Vol. 6, No. 1, (2025), 65-81
© 2025, Spring
***Published online* March, 2025**

Journal of Preventive Counseling (JPC)

The Effectiveness of Intervention Based on Coping with Emotional Failure in Promoting Distress Tolerance of Bipolar Patients

DOI: 10.22098/JPC.2025.14956.1227

Roya Rezapur[1]; Nasser Abbasi[2*]

1. Assistant Professor of Clinical Psychology, Faculty of Medicine, Islamic Azad University, Zanjan Branch, Zanjan, Iran.
2 PhD Student in Counseling, Faculty of Educational Sciences and Psychology, University of Mohaghegh Ardabili, Ardabil, Iran. Corresponding Author: naser241@gmail.com

Abstract

Aim: The experience of failure and rejection of emotional relationships is considered a traumatic and fundamental problem in patients with bipolar disorder. This study aimed to investigate the effectiveness of intervention based on coping with emotional failure in promoting distress tolerance of bipolar patients.

Method: The present study was quasi-experimental with a pre-test/post-test design and follow-up with a control group. The study population included all patients with bipolar disorder in Zanjan City in 2022 among them, 30 people were selected by convenience sampling, and they were randomly divided into experimental and control groups after matching based on demographic variables. The Experimental group received 10 1-hour sessions of the protocol of coping with love trauma, and the control group did not receive training. The questionnaires on distress tolerance assessed the participants in three stages: pre-test, post-test, and follow-up (Simons & Gaher, 2005). Data were analyzed by ANOVA with repeated measure test.

Result: The results showed the effectiveness of the intervention based on coping with emotional failure in increasing the distress tolerance of the experimental group compared to the control group in the post-test and follow-up stages ($P < 0.01$).

Conclusion: The present protocol can facilitate the process of coping with emotional failure and managing its consequences by dealing with transdiagnostic factors such as emotional avoidance, rumination, and other factors. In addition to reducing the likelihood of recurrence or exacerbation of the disorder, it can be used as one of the adjuvant, supportive, and rehabilitation interventions along with drug therapies to rehabilitate and improve their quality of life.

Keywords: Emotional Failure; Distress Tolerance; Bipolar Patients.

Introduction

Bipolar disorder, with a high risk of mortality, has been considered the seventh leading cause of disability worldwide (Arici et al., 2018), with one-third of bipolar patients attempting suicide at least once (Goodwin et al., 2016). To diagnose the first type of this disorder, it is necessary to have at least one manic episode (a distinct period during which mood is abnormally and persistently elevated, expansive, or irritable, and there is an increase in energy or activity) before or after major depressive episodes in a person's lifetime (American Psychiatric Association, 2013). The prevalence of type I bipolar disorder is reported to be 4% in the general population and 21 to 26% in specialized care settings (Luu & Rodway, 2018). Functional impairment resulting from the disease during manic and depressive phases has been demonstrated in various studies (Bonnín et al., 2019; López-Villarreal et al., 2019). Models of bipolar disorder have emphasized the importance of emotion dysregulation in this disorder (Gruber, 2011), such that severe emotion dysregulation is considered a vital feature of this disorder associated with engaging in maladaptive or ineffective emotion regulation strategies (Gruber et al., 2012; Johnson et al., 2008). Research (Mathieu et al., 2015; M'bailara et al., 2015) has shown that individuals with bipolar disorder have higher emotional reactivity compared to normal individuals due to reactivity to stress-inducing life events. Matilla et al. (2010) found that emotional dysregulation negatively affects psychological and emotional well-being and is a risk factor for individuals developing psychological problems and emotional distress because emotional dysregulation dysfunction leads to reduced tolerance for distress.

Considering the problems and challenges of today's life, the ability to use skills to cope with these challenges is essential, and one of these skills is distress tolerance. It refers to an individual's ability to experience and tolerate negative emotional states (Simons & Gaher,2005) or behavioral capacity for maintaining goal-directed behavior during emotional distress (MacKillop & De Wit,2013). It has a multidimensional nature, including dimensions such as tolerance capability assessment and acceptance capacity for emotional states regulation mode by the individual and the amount of attention absorption by negative emotions and its share in causing dysfunction (Tusiani-Eng & Yeomans, 2018). Individuals with low distress tolerance describe experiencing emotional turmoil as intolerable; they evaluate emotional turmoil as unacceptable; they try to alleviate negative emotional states and are unable to focus their attention on anything other than their feelings of distress (O'Cleirigh et al.,2007). These individuals demonstrate weaker coping abilities against distress from themselves and, therefore, try to avoid these emotions by employing strategies aimed at reducing negative emotional states (Mitchell et al., 2013). Simons and Gaher (2005) explained that individuals with low distress tolerance are more attracted to negative emotions and less attracted to positive emotions. The attention of these individuals is more drawn towards negative emotions, which leads them towards severe estimation of these emotions and faulty evaluation, which itself results in decreased performance in managing emotions and tolerating these emotions. Ultimately, this leads to disruption in their personal and social functioning.

