Original Article

The effect of group psycho-educational program on quality of life in families of patients with mood disorders

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Abstract

Background: Mood disorders related behaviors are imposed on family members and influence the family's mental atmosphere and level of quality of life. Therefore, the researchers decided to study the effect of group psycho-educational program on the quality of life in families of patients with mood disorders.

Materials and Methods: This is a two-group interventional study conducted on 32 members of families of the patients with mood disorders selected through random sampling. A group psycho-educational program was conducted in ten 90-min sessions (twice a week) for the study group. (World Health Organization's Quality of Life-BREF WHOQOL-BREF) questionnaire was adopted in the study and was filled before, immediately after, and 1 month after the intervention.

Results: Independent *t*-test showed a significant difference in the scores of quality of life in the domains of mental health, social communications, and environmental health, immediately after and 1 month after intervention in the study group compared to the control group. Repeated measure analysis of variance showed a significant increase in the mean scores of quality of life in the study group.

Conclusions: The results showed that the impact of group psycho-educational program is observed in the prevention of reduction in quality of life and its promotion in the families of patients with mood disorders.

Key words: Affective disorders, group psychotherapy, Iran, quality of life, relatives

Introduction

Mental disorders there was since of human creation, and based on the World Health Organization (WHO) estimation, 25% of the people suffer from at least one of these disorders.[1] These multi-factorial syndromic disorders (genetic, physical, chemical, biological, psychological, and socio-cultural) are known to be associated with destruction in thought, mood, or behavior,[2] and cause maladaptive behavior, disability in coping with usual stress, and destruction in function.[3] Mood disorders are among the mental disorders that are accompanied by mood imbalance, unusual mood, and changes in physical, emotional, and behavioral responses. They range from mania to depression[4] and involve individuals of all ages and of any gender and history.[5] This social function disorder influences the individuals in familial, marital, occupational, and educational dimensions. Statistics show that mood disorders comprise 25% of all diseases in the US with prevalence of 1.2-1.6% in the general population. About 33% of Iranians are involved in a type of mental diseases and the prevalence of mood disorders has been reported to be between 2 and 25%, of which two thirds suffer from depression.[6,7] Trend of type II bipolar disorder as a mood disorder is chronic and needs long-term treatment.[7] About 40% of type I bipolar disorder patients and 20% of depressed patients have a chronic trend.[8] Major depression is the most severe type of mood disorder and the fourth cause of disability in the world.[9] These disorders can highly influence individuals' life.[10] Families are involved in numerous conflicts and problems with these patients, including treatment costs, patients' conduct and control, giving daily care to these patients as a result of their lowered independency, and helping them to join the society and to have social communication with others.[11] One of the determinants for quality of life is familial health which is expressed through family members' physical health, familial psychological atmosphere, and familial socio-population characteristics. Family condition plays a key role in general promotion of the quality of life.[12] Quality of life is a vast concept influenced by personal health, mental status independence level, social communication, and communications with the environment, and each factor which has a negative effect on individuals' well-being and ability in conducting

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their daily activities can lower the quality of life.[13] This concept always includes five dimensions: Physical, mental, spiritual, social, and disease-related signs. In families of patient with mental disease, changes occur in most of these dimensions. In physical dimension, there are problems such as sleep disorder, eating disorder, physical stress related manifestations, changes in health status behavior, and sexual problems,[14] as well as burnout due to lesser leisure time that the family can have. In mental dimension, due to presence of the patient in the family, the family experiences problems such as daily conflicts and concerns about patients' occupational and educational future,[15] emotions like fiasco, anxiety, fear, depression, guilt, and sorrow, hopelessness, insolvency, lowered self-esteem, and feeling of shame and sadness resulting from internalizing negative social attitudes. In social dimension, there are problems like changes in social communications and a reduction in social activities and isolation,[16] and in disease-related signs dimension, with regard to high stress and anxiety, which exists in the family, signs of physical psychosomatic diseases are observed.[17] Family's capability to react toward the disease can be empowered through conducting interventions and making changes in the quality of life. These interventions include group psycho-education, which emphasizes on mental, social, and biological dimensions and makes a cognitive frame that helps the individuals to understand logical ideas and problems in terms of treatment and to make the best use of their acquired experiences in life.[18] Group psycho-education is an intervention based on the needs of the group, which focuses on perception, knowledge, and skills in families who are in relation with a diseased member.[19] The outcomes of this intervention are increased feeling of well-being, lowered level of families' and individuals' stress, improvement of social function, reduced negative signs and symptoms, improved insight and judgment, and lowered family's caring burden and family adaptation.[20]

