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CASE REPORT

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Delivering effective combined treatments in mental health settings with difficult-to-treat patients: A bipolar case study illustrating the role of teamwork and other mediators

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Abstract

Even in well-delivered treatments, a significant proportion of patients with severe diagnoses will not achieve sustained remission. For example, research demonstrates that in Bipolar II disorder, while psychological interventions combined with pharmacotherapy yield much better results than pharmacotherapy alone, relapse rates remain very high. In this article, we show the successful treatment of Mrs. C., who was diagnosed with Bipolar II disorder and fell into the non-responders. The treatment integrated a novel approach grounded on a cognitive-behavioral theory with a systemic perspective. The psychotherapist, the psychiatrist, and a family therapist composed the teamwork and delivered the treatment in three phases. In the first phase, the psychotherapist conjointly with the psychiatrist aimed at reducing symptoms. In the second phase, the psychotherapist and the family therapist addressed the dysfunctional relationship patterns that negatively reinforced emotional dysregulation. Finally, in the third phase, the aim was to consolidate the achievements, changes, and good outcomes.

KEYWORDS

case management, difficult-to-treat patients, evidence-based psychological interventions, teamwork

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1 | INTRODUCTION

Many authors agree that even in well-delivered treatments, a significant proportion of patients with severe diagnoses will not achieve sustained remission (Rush et al., 2022). Moreover, many patients with comorbidities remain "symptomatic" after treatment, and their psychological problems and symptoms are still present, if not worsened. The prevalence of problems in mental and behavioral health is not falling, despite the proliferation of evidence-based treatments defined as the delivery of empirically tested protocols targeting psychiatric syndromes. To address this deficit in reducing the prevalence and rising effect sizes, Hoffman and Hayes propose a new way of understanding what evidence-based therapy means. This new approach is far more idiographic and based on processes of change. This new approach links evidence-based processes to evidence-based treatment kernels or modules that address basic change processes. Despite the development of these modular treatments being in their early stages, emerging evidence suggests that these approaches may be more effective than the protocol-for-syndrome approach. These developments may constitute a positive intermediate step to improve this state of affairs (Hoffman & Hayes, 2021). Within this more idiographic approach, the "transdiagnostic" interventions, such as the Unified Protocol (Barlow & Farchione, 2018), are included, among others.

In this article, the therapists treated the case within this orientation. The patient is seen not only as a "diagnosis," and the treatments are seen not only as "protocols." Instead, the focus is more on identifying what causes, reinforces, and maintains the dysfunction and how the therapeutic interventions can help this person overcome the difficulties more healthily. In this vein, our goal is to target the individual client's needs, maintaining a focus on change processes and types of interventions. So, instead of solely finding the best evidence-based treatment for a given diagnosis, the focus shifts to finding the clients' struggles and what needs to be done in terms of effective interventions to meet their needs and help them accomplish their goals.

The purpose of presenting this case is twofold: on the one hand, to illustrate the benefits of providing a tailored, evidence-based practice within a modular approach to an individual with complex, difficult-to-treat severe problems, in which evidence-based psychological interventions are part of a multi-systemic (Kerman et al., 2015), coordinated treatment plan. On the other hand, it illustrates how and when combined treatment and teamwork are needed.

The starting point of why teamwork is needed is the bio-psychosocial stance that underlies how we understand mental health problems. From an integrated cognitive-behavioral-systemic perspective (Scherb, 2014), particularly in severe patients, their significant others and the context play a role in developing and maintaining the suffering. For example, many authors have indicated how a dysfunctional relationship with one partner can negatively reinforce feelings of low self-esteem in a particular patient suffering from depressive symptoms. In another example, in patients suffering from severe vulnerabilities like Border Line Personality Disorder, the impact of significant others' abusive communication style, lack of attention, or continuous invalidation can trigger intense feelings of rejection that may lead to her/his self-destructive behavior. In this way, a vicious cycle is built, in which, at some point, the therapist may implement interventions at the level of the individual or the context, or both, because of the circularity and multicausality of the phenomenon. In a given therapeutic team, the participants will work together in a coordinated manner to address different aspects of the problem. For example, the psychiatrist will highlight the biological aspect, and the psychotherapist and the family therapist will highlight the psychological aspects and the reinforcing function of the context. Of course, the separation of the roles between all the participants is not always so clear-cut, as in psychologists and psychiatrists. For example, many psychiatrists are also psychotherapists, and, in some countries, psychologists can prescribe psychotropic medications, and of course, many psychotherapists also intervene as family therapists. In this case, the psychotherapist coordinated the team. Each participant, the psychiatrist, the psychotherapist, and the family therapist, played a role in the treatment strategy. The psychotherapist was a 65 years old experienced clinician, mainly trained in cognitive-integrative models, the psychiatrist was a 50 years old experienced clinician that was also a cognitive therapist, and the family therapist was a 56 years old experienced clinician who worked together with the psychotherapist in previous cases.

They all were part of the pre-paid medical insurance company staff at that time. From the beginning, given that this was a complicated case and since the psychotherapist had also been, in the past, one of their professors at their training program, they all agreed that she would coordinate the treatment.

For example, regarding the inclusion of the family therapist, more often than not, significant others are not aware of the impact of their interpersonal behaviors on the denominated patient and do not know how to improve their communication with them. Therefore, for the purpose of addressing dysfunctional communication patterns, the psychotherapist integrated a family therapist into the team. The aim of the interventions was to help significant others increase awareness of these behaviors, how they impact and sometimes reinforce symptoms, and to learn new ways of relating more healthily. This therapist will address specific behaviors identified as reinforcing the symptoms. These sessions must be focused and limited to helping reduce the reinforcement effect on the patient's symptoms, and avoiding blaming each other.

Concerning the combination of psychological interventions and pharmacological interventions, combined treatments represent the most common form of treatment received by individuals with severe and co-morbid disorders across diagnoses in mental health care settings. In routine practice, psychologists and psychiatrists work together as an interdisciplinary treatment and rehabilitation team. As stated above, many psychiatrists are also psychotherapists. Psychiatrists would be responsible for the medication prescription, and psychologists for the psychological intervention. However, to combine interventions effectively, they need to work together collaboratively. This collaboration implies sharing responsibility for identifying targets for treatment, monitoring the impact of medication effects and psychological interventions, which may lead to changes and improvements, if any, and integrating pharmacological and psychosocial approaches (Tucker, 2003). Therefore, psychologists and psychiatrists must work collaboratively to achieve the desired goal. How are psychological and pharmacological interventions combined in a coordinated manner? Even though this is a widespread clinical practice, the science underlying combined treatments remains underdeveloped (Tucker, 2003). Research in combined treatments mainly addresses the issue of treatment adherence to medication intake and the impact of psychological interventions in facilitating that goal (Totura et al., 2018). However, the collaboration itself has received very little attention.

How is this integration achieved in natural clinical settings? As mentioned above, all participants in the team (psychotherapist, psychiatrist, and family therapist) need to share similar representations of what causes, escalates and maintains the disorder within a shared broad bio-psycho-social approach to mental health. In other words, the psychotherapist must provide the team with a well-designed case formulation that could serve as a common platform to understand the patient's experience. Due to this shared understanding, each team's participants will display a coordinated, targeted intervention. Sometimes conflicts may arise in the teamwork at the level of clinical decision-making because of different interpretations of what causes, escalates, and maintains symptoms in any particular case. For example, the relationship between psychologists and psychiatrists is no minor issue, and it is at the core of the foundations of clinical psychology itself (Frank, 1984). Ideally, psychiatrists need to comprehend the psychotherapy perspective in understanding human suffering and change processes, and psychologists need to be aware of the effects of particular medications to work together. Many psychiatrists are also psychotherapists and therefore share a mutual understanding, but this is only sometimes the case. The reason for this state of affairs is beyond the scope of this article.

This successful treatment demonstrates how all the variables are related harmonically. We attribute this harmonious functioning to the shared case formulation understanding and the excellent relationship between all the participants in the team. Even though the psychotherapist coordinated the treatment, when clinical decision-making was necessary, the teamwork discussed the issues. Because of a shortage of resources, the discussion was often on the phone. The authors hypothesize that how the teamwork achieved collaboration mattered. The therapeutic relationship includes the relationship between the client and teamwork and between the clinicians working as a team to build cohesion. The latter contributes to the sense of commonality essential for severe patients' recovery process (Dimaggio et al., 2007).

Lastly, as stated above, the latest developments in evidence-based practice suggest shifting attention from the efficacy of a treatment for a specific diagnosis to a more process-based approach, which necessarily leads to more

personalized treatments (J. C. Norcross & Wampold, 2011). Although we are still under the hegemony of the "protocol-for-syndrome" era, the picture is changing rapidly (Hoffman & Hayes, 2021).

