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Patients' and doctors' attitudes towards bipolar disorder – do we share our beliefs?

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Summary

Aim. The aim of the presented study was an analysis and comparison of patients' and psychiatrists' beliefs regarding the most important aspects of bipolar disorder (BD) treatment.

Method. A group of 100 psychiatrists (with at least 5 years' professional experience) and a group of 100 remitted patients fulfilling ICD-10 and DSM-IV-TR BD criteria (aged 18–65) were enrolled. Their beliefs were investigated with a 41-item structuralised questionnaire (doctors group) and 27-item self evaluation inventory (patients group). The structures of both tools made it possible to compare the results and were based on hierarchical ranking of answers included in each item.

Results. A number of important concordances were indicated between doctors' and patients' beliefs, e.g. both groups considered that: 1/ depression is the most burdensome episode in the course of BD; 2/ pharmacotherapy is the most crucial element of treatment; 3/ improvement in quality of life is the most important aspect of recovery. On the other hand, the results revealed that patients are convinced that doctors consider improving their life quality much less important than alleviating symptom severity. The hierarchy of problems proposed by the patients as the main obstacles in taking drugs appeared to be the exact antithesis of doctors' beliefs on this issue. The patients indicated the side effects of drugs as the main cause, whereas doctors considered compliance a crucial problem. Discrepancies in beliefs were also observed regarding the perceived importance of different psychoeducation topics: coping abilities and quality of life improvement – the two most important issues in patients' opinion were placed in a remote rank in the doctors' hierarchy, giving way to early recognition of relapse symptoms and suicidality prevention.

Conclusion. Discrepancies in psychiatrists' and patients' beliefs regarding crucial aspects of BD treatment revealed in the study may be responsible for the worsening of quality of compliance.

bipolar disorder / treatment / psychoeducation

INTRODUCTION

Despite the increasing effectiveness of the available pharmacotherapeutic methods, bipolar affective disorder (BD) still constitutes a serious therapeutic problem and exerts a significant negative influence on the quality of life of the patients and their families. BD is regarded as the sixth most important cause of functional impairment and incapacity to work. [1]. The phenomena typical of BD course include high relapse rate, a tendency to chronic symptoms, difficulties in diagnosis and too little involvement in the process of treatment on the part of the patients [2]. In the case of diagnostic failures in BD, an important part is played by the frequently occurring non-adherence which, according to various estimates, refers to 10 to 60% of cases in therapy [3, 4, 5]. Jamison [6] distinguished four groups of factors responsible for this high pro-

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portion and the consequent reduction of treatment effectiveness: 1) factors specific to the disorder (type and phase of BD); 2) variables connected with therapy (therapeutic regime, undesirable symptoms); 3) factors connected with the patient (demographic parameters, the patient's beliefs and attitudes towards the disorder and the treatment); 4) variables connected with the physician (beliefs concerning the disorder and the treatment as well as their influence on the patient). The initial investigations concerning the reasons for poor therapeutic cooperation were focused mostly on the demographic and biological factors, and on other characteristics connected with treatment (mostly side-effects), thus tending to neglect the variables connected with the patient and the physician [7]. However, a growing quantity of proof testifies to the significant role of these factors in the prognosis of the course of therapy and therapeutic cooperation in BD [8]. The result of this gradual change in perception towards BD is taking account of the broadly understood psychological and social factors in the understanding of and approach to this disorder. Among these factors, the physicians' and patients' convictions about BD play an important role.

According to the assumptions of cognitive-behavioural psychotherapy, whose usefulness makes it consistently one of the basic elements in the complex treatment of BD, each of us is expected to act in accord with their beliefs, and, being "rational consumers" we undertake only those actions which we believe to be sensible and effective. Therefore, the patients' or physicians' convictions as to which aspects of BD therapy are the most important, and, in particular, any differences between these convictions, may exert influence on the course of the therapy and determine its outcome. This problem has become the subject of the study presented below.

