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The impact of a simple individual psycho-education program on quality of life, rate of relapse and medication adherence in bipolar disorder patients

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ABSTRACT

Introduction: Bipolar disorder is one of ten most debilitating diseases in the world, leading to a lessened quality of life amongst its sufferers. This randomised control trial demonstrates the effectiveness of psycho-education intervention along with a patient support system in the management of this disorder.
Methodology: In this trial, 108 patients, divided equally into two groups, were randomly assigned to receive either pharmacotherapy alone (control group) or psycho-education along with pharmacotherapy treatment (intervention group) for a two year period. Each individual patient in the "intervention" group received eight, fifty-minute sessions of psychological education, followed by monthly telephone follow-up care and psychological support in the subsequent 18 months. Each group was evaluated, once every 6 months for a period of 18 months, in the areas of "quality of life", "symptoms of relapse", "pharmacotherapy compliance" and "number of hospital admission for recurrence of bipolar disorder".
Result: The result of this study indicates that patients in the "intervention" group had a statistically significant enhancement in medication compliance ($P = 0.008$). Regarding every aspect of life quality, this group was at a better position than the "control" group ($P = 0.000$). As to relapse and hospital admission, the "intervention" group reported much lower cases compared with the "control" group at a significance level of $P = 0.000$.
Conclusion and discussion: This research has demonstrated that in the psycho-education intervention group, there was a more significant improvement in all areas of quality of life, number of relapses, and hospitalization due to recurrence of bipolar disorder and medication compliance than it was evident in the control groups.

1. Introduction

Bipolar disorder (BpD) is a well-established and one of the oldest diagnoses of mental disorders in the field of psychiatry. This disorder is the sixth cause of disability amongst the older population of the world (Colom and Vieta, 2009). Even after putting behind the acute periods, one may still suffer the destructive consequences of bipolar disorder. Sufferers generally complain about dissatisfaction with personal and social life, employment and education related difficulties, and are susceptible to other psychological and physiological indispositions.

On the other hand, as reported by Lacro et al. (2002), it is known that the rate of individual bipolar patients routinely and consciously taking the prescribed medicines is only 35%, which is much lower than that of schizophrenics at 50–60%.

Since it is apparent that betterment of a system of pharmacotherapy assists in decreasing the frequency of relapse and in increasing the quality of life, various interventional methods have been employed to assist in potentiating the procedures of treatment. (Pharmacotherapy, in this context, is a reference to each individual patient's self-motivation to make a conscious decision to follow procedurally a prearranged treatment program, put together by the healthcare professional, i.e. adherence to taking the prescribed pharmaceutical medication on one's own accord armed with the knowledge of the disease and indicators of relapse.)

Selected review of research literature revealed that there was a positive relationship between different psychological interventions such as behavioural therapies, family reliant treatments, psychosocial education, and interpersonal therapies with adherence to medical psychotherapy (Bauer et al., 2006; Cakir et al., 2009; Colom et al., 2003; Even et al., 2007; Goodwin et al., 2003; Lincoln et al., 2007; Maczka et al., 2010; Miklowitz, 2008; Osterberg and Blaschke, 2005; Perry et al., 1999; Rouget and Aubry, 2007; Rucci et al., 2002; Simon et al., 2006; Simpson et al.,

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2011; Zaretsky et al., 2007), as well as reduction in the number of relapses and hospitalizations.

There are few studies in Iran on educational therapy for BpD patients (Ghadirian et al., 2009). This randomised control trial aims at evaluating the effectiveness of psychoeducational intervention along with a patient support system in management of this disorder.

2. Methods

This study was performed during the remission phase of patients with BpDs after being discharged from the hospital. The study was done in hospitals affiliated with Shiraz University of Medical Sciences on BpD patients discharged from wards one, three and four of the Psychoneurology Department of Ebn Sina Hospital as well as those discharged from the Psychoneurology Department of Hafez Teaching hospital.

2.1. Inclusion criteria

(1) Age range of 18–60 years inclusive
(2) Duration of disease: history of at least two episodes of relapse in the past two or three episodes in last five years
(3) Inclusion of patients in euthymic state (the Hamilton Depression Rate Scale < 8 and Bech Rafaelsen Mania Rate Scale < 9).

