

PSYCHOSOCIAL INTERVENTION AS THE ADDITIONAL THERAPY FOR BIPOLAR AFFECTIVE DISORDER: A CASE REPORT

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SUMMARY

Psychosocial interventions have been shown to enhance pharmacotherapy outcomes in bipolar affective disorder (BAD). This article describes an application of psychosocial intervention as the additional therapy for BAD.

In this case report we present the course of illness, psychological features and specific chronic stress of a patient with BAD. Following the recent guidelines, we applied the pharmacotherapy together with an adjuvant psychosocial treatment (psycho-education, supportive and psychodynamic therapy). Psycho-education was used to inform patient and family members about the disorder, course of illness and treatment. Supportive therapy helped the patient to deal with her illness and deepened her understanding of her present problems. Psychodynamic psychotherapy was used to examine the meanings of unconscious conflicts and the ways the stressor activates the patient's deeply repressed traumatic experiences.

This case study indicates that psychosocial treatment applied as adjuvant therapy of pharmacotherapy in the treatment of BAD may result in symptom remission, improvement of life quality and illness relapse prevention.

Key words: bipolar affective disorder - psychosocial treatment model – psycho-education - supportive therapy - psychodynamic psychotherapy

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INTRODUCTION

Bipolar affective disorder (BAD) is defined by recurrent manic and depressive mood episodes. It is among the most common mental disorders. The World Health Organization has estimated that bipolar disorder is sixth leading cause of years lived with disability and historically it has been relatively under-researched. The disorder is caused by a complex interaction of biological and psychological factors that are often sensitive to changes in the environment (McDonald et al. 2005).

Recent studies point out to the polymorphisms of specific genes, disturbance of neurotransmission as well as thalamic and hippocampal dysfunction in the pathophysiology of BAD (Ng et al. 2008).

Connection between cerebral dysfunction and environmental stress was explained by several hypotheses (circadian dysregulation, cortisol dysregulation). Genetic vulnerability may moderate

individual responsiveness to stress (Mandell et al. 2007). Major life events are important triggers of both unipolar and bipolar disorder (Kim et al. 2007). Early losses, separation or other painful events may sensitize receptor sites in such a way that the ideas and images associated with depressive states could ultimately act as conditioned stimuli capable of eliciting a major depressive episode, even without actual loss or external stressor in the environment (Gabbard et al. 2007). Based on these findings, Psychiatric Management was placed together with psychopharmacotherapy in Practice Guideline for the Treatment of Patients with Bipolar Disorder (APA 2006). Pharmacological treatment is main and unavoidable in the therapy of bipolar disorder (Treuer et al. 2007).

Psychosocial interventions have been shown to enhance pharmacotherapy outcomes in bipolar disorder (Miklowitz et al. 2006). According to other authors, it is not clear if combined treatment

is advantageous in all cases. Some guidelines suggest that combined treatment is most appropriate for patients who have more chronic or complex disorder or who show less than full response to monotherapy (Gabbard et al. 2007). Combined medication and psychotherapy might increase the magnitude, probability, and breadth of response as well as enhance the acceptability of treatment. Different psychosocial strategies were recommended: cognitive-behavioral therapy (CBT), psychoeducation, family- focused therapy, interpersonal, social-rhythm therapy, supportive and dynamic-oriented psychotherapy. These psychotherapies could be combined or used separately (Miklowitz et al. 2007).

In our practice, in spite of the suggestions about integrative model for BAD treatment, pharmacotherapy is almost always used exclusively. According to recently recommended strategies, we have in this case applied combined therapeutic program, consisted of psychoeducation, supportive and psychodynamic therapy. Different psychosocial strategies are recommended for different phases of treatment. In the beginning, psychoeducation and supportive therapy was used to improve the patient's compliance. Psychoeducation was applied in four sessions, with the aim to inform the patient and her family members about the symptoms and treatment of the disorder and thus enhance the therapeutic compliance (Gabbard et al. 2007). Supportive technique was used in the second phase, during 15 sessions, with the aim to improve the patient's self-esteem and her cognitive and interpersonal processes, in order to prevent depressive or manic reactions to life events (Novalis et al. 2005). When symptoms disappeared, psychodynamic therapy was used to help the patient resolve the inner psychic conflicts and abandon the maladaptive defensive patterns. Psychodynamic therapy was applied in 30 sessions and is still going on.

