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BRIEF CLINICAL REPORT

Telehealth-delivered recovery-orientated well-being plan group program for bipolar disorder: a pilot randomised feasibility and acceptability study

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Abstract

Background: Psychological interventions may assist in the management of bipolar disorder, but few studies have assessed the use of group therapy programs using telehealth.
Aims: The present study aimed to assess the feasibility and acceptability of a well-being group program for people living with bipolar disorder designed to be delivered via telehealth (Zoom platform) using a randomised controlled pilot design.
Method: Participants were randomly assigned to either the 8-week well-being plan treatment condition or the wait-list control condition. They were administered a structured diagnostic instrument to confirm bipolar disorder diagnosis followed by a set of self-report questionnaires relating to mood, quality of life, personal recovery, and stigma.
Results: A total of 32 participants (16 treatment; 16 control) were randomised with 12 participants completing the intervention, and 13 the control condition. The program appeared acceptable and feasible (75% retention rate) with a mean attendance being reported of 7.25 sessions attended out of a possible 8 sessions. Participants reported high levels of satisfaction overall with the intervention, with a mean score of 9.18 out of 10.
Discussion: Preliminary evidence suggests that delivery of the group program online is feasible and acceptable for participants living with bipolar disorder. As the program was designed to prevent relapse over time, further research is needed to determine if the program may be helpful in improving symptom outcomes over a longer follow-up period.

Keywords: bipolar disorder; cognitive behaviour therapy; group therapy; psychotherapy; wellbeing plan

Introduction

Bipolar disorder (BD) is a lifelong chronic mental health condition affecting 1–2% of the population worldwide. Although it is diagnosed based on mania or hypomania symptoms, depression is the most prevalent symptom experienced (American Psychiatric Association, 2022). Well-being plans are a psychoeducation approach that target early warning signs and triggers, and include psychoeducation about symptoms (Cook *et al.*, 2012). However, many people living with bipolar disorder are not accessing psychosocial therapies such as psychoeducation programs due to a lack of availability of these services in their regions (Barbato *et al.*, 2016).

During the COVID-19 pandemic, psychological services were delivered via telehealth platforms, with many of these services now continuing to be offered via telehealth in order to increase ongoing access to treatment. However, although telehealth programs have been shown to be as effective as face-to-face therapy in several studies, few research studies have been conducted that have explored telehealth delivery for psychological therapy for people living with bipolar disorder (e.g. Sankar *et al.*, 2021) In addition, no studies have assessed the feasability and acceptablity of group therapy programs for adults living with bipolar disorder using telehealth platforms.

The present study aimed to assess the acceptability and feasibility of a recovery-orientated well-being group therapy program for people living with bipolar disorder that was developed specifically to be delivered via telehealth (Zoom platform). Feasibility and acceptability were to be determined by at least a 70% retention in the treatment arm or higher (30% drop-out or less) indicating a consistency with other group therapy studies in face-to-face settings with at least six out of eight sessions attended during the program (e.g. Perich *et al.*, 2020). Corresponding qualitative data indicating acceptability of the content, Zoom delivery and group processes were also aimed to be assessed, with data being collected using a semi-structured interview.

Method

Participants

Thirty-six participants expressed interest in the study; four were excluded for not meeting the inclusion criteria. The inclusion criteria were being over 18 years of age, having a confirmed diagnosis of BD, and being under the care of a GP or psychiatrist. Exclusion criteria were being located outside of Australia. Groups were conducted from April 2021 to June 2022. Thirty-two participants were randomised to the trial and were allocated to one of the two groups, with 12 participants completing all elements of the well-being plan intervention and 13 completing all elements of the wait-list control condition, including completing all questionnaires. Four (13%) males and 28 (87%) females in total took part, with 29 (91%) participants being born in Australia. Seventeen (53%) participants reported having a bachelor's degree or higher, with 12 (38%) reporting a vocational qualification and three (9%) reporting other. Most participants ($n = 30$; 90%) were currently taking medication for BD symptom management. Nineteen participants were diagnosed with BD I (59%) with the remaining diagnosed with BD II. All participants were confirmed as being under the care of a GP or psychiatrist.

Participants were recruited from the community via social media (Facebook, Instagram advertising) and existing research participant databases. The trial was listed with Australian New Zealand Clinical Trials Registry (ACTRN12623000043639).

