CASE REPORT

POST-TRAUMATIC STRESS DISORDER SECONDARY TO MANIC EPISODES WITH HYPERSEXUALITY IN BIPOLAR DISORDER: A CASE STUDY OF FORENSIC PSYCHOTHERAPY

Andrea Pozza, Anna Coluccia, Giacomo Gualtieri, Fulvio Carabellese, Alessandra Masti, Fabio Ferretti

Abstract

Post-traumatic stress disorder (PTSD) can arise as a secondary condition to a primary bipolar disorder, an aspect which may be overlooked by clinicians and thus may contribute to the exacerbation of the bipolar disorder itself. The occurrence of manic symptoms can have a traumatic impact on a patient unaware of her/his diagnosis, especially during symptom remission. The present work describes a clinical case of a woman with type-1 bipolar disorder and PTSD secondary to previous manic episodes characterized by hypersexuality. This clinical case is characterized by the fact that the patient had not received an adequate psycho-educational intervention making her aware of bipolar symptoms and helping her to elaborate the trauma of hypersexuality experienced after remission. The psychodiagnostic and psychotherapeutic assessment procedures are described and the forensic psychiatric implications related to the importance of timely and evidence-based intervention on this comorbidity are discussed. Identification of the primary pathology may be complicated by behaviours provoked by the psychiatric symptoms which put these patients at risk of becoming victims of abuse. Therefore, it is necessary to correctly understand these dynamics in order to promptly provide the patient with the correct therapeutic pathways.

Key words: post-traumatic stress disorder, bipolar disorder, trauma, sexual abuse, mania.

Andrea Pozza[1], Anna Coluccia[1], Giacomo Gualtieri[2], Fulvio Carabellese[1], Alessandra Masti[1], Fabio Ferretti[1]

[1] Department of Medical Sciences, Surgery and Neurosciences, University of Siena, viale Mario Bracci 16 - 53100 Siena.

[2] Legal Medicine Unit, Santa Maria alle Scotte University Hospital, viale Mario Bracci 16 - 53100 Siena.

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Corresponding author

Prof. Anna Coluccia
Department of Medical Sciences, Surgery and Neurosciences, University of Siena
viale Mario Bracci 16 - 53100 Siena.
Phone: +39 0577 586409
Fax: +39 0577 233222
Email: coluccia@unisi.it

Introduction

Post-traumatic stress disorder (PTSD) is characterized by recurrent mental intrusions such as flashbacks and nightmares related to an event involving the experience of danger, hypervigilance, explosions of anger/aggression, emotional flattening, avoidance of situations related to trauma (American Psychiatric Association, 2013; Ferretti et al., 2019a, 2019b; Pozza et al., 2019). A clinical picture of PTSD may arise as a secondary condition to a primary type-1 bipolar disorder in a relatively large proportion of patients (Kennedy, Dhaliwal, Pedley, Sahner, Greenberg, & Manshadi, 2002). This type of comorbidity is often observed in female patients (Cerimele, Bauer, Fortney, & Bauer, 2017). In the early phases of the disorder, the emergence of expansive symptoms in a patient unaware of their bipolar disorder can have a traumatic impact on them during the symptomatic remission phase. The recurrence of life events similar to those which had the traumatic impact can in turn predispose to relapses. However, the compresence of PTSD in a primary bipolar disorder is an aspect often overlooked by clinicians. Failure to recognize this co-occurrence can hinder the effectiveness of treatment, thereby contributing to an exacerbation of the bipolar disorder itself (Coluccia, Ferretti, Fagiolini, & Pozza., 2015; Hernandez, Cordova, Ruzek, Reiser, Gwizdowski, Suppes, & Ostacher, 2013; Pozza & Dèttore, 2020).

According to the evidence-based literature, psychoeducation represents the psychotherapeutic strategy of election for bipolar disorder and should be integrated into the first-line psychopharmacotherapy (Soo et al., 2018). On the one hand, this type of psychotherapeutic intervention, aimed at promoting an awareness of bipolar symptoms, can reduce their traumatic impact; on the other, a timely intervention on PTSD associated with previous manic episodes can prevent a relapse of the bipolar disorder itself (Foa & Rothbaum, 1998; Pozza, Coluccia, Gualtieri, & Ferretti 2020).

