ORIGINAL ARTICLE

Affective bipolar disorder and ambivalence in relation to the drug treatment: analyzing the causal conditions*

TRANSTORNO AFETIVO BIPOLAR E A AMBIVALÊNCIA EM RELAÇÃO À TERAPIA MEDICAMENTOSA: ANALISANDO AS CONDIÇÕES CAUSAIS

TRANSTORNO AFECTIVO BIPOLAR Y LA AMBIVALENCIA EN RELACIÓN A LA TERAPIA MEDICAMENTOSA: ANALIZANDO LAS CONDICIONES CAUSALES

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ABSTRACT

This study was performed with an aim to understand the conditions causing the ambivalence of the person with bipolar affective disorder (BAD) regarding following the drug treatment. A qualitative approach was used, with the Grounded Theory as the methodology framework, under the light of Symbolic Interactionism. Participants were 14 individuals with BAD who were being followed at an Outpatient Clinic for Mood Disorders of a university hospital and 14 relatives they indicated. Interviews and observation were the main forms of obtaining data. Results revealed three categories that described the referred causal conditions: experiencing the crises of the disorder; needing the drug; and living with the side effects of the drugs. It was found that there is a need to change the attitude of some health professionals from blaming the patient for interrupting the treatment to one of listening, valuing their symbolic and affective universe as well as the partnership in the treatment.

DESCRIPTORS

Bipolar disorder
Drug administration schedule
Therapeutics
Family

RESUMO

Este estudo buscou compreender as condições causais da ambivalência da pessoa com transtorno afetivo bipolar (TAB) em relação ao seguimento da terapêutica medicamentosa. Foi utilizada a abordagem qualitativa, tendo como referencial metodológico a Teoria Fundamentada nos Dados, à luz do Interacionismo Simbólico. Participaram do estudo 14 pessoas com TAB que estavam em acompanhamento em um Ambulatório de Transtornos do Humor de um hospital universitário e 14 familiares indicados pelas mesmas. A entrevista e observação foram as principais formas de obtenção de dados. Os resultados revelaram três categorias que descrevem as referidas condições causais: vivendo as crises do transtorno; tendo necessidade do medicamento e convivendo com os efeitos colaterais dos medicamentos. Este estudo aponta para necessidade de mudança de atitude dos profissionais de saúde de culpabilizar o paciente pela interrupção do tratamento para aquela de escuta, de valorização do seu universo simbólico e afetivo bem como de parceria no tratamento.

DESCRITORES

Transtorno bipolar
Esquema de medicação
Terapêutica
Família

RESUMEN

Estudio que buscó comprender las condiciones causales de ambivalencia de persona con transtorno afectivo bipolar (TAB) relacionadas al seguimiento de terapéutica medicamentosa. Utilizó abordaje cualitativa, con referencial metodológico de Teoría Fundamentada en los Datos, a la luz del Internacionalismo Simbólico. Participaron del estudio 14 personas con TAB en seguimiento en un Ambulatorio de Transtornos de Humor de un hospital universitario y 14 familiares según su indicación. Entrevista y observaciones fueron las principales fuentes de recolección de datos. Los resultados revelaron tres categorías que describen las referidas condiciones causales: viviendo las crisis del transtorno, teniendo la necesidad del medicamento y conviviendo con los efectos colaterales del medicamento. Este estudio resalta la necesidad de cambio de actitud de los profesionales de salud de culpar al paciente por la interrupción del tratamiento por la de escucha, de valorización de su universo simbólico y afectivo, así como de asociación en el tratamiento.

DESCRIPTORES

Trastorno bipolar
Esquema de medicación
Terapéutica
Familia

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INTRODUCTION

Affective bipolar disorder (ABD) is a chronic condition and consists of the most severe form of mood disorder, as it is recurrent[1]. Adherence to ABD treatment is essential to increase the chances of improving the prognostic. Efficiency has a direct relation to adhesion. Nevertheless, one common problem found in ABD treatment is that people sometimes do not take the medication as prescribed. The non-adherence rates are high in bipolar disorder, up to 47% in some stage of the treatment[2]. Approximately 50% of bipolar patients interrupt the treatment at least once, and 30% interrupt twice[3]. Because of its magnitude, non- or poor adherence to treatment are a public health issue.

