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

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ABSTRACT

OBJECTIVE: To provide a review of journal articles discussing clinical cases or vignettes of psychoanalysis or psychoanalytic psychotherapy of patients affected by bipolar disorder (BD).

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 BD—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 BD. 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\(^1\) and affects \(\sim 1-4\%\) of the global population.\(^2,3\) Although the course of bipolar illness is variable, it often results in cognitive and functional impairments\(^4,5\) and leads to chronic medical conditions\(^6,7\) and suicide attempts (up to 30 times higher than in the general population).\(^8,9\) BD is ranked among the twenty leading causes of disability in the world among all acute and chronic diseases and injuries.\(^10\) Thus, BD appears to be a global health problem for disability.

Pharmacotherapy is often the first option in treating these patients.\(^11\) However, growing evidence indicates that although it effectively reduces acute depressive or manic episodes, medication alone can neither prevent illness recurrences nor fully alleviate post-episode symptoms or achieve a good functional recovery.\(^12\) When provided, psychotherapy is considered an adjunctive treatment\(^13\), although it is crucial in producing behavior and lifestyle changes essential for relapse prevention, long-term maintenance, and promoting positive function (vs. symptom reduction).\(^14\) Indeed, evidence from randomized clinical trials indicates that the combined treatment is more effective than medication alone in stabilizing depressive symptoms and reducing recurrences.\(^15,16\)

Until now, 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,\(^15,17\) while excluding both psychoanalysis and psychodynamic psychotherapies. This despite psychodynamic therapies (which derive from classical psychoanalysis)\(^18\) having proven to be as effective as other forms of psychotherapy for common mental disorders,\(^19\) including depression\(^20-22\) and BD.\(^23\) With regard to psychoanalysis and long-term psychoanalytic psychotherapy, it must be acknowledged that effectiveness for BD has yet to be tested in experimental or quasi-experimental studies. Currently there is no robust evidence for it.\(^24\) However, bipolar patients started sitting on the couch more than a century ago, and psychoanalysts have produced a series of narrative clinical cases—which historically have influenced psychoanalytic research and theorization.\(^25,26\)

The importance of case study methods in investigating in-depth what happens in the therapy room\(^27,28\) and bridging the research-practice gap\(^29,30\) 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.\textsuperscript{31,32}

Hence the question: What clinical-theoretical contribution has psychoanalysis made to the understanding of BD and its psychological treatment? Because there are no review articles on the topic in recent 30 years,\textsuperscript{33,34,35} 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 were published previously or in progress. The Preferred Reporting Items for Systematic Reviews and Meta-Analyses for Scoping Review\textsuperscript{36} statement were followed.

**Study search**

The databases MEDLINE, PsycINFO, Scopus, and Web of Science were searched by abstract and title. In addition, the Psychoanalytic Electronic Publishing (PEP-Web) archive was searched by full text. The search in PEP-Web 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 to be included 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.\textsuperscript{37}

**Study selection**
Two raters (*masked*) 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. Study characteristics: Author(s), year of publication, country; theoretical approach; 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”); therapy characteristics: setting, weekly session frequency, duration, therapist’s sex, and status (i.e., ongoing vs. terminated); main theoretical findings.

**RESULTS**

The initial search retrieved 229 journal articles, with further examination of 5 articles captured via reverse search strategies detailed above (Figure 1). Of these, 24 articles were included in the review (Table 1).

**Study characteristics**

Of the 24 articles selected, eight articles were published in the 1990s, nine in the 2000s, five in the 2010s, and two articles were published in 2021. Regarding the authors who wrote the articles, they worked as psychotherapists/psychoanalysts in eight countries: United States (*n*=12), 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 treatments characteristics**

A total of 29 case reports of patients with BD treated with long-term psychoanalytic psychotherapy or psychoanalysis (from here onwards also called therapy) were found. Most of the patients were adults (apart from one underage case and two missing data), female (62%), and their symptoms met the DSM-5 criteria for diagnosis of 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 and the remaining unknown). Fifteen therapies (52%) were terminated at the time the study 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 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 on its conceptualization, are proposed.