In the clinical description of individuals with bipolar disorder, multiple conflicts have been observed in behavioral, cognitive, affective, and interpersonal domains, leading to

personal, familial, and social consequences for them (Whipple & Fowler, 2011). Most research has shown that these characteristics lead to the emergence of maladaptive communication behaviors in individuals (Vanheule et al., 2007). In addition, clinical experiences show that people with bipolar disorder engage in behaviors that cause problems in their interpersonal relationships due to intense emotional reactions, explosive anger, and failure to understand social signals (negative and biased interpretation of other people's feelings) (Sharp et al., 2011). Smyth et al. (2020) showed that adolescent and young bipolar patients experience continuous and simultaneous challenges in managing symptoms, maintaining social functioning, and simultaneous changes in family and romantic relationships, which cause them to receive minimal social support. This issue is important because for many people, especially young people, romantic relationships can be essential aspects of identity, a source of intimacy, social status, and emotional security (Sailor, 2013). However, one of the most painful events individuals can experience is the end of a romantic relationship. Emotional failure involves a set of severe signs and symptoms that appear after a long-term romantic relationship ends, disrupting the individual's performance in various academic, social, and occupational areas and leading to maladaptive reactions (Rosse, 2007). The desirable expectations of the individual from the relationship and their assumptions about relationship safety are affected and experienced as severe stress that is damaging with psychological, emotional, and physical distress (Dehghani et al., 2011). Research results show that marriage and relationship dissolution have been identified as significant life events that can have various adverse outcomes, including mood disorders and complex grief symptoms (Sailor, 2013).

Bipolar disorder is disabling due to its early onset, severity, and chronicity. Supportive and therapeutic resources must move towards improving the coverage of evidence-based intervention strategies for bipolar disorder, developing solutions to prevent new cases of the disorder, and reducing the disease burden. Therefore, research and exploration into effective psychological interventions to assist these patients must continue. However, a major gap in current intervention protocols and educational programs can be seen as inadequate attention to the significance of emotional failures. Emotional failure acts as a background, perpetuating and exacerbating factor leading to delays in the recovery process and recurrence of bipolar disorder (Sewall et al., 2020).

On the other hand, instability in relationships, as well as mood instability and emotional dysregulation issues, are considered among the most important features of this disorder (Brissos et al., 2008). Nevertheless, limited research has been conducted on romantic breakup, which has a close relationship with mood instability and emotional dysregulation (Smyth et al., 2021). Since experiences of failure and rejection are viewed as traumatic experiences and fundamental challenges in individuals with bipolar disorder leading to disease relapse (Rezapur et al., 2021); Therefore, the current study seeks to answer the question, is the intervention based on coping with emotional failure effective in increasing the distress tolerance of bipolar patients?

Methods

The present study was a quasi-experimental study with a pretest-posttest design followed by follow-up with an experimental group. The research population included all individuals with bipolar disorder referred to hospitals and psychology clinics in Zanjan city in 2022. Based on Cohen's table, at a 95% confidence level, the effect size of .50 and test power of .80, 15 individuals were determined for each group. So, 30 people, including 17 women and 13 men, were selected based on inclusion criteria using the convenience sampling method After matching based on demographic variables such as gender, education level, and age, they were randomly assigned into two groups: an experimental group and a control group. The inclusion criteria were: 1- End of a romantic relationship within three months to one year ago; 2- Age range between 19 to 38 years old; 3-Not receiving other psychotherapeutic interventions simultaneously. The exclusion criteria were: 1- Substance abuse disorder; 2- Current suicidal risk; 3- History of moderate to severe learning difficulties or disabilities; 4- Acute physical illness; 5- Presence of other mental disorders or comorbidities.
The tools used in this study included:

