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EFFICACY OF A NURSE-LED SOLUTION-FOCUSED BRIEF THERAPY (SFBT) IN THE MANAGEMENT OF BIPOLAR DISORDERS, IN SELECTED HOSPITALS, ONDO STATE, NIGERIA

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ABSTRACT: *Bipolar disorder is a common and often disabling major mental illness. It account for a high proportion of idiopathic psychotic illnesses. Antipsychotic, mood-stabilizing and antidepressant drugs are very effective in managing many prominent and distressing symptoms of these illnesses, but as many as one-third of medically treated patients diagnosed with bipolar disorder relapses after hospitalization, this calls for the use of an adjunctive psychosocial treatments like solution focused Brief therapy. This is a pre-test, post-test and control design structure in 2 x 2 factorial paradigm. Subjects were randomly selected and divided into experimental and control groups. The patients were administered with General Behaviour Inventory (GBI) a 73 item questionnaire (Depue et al, 1985). Three Hypotheses were set and tested and analysis was carried out using student "t" test at 0.05 level of significance. The subjects exposed to the brief solution focused therapy performed better than the control. The patient with Dysthymic disorder performed better when exposed to solution focused brief therapy. The patients with Bipolar were found to improve better when exposed to the therapy. The improvement was shown in the differences observed in the means of the statistical analysis. Women exposed to solution-focused therapy improved better than their men counterparts. It was concluded that adjunctive psychological management by psychiatric nurses should be offered simultaneously with the pharmacological management*.

KEYWORDS: Efficacy, SFBT, Management, Bipolar Disorders, Ondo General Behaviour Inventory (GBI)

INTRODUCTION

Background

Bipolar disorder is a common and often disabling major mental illness. It accounts for a high proportion of idiopathic psychotic illness, and together with psychotic disorders, the combined lifetime prevalence may exceed 3% of the general population (Yalom, 1985). Their treatment has been revolutionized by modern pharmacotherapies in the past half-century. However, these treatments have strongly encouraged contemporary psychiatrist to explain these complex disorders biologically and to treat them with maximum apparent cost efficiency (Baldessarini, 2000). According to Townsend (2002) A bipolar disorder is characterized by mood swing from profound depression to extreme euphoria (mania), with the intervening periods of normalcy. Delusions or hallucinations may or may not be a part of the clinical picture and onset of

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symptoms may reflect a seasonal pattern. During a manic episode, the mood is elevated, expensive, irritable. The disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others or to required hospitalization to prevent harm to self or others. A somewhat molder degree of this degree of this clinical symptom picture is called hypomania. Hypomania is not severe enough to cause marked impairment in social or occupational functioning or to require hospitalization, and it does not include psychotic features.

Diagnostic criteria for Manic Episode:- The DSM-IV-TR for mania (APA, 2000) are as follow:-

(A) A distinct period of abnormal and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary).

(B) During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:

- Inflated self esteem or grandiosity.
- Decreased need for sleep (e.g. feels rested after only 3 hours of sleep).
- More talkative than usual or pressure to keep talking.
- Flight of ideas or subjective experience that thoughts are racing.
- Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli).
- Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation.
- Excessive involvement in pleasurable activities that have high potential for painful consequences (e.g., engaging in unrestricted buying sprees, sexual indiscretions, or foolish business investments.

(C) The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

(D) The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication or other treatment) or a general medical condition (e.g. hyperthyroidism)

Dysthymic Disorder: Characteristics of dysthymic disorder are similar to, if somewhat milder than those ascribed to major depressive disorder. Individuals with dysthmic disorder describe their mood as sad or "down in the dumps" (APA, 2000). There is no evidence of Psychotic symptoms. The essential feature is a chronically depressed mood (or) possibly an irritable mood for most of the day, more days than not, for at least 2 years). According to Townsend (2002), dysthymic disorder may be classified as; Early on set or Late on set.

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Bipolar Disorder:- It can be classified as Bipolar I or Bipolar II disorders (DSM – III – R) (APA, 2000).