In the following case, the authors illustrate the benefits of implementing evidence-based psychological interventions combined with other treatments and the role of teamwork and mediators in a patient with complex and comorbid problems in a naturalistic setting.

2 | CASE ILLUSTRATION

2.1 | Presenting problems and client description

Mrs. C was a divorced 55-year-old woman architect with two young adult daughters living with her when we first met her. Both daughters had finished high school, one was about to graduate as an architect, and the other was doing freelance work linked to tourism and the organization of events. She arrives at the consultation office referred by the Health Insurance Company, bearing a diagnosis consistent with Bipolarity. Mrs. C had sent an email to the Health Insurance Company raising a complaint about the lack of an adequate response from her previous psychiatrist concerning her request for an alternative treatment.

At intake, she was in terrible shape. She told us that when she was at home, she could barely leave the bed and was not working for already 1 year and a half. She had been prescribed Fluoxetine and Olanzapine during that time. Previously, that same psychiatrist prescribed her Lamotrigine, which she refused to take after a few months. In response to her complaints about not feeling any improvement in the last months, the psychiatrist added Quetiapine. This medication made her feel even worse. Not only was she not improving in her mood state, but she was gaining weight, making her feel miserable with herself-image. Due to this self-concept problem, her negative thoughts, and feelings of embarrassment, failure, and shame, she could not leave her house or have contact with her clients for months. She was deteriorating. In this first interview, she looked in bad shape and unkempt.

As aforementioned, she was disappointed and angry with the harmful outcomes of previous treatments. After not responding satisfactorily to her claims, she filed a complaint with the Mental Health Insurance company, which referred her to us. During the first interviews, her main complaint was that she was not improving, deteriorating, and losing control of her life. She felt like she were at the bottom of a well and could not find the way out. She also felt terrible in front of her daughters, both guilty and demanding they save her. Finally, she wanted the psychiatrist to free her from the medication regimen. She believed it did not help her and made her gain too much weight, lose concentration for work, and feel miserable.

2.2 | List of problems

Mrs. C had multiple problems, like Depressive symptoms, Financial issues, Relationship difficulties, Pre-existing physical illness, Isolation, Helplessness, Unwanted side effects of long-term medication intake, and suicidal thoughts. Table 1 shows the details.

3 | DSM DIAGNOSIS

Mrs. C. met the criteria for a Bipolar II category, given the presence of a Major Depressive Episode and the moderate characteristic of the manic episode (DSM 5, American Psychiatric Association, 2013).

TABLE 1 Mrs. C. list of problems.

Depressive symptoms	Mrs. C had not left her house for months. She had not had contact with clients for more than a year. Her vision of the future was very negative, with predominating automatic negative thoughts. She felt virtually "hopeless" which made her feel very guilty towards her daughters. She did not want to burden them with her problems but, at the same time, she continually made was posing complaints to them. She felt unable to resume work with her clients, nor did she conceive any chance of improvement in the future. She saw herself as a fat and ugly woman, when in the past she had always considered herself an attractive woman, to the point that she had never been left by a man but, on the contrary, it had always been her who had left the other (low self-esteem). She had recurring catastrophic thoughts regarding her future and that of her daughters.
Financial issues	Mrs. C. was heavily in debt as a result of a major refurbishment of her office, which she had not been able to afford. Years ago, she had received a considerable sum as payment for professional advice and thought that it was time to make the refurbishment she had desired for so long, and that she would be able to afford it, overestimating her financial resources. But the economic and financial conditions changed, which is very common in Argentina, and in the middle of the works she found that she could not meet the outstanding debt obligations, so she applied for bank loans. Once again, she made a bad decision when she took bank loans as a way out amid an unfavorable economic context, with 95% interest rates. As one could expect, the interest rate on the bank loan coupled with the decrease in her monthly income made it even harder for her to meet the monthly payments, which led her to take another loan, and then another one. The snowball effect was so harsh that, at the time of the 1st interview, she had 20 outstanding loans.
Relationship difficulties	Over the last 2 years, the relationship with her daughters had deteriorated, as the emotional and psychological difficulties that she displayed had become more intense and enduring. They argued mainly about money. Mrs. C. demanded, on the one hand, greater help from her daughters for the maintenance of the home and expenses, but, on the other hand, feeling guilty for that claim, she would not accept their money, or she would spend more than she could afford, also out of guilt, thus further increasing their debts. This was particularly the case with the youngest daughter, who found it more difficult to become independent and who had the greatest contradictions. Moreover, her daughters complained about the "victim position" in which their mother put herself, alleging that, if she wanted, she would be able to work. Those arguments had escalated into a vicious circle of recriminations and guilt that prevented them from having a constructive dialog.
Pre-existing physical illnesses	Mrs. C had been asthmatic since her early days, for which she had regular check-ups and took medication for her asthma. Even though she had not had acute episodes for several years, she was always haunted by the specter of the disease and the presence of this condition generated an ambivalence in self-representation between vulnerability and empowerment.5. Isolation: Mrs. C. had gradually withdrawn from her clients, friends, and social relationships, partly because of embarrassment about her appearance, partly because of her depression, to the point that, when she came to consultation, she had not been looking at her client calendar for months. She would not see her family or her friends.

(Continues)

Helplessness	Mrs. C felt helpless in the face of what she experienced as the gradual loss of all her functions. At work, she had lost clients and distanced herself from others; at the interpersonal level, she had lost a relationship with a man that lasted several years after her divorce; at the financial and economic level, the collapse of her income and finances; and, at the social level, the estrangement from friends and family. She had fantasies of ruin, where she pictured herself also losing her apartment and becoming homeless.
Unwanted side effects of long-term medications intake	Dizziness, headaches, dry-mouth, muscle spasms and cramps, constipation, and loss of sex drive.
Suicidal thoughts	Mrs. C had suicidal ideas. Whenever she passed through the train tracks, she thought she would be better off if she jumped when the train came so that she could end her suffering for good.

4 | CASE CONCEPTUALIZATION

Mrs. C. is a woman with a high degree of self-demand. She comes from a well-respected wealthy family in Chile. Her father had been a highly respected professional in his town, and her mother was a powerful and dominant woman. She had good memories of her childhood, where she felt proud and happy within her extended family. Nevertheless, her life was marked from the beginning by her asthma condition. She remembers that they had always treated her like crystal glass as if she were going to break into pieces, and in the face of it, Mrs. C strived to show that she could be like anyone else and that it was not necessary to take special care of her. Mrs. C. had always thought that even though she felt vulnerable and sensitive, she had to conceal it and demonstrate to herself and others that she was invincible. At this point, this dissonance in which she negatively valued feeling vulnerable and sensitive and forced herself to conceal that feeling and show an image of being strong and not needing any help, like the "impostor syndrome," was at the core of the cognitive distortion. On the one hand, she bared this core dysfunctional belief of being incapable or less capable than others, and on the other hand, she had to conceal it and pretend to be invincible. The contradiction between the two opposite self-images led her to distorted cognitive interpretation of external events, and was at the core of the deficit in achieving balance when facing challenges.

According to the underlying cognitive-behavioral theory adopted to treat this case, these dysfunctional cognitive beliefs imply conflicting, extreme personal appraisals of changes in internal states, meaning mood, physiology, and cognition, that drive extreme attempts to control mood in opposing directions. This difficulty in controlling mood states leads to failure in achieving goals, which reinforces the core dysfunctional beliefs and constitutes a vicious cycle that maintains the disorder. As explained later in this article, the deficit in achieving balance is at the disorder's core.

In the face of challenges, Mrs. C came off with "flying colors," meaning overly excited, unable to estimate the relationship between desire/aspiration and goal attainment. Sometimes in her life, her elevated level of aspiration had been functional. For example, she was the only one in her family who had managed to be a professional and succeed. When she got married, her marriage was not a happy one. She felt nothing for her husband and thought she had to stay married, at any rate, because of her mandates. On the one hand, she had this distorted belief that she did not deserve to be properly loved or even love somebody properly, as she pictured it to be in others' life. She believed that because she had this underlying core dysfunctional belief of being incapable or less capable than others. But on the other hand, she also felt that she could overcome any obstacle and be invincible. As aforementioned, this distortion could have originated in her childhood, when she needed special care because of her chronic illness, making her feel less capable than others. While growing up, she rejected the idea of being needy and tried to picture herself as the opposite.