The present paper describes the clinical case of a woman suffering from a type-1 bipolar disorder with PTSD secondary to previous manic episodes characterized by hypersexual behaviours. This case is characterized by the fact that the patient had not received an adequate psychoeducational intervention that made her aware of bipolar symptoms and thus able to process the trauma of hypersexuality experienced after remission from the manic episodes. We discuss the assessment and psychotherapeutic procedures and their forensic psychiatric implications, highlighting the importance of timely evidence-based intervention on such a comorbidity.

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Case study

Psychological anamnesis

T. was a 41-year-old, single and unemployed woman living with her elderly parents. In slightly overweight (BMI = 27.43), she had not a familiarity for psychiatric disorders. T. described the relationship with her mother when she was a child as follows: "[…] *the normal parent-child roles were reversed: I was a mother, she was a daughter*", and defined the father "*authoritarian, perfectionistic, judgemental, unable to support frustrations, insistent on good school marks*". She described her early childhood as characterized by hyperactivity, impulsivity and difficulty respecting the rules. The period of secondary schools was marked by depressive features, i.e. social withdrawal, difficulties in relations with peers, abulia, anhedonia, hypersomnia, high distractibility, fatigue.

The clinical history of T. was characterized by frequent hospitalizations for (hypo)manic episodes within a few years when she was in her thirties (the first hospitalization occurred when she was 32 years old). Most episodes of mood alteration had a mixed picture, which began with excitatory symptoms, and then also including depressive features. The prodromal phase of the bipolar disorder was between 22 and 25 years of age and consisted of continuous subthreshold mood fluctuations, when she was not yet in the care of psychiatric services. She displayed a reduced need for sleep; she felt full of energy but also reported outbursts of anger, agitation and irritability, alternating with apathy. Frequent quarrels occurred in the workplace. She told us that another typical aspect of that period was promiscuous sexuality and hypersexuality. She tended to have sex several times every week with people she had just met. She told us a traumatic memory dating back to that period. One evening, walking in an isolated area while returning home alone after a dinner, she was attacked by a man who pushed her to the ground and tried to sexually abuse her. While the attack was taking place, the man was distracted by some people around them and was forced to go away, and so the abuse was aborted. While she was narrating the episode, she expressed strong feelings of shame, disgust and guilt. In recent years, it had been very painful for her to live with her feelings of anger towards males who she continued to fear might overwhelm her. She often wondered why this had occurred to her and she thought the reason was that the way she was dressed had attracted the man's attention. In remembering the promiscuity phase, she reported feeling a sense of guilt towards herself and moral disgust when thinking about promiscuous sex and intrusive memories. This led her to live with feelings of revenge in relationships with men. At that time, she did not know she had bipolar disorder; promiscuous sexuality and hypersexuality were the most distressing and traumatic symptoms for her. She remembered that when her mood re-stabilized, she had long ritual showers to purify herself of the feeling of moral dirt on her body. This picture can be ascribed to PTSD secondary to the manic symptoms of hypersexuality.

The last episode of mood swings occurred a few months before the clinical interview we conducted. We observed symptomatology attributable to a mixed state with psychotic characteristics. In previous days, T. had displayed frequent mood changes; she felt extremely full of energy and hyperactive. She dressed seductively, had high self-esteem, unlike usual, and a reduced need for sleep. At the same time, she was very irritable, and she thought of stopping her medications. For some days T. had been dating a man, her manager at work. After a few weeks, however, the possessive attitudes of this man provoked clashes between the two which culminated in an episode in which he threw a tray at her while shouting insults in front of customers. This episode recalled the trauma of the attempted abuse and triggered feelings of anger towards males but also of guilt and self-criticism. Within a few days, she gradually developed self-denigrating beliefs and traumatic feelings of self-punishment. Consequently, a relapse started with progressively increasing mixed symptoms (i.e. social withdrawal, depressed mood, loss of appetite, anhedonia, constant rumination on the episode, outbursts of anger, irritability, insomnia, psychomotor agitation, parasuicidal ideation).

