# Bipolar Patient 1

# Anne-Marie



## Bipolar I Disorder

## Young-old (62)

## High education level (university)

## Diagnosed in her late-30’s

## High Risk of relapse

### Disease History and Current Situation

Anne-Marie has a master’s degree in history and taught GCSE and A-levels at a community college before she got married. She experienced a great deal of insecurity and distress in her job but labelled it as normal difficulties adjusting to the stress of a strenuous teaching job. She was diagnosed with a postpartum depression with psychotic symptoms after her daughter was born in her late 20s. She was convinced during this time that the baby was a mistake and that she and her husband would be better off without it. She showed no affection towards her child and eventually had to be hospitalized because she threatened to hurt her baby. After 6 weeks of hospitalization and medical treatment her mood stabilized and she was able to start forming a bond with her new born daughter. In the years that followed periods of relative stability, manic and depressive episodes alternated. She had various treatments on and off and was diagnosed with bipolar I disorder after a second psychiatric admission.

She began treatment and generally reduced the severity of her episodes but had occasional relapses due to medication changes or external stresses. She has no comorbid mental health problems or any chronic physical conditions - just a bit of arthritis.

She doesn’t drink alcohol much anymore as she says she can feel herself losing control and has never used drugs. Social situations can be stressful and have led Anne-Marie to be quite a shy person most of the time. Her husband prefers it when she’s being boring!

Work and personal relationships have often suffered during extreme episodes in the past.

***Husband***

* Her husband usually spots warning signs and helps take action, whether Anne-Marie agrees with it or not.
* Has learnt a lot about the condition through clinical sessions and own research.
* Knows he cannot understand everything about Anne-Marie’s condition but wants to be able to spot mood changes earlier and do more to help stabilise Anne-Marie.

Recently Anne-Marie’s husband took her to see her psychiatric specialist after she became increasingly anxious and agitated. She had been taking less lithium after reading about it causing renal problems in later life. She is determined to stick to her new course of medication and to trust her specialist.

***Daughter***

Keeps in touch, but the relationship with A-M is complicated. She wants to be there for her mom but at the same time she feels overwhelmed when her mom is in a depressed or manic state. She feels that she has had to look after her mother from an early age and that it is just too strenuous for her. A-M finds this very painful and especially when she is depressed, she does not seem to understand that her daughter is not more involved. Her husband understands where her daughter is coming from, which sometimes causes tension in the marriage.

### Psychiatrist A-M

* Worries that Anne-Marie will stop taking her medication again.
* Is worried that Anne-Marie is too withdrawn now which may affect her mood.

**Social Worker A-M**

* Tries to get A-M to be more involved in social activities but finds it difficult to motivate her.
* Occasionally sees A-M with her husband and has also seen the family (A-M, husband and daughter) on a few occasions, in order to address everyone’s needs in the relationship and to try to come to an understanding that works for everyone. However, it remains difficult for A-M to accept that her daughter needs more distance (emotionally) than A-M would like.

# Bipolar Patient 2

# Jan



## Bipolar II Disorder

## Young-old (68)

## Diagnosed in his mid-50’s

## Wife Passed Away Recently

### Disease History and Current Situation

Jan often felt depressed when he was younger but thought it was just because he didn’t like his job. He was generally outgoing and talkative but there were other times when he couldn’t face leaving the house and would sleep twice as much as usual.

A few years after getting married, having children and getting a new job, Jan had a major depressive episode. He had struggled with maintaining a steady job, which left him and his family facing some financial pressures. He lost motivation to go find work or interact with his wife and young children and was eventually hospitalised after an attempted suicide.

During his 40’s Jan managed his depression with medication and made the most of his ‘happier moods’. In his 50’s he became increasingly obsessive over new life plans that he would then abandon or lose interest in weeks later. When not depressed he became increasingly anxious and hatched unrealistic plans to make money and retire early.

His wife thought it was down to side effects from the anti-depression treatment, but in a review with a new psychiatric specialist Jan was diagnosed with bipolar II disorder. He retired after diagnosis, gained several hobbies and enjoyed exercise. He still had occasional episodes but now had time to deal with his thoughts.

After his children moved out and a close friend died, Jan found he had less to do. He became less active but his wife helped him keep busy following her retirement.

***Wife/children***

His wife died quite suddenly aged 67 from a heart attack. Jan’s children are worried that he will ‘never recover’ from the grief and feel uncomfortable about leaving him alone.

