PSYCHOEDUCATIONAL GROUP INTERVENTION IN ADDITION TO ANTIDEPRESSANT THERAPY AS RELAPSE PREVENTIVE STRATEGY IN UNIPOLAR PATIENTS

Linda Franchini, Fanny Bongiorno, Chiara Spagnolo, Marcello Florita, Alessia Santoro, Danilo Dotoli, Barbara Barbini, and Enrico Smeraldi

Summary

The need for additional strategies for medication adherence in unipolars, is striking. In fact, as well as bipolar forms, despite the planned long-term use of antidepressants, a variety of evidence suggests that adherence often fails within the first months of treatment after remission from a depressive episode. This requires appropriate patient education and support to develop a greater adherence to treatment. The aim of the present study was to verify the risk of relapse during a 6-months continuation period in two groups of unipolar patients participating (N=58) or not (N=41) in psychoeducational group sessions during the acute treatment of a depressive episode treated with fluvoxamine. At the end of follow-up period we observed a significantly ($p<0.005$) higher number of relapsed in the group of patients who did not participate in psychoeducational intervention (31.7% vs 13.8%). Among patients who participated in psychoeducational intervention the risk of relapse was affected by the number of psychoeducational group sessions performed ($p<0.0001$).

Key-words: Unipolar – Psychoeducational Treatment – Relapse

Declaration of interest: None

Franchini L., M.D., Bongiorno F., M.D., Spagnolo C., M.D., Florita M., Ph.D, Santoro A., Ph.D., Dotoli D., M.D., Barbini B., M.D. and Smeraldi E. M.D.
H. San Raffaele-Turro, Department of Neuropsychiatric Sciences, School of Medicine, Università Vita e Salute, Via Stamira d' Ancona 20, 20127 Milan, Italy

Corresponding Author
Franchini Linda, Istituto Scientifico H San Raffaele-Turro, Department of Neuropsychiatric Sciences, School of Medicine, Università Vita e Salute, Via Stamira d'Ancona 20, 20127 Milan, ITALY - Tel +39-02-26433478 - Fax +39-02-26433265 - E-mail franchini.linda@hsr.it

Introduction

Major depressive disorder (MDD) is a common, recurrent disorder that requires long-term management. Adequate acute phase treatment of MDD is essential to reduce symptomatology and to improve the quality of life and the clinical course of illness. After remission, pharmacological treatment should be continued for 4-9 months to consolidate the remission and to prevent relapse (Moller et al. 2003, Geddes et al. 2003, Melfi et al. 1998). Nevertheless, the need for additional strategies for medication adherence in unipolars is striking. In fact, as well as bipolar forms, despite the planned long-term use of same antidepressant effective in the acute phase, a variety of evidence suggests that adherence often fails within the first months of treatment after remission from a depressive episode (McFarland and Johnson 1996).

Several interventions to improve unipolars adherence have been tested and collaborative care interventions in primary care have demonstrated significant improvements in adherence during the acute and the continuation phase of treatment, associated with clinical benefit, especially in patients suffering from major depression who were prescribed adequate dosages of antidepressant medication (Vergouwen et al. 2003).

The aim of the present study was to verify the role of the psychoeducational group intervention acutely administered in association with antidepressant treatment as support in relapse prevention for unipolar subjects hospitalized for a major depressive episode.

Experimental procedures

Sample

In Neuropsychiatric Sciences Department of San Raffaele-Turro Hospital in Milan there is a Mood Disorder unit consisting of nurses, psychiatrists and psychologists with a specific training in depression and mania management. This unit can house 48 inpatients, coming from outpatient services, first- aid and primary care. From March 2004 to March 2005 we have recruited the sample within unipolar inpatients, hospitalized for a major depressive episode (DSM-IV criteria),

Received October 2005, accepted June 2006

and treated with fluvoxamine up to 300 mg/die according to our standardized protocol (Zanardi et al. 2001). When they achieved the almost complete remission of the symptoms according to clinical judgement and according to a mean HDRS score ≤ 8, their psychiatrists proposed them to take part in a minimum of three sessions of psychoeducational group therapy, until the discharge from hospital.

Inpatients who preferred to not participate in psychoeducational group sessions continued the pharmacological and individual intervention with their own psychiatrist.

Group Intervention during hospitalization

The group session takes place weekly with the duration of one hour; it is managed by a experienced psychologist (F.O. or S.G.), trained on mood disorder. A senior psychiatrist (F.L. or B.F.) and a member of nursing staff also participate during the group session. The program is performed in a 10-12 inpatients group setting, in an appropriate room in the afternoon. The therapist explains symptoms, features, treatment strategies and prognosis of mood disorder illness, also using supports; the therapist permits patients to share one another the troubles related to their acute phase and the participants can interact, asking and clearing up their doubts. We promote a traditional psychoeducational approach because it facilitates member to member feedback. In fact, this kind of leadership could permit a personal growth and symptoms relief through the group's development into a "social microcosm" of its members' lives (Bongiorno et al. 2005).

