Existential Despair and Bipolar Disorder: The Therapeutic Alliance as a Mood Stabilizer

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The major clinical morbidity of bipolar disorder is chronic depression. Yet this depression, which is resistant to our best pharmacological treatments, may represent something else. We suggest it may involve existential despair, as a consequence of the losses incurred by this illness, as well as the result of our treatment approaches. Such chronic depressive symptoms may be seen as existential, rather than biological, consequences of the failed hopes of mania. Contrary to traditional psychoanalytic views, we suggest that psychotherapeutic work can be done with manic patients through existential and interpersonal methods to develop a strong therapeutic alliance with the manic patient. We draw on the existential work of Karl Jaspers and the counter-projective methods of Harry Stack Sullivan to lay out these approaches. An existentially oriented therapeutic alliance can be seen as a mood-stabilizing treatment in patients with bipolar disorder, which augments the benefits of mood stabilizing medications.

THE CLINICAL PROBLEM: DESPAIR

It is commonly agreed today that the major morbidity of bipolar disorder is chronic depression (Judd et al., 2002). In long-term treatment, patients with bipolar disorder spend about one-half of their lives depressed, compared with only about 10% manic or hypomanic (Judd et al., 2002). The presence and resilience of this chronic depression is surprising and disheartening. Manic symptoms seem to respond well and quickly to lithium, antipsychotics, and anticonvulsants (Baldessarini, 1996). But depression does not respond well to antidepressants, at least in the long run,

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limited with manic patients, however. In this paper, we want to suggest that the best alternative for communicating with these patients is to use "counterprojective" techniques, derived from the work of Harry Stack Sullivan (Sullivan, 1954; Havens, 1983). (These methods have also been termed "paradoxical intention" in family/systems models, or "siding or joining the resistance" in relational and some psychoanalytical models). Sullivan, perhaps, has most focused his therapeutic work and writing on these methods, which are too often ignored in modern psychotherapeutic practice.

It is also important to note that a body of psychiatric research suggests that the therapeutic alliance between clinician and patient is a very important factor, if not the most important factor, in beneficial outcome. In addition to what the therapist does, the relationship itself seems to be an important vehicle for recovery. We suggest in this paper that these two topics go hand in hand. If we existentially meet with our patients, and then counterprojectively help them to get a handle on their emotions, then we can develop the beneficial therapeutic alliance that can lead to their clinical recovery.

THE THERAPEUTIC ALLIANCE

In her autobiography (1995) Kay R. Jamison, a researcher and psychiatry professor who has bipolar disorder, commented that her psychotherapy was invaluable to her survival. She said that it was not so much what her therapist said that was important; it was what he did not say. Sometimes talking with patients entails not talking with them. This is especially the case with a manic patient. Hypervigilant, aroused, overactive, the manic patient cannot tolerate much talking on the part of the clinician. On the other hand, s/he might need a very good listener.

In the era when psychoanalytic models predominated, some clinicians claimed that persons with bipolar disorder often has superficial relationships with other persons in their lives (Ablon, Carlson, & Goodwin, 1974). For instance, people with bipolar disorder would not have long-lasting intimate relationships, and frequently experienced multiple divorces. However, clinicians in the psychoanalytic era sometimes noted that patients with bipolar disorder might have one intimate relationship with someone else, often their therapist, and the therapist could chart the course of that person's illness by the vicissitudes of that relationship. Whether as cause or effect, the relationship of a therapist with a person who has bipolar disorder may be a clinically important aspect of the course of the illness.

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Elvin Semrad, the great existential teacher of generations of clinicians in the Boston area, focused on these issues in relation to psychosis (Semrad, 1984). He argued that if patients have one relationship in which they feel comfortable, they don't go crazy. We think the same may hold true for patients with mania. Our colleague Ronald Pies (Personal Communication, 2004) has suggested that the therapeutic alliance may be a mood stabilizer, much as medications are. We think there is validity to this concept.

