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PSYCHOSOCIAL INTERVENTION FOR REDUCING RELAPSE AND IMPROVING TREATMENT ADHERENCE IN BIPOLAR AFFECTIVE DISORDER WITH POOR SOCIO-OCCUPATIONAL FUNCTIONING AND HIGH EXPRESSED EMOTION IN THE FAMILY: A CASE REPORT

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ABSTRACT **Introduction:** Bipolar affective disorder (BPAD) is a chronic psychiatric disorder with an admixture of frequent and recurrent episodes of mania, hypomania, depression, or mixed episodes. More than 1% of the world's population and at least 0.3% of the Indian population are affected by BPAD. We have chosen a case of BPAD with multiple episodes to study the impact of psychosocial intervention in the management of the illness of the affected person and family. **Presentation of the case:** The index client, a male, 32 years of age, visited the Institute of Psychiatry (IOP) with caregivers and was referred to the psychiatric social work department of the IOP on April 24, 2019, with symptoms of mania and psychosis. He had 7-years history of psychiatric illness, including multiple episodes of mania and depression, as well as frequent irregular medication; burden and conflict, insufficient social support, poor communication and interaction patterns, poor coping and problem-solving skills in the family. Therapists imparted Interpersonal and Social Rhythm Therapy (IPSRT) and family-focused therapy to the client and family members. **Discussion:** It was found that there was a significant difference between pre- and post-psychosocial interventions in the life and wellbeing of a person with BPAD and his family. Post intervention, client's level of social and occupational functioning was increased, high expressed emotion had been notably decreased, adaptive patterns had been improved, and cohesion in the family had been strengthened. The client and his family members learned to prevent development of future episodes. **Conclusion:** Psychiatric social work interventions have been a key area in the management of BPAD involving the family, which helps in maintaining a prolonged euthymic period and better treatment compliance.

KEYWORDS : bipolar disorder, psychiatric social work, expressed emotion, psychosocial intervention.

1. INTRODUCTION:

Bipolar affective disorder (BPAD) is a common and complex psychiatric (mood) disorder characterized by an admixture of frequent and recurrent episodes of mania (extremely elevated mood, unusual thought patterns, and sometimes psychosis); hypomania (a less severe form of mania), depression (low mood, anhedonia, negative automatic thoughts, somatization, and often a suicidal state), or mixed episodes (WHO, 1993). More than 1% of world's population (Grande et al., 2016) and at least 0.3% of the Indian population (Gautham et al., 2016) have BPAD. The lifetime prevalence of BPAD is about 3% in the general population and globally it is the sixth leading cause of disability (Boland et al., 2013; Schmitt et al., 2014). Bipolar disorder typically manifests itself between the age of 20-25 years (Carvalho et al., 2020). The suicidal risk is high. Over a period of 20 years, 30-40% of persons with BPAD engage in self-harm, and around 6% die by suicide (Anderson et al., 2012).

The etiology of this disorder is not clearly known, but environmental and genetic factors are considered to play a role (Schmitt et al., 2014). As result of the illness, approximately one-quarter to one-third of people with BPAD has social and work or employment related problems (Boland & Alloy, 2013). Two-thirds of people with BPAD have impaired psychosocial and/or occupational functioning in between episodes even when their symptoms are in remission (Cipriani et al., 2017). BPAD has an adverse impact on family and caregivers, who has developed anger, guilt, stress, and anxiety (Tracy, 2021). BPAD is associated with higher caregiver burden (Gania et al., 2019). Persons with BPAD and their family members have been characterized by levels of high expressed emotion, absence of family cohesion and family adaptability, and inadequate interpersonal relationships with considerable impact on caregivers' employment, finances, legal matters, and other social relationships too. Violence was a particular worry for caregivers when the person was in manic episode (Dore & Romans, 2001; West & Cosgrove, 2019; Zhang et al., 2019).

This study signifies the importance of psychosocial intervention in the management of an individual with BPAD who has had multiple episodes. It also aimed to investigate whether psychiatric social work intervention has any significant role to play in strengthening social and occupational functioning of the individual with BPAD, reducing expressed emotion and increasing cohesion in the individual's family, thus maintaining treatment compliance, preventing future episodes, minimizing caregivers' burden and maintaining wellbeing, and improving communication and adaptive patterns of the person and the family members.

