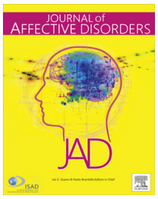
Journal of Affective Disorders 200 (2016) 31–36

Contents lists available at ScienceDirect

Journal of Affective Disorders

journal homepage: www.elsevier.com/locate/jad



Research paper

Brief group psychoeducation for caregivers of individuals with bipolar disorder: A randomized controlled trial

Alison A. Hubbard[a], Peter M. McEvoy[a,b,*], Laura Smith[b], Robert T. Kane[a]

[a] School of Psychology and Speech Pathology, Curtin University, Perth, Australia
[b] Centre for Clinical Interventions, Perth, Australia

ARTICLE INFO

Article history:
Received 23 November 2015
Accepted 11 April 2016
Available online 11 April 2016

Keywords:
Bipolar disorder
Psychoeducation
Self-efficacy
Caregivers
Anxiety
Depression
Stress

ABSTRACT

Background: Bipolar disorder is associated with significant impairment in personal and social functioning for the individual and their caregivers. Psychoeducation for caregivers is beneficial, but interventions have typically required a significant time commitment and have not assessed changes in self-efficacy. This study evaluated the effectiveness of a brief, two-session psychoeducational intervention for caregivers. It was hypothesized that the intervention would reduce caregiver burden and distress, and increase bipolar disorder knowledge and bipolar disorder self-efficacy.

Methods: Participants ($N=32$) were randomized to immediate or waitlist control conditions. The intervention involved two, 150-minute group sessions spaced one-week apart. At pre-, post-, and one-month follow-up participants completed the Depression, Anxiety, Stress Scale (DASS-21), Burden Assessment Scale, Knowledge of Bipolar Disorder Scale, and a Bipolar Disorder Self-efficacy Scale.

Results: Compared to the waitlist control group, the immediate treatment group demonstrated large and significant reductions in caregiver burden, and increases in bipolar disorder knowledge and bipolar disorder self-efficacy. These improvements maintained or increased to follow-up. No significant change was observed on the DASS-21.

Limitations: Reliance on self-report and the sample comprised mostly of parents and partners, so it unclear if results generalize to other carer groups.

Conclusions: Large and enduring improvements in carer burden, knowledge, and bipolar disorder self-efficacy can be achieved from a very brief, two-session intervention.

Bipolar disorder is a chronic and recurrent illness characterized by extreme fluctuations in mood (Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, DSM-5, American Psychiatric Association, APA, 2013). The disorder is associated with significant impairment of personal and social functioning for the individual, as well as their family, friends and carers, referred to here as 'caregivers' (NICE, 2014). The caregiving role can be demanding and distressing, and can impact on the health and quality of life of the caregiver (Struening et al., 2001). Perlick et al. (2005) examined the use of mental health and primary care services by caregivers of individuals with bipolar disorder and found that service utilization rates were considerably higher among caregivers than the general population. Given the significant cost associated with health service utilization there is a clear need for cost-effective and targeted interventions for caregivers.

Over the last 20 years the literature on the treatment of bipolar disorder has grown significantly and has repeatedly acknowledged the importance of involving caregivers. The NICE guidelines (2014) stipulate the importance of providing carer-focussed education and support programs as early as possible. Despite this recommendation, the opportunity to engage in such programs is limited and lacks thorough evaluation.

A randomized controlled trial (RCT) by Reinares et al. (2004) explored the efficacy of a psychoeducational family intervention for caregivers of individuals with bipolar disorder. Relatives of 45 medicated euthymic bipolar outpatients received either 12 psychoeducation sessions about bipolar disorder and coping skills or no treatment. The intervention was associated with a significant increase in participants' knowledge of bipolar disorder, as well as reductions in subjective burden and caregiver beliefs about the link between objective burden and the impact on the patient (Reinares et al., 2004). These preliminary results were promising in regards to the positive impact of caregiver psychoeducation.

A more recent study by Madigan et al. (2012) also found

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[*] Correspondence to: School of Psychology and Speech Pathology, Curtin University, GPO Box U1987, Perth, Western Australia 6845, Australia.
E-mail address: peter.mcevoy@curtin.edu.au (P.M. McEvoy).

http://dx.doi.org/10.1016/j.jad.2016.04.013
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substantial benefits from a psychoeducational intervention for caregivers of individuals with bipolar disorder. The authors conducted an RCT with 47 participants allocated to one of three groups; Multi Family Group Psychoeducation, Solution Focused Group Psychotherapy, or Treatment As Usual (TAU). Participants who attended the psychoeducational groups and solution focused groups reported significant improvements in knowledge of bipolar disorder and significant reductions in burden compared to those receiving TAU. One and two-year follow-ups revealed that gains were maintained for caregivers in the active conditions.

