Patient Education and Counseling xxx (2015) xxx–xxx

Contents lists available at ScienceDirect

Patient Education and Counseling

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

Review article

Communication and decision-making in mental health: A systematic review focusing on Bipolar disorder

Alana Fisher[a,b,*], Vijaya Manicavasagar[c,d], Felicity Kiln[a], Ilona Juraskova[a,b,*]

[a] School of Psychology, University of Sydney, NSW 2006, Australia
[b] Centre for Medical Psychology and Evidence-based Decision-making (CeMPED), University of Sydney, NSW 2006, Australia
[c] School of Psychiatry, University of New South Wales, NSW 2031, Australia
[d] Black Dog Institute, University of New South Wales, NSW, 2031, Australia

ARTICLE INFO

Article history:
Received 17 November 2015
Received in revised form 10 February 2016
Accepted 16 February 2016

Keywords:
Bipolar disorder
Treatment
Decision-making
Communication
Patient involvement
Patient outcomes

ABSTRACT

Objectives: To systematically review studies of communication and decision-making in mental health-based samples including BP patients.
Methods: Qualitative systematic review of studies using PsychINFO, MEDLINE, SCOPUS, CINAHL, and EMBASE (January 2000–March 2015). One author assessed study eligibility, verified by two co-authors. Data were independently extracted by two authors, and cross-checked by another co-author. Two independent raters assessed eligible studies using a validated quality appraisal.
Results: Of 519 articles retrieved, 13 studies were included (i.e., 10 quantitative/1 qualitative/1 mixed-methods). All were cross-sectional; twelve were rated good/strong quality (>70%). Four inter-related themes emerged: *patient characteristics* and *patient preferences*,*quality of patient-clinician interactions*, and *influence of SDM/patient-centred approach on patient outcomes*. Overall BP patients, like others, have unmet decision-making needs, and desire greater involvement. Clinician consultation behaviour influenced patient involvement; interpersonal aspects (e.g., empathy, listening well) fostered therapeutic relationships and positive patient outcomes, including: improved treatment adherence, patient satisfaction with care, and reduced suicidal ideation.
Conclusions: This review reveals a paucity of studies reporting bipolar-specific findings. To inform targeted BP interventions, greater elucidation of unmet decision-making needs is needed.
Practice implications: Eliciting patient preferences and developing a collaborative therapeutic alliance may be particularly important in BP, promoting improved patient outcomes.

Contents

* Corresponding author at: Brennan MacCallum (A18), School of Psychology, The University of Sydney, NSW 2006, Australia. Fax: +61 2 9036 5292.
E-mail address: ilona.juraskova@sydney.edu.au (I. Juraskova).

http://dx.doi.org/10.1016/j.pec.2016.02.011
0738-3991/

1. Introduction

Bipolar disorder (BP) is a chronic, relapsing and remitting disorder of mood, thinking, and behaviour characterised by "lows" (depression) and "highs" (hypo/mania). Current diagnostic classifications recognise two subtypes, BPI and BPII; BPII is considered the less severe due its absence of impairment and psychotic features during "highs" [1]. By contrast, empirical evidence suggests comparable overall impairment across subtypes [2].

Pharmacological treatments represent the primary therapy for the acute treatment and long-term prophylactic management of BP [3]. Indeed, pharmacotherapy decisions in BP may be especially challenging, due to an incomplete evidence base [4], and high potential side-effect and quality-of-life burden of options [3,5]. Further, treatment adherence—a well-documented problem among BP patients [6]-depends on the subjective value that BP patients assign to treatment efficacy versus side-effect burden [4].

Given medical uncertainty underlies BP treatment decisions, and the potential link between patient involvement and outcomes, patients should participate in treatment decisions. Patient involvement is particularly important in BP, as patients are responsible for actively self-managing their illness to prevent further relapse and/or recurrence [3,7]. To this end, mental healthcare professionals are increasingly encouraged to practice shared decision-making (SDM) in patient treatment and management. SDM is well-suited to treatment decisions that are sensitive to patient values and preferences, as in BP [8]. Key elements include: providing patients with treatment option information, checking patient understanding of options and involvement preferences, and incorporating both patient and clinician perspectives and preferences into final decisions [9].

