Psychoeducational group and bipolar affective disorder: a reflection on the asylum and psychosocial models*

GRUPO DE PSICOEDUCAÇÃO NO TRANSTORNO AFETIVO BIPOLAR: REFLEXÃO SOBRE O MODO ASILAR E O MODO PSICOSSOCIAL

GRUPO DE PSICOEDUCACIÓN EN EL TRANSTORNO AFECTIVO BIPOLAR: REFLEXIÓN SOBRE EL MODELO ASILAR Y EL MODELO PSICOSOCIAL

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ABSTRACT

Bipolar Affective Disorder (BAD), known by its chronicity, complexity and high rates of morbidity and mortality, is one of the main causes of disability in the world. There is growing evidence that its path can be changed by psychotherapy approaches, such as psychoeducation, which improves one's social and occupational behavior and capacity to deal with stressful situations. This study is an experience report about a psychoeducational group for individuals with BAD and their relatives, which consisted on reflecting upon the components of the mental health practice paradigm. Reflecting upon the psychosocial and asylum ways regarding the conceptions of *object* and *mode of work* permitted to locate the group in a psychosocial manner, as knowledge and experience favor the autonomy of the individuals, who have more chances to face the difficulties that occur in their suffering-existence process.

DESCRIPTORS

Bipolar disorder
Therapeutics
Mental health
Psychiatric nursing
Health education

RESUMO

O Transtorno Afetivo Bipolar (TAB), conhecido por sua cronicidade, complexidade e altos índices de morbidade e mortalidade, é uma das principais causas de incapacitação no mundo. Há evidências crescentes de que seu curso pode ser modificado por abordagens psicoterápicas como a psicoeducação, que promove o aumento do funcionamento social e ocupacional, bem como da capacidade de manejarem situações estressantes. Trata-se de um relato de experiência sobre um grupo de psicoeducação para familiares e portadores de TAB, sendo esse pautado pela reflexão dos componentes do paradigma das práticas em saúde mental. A reflexão sobre os modos asilar e psicossocial quanto às concepções de *objeto* e *modo de trabalho*, possibilitou situar o grupo no modo psicossocial, pois o conhecimento e a vivência experimentados favorecem a autonomia dos sujeitos, que têm maiores chances de se posicionarem frente às dificuldades que lhes sobrevêm na sua existência-sofrimento.

DESCRITORES

Transtorno bipolar
Terapêutica
Saúde mental
Enfermagem psiquiátrica
Educação em saúde

RESUMEN

El Transtorno Afectivo Bipolar (TAB), conocido por su cronicidad, complejidad y altos índices de mortalidad y morbilidad, es una de las principales causas de incapacidad en el mundo. Existen evidencias crecientes de que puede modificarse su curso con abordajes psicoterapéuticos, como la psicoeducación, que promueve el aumento del funcionamiento social y ocupacional, así como de la capacidad de manejar situaciones estresantes. Se trata de un relato de experiencia sobre un grupo de psicoeducación para familiares y pacientes de TAB, pautado en la reflexión de los componentes paradigmáticos de las prácticas de salud mental. La reflexión entre los modelos asilares y psicosociales referidas a las concepciones del *objeto* y *modalidad de trabajo* posibilitó situar el grupo en el modelo psicosocial, pues el conocimiento y la vivencia experimentados favorecen la autonomía del sujeto, que tiene mayores chances de posicionarse frente a las dificultades que devienen de su existencia y sufrimiento.

DESCRIPTORES

Trastorno bipolar
Terapéutica
Salud mental
Enfermería psiquiátrica
Educación en salud

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INTRODUCTION

Bipolar affective disorder (BAD) is know for being a chronic and complex illness with high morbidity and mortality rates, characterized by manic or hypomanic episodes alternated with periods or depression and/or euthymia[1].