Nevertheless, deep inside, she knew that she had to come to terms with what she could achieve, even if it were not her genuine aspiration. So, because of her distorted core beliefs, she thought she had to resign from her search

for happiness and remain in her unhappy marriage. These dysfunctional core beliefs of being incapable and not deserving to be loved appropriately were a limitation to going on with her life. However, finally, she could overcome these limitations and move out of that unhappy marriage. She recalls that she felt free and powerful, although a feeling of "not being herself" prevailed. In the following years, she raised her two daughters alone, feeling that she was a "superwoman," although, in her intimate self, Mrs. C. felt incapable and vulnerable and had to conceal that feeling from the rest. In some ways, she perceived that her aspirations and goals were beyond her capacities. However, she tried very hard to overcome that feeling, and that is when the sense of "not being herself" prevailed. As aforementioned, her two daughters' expectations also played a role in this state of affairs because Mrs. C. felt she had to demonstrate to them that she could be in charge and take care of everything in their lives as if she had to compensate for being responsible for the consequences of the divorce. Although she had no regrets for taking the lead in divorcing their father, she was constantly feeling guilty in front of the daughters. Moreover, these feelings of guilt, remorse, and overcompensating with the daughters reinforce the symptoms.

Over the last 5 years, she had been suffering a series of losses, which Mrs. C. tried to overcome with the mechanisms she had, her superpowers, but this time they would not work. She believed she could do it alone, not letting herself feel sad, advancing at any cost, being free, not needing help from anyone, and hiding her feelings of impotence and helplessness. However, this time, these mechanisms did not work. Failing to reach her goals, she fell into an ever-growing pit, alternating between euphoria and depression until depression finally kicked in.

5 | COURSE OF TREATMENT

5.1 | The context of the treatment delivery

A Prepaid Health insurance company in Argentina referred the treatment to the clinicians. In this context, the routine practice implies that the patients are admitted for treatment and referred to combined treatment when they present comorbidities and severe diagnostic characteristics. The patient can choose the clinicians with no further specification of the psychological intervention most appropriate for a particular problem. In this case, the patient had undergone more than three previous treatments without good outcomes and filed a complaint with the Company. The clinic did not offer effective evidence-based psychological interventions before, either.

In this particular setting, the state of affairs for case management does not include selecting effective psychological interventions. The reasons for this are largely beyond the scope of this article. However, in this case, the patient was finally assigned to this new treatment with psychotherapists trained within an evidence-based perspective. Furthermore, the designated psychologists and psychiatrists had similar training in integrative cognitive-behavioral-systemic grounds.

5.2 | Selecting the effective psychological intervention

Cognitive therapy is the effective psychological intervention recommended by APA Div. 12 for Bipolar Disorder, albeit it has modest research support for both Depression and Mania. Mrs. C was diagnosed with Bipolar II, where psychological interventions combined with pharmacotherapy look like the more effective treatment (Novick & Swartz, 2019). However, relapse rates are high. Moreover, after recovering from a manic episode, symptoms of depression persist in the long-term for the majority of patients that undergo treatment.

As aforementioned, the patient was referred to the psychotherapist through the prepaid medical insurance company in the context of a complaint toward the psychiatrist attending to her. This conflict challenged the psychotherapist because she had to look for treatment alternatives, including changing the psychiatrist. Clearly to her, Mrs. C. fell into the category of non-responders, so she opted for adopting a novel approach grounded on an integrative cognitive-behavioral

theory, which was undergoing a randomized controlled study in the UK then (Mansell et al., 2014). To work with the newly selected psychiatrist, she offered her this new treatment, which the psychiatrist did not know about, but as a trained cognitive therapist, she could come to terms with this new model. This approach, TEAMS (Think Effectively About Mood Swings), is based on an empirically based model. The model explicitly targets current problems specific to the patient; therefore, it implies a more personalized treatment design. The treatment focalizes on developing a case formulation based on a shared understanding of how thinking styles and behaviors maintain and escalate current symptoms. This approach, known as TEAMS (Think Effectively About Mood Swings), is based on an empirically based model. These dysfunctional cognitive beliefs imply conflicting, extreme, personal appraisals of changes in internal states, meaning mood, physiology, and cognition, that drive extreme attempts to control mood in opposing directions. This difficulty in controlling mood states leads to failure in achieving goals, which reinforces the core dysfunctional beliefs and constitutes a vicious cycle that maintains the disorder.

Every human being has dissonance between expectations and realizations in a given moment of their lifetime. In these circumstances, people are better or worse prepared to integrate losses and gains. In the case of patients that meet the criteria for Bipolarity, there is a noticeable difficulty in adjusting to this transitory imbalance, which leads to an exaggerated emotional disruption as a consequence. For example, at sometimes, high moods may be encouraged by elaborative thinking and increased activity, whereas at other times, they may be suppressed and controlled through self-criticism. Thus, the individual's mood shifts between extremes rather than being allowed to stabilize. Within the model, the recovery process is associated with the gradual acceptance and tolerance of internal state changes and their related self-appraisals that promotes the use of less extreme behaviors, challenge existing beliefs about mood and its management, and promotes the development of a more coherent self-concept that is less dependent on specific internal states. The model would predict that a recovery approach that encourages self-coherence (e.g., mindful awareness; developing long-term supportive relationships) would be more enduring than approaches that maintain ambivalence about internal states (e.g., trying to suppress or enhance specific mood states). The treatment aims to help people develop an awareness of how they manage their moods and develop alternative ways to live a more fulfilling and balanced life (Mansell et al., 2010).

As reported in the pilot study (Mansell et al., 2014), people diagnosed with bipolar disorders reported that their recovery involved not simply remaining free of relapse but also regaining a sense of purpose in their lives and facing their longstanding problems. Although the deficit in emotional regulations is bio-psychosocially determined, the genetic disposition as the biological factor interacts with the psychological one, that is, the distorted cognitive interpretation. Accordingly, the therapist orients the treatment to identify inflated cognitive appraisals, altered emotional states, destructive behaviors, vicious cycles, the context as reinforcement and maintenance, and the promotion of change at the level of mental representations and distorted core beliefs. The psychological interventions aim to help the patient find alternative ways to manage this relationship between thoughts, emotions, and behaviors at a cognitive and metacognitive level. Here, metacognitive refers to the ability to reflect on one's and significant others' cognition and mental states. Thus, the metacognitive level addresses not only the mental representations of self but also the representations of others.

In addition, integrating the systemic perspective implies understanding that the context, as a psychosocial factor, reinforces and maintains this imbalance. For example, significant others' perceived unmet expectations can help or hinder the ability to acquire balance. This inability can also be related to the patient's interpretation of what she/he believes significant others' expectations are. The metacognitive level is where we relate to and interpret others' minds.

5.3 | Case formulation

Psychotherapy case formulation is developing a hypothesis about the causes, precipitants, and maintaining influences of a person's psychological, interpersonal, and behavioral problems, as well as a plan to address these

problems (Eells, 2022). In the case of Mrs. C., from the integrative cognitive-behavioral-systemic perspective, the hypothesis is that she suffers from a deficit in emotional regulation. This deficit is characteristic of Bipolar patients and is bio-psychosocially determined. Genetic disposition as a biological factor interacts with the psychological one. The psychological factor is at the level of mental representations. These mental representations or beliefs are responsible for the distorted cognitive interpretation of events and self-representations that impede her from regulating her emotional reactions. The exaggerated emotions and distorted interpretations of external circumstances and internal estates lead to harmful behaviors that fail to achieve desired goals. Emotional dysregulation and cognitive distortions are fueled by core dysfunctional beliefs and reinforced by specific interpersonal relational patterns with significant others in the face of a triggering event. These failures reinforce the imbalance, the dysfunctional core belief, and the distorted interpretation, thus perpetuating the dysfunction in a vicious cycle. In this way, the triggering event, the core dysfunctional beliefs, the cognitively distorted interpretation, the emotional dysregulation, the maladaptive behavior, the lack of goal achievement, and the context reinforcement constitute a vicious cycle that perpetrates the symptoms. The integrative-cognitive behavioral model we selected to understand this patient allows us to focus on the present moment and allocate this chain of events at any given moment in time.

The triggering event that we could identify together with the patient occurred 5 years prior she started this treatment. It was ignited by the failure in emotional regulation and, hence, the whole vicious cycle that finally led to her falling into an ever-growing pit, alternating between euphoria and depression until depression finally kicked in.

