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Symptoms and Current Interventions in Individuals with Bipolar Disorder

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ABSTRACT

Background: Bipolar disorder (BD) is a devastating lifelong mental illness with a high emotional, social, and economic impact on the lives of patients and family members. People with BD experience dramatic shifts in mood, energy, and ability to think clearly. **Purpose:** The present review aims to analyze how BD impacts an individual's life and discuss common problems faced by people with this disorder. **Method:** Peer-reviewed journals from various sources were analyzed to obtain information on 12 scholarly articles on this topic. **Findings:** A thorough literature review validates the association between BD and the presence of co-morbidities such as substance abuse, personality disorder, and anxiety in people with this disorder. It also reviews the different factors affecting their quality of life and interventions to reduce symptoms and promote coping. **Conclusion:** The literature review results indicate the need for more interventions to address the problems faced by people with BD.

INTRODUCTION

National Alliance on Mental Illness (NAMI) defines BD as a mental illness that causes dramatic shifts in a person's mood, energy, and ability to think clearly. BD is also known as manic depression. It is a condition in which a person has periods of depression, periods of extreme happiness, being cross or irritable. BD-I is composed of mania and depression. To be diagnosed with BD, a person must have experienced at least one episode of mania and depression [1]. The purpose of the review was to explore the symptoms and current interventions in BD. Research question: What are the symptoms and current interventions in BD?

Background

BD is a devastating lifelong mental illness with a high emotional, social, and economic impact on the lives of patients and family members. The outcome of the illness often results in the loss of partners, families, friends, employment, and financial security [2]. Individuals with BD experience repetitive and intense emotional states called mood episodes. Manic episodes are significantly elevated and excitable moods, whereas depressive episodes are extremely sad or hopeless states. Sometimes, patients may experience both mania and depression, called mixed episodes (see Figure 1). When an episode occurs, the individual may experience the onset symptoms every day, lasting a few hours to the whole day, depending on the severity [1].

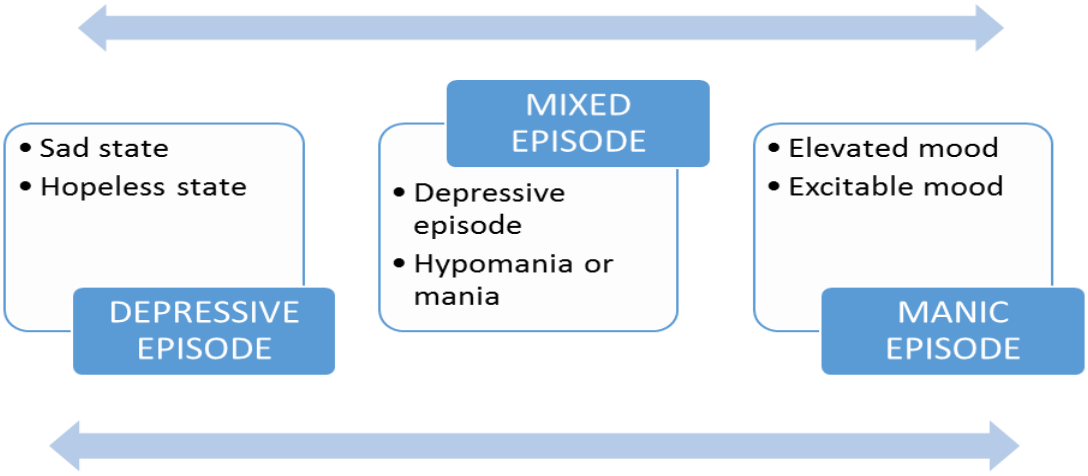

Figure No. 1: Repetitive and intense emotional states and mood episodes in BD.

Behaviors of Patients with BD

Patients may experience euphoria highlighted by an exaggerated sense of well-being and self-confidence during a manic episode. They may also feel highly irritable or touchy. They are more likely to behave impulsively, make reckless decisions and take unusual risks as they experience racing thoughts, feeling jumpy, weird, and unusually active. They have an excessive appetite for food, drinking, sex, or other pleasurable activities. People with mania or hypomania may feel that they have less need for sleep.

Patients with depressive episodes feel down or anxious and slowed down or restless. They are more likely to have difficulty concentrating and falling or staying asleep. They may also have trouble making minor decisions such as what to eat for dinner, which can be overwhelming for them [1]. They may become obsessed with feelings of loss, personal failure, guilt, or helplessness, leading to thoughts of suicide.