In agreement with the patient and her family, the psychiatrist who had initially decided on urgent hospitalization decided to carry out home care with a pharmacotherapeutic plan including Escitalopram, Aripiprazole and Bupropion Hydrochloride. The patient preferred home care; she had become impatient with the frequent hospitalizations she had experienced in recent years. After about ten days, the symptoms went into complete remission. Gradually she recovered from the episode of bipolar decompensation; she decided then to end the relationship with her job manager and not to resume work. She continued pharmacological treatment and after a few weeks, she contacted us to start a psychodiagnostic assessment and a psychotherapeutic pathway.

Psychodiagnostic assessment

She was administered the Minnesota Multiphasic Personality Inventory-2 (MMPI-2; Hathaway & Mc Kinley, 1989), Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II; First, Gibbon, Spitzer, Williams, & Benjamin, 1997), Beck Anxiety Inventory (BAI; Beck, Epstein, Brown, & Steer, 1988), Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996); Penn State Worry Questionnaire (PSWQ; Meyer, Miller, Metzger, & Borkovec, 1990).

The configuration on the MMPI-2 Validity scale corresponded to the profile most frequently observed in psychiatric settings (Caldwell, 1997), and suggested a very high level of psychological distress (Table 1). The answer was omitted for nine items (Cannot Say scale -? = 2). For this scale, profiles are considered valid if there are not more than 20 missing answers in the first 370 items and over 16 in the whole test (Greene, 2011). The T-scores on the L-Lie and K-Correction scales, respectively 50 and 51, did not suggest a tendency to mask or under-report psychopathology. The T-score on the TRIN scale was below the 84-threshold, thereby suggesting a coherent style in the responses (Greene, 2011). The T-score on the F-Infrequency scale, equal to 54, was below the threshold of 65, suggesting the absence of a tendency to over-reporting the symptoms, as shown by the value of the Gough Dissimulation Index which was below the threshold of 9 (Gough, 1950).

An elevation was observed only on the 4-Pd Psychopathic Deviate scale which suggested problems with authority, contempt for social norms, impulsive behaviour characterized by a tendency to externalize blame and manipulate relationships. Elevations on this scale are routinely reported in studies of patients with antisocial, borderline, dependent, histrionic, narcissistic, paranoid and passive-aggressive disorder (Nichols, 2001). The score on the Pd1-Familial Discord Harris-

Lingoes subscale suggested a lack of emotional support and conflicts in the family of origin. There was also a very high score on the 3-Pd-Social Imperturbability subscale suggesting emotional coldness with cynicism, hostility, use of social relationships to manipulate, exploit and intimidate.

episode and mixed/psychotic characteristics congruent with the mood in a complete remission phase. T. reported a history of repeated hospitalizations due to mood alteration episodes, mainly characterized by manic symptoms. In several of these episodes, the manic symptoms were followed by the emergence of depressive features or a mixed symptomatology.

Table 1. *Scores on the MMPI-2*

Scale	Raw score	T score
L - Lie	5	50
F - Frequency	8	54
K - Correction	15	51
1Hs - Hypochondriasis	14	47
2D - Depression	20	45
3Hy - Hysteria	27	54
4Pd – Psychopathic Deviate	34	**71**
5Mf-f – Masculinity-Femininity	39	38
6Pa - Paranoia	11	54
7Pt - Psychasthenia	32	53
8Sc - Schizophrenia	30	55
10Ma - Mania	21	52
11Si - Social Introversion	18	38
Cannot Say	9	
ANX - Anxiety	11	56
FRS - Fears	6	48
OBS - Obsessions	3	43
DEP - Depression	9	51
HEA – Health Concern	8	51
BIZ – Bizarre Mentation	0	38
ANG - Anger	11	67
CYN - Cynicism	14	53
ASP - Antisocial Practices	12	64
TPA - Type A	13	61
LSE – Low Self-Esteem	8	53
SOD - Social Discomfort	3	43
FAM – Family Problems	13	62
WRK – Work Interference	8	47
TRT – Negative Treatment Indicators	8	53

Results on the SCID-II

The profile highlighted the absence of a personality disorder diagnosis. The diagnostic category that showed the highest score ("3") in one or more items was the histrionic personality disorder, for which we observed the presence of 3 items coded as "3". This result suggested the presence of histrionic personality traits. Finally, we found the presence of two traits coded as "3" for borderline personality disorder and one trait coded as "3" for narcissistic and passive-aggressive disorder.

