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Original Article

PREDIÇÃO DA ADESÃO AO TRATAMENTO E QUALIDADE DE VIDA DE PACIENTES COM TRANSTORNO BIPOLAR

PREDICTION OF TREATMENT ADHERENCE AND QUALITY OF LIFE OF PATIENTS WITH BIPOLAR DISORDER

PREDICCIÓN DE LA ADHERENCIA AL TRATAMIENTO Y CALIDAD DE VIDA DE PACIENTES CON TRASTORNO BIPOLAR

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RESUMO
Objetivo: Descrever a predição de adesão ao tratamento e a percepção de qualidade de vida de pacientes com transtorno bipolar. **Métodos:** Estudo transversal realizado com 35 pacientes de um Centro de Atenção Psicossocial III. Foi utilizada uma escala de avaliação da predição da adesão ao tratamento e outra, para avaliar a qualidade de vida dos pacientes, realizou-se análise descritiva dos dados. **Resultados:** Observou-se maior predição de adesão nos aspectos relacionados à aliança terapêutica com os profissionais (91,4%); dificuldade em seguir o tratamento e efeitos adversos da medicação impactaram, negativamente (91,4%). A maioria (77,2%) apresentou média de qualidade de vida regular. A qualidade de vida foi melhor no domínio relações sociais (31,5%) e pior no domínio meio ambiente (25,7%). **Conclusão:** É necessário construir estratégias de cuidado, pela Enfermagem, que minimizem os desconfortos da medicação e que promovam a reabilitação psicossocial, com o intuito de potencializar a adesão e promover a qualidade de vida dos pacientes.
Descritores: Enfermagem; Transtorno Bipolar; Serviços de Saúde Mental; Cooperação e Adesão ao Tratamento; Qualidade de Vida.

ABSTRACT
Objective: To describe the prediction of treatment adherence and quality of life of patients with bipolar disorder. **Methods**: Cross-sectional study with 35 patients from a Psychosocial Care Center III. Scales were used to assess the prediction of treatment adherence and the quality of life of the patients, performing descriptive analysis of data. **Results**: There was a higher prediction of adherence in aspects related to therapeutic alliance with professionals (91.4%), while difficulty in following treatment and adverse effects of medication caused a negative impact (91.4%). Most (77.2%) had an average of regular quality of life. Quality of life was better in the social relations domain (31.5%) and worse in the environment domain (25.7%). **Conclusion**: There is need to build nursing care strategies that minimize medication discomfort and promote psychosocial rehabilitation, in order to enhance adherence and promote patients' quality of life.
Descriptors: Nursing; Bipolar Disorder; Mental Health Services; Treatment Adherence and Compliance; Quality of Life.

RESUMEN
Objetivo: Describir la predicción de la adherencia al tratamiento y la calidad de vida de los pacientes con trastorno bipolar. **Métodos:** Estudio transversal realizado con 35 pacientes de un Centro de Atención Psicosocial III. Se utilizaron escalas para la evaluación de la predicción de la adherencia al tratamiento y otra para evaluar la calidad de vida de los pacientes, se realizó el análisis descriptivo de los datos. **Resultados:** Se observó mayor predicción de adherencia en los aspectos relacionados a la alianza terapéutica con los profesionales (91,4%); dificultad para seguir el tratamiento y efectos adversos de la medicación impactaron negativamente (91,4%). La mayoría (77,2%) presentó promedio de calidad de vida regular. La calidad de vida fue mejor en el dominio de relaciones sociales (31,5%), y peor en el dominio de medio ambiente (25,7%). **Conclusión:** Es necesario desarrollar estrategias de atención de enfermería que minimicen la incomodidad de los medicamentos y promuevan la rehabilitación psicosocial, para mejorar la adherencia y promover la calidad de vida de los pacientes.
Descriptores: Enfermería; Trastorno Bipolar; Servicios de Salud Mental; Cumplimiento y Adherencia al Tratamiento; Calidad de Vida.

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INTRODUCTION

Bipolar disorder is a mental, chronic and recurrent disease, characterized by episodic frames of mood swings that manifest in the form of depression and mania (euphoria - type I) or hypomania (type II), with different degrees of intensity, subsequent or interspersed with periods of remission. It has complex and multifactorial etiology, resulting from the interaction of genetic, psychosocial and environmental factors. It is responsible for economic and social impacts, contributing to the increased use of services and spending in health[1].

