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Functional Improvement of Bipolar Affective Disorder

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ABSTRACT

Bipolar disorder is a common, chronic and severe mental disorder, affecting approximately 1-2% of the adult population. Bipolar disorder causes substantial psychosocial morbidity that frequently affects the patient's marriage, children, occupation, and other aspects of the patient's life. Few studies have examined the functional impairment in patients with affective illness.

Bipolar disorder is a very serious condition associated with impulsive and self-destructive behavior. Bipolar suicidal thoughts behaviors are frequent, as are impulsive sexual behaviors and reckless spending. Not surprisingly, families are frequently deeply affected by their bipolar member, and themselves experience a range of deeply felt emotions, not the least of which is a sense of helplessness to fix bipolar symptoms. With appropriate drug treatment, only about 40 percent of recovered patients will suffer relapses. The functional consequences of bipolar disorders are staggering. Bipolar disorder is the 6th leading cause of years lost to disability among all medical conditions according to World Health Organization 2001 report. Knowing about functional level and how to improve the level of function, understanding about the consequences are too important for health care professional.

KEYWORDS

Bpad, Bipolar, Functions of BD

INTRODUCTION

Bipolar disorders (BD) are severe, chronic and episodic in nature. Illness may be a short duration but it affects the functional ability of the patient during illness as well as in remission[1]. The United States had the highest prevalence rate of bipolar spectrum (4.4 percent), while India had the lowest rate (0.1 percent). More than half of those with bipolar disorder in adulthood note that their illness began in their adolescent years[2].

Bipolar disorder has traditionally been associated with a better outcome than schizophrenia because of a presumed absence of cognitive impairment and seemingly normal functioning between episodes[3]. Thus, generally little attention has been given to psychosocial outcomes in patients with bipolar disorder. However, in contrast to early studies[3-4] recent studies have shown bipolar patients not only have impairment in cognitive functions but also have impairment in day to day functions and to live normally.

Functioning is a complex concept since it involves the capacity to work, study, live independently and engage in recreation and romantic life[4]. Functional recovery has been described as the ability to achieve the level of functioning prior to the most recent episode[5]

Functional level refers to individual ability to function socially, occupationally and to live independently. Functional recovery indicates the restoration of fullest possible level of function.

Functional Ability of Bipolar Clients

Bipolar illness patient's functional levels vary during illness period. Functions may be divided according to the capacity of its performance from total impairment to fully functional level. Autonomy refers to the patient's capacity to do things alone and make his or her own decisions. Occupational functioning refers to the capacity to maintain an employment, according to the level of the employment position. Cognitive functioning is related to the ability to concentrate, perform simple mental calculations, solve problems, and learn and recall new information. Financial issues involve the capacity of managing the finances and spending in a balanced way. Interpersonal relationships refer to relations with friends and family, involvement in social activities, sexual relationships, and the ability to defend one's own interests. Leisure time refers to the capability of performing physical activities (sport, exercise) and maintaining hobbies.

Studies have found that over half of Bipolar patients experience persistent unemployment while 40% self-report impairment in social, cognitive, work, or household functioning (Tohen et al., 2000)[5] While impaired everyday function has been reported across all phases of BD, most studies have used subjective and imprecise measures such as the Global Assessment of Functioning Scale (GAF) and/or relied on self-report and survey tools that do not control for demographic or socioeconomic factors.[6]

Bipolar illness affect the psychosocial functions severely which can be explained by the following two variables .Bipolar illness occurs at the young age of life which affects psychosocial development at an earlier stage, altering the trajectory of educational, professional, and interpersonal growth. In addition, the break of psychiatric illness early in life likely to carry a disastrous effects on individual development[7,8] coupled with the stigma associated with mental illness in general and Bipolar illness in particular. These two variables effect may hinder to achieve psychosocial functions.