CASE STUDY

The following case studies consist of three patients with BD presenting a solid presence of compromised quality of life. These case studies are a brief overview of their experiences on how BD affected their life and health. Verbal consents were obtained for the case study.

Patient A

Patient A was an 18-year-old male who was brought by police related to a manic episode. He was heard stating, “I took the responsibility to pull multiple fire alarms in my dorm to ensure that they worked, given the life-or-death nature of fires.” The patient had changed his major, and the stress from learning new information increasingly reduced his sleep. He was spending long hours engaging his friends in conversations about the nature of reality. He grew increasingly irritable and intolerant of anyone who disagreed with him. He was also involved in high-risk behaviors such as drinking and engaging in sexual relations in a way that was unlike his previous history. He returned home from the hospital and has been placed on a mood stabilizer after a period on an antipsychotic drug. His psychiatrist was requesting adjunctive psychotherapy for his BD. The patient's parents are somewhat shocked by the diagnosis. However, they acknowledge that he had early problems with anxiety during pre-adolescence, followed by some periods of

withdrawal and depression during his adolescence. His parents are eager to be involved in treatment, if appropriate.

Patient B

Patient B was a 36-year-old female with BD-Hospitalized with aggression and sexual preoccupation related to a manic episode. She currently lives in a supervised living facility. She is divorced and has four children whom she sees once a month. The patient was petitioned for treatment. Following discontinuation of the patient's medications, she began to show signs of delusions. She was verbally aggressive, threatening to use drugs and kill herself. She also threatened to harm others and tried to destroy other's properties. The patient stated, "I do not know what happened," when asked why she was hospitalized. Throughout the day on the unit, the patient exhibited unpredictable and bizarre behavior by increasing aggressive, erratic, and hypersexual behavior. The patient was placed on lithium and risperidone to reduce her manic symptoms. When discussing the treatment plan with her, she showed an interest in managing her condition and getting back to her family.

Patient C

Patient C was a 54-year-old female admitted voluntarily. She experienced suicidal ideation in the context of auditory hallucinations. She has a diagnosis of post-traumatic stress disorder (PTSD), major depressive disorder (MDD), and BD-I. She was sexually abused from 14-18 years of age. She has been widowed for several years and has two children, son, and daughter, who are now adults and living their own lives. She reports hearing voices for over a year, laughing at her and telling her that she is worthless, but it has progressed to telling her to kill herself. She stated, “I keep hearing trauma voices telling me that I am worthless and that I should kill myself.” She had a history of a suicide attempt two years ago. Due to the traumatic events, she feels highly worthless, guilty, and has a sense of failure during her manic-depressive episodes. She received electroconvulsive therapy (ECT), but it was discontinued due to the Covid-19 pandemic outbreak. She also suffers nightmares, which is causing insomnia, leading to a lack of sleep and energy to perform a simple activity such as getting out of bed or fixing a meal. The patient is taking proposing, melatonin, and trazodone hydrochloride at bedtime for nightmares and to aid a good night's slept. The patient is currently on duloxetine and risperidone for depression and

auditory hallucinations. Trihexyphenidyl is also given to prevent Parkinson-like symptoms. She also has hydroxyzine and olanzapine as needed. The treatment team plans to find her a place where she can participate in activities. The goal is to find enjoyment in life again upon discharge while continuing with current medications and treatments.

LITERATURE REVIEW

In conducting this literature review, databases such as The Cumulative Index to Nursing and Allied Health Literature (CINAHL), OVID Nursing Journals, NCBI-NIH, and the university library from 2016 to 2021 were researched. The literature review analyzes the impacts of BD on the patients' quality of life, including but not limited to how it affects their concentration, energy, sleep, and suicidal ideation. Non-pharmacological and pharmacological interventions are also reviewed. The discussions include factors such as stress and lifestyles that increase the risk of relapses. Coping mechanisms, self-care strategies, and early interventions to reduce the rate of suicide are also discussed.

Factors Affecting Patients with BD

Ramírez-Martín et al. [3] conducted a systematic review and meta-analysis of the extent to which impulsivity, decision-making, and risk-taking behavior are impacted in BD patients considering behavioral measures only. A total of 30 publications were included in the study. The study's findings support previous literature suggesting that impulsivity appears to be higher among BD patients and affected in all illness phases, relatively independent of mood state [3]. The results also indicate the possibility of impairment in decision-making and risk-taking behavior in individuals with bipolar. BD-I and euthymic patients were more likely to become involved in behaviors that could lead to danger or loss.