Based on its repercussions, this disorder is considered one of the most serious and prevalent psychiatric disorders. Global data indicated that, between 1990 and 2013, the number of prevalent cases increased from 32.7 million to 48.8 million (49.1%). The mean age of onset is 25 years, although it may occur later, after the age of 40 years[2]. It occurs without distinction of race, ethnicity and social class, but with serious distinction in magnitude between genders. In Brazil, the bipolar disorder presents similar epidemiological profile, with a prevalence around 1 to 4% of the population, onset of symptoms before the age of 30 years, being more prevalent in women[3]. The bipolar disorder can increase by up to 20 times the risk of suicide and, depending on the age of onset of symptoms, can also reduce the life expectancy between 11 and 20 years[2].

The main therapeutic measures directed to the bipolar disorder focuses on pharmacological and psychosocial interventions for the control of acute episodes and maintenance of the picture, in the long term. The continuous pharmacological treatment is configured as an essential condition for a better prognosis, resulting in reduced manic symptoms, frequency of acute episodes and mood alternation[4]. In this sense, the current mental health policy advocates that the treatment of cases of severe and persistent mental disorders in Psychosocial Care Centers (CAPS), open community-based services that propose, in parallel, community strategies for social inclusion, and the Psychosocial Care Center type III (CAPS III), beds of embracement and night observation for cases of psychological crisis[5].

Within this context, there emerges the need for treatment adherence as one of the main pillars to improve the patient's symptoms and quality of life. The effectiveness of the treatment is linked to the adherence, understood as the patient's compliance with the clinical recommendations. However, studies on adherence in chronic diseases, including psychiatric disorders, show that patients have difficulties in following the requirements due to clinical, economic, cultural and social factors, which lead to a worsening of the disease[6]. In addition, studies on pharmacological treatment adherence and its clinical results should be analyzed carefully, taking into account the methodological limitations and high dropout rates, hindering the generalization of the results[7].

In Brazil, the treatment adherence of patients with bipolar disorder has been researched, especially in conditions in which they are already inserted in their social and family context, after discharge from the treatment of acute crisis. In general, they are assessed in outpatient mental health services for monitoring and maintenance of treatment[8]. However, there is a scarcity of studies that estimate the prediction of treatment adherence of bipolar disorder, at the time of patient discharge, verified through a literature review, emerging an important gap. The knowledge of the predictive factors of adherence or non-adherence can be set as essential tools for structuring and reorganizing the actions of health services at all levels, in order to contribute to the patient's stability and, consequently, to reducing relapses and hospitalizations[9].

Considering the above, the present study aimed to describe the prediction of treatment adherence and the perception of quality of life of patients with bipolar disorder.

METHODS

This is a cross-sectional study conducted in CAPS III, in a medium-sized city, located in Midwestern Minas Gerais. According to the IBGE, the estimated population for the city in 2019 is 238,230 inhabitants, and the said service meets a population of approximately 300,000 inhabitants, including five neighboring cities, configuring it as reference, in the region, through inter-city agreement. According to the DATASUS, the psychosocial care network of the city consists, in addition to the cited CAPS III, of a CAPS Alcohol and Drugs III (CAPS AD III), a Therapeutic Residential Service (SRT), an Emergency Care Unit (UPA), which provides backup assistance and 36 family health units.

The study population was composed of patients with a diagnosis of bipolar affective disorder admitted between February 2017 and February 2018 at the CAPS III for intensive

treatment, due to the crisis. The sample was obtained through a non-probabilistic convenience sampling of accidental subtype, i.e., there was no established statistical sample calculation, because, in order to evaluate the prediction of adherence to the proposed treatment, it would not be feasible with patients who were hospitalized and in process of discharge[10]. In this way, being a non-predictable number and only known from monitoring the occurrence in a given period.

The inclusion criteria adopted were the patient diagnosed with bipolar affective disorder established by the assistant psychiatrist; age greater than or equal to 18 years; being able to communicate verbally; presenting stabilized picture and discharge from intensive treatment defined by the reference team. The exclusion criterion adopted was the patient that had interrupted or abandoned the treatment.

The data collection occurred throughout the study period, from the communication from the patient discharge to researchers, by the reference technician of the patient's treatment in the CAPS III, and the specific moment was the day of psychiatric discharge from the intensive treatment modality. In the established period, 168 patients were admitted to hospital, and 41 with a diagnosis of bipolar disorder. The final sample consisted of 35 patients who met the inclusion criteria.