Analyzability

Three articles focus on the issues of (a) the capacity to meaningfully engage with and potentially benefit from a course of analysis of a patient with BD and (b) the difficulties in anticipating the course of analysis based on the (pre)treatment initial workup.

Wright\textsuperscript{38} describes how, over the first two years of psychotherapy (3 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 two years of therapy, Wright claims that psychoanalysis is a treatment of choice and starts psychoanalysis five times a week with that patient.

In the second article, the author\textsuperscript{39} claims that the development of a very intense transference in the patient from the very beginning of therapy and the central role of early environmental trauma in their current (pre)œdipal 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\(^40\) illustrates the difficulties common to the management of BD 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 on the present mental conditions of the patient. Although sometimes essential, obtaining information on the patient’s past and current mood status from someone other than him may activate transference problems. With regard to the first two points, the author speaks of the paradox of building an alliance in the face of the patient’s denial of being ill. Salzman not only recognizes denial as a pathologic coping strategy in mania, but he also emphasizes that it may be a normal response to 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 therapeutic alliance may be threatened by negative transference and countertransference, it is usually incorrect to attribute all anger and frustration merely to the mood dysregulation of the patient. Transference shifts should be assessed in a broad psychodynamic context, also while evaluating the necessity for pharmacotherapy changes. Salzman maintains that sometimes an appropriate interpretation can prevent the need for medication adjustments or, alternatively, facilitate necessary dosage changes with minimal misunderstanding.

According to Kahn\(^41\), the utility of dynamic therapy of personality for patients with BD lies in trying to limit the stresses of the patient that precipitate affective episodes (in addition to ‘independent’ bipolar cycling). Stress here is conceptualized as a phenomenon strictly related to the person’s personality to cope with stressful life events. Kahn claims that although a 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 nonrespondent to medication and other psychological interventions, helping to 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 a heavily kindled autonomous pattern).

Jackson\textsuperscript{33} claims that the main task of the therapist is the gradual modification of the patient’s melancholic superego, 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\textsuperscript{34} 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\textsuperscript{42} claims that to obtain an 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 due to its potentially mood-destabilizing effect due to the inevitable intense experiences of joy and sorrow that characterize any successful intensive psychotherapy.

Similarly to Lucas and Deitz, Duckham\textsuperscript{43} 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 with the environment) and then improve affect regulation. By establishing a stronger sense of trust in him/herself and others, the subject can develop a deepened belief in the loving and caring nature of him/herself and his/her environment.

Gomolin\textsuperscript{44} 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, the function of the transference has the sole purpose of enabling the patient to complete and survive the enactment of their instinctual impulses. For the analyst, promoting a therapeutic regression (i.e., a regression to early levels of
emotional development in order to work through them so that the process of development may take place or be resumed\textsuperscript{45} is a continuous clinical challenge that can be facilitated by analyzing their impulses.

Downey,\textsuperscript{46} who focuses on patients with BD whose symptoms were stable with medications except for their drive sexuality, argues that the use of 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 their sexual enactments and, more broadly, their conscious and unconscious experiences. This understanding informs and enhances psychotherapeutic work.

Georgaca,\textsuperscript{47} 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 (supposed to have consistent knowledge of the patient’s experiences/behaviors/feelings/perception). Therefore, the analyst must take on the function of a witness to the patient’s revelation of what they already know, becoming a non-psychotic presence that facilitates the patient’s grounding in a constructed and shared social reality. Gradually, the analyst’s functions expand to include witnessing the patient’s change, ratifying their choices, encouraging the path they take, and providing them with subjective temporal continuity. The purpose of the treatment is to facilitate the patient in constructing a sustainable symptom using their current available psychological mechanisms.

Keeping the focus on psychotic states, Vanheule\textsuperscript{48} argues that faced with psychotic symptoms, the analyst should examine whether and how the psychotic crisis was triggered by specific life events or situations in life. 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.