Procedure

Participants were provided with a link to the study's participant information and online consent, and were directed to a set of questions regarding eligibility. After participants consented to be contacted and to take part in the study, they were contacted via email to book in a telephone interview to confirm their bipolar disorder diagnosis, using the SCID-5 (Research Version). The interview was conducted by a psychologist or clinical psychologist trained in the administration of the SCID.

After confirmation of the diagnosis, participants were enrolled into the study and asked to complete questionnaires which included demographics questions, mood symptoms (Altman Self-Rating Mania Scale, ASRM), Depression, Anxiety and Stress Scales, DASS-21), quality of life (Brief version of Quality of Life in Bipolar Disorder Brief, QOL.BD), personal recovery (The Bipolar

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Recovery Questionnaire, BRQ) and internalised stigma (The Internalized Stigma of Mental Illness). The inventory was administered online via Qualtrics.

Participants were then randomly assigned to either the treatment condition or the wait-list control condition (under the care of a GP or psychiatrist). Randomisation was undertaken by a researcher who was not associated with the research study. The researcher used a computer-generated randomisation list to conduct the randomisation where the participants were then randomly allocated to a condition using a block randomisation sequence with 16 participants in each group (eight per condition). The researcher conducting the randomisation was blind to the conditions.

Participants allocated to the treatment condition then attended an 8-week well-being planning group telehealth delivered via the Zoom platform. Each session lasted for approximate 1.5 hours. The group therapy was conducted by a registered psychologist with a research assistant/Master of Clinical Psychology trainee students attending throughout the trial. Any adverse events that occurred during the session were recorded by the research assistant/student, whilst a daily journal was reviewed for any adverse events that may have been related to the intervention during the trial at completion. At the completion of the 8-week program, participants in the wait-list control and treatment conditions completed the same battery of self-report questionnaires. Participants in the wait-list control condition were then invited to take part in the well-being plan program. Researchers conducting the interviews were not blinded to the treatment allocation and interviews were conducted by telephone.

Data analyses

Data on feasibility and acceptability (number of sessions attended, completion of well-being plan, drop-out rates) were collected throughout the trial in session and recorded into SPSS V 28 (SPSS for Windows). Descriptive data (mean score calculations) were conducted for self-reported measures. Chi-square analyses were conducted comparing group allocation on demographic and clinical features of gender, sexuality, employment status, country of birth, receipt of government benefits, bipolar subtype, rapid cycling history, seasonal mood history, and diagnosis of an additional mental health condition.

Due to the pilot nature of the study, statistical analyses to determine significant differences between groups were not conducted. Effect sizes were reported from pre- to post-treatment for both conditions using intention-to-treat principle where the last data point assessed was used in the final analysis ($n = 7$). This method was chosen due to the small sample size and preliminary nature of the study.

Qualitative data were analysed using a content analysis framework employing a directed approach (Hsieh and Shannon, 2005). For this study, data relating to discussion of the therapy content were extracted for inclusion in this study. Data were then coded into the broad categories as 'helpful', 'unhelpful' or 'areas for improvement'.

Results

A total of 12 out of 16 participants (10 females; 2 males) who were allocated to the treatment condition competed all aspects of the baseline, group therapy program and post-treatment questionnaires, with 13 out of 16 participants (12 females; 1 male) completing all elements of the wait-list control condition assessments. Chi square analysis indicated no significant differences between the groups on any demographic or clinical variables assessed. Retention rates were similar across the two group conditions with 75% completing in the treatment condition and 81%

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completing in the control condition. Reasons for drop-outs are listed in Fig. S1 at each stage of the study (see Supplementary material).

The mean number of sessions attended in the treatment group was 7.25 out of 8 sessions (91%, $SD = 1.21$; range 4–8 sessions), with seven (58%) participants attending the full 8 sessions, three (25%) attending 7 sessions and the remaining participants (16%) attending less than 6 sessions. Of the treatment group participants who reported weekly satisfaction ratings after completing each weekly group session, the overall mean scores for all sessions for helpfulness was 9.02 ($SD = 1.27$; range 5–10); engagement with others 8.95 ($SD = 1.41$; range 5–10); and satisfaction 9.14 ($SD = 9.14$; range 5–10).

