Teaching Wellness

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Elizabeth taught me how to cope with bipolar disorder—she was my psychiatrist. I'd like to think it was because she took a special interest in me, but maybe she just got tired of me turning up on her doorstep every twelve months or so in a raging manic episode.

At the time, my method of coping with bipolar disorder was to ignore it, an excellent method except for one tiny drawback—it didn't work. Every year or two, I'd spend several weeks in full-blown mania, sometimes followed by an episode of depression, and then six months or so of withdrawal in the inevitable "morning-after" recovery that follows mania.

So Elizabeth taught me how to cope. It was her job. But, how many psychiatrists go beyond merely prescribing medication to the other part of the job—teaching us how to cope? It took a while to get the hang of it. Like learning to ride a bicycle, I fell off a few times. Eventually I got really good at it and in the past ten years, I haven't had a full-blown manic episode. (Of course, I'm still taking my medications.)

Many people have a story like mine. Many have learned to cope. Recently, scientists have begun to investigate the effectiveness of teaching people how to cope with bipolar disorder. What they have discovered is very exciting. They found that it really works, that it really works well, and that it really works well without any side effects.

Warning: Science Content

I watch the TV show *Mythbusters* on the Discovery channel. They apply vaguely scientific methods to explore the truth of popular myths. Whenever there is serious science content, they flash a warning on the screen. Likewise here, there's a bit of science content. But the bottom line is a three or four times improvement in staying well for those of us who have bipolar disorder and with no annoying side effects. That's worth suffering some science!

To test the effectiveness of a new treatment for a disease, scientific comparisons are made. Typically, the treatment is a new drug. However, in the following studies (all of which were conducted between 1999 and 2003), the treatments being tested are different ways of teaching people how to cope with bipolar disorder.

All four studies use a similar method. A large group of participants is recruited and each participant is randomly assigned to one of two groups. One group receives the treatment being tested and the other group receives some other form of treatment. When a drug is being tested, the other form of treatment is frequently a placebo—a pill with no active ingredients. As far as possible, everything except the treatment under study is kept the same for both groups.

Treatment is given for a period of time and the progress of all participants is measured. The scientists that perform the measurement do not know which participants are receiving the active treatment and which are in the comparison group. This prevents any bias creeping into the results.

Illness Self-Management

Teaching people how to cope with a long-term illness is often called illness self-management. (For mental illnesses it is also called "psychoeducation.") The major ingredients of illness self-management for mental illness include:

- medication compliance
- early identification of warning signs
- relapse prevention
- coping strategies for dealing with persistent symptoms
- improvement of illness awareness

This is what Elizabeth taught me, and these ingredients lie at the core of the therapies investigated in the following four studies: early symptom detection, family-focused therapy, cognitive therapy, and group education. The difference between the studies is where the emphasis is placed on the core ingredients and the additional elements included in the recipe. In all of the studies, the therapies under investigation were given in addition to the patient's usual medication regime.

Treatments on Trial

Early Symptom Detection

Therapy: Teaching people how to identify early symptoms of relapse and to seek prompt treatment. In the study it consisted of 7–12 individual sessions given by a research psychologist with little previous clinical experience.

Participants: Sixty-nine patients with bipolar disorder who had had a relapse during the previous year (mostly bipolar type I).

Outcome: After 18 months, the group that received the education avoided manic episodes nearly four times longer than the group that received treatment as usual (an average of 65 weeks against 17 weeks). The number of people that stayed free of mania was also better: only 9 got sick

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compared to 20 from the other group. There was no effect on episodes of depression, but overall social functioning and employment were significantly improved[1].

Family-Focused Therapy

Therapy:

- 21 sessions for patients and their caregivers given in their homes by a therapist. The first seven sessions were basic illness self-management: medication compliance, early identification of warning signs, and strategies for relapse prevention.
- communication enhancement training sessions to teach skills for active listening, giving feedback, and requesting changes in behavior.
- problem-solving training, to help identify family problems and select solutions.

Participants: Of the 101 participants, most had bipolar I and had recently had an episode.

Method: The therapy was compared to a less intensive crisis management strategy consisting of two sessions of family education plus crisis intervention sessions as needed.

Outcome: At the end of the two-year study, three times as many patients in the therapy group stayed well compared to the comparison group (52% compared to 17%). On average, for patients who did get sick, those in the therapy group stayed well longer than the comparison group (74 weeks compared to 54 weeks). Also the therapy group showed reduced mood symptoms, particularly depression, and better medication adherence[2].

Cognitive Therapy

Cognitive therapy focuses on patterns of thinking that lead to undesirable moods and on the beliefs behind these thought patterns. Patients are taught techniques to monitor, examine, and change these thought patterns. It has been shown to be as effective as antidepressants in the treatment of depression and superior in preventing relapse. This study examined an enhanced form of cognitive therapy for bipolar patients.