The purpose of this case report is to illustrate the benefits of integral model of treatment, consisting of psychoeducative, supportive and psychodynamic approach together with psychopharmacotherapy, in the therapy of BAD. The patient gave her informed consent for publication of this case report.

CASE REPORT

Personal history

Vesna is 44 year old, married, mother of two children, B.Sc. in civil- engineer, employed as the head of department, the only child in her family. The father was dominant and cold figure; the mother didn't accept father's attitudes, so they often quarreled and Vesna felt upset about that. She was obedient and good child, born in a normal pregnancy. During adolescence there were no any behavioral disorders; sometimes she felt aggression toward her parents, but she would only rarely fight against her father's requirements and act rebelliously. She graduated high school with excellent marks and entered the faculty of civil engineering. After a few years relationship, at the end of her third year of study, she became pregnant and got married for her present husband. She gave birth to a daughter and continued to live in the apartment of her parents in Split, a city in the coastal part of Croatia. Her husband lived and worked on an island and so every weekend he would come to visit her or she would go to him. She took care of her daughter by herself until she graduated and moved into the house of her parents-in-law on the island, where, five years later, she gave birth to a son. Vesna's family and her parents-in-law lived there in two seemingly divided parts of the house, separated by a door that was never closed. When her daughter enrolled in the grammar school in Split, she went back to live there with her during the week, but commuted to the island to work. She was a hard-working person, but dissatisfied by the behavior of her colleges toward her. As an civil engineer working on the construction sites, she was often teased as a woman. She eventually changed the working post. At the new working post the situation was somewhat better. Often she would work overtime and, unwillingly, she would make conflicts with her colleges. She was promoted to the position of head of department, but only one engineer in the department was working with her, which was insufficient for needs of work. At about that time, her daughter finished the high school and moved to study in Zagreb, the capital of Croatia. At the same time Vesna's brother-in-law suffered from carci-

noma and died a year later. His son got psychotic disorder. During the third year of her daughter's studies, her boyfriend committed a suicide.

Clinical impressions

In her family, Vesna felt distant from her husband who is a closed and introvert person. They only discussed about the organization of their life. Talk about the problems was not allowed and everything was "swept under the carpet". Vesna was disturbed about it. She wanted to move somewhere else, actually to build a house far from his parents but he didn't support this idea. She worried a lot about emotional state of her daughter and went to Zagreb to find a psychotherapist for her daughter, although her daughter didn't ask it from her. Before her daughter started the psychotherapy, she herself had visited psychotherapist a few times. At the same time she used to complain to a friend of hers that she is not satisfied and is often tired. Although this friend noticed that she is getting depressive, Vesna rejected her suggestion to visit a doctor. She considered her problems to be normal – the most important was that her children were good and without problems, that at work and at home everything was "ok". She never thought or talked about herself or her feelings.

Data from the history of illness

First symptoms of the mental disorder appeared in September 2006. They were manifested as high excitement which escalated in December of the same year. She felt accelerated, hyperactive and suffered from lack of sleep. She easily communicated with others, which was opposite to her nature, started many jobs at the same time, and felt omnipotent. Paranoid delusions appeared - she thought that, due to her importance, she was followed and talked about. She felt that her behavior has changed but she did not care. Members of her family asked her to visit psychiatrist, which she did a few times. The psychiatrist suspected that she suffers from BAD, but she refused to take psychotropic drugs. In February 2007 she spent three weeks in hospital because of her manic state. The following month

she fell in a depressive state manifested by depressive mood, strong fear and anxiety. She became slow; introvert; she avoided people; rejected to communicate with family members. She was sad, unwilling and worried. She felt worthless, useless, incapable for any activity, with the fear of the future, thinking about financial and other disasters. She was hospitalized twice and treated with antidepressant, antipsychotic and mood stabilizer drugs (olanzepine, sertraline and lamotrigine). Despite the therapy and hospitalization the depressive state continued. Drugs doses were increased during third hospitalization but without results. She used to lie, mainly closed in the room, almost without any communication with family members. She was obsessed with the thoughts that there was no help for her, and she would never be better. Feelings of emptiness and annihilation dominated. After two months of struggling with depression she decided to commit suicide. She went in a field not far from her house, and cut both her wrists and neck with a knife. After she had done it, she felt strong fear and called her husband. She was taken into the hospital and her life was saved. Initially she was hospitalized in the Intensive Care Unit and then moved in to Psychiatry Department where she stayed for about one month. After being remitted from the hospital she was still moderately depressive. She was admitted in our department due to outpatient treatment and afore described psychosocial treatment model was applied.

