

## REVIEW ARTICLE

# Mapping the psychoanalytic literature on bipolar disorder: a scoping review of journal articles

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**Objective:** To provide a review of journal articles discussing clinical cases or vignettes of psychoanalysis or psychoanalytic psychotherapy of patients affected by bipolar disorder.

**Methods:** A thorough search of journal articles was performed in five databases to identify studies published from 1990-2021.

**Results:** Twenty-four articles were included in this review, comprising a total of 29 case reports. The most common theoretical approach adopted by the authors was "object relations." Two main sets of clinical-theoretical considerations and recommendations emerge: the applicability of analytic treatment to patients with bipolar disorder – taking into account their analyzability and practical arrangements for conducting therapy – and theoretical speculations on the nature and development of the illness, as well as on the conceptualization of its different phases.

**Conclusion:** Our findings reveal that there is some psychoanalytic literature providing insight into the psychological dynamics and treatment of patients with bipolar disorder. Elaboration of this literature may help improve our understanding and provide more accurate and comprehensive descriptions of the intrapsychic and interpersonal dynamics of these patients, yielding potentially valuable information for clinical and research purposes, particularly with regard to reducing interpersonal conflict, and increasing insight and engagement with lifestyle changes and other behaviors likely to promote health and stability.

**Keywords:** Psychoanalysis; psychoanalytic psychotherapy; bipolar disorder; manic depression

## Introduction

Bipolar disorder (BD) is a chronic mood disorder characterized by recurrent episodes of depression and (hypo) mania, resulting in psychological distress and behavioral impairment. It often manifests itself in adolescence<sup>1</sup> and affects ~1-4% of the global population.<sup>2,3</sup> Although the course of bipolar illness is variable, it often results in cognitive and functional impairments<sup>4,5</sup> and leads to chronic medical conditions<sup>6,7</sup> and suicide attempts (up to 30 times higher than the general population).<sup>8,9</sup> BD is ranked among the 20 leading causes of disability in the world among all acute and chronic diseases and injuries.<sup>10</sup> Thus, BD appears to be a global health problem for disability.

Pharmacotherapy is often the first option in treating these patients.<sup>11</sup> However, growing evidence indicates

that although it effectively reduces acute depressive or manic episodes, medication alone cannot prevent recurrence, fully alleviate post-episode symptoms, or achieve good functional recovery.<sup>12</sup> When provided, psychotherapy is considered an adjunctive treatment,<sup>13</sup> although it is crucial in producing behavior and lifestyle changes essential for relapse prevention, long-term maintenance, and promoting positive function (vs. symptom reduction).<sup>14</sup> Indeed, evidence from randomized clinical trials indicates that combined treatment is more effective than medication alone in stabilizing depressive symptoms and reducing recurrence.<sup>15,16</sup>

Currently recognized evidence-based models of psychotherapy for BD include cognitive behavior therapy, interpersonal and social rhythm therapy, group psychoeducation, family-focused therapy, and dialogical behavioral therapy.<sup>15,17</sup> Both psychoanalysis and psychodynamic

psychotherapies are excluded from this list, despite the fact that psychodynamic therapies (which derive from classical psychoanalysis)<sup>18</sup> have proven to be as effective as other forms of psychotherapy for common mental disorders,<sup>19</sup> including depression<sup>20-22</sup> and BD.<sup>23</sup> It must be acknowledged that the effectiveness of psychoanalysis and long-term psychoanalytic psychotherapy for BD has yet to be tested in experimental or quasi-experimental studies. Currently there is no robust evidence for it.<sup>24</sup> However, bipolar patients have been sitting on the couch for more than century, and psychoanalysts have produced a series of narrative clinical cases – which historically have influenced psychoanalytic research and theorization.<sup>25,26</sup>

The importance of case study methods for in-depth investigation of what happens in the therapy room<sup>27,28</sup> and for bridging the research-practice gap<sup>29,30</sup> has been increasingly recognized. Compared to nomothetic research methods, these more idiographic methods allow us to more fully understand and map the complexity of the therapeutic process.<sup>31,32</sup>

Hence the question: What clinical-theoretical contribution has psychoanalysis made to the understanding of BD and its psychological treatment? Because there have been no review articles on the topic in the last 30 years,<sup>33-35</sup> the present study aims to answer this question by providing a map of psychoanalytic journal articles that include clinical cases or vignettes of psychoanalysis or psychoanalytic psychotherapy with patients affected by BD.

## Methods

PsycINFO and the International Prospective Register of Systematic Reviews were searched to ensure that no similar reviews have been published previously or are in progress. The Preferred Reporting Items for Systematic Reviews and Meta-Analyses for scoping review<sup>36</sup> statement were followed.

### Study search

The MEDLINE, PsycINFO, Scopus, and Web of Science databases were searched by abstract and title. In addition, the Psychoanalytic Electronic Publishing archive was searched by full text. The Psychoanalytic Electronic Publishing archive search was limited to journals not indexed in any of the other four databases. The literature search included the terms (“psychoanalysis” OR “psychoanalytic”) AND (“bipolar” OR “manic depress\*”) and was limited to English-language journal articles published from January 1990 to August 2022. Reference lists and citations of eligible articles were also searched.

### Eligibility criteria

Studies were eligible for inclusion in this review if they presented any clinical material on patients with BD treated in individual psychoanalysis or psychoanalytic psychotherapy. No exclusion criteria based on study quality could be applied because of the characteristics of psychoanalytic single case reports.<sup>37</sup>

### Study selection

Two raters independently reviewed and screened titles and abstracts and then full-text articles for evidence that the studies met eligibility criteria. Any disagreement was resolved by mutual discussion.

