Modified Short-term Dynamic Psychotherapy in Patients with Bipolar Disorder Preliminary Report of a Case Series

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INTRODUCTION

The following paper describes a brief psychotherapeutic approach based upon a case series of four patients with bipolar disorder who are currently in remission from manic and major depressive states. This approach combines both emotional awareness and behavioral elements with a psycho-educational component that is tailored to the individual patient and provided flexibly over a course of 5 one-hour sessions. Below, the major components of the therapy are outlined and illustrated with short vignettes taken from a treatment session. Following the description of this treatment approach, the preliminary results from the case series are presented. Concisely, the objectives of the therapy were to: 1) increase awareness of the emotional and behavioral factors which can promote depression or mania, 2) allow a grieving of losses incurred due to the illness, 3) investigate whether and when states of anxiety, depression or hypomania were precipitated by warded off emotions, and, 4) improve tolerance of complex emotions such as anger, guilt about anger, grief and affectionate feelings.

METHODS

Selection Process

Patients with Bipolar I Disordered who were having some anxiety, depressiveness, adjustment disorder or interpersonal problems were selected after referral from another psychiatrist. Patients had to be stabilized outpatients and not currently manic or depressed. Patients needed to have intact intellectual functioning. Patients had to have an absence of active suicidal ideation. History of severe separation reactions was considered a contraindication since treatment is time-limited. Patients were informed that the therapy would be tried to see if it would be of benefit to them, and that alternative therapies or medication changes would be recommended as needed. Patients were encouraged to maintain contact with their primary physician for medication monitoring. Patients were informed the therapy was time limited to 5 one-hour sessions.

At the present time, four patients (1 male, 3 females) were included in the case series. The patients were, on average, 32.2 years old, two were married, and two were employed. Three of these patients have completed therapy and one is currently in therapy. Each of the patients was on mood stabilizer medication and three were on atypical antipsychotic medications in addition to mood stabilizers.

Therapeutic Procedure

Initiation and Assessment of Emotional Dysregulation. After discussing the history of the patient's problems and current mood status, patients were offered inclusion into the therapy trial.

The first treatment session began with the central objective to examine the role of emotions and other factors on mood states. Exploring specific situations in which the patient noted anxiety, depression or agitation began this process. On examining the situation, the therapist determined how the patient reacted to the emotions they were describing. The therapist determined whether they became anxious, whether they were aware of the accompanying anxiety, and assessed the physiological format of the anxiety. The therapist also observed whether, on the approach to these feelings, the patient became tired, self critical or depressive. If the situation is one in which anger was mobilized, the therapist observed whether the patient could identify the emotion or whether they became anxious, tired, angry at themselves or had some other response. When these responses were identified they were linked cognitively as responses to the emotions.

Vignette A

Therapist: So we spoke about looking together at what emotional factors and other factors can effect your mood states causing either worsening depression or high moods. How has your mood been the last week? (Clarifying focus)
Patient: Worse as we get close to Christmas. Its supposed to be a family time, but, I don't know how I m supposed to be.... I get irritated.
Th: can you describe a specific time you noticed that?
Patient: (Pt sighs) Last Monday, at thanksgiving, after a couple of hours, I wanted to get home.
Th: What happened to make you think that?
Pt: I got tired
Th: Do you know why?
Pt: I was irritated with everyone.
Th: Who was the first one?
Pt: My daughter, I had to walk away or I would have snapped at her.
Th: What produced the irritation?
Pt: She was giving orders. You mash the potatoes, You make the gravy, You set the table.
Th: How did you feel toward her?
Pt: Irritable. (Patient sighs and hands are clenched)
Th: How did that feel inside your body to feel irritated?
Pt: Tight.
Th: You mean you got tense and anxious?
Pt: Yeah. Nervous and nauseated.... and a headache.
Th: So is this what happens when you have anger inside, that you get anxious, nauseated and a headache?....(Recapitulating)
Pt: 10 years ago I used to get so angry.... I would throw things out the window.

Grieving the Illness. Through this emotional mobilization process, in each of the cases so far, there has been moments in which grief about the illness has been experienced. Allowing the patient to describe the things they have endured and reflecting that there is sadness about it when this is present facilitates this process.