At that time, she was with her partner in a relationship that had lasted for years but was then falling apart. In those days, although she felt despondent and an intense feeling of failure because of the imminent separation from that man, she hid this feeling from herself and the rest of the family. Instead, as a counter-reaction to her feeling of failure, she came up with a mega-project of amplifying her house that implied a significant money inversion. Although she had a good income and worked with many clients in those days, the inversion was out of her reach. Although some of her relatives alerted her of this problem, she would not listen. On the contrary, Mrs. C. felt over-self-confident and challenged every piece of advice from significant others. She started with the project but needed more money in the middle of it. She found herself without a partner, with her house in the middle of a reform she could not afford, with people around her waiting for their pay, with no money, and alone. Again, instead of accepting that she overestimated her possibilities and made an exaggerated positive appraisal, she insisted on finishing her plan and started with the bank loans. Her daughters were increasingly worried at that time, not only because they saw her mother deteriorating but also because Mrs. C. stopped seeing new clients, and they were running out of money very fast. Soon, the three women could not afford taxes or expenses, and the girls turned to their father for the first time in years for financial aid. Meanwhile, Mrs. C started to shift to an extremely low appraisal of herself and her ability to cope, and her pilgrimage for different therapy mecca's started.

When we saw her in the consulting room, she had 50 pending loans and was depressed. As indicated in previous sections, she had already seen three psychologists and two psychiatrists. Mrs. C. was desperate and did not feel that the treatments helped her.

In this patient's case, it quickly became apparent that, on the one hand, she had overestimated her ability to cope, her expectations regarding triumph and success, and her reach as a self-made woman. In contrast, on the other hand, she would underestimate her capacities and perceive herself as a powerless and hopeless individual. This stance's failure to achieve balance and, consequently, failure in goal achievement and perceived control of her life reinforced her distorted self-representation of being incapable and worthless. These extreme opposite cognitive distortions led to harmful behaviors that impeded her from achieving her goals. Therefore, instead of looking for an alternative to cut expenses and ask for help, and lower the intensity of her opposite appraisals, she engaged in more expenses and expensive loans. Then, instead of putting herself together, accepting the miscalculation and looking for more clients and increasing her income, she gave up and progressively abandoned her clients and started staying at home in bed.

During her lifetime, she has faced several challenges, like immigration from another country, two divorces, the simultaneous death of her parents, her chronic illness, risky investments, and the like. On all of these occasions, she

had contrasting solid feelings: either she felt so powerful that nothing would stop her, as if she was a superwoman, and in those situations, Mrs. C. would not listen to significant advice from other people, or felt powerless and hopeless and the only possible way out she perceived was to pray for herself. This time, she felt she had fallen so low that sometimes Mrs. C. preferred she was dead.

Following the tradition of general cognitive therapy, the psychotherapist and the teamwork, in this case, had to establish a general treatment goal. To achieve a consensus on this initial goal, the psychotherapist and the psychiatrist held a meeting to discuss the treatment's first moves. Should they attend to the client's demands regarding the medication side effects? If so, how could they manage the symptoms? The psychotherapist and the psychiatrist decided to listen to the patient's demands and look for an alternative prescription, and simultaneously start with the newly selected effective cognitive-based treatment. Front the beginining, the clinicians monitored the symptoms very closely to check the impact of the new medications and interventions.

After the psychologist and the psychiatrist agreed on goals and interventions, including eventually adding a family therapist, and after having already analyzed the initial psychological assessment report, they discussed the treatment strategy with the patient. By the time the psychotherapist met again with the patient, she had already in mind an initial presumptive diagnosis and the consensus of the psychiatrist. First, the psychotherapist met with the patient, and then the patient met with the psychiatrist. In a shared manner with the patient, the psychotherapist established a general goal for this treatment. The initial goal was to reduce symptom status, negative emotions, and cognitions and address these exaggerated mood reactions and the concomitant distorted cognitions (extremely high arousals and exaggerated positive appreciation vs. incredibly low appreciations) and the imbalance caused by her failed attempts to control her extreme mood, which negatively affected her ability to achieve her broader goals in life. The psychotherapist explained to the patient that she would be working with a new psychiatrist and, eventually, with a family therapist. The treatment would unfold gradually, and each aspect would be monitored and agreed. The combined treatment aspect was not necessarily part of the TEAMs model, but the clinicians agreed that working in combined treatment as a team in this particular patient was necessary.

As aforementioned, this novel integrative cognitive-behavioral treatment allows us to target current problems as specific to this patient. According to the model, the extreme positive and negative appraisals made of internal states escalate manic symptoms. Therefore, recovery may work by helping people circumvent vicious cycles of symptom escalation by disconfirming their extreme beliefs rather than stemming an out-of-control medical illness. Therefore, one of the main goals of the treatment was to help Mrs. C. to gain awareness of these distortive appraisals and the vicious cycle that results as a consequence, so she can identify these appraisals and then dis-confirm them. Together with the patient, in the following sessions, the therapist defined a vicious cycle that escalated and perpetuated the symptoms.

During the treatment, Mrs. C. told us she was unaware of this thought pattern until she started this new treatment. According to the model, this case formulation must imply a shared understanding of how thinking styles and behaviors maintain and escalate current symptoms. The triggering event (being faced with financial problems as a consequence of a bad investment and being unable to pay the money loans and bills and simultaneously separating from her long relationship with her partner) elicited disruptive opposite exaggerated emotions (overly activated enthusiasm and power vs. helplessness, pessimism, and low self-worth) that stem from distorted cognitive appraisals (I am incapable because of my underlying chronic illness vs. I am superior and do not need anybody's help). Then, incapable of finding adequate balance, the distorted cognitive style led her to destructive behaviors, which led her to fail to achieve goals (by not accepting that she overestimated her possibilities and made an exaggerated positive appraisal, and then started asking for money loans to the Bank). Finally, instead of solving the financial problem, she increased her debt. This Vicious cycle that together with the patient, we elaborated along the sessions, appears in Figure 1.

During the sessions with the psychotherapist, it also became clear that Mrs. C. suffered from intense ambivalent feelings of guilt and remorse towards her daughters. Although both were already young adults, Mrs. C. felt she was obliged to sustain them financially. Nevertheless, on the other hand, she also felt that they were

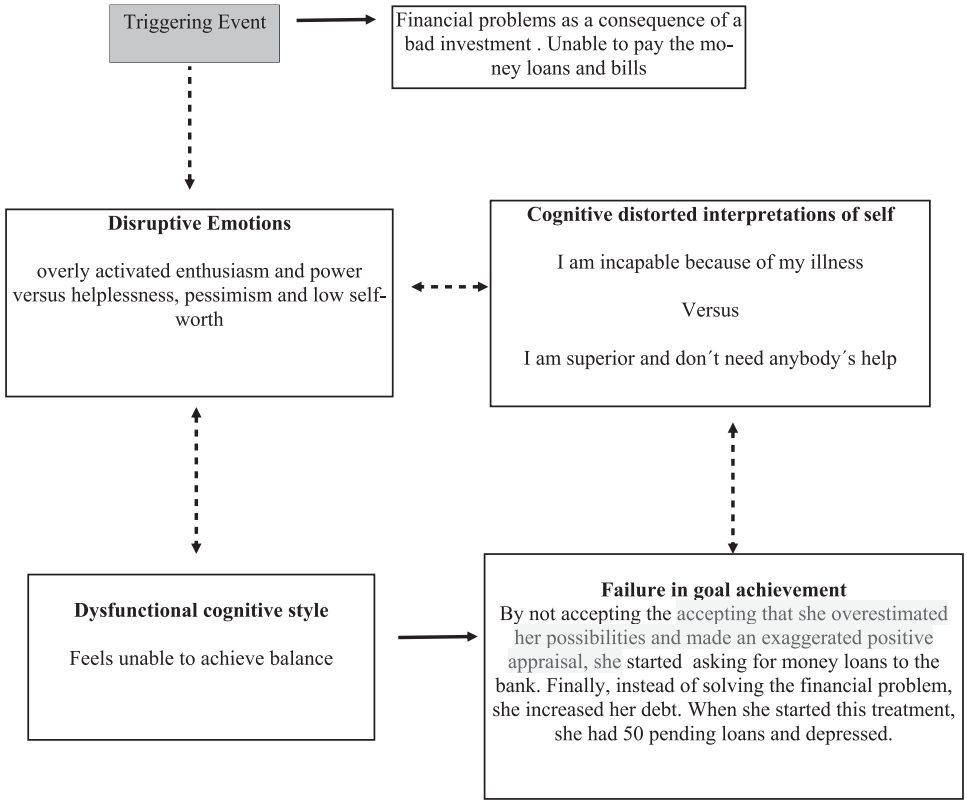

FIGURE 1 Mrs. C Vicious cycle.

already grown-ups and that making a living was mandatory. These contrasting feelings of intense guilt and demand also interfered with the distorted cognitive style aforementioned and hampered every attempt to accept that she was overestimating her capacities. Moreover, sometimes she thought she had this obligation to sustain them financially out of the guilt for having promoted the divorce, thus impeding their father from participating in their money issues. For Mrs. C., sustaining the family economy was also like the price she paid for promoting the divorce of her daughters' father. The daughters, in turn, were also very ambivalent and made her mother feel guilty for not being able to buy certain things or for being in bad shape, not attending to the clients, and not earning money.