Distress Tolerance Scale

This scale is a self-report measure of emotional distress tolerance developed by Simons and Gaher (2005). The items of this scale assess attention to negative emotions when they occur and regulatory actions to alleviate distress. This scale consists of 15 items and four subscales named Tolerance (emotional distress tolerance with items 1, 3, and 5), Absorption (absorption in negative emotions with items 2, 4, and 15), Appraisal (cognitive appraisal of distress with items 6, 7, 9, 10, 11, and 12), and Regulation (regulation of efforts to alleviate distress with items 8, 13, and 14). The items on this scale are scored based on a five-point Likert scale (1- strongly agree, 2- somewhat agree, 3- neither agree nor disagree, 4- somewhat disagree, and 5- strongly disagree). Higher scores on this scale indicate higher distress tolerance. The alpha coefficients for these subscales are obtained as .70, .72, .78, and .82, respectively. The intra-class correlation after six months for the total scale was .82. It was also found that this scale has good criterion validity and initial convergent validity. This scale has a positive relationship with acceptance mood but has a negative relationship with coping strategies scales using alcohol and marijuana for improvement (Simons & Gaher,2005). In the study by Esmaili Nasab et al. (2014), the Cronbach's alpha for the total scale was found to be .86. Shams et al. (2010) also reported the Cronbach's alpha reliability of this questionnaire as .67 and reported the retest reliability as .79. Also, the validity of the questionnaire was calculated by the Cronbach's alpha method of 0.91 in a study by Amini et al. (2018).

Emotional Failure Coping Protocol

This protocol was developed by Rezapur et al. (2021), which is implemented in 10 sessions and is based on Acceptance and Commitment Therapy (ACT), Cognitive-Behavioral Therapy (CBT), and Dialectical Behavior Therapy (DBT) approaches. It focuses on mindfulness, self-soothing techniques, acceptance, emotional awareness,

emotion regulation, emotional confrontation, opposite action, disengagement (observing and distancing oneself from thoughts), and cognitive flexibility. The sessions are described in Table 1.

Table 1. The structure and content of the emotional failure coping protocol sessions

Session number	Topic	Content
1	Introduction and recognition of emotion	Introduction of the instructor and familiarization of participants with each other and increasing motivation, stating the principles and regulations of sessions, presenting therapeutic logic and setting goals, familiarity with emotions, the necessity of regulating emotions, recognizing emotions and tracking emotional experiences, conducting pre-tests
2	Creating emotional awareness	Reviewing the assignment of the previous session, teaching emotional awareness, learning to observe emotional experiences (emotions and reactions to emotions) using mindfulness techniques.
3	Familiarity with avoidance strategies	Reviewing the assignment of the previous session, identifying the patterns of avoiding emotions, getting familiar with different strategies of avoiding emotions and their effects on emotional experiences, and finding out about the contradictory effects of avoiding emotions.
4	Emotional exposure through mental imagery	Reviewing the assignment of the previous session, getting familiar with emotional exposure based on verbal imagery and its stages
5	Visceral exposure to excitement	Reviewing the assignments of the previous session, awareness and tolerance of physical feelings; Increasing awareness of the role of physical feelings in emotional experiences
6	situational encounter with excitement	Reviewing the assignments of the previous session, getting familiar with situation-based emotional exposure, three stages and its necessity, obstacles to exposure

7	opposite action	Reviewing the assignments of the previous session, getting familiar with the opposite action, its applications, emotion-based behavior and emotion communicators
8	cognitive flexibility (1)	Reviewing the assignment of the previous session, getting familiar with cognitive flexibility, its necessity and stages, cognitive flexibility with negative predictions, low estimation of the ability to cope
9	cognitive flexibility (2)	Reviewing the assignment of the previous session, focusing on negative aspects, negative attributions and musts
10	Interpersonal effectiveness	Reviewing the assignments of the previous session, getting familiar with interpersonal effectiveness and its necessity, conducting pre-tests

Among individuals diagnosed with bipolar disorder attending hospitals and psychology clinics in Zanjan city in the year 2022, a total of 30 individuals were selected as research samples based on psychiatrist diagnosis criteria. After matching based on demographic variables, they were randomly placed in two experimental and control groups. The experimental group received training in emotional breakdown coping protocol for 10 sessions, each lasting sixty minutes, while the control group did not receive any training during this period (After the mentioned intervention was completed, it was implemented for control group members). Both groups were assessed using the Distress Tolerance Scale (Simons & Gaher, 2005) in three stages: pre-test, post-test, and follow-up (one month).

The main concern was maintaining confidentiality, including that all assessment results collected from individual participants, which may somehow relate to personal or family issues of participants in both experimental and control groups and could create a conflict of interest, remained confidential and not mentioned in reports. All participant names were converted into random codes to avoid future ethical issues. Furthermore, all participants from both groups were fully explained verbally and written about the study process (to the extent that does not lead to participant bias). After obtaining their consent, agreement forms were received from all participants in both experimental control groups. Descriptive statistical tests were used to report the demographic data. Outliers were checked using a boxplot, which did not show any cases. In the inferential statistics and hypothesis testing section, the data were analyzed using ANOVA with one repeated measurement and LSD post hoc test. Before that, Shapiro-Wilk and Mauchly's Test of Sphericity was used to check the normality and homogeneity of variance of the difference in groups as the prerequisites.