Vignette B

Pt: But I don't do that anymore....
Th: Oh, so was your mood more up or down then?
Pt: It was really terrible, for 10 years I went through that.....
Th: Really, aw, so it was really bad then eh (reflecting sadness)
Pt: I put my foot through a pane of glass because I was angry and all I did was hurt myself.
Th: So a lot of stuff happened back then when it was really bad.
Pt: Today, I try not to let myself get angry. I don't socialize with people and don't have any close friends. (Patient looks sad). I rarely go out of my apartment.

Behavioral Elements Related to Relapse. The effects of anxiety, sleep loss, poor nutrition or self care on mood disorder relapse was highlighted as it became apparent in the situations explored. If patients were unaware of the role of sleep deprivation on manic relapse then this was repeatedly reviewed. If patients noted the effects of missing medications or taking self directed holidays, this was reviewed as a risk factor for relapse. The impact of substance abuse on medication levels and side effects was reviewed if this was an issue. Once the patient observed that the pain the illness caused them they became more motivated to do their best to avoid relapse.

Vignette C

Patient: Now If I'm angry, I don't feel it.... I get down and tired.
Th: Is there any other situation in which you felt anger separate from anxiety?
Pt: I don't feel anger.... If I do I don't recognize it.
Th: If we can get handle on that, because if it sneaks up on you and you don't get aware of it then it could get you tired, lose sleep and effect your mood, right?

Later in session:

Th: If emotions go up and you get anxious then you may lose sleep, this is very important because we know that if someone loses sleep it can trigger off mood states with the mood going up or down.
Pt: Well I don't sleep (when stressed), I'm an insomniac

Coping with Complex Feelings. The central theme of the short-term dynamic element of this therapy involves the role of unconscious emotions, including grief, rage and guilt about rage and craving attachments that have been interrupted. The therapist assessed whether this was an important issue for the individual patient during Initiation and Assessment of Emotional Dysregulation. The process of improving coping involved the following: exploration of specific situations in which anger and other feelings were mobilized, focus on the underlying feelings, focus on the emotional experience of the emotions, and focus on the emotions the patient has had with the therapist during the process. Each of the patients thus far was unable to identify the emotion of anger or to differentiate it from anxiety or defense mechanisms. The major finding in these cases was that situations of anger were resulting in anxiety and defensiveness that stressed their relationships and predisposed them to sleep loss, mania and/or depression.

Vignette D

Th: What type of things generate anger within you?
Pt: People who purposefully abuse people and set out to hurt them. (Patient looks irritated)
Th: So you have had those situations. (Patient sighs) What happens in those situations? Is there one we can look at?
Pt: Yes I had a neighbor and needed a check deposited.
(Patient describes the situation: The neighbor ended up stealing 1000.00 and then left town when she went to press charges)
Th: How did you feel towards him?
Pt: I hate him.
Th: How did that feel inside?
Pt: I got sick and nauseated. I got physically ill.
Th: How did the anger feel?
Pt: I wanted him dead.
Th: How did the anger feel physically inside? (Differentiating anger from anxiety)
Pt: I felt worthless.....got mad at myself..... and got depressed.
Th: You mean it went back on yourself? But how did the anger feel before it went back on yourself. (Clarifying the mechanism of internalizing rage)
Pt: I wanted to explode from my gut (patient has drop in tension, arm is raised and voice is raised moderately)
Pt: And my heart was broke, I had never treated him badly, I saw his children hungry and fed them, he was a single parent of boys (Patient is becoming sad)
Th: So there is sadness in you too.
Pt: Very sad that someone could do something to me when I did nothing to deserve it.
Th: That is a sad thing.....
Th: How would you have felt had you actually put the rage onto him?
Pt: I would feel really bad afterward..... That how I felt when I did that to someone 10 years ago. Really bad. It took 4 people to pull me off. (Patient has guilt and painful feeling)
Th: What if they had been really damaged?
Pt: It would have been really dreadful.....
Th: Pretty bad eh (reflecting guilt).....
Pt: .....I grew up with violence..... As a child I walked in the door once to see my mother straddling my father with a butcher knife.....

