

## **Is psychodynamic psychotherapy a useful approach in treatment of bipolar disorder? A review of research, actualization of technique and clinical illustrations**

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### **Summary**

The author attempts to describe a role of psychodynamic psychotherapy in treatment of bipolar disorder. A general role of psychological interventions in treating this illness is sketched, highlighting the approach of combining psychotherapy and pharmacological treatment as the most common perspective. Recent research data on effectiveness of various psychotherapies in treating BD is presented. Conclusions from review suggest that intervention should be tailored to specifics of BD rather than limited to any single therapeutic modality. A brief review of psychoanalytic concepts regarding BD suggests little practical usefulness of a classic psychodynamic approach, based on concept of improvement through insight into repressed content. Another, contemporary approach is described, which underlines the need to attune level of work to the psychotic functioning and might be better suited to conclusions from reviewed research. A particular focus is put on concepts of psychoanalytically oriented psychiatrists: Richard Lucas, Riccardo Lombardi and Franco De Masi. On the basis of these concepts changes in technique are introduced to actualize the psychodynamic technique to achieve better fitting to needs of patients suffering from bipolar disorder, which is in most cases characterized by psychotic states. Author's ideas are illustrated with clinical examples.

**Key words:** psychodynamic psychotherapy, psychotherapy of psychotic disorders, bipolar affective disorder

### **Introduction**

The aim of this paper is to present a contemporary outlook on the role of psychodynamic psychotherapy in the treatment of bipolar disorder (BD), with regards to its clinical usefulness, limitations, strengths and empirical research results. BD is a mental disorder which results in extraordinary changes of mood, energy and activity levels that severely impair everyday functioning. The prevalence of fully blown BD in the general population is estimated at 2-3% [1]. DSM-5 differentiates between two

of the most common types of BD [2]. BD type I is characterized by episodes of full mania lasting for at least seven days or requiring hospitalization. This is most often accompanied by episodes of depression that last for at least two weeks. BD type II is characterized by alternating depressive and hypomanic episodes, but without the full manic episodes that are characteristic for type I. BD is a condition that severely impairs one's professional career, social functioning and subjective quality of life [3, 4]. Judd et al. [5] have published their findings of a longitudinal study spanning across 20 years that demonstrate that the psychosocial functioning impairment affects both type I and type II BD patients. The search for adequate methods of treatment and systematization of existing knowledge are thus of crucial importance in the context of helping patients suffering from BD, and constitute a rationale for the proposed paper.

### **The role of psychotherapy – findings from empirical research**

Survey of literature points to varying perspectives regarding the role of psychotherapy in the treatment of BD. Some researchers suggest that psychotherapy alone can be a sufficient treatment of BD [6], while others claim that pharmacological therapy without concurrent psychotherapy should be the treatment of choice [7]. The most common attitude is the idea of combining pharmacotherapy and psychotherapy [8, 9].

This attitude is grounded in a widespread model of stress vulnerability that emphasizes the interplay of psychological, social and biological factors in the development of BD. The most notable psychosocial factors include stressful events, family conflicts, social and circadian rhythm dysregulation and irregular intake of medication. It is increasingly accepted that despite genetic and neurobiological determinants, BD can also be influenced by interventions targeted at the social environment [10, 11]. Psychotherapeutic interventions prove to be an effective supplement to pharmacotherapy not only in depressive episodes (where their usefulness is heightened by the fact that antidepressant medication is linked with a risk of extreme mood changes) but also in other phases of BD.

In the last 15 years some attempts were made to summarize the role of psychotherapy in the treatment of BD. I will briefly present the conclusions from selected publications.

Jones [12] has reviewed research on the effectiveness of psychological interventions in BD implemented since 1990. His analysis included studies focused on psychoeducation, cognitive-behavioral therapy, psychoanalytic psychotherapy and interpersonal and social rhythms therapy. The last intervention is an adaptation developed by Ellen Frank of a well-confirmed method of psychological treatment of depression – interpersonal therapy (IPT). IPT is a short-term psychotherapy designed by Klerman and Weissman for treating depressive episodes and is based on the psychoanalytic concepts of attachment theory and Sullivan's theory. It is focused on interpersonal problems and on reduction of symptoms. IPT is highly structured and lasts 12-16 weeks. The effectiveness of IPT has been confirmed in numerous studies [13, 14].

General conclusions from Jones' review suggest that various psychological treatments are beneficial for patients suffering from BD. Nevertheless, Jones underlines weaknesses in methodology of the reviewed studies which might account for overly optimistic estimations regarding the effects of psychotherapy. He stresses the necessity of designing research projects with more rigorous methods and underscores the role of clear theoretical models of BD on which projects are founded. Jones points out the necessity of precisely identifying crucial aspects of psychotherapy in each phase of BD [12].

Swartz and Swanson [15] have formulated several conclusions on the basis of review of 35 publications that were dedicated to research on the effectiveness of psychotherapy in the treatment of BD. The results of 28 studies conducted in randomized, clinical control trials in groups of BD patients were included in the review. They suggest that pharmacological treatment without accompanying psychological interventions leads to more frequent relapses, less frequent remissions, chronic persistence of symptoms and psychosocial disability. On the basis of gathered results, Swartz and Swanson conclude that psychotherapies tailored specifically to BD constitute one of the key forms of treatment of this illness. They point to the reliable, repeated evidence that the combination of psychotherapy and pharmacological treatment leads to better effects than pharmacological treatment alone: both in symptomatology and in preventing relapses. Swartz and Swanson [15] included in their review studies which employed cognitive-behavioral therapy, family therapy and the above-discussed interpersonal and social rhythms therapy.

Miklowitz et al. [16] have studied the effectiveness of psychosocial interventions and psychotherapy in the treatment of BD as a part of the American Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BP). In broadest terms, they suggest that patients who are receiving pharmacological treatment achieve more lasting and faster improvement of health if the pharmacotherapy is accompanied by intensive psychotherapy. The research project included a group of 293 patients diagnosed with BD; some were offered a short-term psychoeducation program, while others participated in an intensive, 9-month psychotherapy in 3 modalities (cognitive-behavioral, family therapy and interpersonal therapy). All participants concurrently received pharmacological treatment. In 12 months, 64% of patients who participated in intensive psychotherapy significantly improved, compared to 52% of patients who participated in psychoeducation. The psychotherapy patients improved on average 110 days faster than patients in the psychoeducation program. After more than one year since the start of the study, the beneficial effects were maintained in the "psychotherapeutic" group 1.5 times more frequently than in the "psychoeducational" group. No significant differences were noted between the three psychotherapy modalities.