DESCRIPTION OF THE METHOD

The investigations involved two groups: physicians (Group 1, n=100) with at least five years of professional practice, and remitted patients (Group 2, n=100) diagnosed as suffering from BD due to their fulfilling of ICD–10 and DSM IV–TR BD criteria. The group of physicians included both physicians in psychiatric training for consultancy as well as psychiatric consultants (1st and 2nd specialisation level) working in psychiatric hospital wards, psychiatric outpatient clinics and private surgeries. The doctors' convictions were examined with the help of a 41-item structuralised questionnaire executed by pollsters from the Pentor Institute of Market Survey. The questions covered, among other topics, evaluation of significance of selected drugs and intervention in treatment of BD and assessment of the arduousness of various aspects of the disorder from the perspective of both the doctor and the patient. Characteristics of Group 1 can be found in Tab.1.

Table 1. Demographic and professional characteristics of group 1 (physicians)

Sex	Females Males	54 46
Age (years)	43.4 ± 9.6	
Place of residence	Town, above 500 thousand	30
	500–100 thousand	36
	100–25 thousand	23
	Below 25 thousand	11
Place of work	Hospital Ward	21
	Outpatient Psychiatric Clinic, Private Surgery	38
	Hospital Ward + OPC/PS	41
Years of practising as a doctor	16.9 ± 10.7	
Stage of training for consultancy	In training	16
	Consultant –1st degree	19
	Consultant – 2nd degree	65
Stage of training in psychotherapy	In training	29
	Certified psychotherapist	17
	Not in training / Not certified psychotherapist	54

Group 2 consisted of patients aged 18 to 65 years in treatment at the Adult Psychiatry Department in Kraków. The group included both hospitalized patients and those treated in the outpatient clinics (Characteristics of Group 2 is presented in Tab. 2 and 3).

Table 2. Demographic characteristics of group 2 (Patients)

		Number / %Group: n=100
Sex	Females	67
	Males	33
Age (years)	43.9 ± 12.9	
Place of residence	Village	23
	Town < 100 000	26
	Town > 100 000	51
Education	Elementary	20
	Secondary	34
	University	46
Work situation	Student	7
	Working	27
	Unemployed	6
	Old age pension	6
	Disability pension	56

Table 3. Selected parameters regarding the formecourse of illness (Patients)

Duration of Illness (years)	Number / % Group, n=100
0-6	26
7-18	48
19-30	15
>30	11
Number of BD episodes	
≤ 6	43
7–18	42
19–30	10
>30	5
Number of hospitalisations due to BD	
≤4	72
5-12	24
13-20	3
>20	1

The patients' beliefs were examined with the help of a 27-item questionnaire. As with the questionnaire for the physicians, the questions were focused on evaluation of the significance of various forms of therapy in the treatment of BD and the arduousness of various aspects of the disorder from the point of view of the patient. The questionnaire also included questions concerning the patients' notions about the physicians' beliefs regarding essential aspects of therapy and the course of BD.

The two questionnaires were constructed in the same way and their structure was based on hierarchical ranking of the answers they included. The present study is an attempt at listing and comparison of physicians' and patients' beliefs concerning BD, based on an analysis of selected corresponding items of the two questionnaires.

The processing of quantitative data included statistical analysis on the basis of mean value and standard deviation. Then, parametric tests were executed respectively – a t test for independent samples or non-parametric tests and Mann-Whitney's U test for independent samples. As regards comparison of qualitative features (components of the tables 2*2) chi^2 test with Yates's correction was executed or, at low numbers in the compared groups, Fischer's exact test was performed. The results of the analyses were recognised as statistically significant for $P<0.05$.

RESULTS

Both in the group of physicians and in that of patients, most persons indicated the depressive episode as the most arduous in the course of BD (52% vs. 67%). Both groups recognised the manic episode as the second most arduous (29% vs. 17%), while the mixed episode (13% vs. 8%) and hypo-manic one (6% vs. 6%) took the third place. It should be emphasised, however, that significantly more patients than physicians put depression in the first place of the most arduous elements (p=0.031) while significantly more physicians placed the manic episode as the second one (p=0.044).

