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CONSIDERATIONS ON ASSISTED RESILIENCE AND INDIVIDUALIZED THERAPY IN BIPOLAR AFFECTIVE DISORDER, WITH A CLINICAL CASE EXEMPLIFICATION

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Abstract

Morbidity, mortality and economic consequences of bipolar affective disorder are very important to be evaluated because many of the costs entailed by this psychiatric disorder come from indirect costs due to inadequate diagnosis and treatment and from the characteristics of the affective symptoms itself. Psychotherapy focuses on diagnosis and the newest pharmacotherapy determines a decreasing of the morbidity of the disorder and also of its social and economic burden . However, more studies are necessary, with more heterogeneous patients, to find more predictors regarding the psychosocial consequences and to find more information about the prognosis of the bipolar disorder.

In this context, in this paper we discuss the role of assisted resilience and the individualization of the therapy of bipolar affective disorder, especially that the resilience must be seen as a continuum and can be used anytime and in any situation, according to the theory of Geanellos. This idea is reflected in a case presentation of a patient with the diagnosis of bipolar disorder.

Keywords: bipolar disorder, affective symptoms, psychotherapy assisted resilience

The diagnosis, treatment and prognosis of the bipolar affective disorder are influenced by a series of factors, part of which are related to the environment. To many people, the affective disorder diagnosis is a stigma, which will make it hard for the patient to find a job, to be promoted, or obtain other social benefits. Moreover, they will find it hard to adapt to a job that implies frequent or sudden changes of the life style or frequent trips. The change in the sleep-wake rhythm, because of the sleep deprivation or international travels, the time zone changes, can favor the exacerbation of the affective symptoms of the manic, hypomanic or mixed episode. The side effects of the mood stabilizers, such as somnolence, will make it impossible for the patient to work, for example, in the constructions field, or with heavy equipment, or as a driver [1,2].

Untreated affective episodes, be they of the manic or the depressive type, determine an unfavorable prognosis and will affectthe subsequent response to treatment. Stressful life events determine relapses, manic episodes being favored by life events that, theoretically, have a positive impact [3]. A series of stressors determine a higher suicidal risk, namely [4]:

- The evolution of the disorder, the severity of the manic symptoms, early onset of the disorder and the frequency of relapses;
- Co-morbidities like anxiety or metabolic diseases;
- Functional status at a social, family or occupational level;
- The social support system, for example the death of a close person;
- Genetic factors, family history of suicide or drug abuse.

Like any chronic condition of long evolution, the bipolar affective disorders need a treatment similar to a recurrent medical condition, whose purpose is the

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remission of symptoms, the re-establishment of complete psycho-social functionality and the prevention of relapses. The main purpose of a therapeutic algorithm for the bipolar affective disorder is symptom remission, full social functioning and the prevention of recurrences and relapses [5,6]. Therapeutic guides must not be rigid or limitative, but they should rather aim at supporting patients and clinicians in choosing the best therapeutic strategies, with as fewer side effects, as possible. They will ensure flexibility in choosing therapeutic options, appropriate for each patient. The therapeutic decision must not be based, only on efficacy and tolerability, but also on the patients' history and even their preferences, but ensuring the best safety profile possible [7].

In this context, it is important to discuss the contribution of assisted resilience in psychiatry and especially in this mental disorder, which is so frequently found and so impairing, and also to discuss about the importance of the idea of individualized therapy. It is quite difficult to define the resilience concept, but in a general acceptance Prof. V. Rusu considers it to be the capacity of a person of turning up trumps, in a test that can be traumatic with renewed force [6]. Therefore, we will attempt to identify those internal or external aspects, that make the patients diagnosed with bipolar affective disorder and even their family members face and even overcome this new life situation, represented by the psychiatric disorder itself as well as its consequences.