2. PRESENTATION OF THE CASE:

The index client is 32 years old, unmarried, unemployed, educated up to class XII, from a joint Bengali-speaking Hindu family of middle socioeconomic status in a semi-urban area, with a well-adjusted premorbid personality, presenting with complaints of irrelevant and big talk, an exaggerated sense of well-being and self-confidence, hearing voices without the presence of anyone nearby, from last 2 months; decreased need for sleep, easily getting irritable; and using abusive language from the last 1 week. The client's family brought him to the Institute of Psychiatry (IOP) on April 24, 2019. After prescribing medications, he was referred to the Psychiatric Social Work (PSW) department of IOP for intervention, where the Young Mania Rating Scale (YMRS) was administered, and the score was 37/60, which indicated that the client had a moderate level of mania (Young et al., 1978). The client's mental status examination revealed a dysphoric mood, ideas of persecution, grandiosity, and reference delusions, rapid speech, easy distractibility, flight of ideas, psychomotor agitation, poor judgment, and an absence of insight. Past history revealed that around September 2012, the client was feeling very sad as he was unable to get a good job, unlike a few of his close friends. He was pessimistic about his career and life, and he wished to die. In April 2013, he was badly scolded in his office. It made the client very upset, and he was unable to sleep. In the middle of that night, he heard the voice of an invisible

"divine power" that spoke to him about his job and career. He was frequently talking to himself and crying, then suddenly laughing again, in the following days. Due to his sudden, unusual reactions, his family took him to a psychiatrist at Bardhaman, West Bengal, India; and he was under treatment for 4 years, with irregular compliance, from 2013–2017. Around August 2014, he felt irritated due to his father's critical comments about his career, and he started to break household things, and use abusive language towards his friends and family. During 2015-2016, the client changed his private job twice due to highly troubling relationships with his superior reporting authority and colleagues, which made him feel sad, lose interest in most of the day-to-day things, and have occasional suicidal thoughts. In March 2017, the client's family members expressed strong dissatisfaction with the client's unemployment and his father blamed him for his illness. Soon, the client claimed himself as a chartered accountant and head of the state's detective agency, had increased psychomotor activities, and had a decreased need for sleep. As his condition deteriorated, the client's parents took him to the IOP in April, 2017. He was provisionally diagnosed with Bipolar Affective Disorder, current episode manic with psychotic symptoms (F31.2) (WHO, 1993), and advised to take medications. He took the medicines for 6–7 months and then stopped as he felt well. He tried hard in between, but was unable to find a suitable job for himself. Around April 2018, the client had a low mood, a feeling of worthlessness, hopelessness, lack of energy and suicidal ideas. He visited IOP again in July 2018, and took medicines. He had conflict with his father and was dissatisfied with the attitude of his brother-in-law. For three and a half months, he had irregular medications, increased talk, and decreased sleep needs. Personal history revealed that the client was a planned baby. He was shy as a child. The client's attitude towards siblings, relatives, and friends was favorable. He was an average student. He used to participate in group activities. A feeling of inferiority was present in the client.

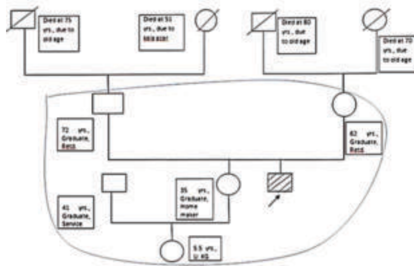
Figure 1: Family Genogram

2.1 Family Interaction Pattern:

Client's sister and mother were very cordial and caring towards the client. The client and his father shared a need-based relationship. The client and his brother-in-law shared a purposeful, though strained, relationship. The client's brother-in-law was critical of the client. The client and his niece shared a friendly relationship.

2.2 Family Dynamics:

Boundary was open and clear. The spousal and sibling subsystem was present. The parental subsystem was not well formed between the client and his father. Leadership was democratic. Client's brother-in-law was the family's nominal and instrumental leader, while his sister was the functional leader. Role allocation was adequate, and role complementarity was present.

Direct, verbal, and non-verbal communication was present among all family members, except between the client and his brother-in-law, who often shared switchboard communication via client's sister. Warmth and positive regard were present towards the client when he achieved a desirable result or made progress. 'We' feeling was not adequately present. There was a high level of noise in the family. Blaming and conflict between parents were reported, mainly due to the client's illness. Client's father often compared the client with his brother-in-law. The family members (especially the parents and sister of the client) had inadequate adaptive patterns. Relatives' secondary social support for the client was also insufficient.

2.3 Expressed Emotion:

Critical comments were made towards the client by his father and brother-in-law, and hostility was also present from his father. The client's mother displayed emotional over-involvement toward him.

2.4 Psychosocial Diagnosis (WHO, 1993):

Z56 Problem related to employment and unemployment
Z63.1 Problem in relationship with parents and in-laws
Z63.2 Inadequate family support
Z73 Problem related to life-management difficulty

3. Evidence-Based Brief Psychiatric Social Work Intervention

When the client had one and a half months of medication compliance and before initiating psychosocial intervention in this case over 25 sessions, the level of mania [found mild at the YMRS (Young et al., 1978)] and social-occupational functioning of the client, and expressed emotion in the client's family were measured via the administration of relevant scales, as mentioned below.