Generally speaking, the effectiveness of cognitive-behavioral interventions in facilitating the outcome of treatment and preventing relapses of BD is relatively well documented [17-19]. In contrast, there is an insufficient number of publications and research projects focused on psychoanalytic or psychodynamic treatment of BD. One

notable exception is the interpersonal therapy and its derivative, interpersonal and social rhythms therapy, which on the one hand has distinct psychodynamic roots, but on the other hand differs in a few key aspects from what is commonly termed “psychodynamic psychotherapy” [20]. These crucial points include refraining from transference interpretations and limiting the ambition from an aim to change the personality to an aim of coping better with illness understood in medical terms. I will elaborate upon these important differences later.

Gonzalez and Prihoda [21] presented one of few research studies concerning a psychodynamic approach in the treatment of BD. They proved that psychodynamic group therapy led to a clear improvement of symptomatology in 73% patients in the study group, with improvement limited to symptoms of depression. The authors suggest that psychodynamic psychotherapy should be combined with pharmacological treatment in patients suffering from BD. Bush [22] presents a contemporary psychoanalytic approach to treating BD. She suggests that contemporary psychodynamic psychotherapy can contribute to effective treatment of BD patients, if the therapy is focused on transference/countertransference dynamics, support for pharmacological treatment, psychoeducation, daily rhythms stabilization, interpersonal difficulties and reduction of destructive behaviors.

Conclusions drawn from the cited research, remaining in line with current APA guidelines for treating BD, point to the idea that the most crucial aspect of treatment is not as much a specific therapeutic modality, but the intensity of psychotherapy [16], coexistence of pharmacological treatment [9], and tailoring interventions to the particular clinical picture of BD [15] and grounding them in theoretical understanding of psychological mechanisms involved in BD [12].

### **Psychodynamic approach to BD: early concepts**

Psychoanalysts have tried to treat patients with bipolar disorder (previously called maniacal-depressive psychosis) early on. In some writings Freud seemed to point to the possibilities of treating this condition [23], while in others he expressed serious doubts about this psychoanalytical treatment approach [24]. Freud perceived BD in light of his theory of depressive disorder (which he called melancholy). Freud saw depression as a pathological refusal of loss: the ego refuses to lose its loved object and thus identifies with it, taking responsibility for the loss and simultaneously punishing itself for it; such internal punishment accounts for the energy loss in depression [23]. In Freud’s early theory the episode of mania was seen as a situation in which the emotional energy, imprisoned in melancholic suffering, can be suddenly freed due to recognition of loss of the object. In later writings Freud developed an alternative concept of mania as a temporary escape from the ego ideal (the concept of ego ideal stems from structural theory and describes an unattainable, idealized version of ourselves, which – when made conscious – delivers a narcissistic blow) [25]. In spite of the usefulness of Freud’s ideas regarding depression (melancholia), which find evidence

in recent research on the effectiveness of psychoanalytic treatment of depression [26], Freud's formulations about mania seem to have failed the test of time, probably due to their relatively small practical usefulness: the insight formulated on the basis of these concepts does not result in improvement in BD patients.

Abraham [27, 28] developed his ideas on manic-depressive psychosis simultaneously to Freud. He suggested that in manic states the ego might free itself from the boundaries of the superego by merging with it. It seems that this idea might hold some practical usefulness when translated from a somewhat archaic language of psychoanalytic structural theory: if we assume that self-denigrating delusions in severe depression, accounting for a psychotic aspect of depressive disorder in some cases, might be seen as a derivative of a "strict superego," then we might perhaps suppose that maniacal states bear some resemblance to the "psychotic superego," because they also are founded upon a delusional background.

Ideas of Klein [29] and Segal [30] also occupy an important place among classic psychoanalytical theories of maniacal states. Klein [29] includes maniacal states as a part of her original conception of experiencing depressive states. She describes the depressive state as a situation in which beloved, good objects are threatened by something that comes from within a person. When one feels a painful awareness of the inability to protect the loved object from destructiveness, the result is a state of severe depression and despair. Klein claims that suffering from these depressive feelings can lead to reparation and restoration of a more integrated and safer internal world. Failure in recognizing and working through one's destructiveness toward the object has severe consequences, as it forms the basis of maniacal pathology, which consists of an omnipotent denial of reality, feelings of control, triumph and contempt. Segal [30] elaborated upon the dimension of control intrinsic to the so-called "maniacal reparation."

The contemporary usefulness of the above-mentioned classic psychoanalytic theories in psychotherapy of BD seems to be at best disputable. On the one hand – Freud's ideas, more notably regarding depression, and the concepts developed by Klein and her followers, form a consistent theoretical system that gives a psychotherapist a foundation for understanding the psychology of patients suffering from BD. This positive aspect of the psychoanalytic theory concerning BD was taken up by Solimano and Manfredi [31]. Koutsoukos and Angelopoulos [32] take a step further and suggest that an analogy can be drawn between Freud's "hydraulic" metaphor and contemporary psychiatric knowledge by underlining linkage between "the homeostatic model implicit in Freud's psychodynamics and most neuroamine deficit/excess theories and the oscillatory model of exaggerated biological rhythms" [32, p. 2]. On the other hand – clinical practice based on classic psychoanalytic technique that includes attaining insight by transference interpretations and making unconscious content conscious did not bring expected improvement. From the perspective of contemporary knowledge, attention can be brought to the fact that an attempt to make use of the therapeutic impact of a patient's insight into his or her feelings was

doomed to failure when applied to a group of patients whose illness by definition is characterized by severe difficulties in attaining insight [33]. By the middle of the past century, Fromm-Reichmann and her co-workers [34, 35] agreed that psychoanalytic therapy “was not generally successful with the manic-depressive” [34, p. 158]. The very limited role of insight in the psychotherapy of patients suffering from BD can be illustrated by a short clinical vignette:

*Mr. A, a patient in his 40s, started twice-weekly psychotherapy as suggested by his doctor, right after leaving the psychiatric ward. He was admitted to the hospital in an episode of mania. Mr. A's psychotherapy was conducted in a standard psychoanalytic manner, with a central role of insight and transference interpretations. His maniacal episode had started after he returned from a long foreign professional contract, covering a couple of years, and after he underwent a tough divorce. In initial sessions Mr. A eagerly spoke about the home he had grown up in, feeling unappreciated by his parents, about loss of parental love and about his feeling of loneliness and low self-worth. In further sessions he started presenting detailed stories from his foreign professional career and complaints about his ex-wife. He was indifferent toward comments that were aimed at linking his mental state with past experiences from his childhood and with his present marital difficulties. He was equally indifferent toward attempts to explore the transference relationship. In numerous therapeutic sessions he repeated the same stories over and over again. His overall functioning improved slightly, which was likely related to the regular intake of prescribed medication; however, from the perspective of developing understanding of himself or gaining insight into his experiences, the therapy of the patient made very little progress over the span of many months in spite of Mr. A's regular attendance.*