Diagnosis according to the DSM-5

The following diagnosis was formulated: 296.46 (F31.72) Type-1 bipolar disorder with a recent manic

The mixed symptoms emerged during the last episode a few months before our clinical interview, lasted for at least a week, and their development was related to the interruption of the drugs. During this period, T. showed a sharp increase in motor activity and agitation. Depressive symptomatology was observed since a few days later she retired completely to her house, stopped working and eating, developed ideation of guilt, feelings of punishment and revenge, and then parasuicidal behaviours.

The mixed symptomatology acquired psychotic characteristics congruent with the mood tone; she developed a delusional belief of guilt (she believed herself possessed by the Devil and in need of purification by Holy Water). After the 10-day course of treatment, a complete remission of symptoms was observed.

However, T. came to our attention without knowing that she was suffering from bipolar disorder and

without being aware of its symptoms. She was not aware of the recurrence of episodes and she did not know that hypersexuality may be a typical symptom of this condition, rather than reflecting an individual trait, a belief that the patient had matured over time. In addition to the diagnosis of bipolar disorder, we diagnosed PTSD (309.81, F43.10), a clinical picture hypothesized to be secondary to the manic episodes characterized by hypersexuality, which at the time the patient did not know she suffered from, and also connected to the episode of attempted sexual abuse. The PTSD picture was characterized by withdrawal from intimate relationships and distinguished by emotional detachment, coldness, anger and need for revenge towards men, intrusive memories related to traumatic episodes, and experiences of guilt and disgust towards herself and her partners.

Case conceptualization

The case was conceptualized according to the Basco and Rush model (1996) (Figure 1) which identifies vulnerability, maintenance, precipitating and protective factors for bipolar symptomatology. Among the vulnerability/maintenance factors we identified were a hypercriticism interpersonal schema (the implicit belief of having to do everything to meet extremely high internalized standards of performance, generally to avoid being criticized), a self-punishment interpersonal schema (the belief that people should be severely punished for their mistakes), and an interpersonal abuse schema (the expectation that others will cause suffering, abuse or humiliation or will be liars or manipulators).

Among the precipitating factors, on one hand we identified the stressful life events occurring before the onset of bipolar disorder, particularly the episode of attempted abuse; on the other hand, we identified more recent life events which had contributed to the development of the last episode of decompensation characterized by mixed symptoms (i.e., the episode of emotional disappointment with her job manager). Another precipitating factor was the interruption of psychotropic drug medication during the days immediately before the decompensation.

The self-punishment and abuse schemas were activated during the shift from the excitatory to the depressive phases in the various episodes of decompensation, when T. developed feelings of self-blame for having attracted the attention of men. The traumatic episode of the attempted sexual abuse confirmed the self-punishment interpersonal patterns that had been created in the relationship with her father, perceived by her as an authoritarian and judgmental person. T. developed the belief that she must constantly defend herself against males. She developed a form of avoidant attachment; she was afraid of having humiliating relationships with men. Therefore, she lived her relationships with men with feelings of revenge. Attracting the attention of a man, feeling desired by him, reinforces her self-esteem, whether or not she was truly interested in him. She tended to eroticize relationships with men and, and then when she felt desired, tended quit the relationship.

During the last episode of mixed-state decompensation, this schema activated the delusional belief that she was possessed by the Devil, that she had committed sins and had to be purified. The hypercriticism schema which led the patient to believe that she did not deserve the esteem of others, was formed during her childhood in the relations with her parents (i.e. the maternal figure was perceived as absent and passive and the paternal one as judgmental and hypercritical).

In the prodromal phase when, at age 22, she still did not know she was suffering from bipolar disorder, the episodes of compulsive and promiscuous sex strengthened her sense of disgust and guilt towards herself and, simultaneously, her view of men as bullies.

Precipitating factors that contributed to the development of the symptoms of the last decompensation were identified in the emotional disappointment experienced by T. towards her employer, who had dealt with her in a hypercritical and abusive way. This episode triggered the patterns related to self-punishment, abuse and hypercriticism, which in turn led to the mixed state symptomatology characterized by feelings of both revenge against her employer and strong self-criticism. These interpersonal patterns were linked to specific post-traumatic cognitive distortions, such as dichotomous thinking ("It was all my fault"). The interruption of the drugs contributed firstly to the exacerbation of the excitatory symptoms and then to the depressive symptoms.