### Data extraction

The following information was extracted from each study: i) study characteristics (author/s, year of publication, country), ii) theoretical approach, iii) patient characteristics (age, sex, DSM-5 diagnosis [derived from the patient’s clinical history and symptoms as described in the respective article, when the therapist used the term “manic depression”]), iv) therapy characteristics (setting, weekly session frequency, duration, therapist’s sex, and status [i.e., ongoing vs. terminated]), and v) main theoretical findings.

## Results

The initial search retrieved 229 journal articles, with further examination of five articles captured via the reverse search strategies detailed above (Figure 1). Of these, 24 articles were included in the review (Table 1).

### Study characteristics

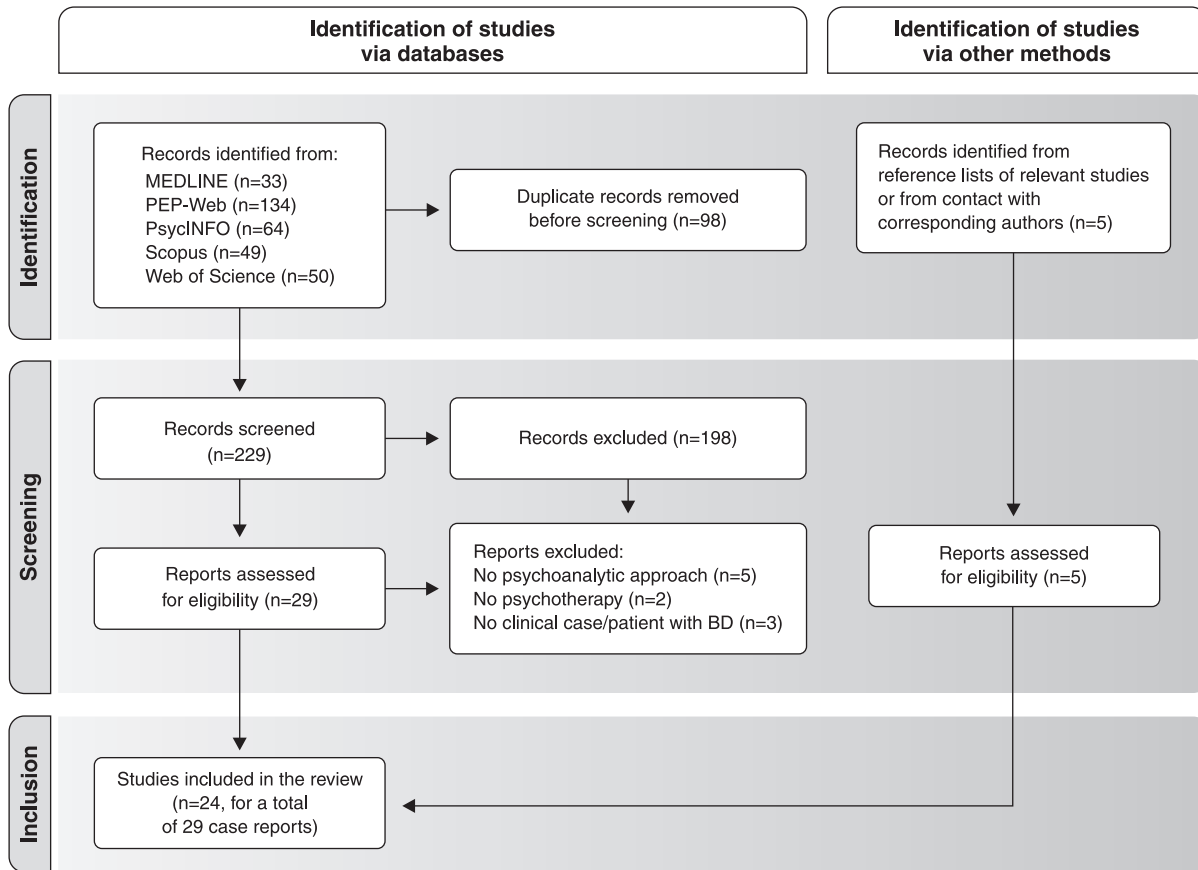
Of the 24 selected articles, eight were published in the 1990s, nine in the 2000s, five in the 2010s, and two in 2021. The authors worked as psychotherapists/psychoanalysts in eight countries: the United States (n=12), the United Kingdom (n=5), Belgium, Canada, France, Italy, Poland, and Spain. The most common theoretical approach adopted by the authors was “object relations” (n=11).

### Patients and treatment characteristics

A total of 29 case reports of patients with BD treated with long-term psychoanalytic psychotherapy or psychoanalysis (from here on also called therapy) were found. Most of the patients were adults (apart from one adolescent and two cases with missing data), female (62%), and their symptoms met the DSM-5 criteria for bipolar I disorder (62%; followed by bipolar II disorder, 24%). Most of the patients were treated in private practice (52 vs. 24% in public health service, with the remaining unknown). Fifteen therapies (52%) had been terminated by the time the article was written (mean duration: 3.91 years; range: 0.5-10 years; data based on 11 of 15 clinical cases) while 13 (48%) were still ongoing (mean duration: 5.64 years; range: 2-15 years; data based on 11 of 13 clinical cases). The number of weekly sessions ranged from one to six.

### Main clinical-theoretical findings

By summarizing the content of the articles included in this review, two main sets of clinical-theoretical considerations



**Figure 1** The Preferred Reporting Items for Systematic Reviews and Meta-Analyses diagram of the study selection process. BD = bipolar disorder; PEP-Web = Psychoanalytic Electronic Publishing.

and recommendations emerge. On the one hand, there are those that focus on the applicability of analytic treatment to patients with BD, taking into account their analyzability and practical/technical arrangements for conducting such a therapy. On the other hand, theoretical speculations on the nature and development of the illness, as well as its conceptualization, are proposed.

**Analyzability**

Three articles focus on the issues of: i) the capacity of patients with BD to meaningfully engage with and potentially benefit from the course of analysis and ii) difficulties in anticipating the course of analysis based on the (pre)treatment workup.

