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**Research Paper**

# Psychosocial management of bipolar affective disorder

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## ABSTRACT

Everyday life is a roller coaster of emotions. We may feel on top of the world one day because of a high-profile promotion or an awesome grade on a test. Another day, in opposition may feel down. These are normal fluctuations in mood that come and go. When our mood starts to have an impact on your daily activities and in your social, educational, and vocational relationships, you may be suffering from a mood disorder/bipolar disorder. Bipolar disorder is very common disorder found in psychiatric illness. It is related with disturbance in mood, affect and feeling. Later on with the severity of illness it also effect on cognitive functions as well as other health conditions. These have been found to affect approximately 20% of the general population at any given point. These are treated primarily through medications and psychotherapy. In the psychotherapies various therapy is available such as; Cognitive Behaviour Therapy, Psycho-education, Social Rhythm Therapy, Play Therapy, Music Therapy etc.

***Keywords:*** *Psychosocial Management, Bipolar Disorder*

**B**ipolar disorder, previously known as "manic depression," is a brain-based disorder. This condition is characterized by one or more occurrences of manic or "mixed" episodes, and in some cases, may include a major depressive episode. While depression has commonly been associated with the disorder, we now know a bipolar diagnosis does not need to include depressive episodes, though it can. Moreover, the disorder has the potential to affect virtually all other areas of your body, from your energy levels and appetite to your muscles and even libido.

Bipolar disorder is a well-known affective disorder. It is affected the mood, emotion, cognition and later on behaviour of the human being. Bipolar disorder is a major psychiatric illness, with a life time prevalence of 1-3%. It is estimated that an adult developing Bipolar disorder in his/her mid 20s effectively losses 9 years of life, 12 years of normal health, and 14 years or work activity.

### *Types of Bipolar Disorder*

Episodes of mania and depression typically come back over time. Between episodes, many people with bipolar disorder are free of symptoms, but some people may have lingering symptoms,

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1. **Bipolar I Disorder** is mainly defined by manic or mixed episodes that last at least seven days, or by manic symptoms that are so severe that the person needs immediate hospital care. Usually, the person also has depressive episodes, typically lasting at least two weeks. The symptoms of mania or depression must be a major change from the person's normal behavior.
2. **Bipolar II Disorder** is defined by a pattern of depressive episodes shifting back and forth with hypomanic episodes, but no full-blown manic or mixed episodes.
3. **Bipolar Disorder Not Otherwise Specified (BP-NOS)** is diagnosed when a person has symptoms of the illness that do not meet diagnostic criteria for either bipolar I or II. However, the symptoms are clearly out of the person's normal range of behavior.
4. **Cyclothymic Disorder, or Cyclothymia**, is a mild form of bipolar disorder. People who have cyclothymia have episodes of hypomania that shift back and forth with mild depression for at least two years. However, the symptoms do not meet the diagnostic requirements for any other type of bipolar disorder.
5. **Rapid-cycling bipolar disorder,** this is when a person has four or more episodes of major depression, mania, hypomania, or mixed symptoms within a year. Some people experience more than one episode in a week, or even within one day. Rapid cycling seems to be more common in people who have severe bipolar disorder and may be more common in people who have their first episode at a younger age.

In addition, the psychological repercussions of this illness, such as disability are severe. The main focus is on pharmacological treatments, but only about 60% of bipolar patients respond to Lithium or anticonvulsants alone. Furthermore, only about 40% of patients remain without an illness recurrence over 2-3 years period even when maintained on standard dosages. Also it is clear that even with remission of affective episodes, substantial sub-syndromal symptoms, particularly depression remain in a large proportion of patients. It has been estimated that psychosocial factors may contribute to 25-30% to the outcome variance in bipolar disorder. So, these statistics, as well as QOL and cost of care can be improved on by integrating psychosocial treatments with the widely used drug regimens (Ameen & Ram, 2001).

## PSYCHOSOCIAL ISSUES IN BIPOLAR DISORDER

Most patients with bipolar disorder will struggle with some of the following issues, which need consideration in all psychosocial interventions.

**PSYCHOSOCIAL ISSUES IN BIPOLAR DISORDER:**

1. Emotional consequences of effective episodes
2. Developmental deviation and delays caused past episodes.
3. Problem also associated with stigmatization.
4. Fear of recurrence and consequent inhibition of normal psychosocial functioning.
5. Inter personal difficulties.
6. Problems in learning to discrimination.
7. Academic and occupational problem.
8. Marriage family childhood bearing and parenting issues.
9. Concern about genetic transmission.

