Analysis of a Bipolar Affective Disorder and COVID-19 Clinical Case from a Phenomenological Approach

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Introduction: the new disease called COVID-19, which emerged at the end of 2019 in China, and its consequences, such as social impact, grief, and the stress that it has generated, have become stressors that generate acute psychiatric pathology. An attempt is made to show, in a clinical case, how these factors are as important as the morbidity and mortality of the virus itself.

Method: Through semi-structured clinical interviews, with a phenomenological approach, data was collected. Then, a medical history presenting the case of a patient with a history of bipolarity who had SARS due to COVID-19 was prepared.

Conclusions: Although the evidence of the development of post-COVID-19 psychiatric pathology is still scarce, it is possible to infer that it significantly affects the future lifestyle of the person who experiences it, as it may generate feelings of anguish, fear, or anger, as well as post-traumatic symptoms. The use of a phenomenological research methodology opens the possibility of individually understanding phenomena from the unique perspective of the individual who experiences them.

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INTRODUCTION

Generalities:

In December 2019, a new beta coronavirus appeared in the city of Wuhan, Hubei province, China, causing a new severe acute respiratory syndrome (SARS), different from those known. In January 2020, the World Health Organization (WHO) gave it the name of SARS-CoV-2. Because of the vertiginous expansion that occurred in the following weeks in many countries of the world, WHO called the clinical expression of the disease coronavirus 2019 (COVID-19) and declared that the disease caused by SARS-CoV-2 was a pandemic on March 11, 2020[1].

At the time of writing, more than 16 million positive cases have been reported in 218 countries at the end of July, and it is estimated that more than 656,000 people have died[2]. Two other epidemic outbreaks of coronavirus have already been reported in this century, SARS-CoV in 2003 and MERS-CoV in 2012. From here, we can extrapolate a large part of the epidemiological evidence and the impact it subsequently caused from a psychiatric point of view[3].

COVID-19 Clinic and Psychiatry

Although there are practically asymptomatic forms, in some cases, COVID-19 can progress to severe

respiratory syndromes with high lethality. It can also infect other organs during the disease, including the nervous system, the latter being postulated to be a cause of neuropsychiatric manifestations.[4] The evidence of neuropsychiatric manifestations in patients with COVID-19 is still emerging, and the etiology of the psychiatric consequences is likely multifactorial. It is suggested that, in the context of an acute or subsequent viral infection, various types of neuropsychiatric syndromes may appear that affect the cognitive, affective, behavioral, and perceptual domains[5-6] and are expressed as insomnia, anxiety, depression, mania, psychosis, suicidal tendencies, and delirium[7].

A Lancet meta-analysis identifies a higher incidence of depression, anxiety, and post-traumatic stress disorder after the onset of the illness[8]. While social support is the main protective factor linked to the prevention of these disorders, there is consistent evidence showing that social isolation and loneliness are linked to worse mental health outcomes[9].

COVID-19 and Mood Disorders

The rapid spread of COVID-19, in addition to the implementation of preventive measures such as social distancing and isolation, its indirect consequences such as increased unemployment and the economic impact and people's concern for the evolution of their disease, social stigma, and traumatic memories, are potential generators of psychiatric pathology. People with psychiatric illnesses can be affected by the pandemic directly (contagion) and indirectly (social impact), which is why an increase in acute crises and exacerbations of psychotic and affective disorders is expected in the short term[10].

In patients with bipolar illness, it is crucial to consider the degree and duration of social isolation and the limited physical space in which isolation occurs because they can be associated with a wide range of adverse psychological effects, which include depression, decreased self-esteem, impotence, and anxiety. Some of these emotional disturbances will go away, but some people may also show late effects in the form of anxiety and mood disorders10. Overexposure to news media adds further stress while social distancing measures reduce opportunities for exercise, exposure to sunlight, participation in meaningful activities, and social engagement. Isolation can also affect zeitgebers that help keep sleep and physical activity stable. Possible adverse psychiatric effects and interactions of Hydroxychloroquine, the primary drug used in patients with COVID-19, should also be considered, including psychosis, mood swings, mania, and suicidal ideation as potential crisis-generating factors[11].