The recurrent mood episodes and frequent hospitalizations over the course of illness, causing inconsistency to educational and vocational functions and it will make functional recovery after hospital discharge more challenging for patients. Finally, episodes of psychosis and chronic substance misuse contribute to an erratic course of development. Taking in to consideration of all these factors carry direct effects on

psychosocial functioning and development in Bipolar illness. The costs of mood disorders and other conditions are not limited to health care or work productivity. For an affected individual, the impact of mood disorders is diffused throughout the daily life via physical, cognitive, and social limitations, such as poorer psychomotor control, attention deficits, and disrupted social role functioning8.

Factors that affect functional ability of clients

1. Genetic expressions are strong in BD that influences the onset, severity, and progression of the illness.
2. Symptoms of BD have a direct impact on psychosocial functioning. Recurrent mood disturbance, residual symptoms between episodes, hospitalizations, comorbid substance use disorders and psychosis disrupt the consistency of psychosocial engagement required for functional development
3. Recurrent episodes of mood disturbance result in chronic physiological stress
4. The physiological effects of stress are neurotoxic and lead to cognitive decline over time.
5. Cognitive impairment in general, and executive dysfunction in particular, hampers the ability to meet psychosocial demand.
6. They could not maintain the psychosocial demand which makes disruption to social activity and environmental stress.
7. Environmental stress in general and psychosocial stress in particular, aggravates more severe course of illness.
8. The consequent intensification in symptoms and their recurrence exacerbate the disruption to social rhythm and environmental stress.
9. Psychosocial stress contributes to chronic hyperarousal of the autonomic nervous system and HPA axis.
10. Repeated experiences of psychosocial failure intensify anxiety related to psychosocial demand.
11. Anxiety has acute effects on cognitive functioning during psychosocial challenges. The cognitive impairment, anxiety further compromises attentional control and executive functions.
12. Cognitive impairment further declaims the social functions
13. The anxiety associated with functional challenges leads to avoidance of psychosocial demand and marginal psychosocial engagement.

These factors are called malignant factors affecting bipolar disorders by leve and Manove 2012[9]

Care to improve functional ability

In Bipolar illness, clients need to be given particular importance on the psychosocial environment, sources of stress present in the environment that can aggravate the illness. Central to this notion is the goodness of fit between the person and the psychosocial environment. Due to mis-relationship, that may lead to a more severe course of illness and a significant decline in functioning. In BD client, genetic predisposition remains constant; therefore, improvement may occur as a function of changes in the psychosocial environment, When this failure in correction continues despite substantial therapeutic and pharmacological interventions to overcome the effects of the illness. In that case psychosocial avoidance may lead to disability even in the absence of acute symptoms. In other cases, the miss-communication between the person and the psychosocial environment may override the effects of medication, so the person remains disabled by the recurrence of symptoms.

In the current social and economic climate, the client and psychosocial environment gets less attention than pharmacological interventions. In bipolar illness, the beneficial effects of medications are powerful for many people, but they still offer limited remedy for the illness. Psychosocial disability in this illness often lingers despite medication, possibly in part because medications typically do not alleviate cognitive impairment 8 and may, in fact, aggravate it .Although medication can improve psychosocial functioning in BD in general by improving affective symptoms[10], pharmacological interventions alone may not have sufficient power to overcome the destabilizing effects of psychosocial demands that exceed the person's functional capacities [11] Support groups and psychotherapy offer a context in which people can experience acceptance, appreciation and meaningful interpersonal connections. Some interventions such as interpersonal and social rhythm therapy (IPSRT) may also enhance psychosocial competence in Bipolar Disorder [9].

At the same time, these efforts may not be powerful enough to override a misfit between genetic vulnerability to stress and psychosocial demand. If people are unable to maintain consistent social and professional growth that is commensurate with their potential outside therapeutic

settings, their lives remain limited by psychiatric illness and functional disability

HOW TO IMPROVE FUNCTION

To overcome this problem, mental health team working with Bipolar may need to develop expertise in helping people identify psychosocial contexts that facilitate growth. Learning to conduct, or at least interpret, cognitive assessments with ecologically valid interpretations would likely be fundamental to this process

The psychosocial failure may cause fear, which can lead to the avoidance of functional challenges and to the feelings of helplessness and hopelessness. Helping people with cognitive impairment and mood instability overcome the impediments these factors create may require a great deal of expertise and potentially even more highly specialized programs—for instance, an intervention may combine elements of IPSRT with vocational counseling tailored to Bipolar illness. Traditional practices of vocational counseling alone may not sufficient to provide full effect.