Ramírez-Martín et al. [3] concluded that behavior impulsivity is increased in all BD's phases, representing a core and clinically relevant feature that persists beyond mood symptoms. Some of the study's limitations include heterogeneity reflected across the studies on decision-making and risk-taking behavior and lack of reported information in most studies regarding medical treatment used and addiction co-morbidity. Also, the use of multiple outcome measures from the

same task could increase bias. Future research on decision-making and risk-taking is necessary to establish their impairment in BD and analyze the role of mood state.

In another meta-analysis study regarding the role of stress in BD, Lex et al. [4] evaluated the influence of stress on bipolar patients. They examined the differences in experienced stress levels between BD, schizophrenia, and unipolar depression. The authors combined 42 studies to analyze previous data that had examined the link between stress and BD. A significant difference in stress exposure was found between patients with BD compared to healthy individuals and in the different phases in BD. Individuals diagnosed with BD reported more life stressors before relapse when compared to euthymic phases. They also experienced more stressful life events related to healthy individuals and physically ill patients.

Lex et al. [4] found no significant difference in the number of life-changing events when comparing BD to unipolar depression and schizophrenia. However, childbirth as an example impacted BD patients more than patients with unipolar depression. Most included studies were retrospective and relevant information was not specified, such as the chronicity of the stressful life events or BD type. The authors also could not eliminate a publication bias. The authors concluded that individuals with BD were more affected by stressful life events.

BD Pharmacological Interventions

McCormick et al. [5] provided an overview of the frequency, burden of illness, diagnosis, and treatment of BD from the perspective of the advanced practice nurses. Patients with BD experience recurrent episodes of pathologic mood states characterized by manic or depressive symptoms. These symptoms include low energy or fatigue, difficulty concentrating, feeling worthless or guilty, risk-taking behaviors, goal agitation. These mood episodes can impact a person's functioning in work, social, and family roles. The findings suggest co-morbidities (such as substance abuse, personality disorder, and anxiety disorder, including post-traumatic stress disorder) in people with BD.

The study also discusses some of the pharmacological interventions on BD treatment, including mood stabilizers (e.g., lithium, valproate, lamotrigine, and carbamazepine), atypical antipsychotics, and conventional antidepressants. Healthcare providers should be aware of each

of these agents' efficacy and safety profiles to achieve the most effective utilization of the approaches available in managing patients with BD. It can impact all aspects of a person's life, causing severe disruption to relationships, employment, and education [5]. Some of the strengths and weaknesses of this study include tables and charts that organize the information more clearly. There are only twenty sources out of the ninety within the last five years, which could be related to the lack of recent studies focused on this topic. However, the study's primary sources are the most vital sources and essential to include even if they are older.

In another study, Ott [6] described that anxiety is the most prevalent co-morbid diagnosis in patients with BD, which impacts the severity of BD symptoms, increases the risk of suicidality, and decreases psychosocial functioning and quality of life. Serotonergic antidepressant medications are first-line medications for the treatment of most anxiety disorders; however, these medications can be problematic for a patient with BD patients [6]. Antidepressant use in BD has been associated with a risk of potential destabilization of mood. The impact of co-morbid anxiety disorder and BD increase mood episodes, increase the risk for substance abuse, decrease functioning and quality of life.

Findings suggest that close monitoring of medication adherence, effectiveness, and side effects is required when treating BD with co-morbid anxiety disorders [6]. The study presents research evidence and facts in support of the argument. The study also reflects the views and practice of each author as substantiated with evidence-based facts and opinion, and experience. However, there is limited clinical evidence for the appropriate use of effective medications specifically for these co-morbidities, leading clinicians to treat each disorder separately based upon treatment guidelines. Figure 2 illustrates the pharmacological and non-pharmacological interventions in BD.

