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BIPOLAR AFFECTIVE DISORDER: FEELINGS, STIGMAS AND LIMITATIONS

TRANSTORNO AFETIVO BIPOLAR: SENTIMENTOS, ESTIGMAS E LIMITAÇÕES

TRASTORNO AFECTIVO BIPOLAR: SENTIMIENTOS, ESTIGMAS Y LIMITACIONES

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ABSTRACT

Objective: to understand the feelings, stigmas and work, family and social limitations of bipolar affective disorder for the person and family caregiver. ***Method:*** this is a qualitative and descriptive study in a Psychosocial Care Center, size II, with 12 people diagnosed with bipolar affective disorder and four family caregivers. Data was obtained through interviews with semi-structured script, analyzing them using the technique of Content Analysis in the Thematic Content Analysis modality. ***Results:*** it was identified that bipolar affective disorder is viewed with prejudice and carries various social stigmas, such as shame, fear, anger and sadness. Some participants expressed the difficulty in maintaining employment or entering the labor market after the onset of the disorder. ***Conclusion:*** it was understood that bipolar affective disorder bears the mark of chronicity and prejudice. ***Descriptors*:** Bipolar Disorder; Mental Health; Psychiatric Nursing; Mental Disorders; Social Stigma; Caregivers.

RESUMO

***Objetivo*:** compreender os sentimentos, estigmas e limitações laborais, familiares e sociais do transtorno afetivo bipolar para a pessoa e o familiar cuidador. ***Método*:** trata-se de um estudo qualitativo, descritivo, em um Centro de Atenção Psicossocial, de porte II, com 12 pessoas diagnosticadas com transtorno afetivo bipolar e quatro familiares cuidadores. Obtiveram-se os dados mediante entrevista com roteiro semiestruturado, analisando-os mediante a técnica de Análise de Conteúdo na modalidade Análise de Conteúdo Temática. ***Resultados*:** identificou-se que o transtorno afetivo bipolar é visto com preconceito e carrega vários estigmas sociais, como vergonha, medo, raiva e tristeza. Expressou-se, por alguns participantes, a dificuldade em manter vínculo empregatício ou ingressar no mercado de trabalho após a manifestação do transtorno. ***Conclusão*:** compreendeu-se que o transtorno afetivo bipolar carrega a marca da cronificação e do preconceito. ***Descritores*:** Transtorno Bipolar; Saúde Mental; Enfermagem Psiquiátrica; Transtornos Mentais; Estigmas Sociais; Cuidadores.

RESUMEN

Objetivo: comprender los sentimientos, estigmas y las limitaciones laborales, familiares y sociales del trastorno afectivo bipolar para la persona y el cuidador familiar. ***Método:*** se trata de un estudio cualitativo y descriptivo en un Centro de Atención Psicosocial, tamaño II, con 12 personas diagnosticadas con trastorno afectivo bipolar y cuatro cuidadores familiares. Los datos se obtuvieron mediante entrevistas con guiones semiestructurados, analizándolos en la técnica de Análisis de Contenido en la modalidad de Análisis de Contenido Temático. ***Resultados:*** se identificó que el trastorno afectivo bipolar es visto con prejuicio y conlleva varios estigmas sociales, como la vergüenza, el miedo, la ira y la tristeza. Algunos participantes expresaron la dificultad de mantener el empleo o ingresar al mercado laboral después de la manifestación del trastorno. ***Conclusión:*** se entendió que el trastorno afectivo bipolar lleva la marca de cronicidad y prejuicio. ***Descriptores*:** Trastorno Bipolar; Salud Mental; Enfermería Psiquiátrica; Trastornos Mentales; Estigma Social; Cuidadores.

