze during it," and had feelings of guilt and shame. She was able to resolve this stuck point and realized that she had no responsi-

bility for the military sexual trauma. Overall, modifications to CPT were not required throughout Sessions 4 through 7, and Margaret was able to address assimilation appropriately.

Processing Overaccommodated Stuck Points

The remaining five sessions were devoted to resolving any remaining assimilated stuck points and shifting focus toward overaccommodated stuck points on the five cognitive themes: safety, trust, power/control, esteem, and intimacy. Throughout the remainder of CPT, stuck points related to her bipolar I diagnosis and symptoms were able to be incorporated into therapy. More specifically, during Session 8, she explained that mania "felt good" and helped increase her productivity. At this time, she endorsed pressured speech and was slightly distracted in session. Therefore, an assessment of medication adherence was conducted in order to prevent the onset of a manic episode. In the framework of CPT, medication nonadherence can be conceptualized as a safety concern, given that Margaret endorsed beliefs concerning the benefits of mania. Through Socratic discussion, she recognized the negative aspects of mania, including spending too much money and reckless driving. In concert with motivational interviewing techniques, Margaret developed the realistic belief that it remained important to continue with her medication regimen. She expressed no desire to stop taking her medications at the end of the session. It was important to continually redirect Margaret, and the CPT worksheets helped her stay focused.

During the next session, Margaret indicated that she had been "depressed" after the last session, which may have been a result of having experienced hypomanic symptoms. She indicated continued commitment to taking her prescribed medications and wanted to proceed with therapy, as normal. Session 9 of CPT is primarily focused on trust-related issues, and Margaret indicated that she could not trust herself due to her diagnosis of bipolar disorder. Dimensions of trust were useful to explore, and after Socratic dialogue, she was able to recognize that her bipolar diagnosis is not related to whether she can trust herself, in general. She identified that she can trust herself to make healthy decisions in the context of friendships and relationships, to take her medication and attend scheduled appointments, as well as to take care of her pets. It remained important for Margaret not to allow a psychiatric diagnosis to overshadow dimensions of her life in which she is functioning well.

The concern and anxiety associated with bipolar disorder was revisited in relation to power and control. In addition to trauma-related stuck points concerning power and control (e.g., "If I do not have full control, I will get hurt"), Margaret also focused on the lack of control she experienced during previous manic episodes, causing extreme anxiety. It was important for Margaret to recognize that while defining symptoms of mania include difficulty in maintaining focus, exaggeration about "no control" was not helpful or accurate. She identified that she has never physically harmed anyone, which is evidence that she has some control over her actions. In addition, the likelihood of experiencing manic episodes in the future was reviewed. Though hypomanic episodes were identified as more typical, she realized that she had not experienced a manic episode for over 6 months, and that her medications were helpful. In the remaining sessions, Margaret demonstrated increased flexibility regarding her own self-worth. She did not want her diagnosis of bipolar disorder to serve as evidence that she was unworthy.

Prior to the last session, Margaret wrote a new Impact Statement about why she thought the traumatic event happened to her as a child and how the event had impacted her views of herself, others, and the world, in the domains of safety, trust, power/control, esteem, and intimacy. Some of the statements in her final Impact Statement follow:

xxxI am a survivor of rape. Our family friend and his friends raped me. I now know it was his fault, his choice, I feel justified in all my decisions. . . Finally realizing it was not my fault. My mother's actions do not define me or my emotions. . . Questioning myself and blaming myself for my childhood trauma is now a thing of the past.

Her progress throughout therapy was reviewed, in which her PTSD and depression symptoms had significantly decreased. She was no longer experiencing clinically significant symptoms of either PTSD or depression, and a graph of her scores was shown to her to demonstrate this improvement. She mentioned that she quit drinking about halfway through therapy because she "didn't need the emotional crutches," which conveyed her ability to reduce her emotional avoidance and tolerate uncomfortable feelings. Reduced drinking was not a target of therapy, but rather a secondary outcome of treatment for PTSD that may also help manage bipolar I symptoms. Additionally, Margaret did not endorse any suicidal ideation at the end of therapy.