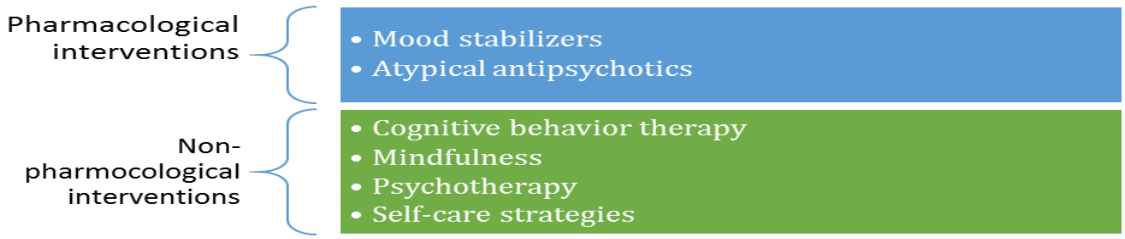

Figure No. 2: Pharmacological and non-pharmacological interventions in BD.

BD Non-Pharmacological Interventions

Maassen et al. [7] investigated the challenges experienced by BD patients and examine what these challenges imply for health care and research needs. Two qualitative studies were used, one to formulate research needs and another to formulate healthcare needs. From both studies, two main challenges related to the treatment of BD were derived [7]. The first challenge is finding appropriate and satisfactory treatment. Participants in the study explained that it is difficult to find the proper medication and dosage that is effective and has acceptable side effects. The second challenge is finding non-pharmacological therapies that fit patients' needs. According to the participants, the health professionals often do not know which non-pharmacological treatments are available and effective [7].

The participants mentioned non-pharmacological therapies that they found helpful, like cognitive behavior therapy, running therapy, mindfulness, and psychotherapy. In general, participants considered frequent contact with a nurse or psychiatrist supportive; to help them monitor their mood and find self-management strategies [7]. This study's strengths include that it contributes to the literature on the challenges and needs of BD patients. Also, the study is conducted from a patient's perspective. In conclusion, the research indicates that clinical practice guidelines should be addressed and integrated to be responsive to the needs of patients and their caregivers.

Wynter and Perich[8] explored the use of self-care strategies to manage BD. They also examined the relationship between the use of the strategy and symptoms, illness intrusiveness, and life quality. A total of 80 participants with BD were included in the study and participated in an online survey. Information was collected regarding clinical backgrounds and current symptoms of depression, mania, anxiety, stress, perceived illness intrusiveness, frequency of use, and perceived usefulness of 69 self-care strategies.

The study's results show the most commonly tried self-care strategies were spending time with others, staying in contact with important people in their life, and finding things that make them laugh. The least tried strategies were practicing yoga, Tai Chi, or Qi Gong, praying, and getting massages. The frequently used strategies and rated as most helpful were spending time with pets and getting enough sleep. Self-care strategies were shown to significantly enhance life quality, reduce illness intrusiveness, and reduce depression, anxiety, and stress scores [8]. However,

generalizations about a self-care strategy's causal impact are limited since the study's design was non-experimental. Limitations also include the small sample size, the use of a questionnaire not specific to strategies, and the lack of assessment of bipolar states.

Gold and Sylvia [9] examined the partnership between circadian system functioning and sleep-wake homeostasis on optimal sleep functioning and explore the role of disruptions in both systems on sleep disturbances in BD. During mania or hypomania, sleep disruptions are commonly presented. BD individuals report a lessened need for sleep during a manic episode. An accepted explanation for sleep disturbances in BD is determined on a circadian system model, positing that dysregulated circadian rhythms can cause sleep problems among bipolar patients.

Circadian rhythms are regulated via the suprachiasmatic nucleus in the anterior hypothalamus above the optic chiasm. Our internal clock is synchronized with the external world through zeitgebers, which are environmental cues that provide the necessary stimulus to entrain the 24-hour light/dark cycle [9]. Failed synchronizing between these internal rhythms and external cues may disrupt circadian systems, leading to mood episodes and sleep disruptions in BD patients. Moreover, study findings show that euthymic BD patients demonstrated clinically significant sleep disturbances, reduced sleep efficiency, low activity levels during the day, and heightened fear and anxiety about not sleeping well.

In conclusion, sleep disturbances persist across the phases of the condition (depressive, manic, and euthymic) and lead to a worse course of illness. Given the impact of sleep disturbances on BD, future research would benefit from examining novel psychosocial, pharmacological, and technological strategies to improve sleep [9]. Data in the study suggests that mindfulness could be a helpful adjunct treatment for sleep. However, an integrated approach may give the best findings for informing future treatments for individuals with sleep disturbances in BD. Given the impact of sleep disorders on the BD population, future research would benefit from examining novel psychosocial, pharmacological, and technological strategies that could improve sleep in this population.

