CASE STUDY

AN EFFECTIVE MANAGEMENT OF BIPOLAR DISORDER

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ABSTRACT

Bipolar disorder is characterized by manic, hypo-manic and depressive episodes. This case study describes how psychosocial factors lead to psychological illnesses, which then impairs individual's social, occupational and other areas of functioning. The client H.K. was 22 years old boy, unmarried, educated up to middle, was 2nd born among 3 siblings and lived in a nuclear family. He was brought to the Lahore general hospital by the end of May, 2019 with the presenting complaints of self-talk, labile mood, forgetfulness, poor sleep and appetite, flight of ideas and anger. Informal assessment was done through behavioral observations, mental status observation, clinical interview, baseline charts, and subjective rating of symptoms. Formal assessment was done through positive and negative syndrome scale, young's mania rating scale, and beck's depression inventory. The client was diagnosed with bipolar I disorder according to DSM 5. It took 12 sessions to manage client's symptoms and Deep Breathing, Progressive Muscle Relaxation, Peripheral Questioning, Energy Channelization, Mood Monitoring etc. were used for this purpose. The client reported overall improvement of 80 % in his symptoms after therapeutic intervention.

Key words: Bipolar disorder, Cognitive Behavior Therapy, Efficacy, Mania

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INTRODUCTION

Bipolar disorder is a mood disorder which is characterized by manic, hypo-manic and depressive episodes. The mania is a mood episode in which the person's level of functioning is impaired in comparison with his pre-morbid level of functioning. The hypo-manic episode of bipolar disorder has same symptoms as mania but it does not impair individual's level of functioning. Depressive episode is mental health problem which is characterized by loss of interest in activities, loss or gain in appetite, hypersomnia or insomnia, psychomotor agitation or retardation, feelings of guilt and low self-esteem etc. Acute mania is further classified into three distinct categories, which includes classical or pure, psychotic features and mixed state.

The prevalence of bipolar disorder is reported to be 0.6% for bipolar I disorder, prevalence rate of bipolar II disorder is 0.4%, the prevalence rate for sub-threshold bipolar is 1.4% and is 1.5% for bipolar spectrum disorder. Manic and depressive symptoms become more severe from sub-threshold to Bipolar I disorder. The suicidal behavior is also high in bipolar I disorder than sub-threshold bipolar disorder. Symptoms of depressive episode are more severe than manic episode. 74% of the individuals with depressive features report role impairments but only 50% of individuals with mania report severe role impairments. Three quarters of the individuals diagnosed with bipolar spectrum has co-

morbid psychological illness. Anxiety symptoms are the most common co-morbid symptoms[1].

According to biological perspective bipolar disorder is caused by imbalances of neurotransmitters in brain. The neurotransmitters involved in bipolar are norepinephrine and serotonin. The increased activity of norepinephrine and serotonin causes mania whereas the decreased activity of serotonin and norepinephrine in the brain is linked to depression. According to ion activity theory, bipolar disorder is associated with the inappropriate in and out transfer of ions across neuron membrane. Abnormalities in brain structure also leads to bipolar disorder. The brain images show that basal ganglia and cerebellum of these people tend to be smaller and have lower volume of gray matter. Similarly, abnormalities in prefrontal cortex, amygdala, hippocampus and dorsal nucleus also cause bipolar disorder. Genetics play a great role in developing bipolar disorder which is proved by family pedigree studies that states that, chance of development of bipolar disorder among identical twins is 40 %, and chance of developing it through fraternal twins, siblings or other close relatives is 5-10 % percent. Researchers have also found genetic linkage to be a strong factor for an individual to develop bipolar disorder as it runs in family from generations[2].

Psychodynamic theorist suggests that mania, like depression, emerges from the loss of a love object. Such that some individual introjects the loss and becomes depressed while others deny it and becomes manic. They avoid the terrifying conflicts generated by the loss by escaping into dizzying activities[2].

According to socio-cultural perspective, mania is linked to sleep disturbances and circadian rhythms. Research was conducted in which people who were suffering from depressive phase of bipolar disorder were allowed to stay at sleep center however they were allowed remain sleep deprived whole night and later it was observed that 10 % of the individuals experience at least mild symptoms of mania. Reward sensitivity theory suggests that mania reflects a disturbance in the reward system of brain. Researchers have demonstrated that people with bipolar disorder are highly sensitive to rewards. Being reward sensitive indicates a high onset and prediction of mania. Environmental stressor predicts increased manic symptoms among people with bipolar disorder specially life-events that involve attaining goals such as a job, academic achievement, satisfaction in marital life etc. [2].