### Psychiatrist

* Also concerned following news of Jan’s wife’s death - wants to keep a closer eye on him but is less convinced than the children that his wife’s death will inevitably trigger a major depressive episode.
* Is concerned that Jan might stop taking his medication now that his wife is no longer there to monitor him - would like Jan’s children to monitor this more closely

### Social worker

* Jan’s councillor says he is very cooperative and rarely misses a meeting. She sees that Jan is distraught and sad over his wife’s death, but labels this as a normal grief reaction.
* She understands the children’s worries but feels that they might be overcrowding him and not giving him a chance to deal with his grief, because they find it hard to distinguish between ‘normal’ sadness and symptoms of depression. She wants to see the children and Jan together for a session to address this, once things have settled a little.
* Is a bit worried that his wife was the one who kept in touch with relatives and friends and that Jan might become isolated now that she’s gone
* Is trying to motivate Jan to share his feelings of loss with his wife’s relatives (brother and sister, a cousin) who also miss her and to look after himself (cook, do the groceries, take his meds etc) even though she’s gone. She finds that helping Jan remember what his wife would say or do, helps him to get through the day and to keep going, even though it is difficult for him to continue without her.

### Neighbour (Jan)

* Jan’s younger neighbours have often helped him and, in the past, his wife with shopping.
* They worry about him now that he is alone; they have noticed he has acted a little ‘strange’ in the past but are not aware that he has bipolar disorder.

# Bipolar Patient 3

# Willem



## Bipolar I Disorder

## Older-old (74)

Lower education level (primary education)

## Diagnosed in his early-30’s

## Lonely and Vulnerable

### Disease History and Current Situation

Willem always had difficulty concentrating in school and suffered from behavioural problems as a child. He had temper tantrums and would be aggressive towards other children in school. He quickly dropped out of high school and became a truck driver. He settled down, got married and had children in his early 20’s. At first, Willem seemed to manage okay. However, his wife got increasingly concerned with the fact that he had very intense episodes where his energy would seem limitless, hardly requiring any sleep or food. During these episodes he would often leave the house at night, come back drunk and agitated and he would say things that did not make any sense. After a few weeks, his mood seemed to shift and he would be very apologetic and ashamed over his behaviour. His wife eventually left him and he barely had any contact with his children for many years.

He cycled rapidly between episodes and frequently lost jobs and friends. He ‘self-medicated’ with alcohol and drugs, eventually being hospitalised following an intense psychotic episode where he believed he was The Archangel Gabriel.

After different treatments and relapses Willem was eventually diagnosed with manic depression in 1982 and was prescribed lithium.

Under treatment, Willem began to learn about the condition and sought to improve his lifestyle and get a job. He gained contact with his children and began to rebuild his relationship with them; however he did not explain his condition to them. He has reduced his drinking but it is still difficult for him to keep it in check. He does realize that alcohol can counter the effect of his medication but sometimes he feels it is the only thing that really relaxes him.

He is very private about his mental health but maintains a strong relationship with his psychiatric specialist and sees a councillor regularly. He has tried to involve himself in community schemes and activities but hates anything that he feels labels him as ‘mentally ill’.

He has been tracking his mood for several years to share with his psychiatric specialist. It helps him know when he should see his councillor or if he’s getting enough medication.

Over the years his independence has decreased and his driving licence has been revoked. Some of his peers have passed away and he has become increasingly isolated. The majority of his social contact is with health professionals. He says he prefers to spend time alone to “avoid the stress that other people cause”.

**Children** (Willem)

* Willem’s children live far away but have occasional contact over the phone. They visit every now and then but do not know about his condition.
* They worry about him spending so much time alone and its impact on his physical health.

### Psychiatric Nurse (Willem)

* One of the few people with regular contact with Willem, she feels unable to spend as much time with him as he needs.
* Feels that she is unable to be a substitute for the lack of support system and has tried to get him to be more involved in some kind of social activity (e.g. playing darts at a local senior activity centre) but finds it hard to motivate Willem. He sais he’s better off this way and is easily put off by people.

**Unipolar patient 1.**

# Margaretha



## Unipolar recurring depression

## Old-old (80)

## Diagnosed in her late 60’s

## Chronic Illnesses

### Disease History and Current Situation

Margaretha suffered with depression occasionally throughout her life. She always felt she was a bit different from other people when she was younger but concentrated on school work and read novels to escape her thoughts. Family stress was usually the cause when she felt really bad.

After she married, had children and grew older, she would find that her depression got more intense and had less ‘reason’ behind it. It also became more predictable but she was used to feeling very low sometimes.