A prominently-cited model of SDM by Charles et al. [10,11] recognises three decision-making stages: *information exchange* (providing information about treatment options), *deliberation* (discussing treatment preferences), and *deciding on the treatment to implement* (selecting a specific treatment option from the range of presented options). Each stage may involve the clinician, the patient and/or others (e.g., family or friends). Then, depending on patient's level of involvement, patients may assume a passive, collaborative, or active role resulting in more clinician-led, shared, or more patient-led decision-making, respectively. Although mostly applied model to the acute care context, Charles et al.'s model is also applicable chronic illnesses that require ongoing decision-making and patient self-management, as with BP [12]. Of note, a systematic review highlighted that Charles et al.'s model [10,11] emphasised more SDM elements than other prominently-cited models [13]. Based on this, it provides a comprehensive and integrative model of SDM [13].

Although informative, existing reviews of communication and treatment decision-making in mental health have methodological limitations (e.g., single database, [14]), been limited in scope (e.g., only RCTs, [15]) and have focused almost exclusively on unipolar depression and/or schizophrenia [16,17]. Thus, findings may not generalise to BP. Firstly, BP patients might be expected to differ from others (e.g., schizophrenia) in terms of their preferences and experience of involvement in treatment decision-making [14], given the fluctuating nature of BP symptoms and associated disability together with periods of wellness. Secondly, treatment decision-making in BP may be more complex than in unipolar depression, as treatment addresses two distinct, though sometimes co-occurring sets of symptoms, depression and (hypo) mania [18]. Finally, a collaborative approach to illness management is perhaps of greater importance in BP than in other mood-based disorders (e.g., unipolar depression), given that long-term treatment relies heavily on patient self-management to prevent illness (prophylaxis) rather than the treat of illness symptoms as they occur [19].

To date, no known systematic reviews have focused on studies comprising BP patient samples. To address this gap, this qualitative systematic review aimed to synthesise quantitative and qualitative studies exploring communication and decision-making outcomes in mental health-based samples including BP patients. Where possible, the review aimed to draw preliminary comparisons between patient groups to elucidate any differences (and/or similarities) between BP and other mental health conditions. The review's scope was restricted to cognitively competent adult patients receiving voluntary mental healthcare.

2. Methods

2.1. Search strategy

To minimise the potential for publication bias a comprehensive, systematic approach was employed; electronic searches were conducted using multiple scientific literature databases (PsychINFO, MEDLINE, SCOPUS, CINAHL, EMBASE), manual searches of included article reference lists, and follow-up searches of articles related to published conference abstracts. Search results were limited to English-language articles published January 2000 to end March 2015, to capture the current clinical findings. Quantitative, qualitative, or mixed methodologies were all eligible. For a comprehensive list of search terms see Box 1.

Initially returned articles were independently title-screened by two authors (AF,FK) for irrelevant or review papers, conference abstracts, and duplicates. In cases of ambiguity, abstracts were consulted. All abstracts and full-texts were then independently screened for eligibility by the same two authors (AF,FK) according to specified criteria (Box 2). Additional articles were identified by a manual search of references lists and screened for eligibility according to the same criteria (Box 2). Discrepancies were discussed and resolved. One author assessed final study eligibility (AF), verified by two co-authors (IJ,FK).

2.2. Data extraction

Both inductive and deductive techniques were used for data extraction. Main study aims and findings were recorded by the first author, who then organised studies according to key topics. A

Please cite this article in press as: A. Fisher, et al., Communication and decision-making in mental health: A systematic review focusing on Bipolar disorder, Patient Educ Couns (2016), http://dx.doi.org/10.1016/j.pec.2016.02.011