Wright<sup>39</sup> describes how, over the first 2 years of psychotherapy (three sessions per week), it became more and more clear that the patient’s wandering thoughts, dreams, desires for love and success, and fears of aging and success at the expense of others were all rooted in an unelaborated traumatic childhood experience. Furthermore, over this first phase of therapy, the patient did not experience diminished reality testing or increased thought disorders. For these reasons, after 2 years of therapy, Wright claims that psychoanalysis is a treatment of choice and began performing five sessions per week with that patient.

In the second article, the author<sup>38</sup> claims that very intense transference developed in the patient from the very beginning of therapy and that the central role of early environmental trauma in current (pre)oedipal conflicts was a positive prognosticator of analyzability.

Even if the remaining authors do not specifically address the topic, they all seem to agree that patients with BD are analyzable, although changes in the setting or technique may be necessary.

**Treatment**

Salzman<sup>43</sup> illustrates the difficulties common to BD management and the usefulness of psychotherapy in building a therapeutic alliance, helping the patient overcome denial of illness, addressing transference and countertransference issues, balancing medication doses and side effects, and encouraging significant others to provide information about the patient’s present mental conditions. Although sometimes essential, obtaining information about the patient’s past and current mood status from other people may activate transference problems. Regarding the first two points, the author speaks of the paradox of building an alliance despite the patient’s denial of being ill. Salzman<sup>43</sup> not only recognizes denial as a pathologic coping strategy in mania, but he also emphasizes that it may be a normal response to

**Table 1** Characteristics of the included studies

Author (country)	Theoretical approach	Clinical material	
		Therapy characteristics	Patient characteristics
Anonymous <sup>38</sup> (USA) <sup>†</sup>	Ego psychology	Setting: individual therapy in a public health service Weekly sessions: unknown Duration: > 6 years (ongoing) Therapist sex: F	Age: 26 Sex: F Diagnosis: BD (unclear type), RC
Wright <sup>39</sup> (USA) <sup>‡</sup>	Unclear	Setting: individual therapy in private practice Weekly sessions: three for the first 2 years, then five sessions a week Duration: 3.5 years (ongoing) Therapist sex: F	Age: 25 Sex: F Diagnosis: BD II, RC
Jackson <sup>33</sup> (France)	Object relations	Setting: individual therapy in public health service Weekly sessions: two, sometimes more Duration: 2 years (terminated) Therapist sex: M	Age: "young" Sex: F Diagnosis: BD I
Kahn <sup>40</sup> (USA)	Unclear	Setting: individual therapy Weekly sessions: unknown Duration: unknown (ongoing) Therapist sex: M	Age: 37 Sex: F Diagnosis: BD II, RC
Deitz <sup>41</sup> (USA)	Self-psychology	Setting: individual therapy Weekly sessions: two Duration: 6 months (terminated) Therapist sex: M	Age: 27 Sex: F Diagnosis: BD I, RC
		Setting: individual therapy Weekly sessions: two Duration: > 1 year (terminated) Therapist sex: M	Age: 30s Sex: M Diagnosis: BD II
		Setting: individual therapy Weekly sessions: unknown Duration: unknown (ongoing) Therapist sex: M	Age: 42 Sex: F Diagnosis: DM
Tizón <sup>42</sup> (Spain)	Object relations	Setting: individual therapy in private practice Weekly sessions: five-six Duration: 8 years (terminated) Therapist sex: M	Age: 28 Sex: F Diagnosis: BD I, RCBD
Lucas <sup>34</sup> (UK)	Object relations	Setting: individual therapy in public health service Weekly sessions: five for the first 13 years, then unknown Duration: > 15 years (ongoing) Therapist sex: M	Age: 30s Sex: F Diagnosis: BD II
Salzman <sup>43</sup> (USA)	Unclear	Setting: individual therapy in private practice Weekly sessions: unknown Duration: > 2 years (terminated) Therapist sex: M	Age: 60 Sex: F Diagnosis: BD II
Anderegg & Gartner <sup>44</sup> (USA)	Object relations	Setting: individual therapy Weekly sessions: four Duration: 4 years (terminated) Therapist sex: M	Age: 26 Sex: M Diagnosis: BD I
Georgaca <sup>45</sup> (UK) <sup>§</sup>	Lacanian	Setting: individual therapy in public health service Weekly sessions: one Duration: 2 years (ongoing) Therapist sex: F	Age: 23 Sex: F Diagnosis: BD I
Mills <sup>46,47</sup> (Canada)	Object relations	Setting: individual therapy, first sessions in the hospital and then private practice Weekly sessions: one-two; five during hospitalizations Duration: 4 years (ongoing) Therapist sex: M	Age: 42 Sex: M Diagnosis: BD I, RC
Archer <sup>48</sup> (UK)	Unclear	Setting: individual therapy in public health service Weekly sessions: unknown Duration: unknown Therapist sex: M	Age: unknown Sex: M Diagnosis: BD (unclear type)

Continued on next page

Table 1 (continued)

