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Psychoeducation for major depressive disorders: A randomised controlled trial

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ABSTRACT

Various psychological therapies have been shown to be effective for the treatment of mood disorders. Among them, family psychoeducation has demonstrated efficacy in reducing symptom severity and extending the time to relapse. We tested the efficacy of adding psychoeducation focussed on how to deal with the family's expressed emotion to treatment as usual (TAU) to prevent relapse among patients with remitted major depression. A total of 34 patients with major depressive disorders in full or partial remission were randomised to receive either group psychoeducation over six sessions, each consisting of a didactic lecture and group problem-solving ($n=19$), plus TAU or TAU alone ($n=15$). The primary outcome was relapse by *Diagnostic and Statistical Manual of Mental Disorders* fourth edition (DSM-IV) criteria. Masked raters administered the Hamilton Rating Scale for Depression-17 (HRSD-17). As many as 18 patients in the intervention group and 14 patients in the control group completed the study. Time to relapse was significantly longer in the intervention group than in the control group, with a risk ratio (RR) of relapse by 9 months of 0.12. At 9 months, there was a significantly greater decrease in the HRSD-17 score in the intervention group than in the control group. We demonstrated the effectiveness of patient psychoeducation on the course and outcome of major depressive disorders.

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1. Introduction

Psychoeducation has demonstrated effectiveness for patients with depression as a first step in the treatment protocol in the NICE guidelines ([National Institute for Health and Clinical Excellence, 2009](#)), especially when used together with medication. Psychoeducational approaches to patients with schizophrenia and their families have developed partly based on studies of expressed emotion (EE) in the family ([Brown et al., 1972](#); [Vaughn and Leff, 1976](#)). High-EE status in the family has been shown to be a risk factor for relapses of schizophrenia ([Bebbington and Kuipers, 1994](#)). Since 1982, studies on family intervention using EE as a target have shown the effects of psychoeducational family intervention for preventing relapses ([Falloon et al., 1982](#); [Tarrrier et al., 1988](#); [Shimodera et al., 2000](#)). There have been a variety of psychological therapies demonstrated to be effective for the treatment of mood disorders ([Hollon and Ponniah, 2010](#)). Among

them, psychoeducation is widely accepted as it fits very well with the medical model of illness by being a clinically focussed, commonsense-based intervention ([Colom, 2011](#)). Moreover, it is relatively simple and can be administered by therapists of various disciplines without extensive training.

Most of the research on psychoeducation for patients with mood disorders has been conducted with bipolar disorders. Colom and his colleagues (2003) investigated the effects of group psychoeducation for those with bipolar I and II disorders on the course of the disorders and showed that group psychoeducation significantly reduced the number of relapsed patients and the number of recurrences per patient. Colom and his colleagues (2009) also explored the efficacy of group psychoeducation for those with bipolar II disorders only and showed that psychoeducation plus medication significantly decreased the number of episodes and days spent in mood episodes and increased levels of functioning. Research has demonstrated the effects of family psychoeducation on the course of bipolar disorders. Compared to the control group, the family psychoeducation group showed less experience of any mood recurrence and longer relapse-free intervals ([Miklowitz et al., 2003](#)). Psychoeducation for patient-companion dyads has also been

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applied and has shown its effects on the course of bipolar disorders by reducing the number of relapses and the time to relapse (D'Souza et al., 2010). In the case of major depressive disorder (MDD), interpersonal therapy, cognitive behavioural therapy and behavioural therapy have vast empirical support through many randomised controlled trials demonstrating their efficacy (APA, 2004). The mainstream psychoeducational intervention for patients with depression is the 'Coping with Depression' (CWD) course, which is a cognitive behavioural intervention that treats and prevents depression in many target populations by providing them with instructions on how to cope with their psychological symptoms themselves (Lewinsohn (1975); Cuijpers et al., 2009). However, most of the studies using CWD are on complex target groups because of its flexibility, leading to low mean effect sizes (Cuijpers et al., 2009). The intervention itself is complex and requires eight to 16 sessions. Still, group psychoeducation for MDD can be effective (Colom, 2011). Donker et al. did a meta-analysis of psychoeducation for depression and anxiety (Donker et al., 2009). This meta-analysis revealed that brief passive psychoeducational interventions for depression and psychological distress can reduce symptoms (Donker et al., 2009). However, all the above-referenced psychoeducations are focussed on how to cope with their symptoms and none of them tried to focus on how to cope with their over-complicated relationship due to depression.

There have also been a number of reports describing an association between EE and relapse of depression (Hooley et al., 1986; Okasha et al., 1994; Mino et al., 2000, 2001). Our prospective study suggested that the association of EE with relapse might be even stronger in depression than in schizophrenia (Mino et al., 2001). In fact, we conducted family psychoeducation which sets a goal of reducing the family's EE for members with major depression and found that the time to relapse was much longer in the intervention group than in the control group (Shimazu et al., 2011). The family psychoeducation programme tested was simple and consisted of only four sessions of didactic lectures and group problem-solving exercises (Shimazu et al., 2011). Inspired by these encouraging results, we planned to provide persons with MDDs with a similar frame of psychoeducation without their family and to examine its influence on the course and outcome of the illness. Thus, the aim of this study was to test for patients with MDDs the effectiveness of simple psychoeducation which is focussed on how to cope with family members and colleagues and superiors at the workplace in a randomised controlled design.

