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Psychoeducational Interventions in Bipolar Disorder

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Abstract: Introduction: Psychoeducation is considered to be an integral part of the modern and total therapeutic treatment for mental disorder. It is the main intervention in the application of theory of psychosocial rehabilitation in practice. Purpose of this paper records the psychoeducation programs for mental illnesses, especially in bipolar disorder, in order to present the benefits of psychoeducational intervention both to mental sufferers and their families and / or caregivers through a bibliographic review. Conclusions: Family education and therapy is aimed at the well-being of all members, while psychoeducation aims to effectively treat the patient and maintain the balance. Family education helps members to be more "efficient" in interventions for their mentally ill and achieve better results when it is done in group, as this promotes the exchange of views and the mutual reinforcement.

Keywords: Psychoeducation, Bipolar Disorder, Family Behavioral Therapy

1. Introduction

Bipolar disorder is a disease that characterized by two extreme emotional moods: elation and depression. In their typical form, patients go through cycles or phases of intense mania that are alternated with cycles or phases of deep depression. The basic distinctive feature of bipolar disorder is the elation. As in depression, the elation includes a wide range of emotional dispositions, from the normal conditions of euphoria and joy to the pathological conditions of hypomania and mania. One of the interventions to be followed is psychoeducation. [1]

The ultimate goal of all therapeutic interventions is to encourage patients and their families. In order to mentally ill cope with his illness in the best possible way, it is necessary to understand it and to be informed about the available therapeutic possibilities. Without consolidating a comprehensive knowledge of the disease that leads to empathy, compliance with treatment and the development of skills to cope with the problems associated with a mental illness are likely not to develop. [2]

2. Reasons that Psychoeducation Recommended in Patients with Bipolar Disorder

Bipolar disorder is a chronic and recurrent disease, a percentage > 90% will show at least one more episode. Most patients suffer from distorted perceptions of disease and medication.

The effects of mood stabilizers and atypical antipsychotics are undermined by insufficient compliance.

50-60% of the patients are totally or partially non-compliant from the first time after the invasion of an acute episode, the average interval of compliance in lithium is limited to two months, and only 21% of the patients take lithium systematically. [3]

Poor clinical outcome leads to irreversible psychosocial and professional slippage. It also leaves neurological deficits.

Bipolar disorder, often presents severe symptoms that may be a cause of functional disability for sufferers and poses significant challenges in its management.

The character of its symptoms, including extreme mood

swings, is a serious stress factor for relatives / caregivers. [4]

Care demands have a significant impact on family functionality and may be a cause of family disruption. It is also documented that the functionality of family system can influence positively or negatively the course of severe and chronic mental disorder. [5]

3. Therapeutic Procedure

Psychoeducation enriches the care of sufferers from Bipolar Disorder as:

It offers long-term observation, it is accessible to community patients, it is flexible and adaptable to the needs and potential of patients.

It is implemented by a interdisciplinary team, encourages the active participation of patients in decision-making, it is based on the trust between doctor and patient, it respects the patient's choices, it promotes the participation of families in the healing process. [6]

The goals of Psychoeducation in a patient with Bipolar Disorder are as follows:

Primary goals:

Prevention of relapses, reduction of hospitalizations, avert suicide, improvement of functionality

Secondary goals:

Fighting of stigma and guilt, restoration and shielding of self-esteem, promoting of wellness,

stress management, improvement of functionality, prevention and management of co-morbidity

According to the study of Van Gent & Zwart (1991), fourteen patients who participated in five group psychoeducation sessions was compared with twelve sufferers who were the control group. [7]

The results were as follows:

The knowledge of the patients who formed the intervention group for disease and medication was improved, the social skills supplied but no effect on compliance was observed.

However, the same research team, in later studies, found a clear and distinct increase in behavior focused on medication as well as a reduction in hospitalizations. [8]

In order to achieve the objectives of psychoeducation, the structured intervention should be constituted at three levels:

First level

1. Understanding of disease
2. Early recognition of early warning signs
3. Adherence to treatment

Second level

1. Stress management
2. Avoidance of substance use
3. Adaptation to a healthy lifestyle
4. Prevention of self-destructive behavior

Third level

1. Utilization of the experience and mitigation of psychosocial consequences that episodes cause
2. Improving of interpersonal and social functionality
3. Dealing with residual symptoms
4. Promotion of wellness and quality of life. [9,10]

The structured intervention should consist of the following twelve parameters:

1. Information on the high prevalence rates and the course over time
2. Information on causes and excretory factors as well as training in order to patients aware of the factors that may trigger relapse
3. Information about the medications, the advantages and disadvantages (side effects) of their taking
4. Training for early detection and decoding of early-warning symptoms
5. Design a plan to deal with emergencies
6. Training for symptom control
7. Information on the risks which posed by the use of prohibited substances and the abuse of alcohol and caffeine
8. Emphasize the importance and benefits of maintaining a daily program, particularly the stability of the sleep-wake cycle
9. Promote a healthy lifestyle
10. Training for effective stress management
11. Information focusing on issues of pregnancy and self-destructive behavior
12. Fighting of social stigma and the psychosocial consequences of the disease. [11, 12]