Results

In Table 2, the information related to the demographic variables of gender, age, education, marital status, occupation, and age of the two experimental and control groups is presented separately.

Table 2. Frequency distribution of participants based on gender, education, marital status, occupation and age

Variable		Group	
		Experiment	Control
Gender	Male	6 (%40)	7 (%46.66)
	Female	9 (%60)	8 (%53.34)
	Total	15 (%100)	15 (%100)
Education	Diploma	8 (%53.34)	7 (%46.66)
	BA	4 (%26.66)	6 (%40)
	MA	3 (%20)	2 (%13.34)
	Total	15 (%100)	15 (%100)
Marital status	Single	9 (%60)	11 (%73.34)
	Married	4 (%26.66)	3 (%20)
	Divorced	2 (%13.34)	1 (%66.66)
	Total	15 (%100)	15 (%100)
Occupation	Unemployed	10 (%66.67)	11 (%73.34)
	Employed	5 (%33.33)	4 (%26.66)
	Total	15 (%100)	15 (%100)
Age		Mean (std deviation)	Mean (std deviation)
		28.67 (4.48)	28 (5.09)

The mean and standard deviation of the age variable in the experimental group were 28.67 and 4.48, respectively, while in the control group, they were 28.28 and 5.09, respectively. Descriptive statistics of research participants in variables of distress tolerance and their components separated by experimental and control groups are presented in Table 3.

Table 3. The mean and standard deviation of the distress tolerance variable and its components in the pre-test, post-test and follow-up stages in both experimental and control groups

variables		group	pre-test		post-test		follow-up	
			mean	Standard deviation	mean	Standard deviation	mean	Standard deviation
Distress Tolerance		experiment	27.60	3.24	45.26	1.98	53.27	2.57
		control	28.20	2.11	29.93	2.52	30.80	2.48
Components of Distress Tolerance	Tolerance	experiment	5.27	0.88	8.67	1.29	10.93	1.28
		control	6.53	1.12	4.93	0.59	6.07	0.45
	Absorption	experiment	5.47	1.24	9.60	1.05	10.33	1.63
		control	6.13	1.59	6.13	0.91	6.73	1.38
	Appraisal	experiment	11.33	1.87	18.33	1.91	21.80	1.74
		control	10.53	1.35	12.40	1.88	11.87	1.35
	Regulation	experiment	5.73	1.22	8.66	1.17	10.20	1.61
		control	5.07	0.59	6.47	1.30	6.13	1.35

The results in Table 3 indicated a significant difference between the experimental and control groups in the distress tolerance variable and its four components at the post-test and follow-up stages. The assumptions for parametric tests were examined to investigate the meaningfulness of these changes. One of the assumptions for comparing means is the normality of score distributions in sample groups within the population, for which the Shapiro-Wilk test was used, with results presented in Table 4.

Table 4 Tests of Normality (Shapiro-Wilk)

variables		group	statistic	df	Sig.
Distress Tolerance		experiment	0.954	15	0.591
		control	0.958	15	0.662
Components of Distress Tolerance	Tolerance	experiment	0.888	15	0.063
		control	0.905	15	0.113
	Absorption	experiment	0.908	15	0.126
		control	0.913	15	0.150
	Appraisal	experiment	0.915	15	0.163
		control	0.938	15	0.362
	Regulation	experiment	0.898	15	0.090
		control	0.898	15	0.090

The results in Table 4 showed that the significance level of variables was greater than 0.05, indicating the normality of data distribution in these variables. Since both intervention for the experimental group and time variable were used, a repeated measures. The homogeneity of variances of the difference among the groups, investigated by Mochli's sphericity test. (Table 5).

Table 5 Mauchly's Test of Sphericity

variables		Mauchly's W	Approx. chi-square	df	Sig.	Greenhouse-Geisser
Distress Tolerance		0.85	4.13	2	0.12	0.87
Components of Distress Tolerance	Tolerance	0.96	1.1	2	0.57	0.96
	Absorption	0.79	6.27	2	0.04	0.82
	Appraisal	0.99	0.042	2	0.97	0.99
	Regulation	0.86	3.8	2	0.14	0.88

The results from Mauchly's test indicated that the sphericity assumption is met for the distress tolerance variable and its components, appraisal, and regulation ($P>0.05$), but not for the absorption variable ($P<0.05$). The Greenhouse-Geisser estimation method was used for the absorption variable to conduct the F-test. After checking the normality and homogeneity of covariances, a repeated measures ANOVA with one measurement factor

was performed on experimental and control groups at three stages: pre-test, post-test, and follow-up, with results presented below.

