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Attitudes regarding the collaborative practice model and treatment adherence among individuals with bipolar disorder

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Abstract

An emerging literature suggests that a collaborative care model, in which patients are active managers of their illness within a supportive social environment, is a beneficial approach for individuals with bipolar disorder. One aspect of treatment that is often suboptimal among individuals with bipolar disorder is treatment adherence. Establishing an ideal collaborative model may offer an opportunity to enhance treatment adherence among individuals with bipolar disorder. This paper presents results from a qualitative exploration of patients' attitudes towards the collaborative care model and how individuals with bipolar disorder perceive treatment adherence within the context of the collaborative care model.

All participants were actively enrolled in outpatient treatment at a Community Mental Health Center and part of a larger study that evaluated the Life Goals Program, a manual-driven structured group psychotherapy for bipolar disorder that is based on the collaborative practice model. The Life Goals Program is designed to assist individuals to participate more effectively in the management of their bipolar illness and to improve their social and work-related problems. Individuals were queried regarding their opinions on the ingredients for an effective client-provider relationship. Quantitative data were collected on baseline treatment adherence as well.

Individuals treated for bipolar disorder in a community mental health clinic identified 12 key elements that they felt were critical ingredients to a positive collaborative experience with their mental health care provider. The authors conceptualized these elements around 3 emerging themes: patient-centered qualities, provider-centered qualities, and interactional qualities.

Individuals with bipolar disorder perceived the ideal collaborative model as one in which the individual has specific responsibilities such as coming to appointments and sharing information, whereas the provider likewise has specific responsibilities such as keeping abreast of current "state-of-the-art" prescribing practices and being a good listener. Treatment adherence was identified as a self-managed responsibility within the larger context of the collaborative model. Individuals with bipolar disorder in this study placed substantial emphasis on the interactional component within the patient-provider relationship, particularly with respect to times when the individual may be more symptomatic and more impaired. It is important that clinicians and care providers gather information related to patients' perceptions of the patient-provider relationship when designing or evaluating services aimed at enhancing treatment adherence.
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1. Introduction

An emerging literature suggests that a collaborative care model, in which patients are active managers of their illness within a supportive social environment, is a beneficial approach for individuals with bipolar disorder [1,2]. One aspect of treatment that is often suboptimal among individuals with bipolar disorder is treatment adherence. Treatment nonadherence is relatively common among individuals with bipolar disorder (estimates range between 20% and 55%) and can lead to clinical relapse and such negative sequelae as hospitalization or even suicide [3-6].

Establishing an ideal collaborative model may offer an opportunity to enhance treatment adherence among individuals with bipolar disorder. Kusumakar et al [7] have noted that the foundations for effective management of bipolar disorder comprise a collaborative therapeutic relationship, psychoeducation, and psychotherapy. Ideally, the health care environment should facilitate information access and

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healthy decision making for individuals with illness. Self-determination theory [8-10] proposes that a health care environment that promotes the autonomy and decision-making capacity of the individual is critical in motivating individuals to healthful self-management.

How individuals with bipolar disorder perceive the patient-provider relationship appears to be important for development of an ideal collaborative relationship that optimizes treatment adherence. However, a clear link between a collaborative treatment model and treatment adherence has not been established. Greil and Kleindienst [11] recently suggested that adherence to lithium clearly depends on illness concepts, and it is known that clinicians are not fully aware of the main reasons why patients with bipolar disorder stop medication [12]. Patient's reasons for stopping lithium appear to be influenced by concerns about what having a mood disorder and taking medication say about them [12,13]. An effective collaborative relationship that is bidirectional and dynamic may potentially enhance treatment adherence. Yet, a collaborative relationship may be difficult to establish without input from those with most at stake—patients themselves.

The Life Goals Program, a structured group psychotherapy for individuals with bipolar disorder [14,15], was designed to assist individuals with bipolar disorder to participate more effectively in the management of their own illness and to improve the social and work-related problems that often develop for individuals with bipolar illness. A key feature of the Life Goals Program is that it is based on the collaborative practice model and a standardized manual-driven format. Traditionally applied to chronic medical illness, the collaborative practice model emphasizes that patients are managers of their illness, and successful outcomes are enhanced within a supportive social environment.

The first goal of the Life Goals Program is to improve an individual's illness management skills so that they may be more effective collaborators with medical and other practitioners in the management of their own illness [15]. The second goal is to improve social and occupational function in ways that the individuals themselves identify as meaningful to them [15]. Specifically, the Life Goals Program aims to improve the individual's ability to participate collaboratively in treatment within the medical model, rather than proposing to alter the pathophysiology of the illness directly [15]. Major elements of the model include collaborative definitions of problems, joint goal setting, and planning; provision of a continuum of self-management and support services; and active and sustained follow-up [16-18].