Psychotherapeutic treatment

The therapeutic goals formulated in collaboration with the patient consisted of acquiring awareness of the symptoms/prodromal states of the relapse of manic/depressive episodes, increasing anger recognition and management skills, promoting assertive behaviours, increasing the ability to self-regulate positive/negative emotions and prevent further episodes of decompensation, and elaborating the traumatic experiences connected with the decompensations and the abuse attempt.

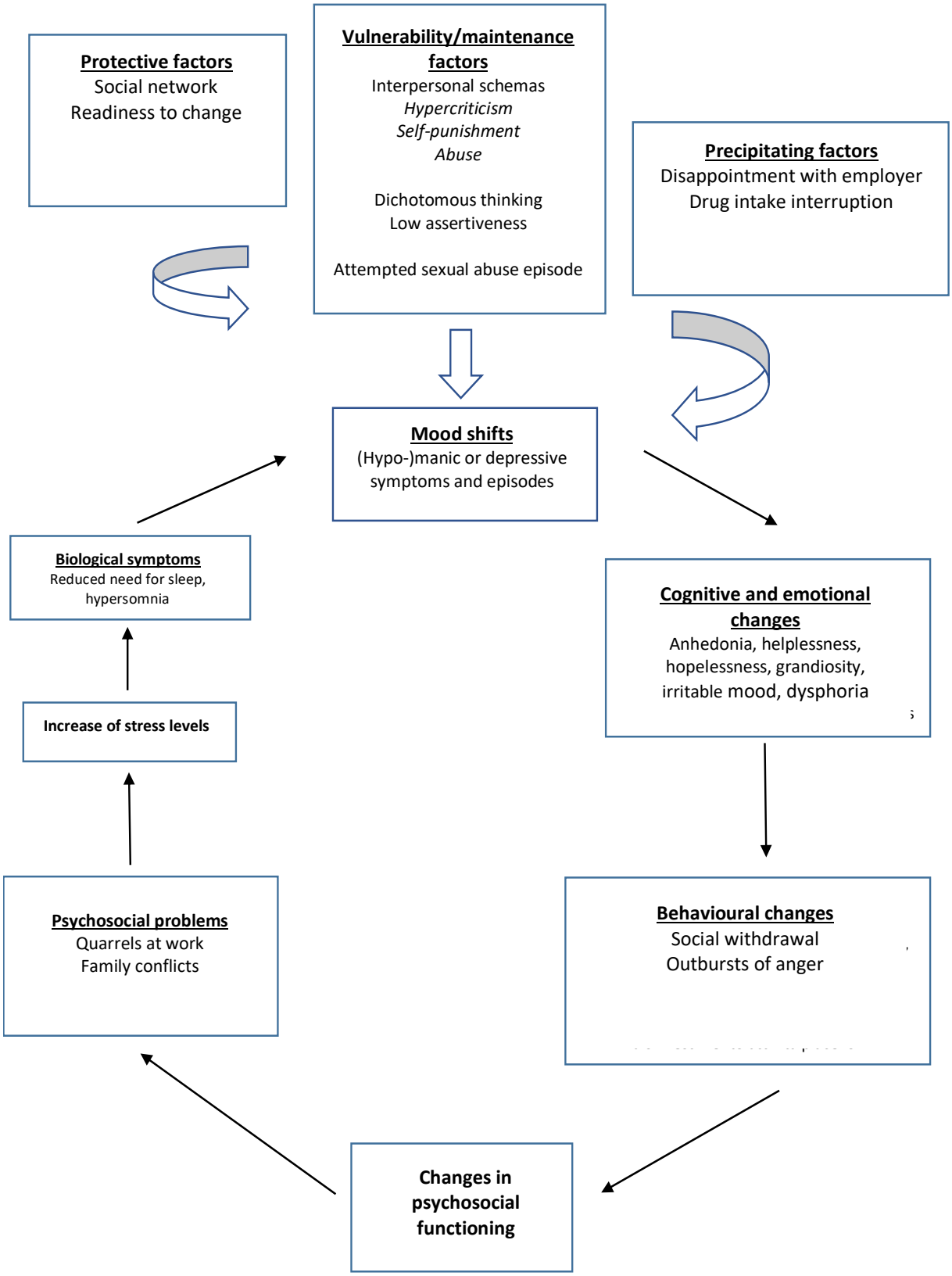
Psychoeducation on bipolar disorder

The therapeutic request made by T. at the beginning of treatment was to acquire greater awareness of what had happened to her in recent years. It was first decided to analyse the patient's beliefs and knowledge of bipolar disorder. This phase of therapy was accompanied by active listening and empathic mirroring regarding her attitude towards her diagnosis. She was given the opportunity to ask questions and express all her concerns and doubts about the characteristics of this disorder.