3.1 Psychoeducation:

Psychoeducation was given to the client briefly about his illness. The treatment plan and procedure for the client, as well as hospital facilities, were discussed with his sister. The client's rights as a person suffering from mental illness had also been explained. Medicine log-sheet and supervised medication was suggested. Myths about psychiatric medicines were also explained during the session.

3.2 Family assessment & intervention:

Family assessment was done with the client's sister. It was found that the client's illness had an adverse impact on his family. Stress, emotional distress, and illness burdens plagued family members. It was also found that the family had no clear understanding or knowledge of the client's illness. They are unable to distinguish between the client's normal behaviour and behaviour associated with illness. The client's sister was concerned about the client's condition as well as that of her elderly, ailing parents. It was also discovered that the sole performer's role as the client's caregiver had a negative impact on his sister's quality of life (QOL). Because of her time-consuming role in the client's needs and treatment, the client's brother-in-law was dissatisfied with the client's sister. She also reported that a few times she was adversely critical towards the client due to irritation or frustration. She received supportive intervention from the therapist. Stress management techniques and coping skills were also taught to her. Externalization of interest was suggested. Psychoeducation about the client's illness was also imparted, along with the importance of treatment adherence and a supportive family environment for the client.

3.3 Interpersonal and Social Rhythm Therapy (IPSRT):

IPSRT is a time-limited, structured treatment for people with BPAD to increase QOL and to prevent the development of future episodes (Frank et al., 2000; Frank, 2005 & Frank, 2007). The index client was exposed to it in four phases. In the ***initial phase***, the therapist reviewed the client's mental health history to understand the patterns in the associations between social routine disruptions, interpersonal problems, and affective episodes. Psychoeducation in detail was continued about the disorder, and the importance of stable routines to maintain mood was provided. The therapist further used the *Interpersonal Inventory* to assess the quality of the client's interpersonal relationships by focusing on the client's grief (loss of a healthy self), role transitions (frequent changes of employment or problems in adjustment at the workplace), role disputes (conflict with parents and brother-in-law), and interpersonal deficits (persistent social isolation). The therapist and the client reached to an agreement to work together on the problematic areas. The therapist further used the *Social Rhythm Metric* (SRM) to assess the client's target and actual times for the following activities on a daily basis: getting out of bed; making first contact with another person; starting work/housework; eating dinner; and going to bed. The intensity of the client's involvement with other people was also rated: 0 = alone, 1 = others present, 2 = others actively involved, and 3 = others very stimulating. At the end of each day, the client's mood is rated on a scale of -5 to +5. In the ***intermediate phase***, the therapist focused on bringing regularity to social rhythms and intervening in the interpersonal problem area of interest. The therapist followed the techniques of questioning (probing assumptions, rationale, reasons, viewpoints and perspectives, implications, and consequences); clarification of feelings, expectations and roles in relationships/role playing; communication analysis; decision analysis; encouragement, exploration, and expression of effect; enhancing social skills; vulnerable styles, which includes anxious, high personal standards, interpersonally sensitive to rejection; reassurance and feedback. Relevant worksheets were also provided to the client for the effective application of the above. The regularity of the client's activities, the frequency and intensity of his social interactions, and other factors were also examined. Importance of increasing suitable social network was explained. The client and

therapist further discussed stabilizing the client's daily routine by focusing on incremental behavioural modifications until a regular target time at which these activities are done was achieved. Individuals in the client's life who disrupt the routine, as well as those who are supportive of the client, were identified. The therapist also focused on building the client's confidence and developing skills to manage shifts in routine as required. In the ***maintenance phase***, the therapist discussed early warning signs of episodes with the client and also reinforced the treatment techniques learned earlier in order to maintain social rhythms and positive interpersonal relationships. He also focused on monitoring symptomatic and functional changes in the client's mood and noted any shifts in the routine using the SRM. In the ***final phase***, the therapist and client were involved in termination, in which sessions were gradually reduced in frequency.

3.4 Home Visit:

It was assessed that there were problems in the client's family, and there was a need for the family members to take part in the treatment process. To address it, and keeping in mind the objectives, goals, and techniques of family-focused therapy (FFT) (Miklowitz et al., 2008), therapists visited the client's home twice. Therapists imparted psychoeducation to the client's family. The client was also present in the session as required. Therapists focused briefly on communication enhancement training and problem solving skill training. He emphasized how countering the client without adequately listening to him could arouse irritability and lead to non-cooperation from the client. Family was educated about the client's inability to understand their position properly due to his illness. He further helped them to understand the necessity of active and supportive listening. He taught the family members to help the client calm down and to identify his emotional exacerbation by himself before asking non-offending questions. Family members should discuss the client's present needs, and negotiate possible solutions with the client. He suggested that a family member involve the client in identifying and defining specific family problems, brainstorming solutions, evaluating their pros and cons, choosing one or a combination of solutions, and developing execution-planning. Therapists further suggested giving responsibilities for small daily activities or household chores to the client and encouraging and rewarding him for completing them. The therapist also discussed the adversity of high expressed emotion and conflict in the family and emphasized the importance of role of family in the client's treatment process, as well as the importance of cohesiveness and unconditional acceptance from family towards him. Early warning signs of manic episodes were also discussed. Therapists requested them to accompany the client in further treatment sessions.