According to theory of mind, people with bipolar disorder are unable to accurately interpret the mental states of other individuals on the basis of cognitive reading of social cues such as tone of voice and facial expressions[2]. There are no enough evidences available regarding the role of schemas in the development of mania. However, evidences are available, proving the importance of cognitive factors in the vulnerability to relapse, of an individual with bipolar disorder[3].

CASE STUDY

History of Present Illness: The client's mother reported that the client was alright, a week ago. On 14th April, 2019, the client went to drop his fiancée to her home at Ichra, after the marriage ceremony of client's brother. On the way back, while he was travelling by metro bus, the client felt that someone was chasing him. He did not see anything unusual, but the images were created by his mind and he developed the suspicion that something was trying to harm him. The client got scared and left the bus and started walking towards his home. The belief that something was following him and was trying to harm him, continued to frighten him. After walking few miles, he saw a mosque and went inside it. There he found Quranic verses hanging on the wall and started reciting them. He continued to recite it for hours while sitting in the mosque. Then he got up and started walking to his home. He continued to recite Quranic verses during whole journey. On reaching home, the client reported that he felt better but was unable to sleep, whole night. Client's mother reported that he asked her to tell how to pray as he forgot it. This information was very weird for the mother but she helped him and after offering prayer the client slept.

After a week, the client was brought to the Lahore General Hospital by his parents with the presenting complaints of poor sleep, fearful thoughts, self-talking, labile mood, anger, and poor appetite. Due to this believe, he was found making Wazu most of the time and reciting verses of Holy Quran. The client's mother reported the symptoms of flight of ideas, irrelevant talk and irritability are present in client for one week. The client also reported decreased need for sleep. According to client his mood shifted within a week and sometimes he experienced sadness and loss of energy while at other times he felt extreme happiness and energy. The client reported that he feels difficulty in concentrating on a task. The client reported that he forgot things very often. Client also reported an associated issue of anger. But according to the client the anger was under control. He never hit or abused anyone. Client's mother reported that all these symptoms had caused impairments in his social and occupational life and she reported that client experienced same symptoms 5 years ago when he failed in class 9.

Background Information: During prenatal period, the client's mother reported that during a fight with her husband she fell down and was then taken to the hospital immediately. According to client's mother, he

achieved all developmental milestones with significant delays.

The client was 22 years old, engaged and educated up to middle. By profession he was a jewelry designer. He lived with his parents at Lahore. His father designed jewelry bags and his mother was house wife. The client had congenial relationship with his mother but had conflictual relationship with his father because he was very strict and neglecting. The client had unsatisfactory relationship with his elder brother but had congenial relationship with other siblings. The client was brought by his mother to the hospital with the presenting complaints of excessive energy, euphoric feelings, increased distractibility, irrelevant talk, sleep disturbances, anger and forgetfulness.

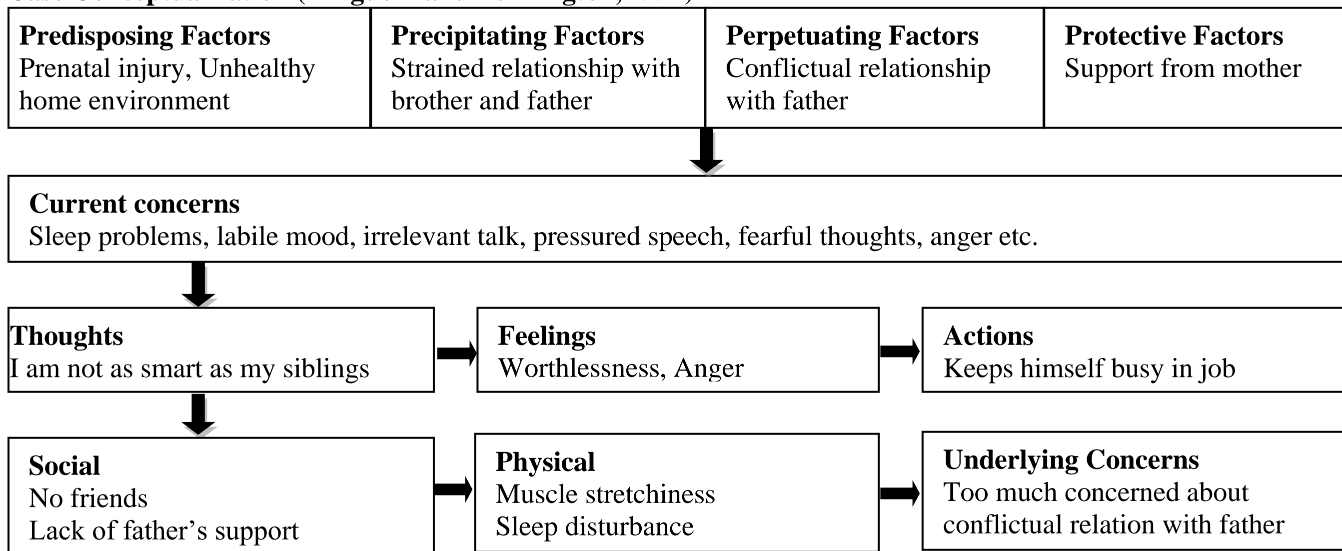
The client mother started going to the school when he was 3 years old. Throughout his academic carrier he obtained below average grades and was never a bright student. Client's mother reported that he had congenial relations with his classmates, teachers and school friends. The client's mother reported that after failing in 9th class, he left studies and started doing job.