Lastly, Kalita\textsuperscript{49} draws attention to the limited ability of insight into unconscious or repressed content of most persons affected by BD and asserts 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: placing transference interpretations in the background, focusing on interpersonal themes, playing a more active role, and investing in the stabilizing role of a good grounding in external reality. The last 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 maniacal phase inevitable, causing another loss of an ideal object and then another depressive phase.

**Empathic Approach**

Chernus\textsuperscript{50} 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 patient’s subjective meaning of everything in the treatment (including psychotherapy, medications, and their feelings about each healthcare provider), is a key element contributing to the 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 between/among clinicians and between the patient and each clinician. The patient’s ability to use adaptively, on a transferential basis, their clinicians is an important factor in stabilizing the patient’s mood.

Similarly, Deitz\textsuperscript{42} describes how empathic concern for the inner affective experience of the BD patient during therapy (a) provides an emotional and relational environment within which an enhanced sense of self can develop through a reworking of past experiences; (b) allows the internalization of mood modulating self-structures (one of which is, for example, the insight into the early signs of the emergence of hypomanic symptoms) through self-object transferences; and (c) helps the patient with BD make pace with his need for mood modulating medication.

**Conceptualizing the Psychotic State**

According to Georgaca,\textsuperscript{47} 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 thus to produce an endless metonymic sliding of the signifier. Moreover, the psychotic patient is under threat of invasion of *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 a social bond.
Vanheule 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”—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 concerning love and procreation, deal with parenthood/authority, life in light of death, and sexual identity. Psychotic crises are triggered upon confrontations (at an unconscious level) with such intimate questions through situations in daily life, while no support can be found employing a master signifier. As a result of the absence of a signifier representing the subject, all subjective order is lost. However, the presence of a psychotic structure does not entail that these self- and other-directed questions invariably lead to hallucinations or delusions.

Nature and Nurture

From the premise that there is an interplay of genetic and environmental factors in the etiology of BD, Jackson speculates that the basic pattern of dynamics common to all cases of BD has roots in infancy and early childhood unresolved conflicts, although the subject’s development is influenced by subsequent life experience.

Similarly, Rossouw 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 predispositions—including, among other things, emotional regulation and impulsivity—also contribute how the care-taking world is experienced by the single subject and therefore create and shape their unconscious fantasy.

Deitz underlines 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 as assumed. More correctly, BD’s difficulties in mood regulation 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 under arousal (i.e., depression), overarousal (i.e., hypomania/mania), or a combination of the two (i.e., dysphoric mania).

Mills\textsuperscript{53,54} highlights the role that severe complex trauma and developmental deficits in attachment and cohesive self-structure can play in the development of bipolar illness.

Downey\textsuperscript{46} 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.

\textit{Intrapsychic and Interpersonal Dynamics}

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

Jackson\textsuperscript{33} conceptualizes that on one side the psychotic depressive phases 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. On the other side, in the manic phase, the normal self is escaping 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, turned very negative and persecutory. This dynamic, if unchecked, may lead to dangerous acting-out, including suicide attempts. Second, the central anxiety of the patient 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 the patient, who acts in such a way that invokes in the therapist anxiety about their destructive impulses and despair similar to those experienced by the patient themselves in order to unconsciously test whether the therapist can or not stand that anxiety and help them to understand and begin to deal with those feelings. Fourth, in the manic phase, the patient no longer wishes to make themselves understood and turns 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 as a psychobiological defense mechanism, the switching of mood, and the etiology of the disease.

Similarly, Ventimiglia\textsuperscript{55} 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 to 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 manic phases’ typical trait of wide-ranging freedom from bonds and rules, often characterized by easy and uninhibited switches from an 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 the unconscious loyalty to one specific identificatory object.

On his part, Lucas\textsuperscript{34} 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 builds silently up to the imposed state of affairs 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 the one always out having a ball?” The above-mentioned explosive unwinding of the tightening spring cannot be stopped once it has started, and continues with a momentum of its own until all the previously suppressed anger has finally been consumed. Major life changes or events are not necessary requirements for triggering another cycle. Once the rage has been vented, the pull to merge with the tyrannical superego can reassert itself.

