A Sample Individual Psychoeducation Model for Bipolar Disorder

Bipolar Bozukluk için Örnek Bir Bireysel Psikoeğitim Modeli

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SUMMARY

Individual psychoeducation model for bipolar disorder is a four-session program aiming to provide various knowledge and skills to bipolar disorder patients about their disorder and developed by the authors and can easily be applied by practitioners and researchers working in this field. The program consists of four sessions; introduction to the psychoeducation program and information about the disorder, symptoms, developing an emergency plan to prevent the recurrence of the disorder and legal rights, assessing effects and side effects of drugs, and communication and problem-solving skills. The purpose of this study is to introduce the individual psychoeducation model for bipolar disorder and mention the results of similar psychoeducation studies. The results of the study show that the individual psychoeducation program for bipolar disorder may be an appropriate and effective program for patients.

Keywords: Bipolar disorder; individual psychoeducation; nursing.

ÖZET

Bipolar bozuklukta bireysel psikoeğitim modeli, bipolar bozukluk hastalarına hastalıkları hakkında bilgi ve beceri kazandırmayı hedefleyen, yazarlar tarafından geliştirilen, bu alanda çalışan uygulayıcı ve araştırmacıların rahatlıkla uygulayabileceği dört oturumluk bir programıdır. Program, psikoeğitim programına giriş ve hastalık hakkında bilgi, haberci belirtiler, hastalığın yinelemesini önleyici acil plan geliştirme ve yasal haklar, ilaç etki ve yan etkilerini değerlendirme, iletişim ve sorun çözme becerileri olmak üzere dört oturumdan oluşmaktadır. Bu çalışmada amaç, bipolar bozuklukta bireysel psikoeğitim modelini tanıtmak ve yapılmış benzer psikoeğitim çalışmalarının sonuçlarına değinmektir. Çalışma sonuçları, bipolar bozuklukta bireysel psikoeğitim programının hastalara yönelik olarak uygun ve etkili bir program olabileceğini göstermektedir.

Anahtar sözcükler: *Bipolar bozukluk; bireysel psikoeğitim; hemşirelik.*

Introduction

Bipolar disorder is generally a long-lasting and recurring disorder that leads to individual and social adaptation problems and affects the patients and their family significantly.[1–4] This disorder is the sixth cause for disability among individuals 15–44 years of age.[5] Its lifetime prevalence is 0.5%–1.6%,[4,6,7] and the average rate is 1%.[3,8,9] Of the patients who have bipolar disorder, 25%–50% seriously commit suicide[5] and 10%–20% of these patients lose their lives after suicidal attempts during the existence of the disorder.[3]

Drug therapy is crucial in both acute and maintenance phases of the treatment.[5] Therefore, a variety of methods, such as psychoeducation, interpersonal social rhythm therapy (IPSRT), family-focused therapy (FFT), and cognitive behavioral therapy (CBT), which are administered along with the drug therapy recently, have gained importance. IPSRT, FFT, and CBT require experienced therapists and high costs. Psychoeducation, on the contrary, is considered to be more suitable for the conditions in Turkey, as it is cost-effective and easily applicable.[10]

Psychoeducation for bipolar disorder can be administered as group psychoeducation[11–13] or individual psychoeducation.[14] Group psychoeducation is advantageousbecause of the ability to establish interaction among patients, a lower cost compared with individual psychoeducation, and the ability to be administered to more patients simultaneously. However, since most of the patients with bipolar disorder are observed to have anxiety disorder as a coexisting disorder, they usually cannot feel themselves at ease during the group psychoeducation. Thus, they feel reluctant to participate in the education or may not complete it. Although individual psychoeducation requires more time and cost, it is advantageous because more time is spared for the patient, the education provided is patient specific, the education can be scheduled with the patient, the sessions allow the students to express themselves more easily, and the patients leaving the education are low in number.[15]

Studies reported that group psychoeducation was conducted in 6–21 sessions[10] and individual psychoeducation was conducted in 7–12 sessions.[14,16] Colom and Vieta (2006) reported that 25% of the patients left 21-session group psychoeducation.[13] Çakır et al. (2009) invited 173 patients who

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had been euthymic for the last 3 months, were 18–65 years of age, and had continued going for regular check-ups for the last 4 years to a 6-week group psychoeducation. Of these patients, 84 agreed to participate in the psychoeducation and 89 rejected to participate for various reasons.[17] Therefore, experimental research was conducted to reduce the number of patients who left the psychoeducation program. A 4-session psychoeducation program was developed in the present study, and it was found that the rate of patients' leaving the study did not exceed 4.88%.[18] In short, this study aimed to introduce the individual psychoeducation model for bipolar disorder and referred to the results of the previous similar psychoeducation studies.