Research has shown that group psycho-education can improve the quality of life in patients with major depression and bipolar disorder in the contexts of occupational, social, emotional, and physical functions,[21] and leads to a better recovery from depression signs and patients' quality of life, compared to conventional and personal treatments.[22] In a study conducted in 2008, it was reported the group psycho-educational program was effective on reduction of disease recurrence and re-hospitalization treatments through increase of caregivers' awareness and promotion of coping skills.[23] A study conducted in 2009 showed that group psycho-education caused improvement in quality of life, a reduction in treatment costs, disease recurrence, and re-hospitalization, and higher capacity of treatment compliance, as well as a reduction in disease signs in bipolar patients.[24] The notable point is that most of the research on group psycho-education focused on the patient and few studies were conducted on the effect of this program on these patients' families and their quality of life. As the patient is a member of the family unit, and in a unit, the members affect one another, and considering the fact that quality of life is of great importance in various social groups, especially among the individuals with special physical and mental conditions and their related tensions,[25] improvement of patients' quality of life cannot be expected prior to improvement of their families' quality of life. Therefore, the researchers decided to study the effect of group psycho-educational program on the quality of life in families of patients with mood disorders.

Materials and Methods

This is a two-group three-step interventional study conducted on 32 families of patients with mood disorders in Iran, Isfahan in 2011.

The research environment comprised Farabi and Nour hospitals in Isfahan and the study population consisted of the family members of the patients with mood disorders (spouse, father, mother, child, sister, and brother) who had caring, supportive, emotional, and economic responsibilities of the patient. Inclusion criteria were feeling to be the principal caregiver of the patient and having caring responsibility in this regard, age >18 years,[20] the ability to understand and speak in Persian, having a fixed contact address or with phone number available, education level above primary school, residing in Isfahan, attending the study as the principal caregiver, not concurrently taking care of more than one patient with a mental disorder or physical disease,[20] taking care of a patient with mood disorder for at least 3 months,[26] no previous attendance in family education classes, and no consumption of psychotic medication or drug abuse.

The subject was excluded if he/she did not attend the family education sessions for more than two sessions or when his/her family members died during the study. Sampling was randomly conducted through referring to Nour and Farabi hospitals and checking the existing files related to the patients with one of mood disorders and meeting the inclusion criteria in the men and women psychiatry wards.

After selecting the patients, their phone numbers were listed. Their families were called and the research process and its goals were explained to them. Then, they were invited to attend the study. Next, based on the inclusion criteria and after obtaining their consent, two 16-subject groups were selected by random numbers' chart as the study and control groups.

The subjects were assured about the confidentiality of their information and they were informed that they could have the research results if they liked. All the subjects were free to enter or leave the study. The subjects in the control group were informed that they would receive an educational booklet and a related CD. Data collection tool was a two-section questionnaire. The first section was on personal characteristics of the family members and the patient, and the second one contained World Health Organization's Quality of Life-BREF (WHOQOL-BREEF) including the four domains of physical health, mental health, social communications, and environmental health. This tool was firstly validated in Iran with a goal of translation and measurement of its validity and reliability and structural factors by Nejat *et al*. (2006). The questionnaire reliability was measured by Cronbach's alpha and intra-class correlation was obtained by test–retest.

The values on intra-class correlation and Cronbach's alpha were obtained over 0.7 in all domains, except for social communications with Cronbach's alpha of 0.55, possibly due to lesser number of questions in this domain or presence of sensible questions. Reliability of the questionnaire was assessed by linear regression in the groups of healthy and diseased subjects by distinguishing the ability of tools. Questions-domains correlation matrix was used for measurement of questionnaire structural factors. The obtained results revealed validity, reliability, and acceptability of structural factors of this tool in Iran in healthy and diseased subjects' groups.[27] The subjects filled the questionnaire before beginning the study, immediately after (after 10 sessions), and 1 month after the intervention. The control group received no intervention and the subjects were asked not to attend any other educational programs during the study. Then, an educational booklet and a CD were given to them.[23] Group psycho-educational program [Table 1] was conducted by an MS of psychiatry nursing for ten 90-min sessions twice a week for 5 weeks in the study group.

Methods such as lecture, question and answer, role play, and techniques like brain storming, group discussion, and small groups were adopted. In the end of the sessions, the related CD containing the relaxation techniques, and anger and tension control, and an educational booklet which was briefly prepared and related to the content of each session were given to the subjects. Collected data were analyzed by descriptive and inferential statistics in SPSS version 12.