In the manic phase, patients show an expansive or euphoric mood, and may be irritable or outgoing. Patients also experience a reduced need for sleep, experiencing restlessness, psychomotor agitation, increased energy and libido. Furthermore, in this phase it is common for individuals to experience ideas of greatness, prolixity, pressure to speak, impaired judgment, and increased impulsiveness. Therefore, social conduct becomes inadequate and individuals may become indiscreet, invasive, and there may be an increased use of alcohol and/or other drugs, they may also spend more money and become involved in potentially harmful activities, such as driving too fast, sexual promiscuity and making debts[2].

The hypomanic state is described as attenuated mania; however, with clear changes, which are perceived by others. Hypomania differs from mania in the sense that the individual does not become functionally compromised and it may not include psychotic symptoms[2].

The depressive episode, on the other hand, is mainly marked by mood swings, as well as changes in psychomotricity, cognition and vegetative functions, which are opposed to those that occur in mania. The main symptoms include: depressive mood; incapacity to feel happiness or pleasure; reduced energy; psychomotor agitation; reduced libido, appetite and sleep; impaired concentration; and having negative thoughts, which may lead to ideas of suicide and/or psychotic symptoms[2].

Patients may also experience mixed episodes, in which they show an overlapping of depressive and manic symptoms, with severe irritability, feelings of rage and hate, with facial expressions a behavior that are incompatible with depressive complaints (affective ressonance), with possible expressions of violence and incontrollable self- or hetero-aggressiveness. Besides the mixed states, there may be rapid cycling, which is characterized by a sudden change from one phase to the other[2].

When patients do not show the aforementioned symptoms, they are euthymic, i.e., in remission. Remission, however, should not be considered exclusively as a clinical response – a 50% reduction in the observed symptoms or even an absence of symptoms, rather as the individuals' functional (re)integration to everyday activities. In this sense, the objective of the treatment for BAD is to keep patients in euthymia, promoting their recovery and avoiding relapse, which is significantly important, as its risk is higher in the first 4 to 6 months after the remission of symptoms, thus the failure to continue treatment is among the major issues[1,3].

It is estimated that about 1% of the global population is affected by bipolarity[1,4-5]. Nevertheless, studies on the bipolar spectrum indicate a prevalence between 5% and 8%. In general, the first symptoms appear in adolescence, more specifically between the ages of 18 and 22[1,4]. Therefore, there may be a rupture in the process of maturing, thus causing significant harms to the biopsychosocial ambit, considering that this period marks several preparations for adult life, including choosing a career, achieving autonomy, and having relationships.

Furthermore, a study that investigated the causes of psychiatric admissions in the national public health system network (SUS- Sistema Único de Saúde) in Ribeirão Preto/SP found that Mood Disorders are the second main cause of hospitalizations between 1998 and 2002[6]. The World Health Organization also considers it to be one of the main existing impairments, as there are higher unemployment rates among the affected individuals[2,7]. That fact becomes evident in the reports of patients, who refer suffering a great deal due to impaired occupational capacity and social performance, as well as to the risk of injuries and suicide, loss of credibility and confidence, fear or relapses: in other words, all the consequences that the disorder may have in their lives.

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The treatment for BAD consists of both pharmacological and non-pharmacological strategies. The former comprise mood-stabilizing medications, such as lithium, anticonvulsants, and antipsychotics. These medications aim at controlling the acute phase and prevent new episodes; they have an important role in repairing synaptic plasticity, compensating for a number of structural and functional changes in certain brain areas caused by the relapse[8].

Psychosocial Strategies

Despite the fact that BAD is characterized by strong biological indicators, and pharmacological treatment being mandatory, psychosocial care is required, considering the high rates of non-adherence and relapses when treatments are exclusively biological. It is, therefore, fundamental to associate alternative treatment that aim clinically applying the biopsychosocial model as well as including and valuing the participation of patients and their family members[9].

In fact, there is growing evidence that the course of BAD can be changed by using psychotherapeutic ap-

proaches, which aim at increasing treatment adherence, reducing residual symptoms, identifying prodromal syndromes with the consequent prevention of relapses, reducing admission rates and length of stay, and improving the quality of life of patients and their relatives. Furthermore, psychotherapy also helps improve the social and occupational functioning of patients and their abilities to manage stressful situations[10].