The patient proceeds to describe an incident in which the mother severely humiliated her. The patient developed a rage inside but got depressed and tired. In the session she experienced a violent urge toward the mother with accompanying guilt about this rage. The picture of the rage was identical to the violent outburst she had had toward the person in the past. Intermittently and at the end of the session, the link between the past and recent emotions is highlighted. Further, the link between the complex feelings, anxiety, sleep loss, fatigue and mood disorder relapse is repeated highlighted.

Other aspects central to this approach include:

1) Therapeutic Stance: The therapist is actively engaged and focused on the task at hand. One works as a co-pilot or co-investigator, avoiding an omnipotent or authoritarian position. One is

actively exploring what happens to emotions and other behaviors and the effects this has on mood states.

2) Absence of interpretation: There is no use of interpretation in the classic psychoanalytic description. Rather, one restricts one's activity to exploring and linking phenomena that are discussed by the patient. For example, when emotions were explored with one patient, the link between old rage/guilt with an abusive parent and the depressing of the rage when her neighbor abused her (or when her daughter bossed her around) became clear to both therapist and patient.

3) Work with feelings toward the therapist: This approach mobilizes complex feelings including positive feelings and irritation. These emotions are explored the same way as the feelings toward anyone else in the current life sphere. These emotions will often link up to complex emotions including rage and guilt about past people. Seeing the link between past and present feelings helps the patient see how these transference phenomena distort their present interpersonal experiences.

4) Highlighting the Complexity of the feelings: Each situation of rage explored with the patients has accompanying guilt about the rage. This needs to be highlighted to reflect to the patient why the emotions are shut down into depression, fatigue, or anxiety. It also reflects the positive feelings the patient has toward the other person.

5) Repetition of what is learned: The linkage between emotional states or other behaviors on mood states is reviewed repetitively to increase the chance of recalling the behavioral cycles.

6) A Bio-psycho-social Perspective: One adapts and maintains a biopsychosocial perspective on the condition, thus avoiding any split between "biological prescriber" and "psychological therapist". This allows the patient to see the importance of all aspects of her care.

OUTCOME MEASURES

At the present time, all four patients are partially or fully remitted from both manic and depressive states. Patients were assessed with the Brief Symptom Inventory (BSI) (1), which captures broad symptom domains and the Inventory of Interpersonal Problems (IIP) (2), which captures domains including assertiveness and style of coping with anger. The mean BSI score decreased from abnormally high ($M = 1.2$, $SD = 0.5$) to within normal range ($M = 0.6$, $SD = 0.1$). The mean IIP score decreased from 1.5 ($SD = 0.17$) to 1.1 ($SD = 0.2$), approaching the normal cut off of 1.0. The mean time since completing therapy is now 3.8 months, and there have been no hospitalizations, emergency room visits or other untoward effects noted from the intervention. Additionally, there were no medication changes during the therapy and there were no untoward effects related to termination after these courses of therapy.

SUMMARY AND CONCLUSION

The above describes a brief integrated therapy approach to augment adjustment and coping in stabilized Bipolar I Disorder patients. The positive response observed in this small series, albeit, preliminary, suggests that there may be specific merits of such an approach as a component of

care. These merits may include emotional awareness, an emotional healing process and awareness of behavioral cycles that may trigger a mood disorder relapse.

Emotional awareness and experience appeared to be a centrally therapeutic component from both therapist and patient perspective. It was common finding that blocked feelings of anger and guilt resulted in anxiety, avoidance and depression in the moment. (Vignette D) One may anticipate that the ability to experience anger, guilt and grief, may account for the reported improvements in assertiveness, thus, improving relationship functioning. In addition, such an exposure appears to reduce the depression, anxiety and physical symptoms associated with the avoidance of these feelings. Experiencing grief of the losses incurred due to the illness seemed to raise the patient's interest in avoiding relapse. Finally, it is worth noting that the use of video recording in this approach allows for empirical qualitative research and provides useful material for teaching this approach. Additionally, the brevity of the approach makes it amenable to quantitative research that employs randomized controlled trials to examine whether the results can be specifically attributed to the brief psychotherapeutic intervention or to other non-specific factors (e.g., the passage of time).

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