In Table 1 we listed the main topics discussed in all the psychoeducational group sessions (Colom et al. 2003).

Table 1. *The topics discussed in psychoeducational group sessions*

What Mood Disorder is
Causal and triggering factors
Depressive symptoms
Manic symptoms
The course of depressive illness
Treatment of acute phase
Maintenance therapy
Non pharmacological treatment for depression illness
Risk caused by the suspension of the pharmacological treatment
Early detection of the depressive episode
Early detection of the manic episode
What to do when a new phase of illness is detected
Management of the biological rhythms

All subjects, both those participating (N=58) and those non participating (N=41) in psychoeducational group sessions, after discharge from hospital, remained in continuation treatment as outpatients for an additional 6-months period. Over this period, they continued fluvoxamine at the same dosage, undergoing regular controls of plasma levels to verify adherence to treatment. Monthly patients were clinically assessed by their psychiatrist. Whenever a patient presented signs of clinical worsening and functional impairment and had a HAM-D score >15, he/she was recognized as having a relapse.

Statistical analysis

We compared clinical and demographic characteristics among patients who participated or not in the psychoeducational group sessions using Chi-square and t-test. We applied regression analysis (Cox) considering relapse as dependent variable.

Results

During the recruitment period, 58 unipolar inpatients have participated in psychoeducational group sessions, whereas 41 did not. Table 2 shows that clinical and demographic characteristics of the two groups of patients were similar except for an earlier age at onset of patients who did not participate in psychoeducational therapy.

Table 2. *Clinical characteristics of the sample*

Clinical Characteristics	Subjects participating in psychoeducational group sessions (N=58)	Subjects not participating in psychoeducational group sessions (N=41)
Patient relapsed	8*	13*
Male/Female	17/41	11/30
Mean current age ± SD	53.7 ± 13.3	52.5 ± 14.1
Mean age at onset ± SD	41.9 ± 15**	33.5 ± 14.2**
Mean duration index episode ± SD (weeks)	19.1 ± 20	25.8 ± 29.1
Mean number of previous episodes ± SD	4.3 ± 4.4	5.1 ± 4.3
Mean fluvoxamine plasma levels ± SD	325 ± 102	308 ± 98

Chi-Square * $p<0.05$; t-Test ** $p\leq0.006$

After discharge, at the end of the 6-months follow-up, 21 (21.2%) patients relapsed: 8 (13.8%) in the sample who participated in psychoeducational group sessions during the hospitalization and 13 (31.7%) in the sample who did not participate in psychoeducational group sessions ($P\leq0.05$). There were no differences in clinical and demographic characteristics between relapsed and non relapsed subjects (see Table 3).

Table 3. *Clinical and demographic characteristics*

	Subjects relapsed (N=21)	Subjects non relapsed (N=78)
Male/Female	3/18	25/53
Mean current age ± SD	52.4 ± 12.5	53.4 ± 13.9
Mean age at onset ± SD	35.9 ± 12.7	39.1 ± 15.7
Mean duration index episode ± SD (weeks)	17.9 ± 23.2	22.1 ± 24.3
Mean number of previous episodes ± SD	7.6 ± 6.6	7.5 ± 8.5

Using logistic analysis, among patients who participate in psychoeducational group sessions during hospitalization, "the number of psychoeducational group sessions" was the only independent variable significantly related to the risk of relapse ($p \leq 0.0001$). In fact, in the combined therapy group (N=58) relapsed patients (N=8) showed a poor adherence to educational intervention participating in lower number of psychoeducational group sessions than non relapsed (N=50): 1.37 ± 0.7 vs 3.96 ±1.2.

Discussion

Maintenance pharmacotherapy is the best validated and most widely used approach to prophylaxis in unipolar depression, particularly in high recurrence rate forms (Kupfer et al. 1992, Franchini et al. 1994-2000). Nevertheless, as previously reported, despite the planned long-term use of antidepressants, a variety of evidence suggests that adherence often fails within the first months of treatment after remission from a depressive episode (McFarland and Johnson 1996). Psychoeducational approach is extensively described as support strategy in continuation and maintenance treatment of Bipolar Disorder, but there are few data about this type of intervention as support strategy in continuation treatment of Unipolar Disorder (Dowrick et al. 2000).

The present study shows preliminary data obtained from naturalistic observation of mood disorder unipolar population suggesting the timeliness in clinical practice of a standardized association of psychoeducational group intervention to the pharmacological treatment for unipolar depressed inpatients. In fact, according to our results, there is an encouraging evidence that the combination of psychopharmacological treatment and psychoeducational intervention as acute treatment for a depressive episode lowered the percentage of relapses (13.8% vs 31.7%) during the subsequent 6-months follow-up. Moreover, the intensity of the psychoeducational intervention, expressed by the number of sessions attended by patients, seems to have a significant role in reducing the risk of relapse in our sample. In fact relapses occurred among subjects with a poor adherence to psychoeducational group sessions. In clinical practice the variety of reasons for patients' poor adherence to treatments is difficult to be defined. Within our unipolar depressed sample, possible explanations are: a different insight of illness, a kind of resistance to the member to member feedback (Hartzler et al. 2001, Yalom 1995) or a general tendency to the non-adherence to treatment. In this sense some unipolar forms are no different from bipolar forms of Mood Disorders in terms of severity of the illness, considering the impact on quality of life of reduced duration of euthymia.