Table 6. The between-subjects effects obtained from the analysis of variance with repeated measurements on the mean of the distress tolerance variable and its components in the experimental and control groups

variables		Sum of Squares	df	Mean Square	F	P	Partial Eta squared
Distress Tolerance		2092.06	2	1046.03	180.99	0.001	0.86
Components of Distress Tolerance	Tolerance	149.75	2	79.87	77.59	0.001	0.73
	Absorption	88.26	1.65	53.28	28.34	0.001	0.50
	Appraisal	314.42	2	157.45	53.22	0.001	0.65
	Regulation	43.48	2	21.74	13.41	0.001	0.32

Based on Table 6, it can be concluded that there is a significant difference between experimental and control groups in the distress tolerance variable and its components tolerance, appraisal, absorption, and regulation at a significance level of 0.01.

Table 7. The within-subject effects of the analysis of variance on the mean of the distress tolerance variable and its components in the experimental and control groups

variables	source	SS	df	MS	F	P
Distress Tolerance	Time	2996.26	1	2996.26	416.42	0.001
	Time* group	1995.26	1	1995.26	277.3	0.001
	Error	201.46	28	7.19		
Tolerance	Time	101.4	1	101.4	103.11	0.001
	Time* group	141.06	1	141.06	143.45	0.001
	Error	27.53	28	0.98		
Absorption	Time	112.06	1	112.06	50.07	0.001
	Time* group	68.26	1	68.26	30.5	0.001
	Error	62.66	28	2.23		
Appraisal	Time	522.1	1	522.1	183.82	0.001
	Time* group	312.81	1	312.81	110.12	0.001
	Error	73.59	28	2.84		
Regulation	Time	114.81	1	114.81	74.18	0.001
	Time* group	43.35	1	43.35	28.01	0.001
	Error	43.33	28	1.54		

Additionally, as shown in Table 7, based on the analysis of variance with repeated measurements there was a significant time interaction effect within groups for the distress tolerance variable and its four components ($P<0.01$). Therefore, after finding significant differences between experimental and control groups at pre-test, post-test, and follow-up stages, post-hoc tests were conducted (Table 8).

Table 8 The results of the LSD post hoc test between the experimental group and the control group on the mean of the variables

variables	Test	Mean difference	Std. deviation	Sig.
Distress Tolerance	Pre-test	-0.6	1.01	0.295
	Post-test	15.33	0.82	0.001
	Follow-up	22.47	0.92	0.001
Tolerance	Pre-test	-1.26	0.37	0.393
	Post-test	3.74	3.73	0.001
	Follow-up	4.86	4.86	0.001
Absorption	Pre-test	-0.66	0.52	0.476
	Post-test	3.47	0.36	0.001
	Follow-up	3.6	0.55	0.001
Appraisal	Pre-test	0.8	0.59	0.44
	Post-test	5.93	0.69	0.001
	Follow-up	9.93	0.57	0.001
Regulation	Pre-test	0.66	0.35	0.68
	Post-test	2.19	0.45	0.001
	Follow-up	۴/۰۷	0.54	0.001

According to the results from Table 8, it can be stated that there is a significant difference between experimental and control groups at the post-test and follow-up stages regarding the distress tolerance variable and its components: tolerance, appraisal, absorption, and regulation ($P<0.01$), indicating the effectiveness of training intervention in increasing distress tolerance. Moreover, significant differences at the follow-up stage suggest that educational intervention helps cope with emotional failure by enhancing distress tolerance components in the research sample over time.

Discussion and Conclusion

This study aimed to investigate the effectiveness of intervention based on coping with emotional failure in promoting distress tolerance of people with bipolar disorder. Data analysis revealed notable disparities in distress tolerance variables and their constituent elements—tolerance, absorption, appraisal, and regulation—between the experimental and control groups during the post-test and follow-up phases. These findings underscore the efficacy of the emotional failure coping protocol in augmenting distress tolerance among bipolars. Given that individuals diagnosed with bipolar disorder exhibit behaviors that lead to challenges in their social interactions because of heightened emotional responses, outbursts of anger, and difficulties in interpreting social cues, including a tendency towards negative and distorted perceptions of others' emotions (Sharp et al.,

2011), the findings of this study are innovative because it is based on a protocol that is relational in nature and is effectivein increasing the distress tolerance of bipolar patients by focusing on coping with emotional failure. However, in terms of facilitating the management of negative emotions and providing supportive resources for individuals, which can create a basis for increasing distress tolerance, the findings are consistent with the results of Jackson [a1] (2019), Trompetter et al. (2017), Kemper et al. (2015), Zeller et al. (2015), and Pidgeon et al. (2014).