Subsequently, we moved on to evidence-based psychoeducation. In the initial phase, the case conceptualization and rationale for the therapeutic techniques were shared with T. The vulnerability, precipitating, maintenance and protective factors that had contributed to the disorder were discussed. An explanation of the phenomenological and functional characteristics of bipolar disorder was provided, highlighting the most specific elements of her case. To provide her with the most complete view of the disorder, she was asked to read a self-help book. This phase was particularly important because it allowed her not to identify herself with mania. The interviews had in fact highlighted how she had lived with shame, moral disgust and guilt for aggressive actions and episodes of decompensation characterized by promiscuous sex. Depressive and manic symptoms were discussed through psychoeducation.

One of the aspects we focused on was the fact that bipolar disorder is a chronic condition, for which drug treatment is fundamental. The patient had initially

Figure 1. *Case conceptualization of the bipolar disorder of T.*



internalized a view of the disorder as an acute disease (i.e. she thought she had to take drugs only during the phases of decompensation). As suggested by numerous authors (e.g., Colom, Vieta, Martinez-Aran, Reinares, Benabarre, & Gasto, 2000), a reduced compliance with drug therapy is very commonly observed in patients with bipolar disorder, particularly during the expansion phases. The previous episodes of decompensation were analysed with T. in a collaborative fashion and it was noted that she had stopped taking drugs due to her expanded mood and increased self-esteem.

Therefore, the negative beliefs towards drugs and the reasons for stopping them were analysed; possible preventive strategies were identified, such as contacting her doctor or the psychologist to discuss the reasons. She was also encouraged to activate contact with the doctor if she experienced any side effects.

Symptom monitoring and routine regularization

The patient was encouraged to complete a daily self-monitoring diary of her mood by noticing the subthreshold symptoms or the early warning signals that anticipated a relapse. She was asked to fill in a self-monitoring worksheet aimed at helping her become more aware of mood modification patterns, i.e. sleep-wake rhythm, anxiety signs, irritability.

A historical analysis of the course of her bipolar disorder was carried out in collaboration with T., in which Life Charts were made with the aim of increasing her awareness of the interactions between episodes of decompensation, prodromal symptoms, initiation/interruption of drugs and stressful life events. To reinforce the patient's ability to recognize symptoms, three-column symptom summary worksheets (depression, euthymia, mania) were used, which listed physical, emotional, cognitive and behavioural symptoms attributable to each one of the three mood phases.

An explanation was given of the importance of maintaining a stable life routine. Specific indications of a modification of the routine were discussed. It was investigated whether she used alcohol or substances or had used them in the past. Emphasis was placed on strengthening her social support network. Rhythm regularization was achieved by inviting the patient to fill in the Social Rhythm Metrics (MRS; Monk, Flaherty, Frank, Hoskinson, & Kupfer, 1990) daily with the aim of achieving mood stabilization. Compiling a MRS requires monitoring the activities carried out during the day, meals made, wake-up/falling asleep times and pleasant social activities, and relating them to mood level on a scale from - 5 to +5.

T. was able to acquire awareness of the relations between changes in daily routines, levels of interpersonal stimulation, sleep-wake cycles and mood. The schedule was reviewed weekly every session and any differences between one week and another were discussed.

In collaboration with the patient, strategies were chosen to regularize the routine, such as identifying regular meal, wake-up and bed times and engaging in bodycare, social and sports activities. The regularization of rhythms and levels of activity was achieved by providing T. with a list of pleasant activities in order to identify those activities that she considered closest to her interests. To counteract difficulties in falling asleep, some cognitive behavioural therapy techniques for insomnia were used, such as stimulus control - she was invited to use her bed only for falling asleep and not for doing other activities. She was encouraged to maintain a pre-sleep routine, i.e. setting a schedule as stable as possible to prepare herself for sleep by brushing her teeth etc. Finally, correct sleep hygiene was proposed, which consisted of avoiding caffeine intake after 7 pm, turning off her mobile phone during the night and having a light dinner.