2. Methods

2.1. Subjects

The subjects were patients who met the following eligibility criteria. The inclusion criteria were:

- a) age between 20 and 70;
- b) diagnosis of MDD in (partial) remission according to the *Diagnostic and Statistical Manual of Mental Disorders* fourth edition (DSM-IV) (APA, 2000);
- c) not having undergone electroconvulsive therapy (ECT) or not having ECT already planned for the index episode; and
- d) a Mini-Mental State Examination (Folstein et al., 1975) score of 24 or higher when patients are over 60.

The diagnostic assessments were done with Mini-International Neuropsychiatric Interview (MINI) (Sheehan et al., 1998). The validity of the Japanese version of the MINI is already confirmed by Otsubo et al. (2005). Patients were excluded if they were suspected of having experienced a hypomanic/manic episode in the past, were diagnosed as having Axis II disorders or had co-morbid severe physical illness. Participants were recruited at the two affiliated hospitals of Kochi Medical School, Atago Hospital and Fujito Hospital in Japan, between July 2007 and January 2008. They were screened with the Mini-Mental State Examination (Folstein et al., 1975) when their age was over 60 and those with a score of 23 or lower were excluded

since they were suspected of having possible dementia. Patients suspected of having organic disease were examined by head magnetic resonance imaging and those diagnosed with organic disease were excluded.

2.2. Procedures

We recruited patients from our practice who agreed to participate in our investigation.

The patients were assessed for eligibility using the criteria described before in Section 2.1 Subjects. The patients who satisfied the eligibility criteria received written informed consent to participate after full disclosure of the purpose and procedures of the study. After the agreement, the participants were randomly allocated to intervention and control groups. We used a straightforward random sequence without stratification or block as generated by use of a random number table. The random allocation list was centrally kept by a research assistant and the allocation was conveyed to the investigators and clinicians only after the participant was registered. Both the intervention and control groups were instructed not to mention whether or not they were receiving psychoeducation to their treating psychiatrists or to those performing psychiatric assessment. The control group received treatment as usual (TAU) while the intervention group received psychoeducation in addition. The details are described in Section 2.3. Nine months after finishing the intervention, they were analysed for the prevalence of relapse.

Ethical approval was obtained from the ethics committees at Kochi Medical School.

2.3. Psychoeducational sessions

Group psychoeducation was administered to the patients for six sessions that were held on a weekly basis. Each group consisted of between two and six patients, depending on the patient accrual and to minimise the waiting time. Each session lasted for about 1.5 h: the first 20–30 min were used for a didactic lecture and were followed by group discussions using problem-solving techniques.

The topics of the didactic parts included 'Patient recognition of depression and its consequences', 'Causes and risk factors', 'Signs and symptoms', 'Drug treatment', 'Side effects of antidepressants' and 'Course/outcome and review of the sessions'. As educational materials, we developed a textbook describing depression and its treatment and videos illustrating the patients' experiences, depressive symptoms and treatment.

In the group meeting, participants were encouraged to raise questions of any kind that they wanted to know or solve. There were a variety of questions raised: how they would inform the boss of their absence, how they should respond to family critical attitudes or emotional overinvolvement, how they could discuss trivial-looking family matters with the doctor in charge, how they could distinguish between mental disorder and character and so on. We focussed on how to cope with family members and the boss at the workplace, prompting use of the problem-solving techniques among the participants. We did not use psychotherapeutic techniques and homework tasks in our sessions.

The staff consisted of one psychiatrist, one clinical psychologist and a clerk. The psychiatrist provided all the lectures and led the group meetings supported by the clinical psychologist.

2.4. Treatment as usual

All the patients received outpatient treatment given by psychiatrists who were different from those administering psychoeducation, performing the psychometric assessments or judging relapse. This TAU consisted of clinical management including assessment of the psychiatric symptoms and subsequent prescription of antidepressant(s) once every 2 weeks. The duration of a clinical visit was about 15 min. All the patients were asked not to undertake any formal psychotherapy during the trial.

2.5. Assessment of psychiatric symptoms and function

When the treating psychiatrists suspected relapse, the patient was seen by an independent psychiatrist (HF), blind to the group assignment, to make a final judgement about whether a relapse had occurred.

To assess the severity of depressive symptoms, we administered the 17-item Hamilton Rating Scale for Depression (HRSD-17), which is observer-rated instrument designed to assess depressive symptoms over the previous week (Hamilton, 1967), and the Beck Depression Inventory-Second Edition (BDI-II), which is a 21-item, self-report measure of depressive symptoms using a 0–3 scale (range, 0–63) (Beck et al., 1961), at baseline, after the last session of psychoeducation in the case of the intervention group, at any point when a relapse was suspected and after 9 months. We also administered the Clinical Global Impression (CGI, Guy, 2000) severity score at baseline and after 9 months, and the CGI improvement score after 9 months. In addition, the Global Assessment of Functioning (GAF, APA, 2000) was rated at baseline and after 9 months. All the observer-rated instruments including HRSD-17, CGI and GAF were administered

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