Meeting the Patient

The manic patient is no different from the depressed patient or the psychotic patient or the worried well patient in many ways. One of these ways is that each of these patients is, first and foremost, a person. Each has a life, loves, failures, hopes, fears, and something we might call a self. The self of each person may be more or less there. It may be riding on their sleeves, easily touched and easily injured, in which case we need to be very gentle in approaching it. It may be hidden deep inside their being, under layers and layers of protection, so absent that even the person rarely sees it. In that case, we have to go in search of it, much as a discoverer of a vast continent seeks to map unknown territory but always stays close to safe harbor. In other words, in therapy, we often need to enter into aspects of a person's self that are painful or partly unknown. As we do so, we have to at the same time stay on firm ground, not fully dismantling useful defenses, for instance. We need to support the ego at the same time as we force it to examine feelings that may cause it to feel temporarily weaker. More frequently, a person's self is partly present, partly absent, sometimes resistant to our approaches, sometimes too inviting.

But each person has a self. And we have to meet each other. Our selves as clinicians have to meet our patients' selves. And we meet not as clinician and patient, but as self and self. We have to bring out of that meeting a sense of being understood.

When we first meet in the clinical setting, it is usually because of a problem. The patient seeks help, or he is brought to the hospital against his will. And he finds us standing there (usually above him) offering to help. We feel a predicament. There is a problem. Is the patient ill? What kind of illness is it? Does the patient need medication? What kind? For how long? What are the risks? How will this affect the patient? We think all these things. And the patient thinks many things, among them: Are they trying to hurt me? Is this a punishment? Why did I end up here? How can I get out? What should I do?

After recognizing the predicament, both clinician and patient are immediately faced with the future and two ways of approaching it—hope or hopelessness. The patient may despair; the future may seem bleak with this new menacing diagnosis and the powerful drugs used to treat it. The clinician may despair; perhaps s/he feels s/he cannot reach the manic patient, that s/he is not sure of the diagnosis, or that the treatments often do not work.

But we have to stand for the possibility of a future, without imposing that future on our patients as a false hope.

The Strengths of the Patient

The process of bringing about a hopeful future begins by recognizing the *strengths* of the patient. Yes, the patient's behavior is consistent with a manic episode. Yes, the patient has made many mistakes, shown poor judgment, ruined some relationships, or lost a job perhaps. But there are some parts of that person which are quite healthy. There have to be because there always are. Think about the analogy with clinical medicine. Even when someone is dying, most of the blood chemistries are normal. Yet one frequently searches in vain through the psychiatric records and never finds a single piece of good news about a patient.

So we search for patients' health. Are they manic but not psychotic? Then they are not psychotic. Are they manic but not in a mixed state? Then they are not depressed. Perhaps they are not anxious, have no current or past substance abuse, no eating disorder, no panic attacks, no past traumas. Perhaps they have periods when they are neither manic nor depressed, and are as functional as everyone else. These are all clinical features of their moods and feelings. But there are also features of their personality that are worthy of assessment. Are they kind? Are they generous? Do they love their children? Do they care for their spouses, and parents, and neighbors? Are they active in their community? What are their virtues?

Everyone has some virtues. Even those with many vices have some virtues. Indeed Abraham Lincoln once said: "It has been my experience that folks who have no vices have very few virtues." Sometimes the problem with the patient is that he has too much virtue. To paraphrase what Aristotle described centuries ago: Generosity can lead to bankruptcy, too much courage to recklessness, too much truth-telling to gullibility. Psychotic patients are sometimes some of the most trusting people one could meet.

A sense of humor in particular is an important strength of manic

patients. We need to unite with them around what they find humorous. Many patients find many of our therapeutic efforts humorous. If we can agree with them, we might be able to exploit our own needed virtue of modesty in the interests of progress.

Sometimes, it can be quite difficult to identify a patient's strengths. Sometimes it appears that there is no self, that the patient almost does not exist psychologically and appears to have no strengths. In those cases, we need to look for something that seems to be an authentic interest. Often we need to go searching for exactly those interests which the person has put aside, which s/he has denied, which others have consistently told him/her are unrealistic. We have to engage, in a way, in a cognitive reframing whereby that which has been labeled pathological is seen as constructive. It is those repressed and unacceptable interests, frequently, that can bring to life an authentic self in someone who has become almost psychologically dead. Seeking the self can mean resuscitating the self from the excessively harsh judgments of the patient and of the outside world (Havens, 1993).