Psychoeducation for Bipolar Disorder

Psychoeducation for patients with bipolar disorder focused on informing the patients about the disease and its treatment, attitude toward the disease, adjusting to treatment, symptoms' getting better, preventing depressive and hypo(manic) attacks, reducing the number and duration of hospital stay, getting better in social and professional functionality, reducing the risk of suicide, and improving the life quality and families' contributions to the treatment.[19–22] Psychoeducation should be accompanied by medications and other treatments.[23] Initiating the psychosocial approaches as early as possible before an increase in biological, social, and psychological loses is vital for both drug treatment and life quality. Psychoeducation for bipolar disorder should be provided for the patients who are in the early stage of the disease and euthymic to enable learning activity by preventing distractibility.[10,13]

Study Results on Individual Psychoeducation for Bipolar Disorder

Psychoeducation studies on bipolar disorder were conducted mostly through group psychoeducation. Only three[14,16,18] individual psychoeducation studies were accessed.

The first individual psychoeducation for bipolar disorder was conducted by Perry et al. (1999). The patients (experimental group: 35; control group: 34) were provided 7-to 12-session individual psychoeducation and 18-month monitoring. The study reported that in the psychoeducation group, recurrent of mania decreased, time elapsed till the first mania recurrence was prolonged, hospital stay decreased, and a better clinical course and social functionality occurred.[14]

In a second individual psychoeducation study conducted by Javadpour et al. (2013), 108 patients (experimental group: 54; control group: 54) were provided with 8-session individual psychoeducation and 18-month monitoring. The study reported that disease recurrence and hospital stay of the patients who received psychoeducation decreased and their life quality improved.[16]

Apart from the current experimental research, no other study on psychoeducation for patients with bipolar disorder was reported in Turkey. In the present study, 82 euthymic patients (experimental group: 41; control group: 41) were provided with 4-session individual psychoeducation and 12-month monitoring. The study concluded that the mean scores of the psychoeducation group's belief in medicament's healing effectiveness and adjustment to treatment significantly increased.[24] The disease recurrence rate was 18.9%, and 71.4% of the patients experienced only one recurrence case. In the group that did not receive psychoeducation, the disease recurrence rate was 34.1%, 57.2% of the patients experienced multiple disease recurrences, and the rate of hospital stay was 7.3%.[18] However, no improvement was observed in the life quality and functionality of the group who received psychoeducation or the one who did not receive it.[24]

Role of the Nurses in Psychoeducation Practices Administered to Patients with Bipolar Disorder

The education provided for the patients by the nurses during the treatment and care contributed to health protection; decrease in the severity of the disease, patients' anxiety, depression, disease findings, and their hospital stay; their obtaining the required information and skills to perform their personal care; their gaining independence; increase in patient satisfaction; and reduction in health care expenditures.[25–27]

Among the routine treatment programs, psychoeducation practices are not at a desired level in Turkey. Therefore, psychiatry nurses are in an appropriate position to evaluate the requirements of the patients, and prepare and conduct psychoeducation programs to meet these requirements, since they are in contact with the patients during their care and treatment process.[28]

Psychoeducation nurses should have the following qualities: being patient, active, and empathetic listeners; trying to sincerely understand the patients' problems; being self-sacrificing; having well-intentioned attitudes; symbolizing trust and respect; relieving the person in terms of potential for change; and encouraging the person to be determined.[29,30] Nurses possessing these qualities enable patients to develop a feeling of trust and maintain their expectation for help.[31]

Patients' learning requirements, patients' and nurses' characteristics and preferences, content of the education, education setting, duration of the education, and available resources should be taken into consideration in choosing the methods and techniques to be used in patient education. A nurse who has proficiency in education can make changes in the method to be used regarding the reactions and behaviors of the patients and their families. However, the nurse needs time and experience as well as information to attain this proficiency. One-to-one teaching, group teaching, process pre-

paratory teaching, and demonstration are the methods nurses can frequently use in the study setting.[32] It is important for the psychoeducation setting to be a homely and comfortable place where patients and their families can interact without experienced any pressure and they can be encouraged for learning.[13]