One of the stages of the resilience process, in patients diagnosed with psychiatric disorders, is taking responsibility for the compulsory aspects of the treatment (Nascimento-Stieffatre, 2009) [8,9]. Along this line, the attitude of mental health professionals and of the wide public regarding the mood stabilizer medication used in the pharmacologic therapy of bipolar affective disorders and especially related to atypical antipsychotics is divergent. The reserved attitude towards this medication is created by the belief that its risks are higher than its benefits. For the therapy to succeed, it is important that patients and their families be as well informed as possible about this treatment. As it is a long-term treatment, many times patients also address their family physicians, and are also influenced by their opinion. Physicians generally show a more positive attitude related to the use of antipsychotics and their efficacy than the patients themselves [10,11]. They advise patients to tolerate the potential side effects of the medication for as long as possible. The capacity to anticipate, solve or tolerate these side effects plays an important role in educating patients and their family members. Patients are also exposed to the negative opinion of people around them, especially as a consequence of the side effects of antipsychotics [12,13]. Hence, it is very important that patients be as well informed as possible on the role of antipsychotics in the therapy of affective disorders, as well as on potential side effects. The side effects of atypical antipsychotics, such as extrapyramidal manifestations, also contribute to the non-compliance of patients with the treatment, because of the disabilities they generate. The patients' tolerance to the side effects is influenced by the nature of the physician-patient relationship and by the attitude of the prescribers of this medication and their capacity of involving patients in the therapeutic process. Though patients think that this medication has a high risk of creating addiction, 80% of the general practitioners know that antipsychotics cannot become addictive [14].

The new aspects of the therapeutic management, which involves the idea of therapeutic decision shared with the patient and a better evaluation and solution for the medication side effects, must ensure the education of people, in order to improve their perception on persons with psychiatric disorders in general, and of those with affective disorders in particular. A treatment initiated as early as possible, immediately after the first symptoms of the disorder will considerably reduce costs. It is more expensive not to treat it than to treat it. A study performed on 500 bipolar patients showed that, after the initiation of the treatment, financial and marital difficulties decreased the risk of self- and hetero-aggressiveness and alcohol and drug abuse became lower [15].

Very important in the same process of assisted resilience and the individualized therapy is the effort of improving the patients' capacities of recognizing prodromal signs, characteristic to relapses, which reduces considerably the rate of hospitalization. Thus, there are efforts of identifying affective episodes, before the full manifestation of the affective symptomatology, as over a quarter of the insight of euthymic patients is modified and they are incapable of identifying affective prodromes [16,17]. Furthermore, a great benefit is the early initiation of the Lithium based prophylaxis, during the first five years after the onset of the disorder, as after this period its efficacy will decrease, both in acute forms and as prophylactic therapy [18]. Premature death of bipolar patients is generated by suicide, especially in women, around the age of 25. Untreated patients with bipolar disorder lose nine years from their life expectancy, as a result of suicide, but with an appropriate treatment, life expectancy is extended beyond the age of 65 [19]. The suicidal risk is higher in the first five years after the onset of the affective symptomatology, and the delay in setting a diagnosis and an appropriate treatment will increase the mortality [20,21].

In the resilience creation process, we do not deal only with the management of symptoms in these patients, given that psychotherapy plays an important role, especially through psycho-educational measures, cognitive therapy or other structural therapies. Both studies related to psychosocial therapies and therapeutic guides support the idea of using psychotherapy as a therapeutic method adjuvant to the pharmacologic therapy. 40% of the patients with bipolar affective disorder experience relapse

in their first year, 60% in the second year and 73% in the following five years [22]. The association of psychotherapy and, especially of the psycho-educational measures, with the mood stabilizers will determine the reduction of the number of hospitalizations and of the incidence of relapses, the increase in the compliance with the treatment and the improvement of global symptomatology. Psychosocial interventions will help the patient regarding a series of problems related to the mental disorder, self-confidence and compliance with the treatment. It will also help the patient avoid stigmatization, have an appropriate sleep program and limit their access to different substances that can have negative influences on affectivity, based on information related to all these aspects of this psychiatric disorder [23].

The table below summarizes the positive effects of the psychosocial interventions, as therapies adjuvant to the medication, contributing to the assisted resilience process in bipolar patients [24]:

The positive effects of psychosocial interventions are:

Objectives	Strategies	Demonstrated efficacy
- helping patients and their families learn the symptomatology of this psychiatric disorder and its therapeutic management; - providing informative materials to enable the population's awareness; - helping patients visualize appropriately their self-image; - managing stress and ensuring a balanced life style.	- emphasizing the importance of the compliance with the treatment; - identifying the precipitating factors; - recognizing relapses early; - visualizing a realistic and true self-image; - regular life program.	- significant reduction of the number of relapses; - increased the time between relapses; - reduction of the frequency and duration of hospitalization; - improvement of the compliance with the treatment; - early identification of affective symptoms and early therapeutic intervention; - improvement of global functionality.