BD and Suicide

A recent study of the impact of psychotic depression on suicidal ideation among BD patients elucidates the association between current psychotic depression and increased suicidal ideation [10]. The authors conducted a secondary analysis of a large pragmatic clinical trial of participants with BD. They utilized baseline data to evaluate suicide risk in participants with psychotic depression compared to those with non-psychotic depression. The study assessed both active and passive characteristics of suicidal ideation and behavior, including negative beliefs regarding the self and the future, perceived absence of social support, irritability, and a wish to be dead [10].

Kuperberg et al. [10] concluded a significantly higher risk of active but not passive suicidal thinking in BD patients with psychotic depression than those with non-psychotic depression. The findings suggest that clinicians should assess psychosis and active suicide plans and methods during bipolar depressive episodes. The study's limitations involve the limited generalizability as the sample included only outpatients; the analysis was cross-sectional and did not allow for causal interpretation; and the lack of information regarding the content and mood congruency of participants' psychosis [10].

Another study by Chia et al. [11] focuses on early interventions for BD with the current treatment guidelines. BD has one of the highest rates of suicide and the fourth most significant contributor to disability in mental health disorders. Most adults may experience the onset of mood symptoms before their 20s and diagnosis with BD five to ten years after the onset of the symptoms. Early diagnosis and interventions can improve the outcomes for those with BD, including their quality of life [11]. They reviewed current recommendations for treatment for early BD stages from clinical guidelines using PubMed and PsychINFO databases. They believe the limitation or lack of early interventions for BD is due to the lack of treatment guidelines focused on the early illness stages (see Figure 3). They identified 14 international and national clinical guidelines on BD. Their findings indicate no consistent recommendations for early-stage disorder aside from the maintenance medication treatment guidelines with the first onset mania episode.

Figure No. 3: Necessities for improved outcomes in BD

The researchers concluded that the lack of emphasis on early BD with current clinical guidelines reflects a gap in the literature and prevents optimal care of people with early-stage BD [11]. However, they discussed a broad recommendation to initiate comprehensive assessment and treatment as soon as the patient presents with the onset of a manic episode. They found confusion regarding the distinction between early-onset BD and early-stage BD as they found guidelines for the adolescent treatment of BD with second-generation antipsychotics. This article's strength is recognizing adolescent treatment guidelines and distinguishing age and the start of the illness while stating further needs of specific guidelines that focus on the early stage of BD. The limitation is the clinical guidelines review in the literature did not include primary data with illness itself and the developmental stages of BD. They also did not include any guidelines more than10 years old, including early stages of BD treatment recommendations [11]. They further expand the need for future evidence or consensus-based recommendations to inform clinical practice for early stages of BD to make changes to the current guidelines to provide rapid implementation and improve quality of life and decrease the suicide rate in BP.

As previously discussed, the high rate of suicide is a major cause of death in BP patients. A systematic review of the literature by Plans et al. [12] aims to provide an overall view of completed suicide with BD literature from Medline/PubMed, PsycInfo, and Cochrane database from 1970 to 2017. They also further contacted clinical experts, bibliographies, textbooks, and the World Health Organization website. The study selection only includes a completed suicide in BP patients, excluding the attempts and suicidal behavior. They reviewed 61 articles, and their findings suggested suicide rates in BD are 20-30-fold greater than the general population. Their findings further included that BD-II patients have a higher rate of completed suicide. They concluded that heritability and genes related to neurotransmitter systems are associated with suicide. Hence, it is crucial to identify factors such as the early onset, family history of suicide,

previous attempt, co-morbidities, and treatment to prevent a successful suicide in BD. They further discussed the treatment with lithium for suicide prevention. The limitation of this review is the limited existing literature on completed suicide in BD. However, it is essential to promote research to understand patients with suicidal behaviors in BD to prevent completed suicides [12].

The Quality of Life in BD

BD is a chronic mood disorder that affects the person's whole world, including physical, environmental, social, and occupational. The treatment is not only measured by the absence of symptoms but also the quality of life. The quality of life represents an individual's satisfaction functioning and access to resources across various domains, including physical, psychological, environmental, and social aspects [13]. Every person's quality of life differs as all humans are uniquely different. In this literature review, we look into how often the quality of life is considered an outcome based on patients with BD. In a systematic review, Mortal et al. [13] investigated the use of the Quality of Life (QoL.BD) questionnaire as a key outcome in evaluating treatment efficacy. They aimed to quantify how often and in what contexts the QoL.BD has been used as an outcome measure in studies of quality of life. They also wanted to focus on the future investigation of condition-specific aspects of quality of life by summarizing empirical studies that used QoL.BD while identifying avenues for future research [13].

