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'PSYCHOEDUCATION MANUAL FOR BIPOLAR DISORDER' BY F. COLOM AND E. VIETA: A BOOK REVIEW AND FUTURE SUGGESTIONS

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There is much evidence of the effectiveness of psycho-education in bipolar disorder: its importance in preventing depressive and manic episodes, reducing the length of hospitalizations and increasing adherence to treatment is proven (Rabelo et al. 2021, Joas et al. 2020). Psychoeducation also has a significant impact on improving the quality of life of users (Michalak et al. 2005).

The mechanism of action of psycho-education spans three levels of complexity:

- disease awareness (recognition of prodromal symptoms and adherence to treatment);
- stress management, avoidance of abusive behaviour and regularisation of lifestyle;
- promotion of general well-being and improvement of quality of life.

Colom and Vieta's handbook provides a largely standardised methodology of psycho-education for patients with bipolar disorder, proposing an activity divided into 21 sessions, each relating to a different topic (Colom & Vieta 2006).

The psycho-educational group is not structured as a simple teaching of contents and explanation of bipolar pathology, but stimulates, throughout socratic dialogue, the active involvement of the participants with their reflections and sharing of their own experience of illness. This aspect, also from personal experience in conducting psycho-educational groups, is essential and much appreciated by participants, who have the opportunity to share their subjective experience of illness with that of other people, thus not feeling alone in facing suffering.

Each chapter is structured in the same way, indicating the objective of the session, some useful hints, some information material for the patient, about the topics dealt with and the homeworks, which consist of questions anticipating the next session. This structure allows participants to consolidate the concepts expressed during the activity by reading the material and to prepare for the next one with the homework.

The manual is divided into five main blocks:

- awareness of illness: aetiological factors and triggers of bipolar disorder, mania and hypomania, depression and mixed episodes, outline of the course and prognosis;
- pharmacological adherence: sessions related to psychopharmacology (antipsychotics, mood stabilisers, antidepressants and anxiolytics), risks related to discontinuation of treatment;
- avoidance of substance abuse;
- early identification of new episodes;
- regulating lifestyle and stress management.

The protocol therefore envisages a programme of 21 meetings, held weekly, for a total length of about 6 months. This organisation may be difficult to maintain due to structural limitations, such as the lack of structured staff or the inability of users to attend all sessions. Therefore, the activity can also be realised in a shorter version, combining some topics in one session or avoiding some topics.

The shorter programme, of course, has disadvantages in terms of group cohesion, more concise treatment of content and 'modelling', a very important concept in psycho-education, i.e. learning behaviour through the error or positive actions of other participants.

To summarise, the advantages of introducing a psycho-educational group in an outpatient setting are various: promoting mutual help between patients, reducing stigma, improving intellectual and emotional insight, increasing the patients' social relationships, and it is a zero-cost intervention, only requiring qualified staff.

The Authors suggest a number of participants between 8 and 12 patients, as a larger group would probably not allow a good involvement of all users and could be dispersive. Nevertheless, considering the dropout rate, which is usually close to 25% (Gaur & Grover 2009, Zucca et al. 2017), it may be useful to start with a group of 15-16 people, which would end up being 10-12 over the course of the activity. The recommended age range is from 18 to 55, trying as far as possible to create a homogeneous group in terms of age and personality of the participants. The heterogeneity of the

group, also based on personal experience, can increase group cohesion, with the 'veteran' patients willingly accepting their role and being a positive figure for the younger ones, who see someone who has managed to live with the same pathology as them for years.

For the success of the activity and the creation of the group, it is also advisable that the conductors carry out individual interviews with each participant, in which the project and its aims are explained.

Usually, no group distinction is made into bipolar I and bipolar II disorder, although the differences between the clinical pictures are clearly explained in the groups, although it might be interesting to investigate through clinical studies whether psycho-educational interventions have the same effect on these two clinical subtypes.