Non-adherence rates may increase the recurrence of mania as well as disorder crises. The former two are one of the causes associated with re-admission to hospital and suicide[4]. A worsening of the disorder may also imply the need for diagnostic or treatment procedures of higher cost and complexity. In the USA, there are estimates that about 10% of hospital admissions are a consequence the medication-related morbi-mortality, and that half of those admissions could have been avoided. The costs involved have increased considerably over the last years, reaching US$ 177.4 billion in 2000[5].

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Thus, in term of continuing health care, failing to follow the prescribed medication therapy consists of one of the most frustrating problems for the mental health care team[6]. Non-adherence to the medication therapy is characterized by the divergence between the medical prescription and the patient's behavior. It is a phenomenon subject to the influence from multiple factors related to sociodemographic conditions, the disease, the therapy, the relationship between health professionals and the patient, as well as the patient per se[7].

Literature points at the following as factors that contribute to the inappropriate use of psychotropic medication in the many types of mental disorders: difficulty to reach diagnosis in mental health; limited availability of extra-hospital services; long treatment for mental diseases; financial limitations of the population and insufficient knowledge about the medication[6].

Among the presuppositions assumed by several authors to study adherence, the most evident differences are found among those who center the phenomenon on the patient and those who seek to understand factors outside the patient, as the factors related to the patient are more difficult to be controlled and are always heavy burden in the adhesion issue[8].

It is emphasized that the patient, or the person responsible for him or her, should be the objective and the object of the investigations and of the actions to promote adherence, considering that he or she is the center of all the factors interfering on the adherence to therapy, reflecting the individual, family and social contexts. Motives considered unimportant by the health professional are often those that actually determine if the patient will follow the treatment or not[9].

In view of the context described above, the following question emerges: if medication use is a necessary condition in the everyday life of patients with ABD, why can non-adherence be present in different stages of the disorder? We believe that a better understanding of the causal factors of this situation, from the perspective of who experiences it, will permit the implementation of intervention strategies at the health services aimed at a quality health care service to these individuals. That is the objective of this study.

METHOD

This study is part of the doctoral thesis *Entre a cruz e a espada: o significado da terapêutica medicamentosa para a pessoa com transtorno bipolar afetivo, em sua perspectiva e na de seu familiar* (Between a rock and a hard place: the meaning of the medication therapy for the person with affective bipolar disorder from their perspective and that of a relative). Prior to its development, the study was approved by the Research Ethics Committee, and it involved visiting patients with ABD who were following treatment at a Mood Disorders Outpatient Clinic (MDOC) in a large-scale university hospital, in the state of São Paulo.

This is a qualitative study, and, thus, the number of participants with ABD and respective relatives was not determined beforehand; rather, the number was obtained through a process of theoretical or convenience sampling, which is part of the methodology used. A combination of techniques was used to determine the patients and patients to be interviewed, such as: participant observation, informal interviews with patients and relatives while they were waiting for an appointment at the MDOC; reviewing the patient's medical record with doctors and nurses to obtain data regarding the medication therapy that had been prescribed. The snowball sampling technique was also used, and participants referred the names of nine people to be interviewed.

The inclusion criteria for patients were the following: have a medical diagnosis for ABD; be suing psychotropic medication(s); be able to talk and provide written consent to participate in the study. Each patient indicated the name of one relative, who they considered to be the person most involved in or responsible for their treatment, who was interviewed and provided written consent to participate in the study.

The recorded interview and participant observation, during the home visits, were the main strategies used to obtain data. The interview, as the primary source for data collection, was complemented by Field Notes taken by the researcher during the home visits and visits to the outpatient clinic. The semi-structured interview with patients was opened with the following question *Tell me what it is like for you to use the medications prescribed by the doctor from the psychiatry outpatient clinic* and, for relatives *Tell me what it is like for your relative to use the medications prescribed by the doctor from the psychiatry outpatient clinic.* The guiding questions only directed to the points being explored in the study. Further questions were added with the purpose to clarify and ground the experience.

Data analysis was based on the methodological framework of the Grounded Theory (GT), in the light of the Symbolic Interactionism.

Symbolic Interactionism focuses on the interaction, definition, present, and on the human being as an active being in the world. The *symbol* is one of its central concepts, as interactionism relates the use of symbols to everything that is human. Symbols are social objects that people use to represent and communicate. They are defined in the interaction between human beings, and are important keys to understand human behavior. Symbols, as well as communication, are dynamic and can change or be changed through interaction[10].