Psychopathology Program for Patients with Bipolar Disorder from the “Barcelona Bipolar Disorder Group”

The Psychoeducation Program as presented by the “Barcelona Bipolar Disorder Group” [13, 14]

A randomized controlled study was conducted according to which:

Two groups consisted of eight to twelve patients was participated

Normothymics (YMRS <6, HAM-D <8, Six months)

Twenty one sessions of ninety minutes each

They were coordinated by two trained psychologists

The medication was not modified

No other psychosocial intervention has been implemented

Medical model that encouraged active patient involvement

He was focusing on the disease. [15]

The content of the sessions includes:

1. Introduction (presentation of participants and the rules that govern the group running)
2. What bipolar disorder is
3. What the causes and trigger factors are
4. Symptoms: (I) mania and hypomania
5. Symptoms: (ii) depressive and mixed episodes
6. Course and outcome of disease
7. Treatment: (i) emotional stabilizers
8. Treatment: (ii) other anti-manic factors
9. Treatment: (iii) antidepressants
10. Drug levels in the blood (lithium, carbamazepine, valproate acid) [16,17]
11. Pregnancy, genetic counseling
12. Psychopharmacology vs alternative therapies
13. Risks resulting from stoppage of treatment
14. Alcohol and prohibited substances: the risks for

Bipolar Disorder patients

15. Early warning symptoms of manic and hypomanic episodes

16. Early warning symptoms of depressive and mixed episodes

17. What should be done when a new phase, a new episode, arises

18. Planning of everyday life

19. Stress management techniques

20. Techniques to solve problems

21. Final session: farewell [18,19]

The individual intervention of Perry team.

Single, blind, randomized controlled study

Sixty- nine sufferers with at least two episodes in the past, of which one in the last twelve months, were randomly divided in two groups.

In the first group (intervention team) the appropriate medication was supplemented with seven to twelve individual sessions focusing on the early identification of at least three early warning points and the direct search for help.

The second group continued to take only the appropriate medication.

This intervention was evaluated every six months (follow-up) for an eighteen-month period.

Results

In the intervention group, the time until to outbreak of the next manic episode was elongated (65 weeks vs 17 weeks, p = 0,008) increased by 30%, the total number of manic episodes that occurred in eighteen months (p = 0, 13) the social and professional functionality was improved.

However, no variation was observed in the overall number of depressive episodes and in the time since their occurrence. [20]

4. Bipolar Disorder and Family - The Special Challenges of Care

The duration in time and the severity of symptoms of Bipolar Disorder often result in severe disruption of the patient's functionality and his inability to respond to his social and family roles.

The repercussions of this illness as well as its chronicity make it clear the importance of a supportive environment that will assume the role of caregiver and also the burden of this specific role for the patient's immediate environment.[21]

The particular nature of Bipolar Disorder differentiates it from other serious mental illnesses where the clinical picture of the patient follows a chronic and continually worsening course.

In Bipolar Disorder, the course of symptoms may present dramatic changes from month to month: patients may switch from depression to mania within a relatively short period of time.

They may also, in addition to changing their clinical image, exhibit hostile or aggressive behavior and cease to be cooperative. [22]

It is understandable that the requirements that the disease poses for the family vary according to the stage of the disease and the type of symptomatology presented, but also depending on the patient role in the family system (e.g. if the patient is a child or a spouse) as well as whether it is a first episode or whether the disease has entered in a series of periodically recurrent relapses.

Here, it should also be noted that many caregivers have insufficient awareness of the disease and are overwhelmed by a number of unanswered questions about how they should handle their afflicted relatives. [23]

Their common concerns are whether they should accept or be opposed to any disruptive behaviors of the patient, how to separate their deliberate behaviors from those resulting from the illness, how to handle their non compliance, identify the precursors Symptoms, or to bring the patient to a health service when he or she does not collaborate. [24]

Families whose a member had Bipolar Disorder expressed stronger fears about the patient's violent behavior, concerns about the quality of marital relationship and parental care, as well as concerns about the consequences of the disturbed family environment in children.

The uncertainty about the unpredictable course of the disease, not knowing someone when a relapse will reappear, is in itself a powerful stress factor for family members.

Studies that examine Bipolar Disorder in its chronicity confirm that the disease is a source of significant psychosocial distress for the sufferers' relatives / caregivers and leads to marital and family collapse. [25, 26]

Bipolar Disorder may have an impact on multiple areas of family life, disrupting the communication within the family and destabilizing the roles of its members.

The lack of insight, the hyperactivity and irritability during manic episodes, or, on the other hand, the withdrawal and apathy in depressive phases, cause problems in communication with the patient.