Non-pharmacological approaches include *Psychoeducation*, which was developed in the 1970s as a complementary treatment with the purpose of keeping patients within the community[9]. Therefore, psychoeducation is characterized as one of the psychosocial rehabilitation models[11], which, by definition, comprises the development of a group of programs and services that aim to facilitate the lives of people with severe and persistent mental health problems[12].

Hence, it is observed that the former psychiatric care paradigm, the asylum, is incapable of meeting such requirements, as it is centered in hospitals, mental illness, and drug therapy, disregarding subjects and their psychosocial context[13].

The psychoeducation approach, therefore, meets the goals of the Psychiatric Reform, i.e., the gradual overcoming of interaction in mental institutions by creating services in the community that develop actions towards prevention and psychosocial rehabilitation[14].

The definition for psychoeducation ranges according to the presuppositions and objectives that professionals wish to achieve; the approach of the psychological aspects is what most differs one practical clinic from the other. Hence, there are different methods and techniques, depending on the type of intervention and the theoretical framework that are used[9].

Nonetheless, in general, psychoeducation is considered to be one of the main strategies used to change the negative aspects experienced by BAD patients, and it involves informing patients and their families about the nature and treatment of the disorder, providing theoretical and practical knowledge so they become able to understand and manage the condition better. Furthermore, one objective of this strategy is to help patients improve their insight on the disease, deal with stigmatization, improve treatment adherence, teach them the early prodromal syndromes, promote healthy habits and the regularity in life style and avoiding substance abuse[10,15].

Psychoeducation can be developed individually or as a group by different health care professionals, as long as they are prepared to deal with relationships associated to the theme in question. This can happen because although it is not considered a form of psychotherapy, approaches affective-emotional aspects with the purpose of promoting changes, which requires certain skills from the healthcare professional[9].

It is certain that education about the disease, as well as identifying and managing comorbidities, and encouraging patients and relatives to make positive changes to their life style are important roles to be played by the multidisciplinary team when treating individuals with mood disorders. In fact, the referred roles should be seen as a duty of healthcare professionals towards patients, as being informed about the disease is among the many patient rights[16-17].

My experience as a member of the coordination board of a psychoeducation group for patient and family members confirms the benefits of this type of strategy. Hence, the objective of this study is to report on my experience, with the purpose of contributing to mental health practice in a time of transformations and development of a new paradigm – the psychosocial paradigm.

METHOD

This study is part of a master's dissertation project with the University of São Paulo at Ribeirão Preto College of Nursing Graduate Program (Psychiatric Nursing), which has been analyzed and approved by the Ethics Committee at Faculdade de Medicina de São José do Rio Preto (Review number 7049/2007). This is an experience report, presenting a reflection based on one of the components of the paradigm of mental health care practices[13].

The referred author denominates the current context mental health practices in two basic paradigms: asylum model and psychosocial model. The author's analysis about the contradictions between the two methods is performed under the light of the following parameters: conceptions of the object and mode of work (conception of health-disease-cure and the means and instruments used for their handling); forms of organizing the institutional device (organogram dimension); forms of relationship with the clientele (different ways of mutual interchange); forms of typical effects in therapeutic and ethical terms (political-sociocultural purposes of the practices).

Among these parameters, I chose to consider the conceptions of *object* and *mode of work*, which will be analyzed based on the knowledge and practice disseminated in a Psychoeducation Group for BAD patients and their families.

The Group

The Psychoeducation Group for BAD patients and their relatives is part of a community extension program offered by Faculdade de Medicina de São José do Rio Preto (FAMERP), which has undergraduate courses in Medicine and Nursing.

The referred group has been in existence sine September 2003 and, at first (until November 2005), was part of the Project for Relapse Prevention in Bipolar Mood Disorder, as a partnership with the Grupo de Estudos de Doen-

ças Afetivas (GRUDA) – affective disorders study group – at the São Paulo Clinics Hospital Psychiatry Institute and some mental health services that were in activity in São José do Rio Preto at the time: the Municipal Mental Health Outpatient Clinic; the Dr. Adolfo Bezerra de Menezes Hospital, and the Psychiatry Outpatient Clinic at Hospital de Base.