Negative emotions and situations that trigger them lead individuals to seek relief from them. Effective emotion management, when an individual is in psychological distress, can reduce the risk of increased distress. It is believed that in the emotional breakdown coping protocol, which focuses on emotional awareness and regulation during its sessions, teaching emotion management and enhancing this ability can enable individuals to use appropriate coping strategies in high-distress situations such as situations involving stress and negative emotions like grief and sorrow. Thus, choosing effective coping strategies in cognitive, emotional, and behavioral dimensions influences the use of adaptive coping mechanisms, which can provide a basis for increasing distress tolerance. Training emotion regulation can play a significant role in reducing physical symptoms, anxiety, depression, and stress by making individuals aware of their positive and negative emotions.

Additionally, emotion regulation training due to having techniques such as emotional awareness, emotion acceptance, re-evaluation, and expressing emotions can moderate positive and negative emotions, leading to positive perceptions of oneself (Kuiper et al., 2009). Improving the ability to change conditions and accept and tolerate negative emotions can predict decreased psychological distress. Therefore, emotion regulation can lead to reduced management of negative emotions. Moreover, emotion regulation can influence how individuals choose adaptive coping strategies to reduce these emotions, ultimately providing a basis for increasing distress tolerance.

The mindfulness skills training within this protocol apparently promotes the observation and acceptance of emotional experiences without actively seeking to initiate changes. Individuals are encouraged to perceive their emotions as passing occurrences that do not necessitate incongruent behaviors and responses. This broad perspective on emotions prevents the re-experiencing of emotional reactions, thereby playing a crucial role in enhancing distress tolerance. Furthermore, focusing on the interpersonal effectiveness component by discussing the advantages of positive connections with others and strategies to enhance these relationships can have twofold benefits. Firstly, it can improve individual relationships and mitigate feelings of isolation. Secondly, it can lead to greater social support, making individuals more patient and compassionate towards others, with a non-judgmental attitude. This approach can foster a more positive self-image and lay the groundwork for enhancing distress tolerance.

Moreover, this protocol emphasizes acknowledging reality and paying attention to the here and now, avoiding overlooking or exaggerating various issues. This approach diminishes individuals' tendency to magnify problems, enabling them to perceive

problems realistically rather than through distorted lenses shaped by different circumstances. So, by gaining a clear understanding and realistic perspective of issues rather than overlooking them, one can adopt a more positive outlook and a hopeful attitude toward life. This can motivate people to gently encourage themselves to change and adjust harmful or undesirable behaviors.

The study encountered several limitations, including convenience sampling instead of random sampling to select individuals for the experimental and control groups. Time and location limitations, along with challenges in patient follow-up, exercise performance, and transportation to the clinic, further impacted the research. To address these issues in future studies, it is suggested to employ random sampling methods, expand the geographic and participant scope, and provide neutral counseling sessions for the control group to minimize expectancy effects.

Disclosure Statements

On behalf of all authors, the corresponding author states that there is no conflict of interest.

ORCID

0000-0002-1313-9939

References

American Psychiatric Association.(2013). Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR). Washington, D.C.: American Psychiatric Association Publication, USA.

Arici, C., Cremaschi, L., Dobrea, C., Vismara, M., Grancini, B., Benatti, B., ... & Dell'Osso, B. (2018). Differentiating multiple vs single lifetime suicide attempters with bipolar disorders: A retrospective study. Comprehensive Psychiatry, 80, 214-222. https://doi.org/10.1016/j.comppsych.2017.10.006

Bonnín, C. M., Jiménez, E., Solé, B., Torrent, C., Radua, J., Reinares, M., ... & Vieta, E. (2019). Lifetime psychotic symptoms, subthreshold depression, and cognitive impairment as barriers to functional recovery in patients with bipolar disorder. Journal of Clinical Medicine, 8(7), 1046. https://doi.org/10.3390/jcm8071046

Brissos, S., Dias, V. V., & Kapczinski, F. (2008). Cognitive performance and quality of life in bipolar disorder. The Canadian journal of psychiatry, 53(8), 517-524. https://doi.org/10.1177/0706743708053008

Dehghani, M., Atef-Vahid, M. K., & Gharaee, B. (2011). Efficacy of short–term anxiety-regulating psychotherapy on love trauma syndrome. Iranian Journal of psychiatry and behavioral sciences, 5(2), 18. PMID: 24644443