Techniques for the management of negative emotions

Anxiety and anger management strategies were introduced such as the diaphragmatic breathing technique. Psychoeducational materials on the phenomenon of hyperventilation and descriptions of the meaning of emotions were provided.

A key ingredient was the activation of a social network aimed at increasing the protective factors against relapse. Efforts were made to strengthen personal characteristics such as assertiveness and self-esteem, in an attempt to reduce conflict in family life and romantic relationships as the anamnesis had shown that these two areas were trigger factors. Some techniques from assertiveness training were adopted (Bonenti & Meneghelli, 1997). In the initial phase, the psychoeducation was focussed on explaining the concept of assertiveness and the difference between assertive, aggressive and passive behaviours through examples taken from everyday life. The patient was then asked to read a short self-help booklet describing the non-verbal signs of the different types of social behaviour.

Some specific situations related to assertiveness were discussed, such as receiving criticism, complimenting and mediating. Some strategies specific to assertive behaviour were examined, such as negative assertion and attenuation, and positive self-affirmation.

Subsequently, the diaries of dysfunctional automatic thoughts were recorded to identify trigger situations of negative emotions caused by the implementation of non-assertive behaviours.

In order to strengthen her self-esteem, she was invited to identify her positive qualities and weaknesses, both physical and psychological, and to relate them to specific behaviours that she tended to engage in.

Social skills were also strengthened through the use of problem-solving. This technique was used with the aim of helping T. identify situations triggering anger and develop functional strategies.

Subsequently, these trigger situations were recalled and addressed through role-playing exercises during the session.

Imaginal prolonged exposure to traumatic experiences

The technique of imaginal prolonged exposure (Foa & Rothbaum, 1998; Mazzoni, Pozza, La Mela, & Fernandez, 2017) was adopted to achieve the extinction and reprocessing of anxiety and disgust conditioned by traumatic episodes associated with sexual abuse and manic hypersexuality. Both the episode of attempted abuse and those related to promiscuous sex due to manic symptoms were perceived by the patient as a reason for shame and self-blame. Relationships with men reactivated feelings of abuse and guilt related to those experiences by reinforcing the schemas linked to her relationship with her father. The interaction between the schemas and the episodes of abuse represented a vulnerability factor for relapses. Traumatic episodes

were identified as a first stage, i.e. the episode of attempted abuse and some episodes of promiscuous sex in the prodromal period of bipolar disorder. The episodes collected were ordered on the basis of the subjective unit of distress. In addition to feelings of anxiety and guilt, they also produced emotions of disgust, so it was decided to start with episodes that triggered mild emotions of disgust, equal to 5-10% distress.

Typically, disgust tends to decrease more slowly than anxiety. Starting from the first episode in the hierarchy of situations in imagination, T. was asked to recount the incident in detail. This phase proceeded very slowly. Given that the level of disgust she felt was very high, it was decided, in agreement with her, to start writing a short story of the incident by entering remembered details at home since it was very distressing for her to remember the episode in front of the clinician. As she proceeded with the hierarchy, she was able to add more and more details. After writing it at home, T. delivered the story to the psychologist who checked it and then invited her to read it aloud and record an audio at home, which she would then listen to numerous times alone, recording the level of anxiety, guilt and disgust experienced. The duration of the listening sessions had to be around 60-90 minutes.

When the degree of these emotions had dropped to at least half, T. was encouraged to move on to the second story in the hierarchy.

Compassion Focused Therapy techniques were used with the rationale of challenging inflated responsibility and guilt beliefs. The Compassionate Supporter Exercise was used, in which she was invited first to imagine and then actually reproduce the physical and sensorial characteristics (e.g. the expression of the reassuring face, the kind smile, the warm tone of voice) of a figure able to make her feel accepted and understood in her frailties, who was not a hypercritical judge but, on the contrary, forgiving. Finally, the patient was encouraged to write a compassionate letter to herself as a form of self-comfort relative to her experience of the trauma of bipolar disorder.