Previous research has not assessed the impact of psychoeducational interventions on caregiver self-efficacy. Bandura (1977) defined self-efficacy as one's perceived sense of mastery, competence and confidence to cope in a given situation. Higher self-efficacy beliefs are associated with increased effort and persistence in the face of obstacles and aversive conditions. Individuals with low self-efficacy believe they are unable to cope with difficult situations, become distressed, and engage in avoidant behaviors (Bandura, 1977). Given the complex nature of bipolar disorder, as well as the burden and impairment associated with caring for someone with the disorder, improving carers' self-efficacy may be beneficial for coping with the carer role. To our knowledge, this is the first intervention study for caregivers of individuals with bipolar disorder that has assessed the impact on carer coping self-efficacy (henceforth referred to as 'bipolar disorder self-efficacy'). Additionally, previous research has applied interventions requiring a significant time commitment from caregivers and facilitators. Reinares et al.'s (2004) intervention involved twelve 90-minute sessions, while Madigan et al.'s (2012) intervention comprised five 120-minute sessions. Brief and effective interventions are likely to facilitate dissemination by increasing the cost-effectiveness and flexibility with which they can be provided by health services with limited resources.

The aim of the current study was to conduct an RCT to evaluate the efficacy of a brief psychoeducational intervention delivered in the community to caregivers of individuals with bipolar disorder. The first hypothesis was that participants would report significantly larger reductions in emotional symptoms (depression, anxiety, and stress) and caregiver burden compared to waitlist controls. The second hypothesis was that participants would report greater improvements in knowledge of bipolar disorder and bipolar disorder self-efficacy, compared to controls. The third hypothesis was that outcomes would maintain to one-month follow-up.

1. Method

1.1. Participants

Participants were recruited through advertisements on radio ($n=5$), at local support and mental health services ($n=11$), and in university broadcast emails ($n=16$). Inclusion criteria were (a) age ≥ 18 years, (b) an ability to speak and read English fluently, and (c) being a caregiver of someone with a diagnosed bipolar disorder, defined as a friend, family member or partner. Exclusion criteria were (a) current engagement in therapy related to supporting the person with bipolar disorder and (b) a caregiver diagnosis of bipolar disorder.

1.2. Measures

1.2.1. Depression, anxiety, stress scale (DASS-21; Lovibond and Lovibond, 1995)

The DASS-21 is a 21-item measure that assesses depression, anxiety, and stress symptoms in adults (e.g., "*I felt down-hearted and blue,*" "*I felt close to panic,*" "*I found it hard to wind down*"). The DASS-21 is widely used and is regarded as having high clinical and research utility (Nezu et al., 2000). Internal consistency in our sample was high ($\alpha=.95$). Individuals are asked to rate items on a scale from 0 (did not apply to me at all over the past week) to 3 (applied to me very much or most of the time over the past week).

1.2.2. Burden assessment scale (BAS; Reinhard et al., 1994)

The BAS is a 19-item measure that assesses the objective and subjective consequences of providing on-going care to the seriously mentally ill (e.g., "*Because of ___'s illness, to what extent have you had financial problems*"). Internal consistency for the current sample was high ($\alpha=.92$). Individuals are asked to rate to what extent they have experienced problems over the last month on a scale from 1 (not at all) to 4 (a lot).

1.2.3. Knowledge of bipolar disorder scale

For the purpose of this study, an 8-item measure was developed to track changes in participant's knowledge of bipolar disorder. Items were developed based on topics related to the symptoms, management, and treatment of bipolar disorder (e.g., "*To what extent do you believe you have sufficient knowledge of the symptoms of mania; Symptoms of depression; Diagnostic criteria for bipolar 1; Medication treatments for bipolar disorder*"). Participants are asked to rate their knowledge on a Likert scale ranging from 1 (no knowledge) to 5 (very informed). Internal consistency for the current sample was high ($\alpha=.94$).

1.2.4. Bipolar disorder self-efficacy scale

An 11-item measure was developed for this study to track changes in participant's confidence in a range of activities related to their caregiving role (e.g., "*At present, how confident are you in performing each of the following activities; Identifying early warning signs of mania; Taking action in response to early warning signs of depression; Identifying the types of stressful events that might trigger a hypomanic or manic episode; Communicating with (___) about their illness*"). Items for the scale were adapted from the Centre for Clinical Interventions, Managing Bipolar Disorder Scale (Smith et al., in prep). Participants were asked to rate their confidence on a Likert scale ranging from 0 (I can not do this activity at all) to 10 (I am certain I can do this activity). Internal consistency for the current sample was high ($\alpha=.94$).

1.3. Procedure

The study was approved by the Health Service's (#01_2015) and University's (HR43/2015) Human Research Ethics Committees, and it was preregistered on the Australian and New Zealand Clinical Trial Registry (www.anzctr.org.au, ACTRN12615000184572). Individuals who expressed an interest were screened for eligibility via telephone (see Participants section). Demographic information was also collected at this point (name, date of birth, gender, and relationship to the individual with bipolar disorder) and individuals were asked to rate the current severity of their loved one's illness on a scale from 0 (no problems) to 5 (severe problems). Eligible participants were then randomized to immediate intervention or a waitlist by a researcher blind to participant identity using a computerized random-number generator (www.random.org). Assessments occurred at pre-treatment, post-treatment and one-month follow-up. Participants in the immediate treatment condition completed the outcome measures at three time points: Time 1 (one week before the first session), Time 2 (immediately after the second session) and Time 3 (one month after the second session). After Time 1 participants attended two 150-minute psychoeducation sessions one-week apart. Waitlist control participants completed the outcome measures at four time points: Time 1 (at allocation to waitlist), Time 2 (two weeks after Time 1), and Time 3 (one month after Time 2). After the control period participants attended the two 150-minute