Case presentation

Taking into consideration all these aspects, in what follows we present a model of an individualized therapy, in a case of bipolar affective disorder. It is the case of a 44-year-old male patient, included in our psychiatric records in 1997, with the diagnosis "Bipolar affective disorder type I (manic-depressive psychosis)"; for the past two years he was admitted five times for affective episodes, especially of manic type (four of them), while the latest one, which needed hospitalization, was of the depressive type. After the improvement of the symptomatology, specific of the acute phase, the patient, in the phase of remission, participated in cognitive psychotherapy sessions, associated to maintenance pharmacotherapy (antidepressants plus mood stabilizers). The patient's personal diseases history is insignificant from the clinical point of view. The hereditary-collateral history reveals that his 20-years old son was diagnosed with "schizophrenia, paranoid type", in 2004. The onset of his latest affective episode was favored by the reduction of his compliance with the medication (the patient says he failed to take his treatment for approximately ten days, as he was very busy at work - he works as an engineer in a private construction company) - and by the association of psycho-traumatic factors, such as the risk of unemployment, generated by his frequent relapses that needed hospitalizations and a large number of medical leaves, his family's conflictual state, generated by financial problems and his son's disease.

The purpose of the first psychotherapy sessions was to educate the patient regarding the bipolar disorder, the characteristics of the treatment he needed to follow and the importance of the compliance with the treatment, the particularities of the affective symptoms, as well as their attentive monitoring.

Each psychotherapy session is structured. It begins by establishing an agenda specific to each session. At the end of each session, the patient was asked to summarize what he had understood from the session in question, and we agreed on the conclusions of the session.

The patient is helped to become aware of his own thoughts, about which he knows very little, so that he can analyze the extent to which these thoughts trigger and maintain his emotions and behaviors that make him suffer and that he wants to change. Therefore, he is explained how cognitive therapy can help him, when he is depressed or choleric, thinks in an illogical and systematically negative way and acts to his own detriment without realizing it. He will learn to identify and eliminate these negative thoughts, in order to be more productive. The patient is also explained that this disorder manifests by symptoms found in two different poles, one made of joy and the other one of sadness ("it opposes during the day the image of joy to the endless night of depression"). To illustrate the symptomatology of this disorder, we used the patient's previous experiences and he was provided with written informative material. In the following session, the patient's knowledge was evaluated and he was provided with the necessary clarifications.

I informed the patient of the physical, emotional, cognitive and behavioral symptoms, characterizing the manic and the depressive episode, as well as the characteristics of the euthymic state. The patient made a list of the main characteristics of each phase. We began with the presentation of the characteristics of the latest affective

(depressive) episode. This list was initiated during the psychotherapy session: for the depressive episode, he mentioned a decrease in his capacity to focus, for the manic episode, the feeling that his thoughts and ideas were too many and he could not deal with them, and for the euthymic state, the capacity of reading the newspaper daily and of successfully performing all his activities. He continued his list at home, as homework, with the help of his family and friends' feedback.

The patient was informed of the prodromes of the manic episode: the decrease of the need to sleep; irritability; exaggerated optimism; involvement in numerous activities; logorrhea; accelerated idea flow; increased sociability; distractibility, and the prodromes of the depressive episode: low interest in different activities; little communication with the people around; sadness; sleep disorders; increased tiredness; low concentration capacity; low motivation. For instance, an early sign of the manic episode is the fact that sometimes he finds the colors brighter, more vivid. These prodromes generally occur in a social context, like in the patient's case, which is why the patient's attendance of these psychotherapy sessions plays an important role in identifying and monitoring them. As homework, the patient made a graph of the daily evolution of the changes in his affective, cognitive and behavioral area and physical symptoms, which were evaluated, depending on certain daily activities: his capacity of watching his favorite TV show to the end, the performance of his proposed daily activities, medication administration.

In order to identify the behavioral and cognitive changes in the manic episode, the over-stimulating factors were evaluated, in order to limit their negative effect. Thus, I found out that almost every evening, before going to bed, the patient would talk on the telephone to his employees to establish the schedule for the following day. This determined the frequent emergence of his sleep disorders and the decrease in his need to sleep and a risk of manic decompensation. This way, we established the clear limits of the duration of his phone conversations, which must end at least one hour before bed, in order for the patient to be able to perform relaxing activities, without having the TV or radio on. As the patient expressed his worry that he might lose important ideas that he could communicate to his employees, he was advised to write down all his ideas. He was forbidden to perform his evening activities in the room where he sleeps and instead of telephone conversations, he should prefer the company of his family and making a list with activities for the following day.

