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Research report

Is structured group psychoeducation for bipolar patients effective in ordinary mental health services? A controlled trial in Italy

Valentina Candini [a,*], Chiara Buizza [a,d], Clarissa Ferrari [a], Maria Teresa Caldera [b], Roberta Ermentini [c], Alberto Ghilardi [d], Gianluigi Nobili [b], Rosaria Pioli [a], Margherita Sabaudo [c], Emilio Sacchetti [c], Francesco Maria Saviotti [b], Giuseppe Seggioli [b], Amneris Zanini [b], Giovanni de Girolamo [a]

[a] IRCCS "St. John of God" Fatebenefratelli—Brescia, Via Pilastroni 4, Brescia 25125, Italy
[b] Department of Mental Health, A.O Desenzano sul Garda, Italy
[c] Department of Mental Health, A.O Brescia, Italy
[d] Department of Clinic and Experimental Sciences, University of Brescia, Brescia, Italy

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ABSTRACT

Background: Recent reviews of evidence-based guidelines for the clinical management of Bipolar Disorders (BD) have recommended that "all patients with BD be offered group or individual psychoeducation" to prevent relapse, improve treatment adherence, quality of life, and functioning. The present study evaluated the effectiveness of psychoeducation in routine mental health services in reducing number of hospitalisations and number of days spent in hospital, at a 1-year follow-up.
Methods: A total of 102 outpatients were recruited from two Italian Departments of Mental Health. Inclusion criteria were a lifetime BD type I or II diagnosis, assessed with SCID, and ≥3 months of euthymia. Exclusion criteria were DSM-IV Axis I comorbidity, mental retardation (IQ < 70), organic brain damage, or deafness. All participants received standard psychiatric care, including standard pharmacological treatment; the experimental group also received 21 group psychoeducation sessions, weekly held and conducted according to Colom and Vieta's model.
Results: The number of patients hospitalised during the 1-year follow-up, the mean number of hospitalisations per patient, and the mean number of hospitalisation days were significantly lower for psychoeducated patients.
Conclusion: Our findings support the view that group psychoeducation is an effective way to prevent hospitalisation and decrease hospital days in pharmacologically treated patients with bipolar disorder also in routine clinical settings. The results confirm that psychoeducation promotes improvement in illness course by preventing acute phases and enhancing mood stability, and consequently, improvement in the quality of life for people with BD.

1. Introduction

Bipolar disorder (BD) is a severe, chronic, and recurrent disorder, which ranks sixth in Global Burden of Disease classification and produces a high degree of economic burden worldwide. BD represents a critical public health problem, due to its lifetime prevalence (approaching 1–2% for BD I, and at least 2% for type II) and related high degree of comorbidity, chronicity, and disability. The illness also presents considerable treatment challenges. Those affected by it must usually continue treatment throughout their lifetimes.

Although medications are considered the mainstay of BD treatment, used alone they do not ensure a favourable course or outcome, mostly due to high drop-out and discontinuation rates (Baldessarini and Tondo, 1998; Colom et al., 2000; Berk et al., 2010). Indeed, both the National Institute for Health and Clinical Excellence (NICE) and the British Association of Psychopharmacology (National Collaborating Centre for Mental Health (NCCMH), 2006, 2009; Goodwin, 2009) recommend long-term psychological intervention in association with drug treatment for patients with bipolar illness. As a result several large-scale research efforts have been conducted to this end. Nonetheless, evidence supporting the effectiveness of psychosocial interventions for BDs in routine clinical practice remains limited (Miklowitz and Scott, 2009), and no pragmatic trial has shown the effectiveness of the method in routine settings.

Among the various psychosocial forms of intervention tested in controlled studies, structured psychoeducation showed high efficacy in a rigorously conducted trial (Colom et al., 2003, 2009), with effects lasting up to five years. Moreover, recent reviews of evidence-based guidelines for the clinical management of BD state that "all patients with BD should be offered group or individual

* Corresponding author. Tel.: +39 30 3501333.
E-mail address: vcandini@fatebenefratelli.it (V. Candini).

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psychoeducation" to prevent relapse and to improve treatment adherence, quality of life, and functioning (Connolly and Thase, 2011; Podawiltz, 2012). Psychoeducation, which can help patients avoid risk behaviours and recognise the early warning signs of relapse, is an effective and necessary adjunct to medication management (Miklowitz et al., 2007a, 2007b; Scott et al., 2007).

Although Colom et al.'s (2009) RCT have achieved invaluable results, their findings have never been fully replicated. This situation poses legitimate questions as to their generalizability to routine clinical settings. To our knowledge, only one pragmatic randomised controlled trial, based on the Barcelona Psychoeducation Program, is currently in progress to determine whether curriculum-based group psychoeducation is more clinically- and cost effective than unstructured peer group support (Morris et al., 2011).

