

Bipolar affective disorder: overcoming treatment adherence issues

Sinéad Boland discusses the issues affecting adherence and how to address them

MEDICATION is the cornerstone of treatment for bipolar affective disorder (BPAD), however, over the course of a year, more than half of patients with prescribed medication will stop treatment completely. Additionally, seven of every 10 patients will stop taking their medications at some time in their lives and nine out of 10 will think very seriously of abandoning it.

The risks of interrupting treatment, with mood stabilisers in particular, is associated with a worsening of the course of the disorder and increased hospitalisations; more than half of those who stop treatment will experience a relapse within five months, and nine out of 10 will have a relapse within a year. The risk of suicide increases significantly and there is an added risk that the medication may not work as effectively as before when recommenced.

The enhancement of treatment adherence is therefore a common therapeutic target, and is considered a priority because of potential neurodegeneration in BPAD and the neuroprotective effects of mood stabilisers and some atypical antipsychotics.

Treatment adherence

Treatment adherence can be defined as the extent to which an individual changes their health behaviour to coincide with medical advice. The term adherence has superseded 'compliance' and its patriarchal connotations, and emphasises the patient's role in deciding to adhere to doctor's recommendations, removing a sense of blame if the patient chooses not to follow recommendations.¹ It also emphasises the need for agreement between patient and prescriber.

Historically, research to identify key predictive factors for non-compliance in BPAD reflected this approach to treatment. These enquiries perceived patients as passive recipients of care which failed to sufficiently acknowledge that avoidance of sometimes complex, costly and unpleasant regimes may be entirely rational. They overlooked the influence of communication between patients and healthcare professionals.² A more collaborative approach to treatment has now been proposed that underscores the importance of the therapeutic relationship and treatment concordance.

Factors that influence adherence

Research into treatment concordance has revealed that many factors can influence a patient's degree of adherence to treatment, these include age, gender, culture, symptom severity, socioeconomic status and opinion of mental illness. Patients' understanding of their condition is positively related to adherence. Attitudes towards BPAD and the patients' health beliefs play

a significant role in the emergence of poor adherence.

Factors associated with non adherence

Medication non adherence can include taking more or less of the medication than prescribed and can be intentional or unintentional. Non adherence can be viewed within the context of four interactive domains: patient, illness, clinician, and drug treatment.

Patient factors

Lack of insight into the nature of the disorder and the need for long-term treatment is strongly associated with non adherence in BPAD. Some patients are unwilling to accept that they have the disorder and hence believe that they do not require treatment. While others may perceive symptom-free periods as a sign of being 'cured' and a signal to discontinue further treatment.³

Non adherent patients are reported as prone to perceive taking medications as akin to 'slavery', fearing dependence, being ashamed because of taking psychiatric medications, considering medications as unhealthy or unnatural. Some patients view taking medications as a sign of personal weakness and as a reminder of their lack of control.⁴ Some patients may remember past hypo/manic episodes positively and unconsciously want to repeat them. Research suggests that patients' motivation to begin and continue treatment is influenced by their beliefs about treatment and how they judge their personal need for it.

Patient adherence is more likely if they perceive that the advice to take medication makes 'common sense'.⁵ Patients who have a strong belief in their personal control over the illness had lower engagement with treatment. Level of knowledge about medication is directly correlated to treatment adherence and patients' attitudes, lower adherence, general opposition to prophylaxis, fear of side effects, denial of therapeutic effectiveness and illness severity.⁶

A study of 65 BPAD patients that evaluated insight into medication found that difficulty with adherence at the initial interview predicted future non adherence at one-year follow-up.⁷ Patients are primarily concerned by how well the treatment works to enable them to lead their daily lives. Patients' expectations may vary from specific symptom relief to hopes for a complete cure, and their fears may be influenced by media and advertisements.

If a medication is perceived as not decreasing debilitating symptoms, a patient is unlikely to continue taking it.⁸ Patients with BPAD feel more affected by depressive symptoms than by manic symptoms, and have indicated that they are more likely to

adhere to and view as successful treatments that reduce depressive symptoms. They are concerned with how safe and tolerable the treatment is.

Patient concerns about possible side effects may contribute more to non adherence, than actually experiencing side effects. Concerns about long-term metabolic side effects from atypical antipsychotics also may limit adherence.