Results

Inferential statistical tests and independent *t*-test showed no significant difference in the means of age, number of family members, and length of care between the two groups [Table 2]. Chi-square and Mann–Whitney tests also showed no significant difference in the personal characteristics of the family members and the patients (variables of sex, marital status, type of accommodation and occupation, relativity with the patient, and the level of education) in the two groups of study and control ($P > 0.1$). Independent *t*-test showed no significant difference in the mean scores of the quality of life before intervention in the dimensions of physical health, mental health, social communications, and environmental health and the mean total scores of quality of life, and in the mean scores of quality of life in the domain of physical health immediately after intervention between the two groups ($P > 0.3$).

Table 1: Content of group psycho-educational program (length of each session was 90 min)

Familiarizing the families with the researcher, the program, general concept of mental disorder, and related social stigma
Familiarizing the families with definition, types, trend, and prognosis, and mood disorders signs
Familiarizing the families with the way to manage and control illusions and delirium, and anger management methods
Familiarizing the families with signs and symptoms of suicide, the way to control and prevent it, the signs of recurrence, and reduction of recurrence as much as possible
Familiarizing the families with the concept of medicational treatment of mood disorders
Familiarizing the families with the concept of non-medicational treatment of mood disorders, and anxiety, stress, and disturbing thoughts lowering techniques
Familiarizing the families with method of adaptation with self-emotions
Familiarizing the families with how to communicate with a person with mood disorder
Familiarizing the families with basic skills to get along with the person with mood disorder
Familiarizing the families with the way of making coordination between families' needs and those of the person with mood disorder

Table 2: Comparison of mean scores and SDs of age, number of family members, and length of care among the subjects in the study and control groups

Group	Study		Control		*t* test	
Variable	**Mean**	**SD**	**Mean**	**SD**	***P* value**	***t***
Family member						
Age	40.6	9.5	41.6	10.5	0.7	0.3
Number of family members	4.9	1.7	4.9	1.4	1	0
Length of caring the patient (months)	17.3	28.6	13.3	9.1	0.6	0.5
Diseased person						
Age (year)	36	10.2	36.6	12.7	0.9	0.13

SD: Standard deviation

But there was a significant difference in the domains of mental health, social communications, environmental health, and the mean total scores of quality of life immediately after intervention ($P < 0.05$).

There was also a significant difference 1 month after intervention in the mean scores of quality of life in the domains of mental health, social communications, and environmental health and the mean total score of quality of life in the two groups ($P < 0.05$), but there was no significant difference in the domain of physical health ($P = 0.1$). Repeated measure ANOVA showed an increase in the mean scores of quality of life in the domain of physical health immediately after and 1 month after intervention in the study group, but this increase was not statistically significant.

In the domains of mental health and social communications, there was a significant increase in three time points, whereas the mean score of quality of life firstly showed an increase and then a decrease in the domain of environmental health, but the changes were not statistically significant.

In the control group, despite a reduction in the mean score, there was no significant difference in environmental health during three time points. In the study group, there was a significant increase in the mean total score of quality of life in three time points. In the control group, although there was a reduction in the mean total scores of quality of life, the reduction was not significant [Table 3].

Discussion

In this study, we tried to investigate the effect of group psycho-educational program on the quality of life in families of patients with mood disorders. Findings showed that intervention led to an increase in the mean total score of quality of life in the study group, while lack of intervention in the control group resulted in a reduction in quality of life, but the difference was not statistically significant. Therefore, the intervention resulted in prevention of the reduction in quality of life and led to its improvement in families of patients with mood disorders. Sanchez (2009) showed that group psycho-education could be effective on reducing the severity of the disease signs and improving the quality of life in patients with minor and moderate depression, and resulted in recovery, reduction in the signs, and improvement of quality of life.[22] Also, Michalak *et al.* (2005), in a study on the effect of group psycho-education with time limitation on the perception of quality of life in bipolar patients, showed that the mean score of quality of life notably increased immediately after the intervention.[21] The common point of the studies conducted earlier with the present study is the type of intervention, which is group psycho-education, and measurement of quality of life concept. Meanwhile, there were differences in the study population, and the number of subjects and educational sessions, and future follow-ups. However, their results are consistent with the present study. Miklowitz *et al.* (2009), in a study on families with adolescents suffering from bipolar disorder, showed that family-focused psychological education resulted in an increase in their quality of life.[28] Omranifard *et al.* (2008), in a study on the efficacy of modified psycho-educational interventions on family burden and improvement of quality of life in families of bipolar patients, showed that the total score of quality of life increased in three

Table 3: Comparison of mean total scores of quality of life and mean scores of quality of life in four domains and three time points in the two groups of study and control