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INTRODUCTION

Bipolar affective disorder (BAD) is characterized by mood swings ranging from deep depression to extreme euphoria. BAD is described by manic or hypomanic episodes separated by periods of normality. In addition, people with this disorder may have delusions, hallucinations, in a seasonal pattern, which may lead to temporary impairment of their cognitive, behavioral and affective functions.[1-2]

BAD is divided into types I and II according to the Diagnostic and Statistical Manual of Mental Disorders (DSM 5). Type I is characterized by mood elevation, in a severe and persistent perspective, called mania, in which there are mild and / or severe depressive episodes interspersed with periods of normality and well-characterized manic phases. Type II is characterized by mild elevation of mood, described by hypomania, which requires one or more major depressive episodes and at least one hypomanic episode during the course of life.[1,3]

BAD is a multidimensional condition involving a complex and dynamic interaction between biological and psychosocial factors. Although pharmacotherapy is the first-line treatment, it is emphasized that psychosocial interventions are also important tools for managing emotional and behavioral factors during the course of the disease.[4]

It is estimated that BAD affects about 1% of the world population, according to a study.[5] It is noteworthy that the clinical manifestations of the first symptoms usually occur in adolescence, specifically between 18 and 22 years. It is emphasized that the risk of developing BAD is higher in young adults, half of whom start before 25 years of age.[6]

Mental disorders are defined as recurrent cognitive and emotional changes, resulting in deterioration or disturbance of brain functioning, which cause losses in social, affective and professional life.[7] Mood disorder is severe as it compromises occupational functioning, interpersonal relationships and usual social activities.[1]

It is emphasized that people with psychological distress face a major barrier, which is stigma. We live in a culture that discriminates and segregates the individual with psychiatric disorder. It is added that mental illness, permeated by prejudice and stigmas, is viewed negatively, which interferes not only in the person with the disorder, but also in the family. It is also reinforced that this hinders recovery and rehabilitation, affecting the quality of life of both those who suffer from BAD and their families.[8]

It is noteworthy that Nursing can positively influence the treatment of people with BAD.[5] It is emphasized that it is up to the nurse, in this sense, to meet the needs of people with BAD and their families and perform health actions aimed at clarifying this disorder. in order to reduce stigmas and improve the quality of life of these people.

OBJECTIVE

- To understand the feelings, stigmas and work, family and social limitations of bipolar affective disorder for the person and family caregiver.

METHOD

This is a qualitative and descriptive study at a Psychosocial Care Center, size II, in Teresina (PI), Brazil, with 12 people diagnosed with bipolar affective disorder, accompanied by reference technique, and four family caregivers. We included people diagnosed with BAD for one year, aged 18 to 60 years and, in relation to family caregivers, those older than 18 years and who had lived with the person with BAD for over a year. People with other associated morbidity and those with chemical dependence were excluded. It is noteworthy that the required number of participants was established in the research field when the study objective was reached. Participants were recruited for convenience.

Data was obtained through interviews with a semi-structured script addressing sociodemographic aspects, stigmas and work, social and family limitations of BAD. It is noteworthy that the interviews were recorded on an MP4 player audio device and later transcribed in full. It is emphasized that, to ensure anonymity, caregivers were identified by flower pseudonym and people with BAD by letter of the alphabet. Data was produced in August 2016.

Data was analyzed using the Content Analysis technique, in the Thematic Analysis mode, divided into three phases: pre-analysis, material exploration and treatment of results and interpretation. In the pre-analysis, an exhaustive reading of the material was performed. In the exploration of the material, the thematic categories were elaborated. In the treatment of results and interpretation, the nuclei of meaning were grouped.[9]

The ethical precepts of Resolution 466/2012 of the National Health Council were obeyed. This study was approved by the Research Ethics Committee of the State University of Piauí, with CAAE 60459616.4.0000.5209 and opinion no. 1,794,126.

RESULTS

♦ Stigmas and work, social and family limitations of the person with bipolar affective disorder from the caregiver's point of view

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It is demonstrated, from the caregiver's point of view, that the BAD makes it impossible to fully perform daily activities, independently and independently.

> *She doesn't work, just stays at home, does dishes, does laundry, sweeps home. Everything I have to keep teaching, say, "Mom, do that ...". Just take care of her, care, attention, teach, because you have to teach her life, because if she does something today, tomorrow she forgets. Then you have to teach it all over again. (CARNATION)*

With regard to the mental patient's ability to work, the belief in the impossibility or difficulty of being prepared to work was verified.

