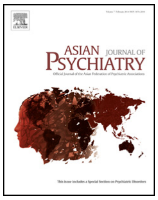
Asian Journal of Psychiatry 15 (2015) 68–72

Contents lists available at ScienceDirect

Asian Journal of Psychiatry

journal homepage: www.elsevier.com/locate/ajp



Illness perception of dropout patients followed up at bipolar outpatient clinic, Turkey

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ARTICLE INFO

Article history:
Received 29 October 2014
Received in revised form 14 February 2015
Accepted 4 April 2015

Keywords:
Illness perception
Dropout
Bipolar disorder

ABSTRACT

Dropout is a common problem in the treatment of psychiatric illnesses including bipolar disorders (BD). The aim of the present study is to investigate illness perceptions of dropout patients with BD. A cross sectional study was done on the participants who attended the Mood Disorder Outpatient Clinic at least 3 times from January 2003 through June 2008, and then failed to attend clinic till to the last one year, 2009, determined as dropout. Thirty-nine dropout patients and 39 attendent patients with BD were recruited for this study. A sociodemographic form and brief illness perception questionnaire were used to capture data. The main reasons of patients with BD for dropout were difficulties of transport (31%), to visit another doctor (26%), giving up drugs (13%) and low education level (59%) is significant for dropout patients. The dropout patients reported that their illness did not critically influence their lives, their treatment had failed to control their illnesses, they had no symptoms, and that their illness did not emotionally affect them. In conclusion, the nonattendance of patients with serious mental illness can result in non-compliance of therapeutic drug regimens, and a recurrence of the appearance symptoms. The perception of illness in dropout patients with BD may be important for understanding and preventing nonattendance.

1. Introduction

Bipolar Disorder (BD) is one of the most common, severe and persistent mental diseases and characterized by chronic conditions with an episodic and recurrent nature. The lifetime prevalence of bipolar disorder is 1–3% (Judd and Akiskal, 2003; Regeer et al., 2004). Effective management of bipolar disorders includes early detection and long-term prophylaxis of bipolar episodes (Swann, 2004). Dropout, defined as termination of treatment by patients against the doctor's recommendation is a common problem in the treatment of chronic illnesses including bipolar disorders (Gaudiano and Miller, 2006; Moon et al., 2012). Dropouts in psychiatric outpatient clinics have been a topic of considerable interest. Moreover, in outpatient clinics of mental health care, 15–46% of patients may inappropriately leave follow-up in the first year of their treatment (Edlund et al., 2002; Killaspy et al., 2000; Lerner and Levinson, 2012; Olfson et al., 2009; Percudani et al., 2002; Rossi et al., 2002; Wells et al., 2013). The insufficient duration of treatment resulting from dropouts can increase the risk of recurrence/relapse, rehospitalization, functional impairment, and suicide (Gaudiano and Miller, 2006; Moon et al., 2012).

The Self-Regulation Model (SRM) developed by Howard Leventhal introduces a causal relationship between illness beliefs and health outcomes (Leventhal and Scherer, 1987). According to this model, illness-related coping responses are strongly determined by a patient's subjective representations of the illness. In SRM, illness perceptions include five main dimensions: (1) causal-beliefs about the cause(s) of the illness; (2) identity-beliefs concerning the illness' label and symptoms; (3) timeline-perceptions about the time course of an illness, characterized along the acute–chronic dimension where individuals may perceive their illness as chronic or acute, or cyclical in nature (where the condition appears under a particular set of circumstances, such as

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http://dx.doi.org/10.1016/j.ajp.2015.04.006
1876-2018/

after stressful life events); (4) cure–control-beliefs about how the condition is treated and effectiveness of available treatment and (5) consequences—the perceived effect(s) of the illness on an individual's life. Together, these beliefs form an illness scheme that determines how a patient copes (e.g., adherence to medical advice, attendance to treatment) (Diefenbach and Leventhal, 1996).

Many studies have investigated patients' beliefs or perceptions regarding their illness using Leventhal's Self-regulatory Model in somatic diseases. Additionally, the SRM has often been used in research within the last decade to explore illness perceptions in mental health. SRM has been used in various researches (Baines and Wittkowski, 2013; Brown et al., 2001). However, the influence of these beliefs on nonattendance in BD patients has not yet been fully understood. The aim of our study is to investigate illness perceptions of dropout patients with BD.

2. Materials and methods

2.1. Study design and participants

Participants were recruited from the Raşit Tahsin Mood Disorder Outpatient Clinic, which is a specialized clinic for the follow-up of patients with bipolar disorders, in Bakırkoy Research and Training Hospital for Psychiatric and Neurological Diseases, the one of the largest mental hospital in Turkey with a capacity of about 1500 hospitalized patients who can be propelled by the whole country.