The group emerged as a strategy to reduce the frequent admissions of individuals with BAD, and to supply the lack of support to those patients and relatives. In general, these individuals had little or no knowledge about the disorder and its treatment, and they also did not know how to avoid relapses and the consequent re-hospitalizations.

After the referred project was ended, the group was maintained at FAMERP due to the interest by the professionals involved, as well as under the request of BAD patients and relatives themselves. At that time, I no longer worked as a nurse at the Psychiatric Hospital in town, but as a professor teaching Psychiatric Nursing and Mental Health in the Nursing Undergraduate Course at FAMERP.

How the Group Works

It is an open group, with monthly meetings and usually counting with an average of thirty participants (patients and relatives together), who are invited by newspaper ads, posters distributed in mental health services in town, as well as in person by the professionals who participate in or collaborate with the group.

A lecture is prepared for each meeting and is delivered by one of the professionals involved, according to the program and his or her expertise (nurse, psychiatrist, psychologist, nutritionist, physical educator, lawyer, among others).

The themes addressed in the lectures are suggested by the participants through a questionnaire, used to evaluate the meetings, which is applied on a yearly basis. In general, themes include the disorder characteristics and its different phases; causal and triggering factors; pharmacological and non-pharmacological treatments; pregnancy; early detection of manic and depressive episodes; alcohol and other drugs; psychological, social and economic impairments; stress management techniques; how to deal with a family member with BAD; strategies to cope with the changes in one's everyday life style and improving quality of life (eating and physical activity); rights of patient and family; among others.

After the lecture, participants volunteer to talk, with the purpose of exchanging experiences and encouragement. In addition to the participants' statements, a strong feature of the meetings is the participation of all those present in terms of expressing their thoughts and/or doubts about the theme. All their questions are answered by the professionals present in the meeting. A snack is offered at the end of each meeting, which provides the opportunity for patients and relatives to become closer to the professionals, thus contributing to strengthen their bond.

Currently, the coordination of the group is composed by three nurses, of which myself and one other work as professors at FAMERP, and the third nurse works at a Psychosocial Care Center for users of alcohol and other substances.

Group coordination involves the following activities: delivering lectures; mediating discussions; clarifying doubts; creating strategies that improve learning, as well as the exchanges between participants and between participants and the professionals involved; putting the time table together, establishing the place, time, and frequency of the meetings, as well as the themes of the lectures, according to the needs and suggestions of participants and welcoming the lecturing professionals, according to the objectives of each meeting; checking it the objectives of the group and participant level of use/satisfaction are being achieved, so as to make any necessary changes.

As facilitators in this process of psychoeducation, we seek to develop an interactional ability that allows for establishing bonds between us and the participants and between participants themselves, so there are constructive exchanges.

***Analysis of the Conceptions of* Object *and* Mode of work *according to the mental health practices paradigm*[13]**

Conceptions of object and mode of work are understood as the conceptions of health-disease-cure and the means and instruments for their handling. In this sense, in the asylum model, drug treatments are preferred, as the emphasis is on the organic determinations of psychiatric disorders in detriment of the individual's subjectivity. This becomes evident in the sense that the individuals are disregarded as participants of the treatment, as according to this conception what really matters is the action of the drug. Therefore, the family and social environments are not taken into consideration, thus excluding the family from treatment practices or assigning them a secondary role in the process.

Work in the asylum model, despite being multiprofessional, is fragmented, similar to the capitalism model of work organization. In the psychiatric hospital –an institution typical to this model – patients are seen by the psychiatrist, who defines the problem (disorder-diagnosis), establishes the treatment (drug therapy), and determines if any action from other specialists is necessary. Hence, there is no teamwork, even less consideration towards patients as a participant of the process. Therefore, in the asylum model, hospitals are the preferred treatment location and wok is centered on medical knowledge, while the other professionals involved – paramedics, non-physicians - are considered secondary.