Author (country)	Theoretical approach	Clinical material	
		Therapy characteristics	Patient characteristics
Pollack-Gomolin <sup>49</sup> (USA)	Object relations	Setting: individual therapy Weekly sessions: unknown Duration: > 7 years (ongoing) Therapist sex: M	Age: 48 Sex: M Diagnosis: BD I
Chernus <sup>50</sup> (USA)	Self-psychology	Setting: individual therapy in public health service Weekly sessions: one-two Duration: > 10 years (terminated) Therapist sex: F	Age: 39 Sex: F Diagnosis: BD I
Rossouw <sup>51</sup> (UK)	Object relations	Setting: individual therapy in private practice Weekly sessions: five Duration: 3 years (ongoing) Therapist sex: F	Age: 40s Sex: F Diagnosis: BD I
Levine <sup>52</sup> (USA)	Object relations	Setting: individual therapy in private practice Weekly sessions: three Duration: 3 years (ongoing) Therapist sex: F	Age: 23 Sex: M Diagnosis: BD I
Winship <sup>53</sup> (UK)	Object relations	Setting: individual therapy in public health service Weekly sessions: two-three Duration: unknown (terminated) Therapist sex: M	Age: 30s Sex: M Diagnosis: BD I
Cambrey <sup>54</sup> (USA)	Jungian	Setting: individual therapy in private practice Weekly sessions: one-two Duration: unknown (terminated) Therapist sex: M	Age: 30s Sex: F Diagnosis: BD I
Downey <sup>55</sup> (USA)	Unclear	Setting: individual therapy in private practice Weekly sessions: unknown Duration: unknown (terminated) Therapist sex: F	Age: 33 Sex: F Diagnosis: BD NOS
Duckham <sup>56</sup> (USA)	Object relations/ intersubjectivism	Setting: individual therapy in private practice Weekly sessions: one-two Duration: 11 years (ongoing) Therapist sex: M	Age: 28 Sex: M Diagnosis: BD I
Vanheule <sup>57</sup> (Belgium)	Lacanian	Setting: individual therapy in private practice Weekly sessions: two Duration: > 6 years (ongoing) Therapist sex: M	Age: 46 Sex: F Diagnosis: BD II
Ventimiglia <sup>58</sup> (Italy)	Object relations	Setting: individual therapy in private practice Weekly sessions: one-two Duration: > 1 years (terminated) Therapist sex: M	Age: 45 Sex: F Diagnosis: BD II
Kalita <sup>59</sup> (Poland)	Object relations	Setting: individual therapy in private practice Weekly sessions: two Duration: many months (terminated) Therapist sex: M	Age: 40s Sex: M Diagnosis: BD I
		Setting: individual therapy in private practice Weekly sessions: two Duration: > 9 years (terminated) Therapist sex: M	Age: 31 Sex: M Diagnosis: BD II
		Setting: individual therapy in private practice Weekly sessions: two Duration: 1,5 years (ongoing) Therapist sex: M	Age: 16 Sex: M Diagnosis: BD I
		Setting: individual therapy in private practice Weekly sessions: unknown Duration: 5 years (terminated) Therapist sex: M	Age: 23 Sex: F Diagnosis: BD I

BD I = bipolar I disorder; BD II = bipolar II disorder; DM = dysphoric mania; F = female; M = male; NOS = not otherwise specified; RC = rapid cycling.

† The intake evaluation of the patient presented in this clinical case (Anonymous<sup>38</sup>) has been described in Anonymous,<sup>60</sup> while the clinical case has been discussed by Bachrach<sup>61</sup> and Trupp.<sup>62</sup>

‡ The clinical case presented by Wright<sup>39</sup> has been discussed by Samberg,<sup>63</sup> Pareja,<sup>64</sup> and Wyman.<sup>65</sup>

§ Georgaca's<sup>47</sup> article has been discussed by Rowan,<sup>66</sup> Urwin,<sup>67</sup> Whan,<sup>68</sup> and Wilkinson.<sup>69</sup>

serious illness for a patient with BD. A solid alliance is necessary so that the patient can share the two burdens of illness, which are the need to give up a seductively grandiose sense of self and to learn to live with less than perfect therapeutic results. Although the therapeutic alliance may be threatened by negative transference and countertransference, it is usually incorrect to attribute all anger and frustration merely to the patient's mood dysregulation. Transference shifts should be assessed in a broad psychodynamic context while also evaluating the necessity for pharmacotherapy changes. Salzman<sup>43</sup> maintains that an appropriate interpretation can sometimes prevent the need for medication adjustments or, alternatively, facilitate necessary dosage changes with minimal misunderstanding.

According to Kahn,<sup>40</sup> the utility of dynamic therapy of personality for patients with BD lies in trying to limit the stresses that precipitate affective episodes (in addition to "independent" bipolar cycling). Stress here is conceptualized as a phenomenon strictly related to the patient's personality to cope with stressful life events. Kahn<sup>40</sup> claims that although therapy focusing on examining and modifying personality is probably unnecessary for many of these patients, it might be appropriate for those who are partially or completely unresponsive to medication and other psychological interventions, helping decrease the frequency and severity of mood episodes. Psychotherapy can help desensitize patients to internal or external stressful cues, especially early in the course of the illness (that is, before the onset of an autonomous pattern).

Jackson<sup>33</sup> claims that the main task of the therapist is gradual modification of the patient's melancholic super-ego, characterized by sadistic and demanding impulses formed during the childhood years. However, he clarifies that all but the mildest cases of BD need to be treated in a hospital setting.

Lucas<sup>34</sup> claims that any patient's past or current positive relational experience is important in relaunching and/or supporting the growth of reflectiveness and providing opportunities to develop a more mature capacity for relations with themselves and others. The author also reflects on why analytic treatment can lead to an intensification of manic episodes, as well as the role of defenses against guilt in maintaining the manic state. Finally, he underlines the importance of the emergence of a third position (a shared reflectiveness between the patient and the therapist) in helping the patient better live with and manage the manic phases of the illness.

Deitz<sup>41</sup> claims that to obtain optimal adaptation to their condition, these patients must come to terms with the fact that BD results from an inborn propensity to emotional lability and vulnerability without catastrophically compromising their sense of self. He also maintains that people with BD are at risk of rapidly becoming disorganized during psychotherapy because of its potentially mood-destabilizing effects due to the inevitable intense experiences of joy and sorrow that characterize any successful intensive psychotherapy.

