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Improving the outcome of bipolar disorder through non-pharmacological strategies: the role of psychoeducation

Melhorando o desfecho do transtorno bipolar usando estratégias não farmacológicas: o papel da psicoeducação

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Abstract

The present paper addresses the efficacy of psychoeducation and related strategies in bipolar disorders. Recently, several randomised clinical trials have shown the efficacy of psychological interventions –namely identification of prodromal signs, cognitive-behavioral therapy, psychoeducation and family-focused interventions- as a prophylactic add-on to medication. All these studies are presented hereby, together with the pioneer studies in the field.

There are several topics that every psychoeducational program should include to ensure its usefulness, and they will be summarized in twelve points. Roughly, psychoeducation should contain general information about bipolar illness, compliance enhancement elements, teaching on early recognition of relapses and lifestyle regularity issues.

Nowadays, several treatment guidelines include psychoeducation as a crucial prophylactic tool. Clinicians should be aware of this and start performing psychoeducation in their everyday clinical practice.

Keywords: *Bipolar disorder/prevention & control; Bipolar disorder/psychology; Patient education; Recurrence/prevention & control; Patient compliance/psychology; Treatment outcome; Randomized controlled trials*

Resumo

O presente artigo avalia a eficácia da psicoeducação e estratégias relacionadas nos transtornos bipolares. Vários ensaios clínicos aleatorizados demonstraram, recentemente, a eficácia de intervenções psicológicas – a saber: a identificação de sinais prodrômicos, terapia cognitivo-comportamental, psicoeducação e intervenções focadas na família – como um acréscimo profilático à medicação. Todos esses estudos são aqui apresentados, conjuntamente com os estudos pioneiros na área.

Há vários tópicos que todo programa psicoeducacional deve incluir para assegurar sua utilidade e eles serão resumidos em doze pontos. Grosso modo, a psicoeducação deve conter informações gerais sobre a doença bipolar, elementos para a aumentar a adesão ao tratamento, ensinar o reconhecimento rápido de recaídas e questões sobre a regularidade do modo de vida.

Hoje em dia, várias diretrizes para o tratamento incluem a psicoeducação como uma ferramenta profilática crucial. Os clínicos devem estar conscientes disso e começar a praticar a psicoeducação em sua prática clínica cotidiana.

Descritores: *Transtorno Bipolar/prevenção & controle; Transtorno bipolar/psicologia, Educação do paciente; Recidiva/prevenção & controle; Resultado de tratamento; Ensaios controlados aleatórios*

Do we need non-pharmacological strategies?

Bipolar illness is a severe, chronic and recurrent condition that represents a major health problem[1] which includes both a great economic burden[2] and high mortality rates.[3-4] The available pharmacological arsenal for treating bipolar disorders has been sensibly enlarged in the last decade with the apparition of newer user-friendly drugs which combine good efficacy with better tolerability. However, even with this unquestionable upgrade of drug treatments, there is still a lot to do to reach good social outcomes, cope with subsyndromal symptoms and improve maintenance management. The recent publication of several well-designed randomized studies on the efficacy of some psychological treatments in preventing relapses is leading the experts to a new view of bipolar disorders treatment, including both drugs and add-on psychological interventions.[5-6]

Psychoeducation is an essential component of the combined treatment of bipolar disorder as shown by the fact that all psychological interventions successfully tested[7-10] contain classical psychoeducative elements such as improving illness awareness, coping stigmatization, enhancing treatment adherence, teaching the patient and the family to early identify prodromal signs, promoting healthy habits and life-style regularity, and avoiding substance abuse.