In the psychosocial model, on the other hand, interventions are focused on subjects as political and biopsy-

chosociocultural beings, thus taking into consideration the pertinence of the individual in a family and social group, which determines that they should be considered agents of the changes being sought.

Furthermore, treatment means aim at the subject's autonomy, so they do not simply suffer the effects from their conflicts, but be recognized as agents involved in that suffering and, as such, as a trigger of changes.

Analyzing the psychoeducation group from this perspective ('object' and 'mode of work'), I realize that it becomes closer to the psychosocial model, as it is focused on the individuals, considering their political and biopsychosocial aspects. In fact, the psychoeducation group is not restricted to the BAD patient; rather, it also addresses their family group, and considers relatives essential participants of the approach instead of simple spectators.

At all moments, we sought the active participation of subjects, making them aware of the role they have in terms of their existence-suffering, as protagonists of changing their life styles, preventing relapses, and in social reinsertion. These meeting are the place where they talk with their peers (patients and relatives) about new possibilities, such as their participation in the Municipal Health Council, and about creating and/or participating in mental health patient associations, among others.

This occurs because the educational process must have a dialogic nature, based on the context of the individuals' lives, their everyday living and experiences, aiming at freeing the individual so he or she can become a social subject capable of intervening in their own life and in the environment, thus winning their autonomy[18].

Through the participants' statements we realized how much the knowledge about BAD can favor their commitment to the treatment, and, thus, how important a role that psychoeducation has in this context. When they understand the dynamics of the disorder, its cyclic and chronic nature, as well as the impairments resulting from the constant relapses, they become aware that they have a mental disorder and must follow the treatment adequately.

We also observed that they become aware of the fact that they can become active participants in the process, and that they would get better quality of life is they adhere to the treatment. In this sense, they mentioned that one of the advantages of rising awareness about the disease and adhering to the treatment is that they would have the chance of living a "normal" life, despite having a disorder, as they would be able to manage their lives instead of being submitted to the highs and lows of the disorder. In this reference, they returned to their regular everyday activities, such as work and home chores, i.e., activities that were deeply compromised for some of them. They also stated the possibility of their needing fewer psychiatric hospitalizations, as now the have learned how to deal with the disease and its consequences better. In addition, they state that their participating in the group improved their self-esteem, made them feel happier and helped them agree, in the best way, with their new life condition.

As for the mode of work, we sought teamwork with the participation of nurses, psychiatrists, nutritionists, physical education teachers, lawyers and other professionals. As opposed to the asylum model, there is no protagonist (psychiatrist), nor is the hospital the typical institution. That is because we work away from the hospital, in the community, where through psychoeducation we seek not only to suppress the symptoms but also to prevent relapses with a view to reducing hospital admissions, and, subsequently, achieve social reinsertion.

Therefore, we sought going beyond the consideration about the disorder (Bipolar Affective Disorder), as we aimed at the unique subjectivity that, at each meeting, is expressed through the conversations, questions and statements of the participants. The focus on the statements is not exclusively on symptoms and relapses, but on the life context of those individuals, their suffering, frustrations, goal they have achieved, losses, dreams, desires, and life plans.

In the asylum paradigm, subjects assume a passive stance, subject to interventions by professionals, i.e., mere deposits of those considered to be healthy and holders of knowledge. In the psychosocial model, on the other hand, it is expected that subjects manage themselves, and that is also what we seek in the psychoeducation group for BAD patients and relatives.

CONCLUSION

Although BAD has strong biological characteristics, and, therefore, pharmacological treatment is essential, it is not enough is used alone due to the complexity of the subject with BAD and his or her biological, social, political, and cultural context. In this sense, an approach that contemplates those dimensions would certainly have more chances of being effective.

Based on that presupposition, the reflection about the asylum model and the psychosocial model in terms of the conceptions of 'object' and 'mode of work' allowed for situating our psychoeducation group for BAD patients and relatives as a strategy of the psychosocial model. That was possible because the knowledge and experience achieved in the meetings favored the subjects' autonomy, who now have stronger chances of coping with the difficulties that may occur in their existence-suffering.