Treatment outcome

This therapeutic path allowed T. to become more aware of her bipolar symptoms and their relation to stressful life events, identified as episodes of emotional disappointment with men. These episodes triggered feelings of self-punishment, abuse and hypercriticism in the patient that were reinforced by the vicious circle of mood changes typical of bipolar disorder. The skills that she was provided with were aimed at increasing her self-efficacy in self-monitoring sub-threshold symptoms, managing unpleasant emotions and preventing relapses. The path was quite long but after three years she was no longer relapsing, after a 10-year period of repeated hospitalizations.

During the second year of therapy, an episode of emotional disappointment occurred. She had met a man who worked in a shop near her home; after several meetings with him, T., who felt attracted to him, discovered that he was married and started distancing herself from him. However, the man was interested in having sexual encounters with her and began to insist and make advances. T. felt the repetition of an interpersonal script which made her feel crushed and humiliated. However, unlike in previous episodes, after two days of rumination, she started to use some of the skills provided by the therapy. She recognized the prodromal signals of a mixed state and began to engage more in pleasant activities, plan daily activities, and avoid social withdrawal. She contacted us on two occasions before our session to discuss the automatic thoughts that suggested to her that she was a depraved, unworthy person and deserved to be punished. In a telephone session, we had a long cognitive restructuring interview. Little by little, she was able to mentalize what was happening, to forgive herself for feeling attracted to him and understand her needs. T. was able to transform what could have been a relapse into an opportunity to learn how to manage trigger situations more effectively and anticipate mood changes. She felt stronger; the event had a positive effect on her self-esteem and confidence in her ability to manage bipolar disorder. She was able to maintain friendly relations with the man and, therefore gain a positive aspect from the relationship with him ("*In these days I thought of characteristics and qualities of myself that were previously masked by bipolar disorder ... it is as if I had made a discovery of myself ... before when the disorder was always present, I could not accomplish anything, I was inconstant. I understand that I am a person who can be constant and who cares a lot about carrying out commitments. I experience all this as a surprise, as a novelty, something that I had not foreseen. I realized that the compulsive sex episodes were related to phases of bipolar disorder. I realize that I feel less resentment towards the men with whom I had those episodes: perhaps they didn't know how I felt, at the time they were too young - also because they didn't know about bipolar disorder and I didn't even know I had it. As I had written down the story of one of the episodes of compulsive sex, for me traumatic, I remember that I had experienced a very strong feeling of indignation and disgust towards myself. After the therapeutic path we have taken, today I feel I am less anchored to those sensations of the past; I feel I live more in the present and that feeling of indignation is milder. Repeated listening to the stories about my compulsive sex episodes - I thought that, after all, those behaviours can be seen as a symptom of bipolar disorder - has been useful. At least it helped me to ask for help and then I could cure myself, unlike the other symptoms that I didn't notice, such as hyperactivity or irritability*.".

In conclusion, from the psychometric analysis, the result on the BAI showed an absence of clinically significant anxious symptoms with a score of 3 out of 63. An absence of depressive symptoms was supported by a score of 0 on the BDI- II. Finally, a score of 31 on the PSWQ suggested an absence of post-traumatic rumination.

Forensic psychotherapy concluding remarks

This work highlights the importance of evidence-based psychoeducational intervention on bipolar disorder aimed at making the patient aware of the symptoms. It is equally important to conceptualize PTSD as a condition resulting from hypomanic decompensation and to intervene on it through psychotherapy procedures aimed at processing the trauma.

An in-depth medical history and psychological analysis is particularly important in subjects with PTSD whose aetiology can be traced back to an endogenous lesion secondary to psychic pathology and which, in the specific case of bipolar disorder, can cause behaviours that at first may appear to be a primary damaging cause, in this case hypersexuality, but which, upon closer examination, are actually the epiphenomenon of a

psychic pathology.

The identification of psychic pathology as the primary cause allows to start an evidence-based psycho-educational intervention aimed at resolving the origin of the disease state, and to make the patient aware of the symptoms of the disease by intervening with psychotherapeutic procedures aimed at processing the trauma. The identification of the primary pathology may be further complicated by the fact that behaviors caused by the psychic symptomatology put these subjects at risk of becoming victims of abuse phenomena. Therefore, it is necessary to correctly delineate the roles in order to understand the dynamics and promptly insert the subjects into the correct therapeutic pathways (Carabellese et al., 2008; Kjærulff, Bonde, & Astrup, 2019).

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