Like Lucas<sup>34</sup> and Deitz,<sup>41</sup> Duckham<sup>56</sup> suggests that the therapeutic potential of a clinical approach based on the patient-therapist relationship lies in its ability to facilitate

the healing of wounds caused by disrupted object relations (specifically those disrupted due to the introjection of negative, punitive experiences in the environment) and then to improve affect regulation. By establishing a stronger sense of trust in self and others, the subject can develop a deepened belief in the loving and caring nature of him/herself and his/her environment.

Pollack-Gomolin<sup>49</sup> claims that in patients with primitive pathology – including, but not limited to, BD – the aggressive and libidinal drives are not fused/integrated. In this situation, transference has the sole purpose of enabling patients to complete and survive the enactment of their instinctual impulses. For the analyst, promoting therapeutic regression (i.e., regression to early levels of emotional development in order to work through them so that the development process may take place or be resumed)<sup>70</sup> is a continuous clinical challenge that can be facilitated by analyzing the patient's impulses.

Downey,<sup>55</sup> focusing on patients with BD whose symptoms had been stabilized through medication except for their drive sexuality, argues that developmentally oriented psychotherapy can help patients understand and change themselves. She underlines the need for the therapist to pay careful attention to the patient's sexual history and personal narrative (which always contains the experience of the illness) to understand, together with the patient, his/her sexual enactments and, more broadly, his/her conscious and unconscious experiences. This understanding informs and enhances psychotherapeutic work.

Georgaca,<sup>45</sup> who deals specifically with the analysis of psychotic states, maintains that the psychotic patient does not see the analyst as a subject-supposed-to-know (i.e., someone who is supposed to have consistent knowledge of the patient's experiences/behaviors/feelings/perceptions). Therefore, the analyst must take on the function of a witness as patients reveal what they already know, becoming a non-psychotic presence that facilitates grounding in a constructed and shared social reality. Gradually, the analyst's functions expand to include witnessing change in their patients, ratifying their choices, encouraging the path they take, and providing them with subjective temporal continuity. The purpose of treatment is to help patients construct sustainable symptom improvement using the psychological mechanisms currently available to them.

Also focusing on psychotic states, Vanheule<sup>57</sup> argues that when faced with psychotic symptoms, the analyst should examine whether and how the psychotic crisis was triggered by specific situations or life events. More generally, working with the psychotic state, the analyst's task is to restore a place for the subject with the other, which is threatened in episodes of acute psychosis.

Finally, Kalita<sup>59</sup> draws attention to the limited insight that most persons affected by BD have into unconscious or repressed content, asserting that a classic psychoanalytic approach is useful. According to him, the following changes in therapeutic technique can result in a better fit to the needs of these patients: backgrounding transference interpretations, focusing on interpersonal themes, playing a more active role, and investing in the stabilizing role of a good grounding in external reality.

The latter point, which recalls the emphasis on balance in dialectical behavior therapy, would be crucial because the limits of physical reality make a breakdown of the manic phase inevitable, causing another loss of an ideal object and then another depressive phase.

#### Empathic approach

Chernus<sup>50</sup> highlights the critical role of an empathic approach to facilitate effective patient-provider collaboration. More specifically, he maintains that the providers' empathic vantage point, which implies being aware of the subjective meaning of everything in the treatment (including psychotherapy, medications, and the patient's feelings about each healthcare provider), is a key element in effective integration and collaboration. According to him, providers must become aware of the nature and impact of the patient's transferences toward them (both individually and as a team), the complex ways in which they used each of the providers in the transference, and the real relationships among clinicians and between the patient and each clinician. The ability of patients to use their clinicians adaptively, on a transference basis, is an important factor in stabilizing their mood.

Similarly, Deitz<sup>41</sup> describes how empathic concern for the inner affective experience of patients with BD during therapy: i) provides an emotional and relational environment within which an enhanced sense of self can develop through a reworking of past experiences, ii) allows internalization of mood modulating self-structures (one example of which is insight into the early signs of the emergence of hypomanic symptoms) through self-object transferences, and iii) helps the patient with BD keep pace with his need for mood modulating medication.

#### Conceptualizing the psychotic state

According to Georgaca,<sup>45</sup> psychosis is characterized by the absence of the paternal metaphor (in neurosis it is introduced in the infant's psyche through the Oedipus complex structures), leading the signifying networks to break loose and produce an endless metonymic sliding of the signifier. Moreover, the psychotic patient is under threat of invasion by "jouissance" (i.e., the excessive pleasure-in-pain of the death drive), while the symptom acts as a barrier to jouissance and enables the patient to shift toward establishing some form of social bond.

Vanheule<sup>57</sup> starts from the hypothesis that psychosis creates a structure with a specific status for the unconscious. Psychotic symptoms mean the occurrence of a subjective crisis without support from signifiers (characteristic of the symbolic order) – which are "the discrete elements of language considered as different sounds, independently of their usual socially determined meaning" –,<sup>71</sup> while the patient is dealing with fundamental self-directed epistemic questions (like "who am I?") or questions about the intentionality of the other (like "what do you want?"). A characteristic of these questions is that they are organized around intimate topics such as sexuality (love, procreation, and sexual identity), parent-hood/authority, and life in light of death. Psychotic crises

are triggered by confrontations (at an unconscious level) over such intimate questions raised through daily life situations, while no support can be found by employing a master signifier. Due to the lack of a signifier representing the subject, all subjective order is lost. However, the presence of a psychotic structure will not invariably lead to hallucinations or delusions when addressing these self- and other-directed questions.

#### Nature and nurture

On the premise that there is an interplay of genetic and environmental factors in the etiology of BD, Jackson<sup>33</sup> speculates that the basic pattern of dynamics common to all cases of BD is rooted in unresolved conflicts from infancy and early childhood, although the subject's development is influenced by subsequent life experience.