Individual Psychoeducation Program for Bipolar Disorder

The psychoeducation program discussed in this study was prepared in accordance with the literature[13,33] using the group psychoeducation programs and the system approach, which was based on the opinion that "if the individual follows preplanned learning activities, the expected behavior change in this individual occurs".[34] This psychoeducation program was completed in four sequential weeks on a once-a-week basis. The psychoeducation program included outpatients who were 16–65 years of age, were diagnosed with bipolar disorder (I and II), had been euthymic for the last 3 months (whose Young Mania Rating Scale score was less than four points and Hamilton Depression Scale score was less than seven points), had standard medication (mood stabilizers, antipsychotics, or antidepressants) and standard clinical monitoring for bipolar disorder, and did not have hearing, understanding, and seeing problems. Each psychoeducation session lasted 45–60 min. Based on the attention status of the patients, a 10- to 15-min break was given. All sessions used reflections that had been prepared on the computer beforehand so as not to distract attention. The sessions employed question–answer method, audio-visual method, role-playing when necessary, and performance feedback stages. Furthermore, the education also focused on experiences as well as information and allowed for making comparison with the topic learned during the education. Availability of the patients was taken into consideration when planning the psychoeducation session hours. The psychoeducation session topics and contents were as follows:

The First Session – Introduction to psychoeducation program and information about the disease: This session was intended to enable patients to have knowledge of psychoeducation program and bipolar disorder.

- The outpatients were guided to sit face to face with the educators in a suitable place so as to have an eye contact with them.
- The educators introduced themselves (name, family name, occupation, work place, and professional experience).
- The patients were asked to introduce themselves (name, family name, occupation, and marital status).
- The patients were provided with information about the purpose, content, and duration of the psychoeducation program, and the duration of each session.
- The patients were asked to share their previous disease experiences (their first disease experience, treatments they had before, their hospital stays, and supports they had, if available).
- Then, the patients were provided with information about the disease and disease concepts (mania, hypomania, depression, and so forth).
- The patients were provided with information about the causes for disease and asked to express their opinions.
- The patients were asked to express their own disease symptoms; they were provided with information about the most common symptoms of the disease.
- Ten misconceptions about the disease [(1) I can overcome this disease using my personality power and avoiding stress; (2) this disease arose since I was sad for a case; (3) this disease was caused by a demon, fairy, or magic, and I have to receive an imam or hodja treatment to recover; (4) disease is a character defect; (5) I should give up my life objectives because of this disease and should always protect myself from everything; (6) treatment drugs are addictive; (7) treatment drugs make me someone other than my normal personality; (8) now that I have not become sick for a certain time, I have recovered; (9) now that I take drugs, I am sick; (10) this disease has no treatment] were shared. The patients were asked to share their opinions about these considerations, and their questions were answered, if available.
- The patients were asked to summarize the points that had been talked about.
- The patients were asked about their expectations about the psychoeducation program.
- The patients were given information about the theme of the second session.
- The date and time of the second session were determined with the patient.
- The patients were thanked for their participation, the session was closed, and the patients were shown out.

The Second Session – Prodromes, development of an emergency plan to prevent the recurrence of the disorder, and legal rights: This session was intended to enable patients to recognize their own prodromes and manage them, and to identify the institutions and organizations from where the patients could obtain help before becoming sick. It was also intended to enable patients to have knowledge of the legal rights about their disease.

- The interview began with asking the patients how they spent the previous week.
- The patients were asked about their premorbid symptoms, and subjective prodromes were expected to be learned.
- The patients were given information about the most common prodromes in bipolar disorder (mania period: superiority thoughts or high self-confidence, accelerated thoughts, euphoria, logorrhoea, reduced sleep demand, increased distractibility, increased interest in pleasurable activities, excessive money spending, behaving in a manner that disturbed others, and changes in appetite and sexuality; depression period: sorrow, grief, worry, irritability, powerlessness, weakness, fatigue, inability to concentrate, increased or decreased sleep, reluctance, loss of interest, feelings of despair/guilt/unworthiness, thoughts of suicide and death, and inability to get out of the bed).
- The patients were asked what they did when the disease symptoms emerged, and their subjective approach was expected to be learned.
- The patients were asked what they would do in case of an emergency, and the emergency action plan that should be adopted was explained to them [when they felt they were sick: (1) they should get an emergent appointment from the doctor who provided the treatment; (2) they should try to speak to their doctor on the phone about their situation; (3) unless they were able to contact their doctor, they should refer to the psychiatric emergency services in a hospital; (4) if they were alone, they should call their families or a close friend and ask them to come immediately].
- The institutions and organizations that could be referred when an emergency for the disease occurred were identified and listed with the patient.
- The patient relatives who could be called in case of emergency were determined with the patient.
- Based on the information obtained, an emergency action plan was prepared with the patient; this plan was turned into text and given to the patient.
- In case the patients needed it/requested information, they were given information about their legal rights about bipolar disorder [if the patients were students, they could receive report from their doctor when their disease became exacerbated and extend the studentship period; if the patients were males, they could continue to do their military service through a medical report from an army hospital and through drug therapy when their disease became exacerbated; if the patients committed a crime, their criminal liability was evaluated in accordance with the exacerbation of the disease at the time they committed the crime; if the patients wanted to be retired due to disability, this situation was determined by a medical report).
- The patients were asked to summarize the points that had been talked about.
- The patients were given information about the third session.
- The date and time of the third session were determined with the patient.
- The patients were thanked for their participation, the session was closed, and the patients were shown out.