Bipolar I Disorder – Bipolar I disorder is the diagnosis given to an individual who is experiencing, or has experienced, a full syndrome of manic or mixed systems. The client also may have experienced episodes of depression. This diagnosis is further specified by the current or most recent behavioural episode experienced. For example, the specifier might be single manic episode (to describe individuals having a first episode of mania) or current (or most recent) episode manic, hypomanic, mixed, or depressed (to describe individuals who have had recurrent mood episodes). This diagnosis is synonymous with what was called bipolar disorder in the DSM-III-R (Townsend, 2002).

Bipolar II Disorder – This diagnostic category is characterized by recurrent bunts of major depression with the episode occurrence of hypomania. The individual who is assigned this diagnosis may present with symptoms (or a history) of depression or hypomania. The client has never experienced an episode that meets the full criteria for mania or mixed symptomatology (Townsend, 2002).

Concept of Solution – Focused Brief Therapy - Solution-Focused Brief Therapy is an approach to psychotherapy based on solution building rather than problem-solving (Iveson, 2002). It explores current resources and future hopes rather than present problems and past causes and typically involves only three to five sessions. It has great value as a preliminary and often sufficient intervention and can be used safely as an adjunct to other treatment. It was developed at the Brief Family Therapy center, Milwaukee (de Shazer et al., 1986), it originated in an interest in the inconsistencies to be found in problem behavior. From this came the central notion of "exceptions": however serious, fixed or chronic the problem, there are always exceptions and these exceptions contain the seeds of the client's own solution. The founders of the Milwaukee team, de shazer (1988, 1994) and Berg, (1991); Bery and Miller, (1992), were also interested in determining the goals of therapy so that they and their clients would know when it was time to end. They found the clearer a client was about his or her goals, the more likely it was that they were achieved. Finding ways to elicit and describe future goals has since become a pillar of solution-focused brief therapy. Since its origins in the mid-1980s, solution-focused brief therapy has proved to be an effective intervention across the whole range of problem presentations. Early studies (de shazer,1988; Miller et al; 1996) showed similar outcomes irrespective of presenting problem. In the UK alone, Lethem (1994) has written on her work with women and children, Hawkes et.al. (1998) and Mac. Donald (1994, 1997) on adult mental health, Rhodes and Ajnal (1995) on work in schools, Jacob (2001) on eating disorders, O'connel (1998) on counseling and Shary (2001) on group work: Solution-focused Brief Therapy was found to be useful among all age groups and problems, including behavioural problems at school, child abuse and family breakdown, homelessness, drug use, relationship problems and the more intractable psychiatric problems. With the latter, there is no claim being made that the cure schizophrenia or any other psychiatric condition has been found, but if a woman wich schizophrenia has the wish to get back to work or one with depression wants to enjoy caring for her children then there is a good chance that these goals will be realized and, in many cases, maintained. In brief, it is a simple all-purpose approach with a growing evidence base to its claim to efficacy (Iveson, 2002).

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Psychosocial Treatments in Bipolar Disorder - According to Huxley and Baldessarim (2003), the specific benefits of psychosocial approaches include:

1. Support and encouragement arising from interactions with others having shared experiences.
2. Education of patients and their families to encourage collaboration in treatment.
3. More effective identification and management of adverse effects of medication that tend to limit its acceptance.
4. Increase compliance with recommended medication.
5. Enhanced detection of early signs of impending illness, and improved skills aimed at minimizing stressors contributing to recurrence. Risk; and
6. Improved interpersonal and family relationship affected by the illness, and promotion of higher functional achievements.

Individual or family focused therapy or psychotherapies are often crucial to forming and maintaining the treatment alliances within which compliance issues can be addressed. Psychotherapy also provides the framework for management of ongoing stressors or dysfunctional behavioural patterns that might precipitate or exacerbate the pipolar disorder (Lyness, 1997). Family therapy is indicated if the disorder jeopardizes the patient's marriage or family functioning or if mood disorder is promoted or maintained by the family situation. Family therapy examines the role of the mood-disordered member in the overall psychological well-being of the whole family; it also examines the role of the entire family in the maintenance of the patient's symptoms (Kaplan, Sadock and Grebb, 1994). As with group therapy, the most effective approach appears to be a combination of psychotherapeutic and pharmacotherapeutic treatments. Some studies with bipolar disorder have shown that behavioural family treatment combined with medication substantially reduces relapse rate compared with medication therapy alone (Miklowitz, Goldstein and Nuechterlein, 1988). According to Townsend (2002), self-help groups offer another avenue of support for the depressed or manic patient. These groups usually are peer-led are not meant to substitute for, or compete with, professional therapy. They offer supplementary support that frequently enhances compliance with medical regimen. Although solution focused brief therapy is a treatment in its own right, it has been found to be effective as a complementary treatments to other treatments (George et al., 1999 Iveson, 2002).