The instruments used in the data collection were two scales, one to predict adherence to the proposed treatment for bipolar disorder and another to assess the patient's perception of the own quality of life. Both scales are validated and free-access, free of charge.

The Clinical Scale to Predict Treatment Adherence in Mood Bipolar Disorder (ECPAT-TBH) is an instrument validated in Brazil[11], comprising 21 items that correspond to the most relevant factors in the process of patients' treatment adherence and non-adherence. It allows evaluating the prediction of adherence to the pharmacological therapy and psychosocial proposal, allowing the identification of factors affecting the behavior of the bipolar patient in treatment adherence. Furthermore, it features satisfactory coefficients of validity and precision and a Cronbach's alpha of 0.79.

The World Health Organization Quality of Life Assessment-bref, or WHOQOL-bref, is an instrument composed of 26 closed questions, two of which are of a general nature, which assess the patient's perception of quality of life and satisfaction with the health. The other 24 questions are distributed in four domains (Physical, Psychological, Social Relations and Environment), with each represented in various facets. The score of questions is obtained with a five-point Likert scale (1 to 5). In this study, the patients were grouped into three classes of frequency distribution: Bad (1.0 to 2.9); Regular (3.0 to 3.9); and Good (4.0 to 4.9). At the end of the application of the scale, the score of each field is calculated individually, which allowed assessing the level of quality of life in each context. In this way, the higher the score, the better the quality of life in each domain.

Moreover, through these instruments, data were collected on the day of the patient's discharge. Upon meeting the inclusion criteria, the patient was, thus, invited to participate in the research, and, upon acceptance, there was an individual meeting with one of the researchers, with the presentation of the study proposal and the questions addressed in the instruments to be answered. After clarifying possible doubts, the patient signed the Informed Consent Form (ICF). Then, the scales were applied to evaluate the prediction of treatment adherence and quality of life. The questions of the instruments were read to the patient and their answers recorded by the researcher. The interviewees received explanation that the confidentiality and anonymity of the information would be preserved.

All data obtained in the samplings were tabulated and processed in the Excel program and, after their organization, there was the analysis of consistency. Additionally, the software Statistical Package for the Social Sciences, version 21, was used. Descriptive analyses were conducted, through frequency (absolute and relative) and central tendency (mean) measures.

The data collected complied with the protection and safety established by the Research Ethics Committee (REC) at the Federal University of São João Del-Rei, Midwestern Campus Dona Lindu, in Divinópolis, Minas Gerais. The process followed the terms of Resolution n. 466/2012 of the National Health Council, which regulates researches involving human beings. The study was approved under opinion n. 1.868.647 (CAAE: 60788516.0000.5545).

RESULTS AND DISCUSSION

The sociodemographic and clinical characterization showed a predominance of

female patients (68.6%), age between 41 and 50 years (31.4%), unmarried (62.9%), basic education (57.1%) and retired (57.1%), in treatment for more than 10 years (74.3%) and using more than 4 types of medications/day (82.9%). During data collection, there was the readmission of 12 of the 35 patients evaluated in this study. In this way, there was a new data collection with these patients, considering valid only the last one.

Table 1 shows the prediction of patients' adherence/non-adherence to the proposed treatment at discharge from hospitalization, considering the mean scores obtained for different groups of the adherence prediction scale. The results obtained indicated a general trend of patients adhere to the treatment proposed at discharge (n=27 - 77.1%). The prediction of adherence was higher in Group 5 (91.4%), Psychosocial Treatment and Therapeutic Alliance with Mental Health Professionals and Services, and in Group 3 (88.6%), Acceptance of Bipolar Disorder by the Patient, Family or Caregiver and by the Community. In contrast, the Group 6 (91.4%), Difficulty in Following the Treatment, and Adverse Effects of Medication, was impacted more negatively in the prediction of adherence.

Table 1 - Distribution of the frequency of patients with bipolar disorder (n = 35) regarding the prediction of adherence to the treatment proposed at discharge from hospital. Minas Gerais, 2018.