In her early 60‘s Margaretha was diagnosed with COPD and had to quit smoking. She entered a deep depressive episode, suffered anxiety attacks and contemplated suicide. Her doctor diagnosed her with clinical depression and prescribed drugs to treat it.

Her husband died two years later, causing a significant relapse and Margaretha was hospitalised.

As she grew older, her COPD grew worse and she developed other physical conditions that reduced her mobility and independence. She says her medication caused her to put on weight, which has led to some heart trouble. She often feels nervous and anxious for no apparent reason. Her clinician suspects that she may experience (mild) cognitive impairment, causing her to lose control and oversight over daily matters.

### Margaretha often feels too weak and unstable to leave the house even though she does miss being able to visit her children, or do her own groceries. Her children, family and neighbours help her continue to live at home with the support of various healthcare services.

### Children

* Margaretha’s children worry about her physical and mental wellbeing. She is on so much medication it is difficult to keep track of prescriptions and what she has recently taken.
* They want to help her, but see her condition only likely to deteriorate. They want to help her remain as comfortable and relaxed as possible.
* One of her children lives nearby and frequently stays with her to look after her when she is ‘low’.

### Neighbour

* Margaretha’s neighbour often helps out with groceries and sometimes takes Margaretha shopping with her.
* She is in contact with Margaretha’s children and promises to inform them of any emergencies

# Unipolar Patient 2

# Grace

## Unipolar recurrent depression

## Married.

## 76 years old

## Diagnosed at age 67.

## Healthy.

Grace has married at a young age. Her marriage is very traditional. She always stayed home to take care of the children and even though she was a bright student, she never pursued a career. She is a Christian and spends a lot of her time in church. She is a secretary for the church, she sings in the church choir and used to go on holidays with fellow church members. This is where she met her husband.

Her husband was a driving force in the family. He had a good and steady job as a consultant, he comes from a large family and he has a large social network and he would plan all the family outings. After retirement, her husband Dick had a stroke and although at first, he seemed to recuperate quite well, he has never shown the same spirit or enthusiasm as before. He tends to sit in his chair all day and even though he is never moody or sad, Grace thinks that he is depressed and that it is somehow her fault for not being able to make him feel better. His physician says that his apathy is a result of the stroke.

Grace is a shy and withdrawn person, she finds it very difficult that her husband is not the initiator anymore and she does not feel up to the task of taking up a more dominant role in her life and her marriage. Over the years, she has had two depressive episodes. When depressed, she rarely invites people over and tends to make up excuses when she and her husband are invited, because she feels she can not cope. She sees every single day as a struggle and does not feel up to the simplest things, such as getting dressed and brushing her teeth. She does still look after herself out of a sense of obligation, she tries to eat at regular intervals, but nothing tastes good anymore. Even her church activities do not give her any joy, something that makes her feel very guilty and ashamed. Her two children, Jack and Judy, are very involved and would like to help her get out of the house more, but she tends to push them away because even visiting her children feels like too much of an effort.

She has had psychological treatment to help her deal with the changes in her life and she has received antidepressants. Since then, she’s been feeling better, but she continues to have very low self esteem.

Her depressive episodes are closely intertwined with her husband’s health. After her husband had another stroke, Grace had another depressive episode.

***Husband***

Dick does realise that his wife is not feeling well, he insists she is asking too much of herself and she should rest more. In a house call performed by the nurse practitioner, it becomes evident that Dick has some form of cognitive impairment. He fell down last week breaking his wrist but does not seem to remember the fall. He also has trouble identifying his children and family members in a picture taken at a recent family gathering.

### *Children*

* Like to stay in close contact and help where they can.
* Do have busy lives and families of their own but try to see Grace at least once a week
* They admit their visits can be distressing and can affect them and their day-to-day lives.

# Unipolar Patient 3

# Christopher

## Unipolar recurring depression

## Divorced

## Has had a relationship for the last 6 years, but living seperately

## 66 years old (Young-old)

## Diagnosed at age 40.

## Healthy.

# Christopher has had a teaching position at the university, at the department of anthropology. He used to travel a lot. He has recently retired. He is a father of two daughters, and a grandfather of a 2-year old boy.

# Christopher had his first depressive episode when he and his former wife where having difficulties in the marriage. He saw a psychiatrist, who diagnosed him with a depressive episode and prescribed antidepressants. He was stable for a few years, but had another depressive episode 10 years later. By then, he had divorced his wife, and had been seeing his new partner Rita for two years. His depression steadily got worse and the medication his GP prescribed did not seem to have any effect. Eventually, he was hospitalized because his partner and his children were worried and pushed him to seek help.