Furthermore, other important concepts of the framework are the *self* (I), the mind and the society. As a term, *self* means merely that the human being may be an object of his or her own actions[11]. Through the *self*, the human being sees him/herself as it would occur when seeing another social object, but within an internal perspective, in which he or she defines him/her as an identity, perception and judgment of him/herself. These actions are referred to as symbolic communication and they make all other actions possible[10]. In the interactionist approach, the concept of *mind* consists in an active communication with the *self* to handle symbols. This means that the human being, through mental activity, constantly makes self indications, assigns meanings and interprets, making the current experience meaningful[10]. On the other hand, *society* is defined as being comprised of individuals that interact with each other, with activities that occur as responses from one to the other[10].

In terms of the GT, considering that the basic premise is constant comparison, in this study the data collection and analysis occurred side-by-side. Therefore, the first step of this analysis is the data transcription, followed by data coding. The coding procedures are presented in three stages complementary to each other: open coding, axial coding and selective coding[12].

Open coding is the part of the analysis that involves specifically naming and categorizing phenomena through a thorough examination of the data, line by line, paragraph by paragraph[12]. The comparison between codes originated the categories, which were integrated through axial coding. The coding paradigm was followed to perform the axial coding, and it involved: the *cause* that triggered the phenomenon, its *context*, the *intervenient conditions*, the *action strategies* about the phenomenon and its *consequences*[12]. By identifying the categories, it was possible to perform the selective coding, which originated the central phenomenon or category Between a rock and a hard place in relation to the medication therapy, revealing the ambiguity of the medication as a symbol. In this stage, all the concepts and categories were systematically related to the central category and from there on the analysis of their relations was performed.

This article presents the triggering causes of the central phenomenon, i.e., of the ambivalence feeling experienced by patients with ABD regarding his or her adherence to the medication therapy. In order to maintain the anonymity of the patients involved, they were named after precious stones, as this is the meaning they have in this study. To identify the patients' relatives, the letter *R* was added before their names.

RESULTS

The analysis of the interview resulted in three categories that reveal the causes of the ambivalence experienced by patients with ABD in relation to the prescribed medication therapy, as shown below.

Experiencing disorder crises

This category shows that when experiencing crises, patients with ABD face risks such as being exposed to embarrassing situations, suicide, and impaired social, professional and psychological performance. The crisis, thus, is a difficult moment that requires the mobilization of people close to the patient– relatives, family, and a mental health team. It was observed in the patients' statements that when they are asked about aspects of the medication therapy, both patients and their relatives initially state the impact that the mental disorder had in their lives, especially because of the crises they experience, and the reflection on their everyday interaction with other people and groups. They describe behaviors of aggressiveness, which are observed especially in the manic phase, towards objects, relatives and other people in their social environment. In fact, one of the patients compares his behavior to that of a *creature* an *animal*:

> That time I felt really angry, annoyed, I was really like an animal, a creature with no destiny.... I made many mistakes, I did things that were terrible, wrong, unpleasant.... (E).

> ...I am already like that, explosive, I would punch the wall, I would get myself hurt if there was glass, you know, it happened one time... I put on a show at the hospital (A).

...there was one day when she took his radio, threw it on the floor and broke it... if she broke a glass like that it could hit someone and really hurt their face, she would attack people, one day she even attacked me... (RB).

Compulsive shopping is part of the symptoms of the manic phase in ABD and this behavior is expressed in the patients' reports, revealing that the harms were no exclusively economical, but also moral:

I passed out a few checks that bounced, and then my husband called me a defalcator. You get worn out, but you still want to go on, sometimes I bought two of the same thing, when I got home I would regret it (L).

The first thing that appeared were the debts. She would shop compulsively. It was not normal for a person to make such a debt... she would spend more than she earned and the debt went on growing. She had a debt of over three thousand reais. She would give people presents. This dog (points at dog in the living room) cost 600 and she told me someone had given it to her (RG).

Greatness and mystical thoughts are also common in the manic phase of ABD. In crisis, some patients believe they have special powers or that they are entities with such powers. Because of such thoughts, the patients may adopt behaviors of omnipotence or perform rituals that may be explained by their having the disorder, but not by the shared social reality.

...he thinks he is Jesus Christ, plays Deus, like he is the best you know... You want to own the world and your nothing like that... you really aren't (H).

...when I'm in the manic phase I think I'm Jesus Cristo, himself. I have taken mud baths as a ritual, Jesus things (I).

