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APPLICATION OF PSYCHOEDUCATION ON SYMPTOMATIC RECOVERY IN INDIVIDUALS WITH BIPOLAR AFFECTIVE DISORDER

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ABSTRACT

AIM: This study aims to examine the applicability of Psychoeducation in stabilizing symptoms of mood in individuals with Bipolar Affective Disorder.

MATERIAL & METHODS: Present study was conducted in RINAPS, Ranchi and consisted of 24 samples. These samples were divided into two groups of 12 of treatment as usual and 12 of treatment as usual + Psychoeducation for 2 month of having 8 sessions of Psychoeducation. After 2 month post intervention and after 4 months follow up carried out to assess the result.

RESULT AND CONCLUSION: The data analysis in the current study was done with help of non parametric test using SPSS version 20 for categorical variables chi square test, comparison between group Mann Witnney U test and for comparison within group Wilcoxon Sign Rank test was used. Post intervention finding indicates that Psychoeducation is helpful in stabilizing symptoms of mood in individuals with Bipolar Affective Disorder.

KEYWORDS : Bipolar Affective Disorder, Psychoeducation And Symptoms Of Mood

INTRODUCTION:

Bipolar affective disorder, known as also bipolar disorder and manic depression, is a serious mood disorder characterized by alternating periods of intense elation and depression. Individuals suffer from severe mood swings and it may range from severe depression to extreme joyfulness and mania[1&2]. The risk of suicide among those with the disorder is high at greater than 6% over 20 years, while self harm occurs in 30–40% [3]. Among the various approaches of psychosocial interventions, Psycho education has been one of the most used. It significantly improves the clinical course, treatment adherence, and psychosocial functioning of the bipolar patients. It also reduces the numbers of relapses and recurrence per patient and increases time to depressive manic hypomanic and mixed recurrences and number and length of hospitalization per patient. Psycho education improves the knowledge of the illness for both patients and caregivers to reduce their distress and improve overall social functioning [4]. Reviews of psychological treatment for BDP have identified that adjunctive psychotherapy is useful in the treatment of BPD for preventing relapse, reducing symptoms severity and possibly reducing the time it takes to recover from an episode of BPD [5]. A possible mechanism of PE is that increased knowledge and awareness improves attitudes and ultimately levels of acceptance towards receiving a diagnosis BPD. Exploring the relationship between improvements in unhealthy beliefs and improvements in symptoms as a result of PE therefore offers possibilities in explaining one of the active treatment components in the intervention [6]. Improvements in mood symptoms are inconsistent in PE studies with some showing no change in depressive symptoms, improvements and one study showing symptoms of anxiety increasing [7&8]. Although any improvement in symptoms may be clinically important to the individual the link between inter- episodes symptoms represent a risk factor for the occurrence of relapses and therefore are an important measure in interventions treating remitted populations [6]. Early identification of relapse warning signs and agreeing personal action plans to access treatment both increase time to manic relapse, reduction of episodes and quicker recovery during episodes [9]. The use of techniques to identify prodromes is commonly included in PE programmes and may explain some of the reported improvements in manic relapse and associated symptoms [6&10].

AIM:

The aim of the present study was to examine the applicability of Psychoeducation in reducing mood symptoms among individuals with bipolar affective disorder.

METHOD:

In the present study those were diagnosed with bipolar affective disorder were selected from the outpatient department of Ranchi Institute of Neuropsychiatry & Allied Sciences (RINPAS).The therapist utilized non probability purposive sampling technique. Socio-Demographic variables like Name, Age, Sex, Religion, Education, Marital status, Domicile and Occupation and Clinical details like Diagnosis, Age of onset, Mode of onset, Course, Progress of illness, number of admission, number of relapse, history of severe physical illness, history of Epilepsy, history of major psychiatric illness, and family history of mental illness and treatment history and for assess mood symptoms Young Mania Rating Scale (YMRS) and Hamilton Depression Rating Scale (HDRS) were used.

PROCEDURE:

Patients were selected from outpatient department as per inclusion and exclusion criterions. Sample was selected to the (TAU+PE) and (TAU) group according to sample recruitment procedure. Socio-demographic data was collected from these patients. After that Young Mania rating scale and Hamilton Depression rating scale was administered to both the groups. 12 patients of group were provided psychoeducation for 8 sessions once per week for about 45-60 minutes duration. The second group was control group and left to follow routine of treatment. After the intervention both the group was administered again with medication adherence rating scale. Both groups were assessed on different outcome variable first before beginning of the therapy, second after two months and then lastly after four months of post assessment

MODULE OF PSYCHO EDUCATION FOR BIPOLAR AFFECTIVE DISORDER (ADOPTED FROM BARCELONA PSYCHO EDUCATION PROGRAMME)

1. What is bipolar affective disorder
2. Causal and triggering factors & Signs and symptoms
3. Evaluation and Prognosis Pharmacological treatment
4. Educating about Psychopharmacology vs Alternative therapies & Risk associated with treatment withdrawal
5. Psychoactive substances: risk on bipolar affective disorder Early detection of signs and symptoms
6. What to do when new phase is detected? & Regularity of habits (Importance of Life style)
7. Stress control techniques & Problem solving techniques
8. Final session

STATISTICALANALYSIS:

Statistical analysis was conducted using Statistical Package for Social Sciences (SPSS) Version 20.0. Descriptive statistics were used to calculate percentage profile of different socio-demographic and clinical variables. Since the sample size was small, non parametric statistical tests were used. In order to determine whether there were any baseline differences in socio-demographic characteristics of patients assigned to experimental and the control group, a series of chi square analyses (for categorical variables) and Mann-Whitney U Test (for continuous variables) were performed. For comparison between the experimental and control group on different outcome variables Mann-

Whitney U Test and for within group comparisons Wilcoxon Signed Rank Test was used.