Both groups recognised pharmacotherapy as the most important element in treatment of BD (84% of physicians vs. 55% of patients). Nevertheless, significantly more physicians than patients indicated the priority of pharmacotherapy (p=0.007). The patients gave the second place to psychotherapy (for 23% of persons it was the most important element), while psychoeduca-

tion was assigned the last position (11%). For the physicians the two latter elements were of little importance (7% and 9% respectively).

Analysis of the subsequent questions revealed that, in the physicians' opinion, the patients – like themselves – believed pharmacotherapy to be the most important element of treatment of BD. As many as 75% physicians were convinced that for the patients this form of therapy was a priority. It is interesting, as has been shown above, that significantly fewer, i.e., a little more than half (55%) of the examined patients placed pharmacotherapy on top of the list (p=0.04). A small proportion of doctors (12%) claimed that psychotherapy and psychoeducation were considered important by the patients (12% and 13% respectively). In comparison with these data, significantly more patients recognise psychotherapy as the most important (23%, p=0.016).

The patients were asked a similarly constructed question whether, in their opinion, physicians were particularly focused on any of the above mentioned elements of therapy. Their answers showed a hierarchy identical with that presented by the physicians, without any statistically significant difference: 1. pharmacotherapy (doctors 84%, according to patients doctors 69%); psychotherapy (9% vs. 16%); psychoeducation (7% vs. 6%).

Another question, concerning the most important problems connected with taking medication revealed significant differences between the hierarchy presented in the doctors and the patients' opinions. The patients placed undesirable side-effects of drugs on the top of the list while the doctors recognised them as the least important (45% vs. 12%, p=0.0001). On the other hand, 69% physicians indicated compliance with treatment as the key issue, while it was considered to be the most important factor to influence taking of medicines by as few as 30% of patients (P<0.0001).

Another question that underwent analysis regarded problems connected with participation of the patients suffering from BD in psychotherapy. The most important limitation, according to the patients, was the necessity to regularly participate in therapeutic sessions (26%) For the physicians, difficulties connected with getting access to a psychotherapist were the most important problem (38%). A similar number of them (36%), just like the patients, recognised the necessity to take part in therapy on a regular basis as the most important obstacle. Duration of therapy as well as being open and sincere in the relation with one's therapist were placed on further positions on the list. In the opinions of both doctors and patients, doing homework assigned by the therapist is the least important problem.

The question referring to the most important aspects of improvement of the health state in treatment of BD revealed that the opinions of the physicians were concordant with those of the patients. Both groups recognised the priority of general improvement of the physical and mental state as well as of the quality of life (40% of patients, 35% of doctors). The second place was assigned to alleviation of symptoms (22% vs. 31%), while increased stability of mood (16% vs. 27%) and decreased duration of relapses (6% vs. 7%) took the last place.

It is interesting that an analysis of the doctors' beliefs as regards their patients' convictions revealed an identical hierarchy of importance in the elements of improvement. The results of the reverse question asked to the patients and concerning their beliefs as regards their doctors' convictions are different. The patients believe that for the doctors alleviation of symptoms is the most important factor (37%) while the improvement of the patient's physical and mental state as well as their quality of life is of little importance (11%).

Another question concerned the improvement of various elements of social functioning. Both the doctors and the patients regarded the improvement of functioning in the family and marriage as the most important issue. The subsequent places were assigned to work activity, improvement of interpersonal relations and leisure time activities.

