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اثربخشی آموزش روانی خانواده بر اختلال افسردگی اساسی: یک مرور سیستماتیک

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چکیده

امروزه از تأثیر آموزش روانی خانواده (FPE)به عنوان مداخله ای جامع برای درمان اختلال افسردگی اساسی مانند خانواده درمانی استفاده می شود. از آنجایی که اثربخشی آموزش روان‌شناختی بر افسردگی موضوعی بحث‌برانگیز است، مقاله حاضر مبتنی بر پژوهشی است که در زمینه آموزش روان‌شناختی بر روی بیماران مبتلا به طیف وسیعی از اختلالات افسردگی انجام شده است. ما چندین پایگاه داده - از جمله PubMed، MEDLINE و Web of Science را برای شناسایی مطالعات واجد شرایط در مورد موضوع مورد علاقه که تا ژوئیه ۲۰۱۴ منتشر شده بود، جستجو کردیم. معیارهای ما شامل مطالعات شرکت‌کنندگان با تشخیص اولیه اختلال افسردگی اساسی و آنها بود. اعضای خانواده و مطالعات حذف شده در مورد افراد مبتلا به اختلالات دوقطبی، اختلال شخصیت مرزی، اختلالات با علائم خلقی مرتبط با مصرف مواد، اختلال اسکیزوافکتیو، علائم خلقی ناشی از اختلالات پزشکی و غیره. بیماری روانی بود. ۱۲ مطالعه مداخله ای بر روی بیماران مبتلا به افسردگی اساسی و تحصیلات اعضای خانواده آنها یافت شد. هشت مقاله از آنها به دلیل محتوای متناقض حذف شدند؛ بنابراین، ۴ مقاله بررسی شد. با توجه به نتایج مطالعات مورد مطالعه، آموزش روانشناختی خانواده نسبت به شرایط کنترل تأثیر محسوسی بر شدت علائم بیماران داشت. پژوهش حاکی از آن است که آموزش روانی خانواده می تواند علائم بالینی MDD را بهبود بخشد؛ بنابراین باید توسط متخصص سلامت روان در برنامه های درمانی افسردگی استفاده شود.

واژه‌های کلیدی: اختلال افسردگی اساسی، آموزش روانی خانواده، علائم بالینی

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Effectiveness of family psychoeducation for major depressive disorder: a systematic review

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Abstract

Today, the effect of Family Psychoeducation (FPE) is used as a comprehensive intervention for the treatment of Major Depressive Disorder (MDD), such as family therapy. Since the effectiveness of psychological education on depression is a controversial issue, the present article is based on the research conducted in the field of psychological education on patients with a range of depressive disorders. We searched several databases - including PubMed, MEDLINE, and Web of Science - to identify eligible studies on the topic of interest published up to July 2014. Our criteria included studies of participants with a primary diagnosis of major depressive disorder and their family members and excluded studies of individuals with bipolar disorders, borderline personality disorder, disorders with substance use-related mood symptoms, schizoaffective disorder, mood symptoms due to medical disorders, and others. It was mental illness. 12 interventional studies on patients with major depression and education of their family members were found. Eight of them were excluded due to inconsistent content. So, 4 articles were reviewed. According to the results of the studied studies, psychological education of the family had a noticeable effect on the severity of the patients' symptoms compared to the control conditions. It seems that family psychoeducation can improve clinical symptoms of MDD. So, it should be used by mental health specialist in treatment plans of depression.

Keywords: Major depressive disorder, Family psychoeducation, Clinical symptoms

Introduction

Depression is a very common mental health disease with a high economic and social disease burden on societies (1-4) and a leading cause of disability worldwide (5).

Data from combined studies from 30 countries show that the one-year and lifetime prevalence rates of depression are 7.2% and 10.8%, respectively. In addition, its high risk of continuous recurrence indicates an increased disease burden (6).

Patients who have experienced their first episode of depression are more than 50% at risk of relapse (7).

Despite the availability of effective drug treatments and psychological interventions, there are still cases resistant to treatment (8-10), which requires better access of patients to health resources and support from society (11).

However, despite the need of patients to receive psychological services, due to the difficulty of accessing mental health specialists (12), or long waiting lines (13), receiving these services is not possible in some cases. As a result, health services needed to change their approach, which has led to receiving psychological services in the form of psychological education (14), which has a lower economic burden for patients and their families (15).

