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Case Studies

PSYCHIATRIC DECOMPENSATION A RESPONSE TO FAMILY TRAUMA PATHOLOGY. INFLUENCE OF ARIPRIPAZOLE IN CASE MANAGEMENT

Keywords
Bipolar Disease
Aripriprazole
Family trauma

JEL Classification
I10

Abstract

Xenadrine (amphetamine) constitutes the drug which triggers physically the Bipolar Disorder, along with the psychological trigger – the familial issues: parents have lost their job, family have moved to another city, money problems, the parents experience a joined depression, mother of the patient acts like a shadow of the daughter, she grows up alone – never having an emotional relation with a friend. Aripripazole will helps controlling the disorder symptoms.

Aripripazole influences the evolution of Bipolar Disease giving the patient the proper instrument to control and understand the reality, to make difference between illusions and reality, ability to build social relations and the reconstruction of will.

Case history (David, 2006):
C. is a 23 year old woman, she has graduated the Faculty of Philology, is unmarried, but in a long distance relationship with an African athlete, and works as an interviewer at a mystery shopping company and also as a secretary in a well-known law company.

A. *The main complaints*:
After 2 years and 3 months since the last manic episode, taking psychiatric medication and following psychodynamic therapy, C. presents:
- obsessive rumination and excessive concern for her relationship with M. ("*I don't know what to do, I feel like I am going crazy with all the researches and the private detectives I hired...*"),
- difficulties in paying attention at work ("*I can hardly concentrate at work, because I can't stop thinking about M.*", "*Even when I am doing something, all I think about is M., and his relationship with G.*"),
- fatigue and low energy ("*I'm dead tired*,", "*Everything is very hard... All this effort for one minute of satisfaction on all levels...*", "*I'm getting more tired, I am behind in my work... They drove me crazy, they exhausted me, they finished me... this man, and his wife, and everyone*"),
- terrifying nightmares ("*I only have nightmares and I can not sleep well, I keep waking up*") and hypersomnia ("*It doesn't matter how much I sleep, I can not get up in the morning, even if I go to bed at 7 pm. I can't, I can't, I can't!*"),
- sadness ("*I am sad, I am feeling worthless most of the time*"),
- loss of pleasure ("*Nothing satisfies me anymore, nothing pleases me, I wouldn't be happy even if everything was perfect... I would still feel like there is nothing for me to live for, I wouldn't have any desire to continue*") and
- increased appetite *("I eat non-stop, I eat from Mc Donald's, I eat pizza, I eat three tons per day, I drink cola, I eat candy... oh my... chips, jellies...").*

a. The history of the present disorder
Until the age of 11, her mother describes her as being extremely ambitious, enterprising, focused on school, on academic and life success (with excessive energy and desire, discordant with her age). After sustaining an exam, she is admitted in the fifth grade in a top school of her city, in a performance class of mathematics, where she finds out she can not cope with the demands. After this mental trauma at the age of 11, when she fails to adapt to the climate of the school, *she insists to prove she can cope*.
Whilst she was learning for her final exam in the spring of the eighth grade (around the age of 14), C. has her first and particular psychotic symptom (it precedes every new manic episode) - **the thought echo**, in an embarrassing and parasitic way, strong enough to disturb her academic activity. Successively, she starts presenting the first affective symptoms of hypomanic intensity. For 6 months she follows a treatment of Risperidone 2 mg and Deparkine 500 mg, with favorable response and she manages to pass her exam. After this episode, C. was no longer able to be as physicaly and mentally „energetic" as before.
The second manic episode occurs at the age of 22 (in 2010), which was a turning episode caused by a treatment with 100 mg Ixel.
The third manic episode, without hallucinations or delusional ideation, started when she was 23 year old (in 2011) and had an onset of about a month, the manic intensity being achieved in the last few days. The **trigger** of this manic episode was a treatment with Xenadrine, recomendend by C.'s fitness coach, for her chronic sleepiness, considered by the pacient the reason of "*her existential unhappiness*". C. was hospitalised for 22 days in a psychiatric ward and received a new treatment, which she keeps following.
The psychiatric evaluation identified (at that moment) an intense psychomotor agitation, a tendency for behavioral disorganization, decisional incapacity, insomnia, lack of criticism, the desire of having fun in the company of *black men* (She insisted to go to the airport so she could meet several men of colour from a football team).
The physical examination on admission indicates BP = 140/80 mm HG; HR = 100 BPM; height= 167 cm; weight = 67 kg, her weight being kept under control by three fitness sessions per week for the last year. She was injected with Abilify immediately after admission, at around 11 AM, and the next dose was administered in the evening, along with 1000 mg of Valproic Acid. The next three days she was treated with two vials of injectable Abilify, along with 1000 mg of Valproic Acid. Further, her treatment consists of 10 + 10 mg Abilify and 500 + 500 mg Valproic Acid, and she kept taking her medication for about 6 months.
Between episodes, C. is hypobulic, her defense mechanism being a quasi-constant state of sleepiness; she is not concerned with finding a job (the two jobs she has now have been found by her parents) and she sustained her license exam with difficulties.