### **Psychoanalytic treatment of psychotic states: a new perspective on BD**

In light of the ideas presented above, it might perhaps be concluded that psychoanalysis has nothing to offer to BD patients except a consistent theory which allows for understanding possible psychological links between experiencing depressive and maniacal states, but nevertheless remains unusable in psychotherapy due to the patient's limited ability to make use of insight in this condition. However, such a conclusion would neglect the input of psychoanalysis – more so contemporary psychoanalysis – in the understanding and therapy of psychotic states, especially in the context of a psychotic aspect of BD. Goodwin and Jamison [36] conducted a meta-analysis of 33 studies to find that 61% of patients suffering from BD experience psychotic symptoms. These are obvious phenomena in full-blown mania, but may also occur in hypomania and in severe depression.

It seems that focusing on a psychotic aspect of BD opens up a new perspective in which psychoanalysis can offer valuable methods of treatment. Psychoanalytic and psychiatric outlook on BD treatment parted ways in the early XX century with differing approaches of Kraepelin and Freud regarding the genesis of mental disorders: Freud [25] emphasized the role of suppression of needs (i.e., dynamic unconsciousness), while Kraepelin [37] underlined the role of biology. Contemporary representatives of the psychoanalytic approach take into consideration both aspects of mental illness when treating patients: a biologic foundation of psychotic states, which are thus impervious to insight, and a dynamic foundation of non-psychotic states, which are susceptible to traditional psychotherapeutic work. Such an approach allows to include psychodynamic therapies into the pool of helpful psychological interventions, which can be beneficially combined with pharmacotherapy. I will briefly present a few contemporary psychoanalytic concepts, proposed by psychoanalytically trained psychiatrists on the basis of many years of clinical work with psychotic patients, including patients suffering from BD.

British psychiatrist and psychoanalyst with a long-standing experience of treating psychotic patients in the hospital ward, Lucas [38], formulated an idea of understanding psychotic states of the mind which is based on Bion's theory [39]. Bion claimed that the mind of a psychotic patient is split into non-psychotic and psychotic parts. The non-psychotic part is grounded in reality (and able to tolerate frustration), while the psychotic part evades reality through denial and rationalizations (which sustain the delusional system). Due to these mechanisms, the psychotic part of the personality is not affected by insight, as it actively attacks the psychological meaning and substitutes it with action. On this background Lucas [40] formulates a practical understanding of the psychodynamics of bipolar disorder, highlighting the psychotic nature of this illness. He claims that in the depressive phase the patient gradually sinks into a delusion of loss of an ideal object and, in consequence, torments himself with guilt for this loss. In maniacal phase there is, in contrast, an escape into the delusion of being an ideal object or possessing it, which in turn frees the patient from tormenting self-criticism. The limits of material, physical reality make a breakdown of the maniacal phase inevitable, thus effecting another loss of an ideal object and starting another depressive phase. An example of such a sequence can be illustrated by a short description of the situation of Ms. B:

*Ms. B, 20 years old, had started consultations toward beginning psychotherapy while still being on a psychiatric ward. In the first meeting she made an impression of a somewhat confused person, but also appeared to be sincerely worried by her mental condition and looking for help. She had been hospitalized after she ran away from home, for the fourth time in the last year. Those "escapes," as she called them, were full of dangerous behaviors: she had unsafe sex with many partners, moved to live with criminals, and during her last "escape" she was living in a squat; when she felt threatened, she*

*started running from the vacant building and broke her foot. At that point she decided to contact her family and reach for help. She agreed to inpatient treatment at a psychiatric hospital, where an episode of mania in the course of bipolar disorder was diagnosed. During the initial consultation, Ms. B strongly complained about her parents' excessive control. She claimed she had always felt empty, stupid and boring. She said she had nothing interesting inside and she would never achieve anything due to her laziness, sloth and lack of commitment. She added that she was disturbed by her own impulsiveness (more so during the "escapes") and by feelings of worthlessness and emptiness.*

This short example points to every aspect highlighted by Lucas: a tormenting self-criticism of delusional quality (the patient's firm belief of not being able to achieve anything in spite of various real achievements, like graduating from high school and starting an academic degree); a maniacal "escape" into a delusion of being absolutely self-sufficient; breakdown of the maniacal phase due to pressure from material reality (broken foot); loss of grandiose delusions and return to a depressive phase.

Lucas emphasizes, however, that the insight itself into this dynamic is not sufficient to stop the developing disorder in most cases: "The explosive unwinding continues with a momentum of its own, until all the previously suppressed anger has been spent. (...) The unwinding process, once started, cannot be halted. (...) Major external-life events are not necessarily required to trigger off another cycle. (...) In the case of serious psychotic disorders – such as bipolar disorder – the patient and psychoanalyst are having to deal with an illness that threatens at any time to erupt like a volcano. The therapist has to accept that in spite of his sincere engagement and devotion to analytic work, subsequent breakdowns and hospitalizations are very probable" [40, p. 207]. Lucas postulates that the therapist needs to tune in to the proper "wavelength" to understand the communication of the psychotic part of personality and to strengthen the non-psychotic part of personality during the phases in which it is in the foreground and can be worked with. He also stresses that psychoanalytic therapists rarely perceive depression as a psychotic condition – working with bipolar patients clearly shows that the depressive phases of mood are not a reaction to external events, but rather a consequence of withdrawal and preoccupation with a delusional world of fantasies [40].

Evans [41], with reference to Lucas' formulations, points out that even in the case of severe psychotic problems the non-psychotic part of personality has to face real life problems. This is a worthwhile remark, as it might suggest a possible direction of psychological work with psychotic states: to support the non-psychotic part of personality in everyday functioning and in recognizing reality in spite of a destructive effect of the psychotic part.

An Italian psychiatrist and psychoanalyst, Lombardi [42], suggests that important changes in the technique of psychotherapy of psychotic states should be introduced. He builds this view upon the theories of Bion and Matte Blanco. Lombardi stresses that psychotic states are linked with an intense flow of unrepressed unconscious con-

tent, i.e., raw emotional content without any cognitive working through. Due to this rationale, Lombardi suggests that when working with psychotic states, interventions based on insight (transference interpretations and reconstruction of the past) can be moved to the background, while the main focus can be placed on supporting the patient's contact with reality: his ability to recognize and experience his own emotions and strengthening connections between the body and mind.