As soon as the symptoms started improving, it became apparent that addressing these issues could help her improve. So, to fully attend to these family issues, the psychotherapist included a family therapist in the teamwork. We will describe how we integrated this family therapist in the treatment plan in the following sections.

6 | TREATMENT PHASES

Mrs. C.'s treatment lasted 18 months, plus ongoing monthly follow-up sessions after termination. The therapist designed it in three phases. Unfortunately, part of the treatment occurred online because of the COVID-19 Pandemic restrictions, but this situation did not alter the results (Durao & Hirsch, 2020).

The first phase lasted 6 months and targeted basic underlying attention processes. In this phase, the psychologist and psychiatrist met to discuss treatment goals and strategies to achieve those goals. As aforementioned, the psychotherapist and the psychiatrist held an initial meeting to discuss the case formulation.

Before they met, the previous psychiatrist had already been dismissed by the patient. So the first two interviews were performed by the psychotherapist. After the information she received from these first interviews, she was ready to hypothesize a case formulation. Then, she contacted the psychiatrist, who, in spite was not working with her together in private practice, had a previous acquaintance. It is mandatory to consider that the psychiatrist was trained in cognitive therapy and had been a student of the psychotherapist in charge. The issues they discussed in this initial meeting were regarding the first treatment goals. We have mentioned that the first goals implied symptom reduction and identifying distorted beliefs, emotions, and vicious cycles. The psychiatrist was in charge of prescribing medication, and the psychotherapist addressed the more psychological issues. However, as stated above, the patient was reluctant to take medications and had a bad experience with this type of intervention. So we discussed whether to consider the patient's perspective or try to impose the prescription to follow the protocol. Fortunately, the psychotherapist and the psychiatrist agreed that the patient's perspective was essential and that the research literature is abundant on the relative benefit of medications for some patients. So, the psychotherapist and the psychiatrists agreed to listen to the patient and look for another alternative medication that would not be perceived as harmful by the patient and could help in the immediate symptom alleviation and focus on the psychological interventions' more mediate but durable effect. Thus, after reaching an agreement, we contacted the patient to explain and offer her this new alternative. We describe the changes in prescription, both in dose and type of drug, later in this section.

This first phase consisted of weekly psychotherapy sessions, monthly psychiatric sessions for the first 2 months, biweekly and bimonthly, and monitoring psychiatric sessions after 6 months. The general goal at this stage, besides what we mentioned above, was to build a solid therapeutic alliance to sustain the required validity and confrontation necessary to achieve change. During this stage, the patient would say things like: “I do not believe in therapies, I do not believe in psychologists, and that is why I went to a psychiatrist. Nevertheless, after my experience with psychiatrists, I don't know which one is worse! However, I'm here because I desperately need to change. I can't go on like this” (sic). Therefore, both clinicians had to build trust through psychoeducation, supportive techniques, and strong cohesion between them as a team. The latter was achieved by working together and discussing treatment goals and specific interventions. The psychologist and the psychiatrist held one initial meeting and several periodical discussion on the phone, in which both professionals agreed on specific treatment goals. They agreed on the importance of considering the patient's perspective concerning medication intake, not only the protocol-diagnosis indication, and on helping the patient find alternative ways to cope with her perceived emotional dysregulation and its negative consequences. The perceived adverse effects of the medication were a very urgent focus for her because, among other adverse effects, she could not cope with gaining weight which contributed to her sense of losing control of herself and her negative self-evaluation. She had also filed a complaint with the health insurance company. So both the psychologist and the psychiatrist elaborated a combined treatment strategy. The combined strategy was to implement evidence-based psychological interventions to address depressive symptoms by gradually reducing medications with unwanted adverse effects. The psychotherapist implemented cognitive-style psychological interventions (Behavioral Activation) to address depressive symptoms. When the patient showed she could better manage depressive symptoms (e.g., leaving the bed, starting with a simple work and exercise agenda, replacing crying with talking, and so on), the psychiatrist would gradually reduce the medications. The psychiatrists replaced medications causing her unwanted effects (e.g., Olanzapine and Fluoxetine) with only an antidepressant. Then, by closely monitoring the impact of both interventions and the improvement in impairing symptoms, the psychologist and the psychiatrist arrived at a point where the patient was more functional and with a moderate medication dose. The psychologist, the psychiatrist, and the patient discussed the interventions. This discussion between the psychotherapist, the psychiatrist, and the patient, does not mean that they are at the same level, namely, everyone on the “same page,” because the patient was asymmetric regarding the psychotherapist and the psychiatrist. So, to establish fluent communication, we targeted the level of goal attainment. For example, if the patient could improve her activation level and thus reduce her depressive symptomatology, she would share this achievement with the psychotherapist in the sessions and with the

psychiatrist in consultation. The psychotherapist and the psychiatrist, each in their session, would explain to the patient that the medication and the psychological interventions had the same goal: to help her feel better than before. So, if she improved, we could adjust the medications, and so forth. In addition, the psychotherapist and the psychiatrist had a monthly discussion on the phone to decide whether it was appropriate to reduce or replace medication or if we noticed something was going not well. Besides, as mentioned earlier, we planned to assess symptom improvement periodically. This assessment consisted of monitoring symptoms and well-being improvement by repeating the same measures that were administered at intake. More details are offered further in the Outcome section. Fortunately, the patient responded to these interventions and gradually started feeling better.

In sum, the combined strategy implied closely monitoring the interventions' impact on the patient's improvement and changing process. The strategy was successful, and as a result, she started to lose unwanted weight and regain a sense of perceived control over her body. This feeling of improved self-efficacy was an important starting point for what happened next.

The following is an excerpt verbatim of the initial dialogs in this first phase:

P.: Honestly, I don't believe in psychologists.

T.: This isn't like religion.

We help patients grow and feel better by working with science-based tools.

P.: They didn't help me. I've tried twice. The first time, they didn't understand me. The second time, they did, but we became friends, and I felt worse each time.

T.: Worse, how?

P.: I felt I wasn't being myself. I was digging deeper into a whole. So I tried going to a psychiatrist.

T.: And how did that go?

P.: Worse than with the psychologist. At first, I felt a little bit better and could get out of bed, but then, as the months went by, I started feeling that the medication had adverse effects on me. I couldn't sleep well and gained weight uncontrollably. I was desperate and didn't feel people were hearing me.

T.: But you insisted on getting better help, that's very good. What makes you think that I'll be able to help you?

P.: You listen to me.

In this first phase, the goal was to build a solid alliance between the patient, the therapist, and the psychiatrist and between the clinicians. There were specific rules regarding the patient's commentaries that we needed to follow to build this alliance. For example, whenever the patient blamed the psychiatrist for being inattentive or too straightforward, or if he blamed the psychotherapist for being too meticulous in pursuing a more authentic disclosure of personal issues, the psychologist and the psychiatrist agreed in not allowing her to "triangle" between the three of us. Even if we were not absolutely per each other, we would appear in the face of the patient as a unified structure. This one key ingredient for succeeding was putting the patient in the center of the discussion, for example, regarding clinical decision-making about medication prescription and not trying to impose each one's perspective. As it was stated in the Introduction (Montesano & Scherb, 2023), putting the patient at the center reduces tension and misunderstandings among the team members and favor effective interprofessional collaboration. On previous treatments, when the psychiatrist and the psychotherapist both had a protocol—syndrome to follow, the patient manifested she was not improving. On the contrary, she was feeling worse. The psychologist and the psychiatrist agreed to seek an alternative that would suit the patient's needs. By listening to the patient (Bohart and Tallman, 2010) and closely monitoring the impact of the interventions, they found this alternative, and the treatment proceeded to the next phase.