Groups	Adherence n (%)	Non-adherence n (%)
Group 1 (Behavior and Feeling Before Drug Treatment)	20 (57.1)	15 (42.9)
Group 2 (Contribution of Religion in Coping with Bipolar Disorder)	18 (51.4)	17 (48.6)
Group 3 (Acceptance of Bipolar Disorder by the Patient, Family or Caregiver, and by the Community)	31 (88.6)	4 (11.4)
Group 4 (Maintenance of Social Life and Comorbidities from Substance Use)	21 (60.0)	14 (40.0)
Group 5 (Adherence to Psychosocial Treatment and Therapeutic Alliance with Mental Health Professionals and Services)	32 (91.4)	3 (8.6)
Group 6 (Difficulty in Following Treatment and Adverse Effects of Medication)	3 (8.6)	32 (91.4)
General Prediction	27 (77.1)	8 (22.9)

Source: Research data, 2018.

The patients' quality of life was evaluated, both in its general aspect as by areas, obtaining regular levels, predominantly, for both aspects. The frequency distribution of the patients, according to general levels of classification of quality of life, followed the indicators of the WHOQOL-bref scale, showing that most of the 35 patients studied (77.2%) presented regular quality of life, and the mean values of scores were between 3.0 and 3.9 (Table 2).

Table 2 - Frequency distribution of patients according to the quality of life classification of the WHOQOL-bref scale. Minas Gerais, 2018.

Quality of life (mean score)	Frequency n (%)
Bad (up to 2.9)	6 (17.1)
Regular (3.0 - 3.9)	27 (77.2)
Good (≥ 4.0)	2 (5.7)
Total	35 (100.0)

Source: Research data, 2018.

Table 3 uncovers the distribution of the frequency by areas of patients regarding the quality of life. The Psychological (68.6%) and Physical (65.7%) domains were those that most contributed to the quality of life, followed by the environment domain, with the worst index for the patients' quality of life (25.7%). On the other hand, the social relations domain (37.1%) most contributed to a good quality of life.

Table 3 - Frequency distribution of patients, according to quality of life domains of the WHOQOL-bref scale. Minas Gerais, 2018.

Quality of Life (Domains)	Bad	Regular	Good
	n (%)	n (%)	n (%)
General (self-perception and satisfaction with health)	5 (14.3)	17 (48.6)	11 (31.5)
Physical Domain	7 (20.0)	23 (65.7)	5 (14.3)
Psychological Domain	6 (17.1)	24 (68.6)	5 (14.3)
Social Relations Domain	6 (17.1)	18 (51.4)	13 (37.1)
Environment Domain	9 (25.7)	24 (68.6)	2 (5.7)

Source: Research data, 2018.

In relation to the characterization of the study subjects, the majority was female (68.6%) and unmarried (62.9%). Overall, evidence shows different magnitudes between prevalence rates of bipolar disorder in relation to the types I (more prevalent in men) and II (more prevalent in women), although, in general, the prevalence of bipolar disorder is similar for both genders[2,12]. The presence of a greater number of women in this study can be explained by differences concerning social, psychological, physiological and manifestation aspects of the course of the disease that differ between genders and lead women to a greater demand for treatment. Regarding the marital status of the interviewees, there was higher percentage of individuals without a partner, corroborating data in the literature that describe higher rates of unmarried patients with bipolar disorder, when compared to the general population, possibly due to the limitations caused by the disease, such as sexual impotence (by the use of drugs), mood swings and difficulties to take care of the children[1].

The general trend (n = 27, or 77.1%) of the patients in adhering to the proposed treatment can be attributed to the predictive character of the instrument, which is applied at the time of discharge from the hospital, when the patient is asymptomatic, with stabilized clinical picture, being more willing to maintain the beneficial effects of treatment. Another relevant issue relates, possibly, to the instrument's wider approach of adherence trend, not restricted only to the optics of medication, but also considering psychosocial, relational, religious aspects, equally decisive for accession.

The higher adherence prediction (91.4%) related to psychosocial treatment and the therapeutic alliance with mental health professionals and services and acceptance of bipolar disorder by the patient, family or caregiver and by the community (88.6%) can be related to the fact that acceptance of the disease is built throughout the process of illness and treatment, in view of the need for information and knowledge about these issues worked by the mental health team[13].

The concept of treatment-alliance as a collaborative and affective bond between professionals and patients is considered in psychotherapeutic literature[6,9] as one of the main factors that contribute to treatment adherence[6], and, therefore, understood as the active involvement of patients in decision making and approaches based on their participation and agreement to better treatment adherence[12]. One of the fundamental aspects of this care strategy consists of the patient feeling embraced and recognizing the existence of listening of the team, mainly nursing professionals, who spend most of the time with patients[15].