In addition to the individual effects of depression, the presence of depression disorder in a family member also has a significant impact on other family members (16).

For many families, the diagnosis of major depressive disorder means long and difficult periods of illness that are associated with high stress, higher divorce rates (6) and lower quality of life (17).

Similar results in another study showed that many relatives expressed a feeling of not living for themselves after living with a depressed person for a long time. Depression affects not only family dynamics, but also the social and occupational life of relatives (18).

On the other hand, based on the evidence, caregivers' coping strategies, such as problem solving, positive thinking, and avoidance, affect both their mental health and the patients' mental health. Caregivers' use of positive thinking and problem solving has been associated with reducing their anxiety levels. On the other hand, the use of caregivers' avoidance, depression and anxiety strategies also increases patients' anxiety (19).

These results show that it is important for both patients and caregivers to get proper information about how to treat depression and implement effective coping strategies against everyday problems in order to recover from depression and maintain mental health.

One of the important topics that predicts the recurrence of depression is expressed excitement. Since 1982, family intervention studies using expressed emotion have demonstrated the effects of family psychoeducation in relapse prevention (20).

The main one is predicted to be expressed as a critical, hostile or overly emotional attitude or behavior towards the patient (21). Patients living with relatives with high EE have a significantly higher risk of relapse compared to patients living with relatives with low EE (22).

Psychotherapy through psychological education (PEP) is one of the 3 tested methods of family psychological education along with skill building. PEP is family-based and includes psychoeducation and skill building. PEP helps reduce anger, mood symptoms, disruptive behavior, and executive functioning deficits. PEP may improve functioning and increase appropriate use of services for years after initial treatment. Family psychoeducation may improve emotional distress and caregiving burden experienced by relatives (23).

Family psychoeducation (FPE) is recognized as an important part of optimal treatment, along with medication and counseling, for people with psychotic disorders (24).

FPE is more than just providing information. This method ensures that people understand the disease. Importantly, FPE focuses on enhancing problem-solving skills, communication and

coping skills, and increasing social support for managing mental illness. In family therapy, the family itself is the object of treatment, while in the FPE approach, the disease is the object of treatment, rather than the family. This intervention has been shown to reduce relapse rates and hospital admissions among people with psychotic disorders and reduce caregiver distress (25,26).

However, FPE is not yet widely available for individuals with MDD and their families. Several studies report the effectiveness of FPE on patients diagnosed with MDD. Shimazu and colleagues investigated the effect of FPE in the treatment of people with MDD compared to the control group. FPE consisted of four sessions for caregivers without patient participation. Findings showed that FPE was effective in relapse prevention for up to 9 months in adults with MDD (27).

The results of some studies suggested that FPE intervention helped to reduce personal and family problems caused by depression and improve social contact, although the follow-up period in this study was short (6 months), with no clarity on long-term effects. To date, there have been limited systematic studies investigating the efficacy of FPE on patients diagnosed with MDD. Our clinical question therefore is whether FPE reduces symptom severity in subjects with MDD compared to controls. The aim of this systematic review is to evaluate the evidence regarding the effectiveness of FPE on the severity of depressive symptoms in people with MDD.

Materials and Methods

We searched PubMed, MEDLINE, Embase, PsycInfo, Cochrane, Emcare, and Web of Science databases to identify eligible studies of FPE for MDD, from inception to July 2014. The search included all relevant terms, such as family education, family psychoeducation, family, family therapy, family relationships, family health, health education, psychoeducation, family therapy, and family intervention, combined with the words depressive disorder. The abstracts identified during the search were reviewed and independently screened by the authors. Potentially eligible articles were read to review eligibility criteria.

Inclusion criteria

Randomized controlled trials (RCTs) and studies without a control or comparison group were included if they met the other inclusion criteria. All published and unpublished randomized controlled trials (RCTs) were included.

The study population included patients with a primary diagnosis of MDD based on DSM or ICD criteria and their family members. Studies of family psychoeducation intervention for family/relatives with MDD aged 18–85 years were included. There were no restrictions on participants' gender, ethnicity, or comorbidities.