In simplification, the method of working with difficult patients proposed by Lombardi is based on supporting the ability to think about experienced sensations, while maintaining a dynamic oscillation between thinking and feeling. Lombardi states that: "A psychoanalytic focus on the internal experience helps the subject emerge from an undifferentiated internal turmoil, as he develops the capacity for representation of this sensorial turmoil and the ability to differentiate his own feelings internally. This working through is accomplished jointly with the exploration of the internal layout and unconscious theories that influence and regulate the patient's body-mind relationship" [43, p. 884]. Lombardi concludes that since it is the flow on the (vertical) body-mind axis that is disturbed, therapists should concentrate on this area instead of the (horizontal) patient-analyst axis – this is why he suggests that the role of transference interpretations should be limited. If patients in psychotic states are confused, overwhelmed and lost not due to the psychological content they are trying to contain (this would be the realm of a dynamic unconsciousness, suppressed content that can be affected via insight), but rather due to lack of the ability to contain, the psychological work should concentrate on restoring the ability to contain (which means, in simplified terms, the ability to think about feelings). The following is an example of a psychodynamic clinical work based upon Lombardi's formulations:

*When C., a 16-year-old boy, was still hospitalized, his mother reached for psychotherapeutic help for the son. He was admitted to the ward with an acute episode of mania. During the episode C. got involved with increasingly chaotic new relationships, including sexual ones, and became increasingly irritable and aggressive; he also started abusing alcohol and illegal drugs. The episode reached its climax when C., overwhelmed by persecutory delusions, tried to shoot his cousin with a hunting crossbow during a conflict. After a three-month hospitalization, I managed to see C. for just a few sessions, during which he confirmed that he needs help, but his mood had already reached the point of severe clinical depression. He complained that return to school is an unbearable humiliation for him. After three meetings we agreed that C. needs another hospitalization, due to a severe episode of depression this time. We arranged to start psychotherapy right after C. left the hospital. In the meantime, I gathered information about the family background. C.'s father had also been diagnosed with and treated for BD. The patient's parents divorced some years earlier in a heated conflict*

*and were still involved in lawsuits over financial issues. C.'s older sister was also diagnosed with BD. The patient's first episode of mania occurred a year before I met him; at that time, he was treated in a day ward and in an outpatient clinic. However, a traditional psychodynamic approach offered in these clinics did not bring improvement. C. complained that he couldn't find a common language with the therapists, who, as he claimed, "were silent most of the time" and tried to impose their psychological theories on him. His second episode of mania – the one already described – began when he was attending psychotherapy in the day ward. Before the first episode of the illness, C. was a good and popular student, who led an active social life.*

*In the first phase of psychotherapy C. presented autoaggressive behaviors – he cut his arms and neck with a razor. I decided on a very simple intervention: I attempted to point out to him that he is expressing his anger, which he and his family found difficult to recognize, as it was instantly associated with his illness. Thanks to such interventions C. managed to gain control over his autoaggressive behavior and to bring it to a stop in just a few weeks. This preliminary intervention exemplifies a therapeutic stance which I adopted in work with C. I decided to focus on helping C. to recognize his own emotions, as he often found himself confused by pressing emotions after devastating episodes of mania. I decided not to introduce transference interpretations and I tried to keep a conversation alive and active, bearing in mind the course of the patient's former psychotherapies. Gradually we were able to work out an alliance based on C.'s trust that I indeed want to support him in achieving his own goals: an independence and sense of competency at least on the same level as before the first episode of mania. It was a difficult task, more so because of the family's attitude. The patient perceived his family, undoubtedly very supportive and caring in the face of his chaotic behavior, as humiliating and controlling.*

*Three fundamental topics in C.'s therapy were the problem of understanding his impulses, increasing isolation, and substance abuse. Aggressive and sexual impulses, natural in adolescence, in C.'s experience had become linked with his illness, and thus he was afraid to use them in any degree; he felt that he can make use of them only in excessive manner. This led him to withdraw from almost all social relationships, with an exception of a few friends from the neighborhood with whom he drank beer and smoked weed. Substance abuse soon became a problem for C. – not as much due to the risk of*

*addiction, as due to the fact that substance abuse substituted every other live experience.*

*The therapy has lasted for 18 months and is still ongoing. Further hospitalizations have been prevented in spite of the patient's severe problems. His inability to function at school led to intermittent phases of individual education and returning to school. C. struggles to understand his impulses and emotional states: in better periods he makes some constructive attempts, for example, to engage in sexual relationships, but in worse periods he reacts anxiously toward these constructive attempts, for example, with hypochondriac fear of sexually transferred infections. Similarly, he intermittently tries to use his aggression constructively, in service of more independent everyday functioning, but after a while reacts with resignation and total submission to his mother. From time to time C. resorts to substance use, but this is a counterproductive solution, as it deepens his isolation and apathy. Thanks to psychotherapy, C. is able to maintain a relatively stable rhythm of functioning. He stopped interfering with his prescribed pharmacotherapy (he used to claim that by giving him prescribed drugs, especially mood stabilizers, his mother is controlling and hostile toward him) and he clearly cut down on illegal drugs and alcohol, which he uses only occasionally. At this time the main point of focus in psychotherapy is an attempt to support C. in engaging in interpersonal relationships: both via discussing his emotions stirred by contact with others, and by his parallel involvement in cognitive interpersonal training, led by another colleague on my request. Another crucial issue in psychotherapy is supporting C. in better contact with his body as a fundamental area of keeping in touch with reality: this includes both basic self-care (work on his obesity and hygiene) and feeling more freedom in a sexual body. Traditional transference interpretations and reconstruction of the past are definitely put in the background of C.'s therapy.*