The family also has an important role in the process of acceptance of treatment by the patient. Studies[10,15] show that attitudes and health beliefs of family members, their knowledge about the disease and treatment have a direct influence on how the patient perceives and deals with his/her mental health problem[14]. This finding may reflect a perception of the patient, stabilized after the improvement of the crisis, of the own ability to better personal and social acceptance. Paradoxically, studies[16,19] reported difficulties of patients and family members to accept the initial diagnosis of bipolar disorder, due to the stigma related to the disease, which hinders the treatment and the maintenance of the clinical picture.

The adverse effects of the medication were pointed out as the major risk factor for non-adherence to treatment by patients (91.4%). This corroborates the results of other studies that reported non-adherence to the treatment of 60% to 90%, due to the reactions from medications[13,17].

The administration of medication is one of the greatest responsibilities of Nursing and other members of the health team involved in patient care. In this way, it is necessary to understand that it is not only a mechanical task to be executed in strict compliance with the prescription. It requires critical thinking and the exercise of professional reasoning, because the large number of side effects and adverse reactions of psychiatric medications, of both oral and intramuscular administration, highlight that the nurse has an important role in the decision of the administration of the medication. Nonetheless, this is not always done by this professional, who sometimes leaves that decision to the team of nursing technicians and assistants[17,19].

Due to such effects and reactions, when choosing that behavior, the nursing team must be attentive to the signs and symptoms that patients present after the same, involving both the constant evaluation of vital signs, regardless of any prior diagnosis of comorbidity, as in the observation of behaviors that the patient may manifest. The medicines are, without doubt, a strong ally in the treatment of patients of the psychiatric clinic. Nevertheless, they should serve as mediators for a better interaction between professionals and patients, facilitating the therapeutic relationship and the adoption of care that seek the rehabilitation and enhancement of the subjectivity of each individual under treatment, providing nursing care directed to the participation of patients in treatment and their autonomy[10].

Thus, the qualified listening must be important part of the practice of Psychiatric Nursing. The nursing staff should enhance the patient's narrative, complaints, suggestions and needs. The listening should leave the place of suspicious speech and move to the place of witness. Before considering any type of care or intervention, the nurse must listen and share with the subject in suffering. The establishment of a therapeutic relationship between nurse and patient thus allows for a nursing care based on the subject, working his/her subjectivity empathetically, in chronic or acute periods. Thus, symptoms such as agitation, insomnia, irritability may be more clearly understood and used as a guide for the nursing care[10,15].

It is important to highlight that caring for a person with mental illness is a task that requires thinking the person with his/her own wills, with possibilities of saying yes, saying no or nothing to the intervention or the nursing care. The nursing, when planning its assistance, needs to consider the participation of the person, object of care, in the preparation, maintenance and assessment of his/her treatment[13,19].

Thus, the difficulty in adhering to treatment due to adverse effects of medication serves as an alert, mainly for the nursing team, which points to the need for a greater participation of these professionals in decision-making processes that involve the drug administration. The side and adverse effects of neuroleptic medications are frequent, making the practice of Psychiatric Nursing essential to establish clinical criteria that indicate the need or not to administer the prescribed medication[9,12].

It is important to emphasize that the effectiveness of psychotropic drugs in an improvement of episodes of depression and mania, as well as in the maintenance of long-term treatment, are consensus in the literature. On the other hand, adverse effects associated with changes in libido, sedation and prostration, affecting patients in their daily activities and causing functional damages[8]. Although this relationship is recognized, studies[16,19] indicate that this problem is more complex and may reflect the opposition between the impact of adverse effects and the acceptance of the discomforts of these effects in exchange for the drug benefit. In this way, the balance between these two influences can be determined by the patient's expectation, and should be considered in the therapeutic approach[16].

In addition, due to the chronicity of the disease, the problems and difficulties reported by the patients meet the difficult task of maintaining an uninterrupted treatment, when they often lack conditions and social and family support to do it. In this sense, the adequate planning and promotion of nursing assistance, for the care and promotion of autonomy of these patients, are essential[12].

Adding to this, stigmas and prejudices are also pointed out as determinant factors for the abandonment of treatment[9,13]. Similarly, the therapy used for the treatment of this disorder is liable to affect the levels of concentration, dissatisfaction with body image and decreased self-esteem of individuals[1].