The movement from one phase to the next phase is related to the level of change achieved by the patient in terms of gaining awareness and control over her exaggerated emotional reactions and maladaptive behaviors. The more the patient improves in controlling her impairing symptoms and gaining agency, the further we advance to the next stage. As a reminder, recovery from bipolar disorder involves not only simply remaining free of relapse but also regaining a sense of purpose in their lives and facing their longstanding problems. As aforementioned, the therapist orients the treatment to identify inflated cognitive appraisals, altered emotional states, destructive behaviors,

vicious cycles, the context as reinforcement and maintenance, and the promotion of change at the level of mental representations and distorted core beliefs. The psychological interventions aim to help the patient find alternative ways to manage this relationship between thoughts, emotions, and behaviors at a cognitive and metacognitive level. Here, metacognitive refers to the ability to reflect on one's and significant others' cognition and mental states. Thus, the metacognitive level addresses not only the mental representations of self but also the representations of others.

The second phase lasted 6 months and it targeted basic cognitive-emotional processes. It consisted of biweekly psychotherapy sessions and several family sessions with her daughters. The specific goal of including a family therapist in the teamwork, and targeted sessions with significant others, was to intervene in helping the family to change the reinforcing pattern of communication between them. These types of intervention were not part of Mansell's selected empirically based integrative cognitive-behavioral intervention. We will explain the role of these sessions and how they unfolded later in this section.

The general goal at this stage was to help the patient gain awareness of inflated cognitive appraisals, altered emotional states, destructive behaviors, vicious cycles, the context as reinforcement and maintenance, and how this vicious cycle maintains and perpetrates her suffering. As aforementioned, Figure 1 represents the vicious cycle. To achieve this goal, both psychologist and psychiatrist shifted the focus of attention to the underlying mechanisms that triggered and maintained the maladaptive response. As soon as the patient showed improvement in symptoms, the session frequency with the psychiatrist gradually reduced until it reached a maintenance dose with no further perceived adverse effects.

As the narrative unfolded, it soon became apparent that the relationship between Mrs. C. and her daughters played a role in the underlying mechanisms that triggered and maintained the maladaptive response and emotional dysregulation. For example, whenever Mr. C. tried to cut expenses, the daughters would demand their mother not to, arguing that she should return to her clients, resume the suspended work, and improve her income again. The daughters did not accept their mother's illness. They wanted to think that their mother was just "pretending." In the face of their demands, Mrs. C. would feel both guilty and angry, not clearly explaining to her daughters her situation and her expectation towards them. She felt guilty because she could not sustain them economically, but at the same time, she was angry because they were not able to make a living.

The following is an excerpt verbatim regarding how these communication patterns between the mother and daughters were impacting the patient in this phase:

P.: I cannot tell her (referring to the youngest daughter) that I cannot afford the cosmetic breast surgical operation

T.: Why can't you tell her?

P.: Because she is my daughter, and I am responsible for her

T.: Of course, she is your daughter, but she is also a grown-up woman. Are you still responsible for her choices?

P.: She always had issues with her body. Furthermore, she is the one that was very little when I divorced her father. So therefore, I am responsible for the divorce and the consequences.

T.: I would agree with you on that. Being responsible also means helping the daughters to become adults. You can help her take responsibility for her choices by encouraging her to earn her own money for the surgery. In this way, you help her to gain agency in her body. She is an adult, and she is 26 years old.

P.: Yes, that is also true. I realize that sometimes, in my mind, I like to think that my daughters are little girls and that, as a mother, I have to be in charge. Sometimes, I forget that they are adults.

The ultimate goal for the inclusion of the two family sessions was to help disentangle the dysfunctional communication pattern hindering the patient and the therapist's efforts to break down the vicious cycle depicted earlier. A trained family therapist performed the two family sessions with the daughters. She was included in a conjoint meeting with the psychiatrist and the psychotherapist, in which they explained the case and the specific target of the sessions. Only after the patient and the daughters agreed on the family sessions were they included in the treatment plan. After the sessions concluded, both daughters stopped asking for more money from their mothers' and improved their working status, showing its positive impact. From then onwards, the daughters progressively gained independence, including moving from their mother's house.

However, this second phase represented an inflection point for the whole treatment process because the therapeutic alliance was at stake at some point. The patient had to both open up about very intimate situations and submit herself to confrontation with the clinician to be able to achieve a certain level of differentiation from her own maladaptive experience. This differentiation process means that, at some point, she had to confront herself with attitudes and behaviors that, although they led her to failure, were the mechanisms she knew. Although the evidence was eloquent, and she could not achieve the desired goals by utilizing her means, Mrs. C. needed to stick to the mechanisms she knew and wanted to think she was right. She had to expose herself more than she preferred and put more trust in the therapeutic team because they were proposing new directions. It was as if she had to learn to let go of her lousy thinking style and try a new one in which she had no previous experience. All those challenges required her to be more committed to the treatment. This shift to a more confrontational style posed a threat to the alliance predisposing to alliance ruptures and reparations. The threat to the alliance was that the therapist needed to intervene in a more confrontational and directive (Fernández-Álvarez et al., 2003) way and not just validate and provide support. In addition, the patient had to increase her trust in the clinicians and in the treatment. For example, when the therapist asked the patient to explain how she was incrementing her debts, she was reluctant to expose her financial situation to the therapist.

Nevertheless, to be able to help her modify her dysfunctional behavior with spending, the therapist needed all the information. So the therapist had to confront her reluctance to expose her financial situation and made it mandatory for her to bring her credit card statements to the therapist and work out a healthy payment plan. To reach an agreement so the patient would comply with the intervention, the therapist adopted a more directive style and assessed, together with the patient, the results of the prescribed behavior (J. Norcross, 2019). For example, the therapist had a directive intervention by prescribing that the patient stop the "önline loans" from her computer, go to the Bank and put an end to the credit card spending, and ask for a plan to refinance the debts retrospectively. After doing it, the patient could confirm with evidence that this new strategy had better results and would help her out of this financial crisis.

The following is an excerpt verbatim of some dialogs along these issues:

P.: I've never felt so low in my life. I always thought I could get by on my own. That's why I asked for the loans. I thought I could pay them back, but my debts just got bigger and bigger each month.

T.: You probably managed to get by on your own for a while, but sometimes what worked out at some point no longer does at another. That's when you need to be able to change strategies.

P.: That's why I'm here.

T.: Would it help you if we tried to figure out how to get you out of all your debts?

P.: Yes, I've hit rock bottom. Could I get out of this?

T.: Of course you can. You need to find a new strategy.

P.: How would I do that?

T.: To begin with, stop asking for more loans. Go to the Bank and ask them to freeze your card spending. In the meantime, let's see your options to cover the debts. For example, on whom could you count?

After that, the therapist suggested the patient to look for more healthy ways to get money to pay her debts. Together with the patient, they built an agenda of acquaintances with people who would be willing to help. For example, one of her sisters and other relatives, who she had helped in the past. Also, there were conversations with her ex-husband, who was also available for financial help. When the patient saw that she started to gain control over her debts and that there was another way out better than engaging in further obligations, she became interested in this alternative. So, progressively from that moment on, with the therapist, she could build a healthier economic plan (regulate spending, increment savings, finish pending loan payments, earn more money). And it worked. It is noticeable that, in Argentina, the interest rate on credit cards is more that annual 120%.

So to perform the above changes, it was essential to reverse her strong belief in not seeking help from her loved ones and overcoming feelings of shame and embarrassment. The fact that the daughters no longer demanded money from their mother, and that they accepted that her mother was recovering from an illness, and no longer

posed unrealistic expectations on her, also helped. During this phase, Mrs. C. gained full awareness of the vicious cycle that caused, maintained, and perpetuated her problems from a psychological stance. She could understand how her core dysfunctional beliefs (I am incapable because of my illness vs. I am superior and do not need anybody's help) fueled her difficulty in achieving the balance between opposite disruptive emotions (overly activated enthusiasm and power vs. helplessness and pessimism), that led her to bad decisions and behaviors (financial problems as a consequence of a bad investment, unable to pay the money loans and bills). She could now understand that accepting her emotional regulation difficulties, seeking help from significant others, and achieving her goals, helped her gain control of her life and strive to achieve broader goals.

During this phase, Mrs. C. also learned alternative ways to deal with disruptive emotional reactions. She could identify the change in her inner estates every time she faced a triggering event and was able to be aware of the distorted cognitive interpretations and exaggerated emotions that emerged as a reaction. In addition, she learned mindfulness techniques and incorporated physical exercise routines that helped her keep under control and reflect upon them, preventing her from doing harmful instead of beneficial things to her life project. So, for example, every time she received a credit card statement or any other document related to payments, she would notice how she felt intensely excited or deficient (I can fix this with a click vs. I do not find a way out), how the distorted and unreal interpretations came to her mind (I am incapable vs. I do not need anybody's help), and instead of clicking on the computer for a new loan, she took a deep breath or went out for a walk in the park, or practiced mindfulness exercises. Only when she felt stable and balanced and dissipated the distorted cognitions would she turn to her budget planning and look into alternative and healthy ways to pay her debts. By the end of this phase, she had paid all the debts and started saving and earning more money with new clients.