Anderegg and Gartner\textsuperscript{56} 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 previous authors, Rossouw’s focus is on the complex interplay between bipolar illness and patient internal experiences. According to him, the actualization of unconscious fantasy would be more bearable for those 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 balance of symbolic capacity of some patients can collapse and consequently, they experience the traumatic event as an actualization of some unconscious fantasy. By becoming real, fantasy opens a door that stops the communication of fantasy and reality and makes the patient vulnerable to the experience so that happenings in the real world directly trigger consequences at the level of unconscious fantasy.

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

Salzman stresses that transference issues abound in the treatment of 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 an 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.

By making a general discourse, not specific of BD, Mills 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 self-structure. This situation establishes a predisposition for the individual to develop disorders of the self with many overdetermined polysymptomatic profiles.

Lastly, the author of the anonymous paper maintains that the severe suicidal crisis may be based on the deepest conflicts of the patient, 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\textsuperscript{57} shows how his patient’s hypersensuality and self-sensuality are closely tied up with her primitive eroticization of both the transference and her life outside the consulting room; they are self-feeding and designed to obscure the awareness of separation and separateness. This self-sensuality may be acted out or confined to fantasy, depending on the individual’s personality development, as well as the position from which mental events are experienced by the individual.

Downey\textsuperscript{46} discusses how the use of developmentally oriented psychotherapy can help patients with BD whose symptoms were stable on medications except for their driven sexuality 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 each individual finds 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 of patients affected by BD to show no diagnosis-specific intrapsychic or interpersonal dynamics, discuss topics that do not fit any of the categories above. More specifically, Cambray\textsuperscript{58} discusses archetypes as emerging phenomena organizing “moments of complexity,” Winship\textsuperscript{59} discusses the central psychobiological role of the testes in sensual and libidinal development, Archer\textsuperscript{60} discusses the topic of shame as a cause of distress and breakdown, while Levine\textsuperscript{61} 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 journal literature containing clinical material on patients with BD. Elaboration 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 and published in journals over the last three 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 not one psychoanalytic article or book has been cited in any of the three sections that the second edition of the Psychodynamic Diagnostic Manual\(^6\) devotes to the 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\(^15\) and are therefore not recommended as an adjunctive second-line treatment by current international clinical treatment guidelines\(^{11,63}\). Consequently, they are not among the forms of psychotherapy that are considered suitable for BD by most psychiatrists. This is in part because, in past times marked by the psychoanalytic dominance of some psychiatry departments, the mainstream of psychoanalysis demonstrated contempt or at least a lack of interest concerning the biological aspect of psychiatric illness and treatment\(^64\). Therefore, in a growing culture of evidence-based practice, most psychiatrists do not consider psychoanalysis and psychoanalytic therapy relevant to modern psychiatric mental health services\(^{65,66}\). Here it must be underlined that although the still-existing prejudice that psychoanalysis is not ‘evidence-based’ has been convincingly rebutted by empirical data\(^{67-70}\), it is indisputable that thus far poor evidence has been provided about the effectiveness of psychoanalysis and psychoanalytic therapy in improving symptoms and global functioning in patients with BD\(^24\).

Second, following from the previous point, although psychoanalytic therapy is nowadays accessible as a psychological treatment offered within 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.\textsuperscript{71–76} In these countries, psychoanalysis is offered mainly in private practice rather than within 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 on the American Psychoanalytic Association website (https://apsa.org/content/common-mental-health-diagnoses), which is the oldest national psychoanalytic organization in the United States and a component of the International Psychoanalytical Association, you can read: “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 and notably, in a country like 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.\textsuperscript{77} However, French psychiatry considers psychoanalysis as a valuable tool to understand and analyze the psychopathological processes involved in BD, as well as the role played by the therapeutic relationship in the changes that occur in the patient’s condition, and as inspiration for adapted psychotherapeutic techniques.\textsuperscript{77}