b. Personal and social history
C. is an only child. Her parents are engineers and have worked many years in a provincial town, having a successful business. **Her father** is an extrovert, an optimist, is very active and needs little sleep. C. says that her parents have always supported her in anything she wanted. **Her mother**, an introvert, is always *too* calm, always trying *to avoid* conflicts for the sake of her husband and her daughter. She seems a little too close to C., in an intrusive, intimate manner.

From the fifth grade, C. finds out she can not cope with the rest of her classmates, along with the competitive system and the envy between her classmates. After the failure in mathematics, she prefers English, where she performed successfully, participating in numerous competitions and contests, in Romania and abroad. Also she „separates" herself from her classmates, remaining "*incomprehensible*" and "*distant*" to them; so, she sets a goal for herself – being "*special*". She proudly states that she was the only one that had a good relationship with her class master, who was an overly demanding man.

All her teenage years she keeps herself at a "safe distance" to any close relationship, even in relationship with her parents. She grows mostly alone, her family being focused exclusively on the financial gain. Her maternal figure is her grandmother, about whom she does not talk much, because they were not "*on the same wavelength*". She becomes preoccupied with foreign languages, with intercultural issues, with the Arab world and with *black people*. In the last two years of high school, she falls in love with passion, her object of affection being a girl, about whom she developed a non-delusional fixation, C. being very affected when the two of them broke up two years later.

After unsuccessful attempts of bussiness recovery, C.'s parents decided to move to Bucharest to take it over again. They did not manage to adapt, so none of her parents is curently working. Her mother gets out of the house exclusively for psychotherapy sessions or for various medical checkups and her father is isolated at home, their savings allowing them to have a good standard of living.

In college, in Bucharest, C.'s preoccupations for Arab and African culture intensify. So she starts being a part of a virtual group of African and Muslim people. She keeps in touch with the members and a period of time she has virtual sex with them, along with dating men from social web sites. She is attracted to those who care just about their bodies and are not interesed by their intellectual development ("black men with eight packs abs"). She involves in a relationship with a black athlete from the virtual group. Although she has a great passion for him, she is not sad at his death; she behaves as if nothing happened and moves easily on to the next partner with an "eight pack", with whom she is in a long-distance relationship at the moment.

She graduates college and finds a job in her field three years later - thanks to her parents -, as a secretary at a well-known law company. At work, even though she says she can deal with her tasks, she can not focus, is behind the tasks and has a dysfunctional relationship with the boss, which she considers *terrible, difficult, uncomprehending*.

Her only close friend, Elena, whom she met in the same virtual group, is married to a black man and is her ally in her relationship with M., C. constantly asking Elena to collect all sorts of information about M.

The patient is very emotionally involved in her relationship with M., a Nigerian athlet who lives in another city of Romania, with whom she keeps in touch mostly just over the Internet and by telephone. C. is feeling used in this relationship because she supports him in his career (she found him an agent) and she also pays a lot of his financial expenses - when they see eachother she is the one who pays for food, for hotels, for clothing and other of his whims, but she also sends him money whenever he asks. C. is "going crazy" because of her relationship with M, but she does not want to let him go, neithter accept him as he is, but hoping he will change in the way she wants.