Similarly, Rossouw<sup>51</sup> speculates that early life experiences enable the personality of some persons affected by BD to be more integrated and, at the same time, recognizes the possibility that biological predisposition – including, among other things, emotional regulation and impulsivity – also contributes to how the care-taking world is experienced by the single subject and, therefore, creates and shapes his/her unconscious fantasy.

Deitz<sup>41</sup> points out that when trying to account for proper deficits of BD in psychic structure and/or functioning, infant and childhood experiences of suboptimal parenting style cannot be taken for granted. More correctly, mood regulation difficulties in BD and subsequent disturbances of psychological organization should be read as a primary deficit in self-structure and/or function. Such a primary deficit (i.e., innate and not acquired) entails dysregulation at the neurobiological level of mood modulation. It results in a biological predisposition to states of underarousal (i.e., depression), overarousal (i.e., hypomania/mania), or a combination of the two (i.e., dysphoric mania).

Mills<sup>46,47</sup> highlights the role that severe complex trauma and developmental deficits in attachment and cohesive self-structure can play in the development of BD.

Downey<sup>55</sup> maintains that the (hyper)sexuality of BD is the product of an interaction between nature and nurture. This interaction acquires different meanings and leads to different consequences in different phases of life. Among the developmental factors that occurred during infancy and childhood, particularly important are experiences of affection, trauma, sexual stimulation, and boundary violations.

#### Intrapsychic and interpersonal dynamics

A series of papers describe the intrapsychic and/or interpersonal dynamics that characterize BD. Most of them adopt an object relations perspective.

Jackson<sup>33</sup> conceptualizes the psychotic depressive phase as a paranoid state in which the healthy self is identified with the bad maternal object and submits to the sadistic power of a narcissistic self. In the manic phase, however, the normal self escapes in excited triumph from the superego to which it was previously submitted. The author describes a basic pattern of dynamics that might

be common to all BD cases. First, the development of intense transferences, initially very positive (idealized) and then, following the slightest frustration, highly negative and persecutory. This dynamic, if unchecked, may lead to dangerous acting-out, including suicide attempts. Second, the central anxiety of patients is related to their awareness of the intensity of their destructive impulses against the object on which they depend (originally, the mother). Third, therapy gives some hope to patients, who act in such a way as to invoke anxiety about their destructive impulses and despair in the therapist. This anxiety is similar to what the patients themselves experience, and it is invoked to unconsciously test whether the therapist can withstand it in order to help the patient understand and begin to deal with it. Fourth, in the manic phase, patients no longer wish to make themselves understood, turning their omnipotent destructive self on the therapist with a triumphant attitude of superiority. In this phase, the patient identifies with the internal representation of an idealized phallic object and, as a result, overcomes any feeling of dependency and inferiority by acquiring a sense of omnipotence. The author also speculates on the potential health benefits of manic-depressive phases as a psychobiological defense mechanism, the switching of moods, and the etiology of the disease.

Similarly, Ventimiglia<sup>58</sup> conceptualizes (hypo)mania as a form of defense against the state of depression resulting from an excessively strong and profound unconscious identification of the patients' self with the depressive object (i.e., someone from the patient's past through whom the depressive state developed) rather than as a periodic rebellion against such an internalized object. According to him, such a narcissistic overidentification occurs in mania and temporarily plays the role of counterinvestment aimed at denying the unconscious desire to reduce or abandon the internalized narcissistic component. Regarding the typical manic trait of wide-ranging freedom from bonds and rules, often characterized by easy and uninhibited switches from one object (i.e., person, idea, or thing) to another, the author clarifies that it is only apparently antithetical to the accentuated identificatory bond with the depressive object, which is a peculiar feature of manic phases. Indeed, the generalized freedom from bonds observed during manic phases displays itself in the shadow of unconscious loyalty to one specific identificatory object.

For his part, Lucas<sup>34</sup> views the manic phase as the explosive uncoiling of a clockwork spring that has been progressively tightened during the depressive phase. In other words, hidden resentment to the imposed state of affairs silently builds up due to dependence on a cruel internal object demanding complete obedience and suppression of the subject's individuality. It is as if the patient asks himself: "Why should I be the one staying at home doing all the housework, while you (the internal mother) are always out having a ball?" The above-mentioned explosive unwinding of the tightening spring cannot be stopped once it has started, and continues under its own momentum until all the previously suppressed anger has finally been consumed. Major life changes or events are not necessary to trigger another cycle. Once the rage has been vented, the pull to merge with the tyrannical superego can reassert itself.

Anderegg & Gartner<sup>44</sup> conceptualize the psychological dedifferentiation in hypomanic states as a reaction to experiences of loss in depressive states. The manic reaction to the loss experience provides a cognitive set that allows for the "translogical" thought processes inherent in the creative act.

Unlike the above-mentioned authors, Rossouw's<sup>51</sup> focus is on the complex interplay between bipolar illness and the patient's internal experiences. According to him, the actualization of unconscious fantasy would be more bearable for patients whose actual attachment relationships were benign in their developmental years and, therefore, have created an unconscious world populated by good internal objects. When faced with a traumatic event, the fragile symbolic capacity of some patients can collapse and they experience the event as an actualization of some unconscious fantasy. By becoming real, fantasy opens a door that stops communication between fantasy and reality, making the patient vulnerable to the experience in such a way that happenings in the real world directly trigger consequences at the unconscious fantasy level.

Kahn<sup>40</sup> also addresses the effects of BD on personality development, describing two clusters of effects: mild forms of affective disorder that resemble personality disorders, and the experience of being manic-depressive, which produces particular kinds of conflict and trauma, shaping the character in specific ways.

Salzman<sup>43</sup> points out that transference issues abound when treating patients with BD. Patients characterized by manipulative, entertaining, and adoring behaviors are often not interested in gaining insight into their grandiosity. A positive transference fueled by manic energy and enthusiasm can define the therapist as heir to an idealized parent, but its affective valence can easily and quickly shift from love to hate when the patient is in a depressive phase or when the clinician attempts to confront denial.

