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Complementary and alternative medicines usage in bipolar patients from Argentina and Colombia: Associations with satisfaction and adherence to treatment

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ABSTRACT

Background: The use of Complementary and Alternative Medicines (CAM) has been reported by around half the patients undergoing medical treatment for chronic conditions. CAM use could be higher in people affected by bipolar disorders (BD). Some questions about CAM use in BD have not been investigated enough. We report here the results of an anonymous survey on CAM-use conducted among BD outpatients of two centers located in Argentina and Colombia. Methods: an anonymous self-survey was administrated to bipolar euthymic outpatients treated at each center. The survey included a self-report measure of adherence to psychiatric treatment and a modified version of CGI to asses satisfaction with the current treatment. Results: 200 patients completed the survey. Although samples differ in socio–economic profile, they do not differ in their reported CAM-usage (more than 40%). CAM-usage did not modify the adherence or satisfaction with the psychiatric treatment reported level. Thirty eight percent of those who were still resorting to CAM failed to inform it to their clinician. CAM-usage was rated as "useful" or "very useful" by 52% of patients. Limits: adherence to current medical treatment and satisfaction with current treatment were investigated by a self-reported instrument. Discussion: the prevalence of CAM usage found is similar to that of other studies. CAM usage seems to be ubiquitous, which takes to posit that a subgroup of patients may be in need of treatment with greater magical–religious components. Half of these patients were reluctant to disclose CAM use. Clinicians may need to consider coexistence between "traditional" treatments and CAM for these patients.

1. Introduction

Complementary and Alternative Medicines (CAM) are a heterogeneous group of practices which include several medical and health care practices and products that are not an integral part of conventional medicine due to insufficient proof of their safety and effectiveness (Barnes and Ernst, 1997. CAM can include from yoga to a folk medicine provider named "*chaman*" or a wide variety of potions. Despite our beliefs, recommendations or hopes, medical doctors would need to admit that we share, at least in one-third of cases, our treatments with these non-medical treatments. The use of CAM has been reported by around half the patients undergoing medical treatment for several chronic conditions, both in developed and in non-developed countries (Eisenberg et al., 1998; Franco and Pecci, 2002; Berenzon and Juárez, 2005; Tindle et al., 2005; Su and Li, 2011).Despite the advances of medicine, the use of CAM is growing. Between 1990 and 2002 usage of CAM among adults in the U.S. increased from 34% to 62% (Pagan and Pauly, 2005). This situation is especially true for psychiatrists. The rates of CAM use could be higher in people affected by psychiatric conditions, specifically depression and anxiety. Eisenberg et al. (2001) found that 41% of people who self-reported severe depression and 43% who reported anxiety had been using CAM in the previous year, a significantly higher rate than the 28% founded in the overall sample. Davidson et al. (1998), using SCID, found that 69% of CAM users met lifetime axis I disorder and 40% for a current axis I diagnosis, most frequently depressive and anxiety disorders. The relationship between CAM use and depressive symptoms may be independent of the illness diagnosis. Depression symptoms correlated positively with recent use of CAM in a sample of women with early stages of breast

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cancer (Burstein et al., 1999).In a study carried out in the general internal medicine program of a university hospital in Buenos Aires, the authors found that 37% of CAM users had been in some time in psychiatric treatment vs. 16% of non CAM users (Franco and Pecci, 2002).

In the last few years a series of works have explored CAM-usage in bipolar patients, including pediatric ones (Bogarapu et al., 2008), finding that close to 40% use these alternative treatments (Kilbourne et al., 2007; Perron et al., 2009; Zeber, 2007).CAM seems used widely among bipolar patients. Contradicting what we might intuitively expect, these studies did not find that the use of CAM was clearly determined by some factor. Perron et al. (2009) did not find a relationship between CAM use and barriers to access conventional treatment among a sample of veterans with bipolar disorders. Although in some studies CAM use was associated with dissatisfaction or complaints with psychiatric treatment (Unützer et al., 2000), new studies have not confirmed this relationship (Kilbourne et al., 2007; Jarman et al., 2010; Perron et al., 2009).

However, some questions about CAM use in bipolar patients remain unexplored. Although CAM can potentially have an impact on treatment compliance (Jarman et al., 2010), it has not been sufficiently investigated. Although some investigations have found ethnic differences in CAM use, little is known about CAM use in bipolar Hispanics who are living and are treated in their own countries (Berenzon and Juárez, 2005; Fang and Schinke, 2007; Kilbourne et al., 2007).

The high rate of CAM-use, its potential interactions with medical treatments and the modifications that it might imply for the patient–doctor relationship, make this an important area of investigation in which an inter-cultural approach could be especially important. We report here the results of an anonymous survey conducted among BD outpatients of two psychiatric centers located in Buenos Aires (Argentina) and Bogota (Colombia) in which we explore the frequency of CAM usage, its associations with social–cultural factors, its relationship with current medical treatment satisfaction and its impact on treatment compliance.

2. Methods

A self-administered survey, tailored for this study, was administrated to the first 100 bipolar euthymic outpatients available at each center to participate in the study. Argentina's sample was collected from the Bipolar Disorder Program of Favaloro University, a private university which assists middle-class patients in Buenos Aires. The Colombian sample was recruited from two general psychiatry practices from the department of psychiatry at Javeriana University, a private university which assists patients from low-medium classes of life in Bogota city.

The inclusion criteria were (a) patients had to be in outpatient treatment in these institutions for a period of not less than 6 months; (b) diagnosis of bipolar disorder type I or II according to DSM-IV by Structured Clinical Interview for DSM-IV (SCID) (First et al., 1996); (c) being euthymic (CGI Mania and CGI Bipolar Depression < 2 points); and (d) age between 18 and 65 years old. Exclusion criteria were (a) substance abuse or dependence within 12 months prior to entry; (b) other co morbid diagnosis for Axis I with exception to General Anxiety Disorder; and (c) presenting an impediment to complete the survey properly without help.

The survey included a list of most prevalent CAMs used in our countries. A self-report measure of adherence to psychiatric treatment (Graphic 1) and a modified version of CGI to self-asses the level of satisfaction with current psychiatric treatment were included (Graphic 2). In previous studies a high percentage of patients informed that they were reluctant to report CAM-usage to their clinicians. Because of that, we have increased the anonymity conditions of the study. Participants were instructed to complete the survey alone, although encouraged to request assistance from the investigator if deemed necessary. After completion, each survey was placed in a ballot box which was

Self-Reported Level of Treatment Compliance

1	Good treatment compliance	Takes regularly the indicated treatment at prescribed dose. Infrequent oversights (i.e. forgets one medicine dose in two weeks period).
2	Partial treatment compliance	Takes regularly the indicated treatment but forgets a dose often (i.e. at least, once a week) and/or changes any medication dose by accident or deliberately.
3	Poor treatment compliance	Takes the prescribed drugs irregularly, does not follow physician indications, frequent oversights some prescription dose.
4	Treatment Non - compliance	Does not follow any prescribed treatment or physician indication.

Graphic 1. Self-reported level of treatment compliance.

Self-reported CGI

Taking into account your personal experience as patient: how much better do you feel with the current treatment you receive at this Hospital?	
1___ far better	5___ slightly worse
2___ much better	6___ much worse
3___ slightly better	7___ far worse

Graphic 2. Self-reported CGI.