Even in the middle of this hard work, she suddenly came up with a trip to Europe, in which it was not clear how and who would pay for it. That was the kind of mood shift that she suffered at that time. After that, however, the vicious cycle started to reverse into a virtuous one. Within a planned strategy outlined conjointly with the therapist, she gradually paid off her debts and engaged in a healthier personal economy. Without the heavy medications, she continued improving herself-image by losing unwanted weight, starting to exercise, and feeling better about herself.

The last phase targeted overt behavior basic process. It consisted of only biweekly psychotherapy sessions for 3 months, an ongoing follow-up with the psychotherapist, and follow-up sessions with the psychiatrist every 6 months. At this final stage, the patient began to reap the benefits of her behavioral change and cognitive restructuring. The new set of cognitions was basically all related to a change in core beliefs: instead of “I am disabled,” it was “I am able,” instead of “I don't deserve to be appropriately loved,” it was “I deserve to be adequately loved.” These changes could be possible not only because she could reflect on the previous maladaptive beliefs but because she could behave differently. While she could make better decisions, she could better achieve her goals, and the latter made her feel good about herself and confirmed herself-value. The change occurred at different levels. As predicted in Mansell's model, the recovery process is associated with the gradual acceptance and tolerance of internal state changes and their related self-appraisals that promotes the use of less extreme behaviors, challenge existing beliefs about mood and its management, and promotes the development of a more coherent self-concept that is less dependent on specific internal states. The model would predict that a recovery approach that encourages self-coherence (e.g., mindful awareness; developing long-term supportive relationships) would be more enduring than approaches that maintain ambivalence about internal states (e.g., trying to suppress or enhance specific mood states). The treatment aims to help people develop an awareness of how they manage their moods and develop alternative ways to live a more fulfilling and balanced life (Mansell et al., 2010). In the case of Mrs. C., she could make the necessary changes to reach a more stable and fulfilling life, accepting the inevitable and facing the challenges with a new, balanced attitude.

She gradually returned to work to consolidate all these changes and continues growing professionally. She won back old clients, partnered with new colleagues, and learned to implement different techniques to manage her emotional reactions better. In one of the final sessions, she said: “before, in the face of any sensation of anguish, catastrophic thoughts would immediately emerge, which triggered desperate and ineffective responses. Now I have

the tools to face situations and let them go little by little, one day at a time. I don't feel threatened anymore by the progress and growth of my daughters. I have a more collaborative relationship with my ex, colleagues, family members, and friends. I no longer feel ashamed or unworthy if I need to ask for help. This therapy has helped me out" (sic).

The following is an excerpt verbatim of some dialogs from this final phase:

P.: It's been a year since I got rid of all my debts, my daughters have become independent, and I don't carry the weight of having to provide for them. Not at all. It's not easy being alone, that's true, but in the end, it's better than the other situation.

T: What do you think helped you the most?

P.: First, you listened to me and looked for a solution, such as the medication issue.

T.: I see.

P.: Secondly, being able to ask for help and not feeling that I was a failure because of it.

T.: Of course. No one can do everything on one's own.

P.: Lastly, I know the battle will continue, but I have better tools to fight.

T.: For example?

P.: When I feel anxious, I try to breathe and tell myself to take it step by step. When I feel alone at home, I remind myself that my daughters are doing well and that we have helped them grow.

Table 2 synthesizes the Phases of Treatment, the treatment's kernel in each phase, and the changes achieved. A treatment kernel is a "specific change method designed to modify the change process" (Hoffman & Hayes).

7 | TEAMWORK AND DIFFICULT-TO-TREAT CASES

Historically, randomized clinical trials have excluded difficult-to-treat cases for several reasons. First, because of the complex nature of the disorder, the comorbidities, and the previous treatments without results, it is not easy to include this particular group in a given diagnostic group of patients. Second, since the amount of suffering is usually very high, implying severity and impairment and affecting the patient and his surroundings, it is sometimes nonethical to put one individual in so much suffering into a control/placebo group. However, clinicians utilize psychological interventions that have proven effective in different dimensions, like mood or anxiety disorders, in a more transdiagnostic and transtheoric manner in new, tailor-made combined treatments. Finally, the complexity of certain clinical situations encourages us to transcend the dominant one-to-one individualistic mode of delivery and try to put into practice effective teamwork interventions in psychotherapy. Research exploring what aids and hinders multidisciplinary and interprofessional team working concurs with a simple but essential idea: putting the patient at the center reduces tension and misunderstandings among the team members and favors effective interprofessional collaboration.

In this case, we have shown that the intervention of a well-coordinated team composed of interdisciplinary by a psychiatrist, a psychotherapist, and a family therapist, was beneficial. Since we have performed follow-along interviews several months after termination, we can also expect no relapse. Relapse prevention is very relevant for these types of cases, given the high percentage of patients that end up in the nonrespondent category. We can attribute this success to an efficient case formulation that allows all participants to share the same vision about what caused, maintained, and perpetrated the illness. In addition, each had a specific role in the therapeutic process. During the conjoint meetings, the psychotherapist in charge discussed with the team participants different issues related to role distribution, clinical decision-making, types, and impacts of the interventions. The essential element was to put the patient's needs at the center of the discussion and to reach agreement and cohesion. We hypothesize that the results are better when the team works cohesively than in the one-to-one approach. In contrast, we could retrospectively observe from previous treatments with this patient that the results could have been more apparent in individual or noncoordinated strategies in combined treatments for the same type of problem.

TABLE 2 Phases of treatment.

	Teamwork	Treatment kernel	Change process
First phase	– Conjoint meetings with psychologist and psychiatrist to discuss treatment goals and strategies – Weekly psychotherapy sessions – Biweekly and then monthly sessions with a psychiatrist	Attention	The aim was to reduce the harmful effects of her medication plan and provide her with other, more effective ways to cope with symptoms that would ultimately enhance self-confidence and self-efficacy. The therapist utilized psychoeducation, relaxation, and mindful techniques to help her gain awareness and control of exaggerated emotions and distorted thoughts, together with a psychiatrist change in medication type and dose. Struggles at this stage were at the level of immediate relief but unwanted consequences versus more mediated and reflexive response and durable benefits.
Second phase	– Bimonthly sessions with the psychiatrist to monitor maintenance dose with no further adverse effects – Bi-weekly psychotherapy sessions – Additional family sessions with a family therapist	Cognitive–Emotional	The aim was to identify the vicious cycle that was the cause and maintenance agent of the disorder together with the patient. The therapist and the patient achieved this by applying cognitive-restructuring techniques and adding goal-specific sessions with daughters to help identify and change dysfunctional interpersonal communication patterns of behavior that negatively reinforce symptoms. As a result, the patient experienced an increased self-awareness which facilitated change. In addition, after the family therapy sessions, the daughters changed their attitude toward their mother, all of which helped the patient break down the vicious cycle. Struggles at this stage were at the level of higher commitment to change processes, challenging core dysfunctional beliefs, and overcoming conflicts with daughters to enhance a more long-lasting and deep relationship with them and other significant others.
Third Phase	– Every 3 months, she had sessions with the psychiatrist. – Biweekly psychotherapy sessions – Monthly psychotherapy follow-along sessions	Overt Behavior	The aim was to consolidate changes and facilitate patients' development of new projects. Whenever Mrs. C. faced a new challenge, she could recognize the tendency to trigger the maladaptive vicious cycle and change it into a virtuous one. She achieved this change by applying different tools to control changes in inner states and destructive behaviors. In this phase, the therapist

TABLE 2 (Continued)

Teamwork	Treatment kernel	Change process
		utilized techniques to help her organize contacting clients, agendas, assertiveness training, and other behavioral techniques. Struggles at this stage were the pervasive reappearance of old bad habits.

8 | OUTCOME AND PROGNOSIS

During the transition from Phase I to Phase II, the psychotherapist and the psychiatrist decided to monitor the clinically observed symptom improvement to confirm the positive impact of changes in prescription medication and the psychotherapy process. Since they observed a consolidated symptom improvement about 7 months after the treatment started, they decided to repeat the initial psychological assessment measures that were administered at intake. The report elicited by the same independent assessment team showed an improvement in depressive symptomatology, hypomania type of thinking, and general welfare. The results of this report are summarized in Table 3.