RESULT

Table 1: Comparison between Psycho education + Treatment As Usual (PE+TAU) and Treatment as Usual (TAU) on Socio-Demo graphic Details (Category Variables)

Variable		Group N=40		*df*	χ^2
		TAU +PE	TAU		
Education	Below Matric	3 (25%)	4 (33.3%)	3	3.27 (NS)
	Matric	6(50%)	3 (25%)		
	Intermediate	1 (8.3%)	4 (33.3%)		
	Above	2(16.7%)	1 (8.3%)		
Marital status	Single	5(41.7%)	7(58.3%)	1	0.66 (NS)
	Married	7(58.3%)	5(41.7%)		
Religion	Hindu	11(91.7%)	8(66.7%)	3	5.47 (NS)
	Islam	0(0%)	2(16.7%)		
	Christian	0(0%)	2(16.7%)		
	Others	1 (8.3%)	0(0%)		
Domicile	Rural	8(66.7%)	11(91.7%)	1	2.27 (NS)
	Semi Urban	4 (33.3%)	1 (8.3%)		
	Urban	0(0%)	0(0%)		
Occupation	Govt. Job	2(16.7%)	0(0%)	3	6.66 (NS)
	Pvt. Job	0(0%)	4 (33.3%)		
	Farmer	4 (33.3%)	2(16.7%)		
	Others	6(50%)	6(50%)		
Types of Family	Nuclear	7(58.3%)	9(75%)	1	0.75 (NS)
	Joint	5(41.7%)	3 (25%)		

NS= Not Significant

Table 1 shows the comparison between both study groups on different socio-demographic variables. It is evident from the table that there was no significant difference between both the groups on any of the socio-demographic. Hence, both the groups were comparable and equivalent in terms of socio-demographic characteristics.

Table 2 Comparison between PE+TAU group and TAU group at baseline assessment, post assessment, and follow up assessment on Young Mania Rating Scale (YMRS) and Hamilton Depression Rating Scale (HDRS)

Variable	Group (Mean ± SD)		Mean Rank		U	Z
	TAU±GT	TAU	TAU±GT	TAU		
Baseline Assessment						
YMRS	16.00±5.98	15.83±5.78	12.83	12.17	68.00	-0.23NS
HDRS	12.66±6.34	12.66±5.01	12.08	12.92	67.00	-0.29 NS
Post Assessment						
YMRS	6.58±3.05	10.91±3.87	9.29	15.71	33.50	-2.24 **
HDRS	4.58±1.31	8.50±3.00	7.50	17.50	12.00	-3.50***
Follow up Assessment						
YMRS	7.50±3.77	10.58±3.34	9.83	15.17	40.00	-1.86
HDRS	4.00±1.34	7.83±2.75	7.54	17.46	12.50	-3.48 ***

Table 2 shows the comparison of two groups, i.e. Treatment as Usual +Psychoeducation (TAU+PE) Group and Treatment as Usual (TAU) Group in relation to YMRS & HDRS on baseline assessment and there was no significant difference found between both the groups in the Variables. This suggests that both groups were similar on both rating scales. Table shows the comparison both groups on post assessment scores. From this part, is clear that statistically significant difference was found between both groups i.e. YMRS (U=33.50, Z=2.24, P<0.01) & HDRS (U=12.00, Z=3.50, P<0.01).

Looking at the provided mean value, standard deviations, U value, Z value and significance level, it is evident that the participants in Psychoeducation intervention had low scored on young mania rating scale and Hamilton depression rating scale which indicates that Psychoeducation is applicable in reducing symptoms of mood in individuals with bipolar affective disorder.

Another part of the table shows the comparison between both the groups on follow up assessment scores. On this front, statistically significant difference was found between both the groups i.e. YMRS (U=15.17.00, Z=40.0, P>0.01) & HDRS (U=17.46, Z=-12.50, P<0.01).