A number of studies have used modified and briefer versions of the Barcelona Psychoeducation Program (Cakir et al., 2009; Maczka et al., 2010; de Barros Pellegrinelli et al., 2012). However these studies have yielded controversial findings, with some trials showing that psychoeducation reduces bipolar relapse rates, as compared to treatment as usual, and others showing that psychoeducation is ineffective for mood episode prevention or improved functioning. Thus, given the relatively thin evidence on the effectiveness of structured psychoeducation, further research is warranted.

The present study evaluated the effectiveness of psychoeducation in routine mental health services and assessed its effectiveness in reducing the number of hospitalisations and the number of days spent in hospital, at a 1-year follow up.

2. Method

2.1. Study design

All patients included in this controlled study were receiving standard psychiatric care at two Italian Departments of Mental Health (DMHs) located either directly in or near Brescia, Italy. Standard care consisted of one monthly visit (sometimes more than one) with the treating psychiatrist and pharmacological treatment specific to bipolar disorder (all patients included in this trial were taking medications for bipolar disorder). Standard care was provided to all patients, but experimental group patients also received additional psychoeducation.

Colom and Vieta (2006) model was used to conduct psychoeducation consisting of 21 weekly 90-min sessions, each aiming at improving four main patient life areas: (i) illness awareness; (ii) treatment adherence; (iii) early detection of prodromal symptoms and recurrences; and (iv) lifestyle regularity.

The need for participants to attend all sessions was underscored, and participants missing more than five sessions were excluded, so as to avoid the potential for insufficient treatment 'dose' in cases producing nil results. The psychoeducation programme was conducted in groups consisting of 8–12 patients by two clinical psychologists who had attended a targeted 5-day training psychoeducation course held in Brescia by one of the method's authors (Francesc Colom). Afterwards these two group therapists had spent a month training at the Barcelona Bipolar Disorder programme, in Spain. As such they strictly adhered to the procedures spelled out in Colom's manual on psychoeducation for bipolar patients (Colom and Vieta, 2006).

2.2. Participants

All clinicians working in the DMHs were informed that they could refer bipolar patients to the psychoeducation group to be conducted at each Centre. As such 127 outpatients fulfilling DSM-IV criteria for bipolar disorder type I or II, aged 18–65 years, were then initially considered for possible inclusion in the psychoeducation groups (see Fig. 1). All referred patients had to meet the following inclusion criteria: lifetime diagnosis of bipolar disorder type I or II as assessed by the Structured Clinical Interview for the Diagnosis of DSM-IV Disorders (SCID-I); presence of euthymia for at least 3 months; sufficient information available on prior illness course collected in a retrospective ≥18 month follow-up; and written consent to participate in psychoeducation. Exclusion criteria were DSM-IV Axis I comorbidity, mental retardation (IQ < 70), organic

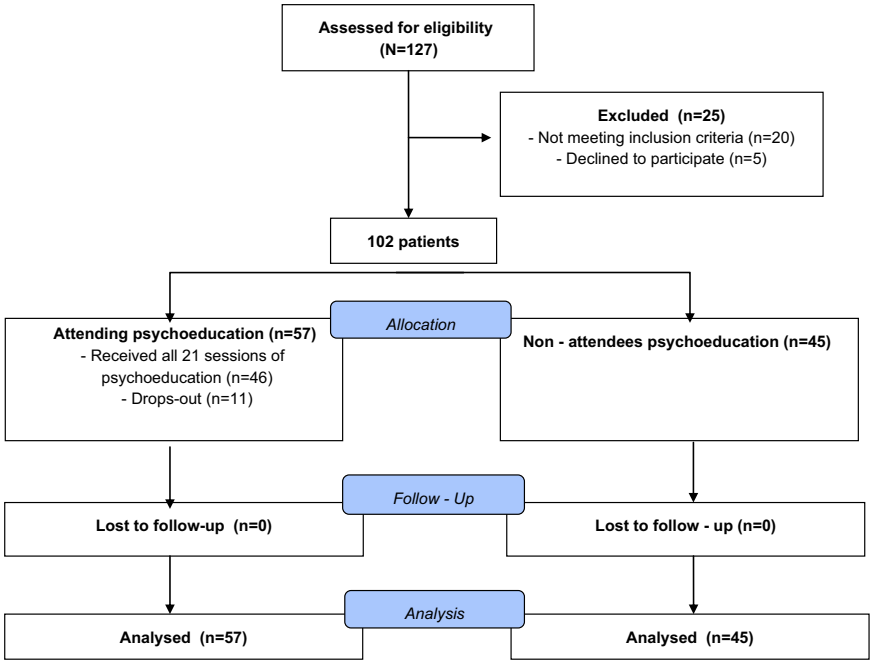

Fig. 1. Sampling procedure flow chart.