Therapy with olanzepine, sertraline and lamotrigine is prescribed.

Treatment and outcome

At the beginning of the treatment, the psychoeducation was applied, i.e. the aim of it was to inform both patient and family members with the type of disorder, symptoms, interpersonal interactions that affects the patient's cognition and behaviors, possible etiological background, course of illness, and pharmacological treatments. Further aim was to introduce life style modifications such as sleep and exercise hygiene as well as to explain the possible consequence of the illness on professional and family life (Gabbard et al. 2007).

The goal of supportive therapy was to help the patient accept her illness and making her aware of the present problems in the family interrelations and at work. Goals were improvement of self-esteem, improvement of cognitive and interpersonal processes to prevent depressive or manic reactions to life events, displacement of aggression into reinforcing activities, improvement of reality testing, maximizing patient function during crisis or when patient cannot perform tasks for herself, supporting the patient's judgment with therapist's reasoning and decision-making skills, and to engender hope for recovery (Novalis et al. 2005).

The problem of adaptation to illness which caused changes in her family and profession role was recognized. For the patient, the illness represented strong narcissistic injury which she accepted with difficulty. She was ashamed of her illness and was afraid to go back to her place due to stigma. She had problem to cope with her regressive position caused from work disability. At the same time, the memories of depressive episode, suicide drives as well as the fear of repeated suicide thoughts were strongly emphasized. By using supportive techniques we tried to improve her self-respect, interpersonal relationships and communication skills. Revival of old friendships, meeting colleagues who understood her work problems were stimulated. She used to speak with her sister-in-law and her son who suffered from mental illness. That young man stimulated her to think about denied family problems and the way of avoiding the problems, particularly in relation to her husband and his mother. The therapy also stimulated dealing with activities to re-establish satisfactory cognitive functional level, as well as searching for activities which would enable her to feel relaxed. For that purpose she enrolled in a painting course, which was her long-time desire, and also in the Autocad software course which would help her to change the job. After she had moved to Split, she ceased to take care of her husband and son. She refused to return to island where she lived.

Goals of psychodynamic psychotherapy were to recognize stressors that trigger biological features of depression that have specific meanings

to the patient and may hold the key to understanding psychodynamic themes in the depression, to examine the meanings of unconscious conflicts and wishes that provoke distress, as well as the ways the stressor activate deeply repressed traumatic experiences. A further goal of psychodynamic psychotherapy was the solution of previous conflicts that caused vulnerability of the patient.

Reasons why the patient refused to return home were explored during psychodynamic therapy. It came out that during twenty years of marital life in the house of her parents-in-law she was very unsatisfied and lonesome. She never accepted a life in the community and lack of privacy. Although they lived in separated apartments, the only door connecting both apartments was never closed, which enabled her mother-in-law to disturb them whenever she liked. Her husband never opposed to it and never obeyed her wife's wishes. One year after her suicide attempt Vesna, for the first time, visited her home. After being there for a month, she became unsatisfied again and could hardly wait to go back to her apartment in Split. She decided definitely to move to Split when her son entered the first year of the high school. Few times she attempted to discuss the divorce with her husband but he couldn't accept it. She also realized that she wasn't strong enough to face with such a big change in her life. She wondered why to divorce when the existing situation was quite enough. During the therapy she was faced with two deaths which had happened before her suicide attempt as well as what they meant to her. The death of her daughter's boyfriend aroused fear of death and fear for her daughter, so she went to Zagreb and found the therapist for her daughter. She didn't have especially close relationship with her brother-in-law, but his death initiated fears from her own or her husband's death. She accepted the therapist's suggestions about importance of those deaths as possible additional stress factors for appearance of bipolar disorder.