De Masi [44], a psychiatrist and psychoanalyst, in his book devoted to the psychotherapy of psychoses formulates a distinction between two types of unconscious. The first type is a dynamic unconscious, which consists of content that could properly be termed preconscious, as it is relatively close to consciousness, since the content has been repressed due to its conflict with other content. This type of unconscious plays a central role in the classic psychoanalytic technique, invented and described by Freud [25]. Along the dynamic unconscious, De Masi distinguishes another type of unconscious, which he terms an emotional-receptive unconscious. This latter form of unconscious consists of content that we have not yet become aware of; Bion [39] can be distinguished as an author whose work is most significantly linked with this type of unconscious. De Masi claims that psychotic disturbances are connected with

a defective functioning of the emotional-receptive unconscious and thus suggests that reconstruction of the past and transference interpretations (techniques proper for work with the dynamic unconscious) should be supplemented by active counteraction of withdrawal from reality and by looking for emotional transformations characteristic for psychosis and responsible for pathological psychotic constructions. De Masi firmly highlights the role of withdrawal of psychotic patients into a delusional, inner world, as he understands this process as a “core of psychotherapy of psychoses” [44, p.227]. He stresses that people who develop psychoses in adulthood had been prone to withdrawal into a fantasy world since early childhood – this factor prevents them from learning from emotional experience and plays a role in developing a psychotic part of personality. A withdrawal into psychosis is an addictive state, as it results in an illusory feeling of omnipotence and in a strong false belief in being able to shape the world accordingly to one’s wishes and needs. In bipolar disorder both maniacal and severe depressive phases are dependent on withdrawal into fantasies: in severe depression the fantasies revolve around struggles with an omnipotent, strict, punitive internal object, while in episodes of mania the patient withdraws into fantasies in which he identifies himself with an omnipotent object, with a resulting feeling of self-confidence, omniscience, omnipotence and full control over reality.

I will present another brief example to illustrate the role of withdrawal as one of the crucial mechanisms that fuel the psychotic part of the mind.

*Mr. D started psychotherapy when he was 31 years old, right after breaking up with his girlfriend. He had been on antidepressive pharmacological treatment for many years, but it was not enough to prevent the breakdown. He was considering hospitalization, but after consulting his psychiatrist he decided to start psychotherapy. During the course of analytic psychotherapy, Mr. D experienced a hypomania episode with a very brief hospitalization; he was diagnosed with BD, and the pharmacotherapy based on antidepressants was replaced with lithium monotherapy. Mr. D’s psychotherapy turned out to be very long, spanning over 9 years, with twice weekly sessions. The patient achieved a lasting remission of depressive and maniacal symptoms and a significant improvement in the ability to cope with life tasks (work, intimate relationship, new apartment).*

*Since his childhood Mr. D spent a lot of time alone, reading books and day-dreaming about fascinating adventures. He remembered his parents as very strict and controlling. He felt they never had any interest in his thoughts and focused only on him fulfilling their expectations. In his experience they were a “two-headed dragon,” with the mother being a “vigilant head” and the father a “fire-breathing head.” Mr. D’s father used to beat him as a punishment. When Mr. D was a teenager, in several instances his father hit him hard in the face with his fist. After these violent interactions, Mr. D used to look*

*outside the window and pretend he does not exist. His conflicts with his parents most often revolved around his education. The parents used to say he is "distracting himself" with interests other than school and pressured him to focus only on school education, even though he always had good grades. In high school Mr. D felt more and more depressed and helpless; he consulted a psychiatrist, was diagnosed with severe depression and had a brief hospitalization. The improvement of his mental state was significant but temporary. A year after his first hospitalization, Mr. D attempted suicide as a solution to the fear of conflicts with his father. He was hospitalized again and the improvement once again proved to be only temporary. A paralyzing depression continued to torment Mr. D throughout the following years. He started university three times, with only the third attempt motivated by his interests, not his parents', but each time he dropped out after a couple of months. He could not study, as he found himself petrified by anxiety of upcoming exams; he also kept his failures a secret from his family and tried to keep himself busy with various abstract or technical ideas not related to his studies. Despite chronic depression Mr. D was able to learn computer programming, which allowed him to find a job and live on his own. He said that moving out from his parents' house (to the apartment they bought him) was his only life achievement. He noted that he felt enormous relief when he left the cave of the two-headed dragon, but was unable to build anything on this success. After work he spent his days staring at the computer screen, absent-mindedly browsing random Wikipedia pages. He had tried to build relationships with women, but each time he felt he wasn't good enough and it was an exhausting experience. The women, discouraged by his passivity, would leave. He used to say that his life is organized around "the rule of three A's: apathy, abnegation, alienation."*

### **An actualization of the therapeutic technique in psychodynamic treatment of BD**

On the basis of the literature of the mentioned authors and in reference to the cited research in the first part of the paper, an actualized technique of psychodynamic work can be suggested, taking into account the psychotic part of personality in the functioning of patients suffering from BD. The most important changes in the technique would be: a central role of supporting better contact with emotional and material reality; a strengthening of the non-psychotic part of the mind by enhancing an awareness of the patient's own feelings, wishes and needs, including the role of the body; recognizing the psychotic part of the mind and its mechanisms; careful and limited use of recon-

structive and transference interpretations; an active and engaged stance of the therapist; and an attitude of humility and acceptance toward an internal autonomy of psychotic disturbance. Understanding the dynamic of phase change may serve the therapist, but one should not expect that insight into this dynamic will heal the patient. Crucial themes specific to the psychotherapy of bipolar patients include solving interpersonal difficulties and reduction of destructive behavior, pharmacological support, elements of psychoeducation and focus on stabilizing daily rhythms of activity and sleep. Supporting the patient's better contact with external reality includes highlighting his progressive, constructive, autonomous behavior and developing his self-sufficiency [42]. It should be noted that a progressive and supportive approach does not necessarily mean lesser intensity or superficial treatment. Moreover, the cited contemporary authors, along with other psychoanalytically oriented psychiatrists [38, 40-45], point to the importance of cooperation between professionals (psychiatrists, psychotherapists, social workers) and of including patients' families in the treatment process.

It seems that psychodynamic or psychoanalytic psychotherapy reframed in such a way described above bears resemblance in some aspects to interpersonal therapy (and interpersonal and social rhythms therapy), mentioned earlier in this paper. These similarities are most notably: placing transference interpretations in the background, focus on interpersonal themes, a more active role of the psychotherapist and inclusion of the stabilizing role of good grounding in external reality. Interpersonal therapy remains a highly structured and time-limited approach, while the presented suggestions regarding the technique of work can also be implemented in more elastic and long-term psychodynamic/psychoanalytic treatments.

I will present a longer and more detailed example of a treatment in which the actualization of therapeutic technique in line with these suggestions led to a significant improvement in functioning of a bipolar patient whose acute episodes of mania in the course of BD put her at risk of chronic professional and social disability.