Time group and domains	Befor intervention		After intervention		One month after intervention		Repeated measure ANOVA intervention	
	M	SD	M	SD	M	SD	*P* value	*t*
Study group								
Physical health	63.3	18.4	66.8	14.8	66.4	13	0.1	0.5
Mental health	53	22	59	17	59.6	12	0.04	0.9
Social communications	51.9	23.1	57.1	18.1	61.8	13	0.04	0.8
Environmental health	50.4	15.6	54.7	13.3	52.5	12.1	0.1	0.6
Mean total score of quality of life	54.4	15.9	59.1	12.9	59	10.2	0.04	0.8
Control group								
Physical health	61.8	9.1	60.3	8.2	61.4	8	0.4	0.9
Mental health	49.9	12.2	49	10.6	46.5	9.2	0.3	1.09
Social communications	51	12.1	47.4	9	46.9	12.1	0.1	1.5
Environmental health	47.9	9.1	46.9	8.6	46.5	7.6	0.4	0.9
Mean total score of quality of life	53.1	9.3	51.6	7.6	51.1	7	0.09	1.6

SD: Standard deviation, ANOVA: Analysis of variance

time points (at the time of intervention and at 3 and 6 months after the intervention) in the study group.[29] In these studies, the quality of life in families of patients with bipolar disorder, as one of the mood disorders, was measured, which is similar and consistent with the present study. Meanwhile, there were differences in the type of educational intervention, number of subjects, and future follow-ups. Khayamnekooee *et al.* (2010), in a study on the effect of cognitive–behavioral training on improvement of quality of life in cardiac patients, showed that cognitive–behavioral education had a significant effect on the three subscales of emotional, physical, and social functions of quality of life, as well as the total score of quality of life.[30]

Taleghani *et al.* (2012), in a study on the effects of peer support group on promoting quality of life in patients with breast cancer, showed that the patients, supported by peers, had a higher quality of life after the intervention, and the increase in mean total score of quality of life was significant.[31] The common point between these studies and the present study is the measurement of quality of life and its final outcome, but the study population, the type of intervention, and the number of subjects are different from those of the present study. Despite this, it is observed that the interventions with educational origin can affect not only patients' quality of life but also their families' quality of life in different populations. The reason can be attributed to the increase of awareness, perception, knowledge, and insight, which is obtained through receiving information by this type of intervention. Quality of life is defined as individuals' perception from their situations in life from the cultural point, the value system in which they live, as well as their goals, expectations, standards, and priorities. It is absolutely personal and cannot be observed by others, and is founded on individuals' perceptions from their life, so these positive results and effects can be interpreted.[33] Repeated measure ANOVA showed an increase in the mean scores of quality of life immediately after and 1 month after the intervention in the domains of physical health, mental health, and social communications in the study group, of which except for the domain of physical health, the increase was significant. In the domain of environmental health, the mean score of quality of life firstly showed an increase and then a decrease, but the difference was not significant. Michalak *et al.* (2005), in a separate study on the domains of quality of life, reported significant changes in the domains of physical health and general satisfaction, but no significant difference in the domain of social communications despite its increasing trend.[21] Omranifard *et al.* (2008) showed that there was an increase in the mean scores of physical health, mental health, and environmental health and a decrease in the mean score of social communications, 3 months after intervention, but the increase and decrease were not significant. Six months after intervention, there was an increase in the mean scores of physical health, mental and environmental health, but the difference was not significant. There was a decrease in the mean score of social communications, which was not significant. In the study group, only in the domains of physical health and mental health, there was a significant difference in the 6th month.[29] Taleghani *et al.* (2012) showed that the differences in subscales were significant in two phases of intervention in Tehran.[32] The differences in the results of some of the domains including physical health and social communications in the studies conducted, compared to the present study, can be due to the difference in sample size, type of intervention and its length, and the follow-ups. In the present study, a lower sample size has been adopted compared to other studies and the follow-up lasted for 1 month after intervention, but in other studies, a longer time was considered to investigate the longevity of effect for intervention. Therefore, the difference can be somehow interpreted.

Conclusion

The obtained finding of the present study showed the positive effect of the group psycho-educational program on quality of life of the families with patients of mood disorders. The findings of the present study are expected to be applied in counseling, clinical and research domains. Psychiatric nurses are in touch with these families in their counseling sessions and can use group psycho-educational method for family group counseling. Research showed that if group psycho-education is administered by trained nurses, more participants join the program. Nurses can also conduct this program in psychiatric ward to increase patients' and families' awareness and knowledge, in order to take steps toward promotion of their quality of life. The limitations of the present study included less number of subjects and short time of follow-up to investigate the longevity of intervention effect. Therefore, the result cannot be confidently generalized to the general population. The researchers hope their obtained results to be useful to conduct further studies to promote the quality of life of the families with a patient of a mental disorder. It is suggested to conduct a study with higher sample size and longer follow-up to investigate the effect of a group psycho-educational program not only on the quality of life of families of patients with mood disorders but also on the families with patients of other mental disorders.

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