Psychomotor agitation and accelerated thinking are behaviors present in the mania crisis and they appear as insomnia, inquietude, rapid speaking, and are described by patients with ABD as being *crazy*, *high*, *agitated* but *very happy*. This feeling of happiness can be a hindrance to treatment adhesion, considering that the medication could symbolize a reality in which happiness is not constant:

I was crazy, high. Whoever saw me would think I was on drugs... I would fall in the bus, I was weak, I couldn't sleep. I was always like a zombie, I couldn't sleep for over a week, I was groggy (G).

...my mind was really accelerated, I was working and hadn't slept for over a week. I was really agitated but also really happy (M).

As for the depression phase of the disorder, participants reported the occurrence of sadness, crying, lack of motivation for work and self-care and, in terms of the interaction with the referred feelings/behaviors, they find difficulty to maintain attachments, including with their family:

...I just started feeling sick, so I went to the hospital... I couldn't leave the house, that sadness, I was crying... I would lie on the floor, I couldn't do anything, I couldn't work, I couldn't take care of the house, of my family, I couldn't even take care of myself (K).

I reached apathy, I reached the phase of disaffection, not to say indifference (L).

The statement of the participants show the identification of standard behaviors that they do not accept themselves, and, thus, at the risk of being rejected by the social group, which may cause limitations and considerable harms to several aspects of their everyday lives. One of the factors that cause these limitations is the need of psychiatric admission during the crisis.

I've been admitted 40 times, I have been in every hospital there is, I was hospitalized quite often. There were years when I would stay in hospital for six months and, sometimes I would be admitted two or three times a year (D).

It is traumatizing, I cannot deny that. It really is traumatizing, what we have been through, it is traumatizing. We don't want to go through it again. It makes me more than scared... I am scared of being admitted, I'm scared for being away from my family. I is a great fear I have, gosh! I can't even think about it. The thing is that I don't worry about my kidney, what I worry about is that in the future I may have to move away from home, from my family, that is what I fear (E).

The trajectory of frequent admissions followed by patients with ABD causes feelings of fear, especially because they consider that, despite taking the medications as recommended, stressful events, such as the death of a relative or friend, or losing a job may trigger the recurrence of the disorder. In spite of experiencing the crisis while following an adequate treatment, they believe that by using the medication there is a smaller chance of having a crisis, and that they are *safer* in this regard:

When I enter a crisis it is usually because of a loss... either I lost a job or a relative, it is always like that, related to a loss (I).

It is the problem of experiencing a loss, when I heard about my mother (passing), I took the medication, I would never miss it, ju-di-cious-ly, because I know it's no game, I know it's serious. (N)

I think that the crisis... is because of the circumstance. In my case, I can't take pressure. (J).

I know I can go through other crises, thy disorder is cyclic, it's chronic, but I know that if I take the medication, I'll be safer... (N).

Although patients with ABD know he or she may face a crisis despite taking the medications, their experience shows that not using the medication will likely result in a crisis.

I went for two months without medication, from then on I crashed, the sky fell on my and the floor opened right in front of me, just as if I had fallen in a black hole (E).

> If he stops the medication for a while he can feel depressed, feel bad, I know something serious happens, I'm aware of that... I think he really gets out of control, there is a reason why he takes fourteen pills a day (RI).

The behavior presented by patients with ABD, when experiencing a crisis, and the frequent admissions cause distress to relatives, because living with the crisis is marked by a feeling of insecurity in view of the unpredictability of the patient's actions. That uncertainty emerges as an important element in the lives of these patients and relatives, and is reported as a fear of a crisis taking place.

> I am afraid of experiencing a crisis, because if you do, you can do something wrong, or hurt someone, if you go crazy you don't know what can happen (A).

> There was a time when she would spend without us knowing... she would take checks, she lied... I really fear that can happen again (RL).

In the interactionist perspective, things are noticed and defined by human beings through the activity of their minds, and action is a response not to the objects but to the activity of interpreting those objects. Therefore, from the experience of the crises, especially when not taking the medication, patients with ABD assigns new meanings to the medication therapy, expressed by their perception of needing the medication.

Needing the medication

This category reveals that, in the beginning, patients feel uncomfortable with the fact that they will have to take medications continuously. However, because crises and admissions affect the lives of patients and their families considerably, causing negative emotions, the medication appears to balance the situation they have already experienced, and, thus, patients conclude they really need the medication. Hence, the balance is positive. When patients see the medication as something *essential*, *indispensable* in their lives, they begin to take the therapy seriously.