So we search for patients' strengths, by identifying and reassuring them about the illnesses they do not have, by seeking out those aspects of their personality and relationships that are admirable and allying with them, by identifying their virtues and applauding them. It is the strengths of the patient, allied with the strengths of the clinician, that combine to form the therapeutic alliance. The patient needs to feel that the two of us, together, with our strengths, are facing this predicament.

After we meet manic persons, we seek a way to move ahead from our predicament by speaking with them about their strengths and not just their illness. We point the direction to a hopeful future by exploring the reasons for hope in their present and past. We can then begin to work with them on two fronts, one for treating their illness and one for encouraging their strengths.

The Encounter

It is usually not this bloodless. There are a lot of conflict between therapists and patients. The meeting and initial work with manic persons is often complicated. When we meet with them, we collide with them. We have to confirm the collision, not deny it. Too often the collision is too abrupt, perhaps too painful, for both parties. The easiest recourse is to deny it, to go elsewhere. But the therapy moves forward because such conflict can lead to a better understanding of the other person: "Aha! That's who you are." We should avoid labeling such conflict as harmful, and in fact, encourage it, up to a point. And it is not only the therapist who

learns more about the patient through such encounters, but also the patient who learns more about the therapist. This two-way learning leads to a stronger alliance over time.

Counterprojection

The patient comes to treatment with assumptions about the doctor, and the doctor with assumptions about the patient. These assumptions sometimes doom the treatment before it begins. The most noxious assumption that doctors can fulfill is the feeling by patients that we, their doctors, represent the "system," the status quo of power and privilege. We will label the patient as sick, and then send him through a rigamarole of diagnosis and treatment that will end up with his extrusion as a "patient," often without an active and productive role in society or a strong sense of self-worth. The resistance of patients to treatment is often a reflection of their justifiable, if sometimes exaggerated, hesitation to enter this process.

Harry Stack Sullivan (1954) taught us that sometimes, contrary to our comments on the encounter, it is better to avoid conflict with patients, especially if they want it. If patients expect us to confront them, we should agree with them instead. In so doing, we are disabusing patients of their assumptions about us and removing such distortions from the interpersonal field, again in the interest of real valid relationship-building.

The basic idea of this counterprojective position is that sharing feelings reduces them (Havens, 1983).

So, in perhaps the most controversial perspective of this paper, we would argue that when a manic patient makes a grandiose statement, it is (more often than not) best to agree with it, at least initially. Joining with elation, and not just depression, is an essential part of forming a human connection with the manic patient. In the old days, especially in the Boston area, any young manic patient worth his salt would aspire to be like that other Boston Irishman who made it big: (patients used to say, and truly believe, that they were) John F. Kennedy. He has fallen a bit out of favor these days, but whether it is Kennedy or Christ (who never seems to fall out of favor), our manic patients deserve at least some acknowledgment of their worthiness as human beings. If someone says, "I'm Jesus Christ," one might respond: "Well, I was hoping to meet him some day." Or perhaps: "Please don't tell anyone else, because you know what they always do to the Messiah. They crucify him. And I don't want that to happen to you."

The world is full of people who think they are the Messiah. But then again, didn't Jesus Christ think he was the Messiah? A person's aspirations should not be discouraged or pathologized. This usually produces the

opposite reaction: the manic person realizes s/he cannot connect with the clinician, and treatment ends. Or perhaps the manic patient accepts treatment, but at the price of giving up all his or her hope. That chronic depression, which seems to be the most common course of patients with bipolar disorder despite our current best treatment (Judd et al., 2002), may reflect such loss of hope.

Elation is seen not only in manic pathology. We should be able to find aspects of our own experience that allow us to empathize with it. Take New Year's Eve celebrations, for instance. In some ways, what a foolish idea such celebrations are: Why would the events of the next year be any better than those of every year past? And yet, we celebrate the New Year with renewed hope and renewed ambitions.

Encouraging grandiosity diminishes it. The best reaction to a grandiose comment is to say: "How wonderful! I wish I could feel more that way myself." Once a patient meets a clinician who actually believes in him/her, who takes seriously all of his/her wildest dreams, s/he then begins to dream a bit more realistically. Then s/he might be able to listen to the clinician when the discussion turns later to realistic goals.

This failure of clinicians to appreciate grandiosity is concerning to us. Clinicians are not afraid to engage depression empathically. We know that an empathic approach to depression reduces the depressive burden, which is passed on to the therapist. But why are we afraid to empathize with grandiosity, or paranoia for that matter?