Consequently, analysts are likely to receive patients with BD only from time to time in the private consulting rooms. 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 decades considered. Nevertheless, many analysts have worked and are still working analytically with patients affected by BD, even for very long periods (as suggested by the average long duration of the therapies reported in this review). Furthermore, although perhaps very few, there could be some contributions in the current and future psychoanalytic literature that may help better understand the psychological functioning underlying one or more of the 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.\textsuperscript{78–83} This predominance is quite consistent with
previous findings on the diffusion of the leading contemporary psychoanalytic schools\textsuperscript{84,85} and the most represented in published psychoanalytic case studies.\textsuperscript{86}

The last point that deserves a brief comment is the absence of clinical cases involving children ($n=0$) or adolescents ($n=1$). This opens the discourse to the status of diagnosis within the psychoanalytic community, many of whose members question the usefulness of any diagnostic system,\textsuperscript{62} especially the Diagnostic and Statistical Manual (DSM). Indeed, despite empirical data indicating that lack of rigorous diagnosis often leads psychoanalytic candidates to miss clinically significant mood disorders in their patients,\textsuperscript{87} one old and still a current critical issue about psychoanalytic education is the lack of importance given to a comprehensive clinical diagnosis when evaluating patients for psychoanalysis.\textsuperscript{88} It follows that something can get lost in the gap between psychiatric and psychoanalytic nosologies.\textsuperscript{89,90}

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 be undetected or misdiagnosed, especially in the case of 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, there are three key points that deserve to be briefly discussed 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 the proposed changes in the technique, a notable example is the one concerning the transference interpretations: some authors\textsuperscript{e.g.,49} put them in the background, whereas others give them an important role.\textsuperscript{e.g.,39} This could be due to the clinical heterogeneity of BD and the high rates of coexisting psychiatric conditions, including personality disorders and substance use.\textsuperscript{4} 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.\textsuperscript{91} 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 the 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 of specific elements/aspects such as the use of countertransference or the changes in technique introduced to work with these patients successfully. Second, as a reference source to design and conduct experimental or quasi-experimental research studies to test specific psychoanalytic theorizations.

Future research efforts within the psychoanalytic field should be directed to supplant the narrative case study method with quantitative single-case research methods based on recordings of the entire therapeutic journey, verbatim transcription, and computer-assisted and artificial intelligence content analysis. Quantitative single-case research methods will allow to preserve the possibility of grasping the complexity of what happens within and between patients and therapists in the therapeutic setting, while reducing methodological errors and bias. Obviously, more evidence is needed to recommend psychoanalytic approaches to therapy for patients with BD, but for those who are stable under medication and having received some psychoeducational tools and skills, psychodynamic interventions may be a satisfactory complement in the context of “precision psychotherapy” or “personalized psychotherapy.”

Limitations

The findings of this review should be considered in light of some main limitations. First, the psychoanalytic school to which each case study belonged 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 the psychoanalytic authors feel attached to more than one school). Second, most of the patients’ diagnoses reported in the articles 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 other languages.

CONCLUSION
This review uses 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 treatments if pursues the publication of further single-case studies making greater use of advances in qualitative research methodology and quantitative single-case research methods. This would be particularly important when considering the only partially met need for a diversity of approaches to BD, a diversity that should reflect that of the individuals’ subjective experience of illness, problems faced, and recovery pathways.

References


24 Probing the impact of psychoanalytic therapy for bipolar disorders: a scoping review.


Tizón JL. Self-sensuality in fantasy: reflections on early development based on a case history. Int


68 Fonagy P, Lemma A. Does psychoanalysis have a valuable place in modern mental health services? Yes. BMJ. 2012;344:e1211–e1211.