> I take it as serious as the spiritualist doctrine. I know it may harm my liver, kidney, heart... If you read the note for lithium you won't take the medication, so I prefer not to read the drug note and take it (N).

> But it is necessary, today I know that the medication is essential... (D).

> I think it is indispensible for him, I think he can't live without the medication. I think it is everything for him, it helps him live to see the real world (RE).

Hence, the medication now symbolizes *support*, a *blessing*, a *salvation board*, and is an indispensible resource to control crises:

> ...the medication symbolizes, like, support... (F).

> To me it's a blessing... The medication to me is a blessing (M).

> A support. A salvation board. If you are on it, everything is fine, if you aren't, you drown. So you must be on it (J).

The *must be*, referring to the analogy of the medication to a *salvation board* is evidence that the patient does not see any other alternative to control the crisis besides using the medication. This reveals the ambiguity as a symbol, because despite *saving* the patient, they feel forced to use it. One participant compares the medication to a crutch over which she has to sustain herself to walk, as observed in the following statement:

> I have to sustain myself on this crutch so I can walk, you see? It is the same thing as if I were crippled and needed a crutch (J).

Like people with a handicap, who are unable to walk without using crutches, patients with ABD, who have a chemical handicap, is unable to live free from crises without using a mood stabilized. Hence, the mood stabilizer is the chemical equivalent to the crutches, and may symbolize health and disease at the same time.

In view of the true need of the medication to keep crises under control, patients with ABD is concerned with the fact that they may not have access to the medication. Hence, even when families experience economical hardships, the medication becomes a priority in their lives:

> Not being able to take the medication, not having access, not having the necessary conditions... I think that what would worry me is if I didn't have the medication (G).

> We would sometimes choose to buy something later, but we would always get the medication... because you can't stop taking it, because now she knows she really needs it. After she had that crisis, we learned that she can't go on without the medication (RD).

Because they believe *there is no way out*, and they really need the medication to be emotionally balanced, the patients feel compelled to adopt the medication as a habit, often doing this with resignation. Patients prefer using the medication despite the adverse effects, as they fear to jeopardize their own stability. For others, the medication is an obligation that must be followed by patients with the purpose not only to maintain the disorder latent, but also free them from the responsibility if any symptoms recur:

> Because it is a disease of emotions, I feel better when I take the medication because I will be complying with my obligation, if any crisis takes place it won't be because I didn't follow the orientations, it is because it had to happen (F).

> I think I have to continue and I have to accept what is to come because there is no other way, I have always known. It is her dream (wife) that one day I won't need the medication any more. That dream is abstract and absurd. Because there is no way I can go on without the medication (E).

> I am very submissive... If the doctor said I have to take it, I take it (G).

Based on the re-significations assigned to the medication, patients with ABD choose to adhere to the therapy, despite experiencing adverse effects every day.

Living with the adverse effects from the medication

This category reveals that patients with ABD complain about the incontrollable desire for sweets and become worried about excessive weight gain. In this study, there are reports from patients who experienced a weight gain of 40 kilograms. Weight gain causes a series of physical and emotional consequences for patients, which affect their self-esteem. Because of the excessive weight, they feel embarrassed, which is understandable when we observe in the media and in our society the imposition of a beauty standard represented by extremely thin men and women. The patients' self esteem may be further compromised by another side effect: hair loss, which is often associated with this type of medication. With such changes to one's appearance, the patients may soon feel that their social identity is also compromised. The statements of the patients with ABD reveal the referred changes:

> Then, after I began taking valproic acid, that would be two and a half years, I gained 40 kilograms... My hair is ruined, depakene, it changed me completely... my hair wasn't like this (G).

> It has an effect because when I began taking it I gained 10 kilograms, and t really worries me, I take morning tea to see if I can lose some weight, if you tell me that something helps to lose weight, I'll take it... because I want to go back to the ideal weight I used to have... (K).

> I took tofranil, and then I started to eat sweets, only sweets. I gained weight and was terrified from the idea of gaining weight. I was embarrassed... because I gained 30 kilograms and I had always been thin (L).

Several other adverse effects occur, causing discomfort and restricting the daily life activities of patients with ABD. The most common complaints are *tremor*, *impregnation*, *insomnia*, *dizziness* and *dry mouth*.