The psychosocial interventions should aim at improving social and occupational outcomes through cognitive remediation, and with other family focused interpersonal therapy. Given the impact of both residual symptoms and cognitive impairment on functioning, and the correlation between them, a thorough assessment of each should be included as part of the standard of care in BD.

In forthcoming years, identified cognitive deficits may be given importance to some degree with direct interventions including compensatory [10]and restorative cognitive remediation programs both manualized and computerized like Family-focused care[12,13,14](FFT).FFT is a method of care delivery that recognizes and respects the pivotal role of the family. FFT views the patient and family as a complete unit, while supporting families in their natural care giving roles and ensuring family collaboration and choice in treatment decisions affecting patients. By its very nature, family-focused care opens up the care delivery system to include support and communication with families.

Research evidence

Miklowitz and colleagues have pioneered family-focused[12, 13] psychoeducational treatments for bipolar disorder (2000, 2003and 2008). Their family-focused treatment involves all available immediate family members in 21 one-hour sessions delivered over 9 months (12 weekly, then 6 fortnightly, then 3 monthly). Family focused therapies includes

Psychoeducation focusing on the signs and symptoms of bipolar disorder, the etiology of bipolar and strategies to prevent relapses; communication enhancement training sessions using role-play and between-session rehearsal to teach skills for active listening, ways to deliver positive and negative feedback and constructive ways to request changes in behavior; Problem-solving skills training sessions in which participants learn to identify specific family problems that might contribute to relapse and develop skills for finding acceptable solutions to these problems[13].

After clients take action to re-engage in occupational pursuits, health team members may need to help them persevere in the face of the natural frustrations that accompany efforts to obtain psychosocial accomplishments on an alternative schedule. They may also need to assess and monitor the person's stress effectively. Taking significant steps toward psychosocial development in BD is desirable but can increase stress, and thus lead to relapse. Clinicians will have tough job to help clients to manage stress without affecting their psychosocial growth or resigning themselves to state of disability.

Given all of these challenges, progress toward psychosocial growth in BD may well be inconsistent. In many cases, a successful outcome of counseling would be to keep the growth from being eliminated completely in the face of recurring symptoms. Ultimately, a positive trend in psychosocial growth may be more important than measuring any one sizable change in outcome in BD.

Finally, in future the social climate of bipolar patients needs to be improved to achieve better functional outcome. At present, few mainstream environments accommodate the special needs of people with BD. Stigma and discrimination against people with mental illness in the workplace need to be removed to have a better psychosocial outcome. Consequently, in most settings, the intensity of functional demands and inhospitable atmosphere may be too stressful to negotiate with sufficient long-term consistency. The chronic mismatch between the functional limitations of persons with BD and the environmental demands in the absence of ongoing support will lead negative impact on psychosocial adjustment and development. Developing effective support for psychiatric disability in mainstream settings may, therefore, improve clinical and functional outcomes. More broadly, mainstream support and an inclusive shift

in social climate may be essential for curbing the downward psychosocial spiral that so many people with BD experience after illness onset.

CONCLUSION

The factors that contribute to psychosocial functional impairment in Bipolar may be looped together in intricate ways, creating an effect that traps people in a course of functional deterioration. To change this we may require both searching for and actively creating psychosocial environments that are hospitable to the specific needs of people who suffer from Bipolar Disorder. In basic understanding, psychosocial impairment is environmentally dependent and not a constant. For this reason, in addition to medications and conventional forms of therapy like Social Rhythm Therapy and Family Focused Intervention, Simple counseling, Cognitive behavior Therapy and a strategic approach that enhances the goodness of fit between persons with Bipolar Disorders and their psychosocial environment may change their possible functional outcomes. Most importantly, improving this fit may shift the lifelong path of persons with Bipolar Disorders from malignant psychosocial decline to growth.

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