A Case of Psychotherapy During Mania: A Robust Response to Psychoeducation

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Bipolar disorder is a debilitating disorder and remains difficult to treat. Pharmacotherapy continues to be first-line therapy,[1] but the 5-year risk for relapse into mania or depression is as high as 73%, even with adherence to pharmacotherapy regimens.[2] Various psychotherapies have been a well-studied adjunctive intervention in bipolar disorder in addition to pharmacotherapy regimens, and they appear to be an effective adjunct in select outcomes.[3-7] However, there have been few studies or case reports studying the outcomes of psychotherapy during a manic episode.

This case report describes the interesting clinical experience of a patient who engaged in outpatient psychotherapy during a manic episode, and it also serves to highlight, in closer detail, the specific clinical experiences that correlate with the more generalized study findings.

CASE REPORT

A 23-year-old woman initially presented to our clinic during her first manic episode. Pharmacotherapy with olanzapine had already been initiated by another physician. She had no history of psychiatric illness prior to this manic episode, and she had no family history of bipolar disorder. During this initial episode, she exhibited an elevated mood, increased goal-directed behaviors, less need for sleep, involvement in high-risk activities, and psychotic symptoms of auditory hallucinations, disorganized thoughts and behaviors, thoughts of reference, and hyperreligiosity. She was diagnosed with bipolar 1 disorder and responded to ongoing pharmacotherapy with the addition of lithium and the eventual tapering of olanzapine.

After the mania resolved, the patient had symptoms of depression and anxiety and was referred to a resident psychotherapy clinic. Treatment modalities used were cognitive behavioral therapy (CBT) and acceptance and commitment therapy (ACT), which is a third-wave CBT approach. Psychotherapy sessions also regularly included psychoeducation and supportive techniques.

The patient remained engaged in therapy and responded well; however, roughly 1 year after her initial manic episode, the patient had a relapse into another episode of mania. This episode was most likely precipitated from a sleep disturbance and an interpersonal stressor. This episode was characterized as being similar to the first episode, but with less-prominent hallucinations and with no involvement in high-risk activities, and her sleep disturbance was quickly alleviated with pharmacotherapy.

Another key difference in the second manic episode was an increased level of insight, evidenced when the patient called both her psychotherapy resident and her medication management resident to inform them when her symptoms first appeared. Her family noticed that she was acting unusually, and after they had a discussion, the patient admitted that some of her thoughts may be due to bipolar disorder, which prompted her to call the clinic. She was quickly seen and restarted on an antipsychotic medication (quetiapine) and was continued on lithium.

The patient also desired to continue engaging in individual therapy during her mania. In her psychotherapy sessions, she exhibited varying levels of insight into her illness, at times understanding that some of her thoughts were due to her bipolar disorder and at other times holding on to the belief that she was having a profound spiritual experience and was receiving special messages. The patient was able to apply CBT and ACT concepts during this time but benefited most from psychoeducation, which helped her to better understand her mania.

This second manic episode resolved in approximately 6 to 7 weeks, and approximately 2 weeks later, the patient had a major depressive episode that lasted roughly 8 weeks. She remained adherent to her medications and engaged in therapy throughout the process, and approximately 4 months after the onset of mania symptoms, the patient was free of depression and had regained all of her social, family, and occupational functioning.

Roughly 4 months into remission, the patient had a return

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of prodromal mania symptoms; she responded to pharmacotherapy adjustment and did not have full relapse into mania, and she continues to do well.