After his dysfunctional thoughts were identified, cognitive restructuration was initiated, namely, the patient was instructed to use, as well as he could, his capacity of logical elaboration of cognitive answers. This activity was began together with the therapist and continued at home. He used a thought record sheet, which was completed between sessions, containing: the date, situation, emotions, associated dysfunctional thoughts, and possible rational thoughts. These were generated by teaching the patient to ask himself the following question: "What else could I think in situation X?" or "What else could I think in a similar situation?", "What else could someone else think in a similar situation?", "What did I use to think in a similar situation, before becoming depressive?"

The patient was taught to perform his activities according to a well established programme: for the prodromes of the manic episode, he was recommended to engage himself only in calm activities, to extend his resting hours, to reduce stimulating or exciting factors, to reduce the number of his activities; for the depressive episode: to occupy his time with an increasing number of activities, and subsequently make a plan for the performance of his activities at work.

The patient's evolution was favorable, meaning that his psychiatric disorder remission was consolidated, he increased his compliance with the treatment and the patient appreciated the importance of monitoring his own symptoms and solving psychosocial problems, thus consolidating a process of assisted resilience.

I presented this case and its therapeutic management with the purpose of highlighting the assisted resilience process in these situations and also the possibility to individualize the therapy, according with each case situation. The psycho-educational programmes approach the following aspects: educating patients, ensuring their education and access to specific organizations for an appropriate therapeutic management.

The organizations that offer care and support to patients and their families play an important role in the long-term management of the treatment of bipolar affective disorders in reducing the costs of the treatment and the burden of the family and community. These manners of organization will help the patient reintegrate in active productive life, especially for patients with a long evolution and frequent relapses [25].

Within the therapy for bipolar patients, all these roles must be shared by several family members and they should ask for the help of support groups of families and patients. The organizations support and information groups must participate in mental health programmes and influence governmental decisions. Therefore, a better co-operation between patients, their families, psychiatrists, family physicians, governmental agencies is desirable to improve the quality of the psychiatry services [26].

For the increase in the long-term efficiency of the therapy of psychiatric disorders in general, separate institutions were created for ambulatory, semi-ambulatory and hospital cares. For a long time, it was believed that by creating competition between the three types of facilities, the ambulatory would manage to limit the number of individuals who use the semi-ambulatory care system and both of them would limit the number of admissions

in the psychiatric hospital [27]. This way, the ambulatory unit could have functioned like a filter, allowing only severe cases use intramural facilities. Despite all these, the hospital institutions continued to do what they were doing before and even more, under the pressure of the others. As the semi-mural facilities develop too slowly, as an alternative to intramural care, the ambulatory and extramural centers were invaded not only by psychiatric patients with a diagnosis in compliance with the DSM/ICD, but especially by an increasing number of clients with psychosocial problems [28,29].

For the past eight or ten years, fusions have occurred between psychiatric hospitals, mental health centers, group homes etc. Nowadays, there are integrated mental health organizations that can deliver any care product to almost any place. These fusions happened for two reasons. The first is professional, in order to ensure the continuity of cares; the other is economic, offering the benefit to a large organization and several possibilities to decentralize its functions and place them closer to the population [30,31].

The interest in the economic aspects of the treatment of bipolar affective disorder is not only scientifically important, but it aims at improving different aspects of life quality. There is a series of prejudices related to patients with different psychiatric disorders, especially those with affective disorders, namely: the consequences of a psychiatric disorder are less harmful than those generated by somatic conditions; the consequences of psychic disorders are relatively fixed, with small possibilities of improvement; treatments are relatively inefficient, which is why social investments are very small [32]. Despite all these, social costs reflect in the decrease of the number of active days and the increase in the absence from work, productivity decrease, as well as costs associated with the legal system related to the aggressiveness risk. The elements whose costs are the hardest to evaluate are the reduction of the possibilities to complete one's education, divorces or family problems. The improvement of life quality must consider the identification of that priority group of patients whose life quality we will try to improve, in order to have higher social benefits. Therefore, we should not focus only on reducing affective symptomatology, because, from the point of view of patients or their family members, functional rehabilitation is much more important [33,34].

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