Sociodemographic factors are not strongly associated with non adherence however several studies have identified a possible association with both ends of the life span – younger and older age, however the findings are contradictory. Adherence decreased in patients up to 41 years of age and increased thereafter.

Illness factors

Manic episodes carry the highest risk for non adherence. Evidence suggests that non adherence becomes a significant problem within the prodromal phase of an acute episode, occurring in 60-80% of patients who relapse in the month prior to hospitalisation. Cognitive impairment associated with frequent episodes has been proposed as a possible explanation. The presence of residual depressive symptoms is significantly associated with non adherence.

Clinician factors

Therapeutic alliance and access to care: Studies have highlighted the role of the therapeutic relationship and accessibility of services in non adherence. Clinicians communication style during follow-up and client satisfaction were both predictive of better medication adherence. The quality of the relationship between patient and clinician is associated with greater acceptance of BPAD and improved adherence and clinical outcomes.⁹

A collaborative communication style by the clinician enhanced client knowledge of the medication, improved satisfaction with medication and improved reliability of medication use. Bhugra and Flick reported that only about 50% of patients receive appropriate treatment for BPAD because of systemic barriers to gaining access to appropriate care.¹⁰ They assert that the current treatment environment relies heavily on a crisis response rather than an ongoing, long-term illness management approach.

Drug factors

Until recently research emphasised efficacy of medications as the most commonly cited reasons for stopping treatment. However adverse effects are now recognised as primary drivers of non adherence with weight gain as having the most affect. In an internet-based survey, 469 patients with BPAD indicated that medication-related weight gain and cognitive impairment were the most significant factors that affected adherence.¹¹ Gianfrancesco and colleagues 2006 reported that antipsychotic treatment adherence in individuals with BPAD varied according to the type of antipsychotic medication, reflecting differences in both efficacy and adverse effects.¹²

The number of different medications prescribed and the complexity of the regime are described as risk factors because of the inherent difficulty for the patient to manage. The duration of treatment has been found to increase the likelihood of discontinuation when the patient feels well and does not understand the need to take medications to keep them well as opposed to getting them well.³ Other factors that may contribute to medication non adherence in BPAD patients include comorbid substance abuse or personality disorders, both of which are associated with more frequent relapse^{13,14,15} single status, low education level,

duration of being prescribed a mood stabiliser, family dysfunction and having a parental history of psychiatric hospitalisation.¹⁰

Improving adherence

Medication strategies

One of the most important factors influencing non adherence is the tolerability of the adverse effects. Hence the importance of choosing a medication with good tolerability. Medications that approach an optimum balance between efficacy and adverse effects may be associated with higher rates of adherence, better health outcomes and lower levels of health resource use. Johnson et al suggest that patients can contribute to clinical decision making regarding the management of their BPAD and stress the importance of involving patients in decision making and discussing tolerability versus efficacy when prescribing and planning future treatments.¹¹

To manage emergent adverse effects during long-term treatment the following is recommended: use of sustained-release preparations to minimise peak levels and, hence, adverse effects; lowering of the dosage with more frequent follow-up visits; close monitoring of adverse effects; and using lower doses of a poorly tolerated drug in combination with another drug. Switching to another medication is an option, in the event of failure of the above mentioned strategies.

Treatment alliance and access to care

Key elements of collaborative care include the use of evidence-based treatment guidelines, patient psycho-education, collaborative decision making and a system to facilitate planned follow up and monitor outcomes.¹⁶ Research to address the gaps in healthcare services suggest the need to reorganise the current model of primary care, which is geared towards acute care. Instead, a planned approach to chronic care using evidence-based guidelines and protocols to support patient participation and self management was recommended.¹⁷

Education

A clinician's ability to help patients build insight is invaluable for their current and future treatment. The primary goal is to increase knowledge about the properties of medications and awareness of the patients role in managing medications. Information about the chemical changes in the brain that contribute to mood destabilisation or mood stability may help patients understand how symptoms are triggered and how medications work to protect mood stability.

Patients knowledge about medication and the illness is proven to be a direct influence on adherence to lithium. The fact that the patients are informed about the illness, the treatment and risks of not taking it, positively influences adherence because it facilitates their acceptance of the illness and maintenance therapy. The higher the knowledge level the higher the adherence and the lower the toxicity risks.

