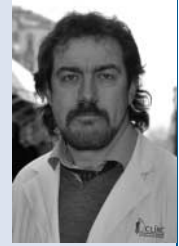


Editorial

Keeping therapies simple: psychoeducation in the prevention of relapse in affective disorders†

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Summary

Psychological interventions for mood disorders can be divided into 'skilled' and 'simple'. Psychoeducation belongs to the latter group: a simple and illness-focused therapy with prophylactic efficacy in all major mood disorders. Successful implementation of psychoeducation requires a proper setting, including open-door policy, team effort and empowerment of the therapeutic alliance.

Declaration of interest

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The current therapeutic approach for severe mental disorders includes increasingly the combination of psychopharmacological and psychological interventions, as advised both by the National Institute for Health and Clinical Excellence^{1,2} and the British Association of Psychopharmacology.^{3,4} However, defining and choosing which drugs and psychotherapies clinicians should use is still a matter for discussion that cannot be solved in the absence of data. Defining which treatments should be used for a certain pathology is about efficacy. Choosing a treatment goes beyond efficacy and has to do with efficiency, effectiveness, personal preferences (both of the therapist and the client) and availability of therapists.

The efficacy (i.e. how well a treatment works in ideal circumstances) of a drug is determined through rigorous phase III randomised controlled trials (RCTs) required by the regulatory agencies. Unfortunately, there are no such regulatory agencies for psychological treatments and the investment in this field is slightly inferior than for drugs – relying usually on public or non-profit funding trusts rather than on private initiatives. However, the past two decades have been very productive with regard to the emergence of rigorous clinical trials on the efficacy of psychological interventions in severe psychiatric disorders.

The effectiveness of a treatment (i.e. how well it works in clinical practice) is usually determined through open studies and clinical reports both for drugs and psychological treatments. More effectiveness studies are needed both for drugs and psychotherapies.⁵ The paradox here is that some psychological treatments still claim to be effective by presenting case series or anecdotal reports without actually having shown any efficacy through proper RCTs.

Psychological interventions for mood disorders: 'skilled' v. 'simple'

In the field of mood disorders, several psychological interventions have proven both their efficacy and effectiveness, especially in the

case of unipolar depression, although 1999–2009 deserves to be described as the Golden Decade regarding evidence-based psychological therapies for bipolar disorders, with no less than ten RCTs published during this period.⁶

If we stick to tested and efficacious psychological treatments for affective disorders, we could easily make a rough – and, yes, oversimplistic but still useful – distinction between skilled and simple therapies. Skilled therapies usually have a strong theoretical background, have their own model of understanding the disorder to be treated, require complex training and demand highly skilled therapists. Simple therapies do not require a highly developed theoretical background, lack complexity (for both therapists and clients), fit easily into the clinical setting and target very specific and limited therapeutic goals. Among the former we must mention cognitive-behavioural therapies and interpersonal therapy. The evidence for the use of both approaches in unipolar depression is simply overwhelming, while in the case of bipolar disorder the evidence is perhaps more controversial possibly showing good efficacy⁷ but less effectiveness⁸ probably due to its complex implementation.⁹ The dramatic outcome differences between both studies have been widely discussed in earlier issues of this *Journal*.

Among the simple therapies it is worth mentioning the psychoeducation-based approaches. The current issue of *British Journal of Psychiatry* contains a good example of psychoeducation for unipolar disorder;¹⁰ an extremely simple psychoeducational intervention improving clinical outcomes in a group of patients with different severity of illness, which proves both the efficacy and effectiveness of the intervention. Psychoeducation also plays a core role in the treatment of bipolar disorder as an add-on to pharmacological treatment, with long-lasting effects. In an RCT on the efficacy of a structured group psychoeducation intervention for patients with bipolar disorder, at 5-year follow-up, the psychoeducation group showed a longer time to recurrence (log rank = 0.953, $P < 0.002$) and had fewer recurrences than the non-psychoeducation group (3.86 v. 8.37, $t = 4.33$, $P < 0.001$). Moreover, the psychoeducation group spent much less time acutely ill.¹¹ This was mainly due to the dramatic differences accounting for time spent in depression (364 days v. 399, $t = 5.387$, $P < 0.0001$). Interestingly, the number of days depressed has been reported to be a strong predictor of recurrences according to the STEP-BD data.¹²

Previously, Perry *et al*¹³ reported how a very simple intervention consisting only of 7–12 sessions of training on early

†See pp. 385–390, this issue.

warning sign detection was associated with a significant increase in time to first manic relapse (25th percentile, 65 weeks *v.* 17 weeks; $P=0.008$) as well as a 30% decrease in the number of manic episodes over 18 months ($P=0.013$). Time to first depressive relapse and number of depressive relapses were unaffected, although overall social functioning and employment over 18 months were significantly improved with the treatment sessions. However, a larger study of the same approach failed to show any benefit,¹⁴ which may point at the fact that the efficacy of psychoeducation goes beyond early warning sign identification. Similarly, despite the fact that psychoeducation helps improve adherence in patients treated with lithium,¹⁵ it is also true that even patients without adherence problems at study entry benefit from the intervention.¹⁶ So, both early warning sign detection and adherence enhancement might be active ingredients of psychoeducation, but it is their combination (together with other critical topics) that makes psychoeducation so efficacious.