***Impact of Illness on Major Life's Domains***

In fact, bipolar disorder is the sixth leading cause of disability worldwide. Disability is partly a consequence of the high rate of relapse for episodes of both mania and depression. For example, in a study of people with bipolar disorder type 1, characterized by episodes of mania (rather than hypomania) with or without depression, researchers followed patients after they suffered a manic or depressive episode. They found that 37% of patients experienced a recurrence of mania or depression within a year, 60% within two years, and 73% within five years. Full recovery from a manic or depressive episode — if it is achieved — may take months to years. The domains could be divide into two major parts i.e. physiological impact and psychological impact.

***Psychological impact***

1. **Occupation:** Work functioning is a major area of vulnerability. In the bipolar disorder the major impact was seen in the occupation disturbance. One study found that only 33% of patients with bipolar disorder worked full-time and 9% worked part-time, while 57% said they were unable to work at all, or could work only in some type of supportive (sheltered) environment.
2. **Society:** In bipolar disorder, the brain's ability to regulate emotion is probably compromised, so stress and conflict, which trigger negative emotions, tend to worsen symptoms, especially depression. Thus people with bipolar disorder are particularly vulnerable to inadequate social support, traumatic life events, and hostility or criticism from family members. High levels of neuroticism (a tendency to overreact or interpret situations negatively) or a dysfunctional cognitive style also increase (or may underlie) vulnerability (Lam, Wright, Smith, 2004).

***Physiological changes***

**Central nervous system:-** Bipolar disorder primarily affects the brain, which is part of your central nervous system. Composed of both the brain and the spine, your central nervous system is made up of a series of nerves that are in control of different body activities (Timothy, 2018).

***Some of the effects include:***

- ✓ Irritability
- ✓ Hopelessness
- ✓ Severe sadness
- ✓ Feelings of hyperactivity
- ✓ Forgetfulness
- ✓ Having a provocative attitude
- ✓ Being in an excessively good mood
- ✓ Loss of interest in activities you normally enjoy
- *Aggressiveness
- *Feelings of guilt
- *Over-activity
- *Being easily distracted
- *Being overly defensive
- *Difficult to concentrate.

**Cardiovascular system**

Whenever you feel anxiety in addition to bipolar disorder, this can also affect the cardiovascular system.

This includes:

- Heart palpitations *Rapid heart rate
- Increased pulse *Higher-than-normal blood pressure

***Endocrine system***

The endocrine system consists of hormones that rely profoundly on messaging signals from the brain. When these signals are disrupted, you can experience hormone fluctuations. If the fluctuation occurs it leads or cause changes in libido of the person. Mania may put sex drive on overload, while depression can significantly decrease it. Some people experience poor judgment with this disorder, which can also increase the risk for poor decision-making in terms of sexual health. Bipolar disorder may also affect weight, especially during depressive phases. With depression, you might experience a decrease in your appetite, resulting in weight loss. It's also possible to have the opposite experience — your appetite might *increase*, thereby making you gain weight (Timothy, 2018).

***Skeletal and muscular systems***

Bipolar disorder doesn't directly affect the bones and muscles, but if the depressive episodes, can affect skeletal and muscular systems at some extent. Depression can lead to unexplained aches and pains, which can make everyday activities difficult to manage. You might also find it difficult to exercise due to your discomfort. Moreover, if you do experience depression, weakness and fatigue are common and can be accompanied with sleeping too much or an inability to sleep (Timothy, 2018).

***Gastrointestinal system***

Anxiety associated with bipolar disorder can make your feel tired and irritable. It can also affect your gastrointestinal system. Such symptoms are often accompanied with feelings of panic, or a sense of impending doom. Sometime the person might also have sweat and breathe rapidly.

Some of these effects include:

- Abdominal pain
- Diarrhea
- Nausea
- Vomiting

## PSYCHOLOGICAL THERAPIES IN BIPOLAR DISORDER

Psychological interventions can help to improve the condition of a patient with bipolar disorder and the course of the illness, and maintain psychosocial functioning. Due to the nature of a patient in a manic phase, it is difficult to do psychological intervention during such times. The aim of psycho educational interventions is to provide patients (and sometimes family members and/or caregivers) with information about their illness and its treatment. Psychological intervention should include training in recognizing early warning signs of relapse of depression or mania, in order to prevent recurrence of illness. Such early warning signs of depression or mania are often different for different people, suggesting that individuals have distinctive "relapse signatures".

Psychotherapy and social interventions offer an essential adjunct to drug treatment of bipolar disorder. A large body of research shows that such therapies, when combined with mood-stabilizing medications, help to alleviate symptoms, increase the number of months a patient feels well, hasten recovery, and decrease the risk of relapse. The evidence is strongest for four methods: psycho education, cognitive behavioral therapy (CBT), family-focused therapy, and interpersonal and social rhythm therapy.

Psychotherapies are probably useful because they address aspects of recovery that medications alone do not.