Esmaeilinasab M, Andami Khoshk A, Azarmi H, Samar Rakhi A. (2014). The Predicting Role of Difficulties in Emotion Regulation and Distress Tolerance in Students' Addiction Potential . etiadpajohi; 8 (29) :49-63 http://etiadpajohi.ir/article-1-607-en.html

Faravani, R., Amini, N., Deyreh, E., & Shafiabadi, A. (2019). Structural Equation Modeling Prediction Addiction Potential Based on Independence/Incompetence Schema and Distress Tolerance with Mediation of Brain-Behavior Systems Among Students in Karaj. Counseling Culture and Psychotherapy Quarterly,10(38), 31-58. https://doi.org/10.22054/qccpc.2019.37724.2021

Goodwin, G. M., Haddad, P. M., Ferrier, I. N., Aronson, J. K., Barnes, T. R. H., Cipriani, A., ... & Holmes, E. A. (2016). Evidence-based guidelines for treating bipolar disorder: revised third edition recommendations from the British Association for Psychopharmacology. Journal of Psychopharmacology, 30(6), 495–553. https://doi.org/10.1177/0269881116636545

Gruber, J. (2011). Can feeling too good be bad? Positive emotion persistence (PEP) in bipolar disorder. Current Directions in Psychological Science, 20(4), 217–221. https://doi.org/10.1177/0963721411414632

Gruber, J., Harvey, A. G., & Gross, J. J. (2012). When trying is not enough: Emotion regulation and the effort–success gap in bipolar disorder. Emotion, 12(5), 997. https://doi.org/10.1037/a0026822

Jackson, J. (2019). Commentary: Optimism and distress tolerance in the social adjustment of nurses: examining resilience as a mediator and gender as a moderator. Journal of Research in Nursing, 24(7), 513–514. https://doi.org/10.1177/1744987119839539

Johnson, S. L., McKenzie, G., & McMurrich, S. (2008). Ruminative responses to negative and positive affect among students diagnosed with bipolar disorder and major depressive disorder. Cognitive Therapy and Research, 32(5), 702–713. https://doi.org/10.1007/s10608-007-9158-6

Kemper, K. J., Mo, X., & Khayat, R. (2015). Are mindfulness and self-compassion associated with sleep and resilience in health professionals? The Journal of Alternative and Complementary Medicine, 21(8), 496-503. https://doi.org/10.1089/acm.2014.0281

Kuiper, N. A., McKee, M., Kazarian, S. S., & Olinger, J. L. (2000). Social perceptions in psychiatric inpatients: Relation to positive and negative affect levels. Personality and Individual Differences, 29(3), 479–493. https://doi.org/10.1016/S0191-8869(99)00209-3

López-Villarreal, A., Sánchez-Morla, E. M., Jiménez-López, E., Martínez-Vizcaíno, V., Aparicio, A. I., Mateo-Sotos, J., ... & Santos, J. L. (2019). Progression of the functional deficit in a group of patients with bipolar disorder: a cluster analysis based on longitudinal data. European Archives of Psychiatry and Clinical Neuroscience, 1-11. https://doi.org/10.1007/s00406-019-01050-9

Luu, B., & Rodway, G. (2018). Lithium therapy for bipolar disorder. The Journal for Nurse Practitioners, 14(2), 93–99. https://doi.org/10.1016/j.nurpra.2017.09.025

MacKillop, J., & De Wit, H. (Eds.). (2013). The Wiley-Blackwell handbook of addiction psychopharmacology. John Wiley & Sons.

Mathieu, F., Etain, B., Dizier, M. H., Lajnef, M., Lathrop, M., Cabon, C., ... & Bellivier, F. (2015). Genetics of emotional reactivity in bipolar disorders. Journal of Affective Disorders, 188, 101-106. https://doi.org/10.1016/j.jad.2015.08.037

Mattila, A. K., Luutonen, S., Ylinen, M., Salokangas, R. K., & Joukamaa, M. (2010). Alexithymia, human relationships, and mobile phone use. The Journal of nervous and mental disease, 198(10), 722-727.