*Ms. E started psychotherapy when she was 23 years old. In the prior year she had experienced six episodes of mania, she was moving around the country and was briefly hospitalized after each episode. Participation in on-going psychotherapy was one of the conditions her parents gave her, when they allowed her to move back into their house. Ms. E wasn't explicitly against the psychotherapy and accepted the condition with indifference, although she expressed serious doubts whether psychotherapy can help her. Nevertheless, she was very scared with the course her life took in the recent year.*

*Ms. E's external appearance expressed her withdrawal and confusion. It looked as if she put on some random pieces of clothing, without any consistency regarding colors or style. Her body was stiff and mannequin-like and Ms. E seemed to have little connection to her body. She was verbally coherent and eloquent, but totally devoid of spontaneity. She answered every question and when asked to elaborate*

*– spoke another couple of sentences, but she did it an automatic way, like she was playing recordings.*

*Until the first episode of mania Ms. E was studying in another city, working part-time and living with her fiancé in a rented apartment. After a sudden quarrel she threw her fiancé out and only a couple of hours later started an affair with a random outlander. She decided to move in with him, but when he left her for a few minutes in the bar, she met another man and decided this is the one she should be in a relationship with. Ms. E couldn't remember precisely what happened next, but after a few days her parents visited her, alarmed by her concerned fiancé. They were terrified by her state and brought her immediately to the hospital. This incident started a series of six subsequent episodes of mania occurring intermittently with short hospitalizations. Ms. E dropped out of university, lost her job and started traveling around the country to visit various men. One of them turned out to be a mobster, another stole a substantial sum of money from her and the last one beat and raped her. Ms. E remembered those episodes as a chaotic combination of confused facts, which typically concluded with her parents' intervention, as they were able to find her and put her in the hospital against her will. The last hospitalization, however, was with Ms. E's consent, as she felt extremely threatened after the assault and rape and reported to the hospital herself. Her parents agreed to take her home after she had left the hospital and to take care of her until she would be ready to resume her studies.*

*Ms. E remembered her childhood as one dominated by controlling and overprotective parents. As a child, Ms. E felt that her parents wanted to know everything about all aspects of her life. She felt their attitude expressed concern, but it was very uncomfortable nonetheless. She had much pleasure in day-dreaming, as this was an activity her parents could not control. Sometimes she would dream of quite uncanny things: as a little girl she wanted to inhabit a mental hospital with various interesting people. When she entered adolescence, she started to look for more active ways of escaping parental control. She spent most of her time out of home and started taking drugs. Her parents intensified their controlling attitude – it turned out that at this point Ms. E had her first, previously unmentioned episode of mania. She was hospitalized for almost half a year and she remembers it as a bad time. Afterward she adopted a compliant attitude toward her parents. She finished high school, started university, had good grades and called her parents every now and then – until the events already described occurred. The beginning of Ms. E's psychotherapy was a difficult experience. The patient, encouraged by me, tried to talk about "everything that*

came to her mind"; most of the time she presented emotionless descriptions of external events between the sessions. She was talking in a very flat, unemotional way. Usually I found myself unable to relate meaningfully to these descriptions, as all I could think of were only thoughts as flat as the patient's expression. Sometimes I had tried to formulate a comment, but I had an impression that my interpretations sound very superficial and awkward.

This first phase of treatment was conducted according to the classic psychodynamic technique and was based on attempts at formulating insight and on transference interpretations; this technique had encountered the limitations described earlier. A regular session time and a relationship full of good-will and focused on the patient might have served as an unspecific supportive factor, but attempts to make Ms. E aware of a possible repressed psychic dynamic and to point to patterns we were creating in transference proved useless.

After 6 months of therapy Ms. E started to sink into severe depression. On the one hand, this made our contact even more problematic, as the patient barely had the energy to speak; while on the other hand, at least some emotional content began to emerge in her utterances, although it concerned very painful emotions. Ms. E looked at her present life with despair. She was absolutely sure she wouldn't be able to return to university, she was afraid to leave the house and she imagined herself spending the rest of her life dependent on her parents or on social assistance due to mental illness. I was trying to support her in this difficult time by highlighting her smallest successes, without denying the reality of the huge losses she had suffered.

Very slowly Ms. E started to emerge from the severe depressive state. She started to talk more about her parents – how they oppress her, strip her from her autonomy, treat her like a little child. With a little gain in energy she resumed her studies on a part-time basis and started low-paid work as a waitress for few hours a week. Almost instantly she started to imagine she could move to another city. She thanked me for the help she received, conventionally claimed that psychotherapy had guided her way out from depression and declared she would have to terminate the treatment very soon, as she's moving away. Nevertheless, she still attended her sessions. My attempts at interpreting her escape from an oppressive therapist were met with angry frowns; I clearly irritated her with such comments. Soon her thoughts and behaviors achieved a frantic pace. After a session in which she confusingly spoke about her unrealistic plan to leave town, participate in music festivals and earn a lot of money, together with her worried parents we managed

*to convince her to a brief hospitalization. Ms. E returned to her sessions broken and despaired. Her dream of autonomy vanished; she took a sick-leave for another semester at the university and quit her job. Once again she had to witness a huge scale of destruction in her life. This pattern had repeated a few times in the subsequent months. Phases of severe depression, in which Ms. E tried to make painstaking, small steps toward recovering some of her important life goals, were followed by phases of good mood that quickly transformed into an explosive mixture of rebellion, anger and a wish to escape. Episodes of mania and hypomania usually led to some spectacular problems: one time Ms. E was arrested for smoking marijuana and spent the night at the police station, in another instance she started an unusual sexual affair with a total stranger. Thanks to close cooperation with her family and psychiatrist, each episode was always met with adequate pharmacological treatment.*

*In the second year of therapy, shortly before my summer break, Ms. E told me – in a highly unusual manner for her – that she is afraid of the break in therapy. She asked me whether I would be available if she experienced any crisis. Taking into account our stiff and indifferent relationship so far, this was the most surprising question. I told Ms. E that in case of a crisis I would be available on the telephone and if the necessity occurs, an emergency meeting could be possible at some point of my holiday. But I also told her that I think it might be possible she could cope on her own. She accepted this proposition with gratitude, although she did not contact me during the break. After the break, the therapeutic relationship was given a new depth; Ms. E stressed how important my answer to her request was. She explained to me that for many months she didn't want to tell me anything because she did not trust me: she was sure that I was hired by her parents to control her, yet she had to stick to psychotherapy, as she would have no place to live otherwise. But as time went by she observed that I accepted her impulses toward independence calmly, without trying to persuade her to be compliant to her parents, focusing instead on attempts to understand her feelings and to offer my comment. Nevertheless, the most important thing to her was the feeling that in spite of numerous episodes of her illness I was still hoping she could resume her studies and live on her own. She was convinced that everyone else stopped believing in this scenario and she had grievous doubts herself. She was sure that I was waiting for a summer break to have some relief from her hopeless situation; therefore, my readiness to see her in an emergency situation had so much meaning for her.*

