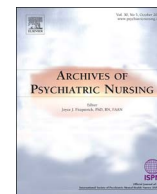




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A Qualitative Study Investigating Bipolar Patients' Expectations of a Lifestyle Intervention: A Self-management Program

Isabelle E. Bauer^{a,*}, Litza A. Kiropoulos^b, Nicholas P. Crist^a, Jane E. Hamilton^a, Jair C. Soares^a, Thomas D. Meyer^a

^a Department of Psychiatry and Behavioral Sciences, McGovern Medical School, University of Texas Health Science Center, Houston, TX, USA

^b Melbourne School of Psychological Sciences, University of Melbourne, Melbourne, Australia

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ABSTRACT

Background: There is some evidence supporting the efficacy of lifestyle interventions in changing unhealthy habits and reduce the risk of developing comorbid conditions in Bipolar Disorder (BD).

Aims: This qualitative study aimed to identify what an optimal lifestyle intervention would look like for individuals with BD.

Methods: The current findings are based on one focus group and two paired interviews including a total of 10 individuals with BD (44.20 ± 11.11 years; 6 females). Groups' transcripts were analyzed using a narrative approach. Primary themes included facilitating factors and barriers, general content, outcomes, format of the intervention, and background factors.

Results: Participants were in favor of a group-based lifestyle intervention as part of their usual treatment. The optimal group format would include 4 to 10 individuals, and comprise of 12 to 18 sessions lasting 1 to 1.5 h each. Accountability, motivation, interaction, and group activities were identified as contributing to the success of a lifestyle intervention.

Conclusions: This qualitative study provides important information regarding aspects of lifestyle intervention format and delivery for individuals with BD. We identified barriers and facilitating factors that should be addressed in health promotion interventions delivered within community mental health settings.

Introduction

Bipolar Disorders (BD) are persistent and recurrent mental illnesses with a 3% to 5% lifetime prevalence (Cerimele, Chwastiak, Dodson, & Katon, 2014; Merikangas et al., 2007). They are considered one of the leading cause of years lost to disability in young adults (Whiteford et al., 2013). The most characteristic manifestations of BD are fluctuations in mood and activity levels, ranging from mild to severe forms of mania and depression, usually interspersed with periods of mood stability and euthymia (Grande, Berk, Birmaher, & Vieta, 2016). Evidence shows that frequent depressive episodes, comorbidity with substance use, and longer prodromal periods predict poor clinical outcomes (Serra et al., 2017). Alongside these clinical manifestations, BD is associated with a high incidence of medical conditions such as overweight/obesity, type 2 diabetes (T2D), cardiovascular disease (CVD), and stroke (Galvez et al., 2014; Prieto et al., 2014; Sharma et al., 2014; Sylvia et al., 2015). These medical conditions have negative effects on

the course of the illness and pose a challenge for health professionals (Bai et al., 2016).

We recently performed a systematic review of the existing literature on health promotion interventions targeting diet and exercise in patients with BD (Bauer et al., 2016). Surprisingly, we found that, to date, only six clinical studies attempted to develop lifestyle interventions individualized to the needs of BD patients and test their long-term efficacy. The first randomized control trial in the field (Gillhoff et al., 2010) found a significant decrease in body mass index (BMI) following an individual 5-month multimodal lifestyle intervention compared with standard care. Another clinical trial highlighted the positive effects of a 24-month intervention involving patient self-management on physical health. This program was called 'Life Goals Collaborative Care' (LGCC) (Kilbourne et al., 2013). LGCC led to reduced systolic and diastolic blood pressure and decreased severity of manic symptoms. Further, the patients' overall health-related quality of life was rated as significantly higher compared to that reported in individuals receiving treatment as

* Corresponding author at: University of Texas HSC at Houston, UT McGovern Medical Center, Center of Excellence on Mood Disorders, Biomedical and Behavioral Sciences Building (BBSB), 1941 East Rd Suite 3118, Houston, TX 77054, USA.

E-mail address: Isabelle.E.Bauer@uth.tmc.edu (I.E. Bauer).

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usual. NEW TX, a 20-week individual lifestyle intervention focusing on Nutrition/weight loss, Exercise, and Wellness treatment (Sylvia et al., 2013) helped participants make healthier food choices (e.g. higher vegetable and lower sugar intake) and increase their physical activity. Participants also reported lower depressive symptoms. These are successful examples of promising individual and group lifestyle interventions for patients with BD.

In spite of national clinical guidelines acknowledging the need for psychosocial support to improve functioning and reduce risk for relapse, these interventions are, however, far from being part of routine clinical services. This situation can be explained by a number of factors. First of all, large-scale efficacy trials testing long-term effects of such programs are missing. It is also still unclear which factors promote sustainable behavior changes that can be maintained after the end of such research studies. Indeed, without knowing the barriers and facilitators to participation in these programs, the development of meaningful, feasible, and effective lifestyle programs runs the risk of failure (Michie et al., 2011; O'Brien et al., 2015). More data on potential barriers and facilitators for participation to support groups and health promotion programs is therefore needed.