The last problem that was analysed referred to the importance that the doctors and patients ascribed to the 14 goals of psychoeducation, which were included in the questionnaires. The examined persons arranged them in order of their decreasing importance. Numerous differences between the two groups were found in this area (Tab. 4). While for the patients the improvement of coping with stress was the most important issue, the doctors placed it in eleventh position. What is more, the improvement in gen-

eral physical and mental state and the quality of life, placed by the patients in second place, ranked seventh in the physicians' hierarchy. In turn, the improvement in compliance with treatment, recognised as important by the doctors (fourth place), took the seventh place in the patients' ranking. It is also worth emphasizing the differences concerning prevention of suicidal thoughts and attempts. In the group of physicians this goal took second place, just after learning to recognise the symptoms of a relapse. The patients placed prevention of suicidal thoughts and attempts in sixth place. Detailed information concerning the hierarchy of importance of particular goals of psychoeducation in both groups can be found in the table below.

Table 4. The hierarchy of goals of psychoeducation by physicians and patients

Hierarchy of goals of psychoeducation according to patients	**Hierarchy of goals of psychoeducation according to doctors**
1.improvement in coping with stress	1. recognition of the symptoms of relapse
2.improvement in physical and mental state and quality of life	2. prevention of suicidal thoughts and attempts
3. recognition of the symptoms of relapse	3. increased self-control in the area of the symptoms of the disorder
4. increased self-control in the area of the symptoms of the disorder	4. prevention of relapses
5. prevention of relapses	5. improvement in cooperation in treatment
6, prevention of suicidal thoughts and attempts	6. providing information on the disorder, support for the patient and their family
7. providing information on the disorder, support for the patient and their family	7. improvement in physical and mental state and quality of life
8. avoiding alcohol, drug and psychoactive substance addiction	8. avoiding alcohol, drug and psychoactive substance addiction
9. improvement in interpersonal and social functioning in remission	9. improvement in interpersonal and social functioning in remission
10. improvement in knowledge and skills in coping with psychosocial effects of the past and future episodes of the disorder	10. improvement in knowledge and skills in coping with psychosocial effects of the past and future episodes of the disorder
11. improvement in cooperation in treatment	11. improvement in coping with stress
12. coping with residual symptoms and disturbances in functioning, caused by the disorder	12. coping with residual symptoms and disturbances in functioning, caused by the disorder
13. prevention of stigmatisation of patients	13. prevention of stigmatisation of patients

DISCUSSION

The present study has shown, among other things, that both the doctors and the patients recognize depression as the most burdensome episode in the course of BD. These results seem to be justified in the light of hitherto conducted investigations: Judd and Akiskal [10] showed that depressive symptoms were present for 31.9% of the 13 years long observation of patients with BD I (n=146) while the other episodes constituted only 14.8% of this period. The disproportion between depression and the other pole of the disorder was even more strongly marked in patients diagnosed with BD II (n=86), for whom depressions constituted 50.3% of the investigated period while hypomanic or mixed episodes took merely 3.4% of the time. In turn, Post et al. [11], after a year of observation, showed that among 258 outpatients diagnosed with BD, 40% manifested recurrent affective symptoms with distinct prevalence of depression, persevering for ca. 120 days. What is more, severity of BD is strongly correlated with the severity of depressive symptoms and not manic ones [11].