The client had jewelry shop and designs jewelry. He had been doing this work since 2017. He had excellent skills of designing and that is why his brother asked him to join their family business of designing and selling jewelry. The client's mother reported that he had very high aims in life and wanted to earn handsome amount of money and to make his mark in the world of designing and because of this he continued to work a lot and he most of the time he stayed at shop and did not come home even at nights.

The client attained puberty at the age of 14 years. The client was informed about this by his brother and the process remained smooth and he had normal reaction to the physical and biological changes. He had no female friend except his fiancée. The client reported that he loved her a lot and they had contact with each other on phone but did not have any physical relationship.

Before the onset of illness, the client had calm nature. He used to talk less. But after the onset of illness the client has started to talk more and the content is usually irrelevant to the context. He has started spending more money on useless things. Client used to have lot of friends and his decision-making skills were great. He used to help her mother in making decisions. Problem solving skills were also average but due to low intellectual capacity he was lacking behind his siblings in all these skills.

Case Conceptualization (Kingdom and Turkington, 1994)



PSYCHOLOGICAL ASSESSMENTS

In order to confirm the diagnosis, psychological assessment was done. Assessment included positive and negative syndrome scale (PANSS) which was administered to rule out brief psychotic disorder. Young's Mania Rating Scale (YMRS) and Beck's Depression inventory (BDI) were also administered to confirm manic and depressive symptoms respectively. BDI and YMRS were also administered to find the severity of manic and depressive symptoms.

PRE-INTERVENTION ASSESSMENTS

Informal Assessment: Subjective ratings of the symptoms were taken from the client before the start of the therapy. This was done to understand the intensity and severity of the client's symptoms and to compare the pretest and posttest ratings of the symptoms in order to gauge the effectiveness of the therapy. Ratings of the symptoms was taken on 0-10 scale, where 0 represents absence of symptoms, 5 represents average and 10

represents intense symptoms. Results are shown in the table.

Formal Assessment: Positive and Negative Syndrome Scale, young's mania Rating scale and Beck's depression inventory was administered prior to the treatment and the results are shown in the table.
The raw scores on PANNS are below the cutoff of 70 therefore, we can conclude that client didn't possess psychotic symptoms. The raw scores on Young's Mania Rating Scale (YMRS) and Beck's Depression Inventory (BDI) are above the cutoff of 20 and 14 respectively, therefore it confirms the presence of manic and depressive symptoms.

Treatment

The treatment included medication and psychotherapy. The client was given the psychotherapy which included energy channelization, recreational work, relaxation exercises, mood monitoring, identification of cognitive distortions and their replacement through vertical descent and evidence for and against methods of Cognitive Behavioral therapy. Treatment was completed in total 12 sessions and the initial sessions consisted of rapport building, supportive work and psycho-education regarding the illness. Later sessions consisted of socialization to CBT and explanation of ABC model according to Cognitive Behavior Therapy. Formal and informal assessments were also done. The client's primary symptoms were first treated and then work was done on the associated symptoms of anger and fear of supernatural beings. At the end of the therapy session post assessment was done and therapy blueprint was given. Relapse prevention was also guided to the client in the termination session.