Although she is aware of the cultural differences between M. and her, she can not understand how important his family and religion are to him. On one hand, M. asks C. to trust him blindly, claiming he is not married to G., a woman with whom his parents would agree, and with whom he has a relationship for 9 years in Nigeria. On the other hand, C. is worried and tries to find all kinds of evidence to determine if M. is married to G.; she even manages to hack almost all his passwords, after she tried thousands of combinations (Facebook, E-mail, Messenger), and she keeps spying on him with the help of a mutual friend, Elena. Although she has evidence that M. and G. are married (her statement, their messages), C. continues to seek evidence (pictures from their wedding, their marriage certificate) before breaking up with M, even if she feels betrayed and used.

B. Medical History

Other health problems and undergoing treatment: HPV infection.

Medication for the Bipolar Affective Disorder:

- Past psychiatric prescription - Ixel 100 mg, Valproic Acid.
- Current psychiatric prescription - Abilify 20 mg per day for 6 months, reduced then to 15mg per day.

C. Temporal status

The patient is spatio-temporal orientated, has an euthymic disposition and her speech suggests a slight depression.

D. DSM-IV diagnosis (***, 2000)

Axis I: Bipolar Disorder Type I. The last episode was a manic one, with severe psychotic symptoms (the thought echo, June 2011).

According to DSM IV, the duration and instensity of the manic episodes are important for diagnostic. In the last episode, the patient was hospitalized for 22 days, the episode started about a month before and she manifested significant manic symptoms in the first period of her hospitalization. She presented psychomotor agitation, with a tendency to behavioral disorganization, sleeplessness,

decisional instability, absence of criticism, the desire to have fun, to be in the company of black men.
Her only psychotic symptoms is the thought echo, a specific feature of this case because it precedes every new manic episode, the thinking perturbation preceding the emotional perturbation.
The patient does not consume substances nor has other illnesses that better describes her condition.
One year ago she had a manic episode, which was caused by Ixel 100 mg, and the onset of her disorder was a hypomanic episode when she was 14.
Axis II: Nothing clinicaly relevant. C. presents some personality traits from the borderline and/or narcississtic personality disorders.
Axis III: Nothing relevant, except some interdictions in the sexual area, because of her previous behaviour in manic episodes (unsafe sex, HPV)
Axis IV: She is overwhelmed by a lot of aspects of her life (insecurity in her relationship, her partner's infidelity, her tasks at work, her license exam) and she has too little social support (C. interacts just with her parents and a single friend, besides her economic status).
The conceptualization of the case from the cognitive-behavioral perspective
A. *Etiologic factors*
Perhaps the intense preparation for a very important exam for C. (trigger), the desire to be "*the best*", her expectation of coping with the competitive and high performance environment (predisposing factors), and her impossibility to adapt to a new school context: the exam, determinant for her admission to school (favoring factors) started and maintained her first hypomanic symptoms, and also the psychotic symptoms (the thought echo). C. was expecting to obtain good results at an exam that required serious preparation. Instead, as the deadline was approaching, she started hearing the echo of her thoughts in an embarrassing and parasitic way, disrupting the entire learning activity, compromising the desired results.
B. *The evaluation of her psychotic cognitions and behaviors*
A particular problematic situation of this patient is related to her first hipomanic episode, when she was 14. The onset of the hipomanic episode seems to be related to the patient's inability to generate alternative explanations, ones that are culturally and socially acceptable for hearing the echo of her thoughts. She describes this phenomenon as being embarrassing and parasitic. The fact that she could not find a cultural acceptable explanation may be due to the distorted picture she had on his own Ego and because of her previous social experiences.
She always saw herself as "*the best of her class*", image maintained by the unconditional and non discriminatory approval of her mother, by her performances in competitions in English and by her desire to prove herself she can cope with the competitive environment of the class. Perhaps, all of these factors determine C. to not tolerate the abnormality of this phenomenon. The lack of boundaries set by her parents makes it hard for her to form a real self-image and contribute at maintaining the statements regarding to herself- *the best of the class hears the echo of her own thoughts.*
This distorted image favors the activation of dysfunctional cognitive and behavioral responses. She uses a type of congnitive distortion for predicting the future : "*I won't be able to pass this exam*", this thought amplifying the vicious circle. She, „*the best of her class*", can not accept hearing her thoughts anticipating her failure at this exam, but because it keeps repeating, her behaviour starts changing and she starts preparing less for the exam.
As the previous mentioned cognitive distortion kept reactivating more often, so did the thought echo, leading to a greater unacceptability of her interpretations. In terms of behaviour, she concentrates even more on study, emphasizing the mental fatigue. Although she hears the echo of her thoughts C. is not delirious, nor has auditory hallucinations, she is aware of what is real and what is not and knows that this phenomenon is something unusual.
Because she was always praised and appreciated for every success, and she was supported to obtain anything she wanted, her image of her Ego is very amplified: She is a good student who can achieve any goal; so good that she understands that an unusual phenomenon is happening to her, but the phenomenon is even more unacceptable in her position - "*the best of her class*". All of these interpretations contribute to the onset and maintenance of a negative emotional affection, of hypomanic intensity, and the related physiological reactions (insomnia) (Holdevici, 2005). (figure 1)
Following the same model of cognitive and behavioral interpretation, if we follow the fixation C. has in relationship with M., we obtain the following description from figure 2.

