

# PSYCHOPHARMACOLOGICAL TREATMENT AND PSYCHOEDUCATIONAL MANAGEMENT IN BIPOLAR DISEASE

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## SUMMARY

*In bipolar disorder there is a deterioration of concomitant diseases, a marked deterioration in the quality of life, an increased difficulty of personal relationships, both in the family and the workplace, and an increased vulnerability and inability to deal with stress. Here we describe how pharmacotherapy can be combined with psychotherapy and psycho-education to improve recovery of a patient with bipolar disorder.*

**Key words:** bipolar disorder – psychoeducation – psychotherapy - pharmacotherapy

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## INTRODUCTION

Bipolar Disorder requires adequate treatment; otherwise it becomes worse over time. This leads to inevitable serious consequences such as increased hospitalisations and a 10-15% increased risk of suicide. However, 'the rate of suicide is the same as the general population in patients with bipolar disorder who regularly take lithium therapy' (Baldasserini 2006).

In bipolar disorder there is a deterioration of concomitant diseases, a marked deterioration in the quality of life, an increased difficulty of personal relationships, both in the family and the workplace, and an increased vulnerability and inability to deal with stress. Poor concordance with medication often occurs because of ineffective therapy and the development of side effects. This then leads to an involvement of the whole family in the disease.

Usually 10 years elapse between the first episode with affective symptoms and the correct diagnosis of bipolar disorder (Lish 1994, Hirschfield 2003).

Difficulties may be caused in the diagnosis because of

- An insufficient case history.
- Vague information given by relatives.
- The criteria for diagnosis give too much importance to the present episode.
- The criteria for correct diagnosis are still open for debate.
- The mood of the patient at the time influences the result of the case history.
- The patient also presents with other concomitant diseases.
- There is a lack of biological markers.
- The presenting clinical picture often has mixed characteristics (Sachs 2007).

A fundamental principle of modern clinical psychopathology is as follows.

Psychiatric diseases are not in fact specific forms of different illnesses, but are in fact a series of complex syndromes or collections of symptoms, and do not therefore necessarily produce any definite diagnosis (Kahlbaum 1863).

The presence of the following symptoms suggest the likelihood of a bipolar disorder:

- Increased appetite/weight gain;
- Sleepiness;
- Lack of pleasurable emotions;
- Seasonal change in mood;
- A case history of short episodes of brief but recurring depression;
- Frequent changes of antidepressants;
- Psychomotor retardation;
- Psychotic symptoms;
- Increased lack of response to antidepressants;
- A family history of bipolar disorder;
- The illness starting at an early age;
- The illness starting in the postpartum period (Marchand 2003).

Delay in diagnosis of the condition implies delay in effective treatment of the condition.

The treatment includes psycho-social support, psychotherapy, and psychoeducational interventions.

The pharmacotherapy is individualized to the patient and takes into account the case history and also the family history if other family members have already received treatment or are being treated.

Individual or family therapy requires several possible approaches including:

- Cognitive behavioural therapy which enable the patient to understand and modify the mental and behavioural schemas which lead to mal-ease and suffering.
- Interpersonal therapy; the illness alters the patient's life and his relationships within work and in the

family, psychotherapy is aimed at restoring the damaged interpersonal relationships.

- Other forms of psychotherapy, including music, art, or dance therapy support the other forms of psychotherapy.

The objectives of psychoeducation in bipolar disorder are as follows:

- Increasing understanding and awareness of the illness.
- To encourage adherence to pharmacological therapy. The continuing adherence to pharmacological treatment is a crucial problem, given that non-concordance with medication affects 30-47% of bipolar patients in a year long naturalistic study (Basco 1996).
- Prevention of drug abuse.
- Early identification of new episodes.
- Organisation of lifestyle and managing of stress.

The objective of psychoeducational therapy in bipolar disorder is to enable acceptance of the illness and the reduction of stigma.

As an example of this approach we present a clinical experience from the territorial department of Trebisacce (CS) Italy.

We present a twenty-three year old girl with bipolar disorder presenting with depression. She had a

- Family history of bipolar disorder (Her older sister had been receiving pharmacological treatment alone for this, and had died in a road accident).
- She was obese.
- Her mother suffered from ovarian cancer which had recurred after surgery.
- There was conflict between the parents.
- The patient was in conflict with her parents.

She had the following psychological case history:

- She had an eccentric and exuberant personality.
- She tended to have an oversensitive reaction to criticism and ideas of persecution and victimization.
- She was in continual search of friends with whom to establish exaggerated relationships and on whose affection she would become dependent.
- She was dependent on nicotine.
- She abused drugs occasionally.
- She abused alcohol with her friends.
- She had a history of failure both at work and at school.

Her family relationships were very strained with little understanding and general anxiety.

Six years ago she came under clinical observation having suddenly developed the following clinical symptoms:

- Serious psychomotor agitation;
- Paranoid ideation;
- Having become introverted and isolated, with a terror of meeting people.

## TREATMENT

- In the acute phase she was managed with antipsychotics and benzodiazepines.
- In the chronic phase she was treated with antipsychotics and mood stabilizers.
- She was helped to reintegrate her personality with psychotherapy and individual and family psychoeducation.

## RESULTS

She has come to terms with her pathology and is now able to understand her early symptoms, to recognize them and ask for help to correct them. She rigorously takes her pharmacotherapy. She has normalized her sleeping patterns. She has resumed her university studies with good results. She practices sport and takes a free but controlled diet. Her family relationships have normalized.

Psycho-education has enabled the patient to understand that when she inevitably experiences normal changes in mood, including depressive periods and periods when her mood accelerates, this is normality, and she does not need to consider such changes pathological.

## CONCLUSION

Bipolar disorder disables the patient herself, and affects her socially both within the family and in the workplace. The family becomes completely involved in the illness and finds itself unable to cope alone with this pathology and to deal with the stress it experiences in an adequate way, with serious consequences for the global health of the family. It is therefore necessary to intervene in a structured way. Pharmacological therapy, psychotherapy, and psycho-education have been shown to manage and control this mental illness. In other words, pharmacotherapy, the understanding of the illness, individual and social education, and the modification of lifestyle are excellent tools to keep under control mental illness, so that it no longer needs to be considered unpredictable and invincible.

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