Through general discourse not specific to BD, Mills<sup>46,47</sup> claims that the attachment pathology is mostly organized on borderline levels of functioning (as a consequence of toxic introjects and disorganized self-states deriving from early developmental trauma) and results in insufficient unconscious organizational processes within the self-structure. This situation establishes a predisposition to disorders of the self, which often leads to overdetermined polysymptomatic profiles.

Finally, the author of the anonymous paper<sup>38</sup> maintains that severe suicidal crises may be based on the patient's deepest conflicts, such as their longing for a symbiotic love-death union with the analyst as a mother figure. This encapsulated narcissistic, pre-oedipal, and negative oedipal issues.

#### Hypersensuality and hypersexuality

Tizón<sup>42</sup> shows how his patient's hypersensuality and self-sensuality are closely linked with her primitive eroticization of both the transference and her life outside the consulting room; they are self-feeding and designed to obscure awareness of separation and separateness.



This self-sensuality may be acted out or confined to fantasy, depending on the patient's personality development, as well as the position from which he/she experiences mental events.

Downey<sup>55</sup> discusses how the use of developmentally oriented psychotherapy can help patients with BD whose symptoms have been stabilized through medication, except for their driven sexual behavior, to understand and change themselves. In the case of BD, sexuality is seen as the product of an interaction between nature and nurture. This interaction acquires different meanings and leads to different consequences in different phases of life. Early experiences of affection, trauma, sexual stimulation, and boundary violations form the "sex script," or rather, that particular set of circumstances and qualities of the object that individuals find arousing. Given that people tend to organize their fantasies by creating private narratives (which are always influenced by their life experiences), the patient's sexual history and personal narrative always contain the experience of the illness.

#### Remaining articles

Four authors, all of whom presented clinical material on patients affected by BD but showed no diagnosis-specific intrapsychic or interpersonal dynamics, discussed topics that did not fit any of the categories above. More specifically, Cambray<sup>54</sup> discusses archetypes as emerging phenomena that organize "moments of complexity," while Winship<sup>53</sup> discusses the central psychobiological role of the testes in sensual and libidinal development. Archer<sup>48</sup> discusses the topic of shame as a cause of distress and breakdown, and Levine<sup>52</sup> discusses how the conflicts that emerge between time and timelessness are affected by and drawn into the individual's conflicts.

#### Discussion

To our knowledge, this is the first study mapping and summarizing the psychoanalytic literature containing clinical material on patients with BD. Further development of this literature can help improve our understanding and provide more accurate and comprehensive descriptions of the intrapsychic and interpersonal dynamics of these patients, yielding potentially valuable information for clinical and research purposes.

However, the first notable result of this review is the limited number of articles addressing BD published over the last 3 decades. More precisely, 15 papers specifically focused on BD, while the remaining 14 presented the clinical case of a patient affected by BD but did not discuss disorder-specific features. This paucity of published studies partially explains why no psychoanalytic article or book has been cited in any of the three sections that the second edition of the *Psychodynamic Diagnostic Manual (PDM-2)*<sup>72</sup> devotes to bipolar or bipolar-related disorders in adults, adolescents, and children.

There are two main underlying reasons for this relative scarcity of psychoanalytic literature on BD, both related to the adoption of evidence-based practice in psychiatry and psychotherapy since the mid-twentieth century.

First, psychoanalysis and psychodynamic therapy are not recognized as evidence-based psychological interventions for BD<sup>15</sup> and are therefore not recommended as an adjunctive second-line treatment by current international clinical treatment guidelines.<sup>11,73</sup> Consequently, they are not among the forms of psychotherapy most psychiatrists consider suitable for BD. This is in part because when psychoanalysis was dominant in some psychiatry departments, mainstream psychoanalysis showed contempt for (or at least a lack of interest in) biological aspects of psychiatric illness and treatment.<sup>74</sup> Therefore, in a growing culture of evidence-based practice, most psychiatrists have come to consider psychoanalysis and psychoanalytic therapy as irrelevant to modern psychiatric mental health services.<sup>75,76</sup> Here it must be underlined that although the prejudice that psychoanalysis is not "evidence-based" has been convincingly rebutted by empirical data,<sup>77-80</sup> it is indisputable that little evidence has thus far been provided about the effectiveness of psychoanalysis and psychoanalytic therapy in improving symptoms and global functioning in patients with BD.<sup>24</sup>

Second, following from the previous point, although psychoanalytic therapy is currently accessible as a psychological treatment in the public health systems of most developed countries, it is significantly outweighed by the availability of other forms of psychotherapy (mainly, cognitive-behavioral treatment) with a more robust evidence base.<sup>81-86</sup> In these countries, psychoanalysis is offered mainly in private practice rather than the public health care sector, where it is usually available in a time-limited form and performed by trainees.

In light of the above, it is not surprising that the website of the American Psychoanalytic Association (<https://apsa.org/content/common-mental-health-diagnoses>), the oldest national psychoanalytic organization in the United States and a component of the International Psychoanalytical Association, reads: "Because bipolar disorder is a biological illness, stabilizing medications are essential for treatment. And as is often the case with such illnesses, psychoanalysis cannot offer a cure. But once a patient is stabilized, psychoanalysis can help a sufferer come to terms with the illness itself as well as the difficulties that the illness has caused in his or her life and, as with any other analysis, work with the person's ambitions, goals, relationship and work difficulties." Similarly, in France, where psychoanalysis still holds an important position in psychiatry, most French psychiatrists think that psychoanalysis does not contribute to understanding the causes of BD.<sup>87</sup> However, French psychiatry considers psychoanalysis a valuable tool for understanding and analyzing the psychopathological processes involved in BD, for the therapeutic relationship's role in changes in the patient's condition, and as an inspiration for adapted psychotherapeutic techniques.<sup>87</sup>

Consequently, analysts are likely to receive patients with BD only from time to time in private consultations. This is consistent with our finding that only 24% of the patients in the reviewed reports were seen in a public mental health service, with a gradual reduction over the three-decade period. Nevertheless, many analysts have worked and are still working analytically with patients

affected by BD, even for very long periods (as suggested by the mean duration of the therapies reported in this review). Furthermore, although perhaps very few, some contributions in the current and future psychoanalytic literature may help clarify the psychological functioning underlying one or more different presentations of the bipolar spectrum and the therapy process of these patients.