. https://doi.org/ 10.1097/NMD.0b013e3181f4ab50

M'bailara, K., Desage, A., Zanouy, L., Minois, I., Bouteloux, M., Jutant, A., ... & Henry, C. (2015). Emotional reactivity in euthymic bipolar patients: two emotional dysregulation profiles associated with impaired functioning. Bipolar Disorders, 17. https://doi.org/ 10.1016/j.encep.2008.06.015

Mitchell, P. B., Slade, T., & Andrews, G. (2004). Twelve-month prevalence and disability of DSM-IV bipolar disorder in an Australian general population survey. Psychological Medicine, 34(5), 777. https://doi.org/10.1017/S0033291703001636

O'Cleirigh, C., Ironson, G., & Smits, J. A. (2007). Does distress tolerance moderate the impact of major life events on psychosocial variables and behaviors important in the management of HIV? Behavior therapy, 38(3), 314–323. https://doi.org/10.1016/j.beth.2006.11.001

Pidgeon, A. M., Ford, L., & Klaassen, F. (2014). Evaluating the effectiveness of enhancing resilience in human service professionals using a retreat-based Mindfulness with Metta Training Program: a randomized control trial. Psychology, health & medicine, 19(3), 355-364. https://doi.org/10.1080/13548506.2013.806815

Rezapur, R., Vaziri, S., Lotfi Kashani, F., & Zakeri, M. (2021). Emotional Failure Coping Protocol. Unpublished.

Rezapur, Roya, Shahram Vaziri and Farah Lotfi Kashani. "The Role of Romantic Breakup in Increasing Vulnerability to Emotional Disorders: A Systematic Review." Clin Schizophr Relat Psychoses 15(2021). https://doi.org/ 10.3371/CSRP.RRSV.091521.

Rosse, R. B. (2007). The love trauma syndrome: free yourself from the pain of a broken heart. Da Capo Lifelong Books.

Sailor, J. L. (2013). A Phenomenological Study of Falling Out of Romantic Love. The Qualitative Report, 18(19), 1-22. https://doi.org/10.46743/2160-3715/2013.1521

Shamsh, J., Aziz, A., & Mirzaei, A. (2010). Correlation between Distress Tolerance and Emotional Regulation With Students Smoking Dependence. Hakim Research Journal 2010 13(1): 11- 18.. https://sid.ir/paper/29476/en

Sharp, C., Pane, H., Ha, C., Venta, A., Patel, A. B., Sturek, J., & Fonagy, P. (2011). Theory of mind and emotion regulation difficulties in adolescents with borderline traits. Journal of the American Academy of Child & Adolescent Psychiatry, 50(6), 563-573. https://doi.org/10.1016/j.jaac.2011.01.017

Simons, J. S., & Gaher, R. M. (2005). The Distress Tolerance Scale: Development and validation of a self-report measure. Motivation and Emotion, 29(2), 83–102. https://doi.org/10.1007/s11031-005-7955-3

Smyth, K., Salloum, A., & Herring, J. (2020). Interpersonal functioning, support, and change in early-onset bipolar disorder: a transcendental phenomenological study of

emerging adults. Journal of Mental Health, pp. 1–8. https://doi.org/10.1080/09638237.2020.1713997

Sewall, C. J. R., Goldstein, T. R., Salk, R. H., Merranko, J., Gill, M. K., Strober, M., ... & Birmaher, B. (2020). Interpersonal relationships and suicidal ideation in youth with bipolar disorder. Archives of Suicide Research, 24(2), 236-250. https://doi.org/10.1080/13811118.2019.1616018

Trompetter, H.R., de Kleine, E. & Bohlmeijer, E.T. Why Does Positive Mental Health Buffer Against Psychopathology? An Exploratory Study on Self-Compassion as a Resilience Mechanism and Adaptive Emotion Regulation Strategy. Cogn Ther Res 41, 459–468 (2017). https://doi.org/10.1007/s10608-016-9774-0

Tusiani-Eng, P., & Yeomans, F. (2018). Borderline personality disorder: barriers to borderline personality disorder treatment and opportunities for advocacy. Psychiatric Clinics, 41(4), 695-709. https://doi.org/10.1016/j.psc.2018.07.006

Vanheule, S., Desmet, M., Meganck, R., & Bogaerts, S. (2007). Alexithymia and interpersonal problems. Journal of Clinical Psychology, 63(1), 109-117. https://doi.org/10.1002/jclp.20324

Vanheule, S., Desmet, M., Rosseel, Y., Verhaeghe, P., & Meganck, R. (2007). Relationship patterns in alexithymia: a study using the core conflictual relationship theme method. Psychopathology, 40(1), 14-21. https://doi.org/10.1159/000096385

Whipple, R., & Fowler, J. C. (2011). Affect, relationship schemas, and social cognition: Self-injuring borderline personality disorder inpatients. Psychoanalytic Psychology, 28(2), 183. https://doi.org/10.1037/a0023241

Zeller, M., Yuval, K., Nitzan-Assayag, Y., & Bernstein, A. (2015). Self-compassion in recovery following potentially traumatic stress: Longitudinal study of at-risk youth. Journal of Abnormal Child Psychology, 43(4), 645-653. https://doi.org/10.1007/s10802-014-9937-y