The family function is also disrupted when, for example, another member of the family has to take over the patient's responsibilities in addition to fulfilling his or her own duties, or sometimes when the patient refuses to give up from roles he is unable to respond to. [27]

In addition, the burden that family members have to face, apart from the interpersonal, marital and parental problems which mentioned above, may also include the financial difficulty, the social pressures of stigmatization, but also problems with the law.

Overall, the high family burden - the extent of which has been found to be linked to the duration of the disease (chronicity) and the degree of dysfunction of the patient -, the major difficulties in intra-family relationships and increased interpersonal conflicts, alongside with the experience of violent incidents or the fear of violence, outline the family landscape of Bipolar Disorder. [28]

Psychoeducational Interventions in Relatives Groups

All studies show the following results:

Improvement of knowledge about the disease

Reduction the subjective and objective burden

Decrease of expressed emotion

These findings are recorded at the end of the interventions and they last in time. [29]

Nowadays, the psychosocial interventions in the family, with predominant psychoeducational approach, are implemented with particularly satisfactory results in Bipolar Disorder and, in addition to pharmacotherapy; they are a valuable ally for the effective, lifelong management of the disease.

The psychoeducational model, combining the provision of information about the illness and its treatment with education in communication and problem management techniques, supports the family as a whole in order to understand and accept the disease, to contribute to good patient compliance in medication and to manage effectively the demands of care.

The improvement of the intra-family climate, the successful management of disease-related problems and a reduction in caregivers' burden feelings prove decisive factors in the overall therapeutic outcome of the patient.[30]

The international bibliography documents the effectiveness of psychoeducational interventions in patients with Bipolar Disorder in terms of reduction of relapses and the elongation of normothymias intervals, as well as reduction of number and duration of hospitalizations. [31]

5. Conclusions

The psychoeducational intervention in the family, with the patient's participation in the healing process, appears to be relieving through its various components.

The information about the disease and the implantation of hope, the improvement in communication and the expression and management of "difficult" emotions seem to be comforting, while the jointly –with the patient's participation- processing of family-related issues offers a framework of tangible and practice problems' solution, with the consequence the alleviation of relative-caregiver burden. [32, 33]

Similar trends are also recorded in international bibliography in studies that highlight the benefits of psychoeducational family interventions in relatives' outcome indicators.

In direct connection with the relative's sense of burden is his / her mental status and level of general health. [34]

Typically, studies have shown that relatives who care for patients with chronic and severe mental illness have depressive symptoms which need of clinical attention at rates of 17-40%.

At the same time, other studies emphasize the contribution of family psychoeducational interventions in reduction of mental stress and strain, with possible mediation mechanisms the decrease of burden and the development of adaptive coping strategies of problems and difficulties. [35]

Over the decades of the first psychosocial interventions in sufferers' families from severe mental illness, the clinical experience and research have led to the gradual development of the psychoeducational model which used today.

Although in initial attempts of implementation the term "Psychoeducation" mostly related to information and knowledge programs, nowadays as a psychoeducation is defined "any structured, group or individual program that approaches a disease from a multifactorial perspective, including of family, social, biological and pharmacological dimension, while provides to health care recipients and their caregivers information, support and management strategies. " [36]

The modern, complete psychoeducational model for the serious mental illness incorporates a psychotherapeutic process in which, along with the provision of knowledge, the development of positive communication skills and problem solving is fostered and the whole family is involved as a participant in therapy.

The psychoeducational interventions that aimed at the family - or, in particular, the spouse of patient with Bipolar Disorder - set as their primary goals the prevention of relapses, the reduction of hospitalizations, the averting of suicide and the improvement of patient functionality. [37]

On second level, the intervention seeks the revitalization and the shielding of self-esteem, the successful stress management, the prevention and treatment of co-morbidity (drug abuse), and finally the improvement of the quality of life and the feeling of well-being of patients.

More specifically, in the context of the psychoeducational approach, the provision of information to the patient and the family promotes the understanding of the disease, thus helping to accept it.

The knowledge about the illness and its treatment is a decisive factor of improvement the patient's attitude towards pharmacotherapy and his consequence in taking it, improving moreover the therapeutic outcome as well.

The primary objective of prevention of relapses also serves the emphasis given by the psychoeducational approach on issues such as the ability to recognize early / warning signs of relapse, the stress management skills, the avoidance of trigger factors, the adaptation to a healthy lifestyle, and the adoption of a fixed sleep-wake schedule. [38]

Bibliography supports the greater effectiveness of group psychoeducational intervention in patients with Bipolar Disorder versus the individual: the group framework supports its effectiveness in the fact that promotes the imitation of a model while at the same time fosters the mutual support among patients, broadens their social network and reduces the feeling of stigmatization. [39, 40]

Research literature on the interactions of serious mental illness and the family system is besides extensive: a modern review confirms the research findings of recent decades, underlining that specific attitudes and patterns of interaction within the family affect the course of Bipolar Disorder, and that the disease has an equally strong impact on family function due to the burden of caregivers and its consequences on their own health and quality of life.

A recent study also highlights the correlation of suicidal of bipolar patients with the low family functionality. [41, 42]

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