The Third Session – Assessment of the effects and side effects of the drugs: This session was intended to enable patients to have knowledge of the effects and side effects of the drugs in their treatment, and to help them cope with the side effects.

Before the interview, the educator obtained information, from the patient reports, about the medication that was previously used and was still being used by the patients, and if available, about the previous treatment incompatibility and its causes.

- The interview began asking the patients how they spent the previous week.
- The patients were asked about their previous treatment experiences (the institutions where they went for treatment, prescribed drugs, and whether they used these drugs or not).
- The patients were asked about the drugs they had been using.
- The patients were given information about the general treatment of the disease (pharmacotherapy, psychotherapy, electroconvulsive therapy, hospital stay when necessary, and outpatient treatment).
- The patients were given information about the four drug groups (mood stabilizers, antidepressants, antipsychotics, and anxiolytics) that could be used in protective treatment for bipolar disorder.
- The patients were given information about the drug groups (mood stabilizers, antidepressants, antipsychotics, and anxiolytics) which were used by them in protective treatment and their effects.
- The patients were asked about their negative experiences with the drugs/their side effects.
- The patients were asked how they coped with mild side effects, and they were given information about the potential coping methods.

- Seven misconceptions about the drugs [(1) drugs are addictive, and they damage and narcotize my brain; (2) I can overcome the disease without using drugs; (3) I will not face any problem if I do not take my drugs for 1 or 2 days; (4) I missed the time to take drugs, time is over, and I should not take them now; (5) Now I am very well, the disease is over, and I do not need drugs; (6) this drug did not work, and I should change it; (7) I cut down on or stopped taking my drugs due to their side effects) were shared, and the patients were asked whether they had any of these drugs.
- If the expression of the patients was a misconception, they were given information about this misconception.
- The patients were asked to summarize the points that had been talked about.
- The patients were given information about the fourth session.
- The patients were asked to think about the issues they had general or communicational problems with and bring them forward in the next session.
- The date and time of the fourth session were determined with the patient.
- The patients were thanked for their participation, the session was closed, and the patients were shown out.

The Fourth Session – Communication and problem-solving skills: This session was intended to raise awareness of patients on communication skills in their interpersonal relations at a basic level and enable them to know that they could show a systematic approach to solving the problems they experienced in their lives.

- The interview began asking the patient how they spent the previous week.
- First, the patients were asked about their knowledge of communication.
- The patients were given information about the definition and types of communication (verbal and nonverbal communication).
- The patients were given information about the verbal and nonverbal communication factors.
- The patients were asked about the points that they found the most difficult, and their questions were answered, if available.
- The patients were given information about the items of effective communication (effective listening, expression of positive feelings, requesting, andexpression of negative feelings).
- Based on the needs of the patients, role-playing was performed using short examples on the points they found troublesome in communication.
- The patients were asked for their feedback on role-playing.
- A 15-min break was given for the patients who needed it.
- The patients were given information about "problem and problem-solving stages."
- Role-playing was performed on the issues the patient mentioned most during the sessions.
- Problem-solving stages could be studied using more general examples with the patients who did not want to express any of their problems.
- If available, the patients' questions were answered.
- The patients were asked to summarize the points that had been talked about.
- The patients were asked for their opinions on the 4-week psychoeducation program.
- The patients were informed that the psychoeducation program had completed.
- The patients were thanked for their participation in the program and provided with the contact address on which they could contact the educator if required. The session was closed, and the patients were shown out.

Conclusions

This study developed a four-session individual psychoeducation model for bipolar disorder. It found that the number of patients who left the education decreased, patients who participated in the education fully attended it, and the patients gave feedback that they were pleased with the education in terms of its content and duration. This program was considered to be an appropriate and effective model that could be easily administered by psychiatry nurses in clinics and was advantageous for all the patients who were capable of receiving the education, particularly the ones who avoided expressing their feelings in the group. Psychoeducation models for bipolar disorder have been developed in Western cultures, and no definite judgment exists on the results that can be obtained when the models are administered in different cultures. Thus, development of an individual psychoeducation program in Turkey can be considered as important.

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