In addition to symptom improvement, recovery from Bipolar disorder also implies a shift from a sense of loss of control to the development of perceived control as the individual begins to accept and face their problems. So the recovery process is associated with being better able to "shift perspective" on stressful situations. Mrs. C demonstrated in follow-up interviews that she could expand her goals in life and sustain longstanding relationships with significant others. Still, cognitive distortions and exaggerated emotions emerged in the face of challenges or triggering events. However, whenever these disruptive emotions appeared, she could gain awareness and a new sense of agency, shift her perspective and find an alternative way out into a more adaptive, less extreme behavior. All these changes helped her better achieve her desired goals, and these achievements reinforced her sense of well-being. As she put it in her own words, she felt that "this therapy helped me out" (sic.). As aforementioned in follow-up interviews 2 years after termination, she remained relapse-free.

9 | CLINICAL PRACTICES AND SUMMARY

The incidence of Bipolar disorders is increasingly high, affecting around 2%–6% of the population. The impact on the quality of life for the sufferer and their significant others is considerable, typically greater than other emotional disorders and physical conditions. The diagnosis of bipolar disorder, based on historical information, is lifelong. Nevertheless, evidence shows that in many individuals, the lack of relapse during long periods means they have reached recovery.

The case of Mrs. C. was initially categorized as nonrespondent when she started this treatment, and now, upon termination, she falls into the category of a recovered Bipolar patient.

Some clinical recommendations to gain better results with these kinds of patients:

- Effective evidence-based psychological interventions in complex, difficult-to-treat patients, when customized to the patient's needs, are beneficial.
- A good fit shared Case Formulation can help integrate interdisciplinary teamwork. It helps share goals.
- Monitoring the impact of the interventions at all levels periodically when possible.

TABLE 3 Symptom improvement report.

Standardized test	Initial	Repeat at 8 months	Result
HAPPI	Hypomanic	Nonclinical	Improvement
Hypomanic attitudes and positive predictions inventory			
RS		Nonclinical	Improvement
Remoralization Scale			
MMPI	Nonclinical	Nonclinical	Nonclinical
Minnesota Multiphasic Personality Inventory			
BDI-II	26 Moderate	19 mild depression	Improvement
Beck depression inventory II	Depression		

Note: The brief HAPPI (Hypomanic Attitudes and Positive Predictions Inventory, Mansell & Jones, 2006), assesses dysfunctional beliefs that are associated with a diagnosis of bipolar disorder. It consists of forwarded and reversed items that assess the level of cognitive-distortions that are present in individual diagnosed with Bipolar disorder. The more the patient rates in forwarded items, the more it is associated with Bipolar characteristics. This measure has correlational and factor-analysis studies, and is under development. The BDI II (Beck Depression Inventory II, Beck et al.), assesses depressive symptoms. It is a standardized measure. The MMPI (Minnesota Multiphasic Personality Inventory, Hathaway, et al.), assesses Personality Disorders. It is a standardized measure. The RS (Remoralization Scale, Vissers et al., 2010), assesses general well-being in psychotherapy process. This measure has correlational and factor-analysis studies, was validated in Argentina and is currently under development.

- Relapses and the "revolving door" phenomenon can be avoided with treatments with good results. This conclusion can be relevant to cost-effectiveness studies in the future with these kinds of patients (Botella et al., 2023; this issue).

Only when the patient could become aware of how she manages her moods, with the help of the treatment, could she develop alternative ways to cope. These changes led her to live a more fulfilling and balanced life, even within her condition. On the contrary, previous treatments did not address these issues or arrive at excellent and durable outcomes.

These clinical considerations help clinicians to better deal with this kind of patient.

DATA AVAILABILITY STATEMENT

Data openly available in a public repository that issues datasets with DOIs.

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PEER REVIEW

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REFERENCES

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed). Author.

Barlow, D. & Farchione, T., (Eds). (2018). *Applications of the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders*. Oxford Press.

Bohart, A. C., & Tallman, K. (2010). Clients: The neglected common factor in psychotherapy. In B. L. Duncan, S. C. Miller, B. E. Wampold, & M. A. Hubble (Eds.), *Heart and soul of change: Delivering what works in therapy* (2nd ed., pp. 83–112). American Psychological Association.

Botella, L., Montesano, A., & Scherb, E. (2023). Commentary. *Journal of Clinical Psychology*, JCLP-22-0254.R3.

Dimaggio, G., Semerari, A., Carcione, A., Nicolō, G., & Procacci, M. (2007). *Psychotherapy of personality disorders: Metacognition, states of mind and interpersonal cycles*. Routledge.

Durao, M., & Hirsch, H. (2020). *Online Psychotherapy: What it is and how it is practiced*, Amazon Kindle Edition.

Eells, T. (Ed.). (2022). *Handbook of Psychotherapy Case Formulation* (Third Edition).

Fernández-Álvarez, H., García, F., Lo Bianco, J., & Corbella Santomá, S. (2003). Assessment questionnaire on the personal style of the therapist PST-Q. *Clinical psychology & psychotherapy*, *10*, 116–125. https://doi.org/10.1002/cpp.358

Frank, G. (1984). The boulder model: History, rationale, and critique. *Professional Psychology: Research and Practice*, *15*(3), 417–435. https://doi.org/10.1037/0735-7028.15.3.417

Hoffman, S., & Hayes, S. (2021). *Learning Process-Based Therapy*. Hoffman, Hayes & Lorscheid Context Press.

Kerman, B. (2015). *Nuevas Ciencias de la Conducta. Las herramientas del Cambio*. Ed. Universidad de Flores.

Mansell, W., & Jones, S. H. (2006). The Brief-HAPPI: A questionnaire to assess cognitions that distinguish between individuals with a diagnosis of bipolar disorder and non-clinical con trols. *Journal of Affective Disorders*, *93*, 29–34. https://doi.org/10.1016/j.jad.2006.04.004

Mansell, W., Powell, S., Pedley, R., Thomas, N., & Jones, S. A. (2010). The process of recovery from bipolar I disorder: A qualitative analysis of personal accounts in relation to an integrative cognitive model. *British Journal of Clinical Psychology*, *49*, 193–215. https://doi.org/10.1348/014466509x451447

Mansell, W., Tai, S., Clark, A., Akgonul, S., Dunn, G., Davies, L., Law, H., Morriss, R., Tinning, N., & Morrison, A. P. (2014). A novel cognitive behaviour therapy for bipolar disorders (Think Effectively About Mood Swings or TEAMS): study protocol for a randomized controlled trial. *Trials*, *15*, 405. https://doi.org/10.1186/1745-6215-15-405

Montesano, A., & Scherb, E. (2023). Introduction. *Journal of Clinical Psychology*.

Norcross, J. (2019). *Psychotherapy Relationships That Work: Evidence-Based Responsiveness* (third. Ed.). Oxford University Press.

Norcross, J. C., & Wampold, B. E. (2011). What works for whom: tailoring psychotherapy to the person. *Journal of Clinical Psychology*, *67*(2), 127–132. https://doi.org/10.1002/jclp.20764

Novick, D. M., & Swartz, H. A. (2019). Evidence-Based Psychotherapies for Bipolar Disorder, *Focus (American Psychiatric Publishing)* (Vol. 17, pp. 238–248). https://doi.org/10.1176/appi.focus.20190004NLM

Rush, A. J., Sackeim, H. A., Conway, C. R., Bunker, M. T., Hollon, S. D., Demyttenaere, K., Young, A. H., Aaronson, S. T., Dibué, M., Thase, M. E., & McAllister-Williams, R. H. (2022). Clinical research challenges posed by difficult-to-treat depression. *Psychological Medicine*, *52*, 419–432. https://doi.org/10.1017/s0033291721004943

Scherb, E. (2014). The case of "sonia": psychotherapy with a complex, difficult patient grounded in the integrated psychotherapy model of hector Fernandez-Alvarez. *Pragmatic Case Studies in Psychotherapy*, *10*(1), 1–29. https://doi.org/10.14713/pcs.v10i1.1844

Totura, C. M. W., Fields, S. A., & Karver, M. S. (2018). The role of the therapeutic relationship in psychopharmacological treatment outcomes: A meta-analytic review. *Psychiatric Services*, *69*, 41–474.

Tucker, G. J. (2003). Combined treatments for mental disorders: A guide to psychological and pharmacological interventions. *American Journal of Psychiatry*, *160*, 202–203.

Vissers, W., Keijsers, G. P. J., van der Veld, W. M., de Jong, C. A. J., & Hutschemaekers, G. J. M. (2010). Development of the remoralization scale: An extension of contemporary psychotherapy outcome measurement. *European Journal of Psychological Assessment*, *26*(4), 293–301. https://doi.org/10.1027/1015-5759/a000039

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