Psychoeducation: a worldwide evidence-based approach

The amount of psychological treatments for bipolar disorders proposed all along history is quite important and there is a considerable variability of paradigms. Most of them have not even been tested and they should not be considered in the treatment routines for bipolar patients until they do it.[11] Fortunately, in the last five years we have moved to a phase of consolidation of well-tested approaches with most studies indicating a high efficacy of psychoeducation-based programs in the prevention of relapses.[7,10,12]

The pioneering studies in the field were carried out in the US by Peet and Harvey[13-14] and reported some changes in patients' attitudes towards lithium. Unfortunately, little attention was paid to major outcome measures such as relapses. In Europe, the studies of Eduard van Gent should be mentioned as well, as they showed a significant decrease of non-compliant behavior and hospitalizations amongst psychoeducated patients.[15]

The Richard Morriss group, in the UK, performed what can be easily described as the first well-designed randomized controlled study in psychological strategies for preventing relapses in bipolar disorders:[7] Sixty-nine bipolar patients who had experienced a relapse within the previous 12 months were randomized to receive either standard treatment alone or standard treatment plus a very simple psychological intervention consisting on 7-12 individual sessions aimed at enhancing early identification of warning signs and to seek prompt treatment from their healthcare providers. At the end of the follow-up, the group that was specifically trained to early identify relapses showed a significant increase in time to first manic relapse (65 weeks vs 17 weeks; $p=0.008$) as well as a 30% decrease in the number of manic episodes over 18 months ($p=0.013$) but no changes were observed in terms of time to first depressive relapse and number of depressive relapses.

The Barcelona Bipolar Disorders Program has shown the efficacy of group psychoeducation in preventing all sort – manic or hypomanic, mixed and depressive – of bipolar episodes and increasing time to relapse at the two-years follow-up.[10] Depressed patients may tend to get only the negative aspects of psychoeducational information and may have serious cognitive difficulties that may hinder the learning processes needed in psychoeducation. Manic patients can be disruptive and do not absorb the information at all because of their distractibility and other cognitive disturbances. Hence, psychoeducation should be always performed during euthymia: in our study patients were required to have maintained a euthymic state (Young Mania Rating Scale [YMRS] <6, Hamilton Rating Scale for Depression [HAM-D] < 8) for at least 6 months prior to entering the study. The psychoeducational group was composed by from 8 to 12 patients, which met for 20 90-minute sessions under the direction of two trained psychologists with expertise in bipolar disorder. The content, which followed a medical model with a directive style, encouraged participation and focused on the illness rather than on psychodynamic issues. At the end of the 2-year follow-up, the number of hospitalizations per patient was lower for the psychoeducation group, although the number of patients who required hospitalization did not change significantly, which can be interpreted as psychoeducation having a good profile for avoiding the impact of the "revolving door" phenomena in the bipolar population. This study had a reasonably large sample size ($N=120$) and a random allocation of subjects to either a treatment condition (psychoeducation plus standard pharmacological treatment) or non-intervention (non-structured meetings plus standard pharmacological treatment).

Interestingly, a recent subanalysis of the study data shows that psychoeducation may be useful even in those complex patients fulfilling criteria for a comorbid personality disorder.[16] This might be particularly interesting if we consider on the one hand the poor outcome of comorbid bipolar patients[17-20] and on the other hand the complexity of its treatment.[21-22] Thus, psychoeducation might be specially useful for the more difficult-to-treat bipolar patients.

Our group tried later to replicate our own former study[10] paying attention to the specific role of psychoeducative elements beyond the simple – but indispensable – enhancement of treatment adherence. To this end, we performed a randomized clinical trial using the same 21 sessions program but including only 50 bipolar I patients that fulfill criteria for being considered as treatment compliant (elicited by compliance-focused interviews with the patients and his/her first-degree relatives or partner and plasma concentrations of mood-stabilizers). This was designed to clarify whether the effect psychoeducation goes beyond the improvement of treatment adherence, and it surely does: the effect size was pretty similar to the Archives study, and so were the results. Time to relapse was higher for psychoeducated patients and, at the end of the two-year follow-up, 92% of subjects in the control group fulfilled criteria for recurrence versus 60% in the psychoeducation group ($p<0.01$). The number of total recurrences and the number of depressive episodes were significantly lower in psychoeducated patients.[12]