Regarding the assessment of the quality of life of patients, the study showed that most of the 35 patients studied (77.2%) presented regular quality of life. Other studies also showed that the

quality of life of patients with bipolar disorder is regular or bad[17]. In this way, when addressing the quality of life of patients, one must understand that life is the result of the interaction of complex and multifaceted factors, such as the individual perceptions of each patient, his/her health, environment, social, cultural, financial, biological and spiritual aspects surrounding him/her. Thus, the disease can jeopardize other areas, which, together, result in the patient's quality of life, and these can also lead to the disease or its stability[4,7].

The psychological (68.6%) and physical (65.7%) domains were those that most contributed to the quality of life, followed by the environment domain, with the worst index for the quality of life of patients (25.7%). This fact can be related to the acute phase of bipolar disorder. As a result of the mood oscillation, depressive and/or mania (euphoria) episodes cause a greater loss of mental, behavioral, physical and social functioning in patients, leading to a more general failure, as well as for the implementation of physical tasks, besides the increased weight gain, fatigue and damage in sexuality, such as loss of libido and impotence. Evidence shows that the chronicity of the disease, the limitations developed and the prolonged use of medicinal products are involved in the worst assessment of quality of life, mainly in the physical and psychological aspects[18].

Evidence indicates the Environment domain as the most sensitive to socioeconomic variations, bearing in mind that patients with bipolar disorder have, in general, limitations and difficulties of work and, consequently, access to leisure activities[14]. This finding points to the need for constructing new strategies of social reintegration of patients into the labor market and the promotion of rights and access to culture and leisure.

The medication posology used in the treatment, for a large part of the patients who participated in the study, was complex, with the association of more than four types of medications/day. In this sense, the nursing team should work actively to promote, by means of nursing assistance, the remission of symptoms and the resilience capacity of patients, which are stressed as essential to improve the quality of life, mainly in the physical and psychological aspects[19].

The Social Relations domain (37.1%) most contributed to a good quality of life of patients. This result shows how the social acceptance of the patient affected by bipolar disorder is an important factor for the treatment adherence. Therefore, it is of utmost importance that mental health professionals, including nursing, strongly work the social prejudice, generated by the stigma of psychiatric illness, either through educational campaigns about the disease and its treatment or the promotion of inclusive activity in society of patients with bipolar disorder. So that, in this way, the society can become increasingly aware about the bipolar disorder and increasingly promote social reintegration of these patients decently and respecting their rights.

It is opportune to emphasize that this process should not be limited only to the bipolar disorder, but also to other mental illnesses. Therefore, the interpersonal relationships among patient, family and society are considered as fundamental for the acceptance of the disease and the adherence and promotion of treatment. In order to reduce/prevent the suffering that already exists from the illness and promote mental health[15,17].

It is worth noting that, although the study has presented a high result of treatment adherence at discharge, there was a phenomenon known as revolving door, characterized as a relapsing cycle of hospitalization-discharge-hospitalization[20]. Although not constituting as objective proposed by the study, during the period of data collection, there was the readmission of 12 of the 35 patients evaluated. Thus, the revolving door highlighted the need to optimize the actions, in the healthcare network, improving service flows, building partnerships and promoting the bond between the teams.

Finally, the limitations of this study were related to external validity, considering that the sample was not probabilistic. However, the design chosen responded well to the guiding questions of the study, since the research occurred with patients with difficult access, under treatment in mental health service and stabilized at discharge. In addition, this unit is the only type III, being a reference in the care with the population in Midwestern Minas Gerais.

FINAL THOUGHTS

The prediction of adherence to the proposed treatment, shortly before the discharge from CAPS III, was high, being greater in the p Psychosocial Treatment and the Therapeutic Alliance with Mental Health Professionals and Services. The group Adverse Effects of Medication had the lowest adherence prediction. The quality

of life was regular, increasing in the Social Relations domain and decreasing in the Psychological, Physical and Environment domains. The findings showed the need for building strategies that minimize the impacts of medication and promote the psychosocial rehabilitation of the patient, in order to intensify the adherence and improve the quality of life. Among the contributions for future studies, there stand out: the need to assess the adherence to treatment by the bipolar patient, with samples involving other contexts; the overburden of treatment for family members and professionals, for being a chronic disease requiring dedication and monitoring, being important to assess the mental health of those actors involved in the treatment of bipolar disorder and their relationship with the patient's better or worse treatment adherence and the revolving door phenomenon, relapsing cycle of hospitalization-discharge-hospitalization.

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