Other comprehensive treatment packages relying on psychoeducation report a significant reduction in time spent acutely ill and reducing manic relapses.¹⁷ Family psychoeducation has also shown a striking prophylactic efficacy for bipolar disorders.^{18,19}

The main reason why psychoeducation appears to be so accepted and widely used for mood disorders is that it fits very well on the medical model of illness, by being a clinically focused, common sense-based and straightforwardly delivered intervention.

On the other hand, one of the problems with psychoeducation is that of a 'branding' problem (common with other therapies, including skilled ones): many health providers claim to use psychoeducation when referring merely to informing their patients about the disorder or giving them some general indications on prevention and crisis management. Psychoeducation goes far beyond these minimal standards of good medical practice. Psychoeducation could be defined as a patient's empowering training targeted at promoting awareness and proactivity, providing tools to manage, cope and live with a chronic condition (i.e. adherence enhancement, early warning sign identification, lifestyle, crisis management, communication), and changing behaviours and attitudes related to the condition. Psychoeducation replaces guilt by responsibility, helplessness by proactive care and denial by awareness.

Psychoeducation's simplicity allows implementation without a long, complex and thorough training of the therapist in the technique. In other words, the therapist has to be a clinician (e.g. psychiatrist, psychologist, nurse), an expert on the disorder not on a technique, and this is the major difference between skilled and simple therapies. Other therapist characteristics include experience in group work and other issues common to almost every intervention: common sense and interpersonal skills.

This explains why psychoeducation does not belong exclusively to the field of psychiatric disorders and is widely implemented among non-psychiatric conditions.

It is, for instance, hard to imagine how a programme to treat patients with diabetes would work without some degree of patients' education – a must in the implementation of insulin, for instance. The literature shows that psychoeducation is associated with reductions in eating disturbances²⁰ and with an increase in physical activity and improvement of cardiorespiratory fitness in overweight and obese individuals with diabetes,²¹ while other studies report benefits regarding glycaemic control among patients with type 2 diabetes.²² Another example of psychoeducation efficacy beyond psychiatric disorders are cardiovascular conditions where patients' education helps reduce the number of new admissions, the total days of hospital stay and improves treatment adherence without increasing the costs of care.^{23,24}

Difficulties in implementing psychoeducation: shifting the treatment paradigm

The efficacy of psychoeducation both in bipolar and unipolar affective disorders has been shown in several studies. A main criticism we all should consider is that, to the best of my knowledge, the most popular and widespread psychoeducation programme for bipolar disorders²⁵ has not been replicated in an RCT outside the centre that developed it. So far, despite being aware of at least six projects – most of them from UK-based teams – willing to replicate our seminal study,²⁶ I am only aware of one ongoing study on the issue. Why is it so? It might well be that all those groups – all of them quite prestigious in the field – faced huge problems in implementing the programme. This may be related to the fact that, in order to successfully implement a psychoeducation programme, no matter how simple you try to keep it, you need to undertake a sometimes huge and ambitious treatment paradigm shift in your clinical setting. Some of the conditions that an ideal environment should fulfil to allow a psychoeducation programme to grow healthily are the following.

- 1 Open-door policy. With regard to the frequency of patients' appointments with their treating psychiatrists, the open-door policy allows fewer arranged appointments but total flexibility for unscheduled visits or on-call availability when the patient suspects a new episode. In fact, it would be cruel to train the patient in early detection without providing them with an early intervention resource. Psychoeducation encourages the patient to have a proactive attitude in dealing with their disorder and so the therapist should have the same proactive and flexible attitude.
- 2 Team effort. Psychoeducation is only meaningful in settings where a multidisciplinary team effort is available. First, because it enhances full availability of someone within the therapeutic team. Second, because each suggested intervention – i.e. checking the early warning sign list, changing a medical prescription, controlling sleeping habits or performing an urgent determination of mood stabiliser serum levels – would belong to a different professional within the team.
- 3 Therapeutic relationship founded on trust, rather than authority. Meaning that the therapist should be open to agree on several treatment issues with psychoeducated patient. Consequently, psychoeducation avoids the potentially pathogenic model of a relationship between a 'healing' physician and a passive patient. Instead, it provides an appropriate therapeutic alliance relying on collaboration, information and trust. The patient knows that we know and the therapist knows that the patient is empowered enough and trustable, resulting in an improved therapeutic relationship.

The three characteristics mentioned above are, sadly, quite uncommon in usually overworked and overwhelmed clinical settings. And this may explain why psychoeducation may not be as easy to implement as it would initially seem. It may also explain the partial failure of some skilled interventions in showing their effectiveness.⁹ Moreover, all these conditions cannot be ignored in the clinical management of affective disorders, not even when they are euthymic (which is at odds with the trend existing in some national health services to discharge patients to primary care as soon as the acute episode is over). I would strongly advise Shimazu *et al*¹⁰ to try to control these issues to promote replications of their beautiful study.

Both skilled and simple interventions are needed in the treatment of affective disorders. Moreover, sometimes, the boundaries between skilled and simple are quite blurry. Settings

and clients are all different: some patients demand a very complex technique and unfortunately few clinical settings are able to provide it. And psychoeducation would be, simply, the best for the rest.

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