Follow up assessment mean value, standard deviations, U value, Z value and significance level indicates that even on follow up, participants in Psychoeducation scored lower on both rating scale which proves that Psychoeducation was proved to be beneficial in reducing symptoms of mood during post assessment which was maintained for longer durations

Table 3 Comparison between baseline and post scores on Young Mania Rating Scale & Hamilton Depression Rating Scale within TAU+PE group and TAU group

Variable	Group (Mean ± SD)		Mean Rank		Z
	Baseline	Post	Negative Ranks	Positive Ranks	
TAU+PE Group					
YMRS	16.00±5.98	6.58±1.05	6.50	0.00	-3.06**
HDRS	12.66±6.34	4.58±1.31	6.50	0.00	-3.066**
TAU Group					
YMRS	15.83±5.78	10.91±3.87	6.50	0.00	-3.074**
HDRS	12.66±5.01	8.50±3.00	6.00	0.00	-2.938 **

Table 3 shows comparison between baseline scores and post interv ention scores on YMRS and HDRS within both groups. First part of the table is showing the result of baseline assessment and post assessment scores on YMRS & HDRS within PE+TAU group and second part of the table is showing the same assessment within TAU group. It is evident from the table that both groups showed statistically significant improvements on post assessment in comparison to their respective baseline scores but improvement in intervention group was more significant in terms of Young Mania Rating Scale and Hamilton Depression Rating Scale. Intervention group reported statistically significant differences on both the scales. Similarly, TAU group also reported significant improvement on both the scales as compared to baseline score. These findings indicate that psycho education along with treatment as usual brought more improvement in Young Mania Rating Scale as compared to treatment as usual group.

Table 4: Comparison between post and follow up scores on MARS within TAU+PE group and TAU group

Variable	Group (Mean ± SD)		Mean Rank		Z
	Post	Follow up	Negative Ranks	Positive Ranks	
TAU+PE Group					
YMRS	6.58±3.05	7.50±3.77	3.50	5.75	-1.46
HDRS	4.58±1.31	4.00±1.34	5.29	4.00	-1.81
TAU Group					
YMRS	10.91±3.87	10.58±3.34	17.50	3.50	-1.63
HDRS	8.50±3.00	7.83±2.75	46.00	9.00	-1.99*

Table 4 shows the comparison between post intervention scores and follow up intervention scores on YMRS & HDRS within both the groups. First part of the table is showing the result of post assessment and follow up assessment scores on both the scales within PE+TAU groups and second part of the table is showing the same assessment within TAU groups. Results of this table indicate that the intervention group did not show further improvement in YMRS and HDRS total (p>0.05) which means though they did not improve further on follow up but maintained the gains which were previously acquired during post intervention phase. Apart from this, treatment as usual group showed further improvement on follow up in YMRS & HDRS score (p<0.05).

DISCUSSION

The present study attempted to examine the applicability of Psychoeducation in reducing mood symptoms in individuals with bipolar affective disorder. In this study, it was found that mood symptoms reduced significantly in the TAU+PE group after completion of intervention. In this study table 1 show all patients were male, age range 21-45 years. Most of them belong to different place of rural backgrounds, educated up matric and belong to nuclear family and work as daily wage worker. Table 1 reveals that equally both group matched married and unmarried domains of marital status respectively. Majority of patients belongs to Hindu. Bond and Anderson [iii] study with 38 participants with bipolar disorder in full or partial remission for at least four weeks for 10 sessions psycho ed ucation using quasi experimental design, self rated scales measured illness and medication attitudes and beliefs, mood symptoms, compliance and functioning by pre and post intervention revealed small but significant improvement in mood symptoms goes with

current finding. Another study did in Pakistan also revealed that psych oeducation intervention is acceptable and feasible, and can be effective in improving mood symptoms and knowledge and attitudes to BPAD when compared with TAU[12]. Reviews of psychological treatment for BDP have identified that adjunctive psychotherapy is useful in the treatment of BPD for preventing relapse, reducing symptoms severity and possibly reducing the time it takes to recover from an episode of BPD [13]. CBT, FFT, IPSRT and PE reduce the burden of depressive symptoms. FFT and IPSRT are most likely to help recovery after an episode with group PE and CBT most likely to prevent episodes if given during periods of remission. Manic symptoms are improved along with time to relapse and recovery from episodes by IPRST and the identification and action of early manic prodromes [7] and these are included in most therapies as a component for relapse prevention [10]. Improvements in mood symptoms are inconsistent in PE studies with some showing no change in depressive symptoms, improvements and one study showing symptoms of anxiety increasing [8, 14, &15]. Although any improvement in symptoms may be clinically important to the individual the link between inter- episodes symptoms represent a risk factor for the occurrence of relapses [16] and therefore are an important measure in interventions treating remitted populations. Larger scale studies are needed to confirm our findings.

CONCLUSION

It is well known that bipolar affective disorder is a highly exhausting and relapsing psychiatric illness associated with significant morbidity and co morbidity. Medications remain a main stay of treatment for bipolar disorder, however despite revolutions in pharmacological interventions some patients remain symptomatic with a high risk for relapse and mood symptomatology just because of high levels of psychological stress, especially living in negative family environment, unhealthy personal beliefs, myths, misconception and prejudices to illness, poor compliance and habits. Thus psychological intervention such as psychoeducation having few components of CBT, FFT and IPSRT is a effective intervention for bipolar disorder in order to increase medication adherence, reducing depressive and manic symptoms severity and recognize early warning signs of an affective episode. Psychological intervention should be employed in combination with pharmacological therapy to optimize the course and outcome of this disorder.

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