C. *Longitudinal evaluation of the cognition and behaviour*
C. grew up in a family with extremely protective and permissive parents who did not set any limits for her, allowing her to do anything she wanted, and to decide alone in difficult and important moments. Her responsibility was to be "*the best of her class*" and "*the most beautiful girl on Earth and Stars*", while her parents ensured her all she needed, even when she changed her mind because she could not accomplish what she previously planned. Her life experiences led to the development of a c**ognitive scheme of grandeur,**

dominance and claiming of personal rights, which developed onto a narcissistic personality structure (Young, 2003).

Her belief that she is **better than the others**, no matter what, started in her childhood. Because of her parent's money and status in the provincial town, because of her great results in primary school and because of her mother's words (you are *„the best"*), she starts feeling superior than others. When her image about herself is not validated by others or by her results, she percieves them as constraints or threats to her self-image and so she developes a "**narcissistic wound**". Instead of learning to accept and master her normal frustration and inferiority in the new class, C. considers she is treated unfairly. So, she either develops active compensatory strategies to strengthen her convictions about her Ego (she starts studying English intensively and participates in national and international competitions where she obtains good results) either she avoids the situations that make her feel vulnerable or uncomfortable (she isolates herself from her classmates; to them she remains "*incomprehensible*" and "*distanced*") (Beck,2011) or she becomes angry, defensive and depressed, when her other coping mechanisms no longer work. In high school, this compensatory strategies continue, following the same pattern: C. becomes very preocupied with the Arab and Black culture and becomes an expert on this subject.

To maintain her belief that she is superior to others, she positions herself as Saviour in relation to other people who need help: she starts volunteering at a nursing home, receiving admiration that confirms her self-image. In college, she joins a virtual social group of black people from Romania and starts a relationship with M. (a man preocupied just for the aspect of his body), validating her superiority. She is more educated, richer and she helps him solve his problems and supports him financially. Even if she is aware of the differences between them and she knows he has a girlfriend, she keeps trying to be better and ignores any evidence she finds (M. spends more time with the other woman, he talks more on the telephone or via Internet with her) she starts getting angry, hostile and aggressive.

Her belief that she has special rights and privileges was formed throughout her childhood. Because her family was wealthy, she had access to things that were out of reach for other children (cultural and travel experience in Africa; international competitions) and structured and maintained this conviction. Her mother's permissive style, who did not know to set some limits encouraged C. to develop this belief. In this way she learns that she deserves everything, even if she does not respect other people's feelings or rights and she is not aware of the principle of reciprocity in relationships. Currently C. **lacks interest in other's needs and feelings**, whether they are small things, such as M.'s interdictions of having sex before matches, or even in more complex issues, such as his desire to not feel responsible for her suicidal tendencies ("*He doesn't want someone whose life depends on him*") (Beck, 2011).

C. learnt that **she can get whatever she wants**, as she wants, even if it is getting in a high performance class, going on holiday to Africa, or having a homosexual relationship in adolescence. C. learns to impose, to control other people's behavior, in accordance to her own desires. Having no limits, when her desires are not easily fulfilled, she learns to insist, whether what she wants is resonable or not. Amid the unconditional acceptance from her mother, a new narcissistic wound occurs in adolescence, after being abandoned by her girlfriend. Currently, her egocentric behavior is activated in her relationship with M., because she wants him to be perfect. Every piece of evidence that contradicts her idealistic requirements causes anger, hostility and aggression ("*All those love and sex messages... It drives me crazy... It's all I can think about... It's too much, too much...* ").

