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A STUDY TO ASSESS THE ATTITUDE AND INSIGHT TOWARDS TREATMENT NON-ADHERENCE AMONG PATIENT WITH BIPOLAR AFFECTIVE DISORDER IN MENTAL HEALTH CARE SETTING M.K.C.G.M.C.H., BERHAMPUR

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ABSTRACT

About half of the patients diagnosed with bipolar disorder (BD) become non-adherent during long term treatment, a rate largely similar to other chronic illness and one that has remained unchanged over the years. Non-adherence in BD is a complex phenomenon determined by a multitude of influences. However, there is considerable uncertainty about the key determinants of non-adherence in Bipolar disorder. In the present study survey research design with quantitative approach was adopted to identify the attitude and insight towards treatment non-adherence among 62 patient with Bipolar affective disorder selected by purposive sampling technique at mental health care setting MKCG Medical college and hospital, Berhampur. A structured questionnaire was used to for gathering socio demographic data, Likert scale to assess the attitude of bipolar disorder (BD) patients, grading scale to assess the insight among bipolar disorder patients and rating scale to assess the treatment non-adherence of BD patients. Findings revels a spectrum of attitudes 9.7% of patients exhibit poor attitude, 30.6% having low attitude & 59.7% maintain an average attitude. 12.9% of patients exhibit poor insights,83.9%maintainaverage insight, and a mere 3.2%exhibit good insight and 61.3% of patients, falls under the category of complete denial of illness. Meanwhile, 14.5% of patients exhibit slight awareness of being sick, and another 14.5% attribute their awareness of being sick to external or physical factors. Assessment of attitude towards non-adherence in this population showed average medication adherence.

Keywords: Non-adherence, drug attitude, insight, Bipolar affective disorder.

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INTRODUCTION

Globally, the life-time prevalence of bipolar I disorder (BPAD) is estimated to be 1% Pharmacotherapy is considered the main principle of treating a bipolar disorder patient, but non adherence is the most common limit to gain the optimal effectiveness of medications among bipolar patients and adherence to medication is the key in the management of this type of severe mental illnesses. Nonadherence is defined by World Health Organization (WHO) as "a case in which a person's behavior in taking medication does not correspond with agreed recommendations from a health care provider". Medication non adherence can include: failing to initially or less of a prescription, discontinuing a medication before the course of therapy is complete, taking more or less of a medication than prescribed and taking a dose at the wrong time.

OBJECTIVES OF THE STUDY

- To determine the prevalence of treatment non-adherence among patients with bipolar disorder at mental health care setting M. K. C. G. M. C. H. ,Berhampur.
- To assess the attitude towards treatment non-adherence among bi-polar affective disorder.
- To assess grade of insight among in patients with bipolar disorder.
- To identify the factor that are associated with treatment non-adherence among patient with bipolar affective disorder

RESEARCH METHODOLOGY

Research approach for the study was quantitative approach with survey research design. The final study was conducted in psychiatric department of M.K.C.G medical college and hospital, Ganjam, Berhampur, Odisha. In this study sample was BPAD Patient and the sample size consist of 62 . Purposive sampling technique was used to select the sample. Tools were developed and used for data collection were socio-demographic data, structured questionnaire .

RESULTS

The data are organized & presented in the following sections.

Section: -1: Findings related to demographic data among BPAD patients.

38.7% of patients are aged 18-30 years, 56.5% are 31-45 years, and 4.8% are 46-60 years. Most patients (80.6%) are male, with 19.4% female and no transgender individuals. Regarding religion, 98.4% are Hindu, 1.6% Muslim, and none from Christian or other groups. Educationally, 29% have no formal education, 32.3% have primary education, 37.1% have secondary education, and 1.6% have higher education. In terms of family type, 74.2% belong to nuclear families, 12.9% to joint families, and 12.9% to extended families. Marital status includes 29% married, 59.7% unmarried, 11.3% divorced/separated,

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and none widowed. Employment status shows 19.4% unemployed, 45.2% unskilled workers, 33.9% skilled workers, and 1.6% employed. About 40.3% have a history of substance use, while 59.7% do not, and 30.65% have a history of mental health treatment, while 69.35% do not. Incomes range as follows: 58% earn ₹5001-10,000, 29% earn ₹1001-5000, 11% earn less than ₹1000, and 2% earn more than ₹10,000. While 46.8% access healthcare, 41.9% do not. Cultural beliefs about mental illness show that 19.4% see it as a weakness, 6.5% attribute it to personal fault, 66.1% believe it is treatable, and 8.1% have no beliefs. Primary support for treatment comes from family (62.9%), friends (25.8%), and caregivers (11.3%). Diagnosis duration is 61% for 1-3 years, 37% for less than a year, and 2% for 4-7 years. Only 1.6% are on medication, while 98.4% are not. Insurance coverage includes 62.9% under private insurance, 27.4% under Biju Swasthya Kalyan Yojana, and 9.7% under PMJAY.