> *He sold popsicles. Even today he wants to sell popsicle. People roll him up anyway, his family's own roll up. He has trouble relating socially to people. He is not about interacting with people. He's crazy about selling popsicle, but I won't let him. (ROSE)*

On the other hand, it is emphasized that a caregiver highlighted the contribution of work in improving the health status of people with BAD.

> *When he's in crisis, I get him to work. I give him strength to work and there the people get along very well with him, both customers and employees. I feel that when he is working he gets much better. (DAISY)*

It reinforces the possibility, even with the diagnosis of BAD, of the person leading a normal life.

> *Today, she does everything herself, is autonomous, does everything normal, like a normal person, with prescription drugs. When the disease is controlled, nothing interferes. Now, when she's in trouble, it gets in the way. (TULIP)*

It is shown in the speech below that people do not take into consideration the potential of individuals with BAD or socialization needs and often ignore them because they consider them to be special people.

> *Some people do is go in one ear and go out the other because they know she's special, and I tell people right away that mom is like that because she's nice, but she goes on top. If she doesn't like it, she already defends herself. She doesn't accept people talking things to her. (CARNATION)*

It is noticed that other people outside the daily life with the mentally ill have misconceptions or mystical about the disease.

> *In front of us, there is no prejudice, but many people know that she is ill and treat her normal. They only treat, when in crisis, because of the way they act. They said she's crazy, sick. We felt very bad because it's our family, right? (TULIP)*
>
> *Just a girl who called him "lelé" and the neighbors who call him, "So, crazy?" I don't even like it when they talk to him like that. I feel offended by him. I dont like. (DAISY)*

♦ Caregiver burden

It was observed, evenly, that the caregiver portrays loneliness in the monitoring of their relatives with BAD, because usually a single family member is in charge of care.

> *My brothers do nothing, it's just me and her. Friday, Saturday and Sunday, I only go out when she sleeps. In one and two hours, I'll be back in the house. The deal is serious. (CARNATION)*
>
> *No, his family doesn't follow him. I take care of him, I say, "You take the medicine right!" And he goes and takes it and he doesn't boot at all. (ROSE)*
>
> *The way was to assume, right? When one likes, one has to fight! Today, only I take care of him. (DAISY)*

♦ Labor, social and family stigmas and limitations of the person with bipolar affective disorder from the point of view of the person with this disorder

It is recognized that BAD carries the mark of chronification and that people with this disorder suffer many prejudices within their own families. It was identified that the interviewee below hid, for many years, this disorder, for fear of stigma and discrimination.

> *At first, I didn't even know what I had. I felt that weird thing, that urge to cry, the urge to be alone. I had no mood for anything. It was a horrible thing and it was for ten years that I was feeling this alone and never told anyone because people, I imagined, no one would believe me. When I started to feel it I was taking it, trying to myself, saying that I had nothing for anyone to realize, only I felt it, it was the worst thing in the world... (G)*

It was understood in this study that some people with BAD had work limitations and others did not.

> *No, no limits. (D)*
>
> *No, no limits. But sometimes we say something that we shouldn't, talk too much. And sometimes some don't understand. (B)*
>
> *Sometimes, like this, I spend so much change, I sell the popsicle, I spend a lot of change. Then I get lost...* (A)
>
> *Some days I'm fine, some days I'm not, some days I have patience, some days I don't have. I have problem only with work because I don't have availability for every day is at the same pace.* (I)

> *It bothers me about work because I get so nervous. I even got a job in 2010, but I didn't know how to handle that work routine. Then I had to take the medicine. I was forgetting to take the medicine and went into crisis; I was fired when they found out why the company didn't know. The company is also prejudiced because when they knew they fired me.* (H)

Decreased motivation, isolation and social withdrawal were some of the BAD symptoms mentioned.

> *Even at home, sometimes I don't feel like doing things. Just that desire to lie down.* (G)

It was observed in one speech that the construction of a solid love relationship, due to BAD crises, is a limitation.