Simple strategies to improve concordance²

Basic communication: Establish a therapeutic relationship and trust. Identify the patients concerns. Take into account the patients preferences. Explain benefits and hazards of treatment options.

Strategy-specific interventions: Adjusting medication timing and dosage for least intrusion. Minimise adverse effects. Maximise effectiveness. Provide support, encouragement and follow up.

Reminders: Consider adherence aids such as medication boxes and alarms. Consider reminders via email or telephone or text. Home visits, family support, counselling.

Evaluating adherence: Ask about problems with medication. Ask about missed doses. Ask about thoughts of discontinuation. With

the patient's consent, consider direct methods: pill counting, measuring serum or urine drug levels. Liaise with GPs and pharmacists regarding prescriptions.

Psychosocial interventions

The factors associated treatment non adherence can be addressed through targeted evidence based psychosocial interventions as adjuncts to medication treatment, a number of which have been developed for BPAD. Important elements include a strong working alliance, psycho-education, structured sessions, goal setting, problem-solving, inclusion of family members in treatment, improving important relationships, and an emphasis on skills training: interpersonal communication, emotional regulation, responding to dysfunctional cognitions, and identification of prodromal symptoms with an action plan to address these symptoms.

Although each has a different emphasis they all focus on medication management and fit with current models of patient centre care, on which the principles of concordance are based. Cognitive behavioural therapy (CBT), interpersonal therapy (IP), family-focused therapy (FFT) and group psycho-education (PE), may be used alone or in combination.

CBT focuses on changing negative thought processes and maintaining behaviours. Numerous studies have found PE to impact positively on treatment adherence as well as improving outcomes.¹⁸ In addition to improving the understanding about treatment, PE can promote better management of the disorder, adherence to treatment, better insight, early recognition of symptoms, a healthy lifestyle, stress management and responsible use of drugs and alcohol.¹⁹

Group PE combines support and self management strategies and is the most common type of group facilitated by nurses. Group PE has been described as 'the mood stabiliser stabiliser' by enhancing the levels of and stability of serum lithium levels. PE may start on an individual basis in the acute setting, depending on the patients cognitive and behavioural state and can continue during the post acute maintenance phase in the form of individual or group sessions where it has most potential

Role of the nurse

Nursing processes for BPAD should aim to improve health and social functioning and decrease the burden of illness for families and patients. This is achieved through the use of action plans, teaching self-management techniques and the establishment of and maintenance of a therapeutic alliance alongside family and patient education.

Mental health nurses are described as being trained in a broad spectrum of medical, psychological and social problems. Additionally, it's reported that patients may be more open to nurses than to other medical professionals and they have closer contact with the patient. Nurses themselves assert that they are on a more equal level than their medical colleagues whose focus they argue is often predominantly biological.²⁰ As nurses manage, and increasingly treat, patients with bipolar disorder in both inpatient and community settings, it means they are the continuous factor in the extended treatment pathway of the patient. Nurses are therefore integral to clinical care and best placed to incorporate psychosocial interventions into their scope of practice.

Nursing interventions for BPAD promoting self-management education have been reported to assist people to develop realistic/helpful illness perceptions, which enhance treatment adherence.²¹

Results from studies exploring self management of BPAD conclude that nurses can support patients by preparing them for potential barriers to effectively self manage and help them to realistically appraise the process involved in self management. They suggest that in order to achieve this, nurses need to learn from patients which techniques they perceive as valuable in self management.

The psycho-educational process allows the individual and the nurse to proactively discuss potential issues regarding treatment adherence. A study in 2010²¹ aimed to explore how the delivery of mental health nursing care could be improved, examined which psychosocial interventions were effective and how they could be delivered by nurses. They concluded that group PE could most easily be implemented by mental health nurses. This manualised approach has very good evidence of sustained improvements over five years. This is a recovery-based approach that encourages self-management and focuses on medication adherence enhancement, identification of subtle early warning signs, lifestyle regularity and illness awareness.

Sinéad Boland is a clinical nurse specialist in affective disorders and co-ordinates the bipolar education programme at St Patrick's Mental Health services in Dublin

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