*I have the impression that one helpful aspect of Ms. E's therapy was an attitude in which I refrained from transference interpretations of dependence and separation anxieties and instead focused on trust and belief in the patient's independence and self-reliance. I agreed to a possible "emergency" meeting, but I also expressed hope that Ms. E has potential resources to contain her emotions during the break. It marked a clear turn into a somewhat different technique of work, emphasizing progressive elements and strengthening the non-psychotic part of personality in its struggle with the psychotic part.*

*From that moment it seemed that Ms. E was slowly but systematically improving. In the third year of psychotherapy she started to engage in relationships other than shallow, random contacts (she started by reuniting with her former childhood friend) and soon after this she started an intimate relationship. At this time, she was nearly finishing her part-time studies, but was unable to hold a stable job, which seemed a realistic appraisal of the situation. Thus, her new relationship was additionally attractive, as it was a chance to move out from her parents' home and to become more independent. However, this apparent development toward independence proved to be premature, as it consisted mostly of an external rebellion toward actual limitations. In the internal world the patient was still struggling with an intolerable recognition of her dependence, which she counteracted by turning to the psychotic part of personality: withdrawal and denial of reality.*

*At first Ms. E felt that her relationship with her boyfriend was very secure, as her partner gave her tenderness and care – but as month passed she started to feel that the tenderness and care are transformed into control and boundaries. I felt that Ms. E found someone in the external world, who seemed well-fitted to play the role of an internal, controlling object, as in sessions she started complaining about the flood of such controlling behaviors by her partner. She reported that her partner prevented her from meeting with her friends, forbade her to leave home on her own, browsed through her phone history and started violent, jealous quarrels with her. Ms. E turned to already known measures of finding relief from a hated, controlling object: she started to withdraw from this relationship and to construct a growing net of lies. She started secretly seeing her old friends and returned to taking drugs, as she felt this is her way of protecting her autonomy. The therapeutic alliance we had developed allowed Ms. E to use psychotherapy to observe her actions from a certain perspective. She was withdrawing from her partner, lying to him and constructing a false reality – but she was not completely lying to herself, as she had tried to use*

*our sessions to see more clearly the dead end her relationship had reached. A situation of a hidden anger, masked by withdrawal and lies, generated more and more tension for the patient.*

*One of the important breakthroughs in psychotherapy occurred on the day when the thoughts of Ms. E started to gain frantic pace again, but this time she was worried enough to consider going to the psychiatric ward on her own. She was also able to share those feelings with me during the session, without blaming her “despotic parents” or their “hired therapist” for her feeling of weakness and dependency, but recognizing that she really feels weak and maybe needs to make use of more intensive help. I supported her in this attitude, perceiving it as an important expression of the patient’s development. I will present some details of this session:*

*The patient started the meeting clearly excited, speaking in a slightly jumbled manner and wriggling in her seat. She said: “I am very sorry for not being able to meet you last Thursday, but the alarm clock failed to wake me up. I had a terrible weekend, it was very bad, very dramatic, I’m feeling bad. Before the weekend it was much better, I spent a few days almost solely with F. (her boyfriend), he was ill, I was cooking dinners for him, we were together for many hours, it seemed we’re getting along very well. I felt closeness and warmth between us. And on Saturday I went to a party with my friends, they invited me, I just wanted to relax, what’s wrong with relaxing from time to time, I spent the whole night at the party. On Sunday morning F. called me and I panicked. I lied to him, as I did not know what to expect, I was worried he would be mad at me for going to the party, so I told him I’m at my parents’ house. And after 15 minutes he called again and told me he is at my parents’ house right now and I’m not there and I have to tell him immediately where I am. So I told him I’ll be there soon. And I got on the bus and got there, and when I arrived, they started brainwashing me. As soon as I entered, I felt weird. My mom was sitting in the kitchen along with F., my two closest people, and they started scolding me together. It’s been a long time since I heard so many bad things about myself. I’ve had enough but they kept on talking and talking. The worst thing was that I went to my room and my mother left me alone, but F. stayed overnight and stayed for another day, and kept on talking and talking, he wanted to talk to me all the time, I wanted him to leave, but he just kept on talking. I even spoke to my mom and she also felt it was weird that F. stayed so long against my will, but she didn’t want to interfere. She even told me that she felt awkward when she saw him coming downstairs, taking something from the fridge without asking and going back up.*

*And for me, the most intense moment was when we were talking, I was crying, eyes swollen, and then I looked in the mirror and I saw how miserable I look, but I saw no compassion in his eyes, only some kind of disappointment, contempt, or maybe even hatred. The weekend was the worst. On Monday things got a little better, until a friend of mine called, he asked about that party, I answered his question, maybe I uttered the name of the place we were at that night, and then F. got angry and in the middle of the street he started shouting that I am probably planning another party. It was too much for me. I can't keep it up, I feel betrayed by him, but most of all I feel very, very tired, I have no strength left."*

*I tried to highlight Ms. E's emotions and to support her ability to contain her feelings by her thoughts, so I just said: "You feel very oppressed by F. You were hoping that this relationship would give your life a new quality, but now you feel that F. is trying to control you along with your mother." The patient looked even more tormented and continued: "He is like a second mom. And during this weekend he was much worse than my mother, when I said I was not feeling well and I was tired – my mom was able to understand this but he kept on pressuring me. It was really terrible... You know, I can't do it anymore, and those Christmas holidays are coming up... But most importantly I want F. to leave me alone; I'm not feeling well, I want to go to the hospital. I would have some peace; he would not torment me at the hospital. I'm not feeling well, I'm not feeling well, really. I feel I have to get to the hospital as soon as possible. I think I should go, I can't sit here any longer, I will be calm at the hospital. Maybe this is an escape, but I feel I just have to. I think I will go; I can't stay here any longer." It looked as she was going to get up and run away from the room. I felt that this patient badly needed a clear intervention, demanded my activity – and at the same time she felt she was losing faith in her ability to contain her own feelings. Moreover, I was aware that the understanding of her mental state alone would be probably not enough to calm her down and I saw her idea of going to the hospital as an expression of concern and maturity. Thus I said: "Maybe you are afraid that I will treat your need to rest in the hospital as an escape – and I suppose you might assume I will scold you for this. But I would say that even if you are running away, you are doing it in a safe way, with concern for yourself. In the past your family numerous times pressured you to go to the hospital and you felt very oppressed by them. And now you feel that the hospital could help you get relief from the feeling of being oppressed by F. and your mom, you don't have to immediately run away to another city." Ms. E instantly calmed down,*