> *Limitation only in love relationship because I start to relate to a person and, as the crisis does not warn when it will arrive ... then suddenly I'm in a cool relationship and comes a crisis. The person I'm relating to is not ready for it. Then it ends up disrupting the relationship and ends up not understanding. (E)*

DISCUSSION

It is noteworthy that lack of information, prejudice and discrimination occur due to negative beliefs about mental disorders, which leads to the rejection and avoidance of most people.[7] The diagnosis of a family member with mental disorder in shock and feelings of fear, shame and sadness.[10] Thus, it is emphasized that it is extremely important for the family to allow and stimulate the social inclusion of individuals with BAD, aiming at minimizing prejudice, stigma and fear.

Thus, BAD is affected by emotional impact, social and developmental difficulties. In addition, the diagnosis of BAD modifies family dynamics, as well as causing stress and apprehension in caregivers, due to the new responsibilities to entrenched social stigma.[11]

It is stated that work overload generates physical and mental exhaustion in the family caregiver, and the accumulation of tasks compromises daily activities, such as work, leisure and self-care.[12] Thus, it was observed that BAD modifies family dynamics, due to changes in routine, financial expenses, physical and emotional exhaustion with care, therefore, the importance of the distribution of tasks among family members in order not to overload only one relative.[13]

It is emphasized that the distrust in relation to the individual with BAD is observed in the work area, with uncertainties about their abilities and restrictions, which often hinders their access to work.[14] It is emphasized that family support, continuous treatment and social inclusion of these people are essential in improving the quality of life and clinical condition of these individuals with BAD.

It is understood that BAD, in some cases, makes patients unable to perform simple activities, such as household chores, personal hygiene, use of medication and preparation of food, or when they perform them, they do not perform them well, as was the case. explained in Carnation's statement. Even with the limitations, it is important to encourage these people to perform activities of daily living, because the division of household chores is an efficient therapy and also a form of inclusion.[15]

It was observed, according to Rose's testimony, that the family member has the desire to return to work, but he has difficulty interacting socially. In addition, as a result, she prefers to preserve it out of fear. This fact was evidenced in another study, because, according to the families' perspective, the person with psychological distress is unprotected and defenseless in the street, so they prefer to preserve them, but this makes their social inclusion with BAD difficult.[16]

It is emphasized that families often do not have knowledge of the pathology and do not know the degree of disease involvement of their loved ones.[16] It is understood that, in addition to understanding that individuals with mental disorders have problems and difficulties in social life, it is necessary to consider their potentialities.[17] It is stated that the possibility of the individual to feel included in society stems from his participation in a network of production and consumption, being the work activity a means of occupying the mind, producing bonds, generating satisfaction, pleasure and improving self-esteem.[18]

It was noted, however, that some individuals with BAD cease to exercise their participatory power in conversations, dialogues and everyday issues, due to the characteristics of the disease or due to the clinical condition, especially when there is no continuous treatment, or even due to biased conception and lack of credibility on the part of people for believing that individuals with mental disorder are incapable and incompetent.[19]

It was identified that fear and shame, linked to insecurity and unpredictability of behavior of people with BAD, corroborate the psychological distress of caregivers. In addition, the rejection and abandonment of people with BAD by some family members also occur due to impatience and misinformation about this mental disorder.[20-21]

Stigma was found to discourage people with BAD from seeking help for fear of being labeled, which is the main barrier for them to seek specialized services and continue treatment for fear of social reprisal. It is known that stigma and

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discrimination can increase levels of distress, stress and decrease the psychosocial functioning of people with BAD, enhancing feelings of anger, sadness, discouragement, low self-esteem and, consequently, a decrease in investment by recovery process, which highlights the importance of family support and the effectiveness of psychosocial care networks to minimize these barriers.[22]

It was evidenced that the discredit, in relation to the capacities and potentialities of the people with BAD, generates situation of economic dependence.[16] It is emphasized that, despite the fact that BAD develops phases of mania and depression, effective and continuous treatment controls these behaviors, improving the social and working life of these people.[23]

It is emphasized that people with BAD have impaired family and love relationships due to unstable, oscillating emotions, unpredictability and inconstancy. During manic episodes, these individuals appear to have more damage, endangering interpersonal life, intimate relationships and even the safety of those around them, emphasizing that appropriate treatment and cognitive therapies. Behavioral behaviors are fundamental to minimize these behaviors.[24]

CONCLUSION

However, it was identified that BAD is viewed with prejudice and carries various social stigmas, generating emotional aftershocks, such as shame, fear, anger and sadness, both for family caregivers and people with BAD. It was observed that some family caregivers are aware of the importance of social inclusion of people with BAD to increase self-esteem and improve the quality of life of these people with BAD.