The following studies were excluded: patients whose primary diagnosis was schizophrenia, bipolar disorders, Alzheimer's disease, anorexia nervosa, bulimia nervosa, psychotic episodes or epilepsy, patients with MDD secondary to physical illness were excluded from the study.

Results

12 articles were selected. Then 8 articles were excluded due to inconsistent content. Finally, 4 articles were remained. The data related to these articles were presented in Table 1.

Table1

Authors	Year	Country	Population	Outcomes
Timmerby et al.	2016	Denmark	Families of 100 MDD patients	Reduced relapse of MDD in 9-momth follow-up through Hamilton depression scale
Shimodera et al.	2012	Japan	First relatives of 57 MDD patients	The intervention group had more free-relapse days and psychoeducation is a cost-effective intervention.
Shimazu et al.	2011	Japan	Families of 57 MDD patients	Time to relapse was statistically significantly longer in the psychoeducation group than in the control group (P= 0.002). The relapse rates up to the 9-month follow-up were 8% and 50% respectively.
Sanford et al.	2006	England	Families of 41 adolescents with MDD	The experimental group showed greater improvement in social functioning and adolescent-parent relationships, and parents reported greater satisfaction with treatment.

Discussion

The present review article aimed to assess the effectiveness of FPE on the severity of depressive symptoms, relapse, and satisfaction about treatment in people with MDD. Although some studies assessed psycho-education in patients, there are limited studies which are related to family psychoeducation without patients' participation. The findings related to the four mentioned articles indicated that FPE is a cost-effective intervention, and is associated to the lower risk of relapse, and longer relapse-free days in patients with MDD. Also, family psycho-education leads to improved patient-family relationship and social function in patients, which may be related to improvement in clinical symptoms.

In this line, Timmerby et al. assessed relatives of 100 MDD patients, who recruited in two groups of family psycho-education and social support. Both groups received four sessions of intervention. The results indicated that family psychoeducation is effective on quick response to the treatment of the disease, provision of social support platform, recovery, prevention of disease recurrence and reduction of the disease burden (29). This findings are consistent with the results concluded by Shimodera et al. and Shimazu et al. (27,30).

In the study of Shimazu et al., Fisher's exact test (P = 0.002) showed that family psychoeducation significantly reduces disease recurrence (27). The studies about family psychoeducation are not limited to depression. The results of Salem et al.'s study in the field of psychological training and skill building for emotional dysregulation on bipolar patients showed that there has been a significant improvement in the severity of mood symptoms and also the executive function and overall performance of the patients. In the mentioned study, 84% of the parents reported that the child's symptoms decreased during the trial period. 82% reported improvement of symptoms in the following years. 50% of parents reported learning

their child's ability to cope with stress. 47% reported a long-term reduction in irritability and discomfort. 87% reported improvement in family functioning. 82% of the adolescents in this study reported that their symptoms decreased during the course, 68% of them reported that the improvement of symptoms remained after the treatment period. 62% of them reported feeling less upset and nervous. 59% reported feeling more relaxed and 79% reported improvement in family functioning (23).

This study is also in line with the study by Sanford et al. in England. In this study, families of 41 adolescents with MDD were divided into two groups. The average recurrence time for the intervention group was 274 days and for the control group was 221 days. In this study, there was no significant difference in other variables such as sex, age, education, living conditions, basic scores on the Hamilton and Beck depression scale, and the basic dose of antidepressants. In this study, the parents of the experimental group were more satisfied than the control group. The average satisfaction scores (standard deviation) of parents in the experimental group was equal to 29.4 (4.8) and in the control group was 24.5 (4.9). These findings revealed the effectiveness of family psychoeducation for MDD (31).

On the other hand, in a study by Shimodera et al. in Japan, on the cost-effectiveness of family psychological training to prevent relapse of depression, they found that family psychoeducation is beneficial and most likely, it is cost-effective in 90% of cases. This benefit was demonstrated by reduced costs and fewer relapse days (30).

According to the above studies, it seems that family psychoeducation can be used as a cost-effective and effective treatment in many interventions. Since in Iran, there are very few randomized trial studies with an acceptable sample size that have been conducted under controlled conditions, and they have mainly been conducted in psychiatric hospitals for severe and debilitating disorders such as schizophrenia and bipolar disorder. Therefore it is suggested that other disorders such as major depressive disorder, anxiety disorders, eating disorders, obsessive compulsive disorders, psychosomatic diseases and even clients who do not have acute clinical symptoms, considered for research in the field of family psychoeducation.