In this qualitative study, we review a case of a patient with bipolar disorder diagnosis who develops post-traumatic symptoms secondary to both morbid and social exposure to the virus. In order to add more information concerning how they are affecting our patients, this study aims to identify the degree of psychological affectation it can be unleashed (psychological consequences). It was conducted with a phenomenological approach to describe the events experienced more precisely.

Phenomenology and Psychiatry

Phenomenology is directed to the study of the lived experience regarding a disease or circumstance by the protagonist of the experience and seeks to describe the meanings of the phenomena experienced by individuals through the analysis of their descriptions. In the same way, it emphasizes reflective intuition to describe the experience as it is lived from his/her point of view, all the distinctions of our experience must be devoid of presuppositions and prejudices; instead, the theoretical foundations must be sought

to create a secure basis for describing the experience[12].

Heidegger specifies that phenomenology emphasizes the science of phenomena; this consists of "allowing to see what is shown, as it shows itself and insofar as it shows itself"; consequently, it is an objective phenomenon, therefore real and at the same time scientific[13]. In simple terms, phenomenology can be defined as a research approach that seeks to describe the essence of a phenomenon by exploring it from the perspective of those who have experienced it[14].

The phenomenological research approach arises as a response to the radicalism of the objectifiable. It is based on the study of life experiences, regarding an event, from the subject's perspective. This approach assumes the analysis of the most complex aspects of human life, of what is beyond the quantifiable. According to Husserl, it is a paradigm that tries to explain the nature of things, the essence, and the veracity of phenomena. The objective that it pursues is the understanding of the experience lived in its complexity; this understanding, in turn, seeks awareness and meanings around the phenomenon[15].

METHOD

In this study, a phenomenological approach was implemented to describe a clinical case and to emphasize the relevant aspects of the dialogic interview and reflect as faithfully as possible the reality of the world as it is for the patient.

The data were collected by direct interview of the patient during 4 semi-structured interviews of 1 hour with an interval of 7 days between each one. Open questions were asked so that the interview was partially guided, giving the possibility of answers that give the patient space to express what she had experienced in her own words. These began in June 2020, once the patient was discharged from the general hospital.

CLINICAL CASE

51-year-old woman, married with three daughters, housewife and diagnosed 15 years ago with bipolar disease, with a course characterized by a predominance of depressive episodes throughout her life. She lives in a coastal town at her home with eleven other people, who together constitute an extended two-parent family and is also a caregiver for her 87-year-old bedridden father. She was referred for admission and controls to the Mood Disorders Unit, which takes place in June 2020.

In May 2020, COVID-19 was diagnosed after being in close contact with her son-in-law with whom she lives and who had recently been in Santiago. Initially, the news is greeted with shock and disbelief, followed by concern primarily for the health of her older father and 1-year-old granddaughter. They were one of the first reported cases, so the news spread quickly, being criticized by her neighbors and judged for being infected. In the story, she constantly refers to the memory of the ridicule they were subjected to, of mistreatment by social networks where they were branded as dirty and irresponsible, intense feelings of anger, shame, and guilt appearing, but also of disappointment when feeling devalued by them. Days later, she went to the emergency room due to increased symptoms with chest pain, dyspnea, and fever. Multifocal Pneumonia was diagnosed for which she is hospitalized for management according to the local coronavirus protocol. From the hospital period, she remembers the feeling of loneliness since visitors were not allowed, that her only means of connection with the outside world was the mobile phone and that she spent much of the day (and night) thinking about