A way to address these methodological issues is to involve service users in the development of new programs or the adaptation of existing services. This approach would ensure that services match patients' needs and have appropriate content, structure, and outcomes. An increasing number of qualitative studies in health and social sciences have used principles of grounded theory to evaluate quality of care and community services (Glaser, 2017). Grounded theory is based on the premise that data collection should be driven by ongoing data interpretation rather than a priori hypotheses. As part of this approach, researchers use focus groups, either independently or alongside other methods, e.g. surveys and one-on-one interviews. Focus group interviews provide patients with opportunities to express their views and preferences about their treatments (Gibbs, 2012). They are aimed at providing an intimate and non-judgmental environment for participants to discuss their experiences with people with whom they share an experience, in this case the same diagnosis (Krueger & Casey, 2014; Vaughn, Schumm, & Sinagub, 1996).

The use of focus groups methods in psychiatry is still in its infancy and only a limited number of qualitative studies have examined the effectiveness of health-related interventions (Dumbaugh et al., 2017; White et al., 2017). Further, evidence of the efficacy of “user-centered” compared to “theory-driven” interventions is lacking (De Cocker et al., 2015; Newby et al., 2017). A previous focus group study collecting BD patients' perspectives on mental health services concluded that inadequate services and exclusion of caregivers from clinical decision making exacerbated the economic and social burden associated with the disease (Highet, McNair, Thompson, Davenport, & Hickie, 2004). Another study focusing on BD patients' expectations from web-based self-management interventions (Todd, Jones, & Lobban, 2013) found that they needed programs helping them to cope with their symptoms and providing tips on how to manage their everyday life. To date, no qualitative study has examined the attitudes of patients with BD towards health promotion programs.

The primary goal of the present study was to understand the needs of individuals with BD with regard to lifestyle interventions targeting nutrition and physical activity. To achieve this goal we conducted a qualitative study based on interviews with adults with BD. The ultimate aim of this endeavor is to assist health professionals develop and implement health promotion programs for BD.

Materials and methods

Participants

We had originally planned to conduct a number of focus groups. However, low recruitment and attendance rates resulted in conducting

only one focus group and two paired interviews. We interviewed in total 10 individuals with BD aged 26–61 (44.20 ± 11.11 years, 6 females). The two paired interviews included 2 participants each, and the focus group comprised 8 participants. The sample included three Caucasian, six African-Americans, and one Hispanic individual. Four participants were employed on a full-time basis at the time of testing. Three were single, two were in a long-term relationship, two were married, two widowed, and one divorced.

The study protocol and the questions asked during the interviews (summarized in Supplementary Table 1) were approved by the local Institutional Review board. Informed consent was obtained from all participants. Participants were given all relevant information about the purpose and nature of the study and reimbursed with gift cards for their time and effort.

Recruitment

Participants were recruited through flyers, advertisements, websites commonly used for research recruitment, such as Craigslist, and through clinicians who referred interested patients to adult psychiatry outpatient clinics. Clinicians were instructed to ask patients if they would be interested in participating. If a patient expressed interest and orally consented to be contacted, the clinician could contact a member of the research team, who will contact the patient. Potential participants were screened over the phone to determine if they were eligible to take part in the study (see inclusion/exclusion criteria here below). Eligible participants were invited to a scheduled appointment to sign the consent form and take part in the planned focus group.

Inclusion criteria

- A current or past clinical diagnosis of bipolar I disorder, bipolar II disorder or other bipolar disorder in line with the Diagnostic and Statistical Manual-5 (DSM-5, American Psychiatric Association, 2013), as determined by a clinician, regardless of whether or not the patient was currently on mood stabilizers.
- Age ≥ 18 years.
- Willing and able to give independently written informed consent.

Exclusion criteria

- Evidence of clinical risk of current self-harm (identified by referring clinician or during screening interview).
- Current mood episode.
- Current alcohol or substance use which is severe enough to require medical treatment (e.g. detoxification) either identified by referring clinicians or as revealed via self-report of the patient. We chose to exclude these participants because alcohol and illicit drugs have negative effects on cognitive performance, self-awareness, and global functioning (Carey, Carey, & Simons, 2003). These factors may alter patients' experience of the bipolar illness.
- Insufficient knowledge of English, as determined by the referring clinician or researcher.

Focus group and paired interviews

We initially aimed to complete three focus group interviews including at least 4 participants. Due to low recruitment rates and last-minute “no-shows” we eventually conducted two paired interviews and one focus group. All interviews were led by a main facilitator and co-moderated by a second facilitator. They were structured following Vaughn et al.'s (1996) guidelines, with additional methods and questions as recommended by Krueger and Casey (2002). The facilitator guide was a checklist developed specifically for this study and was based on Vaughn et al.'s work. The facilitators guided the conversation using a loosely structured interview approach. This type of approach

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