Conclusion

Based on the results of reviewed articles, family psychoeducation is a cost-effective intervention, and is associated to the lower risk of relapse, and longer relapse-free days in patients with MDD. Also, family psychoeducation leads to better patient-family relationship and social function in patients, which may be related to improvement in clinical symptoms.

References

1. Zhdanava, M., Pilon, D., Ghelerter, I., Chow, W., Joshi, K., Lefebvre, P., & Sheehan, J. J. (2021). The prevalence and national burden of treatment-resistant depression and major depressive disorder in the United States. The Journal of clinical psychiatry, 82(2), 29169.
2. Ori, A. P., Wieling, M., van Loo, H. M., & Lifelines Corona Research Initiative. (2023). Longitudinal analyses of depression, anxiety, and suicidal ideation highlight greater prevalence in the northern Dutch population during the COVID-19 lockdowns. Journal of Affective Disorders, 323, 62-70.
3. Ren, X., Yu, S., Dong, W., Yin, P., Xu, X., & Zhou, M. (2020). Burden of depression in China, 1990–2017: findings from the global burden of disease study 2017. Journal of Affective Disorders, 268, 95-101.
4. Prasartpornsirichoke, J., Pityaratstian, N., Poolvoralaks, C., Sirinimnualkul, N.,

Ormtavesub, T., Hiranwattana, N., et al. (2023). The prevalence and economic burden of treatment-resistant depression in Thailand. BMC public health, 23(1), 1-18.

5. Freidrich, M. (2017). Depression is the leading cause of disability worldwide. JAMA, 317(1517), 10.1001.
6. Katsuki, F., Watanabe, N., Yamada, A., & Hasegawa, T. (2022). Effectiveness of family psychoeducation for major depressive disorder: systematic review and meta-analysis. BJPsych Open, 8(5 ,(e148. doi:10.1192/bjo.2022.543
7. Kato, M., Hori, H., Inoue, T., Iga, J., Iwata, M., Inagaki, T., et al. (2021). Discontinuation of antidepressants after remission with antidepressant medication in major depressive disorder: a systematic review and meta-analysis. Molecular psychiatry, 26(1), 118-133.
8. Kverno, K. S., & Mangano, E. (2021). Treatment-resistant depression: approaches to treatment. Journal of psychosocial nursing and mental health services, 59(9), 7-11.
9. Huang, Y., Sun, P., Wu, Z., Guo, X., Wu, X., Chen, J., et al. (2023). Comparison on the clinical features in patients with or without treatment-resistant depression: A National Survey on Symptomatology of Depression report. Psychiatry Research, 319, 114972.
10. Scott, F., Hampsey, E., Gnanapragasam, S., Carter, B., Marwood, L., Taylor, R. W., ... & Strawbridge, R. (2023). Systematic review and meta-analysis of augmentation and combination treatments for early-stage treatment-resistant depression. Journal of Psychopharmacology, 37(3), 268-278.
11. Bennabi, D., Charpeaud, T., Yrondi, A., Genty, J. B., Destouches, S., Lancrenon, S., et al. (2019). Clinical guidelines for the management of treatment-resistant depression: French recommendations from experts, the French Association for Biological Psychiatry and Neuropsychopharmacology and the fondation FondaMental. BMC psychiatry, 19, 1-12.
12. Turpin, G., Richards, D., Hope, R., & Duffy, R. (2008). Improving access to psychological therapies in: A national initiative to ensure the delivery of high-quality evidence-based therapies. Papeles Del Psicólogo, **29**, 271-280.
13. Layard, R., Bell, S., Clark, D. M., Knapp, M., Meacher, M., Priebe, S. et al (2006). The Depression Report: a new deal for anxiety and depression disorders. London: London School of Economics and politics Science: Centre for Economic Performance's Mental Health Policy Group.
14. Kellett, S., Bee, C., Aadahl, V., Headley, E., & Delgadillo, J. (2020). A pragmatic patient preference trial of cognitive behavioural versus cognitive analytic guided self-help for anxiety disorders. Behavioural and Cognitive Psychotherapy, **49**(1), 104–111
15. Cuijpers, P., Berking, M., Andersson, G., Quigley, L., Kleiboer, A., & Dobson, K. S. (2013). A meta-analysis of cognitive-behavioural therapy for adult depression, alone and in comparison with other treatments. Canadian Journal of Psychiatry, 58, 376–385.
16. Denee, T., Kerr, C., Eva, J., Vincent, S. A., Young, A. H., Jacobsen, N., et al. (2023). The impact of treatment-resistant depression on the lives of carers: a mixed-methods study. Journal of Affective Disorders, 325, 194-205.
17. Cheng, W. L., Chang, C. C., Griffiths, M. D., Yen, C. F., Liu, J. H., Su, J. A., et al. (2022). Quality of life and care burden among family caregivers of people with severe mental illness: mediating effects of self-esteem and psychological distress. BMC