These ingrained stigmas, in relation to mental disorders, have been found to discourage people with BAD from seeking help for fear of being labeled, which hinders early diagnosis and continuity of treatment. It is understood, in fact, that people's misinformation about mental health is striking in Brazil and this contributes to the stereotyping of crazy and crazy people being commonly disrespectfully employed by any people with mental problems.

It was noticed that the phases of mania and depression, characteristics of BAD, caused, in some individuals, work, social and family limitations, because some were dismissed from work, could not do simple household chores when they were in crisis, besides presenting difficulty in establishing lasting love bonds. It was also verified that BAD generates physical and emotional overload to the family caregiver.

It is suggested that mental health needs to be worked out in the community through health education in order to demystify false beliefs and stereotypes related to mental disorders in order to facilitate therapy, improve quality of life and enable social inclusion. of people with BAD.

REFERENCES

1. Dalgalarrondo P. Psicopatologia e semiologia dos transtornos mentais. 3th ed. Porto Alegre: Artmed; 2019.

2. Machado D, Soares MRZ, Costa RS. Avaliação de uma intervenção em grupo baseada na terapia de aceitação e compromisso para indivíduos diagnosticados com transtorno bipolar. Contextos Clín. 2019 Jan/Apr;12(1):26-47. DOI: http://dx.doi.org/10.4013/ctc.2019.121.02

3. Zapata CPM, Villa MP, Morales KJR, Arenas AAQ, Febrys ICU, Gómez MLÁ. Características demográficas, de salud, necesidades de cuidado y diagnósticos de enfermería de personas hospitalizadas que sufren trastorno afectivo bipolar. Investig enferm. 2019 Jan/June;21(1):1-9. DOI: https://doi.org/10.11144/Javeriana.ie21-1.cdsn

4. Bridi KPB et al. Differences in coping strategies in adult patients with bipolar disorder and their first-degree relatives in comparison to healthy controls. Trends psychiatry psychother. 2018 Oct/Dec;40(4):318-25. DOI: http://dx.doi.org/10.1590/2237-6089-2017-0140

5. Silva RC, Santos VC, Mochizuki AB, Anjos KF. Transtorno afetivo bipolar: terapêuticas, adesão ao tratamento e assistência de enfermagem. Rebrasf [Internet]. 2017 June [cited 2019 June 18];1(1):10-21. Available from: http://www.seer-adventista.com.br/ojs/index.php/RBSF/article/view/848/669

6. Bosaipo NB, Borges VF, Juruena MF. Transtorno bipolar: uma revisão dos aspectos conceituais e clínicos. Medicina (Ribeirao Preto). 2017 Jan/Feb;50(Supl.1):72-84. DOI: http://dx.doi.org/10.11606/issn.2176-7262.v50isupl1.p72-84

7. Prado AL, Bressan RA. O estigma da mente: transformando o medo em conhecimento. Psicopedagogia [Internet]. 2016 [cited 2019 June 18];33(100):103-9. Available from: http://pepsic.bvsalud.org/pdf/psicoped/v33n100/12.pdf

8. Rocha FL, Hara C, Paprocki J. Doença mental e estigma. Rev méd Minas Gerais. 2015;24(4):596-98. DOI: http://www.dx.doi.org/10.5935/2238-3182.20150127

9. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 14th ed. São Paulo: Hucitec;2014.