75 Plakun EM. Access to psychoanalysis and psychotherapy in the US. Psychoanalytic Psychotherapy.
25

90 Stefana A, Gamba A. Semeiotica e diagnosi psico(pato)logica. 2013.


96 Stefana A, Youngstrom EA, Vieta E. Empirical support for the use and further study of the countertransference construct in the clinical care of patients with bipolar disorder. Bipolar Disorders. 2022;24:84–5.


100 Kelly BD. Balance and connection: bipolar disorder and psychoanalysis in psychiatric practice. The Letter. 2011;46.
Table 1. Characteristics of the included studies.

<table>
<thead>
<tr>
<th>Author (Year) Country</th>
<th>Theoretical approach</th>
<th>Clinical material</th>
<th>Patient characteristics</th>
</tr>
</thead>
</table>
| Anonymous (1992a)* USA | 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 (1992)* USA | Unclear | - Setting: individual therapy in private practice  
- Weekly sessions: 3 for the first two years, then five sessions a week  
- Duration: 3.5 years (ongoing)  
- Therapist sex: F | - Age: 25  
- Sex: F  
- Diagnosis: BD II, RC |
| Jackson (1993) France | Object relations | - Setting: individual therapy in public health service  
- Weekly sessions: 2, sometimes more  
- Duration: 2 years (terminated)  
- Therapist sex: M | - Age: "young"  
- Sex: F  
- Diagnosis: BD I |
| Kahn (1993) USA | Unclear | - Setting: individual therapy  
- Weekly sessions: unknown  
- Duration: unknown (ongoing)  
- Therapist sex: M  
- Setting: individual therapy  
- Weekly sessions: unknown  
- Duration: unknown (terminated)  
- Therapist sex: M | - Age: 37  
- Sex: F  
- Diagnosis: BD II, RC |
| Deitz (1995) USA | Self-psychology | - Setting: individual therapy  
- Weekly sessions: 2  
- Duration: 6 months (terminated)  
- Therapist sex: M | - Age: 43  
- Sex: F  
- Diagnosis: BD I |
|  |  | - Setting: individual therapy  
- Weekly sessions: 2  
- 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 (1997) Spain | Object relations | - Setting: individual therapy in private practice  
- Weekly sessions: 5-6  
- Duration: 8 (terminated)  
- Therapist sex: M | - Age: 28  
- Sex: F  
- Diagnosis: BD I, RCBD |
| Lucas (1998) UK | Object relations | - Setting: individual therapy in public health service  
- Weekly sessions: 5 for the first 13 years, then unknown  
- Duration: > 15 years (ongoing) | - Age: 30s  
- Sex: F  
- Diagnosis: BD II |
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<tr>
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<th>Country</th>
<th>Setting</th>
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<th>Duration</th>
<th>Therapist Sex</th>
<th>Age</th>
<th>Sex</th>
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<td>Duration: many months (terminated)</td>
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</table>

Note. BD I = bipolar I disorder; BD II = bipolar II disorder; DM = dysphoric mania; RC = rapid cycling.

a The intake evaluation of the patient presented in this clinical case (Anonymous, 1992a) has been described in Anonymous (1992b), while the clinical case has been discussed by Bachrach (1992) and Trupp (1992).
b The clinical case presented by Wright (1992) has been discussed by Samberg (1992), Pareja (1992), and Wyman (1992).
Figure 1. PRISMA diagram of the study selection process

**Identification of studies via databases**

- Records identified from:
  - MEDLINE (n = 33)
  - PEP-Web (n = 134)
  - PsycInfo (n = 64)
  - Scopus (n = 49)
  - Web of Science (n = 50)

- Duplicate records removed before screening (n = 98)

**Identification of studies via other methods**

- Records identified from reference lists of relevant studies or from contact with corresponding authors (n = 5)

**Screening**

- Records screened (n = 229)

- Records excluded (n = 198)

**Included**

- Reports assessed for eligibility (n = 29)

- Reports excluded:
  - No psychoanalytic approach (n = 5)
  - No psychotherapy (n = 2)
  - No clinical case / BD patient (n = 3)

- Studies included in the review:
  - n = 24
  - (for a total of 29 case reports)