psychiatry, 22(1), 672.

18. Stjernswärd, S., & Östman, M. (2008). Whose life am I living? Relatives living in the shadow of depression. International journal of social psychiatry, 54(4), 358-369.
19. Marguerite, S., Laurent, B., Marine, A., Tanguy, L., Karine, B., Pascal, A., & Xavier, Z. (2017). Actor-partner interdependence analysis in depressed patient-caregiver dyads: Influence of emotional intelligence and coping strategies on anxiety and depression. Psychiatry research, 258, 396-401.
20. Shimodera, S., Inoue, S., Mino, Y., Tanaka, S., Kii, M., & Motoki, Y. (2000). Expressed emotion and psychoeducational intervention for relatives of patients with schizophrenia: a randomized controlled study in Japan. Psychiatry research, 96(2), 141-148.
21. Mexicana, A. P., & de América Latina, A. P. (2014). VII. Referencias. Salud Mental, 37(Supl 1), 101-118.
22. Mino, Y., Shimodera, S., Inoue, S., Fujita, H., Tanaka, S., & Kanazawa, S. (2001). Expressed emotion of families and the course of mood disorders: a cohort study in Japan. Journal of Affective disorders, 63(1-3), 43-49.
23. Salem, T., Walters, K. A., Verducci, J. S & ,Fristad, M. A. (2021). Psychoeducational and skill-building interventions for emotion dysregulation. Child and adolescent psychiatric clinics, 30(3), 611-622.
24. Pitschel-Walz, G., Leucht, S., Bäuml, J., Kissling, W., & Engel, R. R. (2001). The effect of family interventions on relapse and rehospitalization in schizophrenia—a meta-analysis. Schizophrenia bulletin, 27(1), 73-92.
25. Bulut, M., Arslantaş, H., & Ferhan Dereboy, İ. (2016). Effects of psychoeducation given to caregivers of people with a diagnosis of schizophrenia. Issues in mental health nursing 11: 800-810.
26. Miklowitz, D. J., & Chung, B. (2016). Family-focused therapy for bipolar disorder: Reflections on 30 years of research. Family process, 55(3), 483-499.
27. Shimazu, K., Shimodera, S., Mino, Y., Nishida, A., Kamimura, N., Sawada, K., . . . Inoue, S. (2011). Family psychoeducation for major depression: randomised controlled trial .The British Journal of Psychiatry, 198(5), 385-390
28. Luciano, M., Del Vecchio, V., Giacco, D., De Rosa, C., Malangone, C., & Fiorillo, A. (2012). A 'family affair'? The impact of family psychoeducational interventions on depression. Expert Review of Neurotherapeutics, 12(1), 83-92.
29. Timmerby, N., Austin, S. F., Ussing, K., Bech, P., & Csillag, C. (2016). Family psychoeducation for major depressive disorder–study protocol for a randomized controlled trial. Trials, 17(1), 1-10.
30. Shimodera, S., Furukawa, T. A., Mino, Y., Shimazu, K., Nishida, A., & Inoue, S. (2012). Cost-effectiveness of family psychoeducation to prevent relapse in major depression: results from a randomized controlled trial. BMC psychiatry, 12, 1-6.
31. Sanford, M., Boyle, M., McCleary, L., Miller, J., Steele, M., Duku, E., & Offord, D. (2006). A pilot study of adjunctive family psychoeducation in adolescent major depression: feasibility and treatment effect. Journal of the American Academy of Child & Adolescent Psychiatry, 45(4), 386-395.