***Psycho Education***

It can be defined as a mutual process that attempts to improve a patient's illness management skill through the bi—directional sharing of relevant information. In psycho education a lower level of psychological ability than in other approaches is needed, so it is cheaper and easier to evaluate. It only requires extensive knowledge of the illness and its management and communication skills. Yet bipolar patients frequently complain about the lack of information they receive. Psycho education is appropriate for patients in all stages of the illness; however depending on symptoms, content and methods vary. Ideally the process involves key members of the person's social network, including spouse, family members and caregivers. It is generally held that the partner can more easily discuss the problems without the patient being present.

***Aims of psycho educative treatment for bipolar patients:***

- Enhancing treatment compliance
- Avoiding drug abuse
- Identifying relapse symptoms
- Stress management
- Preventing suicidal behavior.
- Improving interpersonal and social inter-episode functioning.
- Providing information, assistance, insight and support to the patient and his family.
- Enhancing illness awareness and destigmatization preventing or mitigating recurrences
- Enhancing knowledge and coping of psychosocial consequences of past and future episodes.
- Coping with sub-syndromal residual symptoms and impairment.
- Increasing well-being and quality of life (Colom & Vieta, 2006).

## COGNITIVE BEHAVIORAL THERAPY

The cognitive therapist begins by helping the patient identify which negative behavior patterns he would like to work on. Together, they identify what kinds of thoughts and feelings precipitate these behaviors. Next, the therapist helps the patient figure out strategies for replacing thoughts that have negative consequences with new thoughts that have positive consequences. In other words, the cognitive therapist helps you "think yourself well."

Cognitive therapy works best for handling specific "thought errors" and behaviors. For example, if a teenager with bipolar disorder tends to catastrophize when depressed, seeing only the negative side of everything and then becoming further depressed as a result, cognitive therapy can help him find strategies for breaking this negative thought spiral. These strategies might include the use of affirmations, consulting with the therapist or another trusted adult to double-check negative thoughts, or mentally substituting positive thoughts for the negative ones.

In bipolar affective disorder, behavioral therapy may be useful for patients with mildly depressed or dysthyrnic moods, or on post-manic dysphoria when the patient quite often remains hypoactive and abulic. Self-control techniques, stress management and inoculation, exposition and coping might be useful in the treatment of specific problems derived from the illness. Simple behavior techniques (such as pairing tablet-taking with a routine activity) can be used to facilitate adherence.

The goals of the program are to educate the patient regarding bipolar affective disorder and its treatment, teaching cognitive behavioral skills for coping with psychosocial stressors and attendant problems, helping patients to recognize dysfunctional patterns of information processing in order to prevent relapse, facilitate compliance with treatment and monitor the occurrence and severity of symptoms (Newman, 2002).

## SOCIAL RHYTHM THERAPY

This therapy developed by psychologist Ellen Frank and colleagues (2005) at the university of Pittsburgh. They focused on stresses the importance of establishing regular routines, such as going to bed and getting up at the same time every day, to avoid triggering a relapse. Therapists also help patients cope with grief over having a chronic illness. In addition, they focus on how interpersonal relationships affect mood and help patients renegotiate interpersonal roles in light of the illness. Studies have reported that this therapy can help patients keep symptoms under control and avoid relapse, and may speed recovery from depression.

### *Play Therapy*

Play therapists can work with children as early as infancy to build and improve skills in the areas of attention, interpersonal relationships, perception, and mood. They can also help young children who have been victimized by abuse or who have experienced other kinds of life traumas, such as the death of a parent.

Most play therapists work in a clinic or school setting, and use toys, games, and art supplies in their practice. For example, they might employ dolls or stuffed animals to help a young child talk about conflicts in the home, or they might use animal figures and a sand table to model desirable behaviors. With older children, art-based activities may be more interesting and a better communication tool. Communication, of course, is the goal. Parents might or might not be part of the play therapy session. Because it's play-based, this type of therapy is best suited for preschool or grade school children. Activity choices should be based on the child's developmental level.

### *Family Therapy*

A family is a group formed by individuals for their mutual benefit, with each member having his or her own personality, needs, and desires. Whenever one member of the group is ill or in emotional distress, it affects all the other members. Family therapists work with the entire family together, although they may also see some members individually. The therapist helps each member express his or her fears, angers, and wishes, and then helps the family restructure itself in healthier ways (Miklowitz, et al., 2003).

### *Group Therapy*

Arguments in favor of group therapy for bipolar patients are based on illness effects in social adjustment, interpersonal aspects of coping with the illness, and the well-known economic advantages of treating chronic illnesses in group setting. The group can also offer a safe and

controlled atmosphere, which could function as a buffer during stressful periods, and would allow an effective change of denial mechanisms. Other authors suggest starting group therapy during hospitalization, even when in acute phase.