References

Bongiorno F, Franchini L, Spagnolo C, Florita M, Santoro A, et al (2005). Psychoeducational group intervention in depressed hospitalized patients: a pilot study. *Italian Journal of Psychopatology* 11, 2, 151-156.

Colom F, Vieta E, Martinez-Aran A, Reinares M, Goicokolea JM, Benabarre A, et al.(2003). A randomized trial on the efficacy of group psychoeducation in prophylaxis of recurrences in bipolar patients whose disease is in remission. *Archives of General Psychiatry* 60, 402-407.

Dowrick C, Dunn G, Ayuso-Mateos JL, Dalgard OS, Page H, Lehtinen V, Casey P, Wilkinson C, Vasquez-Barquero JL, Wilkinson G (2000). Problem solving treatment and group psychoeducation for depression: multicentre randomised controlled trial. *British Medical Journal* 321, 7274, 1450-1454.

Franchini L, Gasperini M, Perez J, Smeraldi E, Zanardi R (1997). A double-blind study of long-term treatment with sertraline or fluvoxamine for prevention of highly recurrent unipolar depression. *Journal Clinical Psychiatry* 58, 3, 104-107.

Franchini L, Gasperini L, Perez J, Smeraldi E, Zanardi R (1998). Dose-response efficacy of paroxetine in preventing depressive recurrences: a randomized, double-blind study. *Journal of Clinical Psychiatry* 59, 5, 229-232.

Franchini L, Gasperini M, Smeraldi E (1994). A 24 months study of unipolar subjects: a comparison between lithium and fluvoxamine. *Journal of Affective Disorders* 32, 4, 225-231.

Franchini L, Rossini D, Bongiorno F, Spagnolo C, Smeraldi E, Zanardi R (2000). Will a second prophylactic treatment with a higher dosage of the same antidepressant either prevent or delay new depressive episodes? *Psychiatry Research* 96, 1, 81-85.

Franchini L, Zanardi R, Gasperini M, Perez J, Smeraldi E (1996). Fluvoxamine and lithium in long-term treatment of unipolar subjects with high recurrence rate. *Journal of Affective Disorder* 38, 1, 67-69.

Franchini L, Zanardi R, Gasperini M, Smeraldi E (1999). Two-year maintenance treatment with citalopram 20 mg in unipolar subjects with high recurrence rate. *The Journal of Clinical Psychiatry* 60, 12, 861-865.

Franchini L, Zanardi R, Gasperini M, Smeraldi E (2000). Four-year follow-up study of sertraline and fluvoxamine in long-term treatment of unipolar subjects with high recurrence rate. *Journal of Affective Disorders* 58, 3, 233-236.

Geddes JR, Carney SM, Davies C, Furukawa TA, Kupfer DJ, Frank E, Goodwin GM (2003). Relapse prevention with antidepressant drug treatment in depressive disorders: a systematic review. *The Lancet* 361, 653-661.

Hartzler B, Brownson C (2001). The utility of change models in the design and delivery of thematic group interventions: applications to a self-defeating behaviours group. *Group Dyn* 5, 3, 191-199.

Kupfer DJ, Frank E, Perel JM, Cornes C, Mallinger AG, Thase ME, McEachran AB, Grochocinski VJ (1992). Five-year outcomes for maintenance therapies in recurrent depression. *Archives of General Psychiatry* 49, 769-773.

McFarland BH, Johnson RE, Hornbrook MC (1996). Enrollment duration, service use, and costs of care for severely mentally ill members of a health maintenance organization. *Arch Gen Psychiatry* 53, 10, 938-944.

Melfi CA, Chawla AJ, Croghan, Hanna MO, Kennedy S, Sredl K (1998). The effects of adherence to antidepressant treatment guidelines on relapse and recurrence of depression. *Arch Gen Psychiatry* 55, 1128-1132.

Moller HJ, Demyttenaere K, Sacchetti E, Rush AJ, Montgomery SA (2003). Improving the chance of recovery from the short- and long-term consequences of depression. *Int Clin Psychopharmacol* 18, 4, 219-225.

Vergouwen AC, Bakker A, Katon WJ, Verheij TJ, Koerselman F (2003). Improving adherence to antidepressants: a systematic review of interventions. *J Clin Psychiatry* 64, 12, 1415-1420.

Yalom I (1995). *The theory and practice of group psychotherapy*. Basic Books, New York.

Zanardi R, Serretti A, Rossini D, Franchini L, Cusin C, Lattuada E, Dotoli D, Smeraldi E (2001). Factors affecting fluvoxamine antidepressant activity: influence of pindolol and 5- HTTLPR in delusional and nondelusional depression. *Biol Psychiatry* 50, 5, 323-330.