# When he was seen at the admission intake he no longer ate, he was underweight, hardly moved at all, and no longer looked after himself. He did not wash himself, or brush his teeth, and his clothes had stains all over, when he used to be such a tidy person. During his admission, different medications were tried, but none of them seemed to have an effect. Eventually Christopher was referred for ECT (electro convulsive treatment). He was very anxious about the treatment but after about two sessions, he already started to make jokes and his eating and self-care improved. After some time, he was able to return home.

# However, his improvement does not seem to be stable. He has been readmitted twice over the last 18 months, for renewed ECT treatment. The treatment is very effective at first, but the effect does not seem to last. He is also experiencing some gaps in his memory, and he feels that these are the result of the ECT treatment. He is starting to lose hope of ever really getting better and is contemplating suicide. However, he says that he stays alive for his children’s sake. He feels his partner would be better off without him.

# At first, Christopher’s colleagues stayed in touch. Since his second admission to a psychiatric hospital, he has lost contact with most of his former acquaintances.

# *Children/partner*

# His children and partner are very involved and very concerned. At the clinic, his children are often frustrated with the clinicians because they feel their father should improve more. Rita is also losing hope but is determined to stick by him. However, she does value her freedom and feels it is too much of a strain on her and on the relationship to look after him 24/7.

# Psychiatrist (maybe in training)

In general, if people are relatively stable, visits to the psychiatrist are limited (maybe once every 2-3 months or even less) and are focused on discussing the medical treatment of the disorder(treatment adherence, interaction/side effects with other meds, sleep quality etc.) and any questions the patient might have with regard to their illness. Of course, the psychiatrist is more involved when there is a crisis and if the patient may need to be (re)admitted. Psychiatrists will also advise their patient if they are concerned about other topics such as level of activities (too much/too little) relationships with others, etc. but in most cases, a more in-depth conversation on such matters is part of the counselling done by a psychiatric nurse, social worker or psychotherapist. Treatment within our facility almost invariably consists of these two pillars; psychiatric (pharmacological treatment) and some form of counselling (the profession of the counsellor can differ, sometimes based on patient’s needs but it can also be coincidental; who has time to see the patient for instance). The psychiatrist is the one responsible for the delivery and contents of the treatment (this also applies to the counselling that is given by another health care professional). So regular contact between psychiatrist and counsellor is key.

# Counselling provided by a Psychiatric nurse/Nurse Practitioner/Social worker/Psychotherapist

The frequency of contact tends to vary a great deal, primarily based on the client’s need, but sometimes also based on availability of the counsellor. Sometimes people only visit their counsellor a few times a year but in more active phases of the illness, people may be seen once a week or biweekly. Nurse practitioners often visit their clients in their own homes, the social worker and psychotherapist tend to see clients at the clinic. The goals of counselling may vary according to the profession of the counsellor. Psychotherapists tend to be more goal-oriented and more analytical in their way of thinking (directed towards a reduction of symptoms, providing insight into patterns, client needs to be active participant in the treatment) whereas both psychiatric nurses and social workers are more system-oriented (involving relatives, how does the care system around the patient function) and tend to focus on more practical issues, such as providing concrete advice on certain activities the patient might wish to get involved in. However, the patient’s own needs in terms of conversational topics will have a major impact on the actual treatment, regardless of the counsellor’s profession.

**GP**

* Refers patients for treatment.
* Is kept up to date at least twice a year of how the patient is doing and what the treatment consists of (through correspondence sent by the psychiatrist and counsellor)
* Is also kept up to date (through correspondence) if the patient needs to be readmitted
* Can consult the psychiatrist/the counsellor if he/she is worried about the patient’s mental health.
* Sometimes when people are stable for a longer period, antidepressant treatment can be prescribed by the GP and the patient is discharged from mental health care.
* This is not the case for lithium users since this requires more specialist care (e.g. monitoring kidney functions and lithium levels in the blood stream).

***Other professions***

The original personas spoke of an administrator. I am not sure what this is and whether we have this profession in the Netherlands. It is up to the psychiatrist to keep track of the meds and whether a patient needs to be readmitted, although the counsellor might prompt the psychiatrist if he /she feels that readmission is necessary or if the counsellor suspects that the patient is not taking his meds. The psychiatrist will also consult other medical specialists if necessary. The pharmacist also has a large responsibility in pointing out interaction effects (also with alcohol and drugs, and whether certain meds influence your ability to drive) to the patient.