There is also good evidence for the efficacy of a psychoeducation-focused family intervention coming from the studies performed by the Colorado group guided by David Miklowitz, in the US. Miklowitz et al[9] carried out a randomized study among 101 bipolar patients who were stabilized on maintenance drug therapy and were randomized to receive either 21 sessions of manual-based family-focused psychoeducational treatment ($n=31$) or two family education sessions and follow-up crisis management ($n=70$), both treatments delivered over a 9-month period. After 2-year follow-up, patients assigned to the longer psychosocial treatment had fewer relapses, longer times to relapse, significantly lower nonadherence rates than patients assigned to the shorter intervention and even some improvement in certain mood symptoms. Thus, it is remarkable the great benefit that professionals may expect from using this integral approach, specially when combining it to other individual therapies.[23]

Topics to be addressed in a psychoeducational program

A psychoeducational program of bipolar patients and their relatives should include at least the following twelve points:

1) Information about the high recurrence rates associated with the illness and its chronic condition.

2) Information about triggering factors and a personal training to help patients identify their own ones.

3) Information about psychopharmacological agents, their advantages and their potential side effects.

4) Training on early detection of prodromal symptoms.

5) Composition of an "emergency plan".

6) Training on symptoms management.

7) Information about the risks associated to the use of street drugs, coffee and alcohol.

8) Stress on the importance of maintaining routines –specially sleep habits.

9) Promotion of healthy habits.

10) Training on stress management.

11) Concrete information about some issues such as pregnancy and bipolar disorders and suicide risk.

12) Coping with stigma and other social problems related to the illness which bipolar patients can not easily discuss with their "healthy" friends.

Psychoeducation is aimed at providing the bipolar patients with a theoretical and practical approach towards understanding and coping with the consequences of illness –in the context of a medical model-, to turn "the" illness in "their" illness –which basically means trying to understand the complex relationship amongst symptoms, personality, interpersonal environment, medication side-effects and becoming responsible (but never guilty) in front of the illness- and allows them to actively collaborate with the physician in some aspects of the treatment.

Destigmatization and improvement of illness awareness is essential to successfully perform a psychoeducative program: Many patients usually share some terrible myths about their illness that may be pushing them to diagnosis denial and treatment

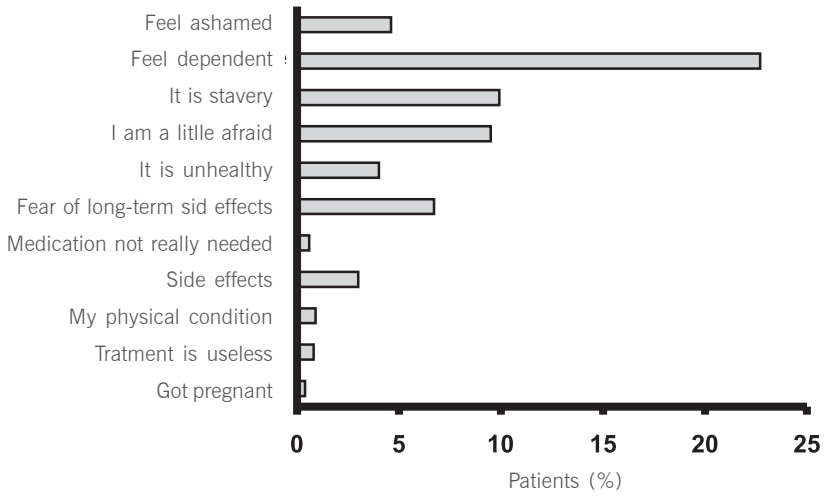

Figure 1 - Concerns about medication, following the BEAM survey (Morselli et al, 2002)

noncompliance. Thus, understanding denial and learning the biological causes of the illness constitute an essential part of the first sessions. Another important issue is the distinction between causes (biological) and triggering factors. This issue will, later on, be crucial for establishing a good treatment adherence.