This paper is a qualitative exploration of patient perceptions of essential components of the patient–care provider relationship in a public health care setting. Perceptions regarding treatment adherence within this relationship are evaluated as well. We anticipated that individuals with bipolar disorder would place value on an interactional approach to care that incorporates expectations and responsibilities on the part of both providers and individuals with bipolar disorder.

2. Methods

2.1. Participants

All participants were actively enrolled in outpatient treatment at a Community Mental Health Center and part of a clinical trial that evaluated the Life Goals Program [15,19], a manual-driven structured group psychotherapy for bipolar disorder that is based on the collaborative practice model. Participant feedback was collected during the clinical intervention phase of a randomized, institutional review board–approved trial—the Life Goals Program versus usual care on treatment adherence attitudes and behaviors of patients with bipolar disorder receiving care in a community mental health clinic [20].

Patient illness-management skill enhancement was addressed in phase 1 of the Life Goals psychoeducation program [14,15,21]. Six weekly group sessions focus on information regarding bipolar disorder in general, supplemented by development of personal profiles of mood symptoms, identification of early warning signs and triggers, "personal cost-benefit analyses" regarding coping responses to symptoms, and individually tailored action plans for symptom worsening. A core focus is to increase awareness of worsening symptoms and to facilitate self-management and care negotiation among individuals with bipolar disorder.

2.2. Quantitative measures of treatment adherence and treatment attitudes

Treatment adherence was measured at baseline before beginning the Life Goals Program via patient self-report. Individuals reported on the percentage of medications taken over the last 3 months. Adherence with clinic visits over the past 3 months was also assessed. In addition, attitude towards medication was measured with the Drug Attitude Inventory (DAI), a self-report scale originally developed to assess the attitudes and subjective experience of patients with schizophrenia being treated with antipsychotic medications [22]. However, the scale has been used with other seriously mentally ill populations receiving psychotropic medication. Higher scores on the DAI have been correlated with better treatment adherence [23]. The 10-item true/false version of the DAI was used [22] and scored from 0 (worst subjective response) to 10 (best subjective response).

2.3. Qualitative data collection

Qualitative evaluation of patient comments was conducted after all cohorts completed phase I of Life Goals Program. A primary goal of the larger study was to evaluate the effects of the Life Goals Program upon treatment adherence behavior and treatment adherence attitudes. During the last session of phase I (session 6), entitled,

"Treatments for Manic-Depressive Disorder," one of the focus points is the Collaborative Practice Model. Before the therapist's explanation of the model, participants in group were asked to respond to the query, "What do you think the ingredients are for an effective client-provider relationship?" Two of the authors (MAD, RH) attended these sessions and recorded patients' answers to this question. Responses were recorded verbatim, assembled, and then grouped by major thematic domains. The themes were discussed with an advanced nurse specialist (LM) with extensive experience with the Life Goals Program with respect to consistency with Life Goals participants in other settings.

3. Results

3.1. Demographics and quantitative measures

Table 1 presents participant sociodemographic information and selected clinical variables including self-reported treatment adherence and DAI scores. To date, 7 group cohorts have completed phase I sessions, representing a total of 52 individuals. Size of the groups ranged from 4 individuals to 11 individuals. The groups were predominantly women (38/52, 73%) and minority individuals made up 24 (46%) of 52 of the group's attendance. Substance abuse was relatively common in the participant sample, with 21 (40%) of 52 individuals having a history of substance abuse. Individuals reported a mean percentage of 87.5% adherence with prescribed psychotropic medication, and a mean clinic visit adherence of 84.7%. Mean ± SD DAI score was 7.39 ± 2.25, range 1 to 9.

Table 1
Demographic and clinical characteristics of participants in a study to evaluate the ideal qualities of a patient-provider relationship from the perspective of individuals with bipolar disorder (N = 52)

Variable	
Age	
Mean ± SD (y)	43.8 ± 10.39
Sex	
Men, n (%)	14 (27)
Women, n (%)	38 (73)
Ethnicity	
White, n (%)	28 (54)
African American, n (%)	22 (42)
Hispanic, n (%)	0
Other, n (%)	2 (4)
History of substance abuse (lifetime), n (%)	21 (40)
Bipolar type	
Bipolar I, n (%)	44 (85)
Bipolar II, n (%)	8 (15)
Treatment adherence*	
Medication (self-report)* (%)	87.5%
Clinic visit* (%)	82.5%
DAI**	
Mean score ±SD	7.39 ± 2.25

* For the previous 3 months.