No serious adverse events were reported by participants or observed in direct response to the intervention during the Zoom group. No significant technical issues were noted with Zoom during the program's delivery, with participants being able to attend or resolve any technical issues with the platform that arose. No participant reported discontinuing the program due to the use of Zoom.

Participants mean self-reported symptom scores at baseline and post-treatment are reported in Table 1.

Discussion

The aim of this study was to pilot feasibility and acceptability of a telehealth-delivered recovery-orientated well-being group program for BD. Retention rates were similar across the two group conditions, with 75% completing in the treatment condition. There was a high overall attendance rate noted throughout, with more than half of participants attending the full program of 8 sessions and the majority attending between 7 and 8 sessions out of 8 sessions.

This study also found that the telehealth platform, Zoom, appeared feasible and acceptable to participants. There were no significant technical issues noted throughout the delivery of the program and any technical issues were able to be resolved by the participants taking part during the program. No drop-outs were reported to have occurred due to technical issues, suggesting that this is a viable form of delivery for this group of participants. However, it is worth noting that this program was advertised as a telehealth-delivered program specifically, and it is unclear how many participants chose not to take part in the study due to this.

The retention rate of 75% found was consistent to other bipolar disorder group therapy programs, including previous research which noted a retention rate of 71% for face-to-face group therapy for anxiety (Perich *et al.*, 2020). However, it was slightly lower than other telehealth programs for young people with BD, with a 77% rate noted in this study (Sankar *et al.*, 2021). This suggests that telehealth delivered programs are similar to or higher than face-to-face programs in participant retention.

There are several limitations noted for this study. Firstly, there was a small sample size and a larger pilot randomised controlled trial would need to have been conducted to review any potential changes in symptoms. Another limitation is the low representation of people who identified as male taking part in the study. More work is needed to ensure that this program is also feasible and acceptable to this population.

Preliminary evidence suggests that the telehealth-delivered recovery-orientated well-being plan group program was acceptable and feasible for participants living with bipolar disorder, suggesting that this approach may be helpful in increasing access to psychological treatment and reducing gaps in health care delivery. Although most participants completed the well-being plan as part of the program, further research is needed to determine if the bipolar-specific well-being plan group program is helpful in reducing symptoms and improving outcomes over a longer follow-up period.

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Table 1. ITT pre- and post-intervention scores for treatment and control conditions

	Treatment ($n = 16$)							Control ($n = 16$)						
	Pre		Post		95% CI			Pre		Post		95% CI		
	Mean	*SD*	Mean	*SD*	*d*	Lower	Upper	Mean	*SD*	Mean	*SD*	*d*	Lower	Upper
Depression	11.13	10.25	12.75	12.65	−0.1	−0.603	0.38	15.88	8.91	18.63	8.12	−0.4	−0.904	0.116
Anxiety	8.5	7.81	9.13	6.73	−0.1	−0.63	0.355	15.75	7.9	17.5	10.77	−0.2	−0.701	0.29
Stress	14.88	12.77	15.75	11.52	−0.1	−0.625	0.36	21.75	22.88	22.88	8.82	−0.1	−0.635	0.351
Mania	3.38	3.44	2.94	2.91	0.1	−0.405	0.576	2.13	2.03	3.69	2.85	−0.5	−0.997	0.042
Quality of Life	40.31	9.68	38.06	9.55	0.2	−0.293	0.698	30.31	6.03	31.94	6.9	−0.4	−0.988	0.121
Recovery	2221.69	256.9	2229.88	272.27	<0.1	−0.531	0.449	2029.13	387.79	2106.63	250.26	−0.2	−0.727	0.267
Stigma	57.69	9.71	60.06	10.95	0.3	−0.821	0.185	68.69	11.06	71.5	11.7	−0.5	−0.981	0.054

Supplementary material. The supplementary material for this article can be found at https://doi.org/10.1017/S1352465824000316

Data availability statement. Data are available on request due to privacy/ethical restrictions.

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Competing interests. The authors declare none.

Ethical standards. Informed written consent was obtained from all participants and the study was approved by the Western Sydney University Human Research Ethics Committee (H14254). The research was conducted conforming to the Declaration of Helsinki.

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