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BIPOLARITY - PSYCHOTHERAPEUTIC AND PSYCHO-PHARMACOLOGICAL INTERVENTION

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Abstract: Bipolar disorder or "bipolar affective disorder" is a chronic illness, being considered a complex mental disorder that affects approximately 60 million people worldwide, according to the World Health Organization (WHO) bipolar disorder is the sixth cause of disability and the third most serious mental illness. Unipolar depressive disorder (UDD), which is on the spectrum of bipolar disorder (BD), affects about 15% of the population during their lifetime, being one of the most frequent diagnoses in psychiatry. In specific populations, it can reach even higher percentages, as observed in cancer patients, reaching 47% of individuals. Psychotherapeutic follow-up is essential in the treatment of bipolar disorder. Several studies prove the effectiveness of psychotherapy associated with pharmacological treatment. Psychotherapy promotes self-knowledge and self-perception, helping to understand oneself and the disease, is a means of creating and establishing strategies to deal with the peculiar difficulties arising from the disorder, and helps resistant patients to adhere to pharmacological treatment. It is estimated that approximately 50% of individuals with bipolar disorder do not adhere to pharmacological treatment correctly and discontinue it at some point. The basis of the treatment of bipolar disorder is the use of drugs that regulate or adjust the patient's mood, mood stabilizers, thus avoiding large fluctuations.
Keywords: Bipolarity, pharmacotherapy, psychotherapy, mood, depressive, unipolar disorder, bipolar disorder.

INTRODUCTION

Bipolar disorder (BD), also known as "bipolar affective disorder" is a chronic illness, being considered a complex mental disorder that affects about 60 million people worldwide, according to the World Health Organization. Bipolar is the sixth leading

cause of disability and the third most serious mental illness. When we talk about mood disorders, sometimes we make immediate associations between depression and TB because the symptoms are similar in their diagnosis, such as sadness, discouragement, apathy, negative thoughts, leading the patient to an increase in risk. of suicide. Depression is characterized by being unipolar, although they can be confused in the initial diagnosis, it must be differentiated, since bipolar disorder is characterized by mood fluctuations, sometimes sudden, with oscillation between the state of euphoria and depression.

According to the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM 5) and the International Classification of Diseases (ICD-10), the disorder is differentiated into two main types: type I characterized by phases of more severe depressed mood and persistent, and there may be interventions for hospitalizations and more specific care due to the increased risk of suicide and possible complications in physical health, so in bipolar disorder type I, moods alternate between mania and depression and in type II characterized by the phases of mood more mild alternating between depression and hypomania (mild changes in agitation, euphoria, optimism, increased energy, and sometimes aggression), in which the person with the disorder does not significantly impair their activities and behavior.

The mood state can be classified as elevated or depressed. When the mood is not part of a psychopathological picture, the individual transits through a wide range of mood states, however, he feels in control of these states. In cases of mood disorders, this control is lost, which imposes subjective experiences that are linked to mental suffering. The 1950s of the last century were also a watershed in the field of neuropsychiatry. At that time, the discovery of the first psychotropic drug, chlorpromazine (Amplictil CR - controlled release, allowing a longer time of action of the drug) occurred, initiating the psychopharmacological revolution, in addition to the publication of the first edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) , currently one of the greatest sources of legitimacy of psychiatric diagnoses.

UNIPOLAR DEPRESSIVE DISORDER (UDD) AND BIPOLAR DEPRESSIVE DISORDER (BDD)

TDU affects about 15% of the population during their lifetime, being one of the most frequent diagnoses in psychiatry. In specific populations it can reach even higher percentages, as in the case of cancer patients, reaching 47% of individuals. This disorder brings with it even more alarming numbers: according to WHO and PAHO, TDU was the leading cause of disability in the world, which in 2020 was the second leading cause of the global burden of disease, second only to coronary heart disease. These data demonstrate that TDU is a serious public health problem. It has a prevalence 2 times higher in women than men and there are some hypotheses for this, such as hormonal differences and psychosocial factors, such as the impact of the generation and upbringing of children. The average age of onset is 40 years, but 50% of individuals first manifest between 20 and 50 years. In addition, it can also occur at advanced ages or in childhood.

Regarding the elderly, the prevalence is around 25%, but when considering residents in nursing homes, this rate can reach 80%, becoming an even greater concern with the increase in life expectancy. In children and adolescents, the incidence has also increased due to factors such as separation from parents and excessive activities performed. When the first episode occurs in childhood or adolescence, the probability of recurrence

is quite high. In prepubertal children, the prevalence among boys and girls is equal, reinforcing the theory of hormonal influence in this disorder. It is more frequent in people without close interpersonal relationships or divorced and there is no correlation with socioeconomic status.