3.5 Family-Focused Therapy (contd.):

In further sessions, other family members also accompanied the client a few times and joined the sessions. Feedback was taken in each session. Client progress was monitored along with interaction patterns, communication and problem solving skills, and expressed emotion in the family, and necessary guidance and feedback was provided to family members to strengthen the above. The therapist was also available over the telephone on a number of occasions. He also explained with the help of metaphors that how poor family function contributed in deterioration of mental health and wellbeing. Family tasks and rituals were also suggested. Family members were further trained in self-management strategies to better cope with their own emotions and with the difficult symptoms displayed by the client. Worksheets related to interpersonal relationship enhancement, interpersonal parenting, and emotional repetition and attention remodeling was given. The therapist also focused on an action plan for relapse with the family members.

3.6 Follow-up sessions:

The client, along with his sister and a few times with his brother-in-law, went for follow-up at regularly scheduled intervals. The client was maintaining himself well, following advice and instructions. The Social and Occupational Functioning Scale (SOFS) (Saraswat et al., 2006) and the Family Emotional Involvement and Criticism Scale (FEICS) (Shields et al., 1994) were administered; family dynamics, interpersonal relationships, interaction and communication patterns were assessed. Vocational guidance about employment was given to the client by keeping his strengths in mind. The frequency of his visits for therapeutic sessions was extended.

Table 1: *Pre- & post- intervention assessment to measure the level of* Social and Occupational Functioning of the person with BPAD

Scale	Maximum Score	Pre- intervention assessment		Post- intervention assessment	
		Score	Impression	Score	Impression
The Social and Occupational Functioning Scale (SOFS)	70	42	Greater impairment in Social and Occupational Functioning	17	Lower impairment in Social and Occupational Functioning

Table 2: *Pre- & post- intervention assessment to determine level of Expressed Emotion in the family of the person with BPAD*

Scale	Maximum Score of each subscale		Pre- intervention aassessment			Post- intervention assessment		
			Score obtained at each subscale	Total Score Obtained (out of 56)	Impression	Score of obtained at each subscale	Total Score Obtained (out of 56)	Impression
FEICS	PC	28	24	46	High Expressed Emotion	08	15	Low Expressed Emotion
	EOI	28	22			07		

FEICS: Family Emotional Involvement and Criticism Scale; PC: Perceived Criticism; EOI: Emotional over-involvement

4. DISCUSSION:

This study showed a significant difference between pre- and post-psychosocial interventions in the life and wellbeing of a person with BPAD and his family, similar to some other studies (Britvic et al., 2009). After our intervention, the client gained insight regarding his illness, and his level of social and occupational functioning increased until his last visit, a few months ago. He was also engaged in employment. High-expressed emotion, illness and emotional burden in the family had been significantly reduced while treatment adherence and the sleep-wake cycle were maintained. The interpersonal relationships, communication, interaction patterns, and adaptive patterns of the family members and the client had been improved; and QOL of the client's sister had been also increased. The client and his family learned to prevent the development of future episodes. Many studies supported the findings of this study. Sahu (2013) also noted that IPSRT and FFT are effective in the treatment and wellbeing of the person with BPAD as well as for his family. Shetty et al. (2022) discovered that caregiver-assisted psychosocial interventions help reduce expressed emotion and improve knowledge of illness and communication, contributing better social functioning and treatment compliance, improving QOL, preventing further relapse and re-hospitalization, and therefore improving the effectiveness of pharmacotherapy, making it an important constituent in the holistic treatment approach to BPAD. No significant study was noted, which contradicts the results of this study and the treatment procedure followed in this case.

5. CONCLUSION:

This study infers that treatment, rehabilitation, and wellbeing of persons with BPAD and their families have been key areas of the psychiatric social work profession. This study also indicates that, in combination with medication, psychosocial intervention focusing on IPSRT and FTT is very effective in the treatment of BPAD and family. Hence, we can conclude that all persons with BPAD (whether the episode is manic, hypomanic, depressive, or mixed) should be referred along with the family member to the therapist for psychosocial interventions. There is also a great need to focus on community-based treatment and rehabilitation.

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