Objectives – The study aimed at resolving the following objectives

1. To evaluate the efficacy of a nurse led solution-focused brief therapy in the management of patient with Bipolar disorders.
2. To determine the efficacy of solution focused brief therapy along the gender attributes of patients.
3. To assess the efficacy SFBT on Bipolar patients and patients with Dysthymic disorder.

Hypothesis: The research answered the following null hypotheses.

1. There is no statistical significant difference between the subjects exposed to the solution-focused brief therapy and the subjects in the control group.

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2. There is no statistical significant relationship in the level of improvement of males and females exposed therapeutic management.
3. There is no statistical significant relationship between the pre-test and post test scores of patients dysthymic disorder exposed to SFBT.
4. There is no statistical significant relationship between the pre-test scores and post-test scores of patients exposes SFBT.

METHODOLOGY

Research Design:- Pre-test, post-test and control design structure in the 2 x 2 factorial paradigm was utilized for the study. While the row was made up of the experimental treatment condition, the column consisted of the subject.

Research setting:- The setting were two psychiatric Hospitals in Ondo State Nigeria.

Federal Medical Centre, Owo is one of about 22 Federal Medical Centre in Nigeria. It was established by the Federal Government of Nigeria as a tertiary health care facility. The Hospital is located along the Owo/Benin Express Road with the bed capacity of 321. It has all the units to take care of all the health /Medical challenges. The Psychiatric unit/ward has the bed capacity of 25. The ward is being manned by consultant Psychiatrist, Registers and Resident doctors. The Nursing unit of the institution is headed by a degree Nursing officer. The ward has all the nurses with post basic qualifications in Mental Health Psychiatric Nursing.

The second Hospital is the Ondo State Hospital, Akure. It has the total bed capacity of 213. All ward/unit are present with the Psychiatric unit are registered psychiatric nurses.

Sample and Sampling Technique:- Subjects consisted of 60 patients diagnosed as suffering from the bipolar disorder. The subjects were purposively selected having considered the diagnosis in the hospital case files. The patients were classified as Bipolar or Dysmythic disorders using the research instrument dichotomy. The patient were randomly put into the experimental or control groups. The sixty (60) selected subjects were made up of 30 males and 30 females with an age range of between 30 and 55 years, and a mean age of 42.5 years.

Instrumentation: General Behaviour inventory designed by Depue, Krauses and Arbisi (1989) was adopted for the study. This is a 73 item self-report inventory. Items on the inventory describe clinical symptoms and are rated on a 4 point Likert self-rating scale. They are scored dichotomously (1 or 2 vs 3 or 4). There are 3 subscales: Dysthymia, Hypomania and Biphasic. Scores for latter two scales are adder. Individuals are identified as dysthymic (i.e. depressed most of the time) if they score above the 95^{th} percentile on Dysthymca scale and below 85^{th} percentile on the Hypomania/Biphasic. Combined scale individuals are selected for Himessinial/Biphasic (i.e. vary between depression and hypomania if they score above 95^{th} percentile on both scale).

Psychometric Properties of the Instrument – The instrument General Behaviour Inventory (GBI) has been used extensively in research, including clinical samples, college students, longitudinal, treatment and other studies.

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Reliability – The GBI has exceptionally high internal consistency because it has long scales with a large number of items. The GBI show high reliability whether completed as a self report or as a caregiver report about youth behaviour. Test re-test reliability r = .73 over 15 weeks, internal consistency (cronbach's alpha, split half = .94 both scales (Depue et al 1981).

Validity - In term of construct validity (predictive, concurrent, convergent and discrimination), GBI shows validity with other symptoms scales, longitudinal prediction of development of mood disorders (Klein et al 1989, Merman et al 2013, and Reichart et al. 2005).