** Scored on 0-10 scale; higher scores indicate better subjective attitudes toward medication.

Table 2
Essential qualities of an effective patient-provider relationship as expressed by individuals with bipolar disorder

Patient-centered	Provider-centered	Interactional
Takes medications	Prescription practices	Weight of provider's opinion
Keeps appointments	Expertise	Trust
Information	Humaneness	Flexibility
Assertive	Listening skills	
	Sensitivity to clients' feelings	
	Availability	

3.2. Qualitative analysis

Over the course of the project, participants in the group sessions cited 12 key elements that they felt were critical ingredients to a positive collaborative experience with their mental health care provider. The authors conceptualized these elements around 3 themes: patient-centered qualities, provider-centered qualities, and interactional qualities. Table 2 outlines these 3 thematic domains and their components.

3.2.1. Patient-centered qualities

A number of individuals voiced the opinion that a primary responsibility of clients/patients is to take their medications and to keep their appointments. This was expressed within the larger framework of expectations and responsibilities for both individuals and their health care providers. Whereas one cohort discussed the need to openly share information with their provider, another cohort discussed a more cautious approach to disclosure. More specifically, one individual in the latter cohort cautioned "Be prepared to be hospitalized if you share everything." Another noted that an important quality for individuals with bipolar disorder was assertiveness and described an incident of calling the clinic's hotline to get needed help during off hours.

3.2.2. Provider-centered qualities

Most of the participants in this project had many years of experience with mental health providers, and a large part of each the discussions focused on provider-centered qualities. Providers' medication practices were an especially important concern for many participants. Comments included concerns about inattention to the effects of medications ("They don't cue in on ineffective prescriptions" and "They must understand that the client knows his own body"), the length of prescription trials ("They give you 4 months of scripts" or "They change the meds too often"), and a lack of consideration of other therapies ("They should not just give you more meds all the time but need to consider other strategies to help."). Many of these individuals with bipolar disorder described wanting a "humaneness" quality to their providers, making comments such as "They admit they don't know everything." Other important provider-centered qualities included being a good listener and sensitivity to

client's feelings. A good listener was defined as someone who "has good people skills," someone who "hears you," and a provider who does not "talk too much and monopolize the sessions." Regarding sensitivity to clients' feelings, one individual expressed her dismay at a statement made by her physician when he arrived at the clinic 1 day. "Looking around the waiting room, he said sarcastically, 'Another day in paradise!'" Another woman described her distress when her provider started "scratching his crotch" during a session.

3.2.3. Interactional qualities

Individuals with bipolar disorder in this study voiced the opinion that although they perceived themselves as managers of their own illness, the interaction with the provider is critical. The desired intensity of involvement by the provider appears to vary depending on current levels of bipolar symptoms or disability. Although the collaborative process is described as "joint," several individuals expressed their belief that they generally managed their illness better if they "gave more weight" to their provider's opinion about treatment decisions than their own. Others described the interactional quality of "trusting" their provider, especially when they felt they could not make an informed decision about their treatment or were too symptomatic to think clearly. Lastly, flexibility included length and frequency of contacts, which participants said were highly dependent on their needs. For example, 1 individual described a flexible amount of time as "enough time to be heard."

4. Discussion

This qualitative exploration of patient perceptions regarding ideal qualities of patient-provider relationship underscores not just the importance of patient and provider activities and values, but also the interaction between patients and care providers. In this study, individuals with bipolar disorder specifically identified and placed value on the primary features of a collaborative practice model. The collaborative practice model has been defined as "an organization of care that emphasizes (*a*) development in the patient of illness management skills and (*b*) support to provider capability and availability to engage patients in timely joint decision making regarding their illness" [19].

Individuals with bipolar disorder participating in this study perceived the ideal collaborative model as one in which the individual has specific responsibilities, such as coming to appointments and sharing information, whereas the provider likewise has specific responsibilities such as keeping abreast of current state-of-the-art prescribing practices and being a good listener. Taking medications as prescribed is cited by individuals with bipolar disorder as a responsibility within the larger framework of the collaborative model. Thus, an active stance towards care (give feedback, seek help when necessary, and self-manage specific care procedures) appears to be critical for individuals with bipolar disorder if a genuine collaborative model is operating. Individuals with bipolar disorder in this study placed substantial emphasis on the interactional component within the patient-provider relationship, particularly with respect to times when the individual may be more symptomatic and more impaired. In addition, individuals with bipolar disorder noted that there must be flexibility within the interactional relationship to allow for individual differences, fluctuations in illness severity, and the demands and realities of daily life.