One of the main targets of psychoeducation concern the enhancement of treatment adherence, usually very poor in bipolar patients even when euthymic[22] which roughly a half of all the sessions. This may be seen as excessive by some professionals coming from other paradigms in psychiatry. Nevertheless, the truth is that poor compliance has often a lot to do with misinformation or ignorance, as shown by the results of the BEAM survey by Paolo Morselli et al.[24] This study runned-out by the GAMIAN advocacy forum wondered about the patients' main concerns about taking their prescribed drugs (Figure 1). The most frequently cited reasons were "feeling dependent", "feeling that taking medications is slavery", "feeling afraid", concern about long-term side effects, and "feeling ashamed". It is noticeable that all these reasons have to do with lack of information whilst other reasons traditionally considered by psychiatrists such as side-effects were cited by less of 5% of patients. Thus, information is never enough to improve treatment compliance.[25] Other specific interventions for compliance, such as the Concordance model by Scott are usefull for improving compliance as well.[26]

The early detection of prodromal symptoms is another main issue approached by our psychoeducation program. As commented above, early detection of prodromal signs has shown its efficacy in preventing mania but not depression and increasing time to relapse, in the study by Perry and colleagues.[7] Patients frequently don't notice new relapses until it is too late, specially when we are dealing with mild – but long-term impairing – hypomanic episodes. Patients enrolled in the psychoeducation program learn to easily identify common signs of manic relapses, which constitutes the first step of early detection. In a second step, the patient – that may be helped for their relatives, friends or partner – chooses which signs are more relevant for him, keeping in mind his personality and temperament, the intimate characteristics of his relapses and which signs is he able to identify. A third step is based on the detection of pre-prodromal signs; for some patients, a small change in behavior (that includes changing preferred readings, music or dress), subtle body sensations or newer interests that tend to repeat on every episode, is completely informative of the onset of a new episode.

We still can not assure that every single content is indispensable for the success of psychoeducation but we know, at least, that the combination of all them has shown good prophylactic results in our Barcelona Psychoeducation Program (Table 1).

Table 1 - Sessions of the psychoeducation program (Colom et al., 2003 a,b)

Contents of the Barcelona Psychoeducative Program
1. Introduction
2. What is bipolar illness?
3. Causal and triggering factors
4. Symptoms (I): Mania and hypomania
5. Symptoms (II): Depression and mixed episodes
6. Course and outcome
7. Treatment (I): mood stabilizers
8. Treatment (II): antimanic agents
9. Treatment (III): antidepressants
10. Serum levels: lithium, carabamazepine and valproate
11. Pregnancy and genetic counselling
12. Pychopharmacology vs. Alternative therapies
13. Risks associated with treatment withdrawal
14. Alcohol and street drugs: risks in bipolar illness
15. Early detection of manic and hypomanic episodes
16. Early detection of depressive and mixed episodes
17. What to do when a new phase is detected?
18. Life-Style Regularity
19. Stress management techniques
20. Problem-solving techniques
21. Final session

FONTE: Colom et al, 2003 a,b

Conclusion

Recently, the use of psychoeducation as an add-on prophylactic tool has been acknowledged by several prestigious treatment guidelines broadening and updating the treatment paradigms of bipolar disorders. Clinicians should keep this in mind in the everyday clinical practice with bipolar patients specially because the benefits – in terms of less relapses and hospitalizations – are unquestionable and the cost very low. To this end, there is an emergent need for training professionals in good communicational skills and psychoeducation techniques to worldwide implement its use in bipolar disorders. Psychoeducation provides us with a strong tool not only to improve our patients' outcome but to help them to manage despair, fears, stigma and low self-esteem. Psychoeducation should be always an add-on to mood-stabilizers as it optimizes their efficacy.

Thus, psychoeducation is the key intervention to enhance treatment adherence and to improve long-term outcome not just in bipolar disorders and other psychiatric conditions but also in several medical conditions such as cardiac illness,[27] diabetes[28] and asthma.[29] Moreover, psychoeducation is a key element of a good medical practice and covers a fundamental right of our patients: The right to be informed about their illness.

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