C. is highly ambivalent about life. On one hand, she states that life "*satisfies her very little*", on the other, she has fantasies about how it would be if *she would live forever, and her black boyfriend would be perfect.*

In common terminology, C. is extremely **stubborn,** denying the reality, playing a game which is borderline psychotic, her mental strength facing the reality barrier.

The patient has a borderline personality structure, and in a long and profound psychotherapeutic approach she can become depressive, because she is a reflective person, who would do anything to keep her boyfriend close (including "scams", fantasized relations and games of addiction). A genuine therapy should consider building a sense of trust, decreasing the negative defending mechanisms and cancelling her ambivalence. It has to make her stronger against the triggers that cause her psychomotor agitation and insomnia, as symptoms of each new episode.

Conceptualization of the pharmacologycal scheme

Initiation of the medicamentation

- She was injected with Abilify immediately after admission, around 11 AM, and the next dose was administered in the evening, along with 1000 mg of Valproic Acid.
- The next three days she was treated with two vials of injectable Abilify, along with 1000 mg of Valproic Acid.
- Further, her treatment consists of 10 + 10 mg Abilify and 500 + 500 mg Valproic Acid, and she kept taking her medication for about 6 months.

The reasons which led to administration of Abilify included the following arguments:
• She did not want to gain weight;
• She wanted an effective treatment for the two symptoms that, as she states, disrupt her life: **excessive sleepiness** and **the thought echo**;
• The necesity to control her psychomotor agitation;
• The need to control her tendency to thought disorganization (her subjective feeling of "dispersion") and her decisional and pulsional instability.

Results / benefits for the patient:
- The dose of Abilify was 20 mg per day for the first 6 months, followed by its reduction to 15 mg per day since February 2011, this being the current dosage as well.
- The Abilify was added to the Valproic Acid which the patient was taking as a background treatment even from the onset of the disease, but which she interrupts for about two months.
- In the short term, Abilify controlled the psychomotor agitation in an effective manner since the second day of administration. In the long term: so far there is no relapse occurred. A slight depression was present before the decision to lower the dose of Abilify from 20 mg to 15 mg.
- The patient began to show interest in school work, succeeded in passing her license exam, which she failed in the previous session.
- She is cooperative and understands the necessity of treatment. She easily accepts, Abilify more than Valproic Acid (because of the positive impact on weight control).
- Has a positive response to medication.
- The subjective experience is of contentment, related to *finding an "activating" drug* that is not amphetamine/antidepressant, because she understood their contraindications and her risk of manic turn.
- Feedback: "I hope I would feel like living. I hope I won't feel this drowsiness anymore. I am glad I'm not hearing the thoughts in my head anymore"
- Quality of life: Management of her will, raising her energy level, lower her "need for sleep".
- Current Status: Euthymic, her speech suggesting a slight ideate depression.

The defense mechanisms against which we believe the Aripiprazole acted:
- Separation of the symbiotic relation between Self and her parents; building the ability to sense between her own depression (because of her affective disorder) and the depression unconsciously taken from the family
- Significant decrease in her need for sleep; wavering of the daytime reverie as a defense mechanism;
- Fading to extinction of the symptom related to the area of mental automatism;
- Decreasing the feeling of embarrassment regarding her own symptoms at cognitive level;
- Building the ability to develop relationships (she has a long distance relationship with an African man, but the idealization is not prevalent anymore; she sees him and interacts with him as he really is, not as she imagines him);
- "Breaking" the affective flattening / Wavering the „not to be present in your own life" attitude, unconsciously conveyed;
-Awareness of the risk of psychotic disorganization of thought and emotions;
- Understanding that the locus of control lies within being, a subjective feeling that was conferred only by Abilify, as the patient states.