The psychopathology of DUD is quite complex. As we have seen, mood disorders are prolonged emotional states. But what are emotions? Well, emotions are "subjective experiences that are accompanied by detectable physiological and behavioral manifestations". This means that an emotion has components, namely: the affective component (feeling), which is the inner experience that the individual has in face of an experience (internal or external), which can be positive or negative, that is, how each one interprets an event, how we feel about it. This feeling promotes endocrine and autonomic adjustments, which represent the physiological component, and also triggers characteristic motor reactions, guiding behavior. Mood disorders not only bring about changes in mental status, but affect the body and certain functions. They present physiological, cognitive and behavioral changes.

Mood-related features that stand out in unipolar depressive disorder are: the presence of sad (or depressed) mood and despondency or apathy for most of the day (nearly every day), with generalized loss of interest, inability to experience pleasure (anhedonia) and mental anguish, accompanied by feelings of guilt. Regarding cognitive symptoms, individuals with DUD present, for example, thoughts of worthlessness, negativism and thoughts of death, as well as difficulty concentrating, memory impairment and slowing of thought. Among the physiological symptoms are: sleep disturbances, usually insomnia, but excessive sleepiness can also occur; changes in appetite, the most common being loss of appetite, but the reverse can also occur; excessive tiredness; and changes related to the sexual act, such as decreased libido and erectile dysfunction. In more severe cases, there are psychotic symptoms (delusions and hallucinations), always associated with feelings of worthlessness and inferiority. And the worst outcome, suicide.

TDU is characterized by oscillation, often sudden, of episodes of mania, hypomania (a milder change than mania) and depression, its cause is unknown, however, issues such as heredity, psychosocial factors and changes in neurotransmitter levels may be related. to the disorder. With treatment based on mood stabilizing drugs, 2nd generation antipsychotics and psychotherapy.

According to the International Statistical Classification of Diseases and Related Health Problems (ICD-10), bipolarity is classified as: bipolar affective disorder (F31), with subclassifications depending on the current episode in which the patient is. The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) classifies the disorder into:

- Type I: at least one manic episode, which may be associated with episodes of hypomania and major depression;
- Type II: at least one episode of major depression and one of hypomania;
- Cyclothymic: depressive and hypomanic periods lasting at least two years.

The epidemiology of bipolar depressive disorder is quite different from unipolar. Its prevalence is similar to that of schizophrenia, on average 1% of the general population. It affects men and women in equal proportion, however, manic episodes are more common in men, while depressive episodes are more common in women. Its onset is around the second or third decade of life, but there are authors who say that it varies from 6 to 50 years. It is also more frequent in people

without close interpersonal relationships or divorced, however, in this case, the early onset of the disorder may represent the cause of separations. The incidence is higher in groups with higher socioeconomic status. It is worth noting that 10 to 20% of individuals with BDD have their diagnosis changed to BDD.

As in TDU, in TDB we have a multiplicity of symptoms. In relation to mood, in this case, the changes are bidirectional, alternating depressive and manic manifestations. In manic episodes, we find expansive or euphoric mood, irritability can also be identified, in addition to excessive involvement in pleasurable activities (such as, sexual activities and excessive shopping).

Cognitively, two characteristics stand out. One of them is tachypsychism, that is, an acceleration of psychic functions, which is represented with exaltation, loquacity, prolixity, accelerated thinking and psychomotor agitation, and the occurrence of excessive distraction (such as, for example, difficulty in sticking to a theme). The elation or expansion of the Self is also notorious in mania, arrogance is striking.

In relation to physiological symptoms, there is an increase in activities (individual engages in various activities, showing little common sense to manage them), psychomotor agitation and less need for sleep. Psychotic symptoms can also occur in more severe cases.

Depressive episodes present symptoms similar to those described for TDU. Most of the time there is no clear precipitant, but sleep deprivation is considered a strong candidate. The frequency of episodes of mania and depression varies greatly from individual to individual, in addition, euthymia (normal mood) may or may not be present between episodes, in some cases there are residual or chronic symptoms, even with treatment. In the table below we see other signs and symptoms of BDD.

IMPORTANCE OF PSYCHOTHERAPY

Psychotherapeutic follow-up is essential in the treatment of BAD. Several studies prove the effectiveness of psychotherapy associated with pharmacological treatment. Psychotherapy promotes self-knowledge and self-perception, helping to understand oneself and the disease, is a means of creating and establishing strategies to deal with the peculiar difficulties arising from the disorder, and helps resistant patients to adhere to pharmacological treatment.

By looking for ways to adjust to and deal with the condition, the patient may be able to more accurately understand the episodes and the disorder itself. Different psychotherapeutic approaches can be used, among them: Cognitive-Behavioral Therapy, Psychoanalysis, Systemic, Humanistic, Behaviorist.

PSYCHOTHERAPEUTIC APPROACH X BIPOLAR DISORDER

The patient diagnosed with bipolar disorder can find psychotherapeutic support in several approaches. I now cite some psychological approaches and how psychotherapy works.