Although there is no common definition for dropout in literature, it is defined as terminating the treatment or lack of contact with a treatment center for at least one month to one year (Miller et al., 2009; Khazaie et al., 2013). The patients who did not attend the expected apply to hospital for at least 6 months up to initiation of the study were defined as dropout patients. All patients who had attended to Raşit Tahsin Mood Disorder Outpatient Clinic between January 2003 and June 2008 for at least 3 visits were accepted as the patient of the clinic followed up regularly. Of the 748 recorded patients, 160 (21.3%) were dropout. Dropout patients who were aged between 18 and 65 years and who met the Diagnostic and Statistic Manual of Mental Disorders, 4th Edition (DSM-IV) diagnostic criteria for BD were included in the study. Patients with a neurological disease, mental retardation, schizophrenia and other psychotic disorders were excluded from the study. Each patient was called by telephone at least 4 different times by different psychiatrists; however, we were only able to reach 59 dropout patients. Forty-five of them accepted the interview, and 39 of those completed the survey. A total of 39 of attendent patients with BD as the same inclusion and exclusion criterias as dropout patients, matched for age and sex, comprised the control group. All patients in control group were BPI.

All participants gave their verbal or written consent and completed all the measures. The study was approved by the local ethics committee of Bakırkoy Research and Training Hospital for Psychiatric and Neurological Diseases and performed in accordance with the ethical standards laid down in the Helsinki Declaration as revised 1989.

2.2. Assessment tools

A semi-structured form was used that included socio-demographic and clinical characteristics. Clinic data were collected from the patients and their medical records.

The validated brief illness perception questionnaire (IPQ-B) had eight new items as well as a portion of the causal scale previously used in the IPQ-R. There is no Turkish validation of IPQ-B. It was translated into Turkish by three psychiatrists and also retranslated into English by three different psychiatrists. We tested the IPQ-B form on ten patients and confirmed comprehensibility of the form. All items except the causal question were rated using a response scale that ranged from 0 to 10. Each item is evaluated in itself so there is no total score of the questionnaire. Five items assessed cognitive illness representations: consequences (How much does your illness affect your life?); identity (How often do you experience illness symptoms?); timeline (How long do you think your illness will continue?); personal control (How much control do you feel you have over your illness?); and treatment control (How much do you think your treatment can help your illness?). The IPQ-B assesses the emotional representations of illness with items, such as concern (How concerned are you about your illness?) and emotions (How much does your illness emotionally affect you?). Finally, this scale assesses illness understanding with an item on illness "comprehensibility" (How well do you feel you understand your illness?) (Broadbent et al., 2006).

2.3. Statistical analyses

We used the SPSS 20.0 statistical software package (SPSS, Inc., Chicago, USA). All tests were two-tailed with significance level set at p less than 0.05. At ordinal variability, descriptive and frequency measurements were conducted. First, the Kolmogorov–Smirnov normality test was used. Differences between the groups variables were calculated using the Mann–Whitney Test, Pearson's chi-square test, and Fisher's exact test where appropriate.

3. Results

Dropout patients had a mean age of 37.0 ± 8.25years, (range, 24–65); and 51% were female, 44% were married, 59% of the patients had primary school education (Table 1).

The clinical features of the dropout patients: 36 patients were BPI, the others were BPII; the mean duration of dropout period was 2.6 ± 1.46 years; illness periods was 14.3 ± 8.3 years with an interval of 3–40 years; euthymic periods 36.5 ± 35.17 months; time from last episode was 1.43 ± 0.55; and the average hospitalization rate was 3.2 ± 3.4 with an interval of 0–14 (Table 2). Of the 39 dropout patients, 30 patients (76.9%) continued to get their medications, only 18 patients (46.2%) had a psychiatric irregular follow up.

Education time of dropout patients was shorter than controls ($p = 0.042$). Sex and social security of dropout patients and controls

Table 1
Sociodemographic characteristics of subjects.

	Dropout BD	Attended BD	p Value
Age (Mean ± SD)	37.0 ± 8.25	35.2 ± 7.7	0.31
Sex N (%)			
Women	20 (51.3)	20 (51.3)	1.0
Men	19 (48.7)	19 (48.7)	
Education years (mean ± SD)	8.7 ± 4.48	11.05 ± 4.03	0.042*
Marriage status N (%)			
Married	17 (43.6)	18 (46.2)	0.61
Single	15 (38.5)	17 (43.6)	
Widowed/divorced	7 (17.9)	4 (10.3)	
Working condition N (%)			
Employed/student	15 (38.5)	21 (53.8)	0.39
Unemployed	9 (23.1)	7 (17.9)	
Retired/housewife	15 (38.5)	11 (28.2)	
Living status N (%)			
Alone	5 (12.8)	3 (7.7)	0.75
With family	30 (77.0)	32 (82.1)	
With relatives	4 (10.2)	4 (10.2)	

Data are provided as means ± standard deviations.
* $p < 0.05$.