REFERENCES

1. Souza FGM. Tratamento do transtorno bipolar: eutimia. Rev Psiquiatr Clin. 2005;32(1):63-70.

2. Moreno DH, Almeida KM. Quadro clínico dos subtipos do espectro bipolar. In: Moreno R, Moreno DH. Da psicose maníaco-depressiva ao espectro bipolar. São Paulo: Segmento Farma; 2005. p. 141-69.

3. Stuart GW. Respostas emocionais e transtornos de humor. In: Stuart GW, Laraia MT. Enfermagem psiquiátrica: princípios e prática. 6ª ed. Porto Alegre: Artmed; 2001. p. 380-437.

4. Kessler RC, Rubinuw DR, Holmes C, Abelson JM, Zhao S. The epidemiology of DSM-III-R bipolar I disorder in a general population survey. Psychol Med. 1997;27(5):1079-89.

5. Angst J, Gama A, Benazzi F, Aidac V, Eich D, Rossler W. Toward a redefinition of subthereshold bipolarity epidemiology and proposed criteria for bipolar I, minor bipolar disorder and hypomania. J Affect Disord. 2003;73(1-2):133-46.

6. Silva EC. O Sistema de Informações Hospitalares do Sistema Único de Saúde: subsídios para o uso de dados secundários em psiquiatria e saúde mental [dissertação]. Ribeirão Preto: Escola de Enfermagem de Ribeirão Preto, Universidade de São Paulo; 2004.

7. Lima MS, Tassi J, Novo IP, Mari JJ. Epidemiologia do transtorno bipolar. Rev Psiquiatr Clin. 2005;32 Supl 1:15-20.

8. Frey BN, Fonseca MMR, Machado-Vieira R, Soares JC, Kapczinski F. Anormalidades neuropatológicas e neuroquímicas no transtorno afetivo bipolar. Rev Bras Psiquiatr. 2004; 26(3):180-8.

9. Andrade ACF. A abordagem psicoeducacional no tratamento do transtorno afetivo bipolar. Rev Psiquiatr Clin. 1999;26(6):1-8.

10. Knapp P, Isolan L. Abordagens psicoterápicas no transtorno bipolar. Rev Psiquiatr Clin. 2005;32(1):98-104.

11. Guerra AMC. Reabilitação psicossocial no campo da reforma psiquiátrica: uma reflexão sobre o controverso conceito e seus possíveis paradigmas. Rev Latinoam Psicopat Fund. 2004;7(2):83-96.

12. Pitta AMF. O que é reabilitação psicossocial no Brasil, hoje? São Paulo: Hucitec; 1996. Reabilitação psicossocial no Brasil; p. 19-26.

13. Costa-Rosa A. O modo psicossocial: um paradigma das práticas substitutivas ao modo asilar. In: Amarante P, organizador. Ensaios: subjetividade, saúde mental, sociedade. Rio de Janeiro: FIOCRUZ; 2000. p.141-68.

14. Rotelli F, Leonardis O, Mauri D. Desinstitucionalização. São Paulo: Hucitec; 1990. p. 17-21.

15. Miasso AI. "Entre a cruz e a espada": o significado da terapêutica medicamentosa para a pessoa com transtorno afetivo bipolar, em sua perspectiva e na de seu familiar [tese doutorado]. Ribeirão Preto: Escola de Enfermagem de Ribeirão Preto, Universidade de São Paulo; 2006.

16. Machado-Vieira R, Santin A, Soares JC. O papel da equipe multidisciplinar no manejo do paciente bipolar. Rev Bras Psiquiatr. 2004;26 Supl 3:51-3.

17. Colom F, Vieta E. Melhorando o desfecho do transtorno bipolar usando estratégias não farmacológicas: o papel da psicoeducação. Rev Psiquiatr Clin. 2004;26(1):47-50.

18. Ruiz VR, Lima AR, Machado AL. Educação em saúde para portadores de doença mental: relato de experiência. Rev Esc Enferm USP. 2004;38(2):190-6.

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