Many grandiose manic patients also become paranoid, because they find that everyone disbelieves them, even the mental health professionals who are paid to be with them. If everyone had a low opinion of you, you might indeed be prone to paranoid thoughts. If a paranoid patient says something like, "Doctor, you are poisoning me," one might respond: "Oh, you're finding that out, are you?" Such a response can put a smile on the patient's face, and add another brick to our therapeutic alliance edifice. One of our old mentors, a director of a major mental hospital and a full professor at a prestigious university, used to claim that he was the most paranoid person in the building. As his students, we felt more secure with our paranoid leader, because we knew he would never be surprised.

So we also need to celebrate paranoia. We in the mental health field are frequently quite naïve about how the world works. There are, in fact, plenty of destructive forces out there, and persons in positions of power often experience a quite realistic sense of paranoia in relation to the efforts of their enemies to ruin them. It took the technology of audiotaping to reveal the extent of such paranoia in the higher levels of power during the

Nixon years, but it is very likely that such paranoia was quite present in years past but never recorded, and it will continue to play an important political role in the future.

There are situations when one cannot be paranoid enough.

CONTEMPORARY PSYCHIATRY

Three decades ago, a psychiatrist was considered skilled if s/he could complete these tasks: First, s/he would elicit thoughts and feelings from patients using the free association method. Then, s/he would organize these thoughts and feelings into a clinical formulation that demonstrated the unconscious motivations behind them. Finally, s/he would present interpretations based on that formulation back to the patient in the course of treatment.

Today, a psychiatrist is considered competent if s/he has a different set of skills: s/he has to collect disease indicators so that s/he can define an entity that s/he can then either medicate or treat psychologically.

The problem now, as then, is that while both of these approaches have benefits, often clinicians do nothing else. It was not enough then to psychoanalyze; it is not enough now to diagnose and prescribe (Ghaemi, 2003; Havens, 2004). What has been put aside is the relationship. The relationship comes first (Havens, 2004). Without it, all other diagnostic and treatment efforts are, at the very least impaired, and at worst, simply wrong.

Making the relationship primary to the diagnostic interview and the therapeutic process results in an approach to the interview that one of us has called "soundings" (Havens, Vaillant, Price, Goldstein, & Kim, 2001). This idea emphasizes that empathizing with grandiosity and paranoia is not only a means of acknowledging the patient's strengths and hopes, not only a means of strengthening the therapeutic alliance, but it is also a means of accurately assessing the extent of a person's grandiosity or paranoia. It entails making statements as diagnostic probes and then judging the patient's response to the statements. This contrasts with the standard question-and-answer approach of diagnostic interviewing, an objective-descriptive approach that tends to produce highly distorted results when used with grandiose or paranoid patients. Using the soundings method, we like to respond to a paranoid situation by responding with an experience of our own that is even more paranoid. Then the patient might respond: "Doc, don't be so paranoid." The patient is puzzled and surprised *to find someone with them.* At that point, we know we have plumbed the outer depths of the patient's paranoia.

SUMMARY

Talking with a manic patient is not easy, but it is also not hopeless. Manic patients are hopeful, ever hopeful, and indeed often too hopeful. But their hopes and dreams, however big, are usually brief and soon damaged by the realities of life. Ultimately, most patients with bipolar disorder become chronically depressed, denied of their hopes by others. Appropriate medication treatment is necessary, but not sufficient, for many such persons.

The job of the clinician is twofold initially: first, to seek to existentially be with manic patients and then, to counterprojectively give perspective to those patients about their manic worldview, without completely denying it. This twofold approach then can lead to a healthy therapeutic alliance, which itself has a mood-stabilizing effect. Along with mood-stabilizing medications, this alliance can then lead patients toward full recovery.

Put more simply, clinicians need to talk to manic patients about their hopes, to explore the limits of their grandiosity without judging it, to seek out their strengths and to validate them. They also need to go where the patients are, to encounter patients and find the person beneath the illness, to provide a strong relationship, an alliance that cannot be shaken, to conflict with the patient sometimes and not at other times. It is a tall order, and one not infrequently avoided. Yet the times seem to call for a return to actually talking with manic patients, and maybe curing them with such talk. Or perhaps that is grandiose.

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