the sadness and guilt she felt for finding herself in that situation. On the third day of hospitalization, she presented rapid clinical deterioration, developing an intense fear of dying, feelings of insecurity, and anguish. She was transferred to the ICU due to respiratory failure and required invasive mechanical ventilation for 15 days. Once stable, she was transferred to medicine, where she spent 37 days hospitalized until she was in discharge conditions. At the end of this period, the need arises for the health team to inform her that while she was on mechanical ventilation, her father died as a result of COVID-19. Upon receiving the news, she said she suspected that something was wrong due to the evasive responses she regularly received from the family-focused on her improvement and not on providing information. Added to the initial sadness appeared a feeling of tranquility and resignation. During the weeks after hospitalization, feelings of anguish appear reflected in constant restlessness, anticipatory anxiety, and sadness, avoidance behaviors of everyday situations such as going out to the street or traveling by vehicle. She feels intense fear of being ridiculed or criticized by her neighbors or acquaintances again. She says that while she can go out, she prefers not to. She has frequent nightmares about it, as well as about the procedures that were performed, mainly describing the fear of general anesthesia as a potential generator of death. She also vividly remembers the fear she felt before hospitalization for her father's health, and feelings of guilt and regret appear because her grief is seen as an incomplete ritual due to the fact that she has not been able to visit his grave in the cemetery due to the COVID-19. After hospitalization, recurrent intrusive thoughts continued, with a significant deterioration in the quality of sleep and quality of life. She feels that the days are gray ("It seems like life loses color") and longer ("Instead of going, one just goes along"). As the days go by, a progressive melancholic tone stands out, associated with asthenia, adynamia, anticipatory anxiety, hypervigilance, and sadness with a tendency to easy and persistent crying. In her appearance, what stands out the most is the development of diffuse alopecia that has worsened over the weeks. She is not using makeup. The tone of voice is low, and the speech at times monotonous. The discourse is about self-improvement, a characteristic under which she defines herself: she has always been the one who has taken care of others, and it seems very strange that now the roles are reversed, and she has to allow others to take care of her.

DISCUSSION

In the intersubjective experience of the encounter between therapist and patient, the phenomenological method makes a distinction regarding corporeality, spatiality, temporality, and affectivity[16].

In relation to corporeality, it recognizes a lived body, the body that I am (Leib), which constitutes a pre-logical relationship between the subject and his body, lived in an immediate manner through movements and perceptions. However, also in the expression 'I have a body', the object body is put into play, the one that distances myself from me when I feel fatigue, discomfort, illness; a body full of meaning, prior to any dualistic abstraction of psyche-soma[17]. When approaching the present case from a phenomenological perspective, corporeality acquires a vital role. Pathological deviations are particular ways of structuring one's presence in the world: her face without makeup reveals a facial expression of sadness and fatigue, which she modifies with the content of the story, revealing displeasure and fear in relation to being in open spaces. Her body posture is continuously changing with

complementary gestures and continuous discreet movement in the hands and legs that suggest anxiety.

For phenomenology, our being-in-the-world always occurs in certain temples or states of mind which open the world to us before any cognitive act, and which are not mere subjective states that would only say something about ourselves but open us to the world prior to any cognitive act. It is because Dasein is already existing, inhabiting a world, that these can be presented as painful, pleasant, and, in return, feel scared or happy[18]. The affectivity of the story has an impact in such a way that both the tonality and cadence of the speech, as well as the modulation and gestures, recall the events suffered loaded with a powerful affective tone. Essentially it transmits the anger, sadness, and resignation of the different moments lived. Heidegger, in his [19]27 work Being and Time, highlights the importance of feelings as the essence of Dasein (which indicates the area in which the opening of the person towards Being occurs), and that, thanks to them, it is that being human acquires the essential characteristic of humanity19.