Morton et al. [13] used QoL.BD citation-based approach using Google Scholar database to gather publications related to the quality of life in BD. The requirements were to have reported empirical data using the QoL.BD, and a peer-reviewed journal. They screened all of the articles to conduct their systemic review. They found 114 citations, but only 37 published between 2011 and 2020 met the requirements. Their findings included six sources with psychometric properties of QoL.BD adaptations, 16 citations with QoL.BD outcomes of clinical trials and 15 sources with clinical/psychological correlates of QoL.BD scores. Their findings supported the psychometric properties and factor structure of the QoL.BD was largely preserved in cross-cultural and web-based adaptations as French-Canadian translation of the QoL.BD was published since this systematic research. They discussed that condition-specific quality of life instruments are aligned with outcomes valued by patients and the specific impacts of the mental disorder. Morton et al. [13] concluded that a question of key importance for the BD literature is how

QoL.BD scores change with treatment. Their research limitation includes using one database source, one person screening all the articles as it could involve bias, lack of control group, and many study populations had low levels of mood symptoms as the baseline. Further, large-scale randomized trials using QoL.BD questionnaire and assessments are required to draw a more decisive conclusion regarding the beneficial effects.

Repetition of negative thoughts can hinder the quality of life, especially with people suffering from mental illness. The two primary manifestations of depressive disorders are major depressive disorder (MDD) and BD. MDD is a severely depressed mood affecting the ability to feel pleasure, and BD is an acute dysfunctional mood state of mania and hypomania with or without depressive episodes. Understanding the common features is essential as BD is often misdiagnosed as MDD, where the manic episodes go unnoticed and untreated. Both MDD and BD have standard features such as impairments in cognitive performance, elevated use of negative cognitive biases, and the extensive use of rumination, which may indicate impaired inhibitory executive function [14].

Kovács et al. [14] conducted a meta-analysis on rumination in MDD and BD as repetitive negative thoughts have been linked extensively with mood disorders, with a growing body of evidence suggesting the importance of ruminating in BD. They used four different databases, including PubMed, Science Direct, Web of Science, and EBSCO host, using ruminative thoughts and bipolar or manic episodes and MDD search engines. They identified 12 studies with an overall sample size of 2071 clinical patients. Their findings include no significant difference of ruminative tendencies in both MDD and BD; however, BD patients reported more rumination on positive affect. Their study limitation is the lack of sufficient literature data as their analysis could not determine the current mood state of both groups. They concluded that rumination is a significant process to MDD and BD, which shows the importance of interventions to reduce negative repetitive thoughts in mood disorders.

DISCUSSION

Based on the literature review findings, BD has a significant impact on people's lives. Individuals with BD experience difficulties sleeping, staying focused, eating, or doing other essential daily living activities. They are also more likely to be affected by stress, leading to

relapses [7]. During manic episodes, problems with controlling impulses, impaired decision-making, or risk-taking behavior may arise and require interventions [3]. BD patients are prone to agitation, resulting in impulsive aggression during manic and mixed episodes. Depressed states can involve intense dysphoria with agitation and irritability, increasing the risk of violent behavior. Additionally, there is a significant risk of suicide in bipolar patients with psychotic depression [8].

As nursing interventions, the nurse can teach individuals with BD some coping skills, including relaxation techniques such as meditation and yoga. Using stress management techniques can help the person express their needs, manage potential frustrating interactions, and handle anger. Cognitive-behavioral therapy is one type of psychosocial treatment modeled on the relationship between thoughts, emotions, and behaviors-correcting inaccurate and distorted feelings and thoughts may lead to more productive behaviors [7]. The nurse should encourage self-care strategies such as spending time with pets and sleeping enough to help reduce stress, anxiety, and depression that may accompany BD.