The participants in the study reported here identified treatment adherence as a self-managed responsibility within the larger context of the collaborative model. Thus, a strong and active collaborative relationship is likely to provide the best chance at facilitating "buy-in" by individuals with bipolar disorder. It must be noted that the individuals with bipolar disorder in this sample were largely adherent with medication and with clinic visits and had generally positive subjective response to treatment.

Basco and Rush [24] have defined nonadherence as "a discrepancy between treatment recommendations derived from clinicians' conceptualization of illness and patients acceptance of these recommendations, which is based on their unique mental model of illness." Some preliminary studies in primary care settings have suggested that there is a relationship between the discrepancy in clinicians' and patients' mental models and adherence levels [25,26]. If providers and the provider interactive process are unable to meet perceived expectations of individuals with bipolar disorder, it might be anticipated that the expectation to take medication as prescribed may likewise be unmet. A clinical implication suggested by the study results is that clinicians must take an active role in attempting to understand a patient's stance towards illness and adherence. Adherence is not simply a "patient problem" but a component of the patient-provider relationship. It is possible that some of the physicians the patients were referring to did not sufficiently listen to them or that the clinicians stuck to medications that were ineffective or caused intolerable side effects. In many mental health clinics, insufficient time to see individual patients, high staff turnover, and inadequate ancillary support impose challenges for both providers and patients. On the other hand, some of the criticism by the patients may better be understood as a result of frustration about the illness and its consequences for the patient's life.

A number of studies have demonstrated that psychoeducation enhances adherence to treatment and may improve overall outcome in bipolar disorder [27]; however, it is likely that psychoeducation combined with therapeutic approaches that address/incorporate an individual's own attitudes and beliefs may further improve treatment adherence [27,28]. Psychosocial interventions that feature the interactive relationship between care providers and individuals/families are associated with improvements in treatment adherence [29]. The results from this analysis suggest that this interactional relationship must be flexible and responsive to changes in clinical status.

Preferences for control in the patient-physician relationship exist on a continuum, with the traditional doctor-patient relationship at one end of the spectrum (powerful physician, acquiescing patient, and focus on disease and bodily functioning), and at the other end, the consumerist perspective where the patient assumes control of health care and the physician serves as a consultant or advisor [30]. In a patient-physician relationship with shared control, the interactants cooperate and coordinate their responses to create a coherent and effective interaction [31]. Street et al [31] have suggested that provider partnership building and active patient participation are reciprocal; thus, a passive patient may become more involved with provider encouragement, whereas a provider may become more active and engaged in response to a patient who asks questions and voices concerns.

Limitations of this study include the relatively small size of the patient sample and the nature of the participants—all individuals with bipolar disorder participating in a group therapy. Querying individuals regarding the collaborative model in a group setting may limit interpretation of the responses obtained—some individuals might be reluctant to be entirely honest in a group setting, and it was not possible to determine how many individuals in each group completely endorsed any specific opinion. However, the group milieu is designed to be a nonthreatening climate of acceptance in which group members are encouraged to question and explore both their own ideas and those of others, as well as to share relevant experiences [15]. Indeed, a strength of the program is the focus on discussion of an individual's perceptions and values in the group setting, which are later used by group members to solve personal problems related to bipolar illness. By session 6, group members have had time to become comfortable with one another and familiar with the group setting.

An additional limitation with respect to generalizability of these study results is the relatively high baseline treatment adherence and positive attitude towards treatment. On average, these individuals with bipolar disorder took 87.5% of prescribed medications and kept 84.2% of scheduled clinic appointments. Their subjective experience with medication was overall quite good. It might be expected that these individuals are among the most motivated for treatment, and thus their opinions may not reflect the perceptions of all individuals with bipolar disorder. Individuals who refused to participate in group or who were too ill to participate were not enrolled. Finally, findings may not be generalizable to individuals with bipolar disorder of all social classes or ethnicity.

5. Conclusions

The results of this qualitative study support the strength of the collaborative practice model from a patient-centered perspective. Individuals with bipolar disorder perceive the taking of medications as a patient responsibility within the larger framework of the patient-provider relationship. The limited number of empirical studies of how to reduce nonadherence offers encouraging evidence that, if recognized, the problem can be overcome [28]. However only 1% to 2% of all publications on the treatment of mood disorder explore factors associated with medication nonadherence [28]. Additional studies are needed to better identify what components of the collaborative relationship are most amenable to change to optimize the important outcome of treatment adherence.

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