- Cognitive-behavioral approach: analyzing the patient's current episode, it is possible to trace behavioral responses, consequences and effects from the presented antecedents. Therefore, there is the possibility of developing self-knowledge and self-control on the part of the patient regarding their behavior and how their cognitive influences their actions, seeking to bring the patient to the reality of their behavior and emotions.
- Humanistic Approach: allows the patient's own decision-making power, being responsible for them. The lived experiences are the focus so that the

understanding about the actions reaches the level of awareness of the consequences and emotions brought by the patient in the session.

- Psychoanalysis realizes that the disorder is linked to unconscious motives, provoked by some repressed conflict, usually in childhood. The aim of psychoanalytic psychotherapy is to bring unconscious contents to consciousness, reliving traumatic experiences from the past. Systemic Approach: the family structure plays an important role in the functional organization of the patient, providing support to individual activities, based on transactional patterns.
    - o Dysfunctional or disorganized family circles is a risk factor for the disorder and can lead to relapses, thus, the reorganization (or its understanding by the patient) of the family structure is of great relevance in this approach.

PHARMACOLOGY OF BIPOLAR DISORDER

It is estimated that approximately 50% of individuals with bipolar disorder do not adhere to treatment correctly and discontinue treatment at some point. There are several factors in psychiatry that speculate this problem in relation to the disorder, they are: beliefs regarding treatment, alcohol and drug use, lack of knowledge about the disease, demographic characteristics, sex, age, personality, family history of psychiatric disorders , family structure, disease severity and polarity, drug-related factors such as complex dosage regimens, adverse effects and drug interactions, and physician-related factors such as their attitudes toward the disease and patient interaction.

The basis of the treatment of bipolar disorder is the use of drugs that regulate or adjust the patient's mood, giving him stability, thus avoiding large fluctuations.

The general principle of treatment of any patient with bipolar disorder, with or without comorbidity, is based on the use of mood stabilizers. This implies the risk of interactions with antidepressants, antipsychotics and benzodiazepines, which are necessary in many situations. The various psychotherapeutic modalities, as well as support and self-help groups, can also contribute significantly to improving the quality of life of these patients, but they do not eliminate the need to use medication.

In general, the treatment of cases of comorbidity is more laborious, requires more in-depth knowledge of psychopharmacology, with often frustrating results. Patient compliance is lower, their response to treatment is not as good and, consequently, remission is more difficult to achieve.

In the case of a chronic disorder, the pharmacological treatment becomes more difficult, due to the fact that this patient will have to use the medication for very long periods or throughout his life. And that is why patient adherence is of fundamental importance and must be monitored so that the treatment has positive results. Combinations of drugs have numerous advantages, including the possibility of lower doses of drugs that are more harmful to the body, but the combination of drugs can cause damage to health, as is the case with the combination of olanzapine and valproate.

The main associations applied in the treatment of the disorder are: Lithium + antipsychotic: Used in maintenance therapy for bipolar disorder; Lithium + carbamazepine: This combination is widely used in addition to being very effective and safe, according to studies carried out by Souza (2005); Lithium + Fluoxetine: This combination prevents

depression in bipolar patients, and is a very effective combination, most of the time; Lithium + Lamotrigine: This combination is useful and effective in some cases, but is less effective; Valproate + Carbamazepine: The addition of valproate to patients who did not respond to carbamazepine alone.

Of all the so-called mood-stabilizing agents, lithium has the most comprehensive efficacy in the treatment of these conditions. It has the disadvantage of delayed onset of effect and therefore anticonvulsants, neuroleptics or benzodiazepines are used in association with lithium at the beginning of treatment. Because its therapeutic dose is very close to the toxic dose, lithium must be used by a specialist and when it is possible to monitor its serum content. Prolonged use can cause thyroid disorders and cognitive and memory deficits. Recurrence of the disease is common with discontinuation, which must be done gradually.

Because bipolar affective disorder is characterized by different phases, some agents may be effective only in one phase of the disorder, and polypharmacy is frequently used. Thus, monotherapy in bipolar disorder is the exception rather than the rule, which is one of the main difficulties for patient adherence to treatment. It is also known that the simultaneous prescription of several drugs, as a therapeutic strategy, and the growing number of these agents on the market can contribute to increase the beneficial effects of the therapy, however, they can also result in unwanted effects and drug interactions. In the case of psychotropic drugs, especially antipsychotics, some of their side effects are painful and even disabling, and may constitute an obstacle to patient adherence.

Faced with the complexity of the process of adhering to drug treatment, it is necessary for mental health professionals to have in-depth knowledge of the different therapeutic modalities, as the approach to this problem, through an exclusively biological or psychological view, may not meet the real needs of the patient. patient demands. In order to act effectively on problems related to non-adherence to treatment, health professionals need to know the reasons that lead the patient to not adhere to the treatment, as well as the conceptions that the patient has about the prescribed medication.

Along with the pharmacological treatment, the psychotherapeutic approach can be associated with the treatment, which are of great value, as their main objective is to increase adherence to treatment, reduce residual symptoms, reduce the rates of hospitalization periods, thus improving the quality of life for patients and their families.

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