Section-1 Association between the attitudes of BPAD patients with selected demographic variables

Table – 1 Association between the attitudes of BPAD patients with selected demographic variables

Sl N0.	Demographic	Variable	ChiSquare	pvalue	Significance
1	Age	12.324	4	0.015	Significant
2	Sex	2.307	2	0.316	Not Significant
3	Religion	.195	2	0.907	Not Significant
4	Educational Status	10.599	6	0.102	Not Significant
5	Types Of Family	6.315	4	0.177	Not Significant
6	Marrital Status	6.479	4	0.166	Not Significant
7	Employment Status	11.923	6	0.064	Not Significant
8	History Of SubstanceAbuse	5.659	2	0.059	Significant
9	History Of Mental Health Treatement	.727	2	0.695	Not Significant
10	Per capita Income (Rupees) Of Family members Per Month	13.413	6	0.037	Significant
11	Acess To Health Care	7.504	2	0.023	Significant
12	Cultural Beliefs About Mental Illness	2.748	6	0.84	Not Significant

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13	Primary Support Person Involve your Treatement	2.752	4	0.6	Not Significant
14	How Long Have You Been Diagnosed With Bpad	7.225	4	0.124	Not Significant
15	Currently Taking Any Other Medication Or Receiving Treatment	6.861	2	0.032	Significant
16	Type Of Health CareCoverage	17.556	4	0.002	Significant

Table–10 Frequency and percentage between the non-adherences of BPAD patients with selected demographic variables

Demographic variables	Poor		Average		Good	
	F	%	F	%	F	%
AGE						
a)18-30yrs	1	4.20%	21	87.50%	2	8.30%
b)31-45yrs	5	14.30%	30	85.70%	0	0.0%
c)46-60yrs	2	66.70%	1	33.30%	0	0.0%
SEX						
a)Male	5	10.00%	43	86.00%	2	4.00%
b)Female	3	25.00%	9	75.00%	0	0.0%
c)Transgender	0	0.0%	0	0.0%	0	0.0%
RELIGION						
a)Hindu	8	13.10%	51	83.60%	2	3.30%
b)Muslim	0	0.0%	1	100.00%	0	0.0%
c)Christian	0	0.0%	0	0.0%	0	0.0%
d)Others	0	0.0%	0	0.0%	0	0.0%
EDUCATIONAL STATUS						
a)No formal education	2	11.10%	16	88.90%	0	0.0%
b)Primary	3	15.00%	17	85.00%	0	0.0%
c)Secondary	2	8.70%	19	82.60%	2	8.70%
d)Higher study &above	1	100.00%	0	0.0%	0	0.0%
TYPESOF FAMILY						
a)Nuclear family	5	10.90%	39	84.80%	2	4.30%
b)Joint family	3	37.50%	5	62.50%	0	0.0%

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c)Extended family	0	0.0%	8	100.00%	0	0.0%
MARITAL STATUS						
a)Married	5	27.80%	13	72.20%	0	0.0%
b)Unmarried	2	5.40%	33	89.20%	2	5.40%
c)Divorced/separated	1	14.30%	6	85.70%	0	0.0%
d)Widow	0	0.0%	0	0.0%	0	0.0%

Table– 4 Association between the non-adherences of BPAD patients with selected demographic variables

Demographic Variable	**Chi- Square**	**DF**	**p- value**	**Significance**
1. AGE	12.324	4	0.015	Significant
2. SEX	2.307	2	0.316	Not Significant
3. RELIGION	.195	2	0.907	Not Significant
4. EDUCATIONALSTATUS	10.599	6	0.102	Not Significant
5. TYPESOF FAMILY	6.315	4	0.177	Not Significant
6. MARRITALSTATUS	6.479	4	0.166	Not Significant
7. EMPLOYMENTSTATUS	11.923	6	0.064	Not Significant
8. HISTORYOFSUBSTANCE ABUSE	5.659	2	0.059	Significant
9. HISTORYOFMENTAL HEALTHTREATEMENT	.727	2	0.695	Not Significant
10.PERCAPITA INCOME (RUPEES)OFFAMILYMEMBERS PER MONTH	13.413	6	0.037	Significant
11.ACESSTOHEALTHCARE	7.504	2	0.023	Significant
12.CULTURALBELIEFSABOUT MENTAL ILLNESS	2.748	6	0.84	Not Significant
13.PRIMARYSUPPORT PERSON INVOLVEDINYOUR TREATEMENT	2.752	4	0.6	Not Significant

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14.HOWLONGHAVEYOUBEEN DIAGNOSEDWITHBPAD	7.225	4	0.124	Not Significant
15.CURRENTLYTAKINGANY OTHER MEDICATION OR RECEIVINGTREATMENT	6.861	2	0.032	Significant
16.TYPEOF HEALTHCARE COVERAGE	17.556	4	0.002	Significant

DISCUSSION

The study was conducted by using a survey design. The samples were selected from the department of psychiatry (ICD, POPD , MKCG, MCH for conducting the study. The sample size was 62 and they were selected by using purposive sampling technique.

The structured questionnaire was used to assess the demographic variables among patients with bipolar disorder at mental health care setting MKCG, Berhampur. The demographic variables were analyzed by using descriptive measures (frequency and percentage) the responses were collected and analyzed by using inferential statistics (pairedt'test), association between the level attitude to wards treatment non-adherence among bipolar affective disorder and selected demographic variables were analyzed by using $\chi 2$test. Discussion on the findings was arranged based on the objectives of the study.

CONCLUSION

The current examination of literature concerning treatment adherence in BD indicates a notable transition towards prioritizing the patient's perspective on non- adherence. Despite this shift, non-adherence remains a pervasive issue within the BD community, suggesting that a mere adoption of a patient-centered approach may not suffice as a complete solution. By delving into non-adherence from the patients' viewpoint, researchers are poised to gain deeper insights into this intricate phenomenon in BD.A patient-centered approach no to lyprompts clinician store fine their grasp of the pivotal aspects of adherence behavior but also encourages them to heighten their sensitivity to patients' requirements and cultivate collaborative, trusting relationships. Thus, while acknowledging the abandonment of the earlier notion that non-adherence so lelyrested on the patient's shoulders ,we can on lyanticipateth at embracing a patient.

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