Benefits in the relational area:
- Acquiring the ability to be in reality, in life, not only in reverie;
- Building an internal state of feeling more protected in relation to what she ***can retrieve as feelings and primitive affects taken from the parents*** (the whole family spends a lot of time together, without leaving the house, but without communicate with each other!);
- Management of control of her own thoughts, disappearance of the thought echo phenomenon
- Detachment from the experience of *existential depression*, active mobilization of the will, increase of energy and active involvement;
- The comprehension of the symbolic meaning of the initial choice of sexual orientation, of the intercultural interests, of choices modelled by the same pattern (African males, athletes, lacking intellectual or academic training, immature, engaged in relationships exclusively in the virtual space - Facebook, internet, social networks)

Benefits in the area of self-perception and functioning in a relationship:
- C. unconsciously chose to present herself to others as being depressed. It is an "existential mood" that if she gave up she considers she would lose the center of her being;
- She instead gave up her self-destruct mechanism if she is rejected by another person;
- Prior to her last episode, she lived a love story with an African male with a narcissistic structure, immature, wanted by all the ladies, the team's sex symbol
- Prior to hospitalization, all the relationships which she built were intensely marked by the aura of lack of sufficient and valid information because they were *virtual relationships* marked by *primitive fears*, *angers* and *jealousies*
- Today she is with another African male, one that seems to be interested in her life, health and professional trajectory. She is satisfied and does not express complaints related to the sexual pleasures. There are only multiple medical interdictions related to this (because of her previous manic behaviors - unprotected sex, HPV

Benefits in the area of affects management:

- The ability to calm her impulses and introduce thinking between the desires / emotions and actions. C.'s marked problems were in the field of commissioning the impulses in act:
- Aggressive = each new manic episode brings a discharge of anger, hatred and hostility against the mother (in the absence of mania, C. is the fusion with her, on a "balanced" model specific to mother - daughter relations in TAB);
- Nourishment = compulsive eating;
- Suicidal = borderline-like= at the beginning of her first hospitalization she had concerns (ideational and pulsional) related to *euthanasia*
- She manages to distinguish between: ***what is happening***, ***what might have happened*** and ***what she wanted to happen.***

Social benefits:

- She has plans related to her career path. She was motivated to learn and get her college degree. Other concerns are the interculturalism and the idea of visiting Africa and helping the poor and traveling alone.
- She diminished the ***narcissistic wound*** related to the fact that she was left by her girlfriend for two years when she was a teenager. A huge insight was to realize that the unconditional acceptance of this situation by her mother did not help but hindered her developing a dropout.
- She realized her immaturity in choosing partners.
- She could not give up the feeling of *being unhappy*, but she "learned" how to use it in her own interest.
- She found two useful activities to make her happy: one is to go as a volunteer at a foundation where she is taking care of the elderly, the other is at a "Mystery Shopping" company where she enjoys the "incognito" aspect as a "transitional job" in trying to be more mature.

Conclusions

Key tips for clinical conduct:

- Choosing the injectable method of commencing the therapy with Abilify starting from the first moment of time, due to the marked psychomotor agitation.
- Finding significant elements of the patient's history, which Abilify could have had a positive effect on. In this case:

-the importance of weight in the history of life of A and

-her mental readiness to mobilize her will in this direction.

- Her satisfaction to having found a drug that works on the thought echo which also has an „activating force" without the risk manic turn
- Aripiprazole's potential to calm psychomotor agitation within two days

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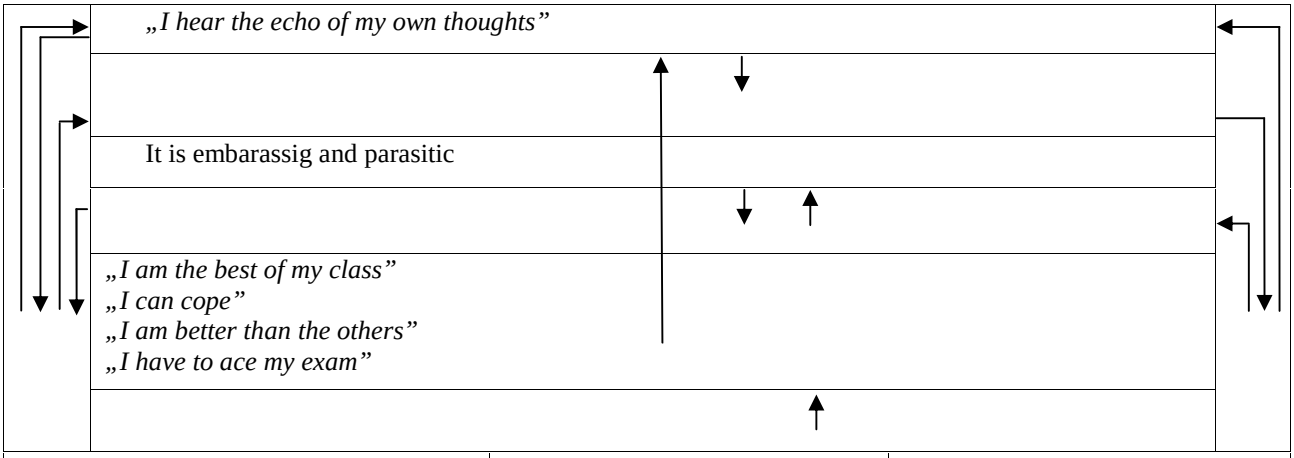