Another finding of this review was that about half of the authors belonged to the object relations school, which is one of the oldest schools of psychoanalysis and historically has played a key role in treating psychosis and severe personality disorders.<sup>88-93</sup> This predominance is quite consistent with previous findings on the diffusion of the leading contemporary psychoanalytic schools<sup>94,95</sup> and the most represented in published psychoanalytic case studies.<sup>96</sup>

The final point that deserves a brief comment is the scarcity of clinical cases involving children (n=0) or adolescents (n=1). This raises the question of the status of diagnosis within the psychoanalytic community, many of whose members question the usefulness of any diagnostic system,<sup>72</sup> especially the DSM. Indeed, despite empirical data indicating that lack of rigorous diagnosis often leads psychoanalytic candidates to miss clinically significant mood disorders in their patients,<sup>97</sup> one old and still current critical issue about psychoanalytic education is the lack of importance given to a comprehensive clinical diagnosis when evaluating patients for psychoanalysis.<sup>98</sup> It follows that something can get lost in the gap between psychiatric and psychoanalytic nosologies.<sup>99,100</sup> For instance, psychoanalysts might be addressing some or many aspects that can be seen in BD without necessarily calling them by this name. Similarly, psychoanalysts sometimes feel uncomfortable using psychiatric diagnostic categories and criteria and prefer a more psychodynamic approach and terminology to understand and discuss psychopathology. These are key reasons why many cases of BD could go undetected or misdiagnosed, especially in children.

With regard to the opinion and theoretical considerations made by the authors of the selected articles, although a detailed discussion is outside the scope of this study, three key points deserve brief discussion here. First, the authors agree that patients with BD may be suitable for analytic therapy during remission periods, although their treatment is difficult and often requires a modified technical approach. There seems to be no full consensus on proposed changes to the technique, notably concerning the interpretation of transference: some authors (e.g., Kalita<sup>59</sup>) background it while others (e.g., Anonymous<sup>38</sup>) foreground it. This could be due to the clinical heterogeneity of BD and the high rates of coexisting psychiatric conditions, including personality disorders and substance use.<sup>4</sup> Second, analysts seem to recognize the contribution of genetic factors to the etiology of BD without overlooking the role of environmental factors, especially early childhood trauma. This perspective aligns with the findings of recent studies investigating gene-environment interactions in BD.<sup>101</sup> Third, most of the theoretical contributions to the intrapsychic and interpersonal dynamics of patients with

BD have elaborated on the fate of internalized objects. The common clinical-theoretical ground of these contributions is the idea that people with BD have difficulties with distortion in the process of internalizing objects, which leads to an inner world populated by bad/cruel/phallic/depressive internal objects, which in turn influences the external relationships.

On a clinical level, clinicians can use this review as a tool – a “map” – that allows quick identification of specific clinical cases according to a patient’s specific psychopathological processes or other clinical features. At the research level, this review can be used in two main ways. First, as a starting point for systematic review (including book chapters and journal articles in languages other than English) and metasynthesis<sup>102-104</sup> of specific elements/aspects such as the use of countertransference<sup>105,106</sup> or changes in technique to successfully work with these patients. Second, it can be used as a reference for designing experimental or quasi-experimental research studies to test specific psychoanalytic theorizations.

Future research efforts in the field of psychoanalysis should be directed toward supplanting the narrative case study method<sup>26</sup> with quantitative single-case research methods<sup>107</sup> based on recordings of the entire therapeutic journey, verbatim transcription, and computer-assisted and artificial intelligence content analysis. Quantitative single-case research methods can help preserve the complexity of what happens within and between patients and therapists in the therapeutic setting, while reducing methodological errors and bias. Obviously, further evidence is needed before recommending psychoanalytic approaches to therapy for patients with BD. However, for those who have been stabilized through medication and have acquired some psychoeducational tools and skills, psychodynamic interventions may be a satisfactory complement in the context of “precision psychotherapy” or “personalized psychotherapy.”<sup>108</sup>

The findings of this review should be considered in light of some main limitations. First, the psychoanalytic school of each case study was identified by us based on the published material and was limited to the most evident one (some evidence indicates that more than half of psychoanalytic authors feel attached to more than one school).<sup>96</sup> Second, most of the reported diagnoses were not based on diagnostic interviews. Furthermore, some patients were diagnosed with manic-depression, and we provided a DSM diagnosis based on the reported symptoms and case history. Third, the focus on English-language journal articles could have excluded relevant studies published in a different format (e.g., book chapters) or in other languages.

This review used single-case reports to outline the contribution of psychoanalysis to the study and treatment of BD, informing clinicians and future research. Even in light of the prevalence of BD, the relative paucity of psychoanalytic journal articles reporting on these patients is surprising only if one does not consider the clinical characteristics of BD and the small number of analysts working as psychotherapists in public mental health services. We believe that psychoanalysis can keep offering helpful insights and improvements to BD

treatment if further single-case studies make greater use of advances in qualitative research methodology<sup>109</sup> and quantitative research methods.<sup>107</sup> This would be particularly important when considering the only partially met need for a diversity of approaches to BD,<sup>110</sup> a diversity that should reflect the patient's subjective experience of illness, problems faced, and recovery pathways.

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