Discussion

Margaret was motivated to improve her symptoms of PTSD, as evidenced by her consistent attendance and the number of completed practice assignments

throughout therapy. Over the course of 7 weeks, she noticed significant reduction in PTSD and depression symptoms (see Fig. 1). Her scores on the PTSD Checklist and Beck Depression Inventory-II at her final appointment were "3" and "0," respectively, considered to be below good end state results (Wachen et al., 2019). Based on her responses on both self-report measures and the clinical assessment of the therapist, she no longer met diagnostic criteria for PTSD or depression. These improvements in symptoms were sustained when Margaret completed assessments at a 3-month follow-up point. At that time, results from the CAPS-5, administered by an independent evaluator, the self-report PCL-5, and the self-report BDI-II demonstrated that she had no symptoms of PTSD or depression. She reported that she continued using her Challenging Beliefs Worksheets to resolve remaining stuck points that were causing her distress. Good end-state functioning was maintained, which is consistent with previous studies that have demonstrated consistency in attendance (Gutner, Suvak, Sloan, & Resick, 2016) and completion of practice assignments (Wiltsey Stirman et al., 2018) are predictive of treatment success.

Although distraction and tangentiality are not necessarily unique to bipolar disorder, strategies were implemented to help keep Margaret focused throughout therapy. Times when she had decreased attention, it was important to direct her to the "step-by-step" process of the worksheets. Strategies to help keep her focused were especially important when she endorsed symptoms of hypomania during one session, including slightly pressured speech with circumstantial content.

Adaptations of CPT were implemented for Sessions 8 through 10 in order to address hypomanic symptoms, medication management, and anxiety concerning future manic episodes and thoughts of uncontrollability. It was possible to address dysfunction related to symptoms of bipolar disorder while remaining adherent to the protocol. Thoughts directly related to bipolar disorder, which served as barriers to processing the traumatic event, were conceptualized as "overaccommodated" stuck points. More specifically, stuck points regarding medication adherence were challenged and Margaret recognized the importance of medication adherence. Furthermore, she experienced less anxiety and concern about future manic episodes as a result of her dedication to medication adherence, realization of the low likelihood of future manic episodes, and less exaggeration of her lack of control. Clinicians working with patients with comorbid PTSD and bipolar I or bipolar II disorder should continue to monitor distractibility and symptoms related to hypomania and mania throughout the duration of therapy and assess for medication adherence. Moreover, it is important that clinicians continue to consult with patient's psychopharmacologist and other health care practitioners throughout CPT and

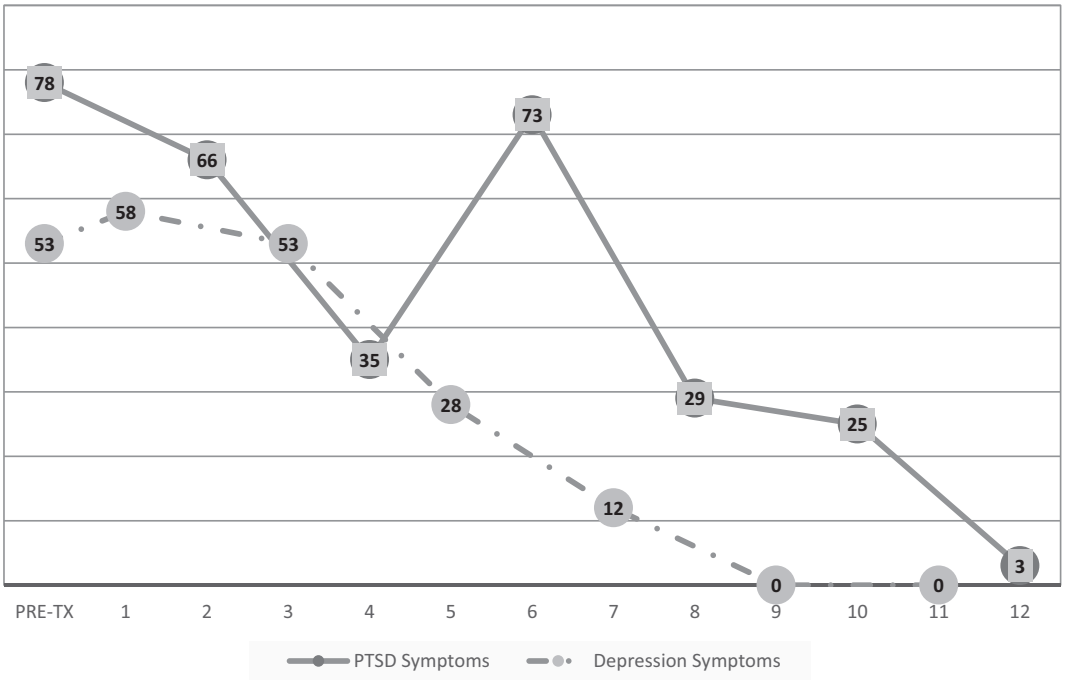

Fig. 1. Session-by-Session PTSD and Depression Symptoms. *Note.* PRE-TX are the PTSD and Depression Scores at Pre-Treatment; The PCL-5 and BDI-II were the measures used to assess PTSD and Depression at even and odd-numbered session, respectively.