Figure 1

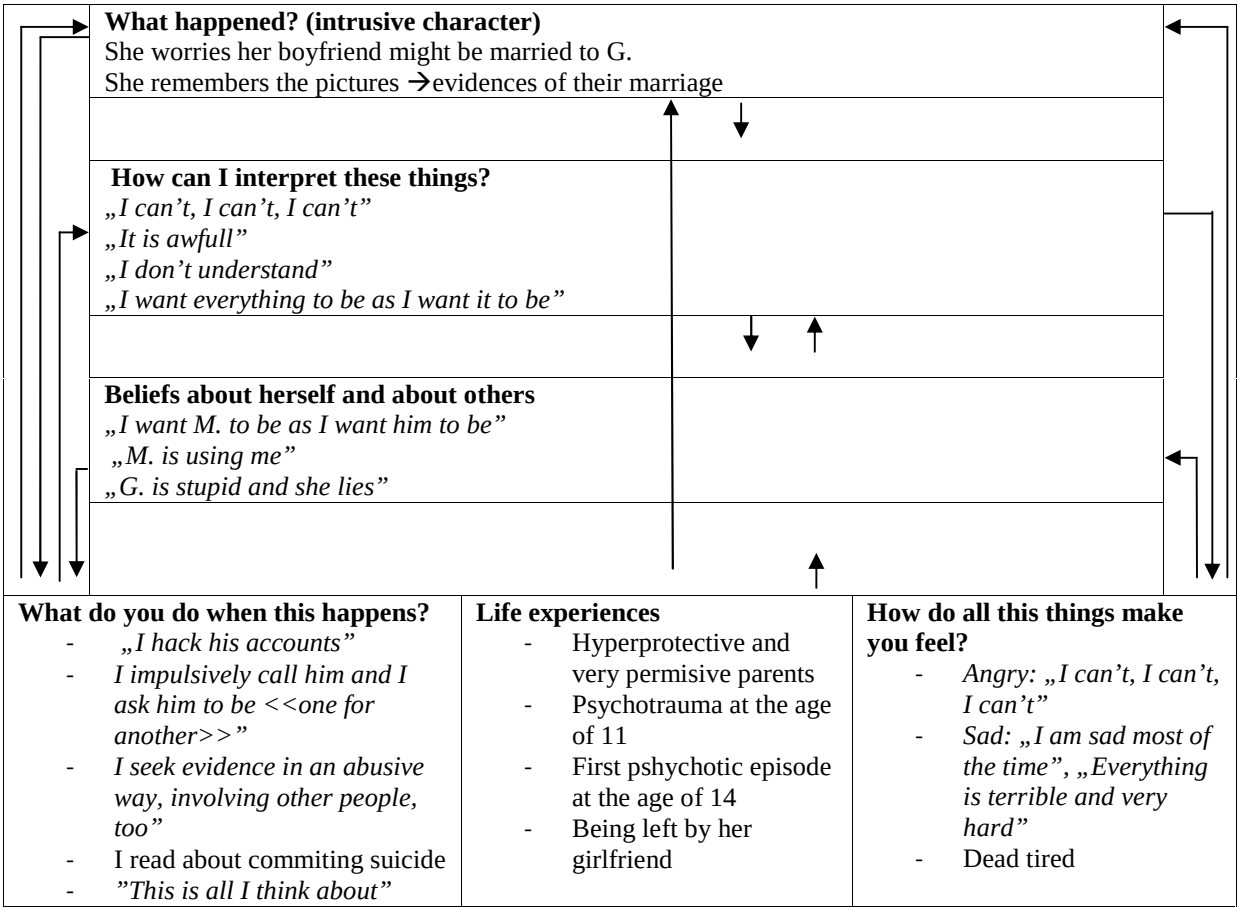

Figure 2