Ethics: Following ethical considerations were taken:

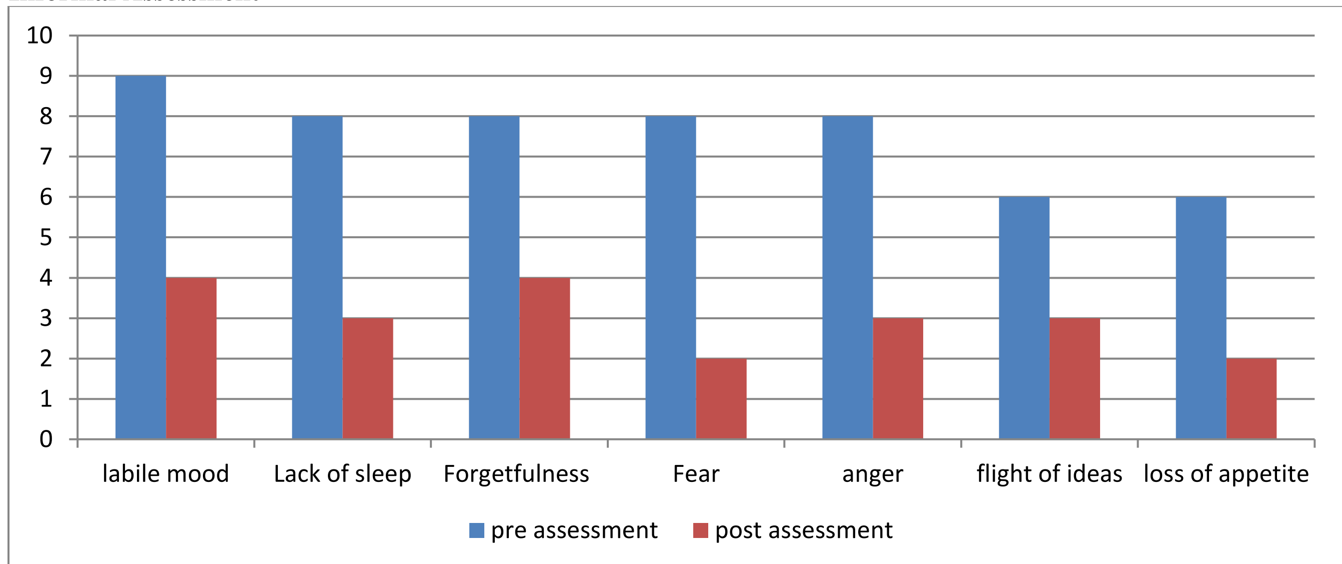
- Consent form was taken from the participants.
- The participant was assured that the information taken by him will be kept confidential.
- Participant was informed that he has a right to withdraw from the therapy at any time.

POST INTERVENTION ASSESSMENTS

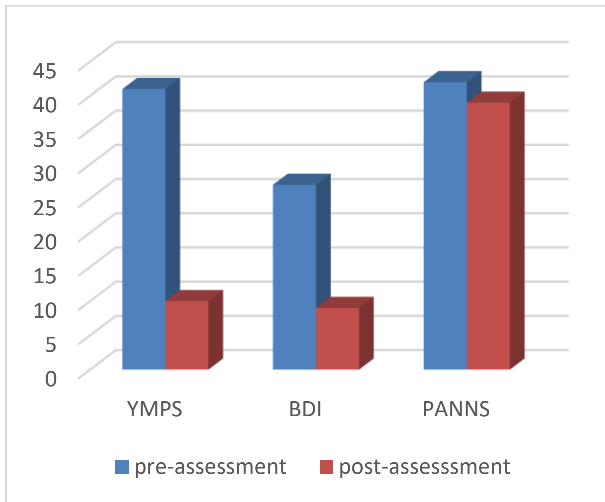
INFORMAL ASSESSMENT

Subjective Ratings of Symptoms: After therapeutic sessions, the post rating of presenting complains initially reported by the client were taken and the results are displayed table.
Formal Assessment: After 12 successful sessions the post assessment was done and the previous scales were re-administered. Scores showed significant decline in the symptom's severity. The results are displayed in table
The raw scores on PANNS are below the cutoff of 70 therefore, we can conclude that client don't possess psychotic symptoms. The raw scores on Young's Mania Rating Scale (YMRS) and Beck's Depression Inventory (BDI) are below the cutoff of 20 and 14 respectively, therefore it confirms the reduction of manic and depressive symptoms.