got back to her chair and said: "You know, I called my doctor to give me the papers needed to get to the hospital, but he was not there, he will be at work in a few days. So I thought maybe I'll figure something out, I don't know, maybe I'll stand on the roof and call emergency telling them I'm going to jump. But right now I actually really think that I can just go to the hospital and say that I need to be taken in because I'm worried about myself. Yes, I would like to find shelter in the hospital. I would get dressed in pajamas, turn on my laptop, stack my books around me and at least I would have a calm Christmas. Of course, everyone would prefer Christmas at home, but maybe right now the hospital is the calmest possible place for me. I think I'll go for it." At this point I decided that I just want to support my patient in the developing ability to contain her emotions and to take care of herself in a constructive, realistic way, expressed in this session; shortly speaking, to support and strengthen the non-psychotic part of her personality. So I said: "It seems that you were a bit calmed by the thought that I'm not going to oppress you when you are feeling tired and threatened, and that I value your mature attitude when you are trying to take care of yourself and think about rest in the hospital." It is worthwhile to note that I was talking about our relationship, but I would not call my intervention a transference interpretation. I was not pointing to any particular patterns of the relationship that Ms. E would be playing out in our meeting; I was rather engaging her as a real person, using our therapeutic alliance to support my patient's confidence in her own abilities, not to stimulate her dependency on me. Ms. E replied: "Maybe I thought you would be disappointed, I think I am disappointed with myself, that there is a hospital again. But this time I really feel that I'm going to the hospital to take care of myself. This relationship with F. would suffocate me, in the last weeks I already felt this was way too much, I have just started feeling well with myself, I have just started getting back up after my exams, I even began to regain some joy in life, but then F. emerged and all those extreme feelings appeared... On the one hand, a real feeling of closeness with him, and on the other hand, anger and my refusal to be suffocated, oppressed, limited by him. This emotional swing is too close to my illness. And I don't want to be ill again, I don't want to ruin another several years. So it will be better for me to go to the hospital. When I get back, I will ask my psychiatrist to set my medication again. Yes, when I leave your office, I'm going to call my parents and ask them to help me pack my things to the hospital." A thing of note is that the attempt at hospitalization was not successful. Due to a lack of unoccupied beds in the hospital (Christmas was

*a busy time on the ward), Ms. E received only an increased dose of her medication and a suggestion for more frequent psychiatric consultations. Of great importance for the patient, however, was the sole experience of confronting a precarious area of her mind, tolerating a sense of humiliation and anger associated with this confrontation, and looking for actual help in spite of the availability of known methods of withdrawing from reality, which would result in a direct relief.*

*I think that Ms. E was able to accept my help in these circumstances primarily thanks to the earlier, long-term, non-spectacular work, revolving around building a basic sense of trust. When she shared her worries and told me she's "not feeling well and has to rest in the hospital," she had to trust me that I'm not going to triumph over her and use her confession as proof that she needs to be controlled. Moreover, she badly needed to feel that I would keep my faith in her even if she decided to go to the hospital: that I would not lose hope that someday she would finish her studies, provide for herself, start a family. I believe that Ms. E built such basic trust on the basis of a lived experience: a series of ups and downs, which also stirred my optimism and terrified me. Some time later Ms. E told me that she couldn't remember if I told her anything important during the first years of therapy. In fact, I agree with her, as I don't think that I formulated any particularly good interpretations in the first phase of therapeutic work. However, the patient strongly stated that what was way more important to her was the fact that in spite of her emotional storms I remained by her side, not trying to control her and keeping a little hope for improvement. She paraphrased the lyrics of a popular song and said that she felt "I would go down with the ship, I won't put a white flag up and surrender."*

*Shortly after those events Ms. E finally broke up with F. Her psychotherapy still went through many stormy phases and lasted almost five years in total. Ms. E got her master's degree, which she experienced as an enormous achievement, a conclusion of eight years of her effort. She started a stable job and was able to pay for her bills, including psychotherapy. She entered a new relationship, but she found herself repeating familiar patterns and the relationship didn't last. About a year after Ms. E started living on her own, she decided to terminate her psychotherapy, mainly due to financial strains. This seemed like a rationally motivated decision rather than an escape. Over the next few years, Ms. E called me from time to time, when she was looking for support or relief, but she always informed me that she's coping well enough with life tasks. She told me that in spite of her moods and some restlessness in her life, she didn't require*

*any hospitalization since the termination of therapy, as she didn't experience phases of mania, hypomania or clinical depression and remained in regular contact with her psychiatrist.*

*In hindsight I suppose that the most helpful aspect of psychotherapy, responsible for Ms. E's better functioning, was an actualization of a technique of therapeutic work: putting insight and transference interpretations in the background and focusing on building a trustful contact, in which the patient learned to better recognize her own emotions and to be aware of developing her own constructive, progressive abilities. I think this therapeutic attitude in the end allowed the patient to take responsibility for herself and to take better care of herself. In the later phases of psychotherapy, a psychoanalytic understanding of the dynamics of depressive and maniacal states was not used to formulate interpretations, but served as an important foundation in moments of crises and hopelessness, such as in long and painful depressive phases or in dangerous episodes of hypomania. Another important aspect in the therapy of Ms. E was a mutually supportive cooperation between the psychotherapist and psychiatrist. Furthermore, this therapy would not be successful – or possible at all – without involvement of her family, who financed the treatment for most of the time and supported Ms. E in all circumstances.*

### Summary

An attempt was made to describe the role of psychodynamic psychotherapy in the treatment of bipolar disorder. The general role of psychological interventions in treating this illness was outlined, highlighting the approach of combining psychotherapy and pharmacological treatment as the most common recommendation. Research data on the effectiveness of various therapeutic approaches in treating BD was presented. Conclusions from the review suggest that intervention should be tailored to specifics of BD rather than limited to any single therapeutic modality. A brief review of psychoanalytic concepts regarding BD demonstrates low practical usefulness of a classic psychodynamic approach, based on the concept of the therapeutic role of insight into repressed content. Another, contemporary approach was proposed, which underlines the need to attune the technique of work to the psychotic functioning and might be better suited to conclusions from reviewed research. A particular focus was placed on the concepts of psychoanalytically oriented psychiatrists: Richard Lucas, Riccardo Lombardi and Franco De Masi. On the basis of their concepts, I have summarized the changes in the technique of work that actualize the psychodynamic technique and result in a better fitting to the needs of patients suffering from bipolar disorder, which is in most cases characterized by psychotic states. The presented ideas were illustrated with clinical examples.

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