Because tremor occurs externally, and is often associated with diseases or the use of medications, patients feel embarrassed to develop certain activities that involve motor skills, whenever they are close to other people, as they fear others will notice their tremor. They believe that people *notice* the fact they are shaking. Furthermore, motor coordination may also be compromised by the signs and symptoms of *impregnation*. As a consequence, patients report having sialorrhea, muscular stiffness and dystonias, among other signs, which, besides causing intense pain, limit their action spontaneity. Impregnation may also be stigmatizing, as it produces signs that are directly related to the several stereotypes attributed to people with a mental disorder such as, for instance, a stiff gait, sialorrhea, and others, as reported in the following statements:

> I didn't have any tremors at all but now with this lithium I am shaking... it is sad! Now I fear that others will notice me... (A).

> Oh, sometimes I get a dry mouth, tremors and I've experienced much worse situations... I once got all crooked, I became a number eight... I remember that sometimes in Itapira I walked on my hands and knees to reach the nursing ward and ask for God's sake to please give me a shot to make it go back, because I was stuck, my whole left side was crooked, I because a small ball and had to crawl to the nursing ward. All because of the medication (E).

> I used to walk like a child. I walked around with a tissue because I couldn't feel my lips, I drooled (G).

Insomnia may be a side effect from the medications, and due to the difficulty that patients have to sleep at night, they usually spend hour in bed, which often contributes to the idea that they are lazy. Dry mouth is another side effect that makes resting at night a difficult task, as patients have to get up several times to drink liquids. The reports show that some mood stabilizers, especially carbamazepine, cause dizziness and diplopia, changing the activities of daily living of patients with ABD, including their leisure, because they do not feel it is safe to leave the house alone, fearing falls and other accidents. Thus, this aspect changes their social interactions, increasing the difficulty of socialization, which is already compromised by the accumulation of adverse effects and prejudice against the disorder, as shown in their reports:

> One day I got up at 3 am without being able to sleep, I was awake in bed for five hours... then I sleep in the morning. Now I am taking Tegretol... I feel dizzy a lot. Then they lowered the dose, sometimes if I have to go out, I don't feel well to go out (G).

> Gosh! At night I get up three or four timed to drink three, four glasses of water...(I).

> ... then they gave me Carbamazepine... it affected my sight and when I walked it was like the curb was higher and all...(F).

> ...after she took that medication, she would fall in the bathroom... difficult (RB).

Because they knew and often experienced the physical and emotional changes caused by the medications, patients with ABD fear their adverse effects.

> I think that the hardest part of taking the medication is its adverse effects, because you are more afraid of that then... the biggest downside of this medication is the side effect. I'm afraid (RJ).

> ...I tried some antidepressives like Remeron, Ziban, and it didn't work, I get the adverse effects, I'm a complicated person... so I started lamotrigine, but I had all the allergies listed on the drug note, my foot cracked, my tongue and mouth got swollen, it was like the roof of my mouth and my tongue were touching. I'm afraid of those effects (L).

Due to the risk of intoxication from lithium, patients taking this medication must take frequent blood dosage tests. In this study, some patients with ABD report having

experienced lithium intoxication before, which, in some cases, caused severe permanent organic and functional limitations:

> ...I took lithium in the beginning of the treatment and according to the doctors it was what worsened the renal insufficiency, it was the lithium intoxication... (E).

> ...he couldn't find her own mouth any more, she said she couldn't see, he couldn't swallow... then I scheduled an appointment with a new psychiatrist, he looked at him and said *he is intoxicated by lithium*, *let's do some tests*. The biologist took the test and said "*gosh, is he still alive?* Then we admitted him or else he would have gone into a coma here with me. Then he had to do dialysis every three hours, he stayed in ICU for 16 or 17 days, in *coma*... he left like that, with a motor problem, this whole side is paralyzed. He stayed in hospital for four months. He is close to having to have dialysis because only one kidney is working, he got this kidney complication after the intoxication (RH).

The medication, therefore, is placed in a general context of meanings, marked by negative aspects such as distress, denial, disease, control, need, obligation, habit, and guilt, as well as by positive aspects, such as the chance to live well with others, keep crises under control, reducing readmissions, support, blessing and salvation board, which may be understood as implying the ambiguity in the phrase: *Being between a rock and a hard place*.