communicate any changes in the patient's mental status. Given that randomized controlled trials may exclude individuals who meet criteria for bipolar disorder, further research is needed to explore additional considerations in treating comorbid PTSD and bipolar disorder.

Margaret's PTSD and depression symptoms improved early in therapy. However, during Session 6, her PTSD scores increased from the previous session by 38 points. The increase in symptoms was attributed to the discussion of mandatory reporting of child abuse. After consultation with colleagues, it was determined that there was lack of information about Margaret's perpetrator to report to authorities.

There are some limitations to this case study. Margaret's bipolar I disorder diagnosis was based on her diagnosis received during hospitalization and was not confirmed with a formal assessment at baseline. Differential diagnoses include borderline personality disorder (BPD), given previous research that has demonstrated high comorbidity rates with PTSD (Harned, Rizvi, & Linehan, 2010), and high comorbidity of BPD among PTSD patients (Zlotnick, Franklin, & Zimmerman, 2002). A recent latent class analysis study demonstrated suicidality and self-injurious behavior was a symptom present in approximately half of individuals with BPD, and fewer patients with complex PTSD or PTSD endorsed these symptoms (Cloitre, Garvert, Weiss, Carlson, & Bryant, 2014). It is also possible that Margaret's previous suicide attempts were a function of her depressive moods after manic episodes. A comprehensive structured diagnostic interview beyond the CAPS-5 may have indicated personality disorders that contributed to Margaret's constellation of symptoms. Finally, Margaret's progression through treatment was ideal. She remained engaged throughout treatment, regularly completing homework with infrequent avoidance. By the end of treatment, she was no longer experiencing clinically significant symptoms of PTSD or depression. It is not uncommon for patients in PTSD treatment to experience more significant barriers to engaging in treatment, including more frequent or more severe avoidance, more severe symptoms of depression, unexpected stressful life events, disrupted sleep patterns, and manic episodes. Clinicians may consider utilizing a measure to track symptoms of hypomania and mania, such as the Mood Disorder Questionnaire (MDQ; Hirschfeld et al., 2000), prior to each session. Further, incorporating social rhythm therapy (Frank, Swartz, & Kupfer, 2000) can help the management of possible stressors that disrupt circadian rhythms, in order to prevent future manic or hypomanic episodes.

Results from Margaret's therapy demonstrates the importance of delivering evidence-based therapies for individuals with PTSD and bipolar disorder when patients are medication stable and compliant. This case study is important because research suggests that veterans with comorbid PTSD and bipolar disorder are significantly less likely to receive evidence-based treatments for PTSD compared to veterans with PTSD alone (Sripada et al., 2018). Furthermore, in a sample of patients from a Veterans Affairs hospital, veterans with comorbid PTSD and bipolar disorder received significantly fewer psychotherapy sessions than veterans with PTSD alone (Thatcher et al., 2007). Given the growing evidence to support the use of cognitive behavior therapies to treat comorbid PTSD and bipolar disorder, this case study supports such findings in that individuals with well-managed bipolar disorder can successfully engage in CPT. Modifications were made in later sessions of CPT to address hypomania, medication adherence, and trust and control issues regarding medications and future manic episodes. It is possible that clinicians may focus on the medication management of bipolar disorder and neglect that engagement in empirically supported therapies, such as CPT, may decrease comorbid psychiatric distress. Moreover, literature on the use of cognitive behavioral therapy for the treatment of bipolar disorder suggests that patients revealed lower relapse rates and improved depressive symptoms (Chiang et al., 2017). Thus, veterans with comorbid PTSD and bipolar disorder are particularly in need of effective and accessible treatments for PTSD. Veterans with PTSD and bipolar disorder can significantly benefit from receiving CPT, with sustained improvements.

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