DISCUSSION

Adjunctive psychotherapy and its role in bipolar disorder is a well-researched topic, with many review articles and meta-analyses available that look into various psychotherapy modalities, such as CBT, psychoeducation, interpersonal and social rhythm therapy, and family therapy (the most studied of which has been family-focused therapy) and how those modalities affect specific outcomes in bipolar disorder, such as time to mood episode relapse, mania length and severity, depression length and severity, medication adherence, length of hospitalization, and global functioning.[3-7] The general consensus is that psychotherapy can reduce relapse rates, decrease mania severity, and improve medication adherence.[3-7] There are mixed results on the effects of psychotherapy during the depressive phase of the illness, but most studies conclude that psychotherapy is beneficial in decreasing depression severity.[4-6]

Again, most of these studies did not study the effects of psychotherapy during manic episodes, but instead how psychotherapy during remission affected the outcomes when mania relapses occurred. This patient's case is a unique example of a patient who engaged in outpatient psychotherapy during remission, during her manic episode, and during her depressive episode. This case can also serve to illustrate specific examples of what certain treatment modalities look like during this process, as well as document where in the process certain modalities were more useful and where they were less useful. Nevertheless, it should be noted that, due to the mixture of therapy techniques used, various techniques could not exist without the influences of the others, and some modalities are integral parts of others—for example, psychoeducation is an integral tool used in both CBT and ACT.

One notable outcome in this case was early recognition of mania symptoms and prompt pharmacotherapy adjustments. Studies have shown benefits of psychoeducation[5,6] and family therapy[3,5] as being effective tools in decreasing relapse rates. While early detection was unable to prevent a full relapse in her second episode of mania, the combination of the patient's insight into mania symptoms learned from psychoeducation, coupled with family intervention, led to early detection and prompt treatment. We can assume that early detection and prompt treatment were able to prevent relapse to a third manic episode, but we cannot say for sure. One hypothesis is that early detection and prompt treatment could be part of the mechanism that decreased the rate of relapse in the aforementioned studies.

The patient most clearly benefited from CBT and ACT during her first depressive episode, during remission, and during her second depressive episode. CBT and ACT techniques were not utilized as often during her manic episode, but notably she was able to apply CBT and ACT concepts during mania. For example, at one point, the patient likened her insight into her unhelpful (delusional) thoughts to a Spider-Man movie, where Spider-Man's senses are thrown off by a villain, and it was not until Spider-Man could recognize that his senses had been altered that he could defeat the villain. She used this analogy to explain her decision-making process about why she was not going to act on certain thoughts, such as wanting to ask her friends if they were sending her hidden messages.

There are 2 pilot studies underway looking at ACT in bipolar disorder,[8,9] and it is a modality about which we await more evidence, but 3 meta-analyses have concluded that CBT is effective in decreasing mania severity.[3-4,7]

During the manic phase, psychoeducation appeared to provide the most robust benefit. One specific example was explaining to her what an idea of reference was, theories on why they happen, and giving examples of other ideas of reference seen in previous patients. For example, the patient was informed of the time another patient had accused a medical student of "spiritually signaling" them just by tapping their pen on the table. That gave the patient pause and helped her to be more skeptical of her own thoughts. Further explanations and examples were used often during the manic phase with good effect.

Most studies conclude that psychotherapy is useful during the depressive phase of bipolar disorder,[4-6] but it remains unknown in this case whether psychotherapy decreased her depression length or severity. One of the struggles early in her depressive phase was that the patient understandably had a hard time accepting that she had a debilitating illness, and understandably had trouble making sense of how different her thoughts were in the preceding weeks. Having to accept being in the throes of a debilitating illness, and reconciling the unusual experiences of a manic episode, might often be strong contributors to the depressive phase in bipolar 1 disorder.

This case highlights a unique clinical experience of a patient engaging in psychotherapy in all phases of bipolar disorder, and the experience largely correlated with existing research. Among the various phases of this patient's illness, psychoeducation, CBT, and ACT proved useful in all phases, psychoeducation appeared to provide most benefit during mania, CBT and ACT provided more benefit during depressive and remission phases, and family involvement was pivotal for early detection of mania symptoms as well as from a supportive standpoint. Based on the subjectively robust effects in this case, more research should be done investigating the role of psychoeducation during the manic phase of bipolar disorder. ■

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