It is crucial that the activity be conducted by more than one professional figure. The authors suggest that these should be psychologists, psychiatric rehabilitation technicians or psychiatrists, with the prerequisite of having good clinical experience in bipolar disorder. Based on personal experience of conducting groups, it might be useful to have also a nursing figure in leading and supporting the activity. Nurses very often have a greater knowledge of the patients referred to the centre and a crucial role within the service, and can therefore provide an important contribution in leading the group. In this way, the activity would involve several professionals within the same service, increasing cohesion and multidisciplinary collaboration.

The material needed consists of a room that can accommodate 15-20 people, a blackboard for drawing graphs or key words and the summary paper material and homework for users. The summary material is very useful if participants miss some sessions to catch up and allows them to consolidate the concepts expressed during the activity. The homeworks usually anticipate the topics of the next session, allowing the most disciplined participants (it frequently happens that homeworks are not done), to be prepared for it.

Authors suggest to arrange sessions that last approximately 90 minutes and can be scheduled at a time that does not interfere with the Centre's routine activities and participants' personal commitments (e.g. late afternoon or lunchtime).

Within the duration of each meeting, it is advisable to devote the first 15-20 minutes to an informal conversation, on how the week went or on current topics. Subsequently, the middle part (about 40 minutes) will be devoted to addressing the topic of the meeting and the last half hour for discussion of the issues, where the presenters stimulate the participants' dialogue so that none of them monopolise the conversation and all share their experiences and opinions.

Very important may be the use of references to films or books concerning psychiatry, and specifically bipolar disorder. This usually stimulates the users' curiosity and allows a different and less serious approach to the subject matter, enabling it to be discussed more lightly. It is also useful to cite examples of famous people who are or have been affected by bipolar disorder (e.g. Van Gogh, Franz Kafka, Winston Churchill or Kurt Cobain). This dispels the notion, often inherent in patients and the general population, that psychiatric illnesses *'affect the weak*', and are usually examples that instil a sense of hope in participants.

Equally important can be references to books or films about bipolar disorder or people suffering from it: for example, during one group, the book '*An Unquiet Mind*', written by Ray Radfield Jamison, a psychiatrist suffering from bipolar disorder, was mentioned, arousing the interest of the participants and prompting two of them to buy the novel.

Among the topics discussed of greatest interest were the sessions devoted to drug therapy.

The explanation of the mechanisms of action and some pharmacological concepts usually arouses much interest in the group. In this way, users can increase their level of knowledge on the topic, with consequent benefits on treatment compliance, as confirmed by several works (Colom et al. 2005, Rosa et al. 2007).

The manual constitutes, to date and according to personal experience, the only evidence-based and well-defined protocol on psycho-education in bipolar disorder.

In addition, there are evidences about psycho-educational interventions on family members of users with bipolar disorder, which have been proven to be effective, either in addition to the user group or on their own (Miklowitz & Chung 2016, Gex et al. 2015).

There are also psycho-educational interventions involving technological tools, such as the use of dedicated apps (García-Estela A et al. 2022; Depp et al. 2015), as well as individual psycho-educational models, either within a psychotherapeutic pathway or separately (Gumus et al. 2015), are also becoming more widespread.

A topic often mentioned in the group sharing is hospitalisation. This experience is obviously perceived as emotionally touching and intense. It happened during the groups that a patient mentioned the days of his bed restraint during his stay in the psychiatric ward. This is a very heartfelt topic among users and often difficult to deal with, for which there is no specific module in the manual: it might therefore be important to expand the topics covered by devoting at least one session to this issue.

In addition to this manual, several protocols for psycho-educational groups on other mental disorders can be found in the literature: to name but a few, Schizophrenia (Falloon 2000), Anxiety (Andrews 2004), Depressive Disorders (Morosini et al. 2004), alcohol and gambling disorder (Magill et al. 2021, O'Neil 2017). Such interventions act significantly on the quality of life of users, in a recovery-oriented approach. It would therefore be important to implement these more and more frequently in mental health services, as they are effective, inexpensive interventions that do not require a high degree of training on the part of the conductors.

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