2.2. Exclusion criteria

(1) Patients below 18 and above 60 years of age,
(2) Patients with first episode of BpD or with a history of interepisode intervals more than two years,
(3) Acute phase of BpD or presence of some residual symptoms of BpD.

2.3. Procedures

The Ethics Committee of the university approved the study. Subjects were randomly assigned into two equal groups of control and intervention. Equal sets of odd and even numbers were selected, left in an opaque sealed envelope, and sent to each researcher. The odd numbers received interventions and the even numbers were allocated to the control group. One hundred forty-seven medical files of patients with BpD in the abovementioned departments were evaluated. All of these patients were in the remission state. Thirty-nine patients were excluded from the study as they did not meet the required criteria. One hundred eight patients, fulfilling the inclusion criteria, signed the informed consent. The trial was thoroughly explained to the study patients by the researcher in charge. Researchers asked each patient to take his/her prescribed medication. After giving their signed consent forms, the patients were assessed at baseline. Each patient was then evaluated for meeting the inclusion and exclusion criteria.

2.4. Intervention groups

Patients in the intervention group received standard pharmacotherapy for BpD and also enrolled for simple, individual psycho-education. The program consisted of eight sessions each consisting of a 50 min session per week in a short form of psycho-education course, adapted from studies by Colom and Vieta (2006). Sessions of psycho-education were performed by a psychiatry resident who was blinded to treatment. All psycho-education treatment sessions for all the patients were performed by the same resident who conducted a one-on-one session with each individual patient.

Psycho-education program and discussions were presented to the patients in the eight sessions including: understanding BpD and its aetiology, familiarisation with symptoms of mania and hypomania, understanding signs of depression and other psychological episodes, awareness of causes and prognosis, education about the function, types and adverse side effect of mood stabiliser medication, functions, types and adverse effects of antimanic and antidepressant medications. Patients also received information about the risk of discontinuation of these medications, learning how to detect any future episodes of relapse as well as strategies and plans on which to base early detection of symptoms and for being self-directed towards new situations.

These eight weekly scheduled sessions were conducted face to face in the clinic of psychology at Hafez Hospital.

After eight sessions of face to face simple individual education, the intervention continued using scheduled monthly telephone contact to remind the patients of their next appointment. Each telephone contact consisted of a 10-min question and answer session when the patient's queries were thoroughly responded to.

Follow-up telephone contact for each patient was then scheduled for the subsequent 18 months.

2.5. Control groups

Patients who were randomised in the control group were continuing standard pharmacotherapy by their psychiatrists of choice for 18 months. They also received written scheduled appointment for follow-up assessment in the next 6, 12 and 18 months by a psychologist involved in the research.

2.6. Assessment

Assessment of the intervention and control groups was performed by a psychologist who was deliberately unaware of the distribution of patients.

Assessments were performed at baseline, at six-month intervals, after randomisation, for up to 18 months.

At each session, the areas of recurrence, pharmacotherapy compliance, quality of life, and number of hospital admissions were assessed based on the following guidelines:

- Recurrence assessment was performed based on Hamilton Depression Rating Score (Hamilton, 1960) and Bech Rafaelsen Manic Assessment Scale (Bech, 2002) at baseline, 6, 12 and 18 months. In Hamilton Depression Rating scale depression is defined as scores equal to or above 17 and in Bech Rafaelsen Manic Assessment Scale, scores equal to or above 15 indicate mania.
- Assessment of hospitalization due to BpD was derived from hospital files.
- Pharmacotherapy compliance assessment was performed by patients' completion of validated questionnaire forms of "medication adherence rating scale" (Fialko et al., 2008). The Medication Adherence Rating Scale is a ten-item self-report measure of medication adherence in affective and psychotic disorders. (This questionnaire is translated from the original English text to Farsi by researchers. Its validity was evaluated by test–retest and the correlation coefficient was: 0/917, which was in favour of positive correlation.)
- Quality of life assessment was conducted and the patient filled out a World Health Organization short form questionnaire. This instrument comprises 26 items, which measure the following broad domains: physical health, psychological health, social relationships, and environment. The World Health Organization Quality of Life (WHOQOL)-BREF is a shorter version of the original instrument that may be more convenient for use in clinical trials (Nedjat et al., 2011) (translated from original English text to Farsi