***Milieu Therapy***

"Milieu" is a French word for site and setting. Milieu therapy endeavors to make the site and setting of everyday activities in a school, hospital, or living center therapeutic. This requires paying close attention to physical characteristics such as making sure that the classrooms and dorms are not dingy and depressing, and ensuring that toys, games, and activities are available that build positive experiences and help to eliminate negative behaviors. Of course, careful structuring of interpersonal relations in the milieu is of prime importance. Every interaction between a patient and a staff member has therapeutic potential, whether that staffer is the cafeteria cook or an actual therapist.

## INTERPERSONAL AND SOCIAL RYTHAM THERAPY

Interpersonal and Social Rhythm Therapy (IPSRT) is founded upon the belief that disruptions of our circadian rhythms and sleep deprivation may provoke or exacerbate the symptoms commonly associated with bipolar disorder. Its approach to treatment uses methods both from interpersonal psychotherapy, as well as cognitive-behavioral techniques to help people maintain their routines. In IPSRT, the therapist works with the client to better understand the importance of circadian rhythms and routines in our life, including eating, sleeping, and other daily activities. Clients are taught to extensively track their moods every day. Once routines are identified, IPSRT therapy seeks to help the individual keep the routines consistent and address those problems that arise that might upset the routines. This often involves a focus on building better and healthier interpersonal relationships and skills.

When Interpersonal and Social Rhythm Therapy is combined with psychiatric medications, research has shown that people can achieve gains in their targeted lifestyle routines, reduce both manic and depressive symptoms, and increase days of maintaining a consistent, regular mood. Like most psycho-therapies, not everyone will respond to a course of IPSRT, but for those people who do respond, most have a reduction in the symptoms associated with bipolar disorder.

***Social Skill Training (SST)***

Social skills training is done in a group format to promote the learning process while also demonstrating skill sets. Social skills training for individuals with bipolar II disorder should not single out specific symptoms of the disorder, rather help the individual recognize his role in society despite mental health disturbances. SST may be used to teach people specific sets of social competencies. A common focus of SST programs is communication skills. A program designed to improve people's skills in this area might include helping them with nonverbal and assertive communication and with making conversation. It might also include conversational skills that are needed in different specific situations, for example job interviews, informal parties, and dating. The skills might be divided further into such subjects as beginning, holding, and ending conversations, or expressing feelings in appropriate ways. Social skills training may be given as an individual or as a group treatment once or twice a week or more often depending upon the severity of a patient's disorder and the level of his or her social skills. Generally speaking, children appear to gain more from SST in a peer group setting than in individual therapy. Social skill training groups usually consist of approximately 10 patients, a therapist, and a co-therapist. Current trends in social skills training are aimed at developing training programs that meet the demands of specific roles or

situations. This need developed from studies that found that social skills acquired in one setting or situation are not easily generalized or transferred to another setting or situation. To assist patients in using their new skills in real-life situations, trainers use role-playing, teaching, modeling, and practice, (Carter & Jane, 1998).

***Role of Social Support In Management***

Social support system is vital to staying happy and healthy. Creating a supportive environment includes not just who you surround yourself with, but who you choose to avoid. In order to take care of yourself, it's necessary to limit your contact with people who drain your emotional energy or leave you feeling discouraged, ashamed, or guilty. Instead, spend time with people who truly value you and make you feel better, (Bellack & Alan, 1979). Support for bipolar disorder starts at home. It's important to have people you can count on to help you through rough times. Isolation and loneliness can cause depression, so regular contact with supportive friends and family members is therapeutic in itself.

***Risk Assessment in Bipolar Disorder***

It is necessary to determine the most appropriate settings for patient care, and assess for suicidal ideations by examining past history of self-harm, current ideation, substance abuse, and the level of social supports. In elevated and mixed states, the possibility of risk taking, impulsive behaviours, irritability, violence and misadventure must be considered. Where risks are deemed high, the patient needs more assertive care, and referral to psychiatric inpatient services is appropriate. Application of the relevant state mental health act may be required. Manic episodes cannot be contained in a general practice or community setting. Given the diagnostic and management challenges of bipolar disorder, psychiatric confirmation of diagnosis and management advice is advisable. For patients with low to moderate risk, their initial care will usually be provided by their general practitioner, who has a pivotal role in assessment, diagnosis, referral and ongoing care (Kessler,et al., 2005).

## CONCLUSIONS

Bipolar disorder is a complex mental disorder requiring a holistic approach to treatment. Whilst medications do playa large role in the management, psychosocial intervention should not be neglected. Psychosocial interventions help to improve patient's compliance with medications and to deal with psychosocial consequences of the illness. Thus, mood stabilizers and psychosocial interventions are complementary treatment approaches that if administered conjointly will offer more efficacious, effective and lasting treatment for patients with bipolar affective disorder.

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***Conflict of Interest***

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