Comparison of Pre and Post Assessments
Informal Assessment

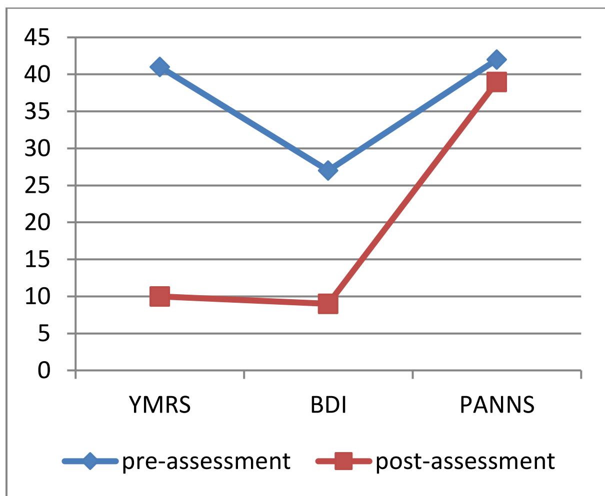


Formal Assessment



RESULTS

Results show significant decline in scores on both the psychological measures. CBT proved to be very effective in the treatment and the client's symptoms of inflated self-esteem, fight of ideas, excessive talking, sleep disturbances and anger were managed, reported by the client, up to 80 %.



Informal Assessment

Table 1: Table of subjective pre ratings of presenting complaints

Presenting Complaints	Patient's Ratings (0-10)
Labile mood	9
Lack of sleep	8
Forgetfulness	8
Fearful thoughts	8
Anger	8
Flight of ideas	6
Loss of appetite	6

Table 2: Table of subjective post ratings of presenting complaints

Presenting Complaints	Patient's Ratings (0-10)
Labile mood	4
Lack of sleep	3
Forgetfulness	4
Fearful thoughts	2
Anger	3
Flight of ideas	3
Loss of appetite	2

Formal Assessment

Table 3: Pre-Assessments

Scale	Raw Scores	Cutoff	Significance
PANNS	42	70	Non-Significant
YMRS	41	20	Significant
BDI	27	14	Significant

Table 4: Post Assessments

Scale	Raw Scores	Cutoff	Significance
PANNS	39	70	Non Significant
YMRS	10	20	Non Significant
BDI	9	14	Non Significant

DISCUSSION

Scott, Reisnecke, and Clarke (2003) conducted a study on cognitive theory and therapy that assessed the main aspects of cognitive models of bipolar disorder and clinical implication of cognitive therapy, the results showed that development of manic symptoms can be linked to negative life events such as death of close relatives, cessation of mood stabilizers, sleep disruptions etc.In the case study under discussion, the client used to remain awake whole night in order to work hard and to earn more money. Hence his symptoms can be attributed to sleep deprivation. We can also relate this research with client's negative experiences such as failing class 9th, as his mother reported that he developed these symptoms, initially, after this incident[3].

HélioTonelli (2009), in a study on cognitive theory of mind processing in bipolar disorder, collected articles titled as Bipolar Disorder and the Theory of Mind that were published during past 20 years in English, German, Spanish or Portuguese languages. Study incorporated the case studies of the individuals diagnosed with bipolar disorder and provided them one or more cognitive tasks in order to evaluate theory of mind abilities. 4 articles were finally selected and the population included adult and pediatric bipolar individuals. The results showed that theory of mind processing problems is evident in individuals with bipolar disorders. The case study under discussion also proved this theory of mind as client's mother reported

that client faced difficulty in understanding non-verbal language of other person4.

LIMITATIONS

- The client was initially not very co-operative and therefore the client did not openly inform about his issues, until the rapport was built.
- Client's father was not very co-operative therefore much information could not be gathered by interviewing client's father.
- The client was discharged from the hospital and further sessions could not be done.
- Sessions were mostly conducted in ward of psychiatry department and therefore distractions affected efficacy of the therapeutic sessions.

SUGGESTIONS

- The psychiatry departments of government hospitals need attention as more cabins are required for clinical psychologists so that sessions can be conducted in separate cambers and hence the confidentiality can be maintained, moreover sessions will be conducted in a peaceful environment.
- Secondly, interpersonal and social rhythm therapy (IPSRT) should also be used with the patients of bipolar disorder in order to treat disruptions of cardiac rhythms associated with bipolar disorder and its efficacy for our population should be determined.

FUTURE IMPLICATION

This case study will be beneficial for the clinical psychologists in dealing with bipolar disorder in future. The management plan used in this study can be helpful for the treatment of patients with bipolar disorder as this case study proofs the efficacy of this plan. This article will increase awareness among people regarding the bipolar disorder, its etiological factors and its cure. It also proves that sometimes it becomes difficult to distinguish between bipolar disorder and schizophrenia spectrum and other psychotic disorders but we, as a clinical psychologist, need to be much vigilant in this regard to avoid mislabeling.

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AUTHOR'S CONTRIBUTIONS

RK: Concept, Manuscript writing
HF, AQK: Proof reading, Supervision