Therapy: The therapy was extended to add relapse prevention by: monitoring mood, detecting warning signs, and taking action to avoid full-blown episodes from developing. Patients received 16 sessions.

Participants: There were 103 participants who had bipolar I and who experienced frequent relapses despite being on mood stabilizers.

Method: The therapy group was compared to a group that received treatment as usual.

Outcome: Those who received the therapy spent three times fewer days in bipolar episodes than the comparison group (an average of 27 days compared to 88 days). The therapy cut the hospital admission rate in half—15% of patients in the therapy group were admitted to hospital compared to 33% for treatment as usual. The group that received cognitive therapy also exhibited significantly higher social functioning, fewer mood symptoms, and significantly less fluctuation in manic symptoms than the comparison group[3].

Group Education

The above studies investigated education therapies administered in individual sessions. As we all know only too well, individual therapy sessions are expensive and this restricts their availability. The group education study is exciting because group sessions are much more cost-effective and thus more likely to become widely available.

Therapy:

- groups of 8–12 participants with 21 sessions, each lasting 90 minutes.
- each session consisted of a speech on a topic followed by a relevant exercise. The major topics were: illness awareness, medication compliance, early detection of warning signs, and lifestyle regularity.

Participants: There were 100 participants who had bipolar I and 20 who had bipolar II; all had been well for at least six months.

Method: The therapy group was compared to a group that attended unstructured group meetings for the same number of sessions, in the same size groups, with the same therapists. The only difference was that their meetings were not structured and contained no education component. This demonstrated that the improvements observed were due to the education itself and not just the natural support that comes from regular group meetings.

Outcome: After two years, four times as many patients in the therapy group stayed completely well compared to the unstructured group (33% compared to 8%). The therapy group spent three times fewer days in hospital (an average of 5 days compared to 15 days). Also, the length of time before getting sick was significantly longer for the therapy group[4].

And The Verdict…

In the words of one of the researchers: "…the usefulness of psychotherapy [teaching self-management] for improving outcome for bipolar patients is now unquestionable,

[1] A Perry et al, *British Medical Journal*, Jan. 1999.

[2] D J Miklowitz et al, *Archives of General Psychiatry*, Sep. 2003.

[3] D Lam et al, *Archives of General Psychiatry,* Feb. 2003.

[4] F Colom et al, *Archives of General Psychiatry,* Apr. 2003.

especially for patients who have achieved a certain degree of remission from acute symptoms."[5]

In other words, it's a free upgrade, a stay-out-of-hospital card, and scientifically tested. From my own experience, I know the improvement that learning illness self-management brought to my own quality of life. But that is just one anecdotal story. Now science has measured the improvement. After learning illness self-management, three or four times as many patients stayed well, and they spent much less time in hospital, than those on medication alone.

From Good Science to Good Sense

The same scientific method that brought us modern medications has shown that teaching wellness works for those of us who have bipolar disorder. By learning to manage our illness, we can stay well longer and visit the hospital less. There is no longer any question regarding the value of wellness education. The biggest question that remains is when will this education become widely available through the health system. Until it does, several non-profit organizations offer free education programs that are widely available across the country.

In the words of two of the researchers: "Psychoeducation, like every effective psychological intervention, is essentially based on common sense."[6] It is a joy and delight to see common sense making further inroads into the treatment of mental illness.

Peter Newman maintains a website on illness self-management for bipolar disorder at: **www.lucidinterval.org**.

Peer Mentors

Trained therapists are not the only source of illness management education. Several free education programs are widely available from non-profit organizations. In these programs people who are successfully managing their own mental illness teach others.

NAMI (National Alliance on Mental Illness) offers the Peer-to-Peer Recovery Education Course. This consists of nine weekly sessions, of two hours each, led by three trained peer mentors. The core ingredients of illness self-management are present: information about psychiatric illness, medication compliance, coping strategies and a personal relapse prevention plan. The course is designed to motivate as much as educate. You can teach someone what to do but it is much more powerful to motivate them to do it. I certainly found this to be true when I took the course. (**www.nami.org**)

Mary Ellen Copeland offers the Wellness Recovery Action Plan (WRAP). A typical WRAP program is eight sessions, of two hours each, led by two trained peer instructors. WRAP is a method of self-management that aims to decrease symptoms, increase personal responsibility and improve quality of life for people with mental illness. Symptom monitoring and early warning sign detection are an important part of the program. (**www.mentalhealthrecovery.com**)

Both of these free programs combine illness self-management with wellness techniques, a recovery philosophy, and practical assistance. Both programs offer an excellent place to start, and start now.

[5] F Colom, E Vieta, *Bipolar Disorders*. Dec. 2004, p484.

[6] F Colom, E Vieta, *Bipolar Disorders*. Dec. 2004, p483.