10. Vicente JB, Mariano PP, Buriola AA, Paiano M, Waidman MAP, Marcon SS. Aceitação da pessoa com transtorno mental na perspectiva dos

familiares. Rev gaúch enferm. 2013;34(2):54-61. DOI: http://dx.doi.org/10.1590/S1983-14472013000200007

11. Granek L, Danan D, Bersudsky Y, Osher Y. Hold on Tight: coping strategies of persons with Bipolar Disorder and Their Partners. Family Relations. 2018 Dec;67(5):589-99. DOI: https://doi.org/10.1111/fare.12328

12. Kebbe LM, Rose LBR; Fiorati RC; Carretta RYD. Cuidando do familiar com transtorno mental: desafios percebidos pelos cuidadores sobre as tarefas de cuidar. Saúde debate. 2014;38(102):494-505. DOI: http://dx.doi.org/10.5935/0103-1104.20140046

13. Costa GM, Pessôa CKL, Soares CA, Rocha SAM. A importância da família nas práticas de cuidado no campo da Saúde Mental. Cadernos ESP [Internet]. 2014 [cited 2019 June 16];8(1):41-57. Available from: https://cadernos.esp.ce.gov.br/index.php/cadernos/article/view/106/85

14. Clemente AS, Santos WJ, Nicolato R, Firmo JOA. Stigma related to bipolar disorder in the perception of psychiatrists from Belo Horizonte, Minas Gerais State, Brazil. Cad saúde pública. 2017 July;33(6):1-10. DOI: http://dx.doi.org/10.1590/0102-311x00050016

15. Mitre ANM. A loucura em diferentes épocas: a convivência da família com o portador de transtorno mental. Mental [Internet]. 2017 [cited 2019 June 15];11(20):4-28. Available from: http://pepsic.bvsalud.org/pdf/mental/v11n20/v11n20a02.pdf

16. Carvalho Júnior ACN, Amparo DM, Nogueira RN. O grupo de escuta como um dispositivo clínico em um centro de atenção psicossocial (CAPS II). Psicol clín. 2019 Jan/Apr;31(1):123-43. DOI: http://dx.doi.org/10.33208/PC1980-5438v0031n01A06

17. Jardim VMR, Kantorski LP, Oliveira MM, Treichel CAS, Rodrigues CGSS, Dias LV. Limitações de comportamento social entre usuários da Rede de Atenção Psicossocial no sul do Brasil. Ciênc Saúde Colet. 2015;20(5):1371-78. DOI: http://dx.doi.org/10.1590/1413-81232015205.15262014

18. Vechi LG, Chirosi OS, Prado JNC. A inserção social pelo trabalho para pessoas com transtorno mental: uma análise de produção científica. Rev Psicol Saúde. 2017 Jan/Apr;9(1):111-23. DOI: http://dx.doi.org/10.20435/pssa.v9i1.368

19. Nascimento LA, Leão A. Estigma social e estigma internalizado: a voz das pessoas com transtorno mental e os enfrentamentos necessários. Hist ciênc saúde-Manguinhos. 2019 Jan/Mar;26(1):103-21. DOI: http://dx.doi.org/10.1590/s0104-59702019000100007

20. Nascimento KC, Kolhs M, Mella S, Berra E, Olschowsky A, Guimarães AN. The family challenge in for people care suffering from mental disorder. J Nurs UFPE on line. 2016 Mar;10(3):940-8. DOI: 10.5205/reuol.8702-76273-4-SM.1003201601

21. Santos CF, Eulálio MC, Barros PM. O sentido do cuidar para familiares de pessoas com transtorno mental. Mudanças. 2015;23(2):25-37. DOI: http://dx.doi.org/10.15603/2176-1019/mud.v23n2p27-35

22. Oliveira ARF, Azevedo SM. Estigma na doença mental: estudo observacional. Rev port med geral fam [Internet]. 2014 [cited 2019 June 16];30(4):227-34. Available from: http://www.scielo.mec.pt/pdf/rpmgf/v30n4/v30n4a04.pdf

23. Motizuki CS, Mariotti MC. Percepções de indivíduos com transtornos mentais e familiares sobre o desempenho ocupacional: contribuições da terapia ocupacional. Rev ter ocup. 2014;2(supl.25):101-10. DOI: https://doi.org/10.11606/issn.2238-6149.v25i2p100-110

24. Malta DL, Cafieiro GM. Transtorno Afetivo Bipolar: fragilidade nas relações afetivas. Rev Brasileira de Ciências da Vida [Internet]. 2018 Dec [cited 2019 July 10];6(1):1-12. Available from: http://jornal.faculdadedecienciasdavida.com.br/index.php/RBCV/article/view/443

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