Being sleep-deprived can sometimes trigger mania in those with BD. The nurse can encourage people experiencing sleep problems to sleep and get up at the exact times every day and relax before bed by listening to soothing music, reading, or bathing. Lastly, research has shown that mindfulness-based cognitive therapy and meditation help fight and prevent depression, anger, agitation, and anxiety [8]. The mindfulness approach uses meditation, yoga, and breathing exercises to focus on the present moment and break negative thinking patterns. Patients in depressive states should be directly assessed for psychosis because it is associated with active suicidal ideation [10]. The nurse should also assess for suicide plans and methods during bipolar depressive episodes.

Chia et al. [11] provide an insight into the importance of early interventions at the beginning of the development stage of BD to decrease the impact of the illness on the patient's life, including satisfaction and daily functioning. The sooner treatment is implemented that works for the patient during the onset of symptoms, the better the quality of life, thus preventing suicide in BD patients [11]. Morton et al. [13] explain the importance of the individual's quality of life as one of the more essential outcomes for treatment plans. Even though BD patients may no longer have

depressive mania episodes or impulsivity, BD is a chronic mood disorder where learning to live with the condition without hindering life quality is crucial. As the quality of life decreases, the rate of suicide increases in BD patients, which is why the QoL.BD is part of an important assessment tool. Suicide ideation and completed suicide rates are high in BD, and lithium is the most effective treatment in preventing suicide [12]. Overall, the early rapid onset implementation and finding the proper medications, including lithium, is vital in preventing suicide in BD patients (see Figure 4).

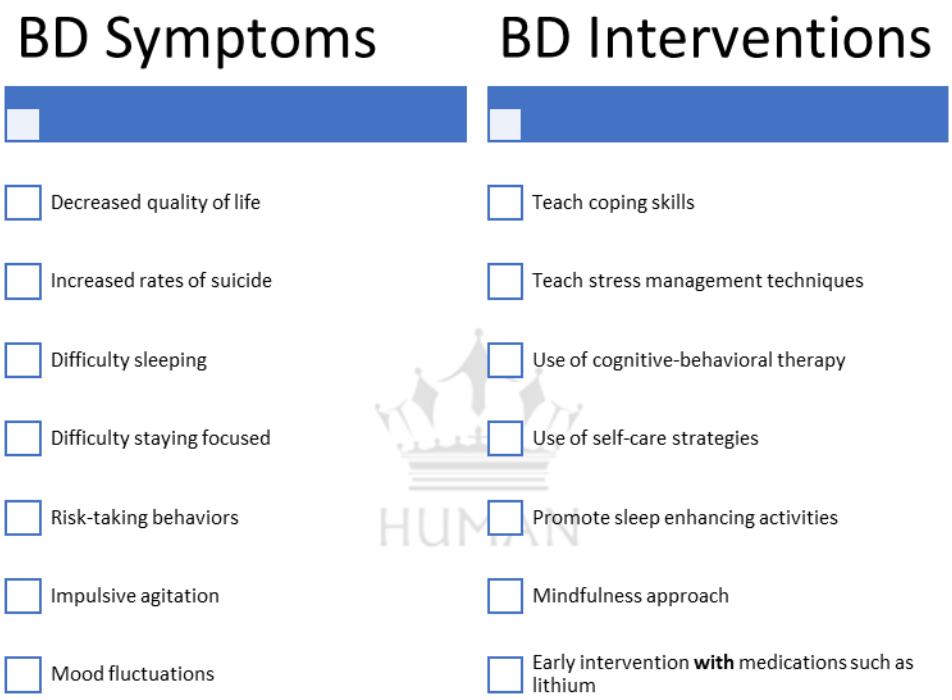

Figure No. 4: Common findings from the review regarding BD symptoms and interventions

CONCLUSION

Based on the findings, it is indicated that BD causes physical and mental exhaustion. Several factors, such as fluctuation of mood episodes and the effects of these episodes on patient well-being, make the treatment more complex. This literature review successfully explored the common problems people face with BD, such as suicidal ideation and quality of life. The case studies also examine three different patients who presented with varying symptoms of BD and affected their life differently, including their quality of life. It is difficult to make a statement that

fits all regarding an individual's mental illness, but it is necessary to improve research on the mood and effect of BD to improve treatment response, reduce relapses, and ultimately prevent or cure co-morbidities. Future research in early interventions and QoL. BD-based comprehensive assessments clinical guidelines are also needed to identify the quality of life for individuals with BD. After identifying the challenges that this population encounters, it is essential to assess individual needs and use the appropriate interventions to address the issues and improve their quality of life.

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