Both the doctors and patients participating in the presented study recognise pharmacotherapy as the crucial element in treatment. This reflects the primacy of pharmacological treatment prevalent in today's standards of treatment of BD. It should be emphasised, however, that the primacy of pharmacotherapy was indicated by the physicians significantly more often than by the patients. 42% of patients and only 16% of doctors assigned the greatest importance to non-pharmacological methods. This might result from the picture of BD, ever dominating among clinicians, as a disease of decidedly "biological" character. It is worth quoting here one of the main conclusions drawn at the conference of NIMH in 1990. It claimed that application of additional non-pharmacological (psycho-social) interventions that might alleviate the difficulties in adjustment to BD is the least developed area of treatment of this disorder [12]. However, non-pharmacological methods like psychoeducation and psychotherapy, which are still underestimated, in particular by the physicians, are gaining increasingly stronger support in the light of both controlled investigations and naturalistic observations. The recent multi-centre, controlled investigations STEP-BD, involving 293 patients with a diagnosis of BD showed that administration of any of the three examined forms of psychotherapy (IPSRT – Interpersonal and Social Rhythm Therapy, FFT – Family Focused Therapy and CBT – Cognitive-Behavioural Therapy) contributed to significantly faster improvement in the patients' clinical state than achieved in the case of standardized minimum intervention [13]. However, no differences have been discovered yet between IPSRT, FFT, and CBT as regards their effectiveness in supporting and maintaining remissions. The number of controlled studies on the effectiveness of psychoeducation (PE) of patients with BD is growing. Among these studies, the Barcelona psychoeducational programme [14] deserves special attention. It has revealed, among other things, the advantage of PE over the standard procedures in the reduction of relapse rate after 6 months (38% of relapses in the PE group vs. 60% relapses in the control group), still present after termination of the two-year-long observation. PE has also proved to be more effective at reducing the time of the patients' hospitalisation. It is worth mentioning that in Poland, in Kraków (Department of Adult Psychiatry, UJ CM – project headed by Grzegorz Mączka, MSc) and in Poznań (Department of Adult Psychiatry, Medical Academy, project headed by Assoc. Prof. Jan Jaracz, MD, PhD) studies on the development, application and effectiveness of psychoeducation programmes in BD are also performed.

In the patient's psychoeducation, the issue of taking into account their preferences regarding the selected topics seems very important since, as we have shown, physicians and patients may have different opinions about their significance and hierarchy. The goals of psychoeducation that proved crucial for the patients, namely, improved coping with stress and improved quality of life (first and second place in the hierarchy, respectively) were assigned low rank by the physicians (eleventh and seventh place, respectively), being replaced by the goals recognized as most important: learning to recognise the symptoms of relapse and preventing suicidal thoughts and attempts. This might suggest the pathogenetic paradigm, which is still present in the physicians' thinking – focusing on the issue of alleviation of symptoms and removal of dan-

ger connected with the disease, and this does not wholly correspond with the patients' needs – increasing of resources as well as improvement of the ability to manage their lives and cope with the disorder.

The study has also shown that the hierarchy of problems indicated by the patients and connected with taking medication is strictly reverse to the views represented by the doctors. The patients consider the undesirable side-effects as the greatest obstacle while for the physicians this problem is of the least importance. On the other hand, the problem that is most important for the doctors, namely, the appropriate compliance with treatment, proved to be the least important one for the patients. The above data may serve as an essential guideline for the medical profession, since they suggest that the path to good cooperation should start with utmost care concerning tolerance of the prescribed treatment. This does not concern only appropriate dosage or taking account of drug interactions and the patient's preferences. The appropriate, exhaustive and comprehensible information concerning the potential duration of pharmacotherapy, usefulness of drug administration, their mechanism of action, possible side effects, and safety connected with their administration and the relation between the patients' risk and their benefit from the applied treatment are also essential. As shown by Morselli [15] the patients' most serious fears connected with medication (e.g., taking medicines is equal to enslavement, dependence, shame; taking medication causes long-term, irreversible consequences for the organism, etc.) often have no rational justification and may be caused by simple lack of information.

In the study discussed here, both the doctors and the patients claimed that the most important aspect of the improvement of health state in BD is the issue of the patient's quality of life. Nevertheless, the patients are convinced that for the physicians this issue is of the least importance of all the examined aspects, and that the medical profession is mostly focused on alleviation of symptoms. This suggests at least insufficient communication between doctors and their patients, which may become a potential obstacle in compliance. Again, it seems that the physicians should pay more attention to formulating clear and distinct therapeutic goals and priorities together with their patients. Maybe the doctors are still inclined to choose the model in which the patient should closely follow their instructions in a passive and disciplined way (adherence), and tend to neglect the model of therapeutic contract in which the patient is an active and responsible participant of the therapy (compliance).

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