Temporality in phenomenological research becomes a coordinate that is given maximum importance.[20]Reference is made to another time, which does justice to human experience; the time lived, which cannot be measured, which is only expressible by metaphors or stories of concrete situations, "is the time lived by each subject from their own individuality, their personal and non-transferable experience, which makes their occurrence and their alterations are singular and unique in each person"[21]. This characteristic becomes evident in the case presented since the temporality is perceived in a lengthening of lived time, devoid of emotion and tends to monotony. Likewise, it must be remembered that temporality is an ontological character of Dasein and a condition of possibility of all knowledge, opinion, and objectification of time21. In this case, she keeps intact her ability to thematize the events of his biography, but she has profoundly changed "the time lived" in her subjective horizon; it is that way of living time that loses its intentional unity and its articulation in the context of past, present, and future"[22].

Of the conflicts in this case, we must mention that the COVID-19 epidemic has caused havoc throughout the world due to the morbidity and mortality it produces, especially in the elderly and people with underlying conditions that make them vulnerable to the most severe forms of this disease. But its consequences have not only been defined by its epidemiological impact, as there are other variables that contribute to a high-stress load.

There are studies that have shown that, as well as losing one's physical life, the loss of role, of social identity and of social networks, and social exclusion, loss of citizenship, economic capital, and access to resources are equally key in generating a problematic grief. However, although people can experience more than one of these losses simultaneously, the extent of their losses varies according to individual circumstances, when a person has experienced an extreme and profound loss, the type of coping skills, the psychological defenses used by the subject, and the social support available to predict the response to this situation[23].

Studies have shown that social support plays a critical role in psychological rehabilitation under the stress of an outbrake16. In the case described, one of the leading crisis triggers was social stigma. It has been said that when societies are under stress, social stigma appears with an emphasis that falls on people associated with high-risk groups, as well as on anyone considered "different" or potentially contagious, as it has happened to some ethnic groups at the beginning

of the pandemic[24]. If we consider that psychiatric illnesses are already prone to stigmatization, combining two stigmatizing pathologies, such as COVID-19, is likely to provoke negative feelings rather than support, leaving the person even more isolated.

One of the elements that make this case a therapeutic challenge is the presence of recent grief. Among all the specific situations of this disease, death from COVID-19 is the most feared of its consequences, not only due to physical death but also because of the social death that it involves. We have witnessed the abrupt decrease in in-hospital accompaniment, as well as family and social accompaniment at funerals, and we realize that death in solitude not only causes suffering for those who experience it, but it can leave sequelae in the form of grief for those who are close to them23. In any of the cases, it is perceived with pain and suffering, fear or hopelessness, which lead us to remove the subject from our daily thoughts; we avoid him or her and prefer to stay away from that single certainty. It is expected that, considering the defensive mechanisms of the patient and the support network she has, through psychotherapeutic intervention, she can achieve stabilization in the medium term.

CONCLUSIONS

As the COVID-19 epidemic continues to spread, we can say that there are already direct consequences on the mental health of the population, especially on patients with a history of psychiatric pathology.

The indirect consequences of COVID-19, including social exclusion, grief, social stigma, economic repercussions, among others, described in this case, seem to be even more traumatic consequences than the disease itself, as well as triggers of acute psychopathology.

The phenomenological perspective in the clinic allows a greater understanding of concrete existence. Also, it allows conceiving the disease as “a new way of being in the world,” creates opportunities to learn from others’ experiences, and has a broader and more in-depth understanding of the psychology of patients with mood disorders15. Thus, in the words of Oyarzun, the setting is placed for an “Encounter with the other”, an other who is not me, who is suffering and who gives us the possibility of treating and providing psychotherapeutic support for the “who,” and not for the disease or the “what,” and to understand the depth of their experience[25], since normality defined as such becomes subjective when experiencing a similar stimulus, as in this case the COVID-19 disease.

Karl Jaspers said that “borderline experiences” are those that lead to philosophical reflection: death, loneliness, pain, anguish, melancholy. Without those experiences that blur that tiny picture in which we inhabit, there would hardly be any philosophical reflection[26]The reflection that we can make about the coronavirus has to do with the changes we will face. It forces us to restructure our “normality” and to observe with a new, more reflective look on aspects of how we deal with stress as a society.

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