Method of Collecting Data: Data were collected through the administration of instrument. The trained professional nurses championed the administration of instrument. Patients were assisted as necessary. Each patient was given the time to reflect on the items before filling the questionnaire. Depending on the level of their insight, the subjects used between 1 and 2 hours to completed the questionnaire. Same were collected the same day. The percentages on the dichomoutous items were carried out by the researchers and the psychiatric nurses that served as researchers' assistants.

METHOD OF DATA ANALYSIS

The Data analysis was carried out using simple percentage in the determination of subjects demographic characteristics while the student "t" test was used to test the null hypotheses at 0.05 level of significance.

Ethical/Consideration: Ethical consideration was taken from the Medical Director and the Psychiatrist consultants of the two hospitals. The written informed consents were gained from the subjects. It was after the gaining of both written and verbal consents that the study instruments were administered.

Treatment Modality:- The Research Treatment was undertaken by researchers and trained psychiatric Nurses. The selected Nurses were given 3 days sensitization training on the use of solution focused Brief Therapy two (2) weeks before the commencement of the treatment. The treatment was for six (6) weeks with one (1) week for the administrations of instruments and distribution of patients into experimental and control groups. In totality, the treatment package took 7 weeks.

The treatment package was 45minutes twice in a week.

Week 1: Administration of instruments and classification of patients into Experimental control groups.

Week 2: Find out what the subjects are hoping to achieve from the meeting or the work together (setting of goals).

Week 3: Find out what small, mundane and everyday details of the subjects life would be like if these hopes or goals were realized.

Week 4: Find out what the subjects are already doing or has done in the past that might contribute to these hopes or goals being realized.

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Week 5: Allow subjects to interact with the researchers and the trained Nurses on how far the goals have been achieved. Asking subjects questions on how well the goals were achieved and deterrent/impediments towards goals attainment. Researchers tried to assist subjects on goals attainment.

Week 6: Find out what might be different if subjects made one very small step towards reading their goals/hopes. Inform them of what would happen in week 7 (i.e. termination of treatment package and the post test).

Week 7: Overview of goals attainment. Administration of post-test and appreciation and disengagement.

RESULTS

Presentation of analysed data in tabular forms

Table 1:- Demographic Attributes of Subjects

Age	**Frequency**	**Percentage**
30 – 34	16	26.7
35 – 39	25	41.7
40 – 44	11	18.3
45 – 49	05	08.3
50 – 54	02	03.3
55 – 59	01	01.7
60 and above	0	0
Total	**60**	**100**

Marital Status	**Frequency**	**Percentage**
Married	43	71.7
Single	06	10.0
Divorce	05	08.3
Widow	03	05.0
Widower	03	05.0
Total	**60**	**100**

Religious Affiliation	**Frequency**	**Percentage**
Islam	17	28.3
Christianity	09	15
Traditional	13	21.7
Others	09	15
Total	**60**	**100**

Level of Education	**Frequency**	**Percentage**
Primary Six Leaving Cert.	13	21.7
Secondary School Cert.	17	28.3
OND/HND	13	21.7
Masters/Doctoral Degree	01	01.7β
No formal Education	01	01.7
Others	0	0
Total	**60**	**100**

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Considering the table 1 above 41.4% (25) of subjects are within the productive age at the age of employment. Majority of respondents 71.7% (43) were married while 35% (21) were Christians while 28.3% (17) were Muslims.

Table 2 – "t" test Comparison of Subjects Improvement On Treatment and Control

Groups	N	X	SD	"t" obs	"t" cotrol	Df	p
Treatment	30	67.6	14.5	5.09	2.00	58	<0.05
Control	30	50.3	16.7				

Table 2 showed the t test comparison of subjects exposed to treatment and those in control. A total of 30 subjects constituted the treatment group and were exposed to solution-focused brief therapy (SFBT) while the remaining 30 formed the control. Subjects exposed to SFBT strategy had a mean score of 67.6 and standard deviation of 14.5 while the subjects who were in control had a mean score of 50.3 and a standard deviation of 16.7. a comparison of the improvement of the two groups using "t" test statistics indicated that the observed t was 5.09 while the critical t was 2.00. this indicated that the subjected to SFBT strategy improved better than those of control.