DISCUSSION

In this study, the participants' reports reveal that when patients choose to not follow the medication therapy, some soon experience a new crisis episode and others temporarily feel well without the medication[13]. This aspect rises doubts among patients with ABD in terms of the true need to take the medication continuously, thus contributing to the patients' non-adherence.

Non-adherence rates may increase the recurrence of mania, as 60% of hospitalized patients with acute mania did not take the medication correctly during the month before his or her admission[2]. Furthermore, the risk for permanent incapacity in these disorders increases with every addiction acute recurrence[13-14]. This aspect is concerning considering that, approximately 50% of bipolar patients interrupt medication use at least one time during their treatment, and 30% of patients interrupt at least twice[3].

Experiencing the crises caused by the disorder is gradually accompanied by losses and limitation in the many contexts of everyday life[14]. In this study, the resports gave evidence of affective and cognitive losses, economical limitations as well as at work and leisure, which, among others, are responsible for the re-significations assigned by the patient with ABD to the action of adhering to the medication therapy.

It is, however, observed that when patients with ABD choose to adhere to the medication therapy, they also experience limitations and losses because of the adverse effects from the psychotropic drugs. Dizziness, diplopia, and sexual impotence are common adverse effects which, directly or indirectly, compromise the patients' universe of social and affective interactions[13,15]. In literature, as well as in this study, there are frequent reports about an excessive weight gain, hair loss and tremors, due to the continuous use of psychotropic drugs, which make patients feel embarrassed, and may, thus, compromise their interaction with themselves and with society[13,16-17].

Also in relation to the reactions to the medication, lithium carbonate, a mood stabilizer commonly used to control ABD, because of its narrow therapeutic window, has serious risks of intoxication, and thus requires a careful control of the blood dosage besides a number of daily care procedures, by the patient, causing changes to their everyday activities[15]. Some patients in this study reported having experienced lithium intoxication with, in some cases, severe permanent organic and functional limitations graves. Because of these adverse effects the patients with ABD is afraid. In fact, the medical team is also afraid of prescribing the drug because of the adverse effects[18].

According to literature, a history of severe adverse effects of a drug is a strong indicator that the patient will not adhere to that specific treatment[13]. Besides experiencing the adverse effects of the medication therapy, some patients with ABD, despite *strictly* using the medication, still experience crises episodes, especially in the case of stressful events[19]. Therefore, in addition to fearing the adverse effects, there is a fear of a crisis and possible readmissions.

It is a fact that ABD accounts for 5% to 15% of the new and longer psychiatric admissions, consuming considerable health system resources. Furthermore, inadequate treatment accounts for most of the disorder burdens, because it results in crises despite the patient is taking the medication[20].

The context described above reveals that from knowing and/or experiencing the adherence or non-adherence to treatment, there are patients with ABD who believe that their adherence to the medication therapy imposes to live with adverse effects, though it may keep the disorder under control. On the other hand, non-adherence to the medication therapy usually results in increasing the frequency and intensity of crises and readmissions. That experience gives evidence of the real need of the medication and, hence, it is observed they are *BETWEEN A ROCK AND A HARD PLACE* in relation to the medication therapy.

CONCLUSION

Having completed the study, we found that the ambivalence in relation to the adherence to the medication therapy permeates the whole trajectory of patients with ABD. The medication is placed in a general context of meanings, marked by negative aspects, such as distress, control, need,

obligation, habit and guilt as well as positive aspects such as the chance of living well with other people, keeping crises under control, reducing readmissions, support, blessing and salvation board. This reflects the causal condition of the ambiguity in the expression: "BEING BETWEEN A ROCK AND A HARD PLACE". Furthermore, it shows the tendency of adhering to the mediation after a long trajectory of crises and admissions, when the patient already has several losses in the different social realms.

It is fact that many adverse effects from the medication are temporary or may be minimized using different strategies, and it is thus fundamental to guide patients and their families aiming at the adherence to the therapy. Hence, the present study results point at the need for health professionals to focus on humanistic care, seeing patients as social subjects, with their own beliefs, values, expectations, knowledge, and have their own paradigms that affect the medication therapy, according to their view of the reality. The challenge appears to be to change the attitude of health professionals, who blame patients for their interrupting the treatment, to one of listening, valuing the patients' symbolic and affective universe and assume a position of partner in the treatment.

It is highlighted that the present study finding s concern the studied population and samples, as well as the chosen context, however, it also outlines the possibility or need for further interventions that consider the experience of patients with ABD related to the medication therapy.

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