After the treatment, the patient started her work again. She is regularly using pharmacotherapy and there were no relapses of illness.

DISCUSSION

This case study describes how a psychosocial treatment was used as an adjuvant to pharmacotherapy in a patient with BAD, with an aim to achieve the symptom remission, improvement of life quality and illness relapse prevention.

Introduction of psychosocial treatment in this case was motivated by two factors: firstly, inefficiency of pharmacotherapy during the ten months of treatment, and secondly, recognition of long-term chronic stress as an important generator of BAD. According to the literature, these factors are indication for using the psychosocial treatment (Rizvi et al. 2007). Despite the pharmacotherapy, our patient had been hospitalized three times after which she committed a serious suicide attempt by cutting her wrists and neck. Detail illness history showed a chronic exposure to stress both at work and in family. Model of resolving stress by use of conflict denial and repression contributed to development of the chronic stress. These conflicts were related to patient's husband as well as her manager and colleagues. She was under the pressure but she refused to confront.

In description of the development of depression state, Arieti (1977) has emphasized that depression appears in people who do not lead their own lives but they live for the "dominant others", most often marital partners, a certain organization or internalized ideals.

At the beginning of treatment, when the symptoms of depressive or manic disorder are present, it is not possible to use more complex therapeutic techniques. However, in that phase, the point is to establish «secure holding environment» by ensuring positive, warm, emphatic therapeutic acceptance of patient. Compliance in taking drugs and attending the sessions are very important in that phase of treatment. On the other hand, psychoeducation is used for disorder demystification, enables easier acceptance of illness, not only for the patient but also for the family members. Family support and decrease of negative attitudes is very important for outcome of treatment (Miklowitz 2004). Positive, warm and emphatic therapeutic acceptance is continued during supportive phase of therapy. By working to

achieve the acceptance of narcissistic injury caused by difficult illness, the stress itself is decreased and new adaptation mechanisms are developed. During that phase, the hope is offered as very important aspect of treatment. The feeling of control over the illness and one's own destiny are enabled by making the patient aware of the etiological facts such as long-term relationship problems in the family and at work.

Psychodynamic therapy is recommended after a complete remission of manic and depression state has been achieved, and the patient has reached a stable and well structured ego. This therapy uses clarification, confrontation and interpretation to disclose the features of transference and self, which are important in the development of disorder. That is how Freud explained melancholia: as loss of the object of phantasm, aggression and identification with lost object, as well as archaic, sadistic superego that causes feeling of guilt due to aggression toward the object (Freud 1917). Melanie Klein considered that manic-depressive state was caused by insufficient internalization of good inner objects, fear of destroying a beloved object by one's own destructiveness, followed by the fear of being prosecuted by bad objects. Manic defenses (omnipotence, denial, despise and idealization) appear as the answer to painful affects caused by loss of good objects and serve for restitution of the same (Klein 1940). During psychodynamic therapy the patient was faced with the loss of idealized objects and with mourning after them. The fear of aggressiveness closely related to experienced fear of aggression during the childhood was also noticed. This fear appeared during childhood each time the patient's parents quarreled, which was dominant behavior between them.

Bibring viewed depressive state as a result of the discrepancy between what patients believe they should be and what they are, as well as failure to achieve narcissist aspirations to be valuable, loved, powerful, superior, good and kind (Bibring 1953). The above described therapy helped the patient to work through the narcissist aspiration which in her case led to masochistic altruism and repression of unpleasant emotions toward husband, family members and also colleagues.

According to Jacobson, who pointed out the role of sadistic super-ego in depressive state, self is experienced as a bad object and is transformed into sadistic superego, where ego becomes its victim. In our patient, the strict sadistic superego and the displacement of aggressiveness toward ego was visible in the act of the attempted suicide (Jacobson 1971).

CONCLUSION

This case study illustrates the complexities of both biological and the stress etiological factors of BAD, which should be carefully considered when creating and choosing the integral model of treatment. This model could be further examined in larger number of patients with BAD, and the prospective study designs should enable more thorough assessment of the proposed model for treatment of BAD.

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