Table 3 – "t" test comparison of Males and Females Exposed to Treatment on their improvement level

Categories of variables	N	X	SD	"t" obs	"t" crit	Df	p
Male subjects	15	59.07	12.84	3.2	2.04	28	<0.05
Female subjects	15	76	10.80				

With reference to the table 3 above, the comparison of male and female subjects improvement levels based on SFBT. The male subjects had a mean score of 59.07 and a standard deviation of 12.84 while female subjects had a mean score of 76 and standard deviation of 10.80. the table value was 2.048 while the critical value was 3.2. This result showed that female subjects improved better than their male counterparts.

Table 4 – "t" test comparison of subjects pre and post-test scores based on treatment Group (Dysthymia).

Types of variables	N	X	SD	"t" obs	"t" crit	df	p
Pre-test scores	15	45.3	4.3	13.7	2.048	28	xx
Post-test scores	15	79.5	6.7				

xx Significant at 0.05

Table 4 above showed that the mean score of the pre-test was 45.3 with a standard deviation of 4.3 while the mean score and standard deviation of the post-test scores were 79.5 and 6.7 respectively with the table value of 2.048 and critical value of 13.7, this inferred that patients with Dysthymia improves between when exposed to SFBT.

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Table 5 – "t" test comparison of subjects with hypomania/Biphasic pre and post-test scores based on treatment Strategy.

Types of variables	N	X	SD	"t" obs	"t" crit	df	p
Pre-test scores	15	30.4	3.5	8.1	2.48	28	xx
Post-test scores	15	55.5	9.1				

xx Significant at 0.05

The table 5 above showed the mean score and standard deviation of Pre-test were 30.4 and 3.5 respectively while the mean score and standard deviation of the post-test scores were 55.5 and 9.1 respectively, the observed t value was 8.1 while the table value was 2.048. This showed that the patient with hypomania/Bipharic (Bipolar) improved better when exposed to solution-focused Brief Therapy (SFBT).

DISCUSSION

The result of the study showed that subjects exposed to SFBT strategy performed better than the subjects in the control group. This depicted that SFBT. Is an effective strategy that could be used in helping patients with Bipolar and other mood disorders to reduce the Psychological symptoms associated with disorder. This finding was congruent with finding of Berg and Miller (1992) which posited that solution-focused brief therapy has proved to be an effective intervention across the whole range of problem presentations. Hawkes et al. (1998); and MacDonald (1994, 1997), found SFBT a useful therapeutic tool in the management of adult mental health. Equally, Jacob (2001), found the SFBT useful in the management of eating disorder. Iveson (2002), found out a growing evidence of greater efficacy the use of SFBT on any psychiatric condition. O'Connel (1998), revealed the efficacy of SFBT as a counseling tool for patients with mental illnesses, in the same way, Sharp (2001), showed the efficacy of SFBT in the management of behavioural problems at school, chil abuse and family breakdown, homelessness, drug use, relationship problems and the more intractable psychiatric problems. The most revealing observation was that female subjects improved better than the male counterparts when exposed to SFBT, however, non of the literature reviewed inferred this new finding; equally the patients with Dysthymic disorders performed better than the hypomania/Biphasic disorder. It should be noted that all the subjects were still on the psychopharmacologic therapeutic regimen. Therefore it could be said that SFBT was used as an adjunctive method of management.

CONCLUSION: In conclusion, the therapeutic efficacy was not in doubt as the experiment revealed that all the patients/subjects exposed to solution-focused brief therapy (SFBT) improved better than the control. However, it should be noted that all the patients/subjects were still on their drugs, therefore the SFBT could be used as an adjunctive psychosocial method in the management of Bipolar disorders.

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RECOMMENDATION:- The following recommendation are suggested.

- All psychiatric nurses should be made to have a refresher training on the use of SFBT.
- Study should be carried out on the outpatients with relapses.
- Study should be expanded to cover other psychiatric problems.

IMPLICATION FOR PSYCHIATRIC NURSING PRACTICE: Since the study has shown the greater efficacy in the management of Bipolar disorders, it is therefore imperative on all psychiatric Nurses to be tubred on the methods of using SFBT on the patients in order to ameliorate or stop the psychosocial symptoms of patients. Equally, the solution-focused brief therapy should reflect in the curriculum of psychiatric training as an adjunctive therapeutic methods in managing all behavioural problems. The method is not effective.

Conflict of interest:- There was no conflict of interest.

Acknowledgement:- The researchers acknowledged the permission granted by the stakeholders in the two hospitals used for the study.

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