Clinical Practice Guidelines for Psychoeducation in Psychiatric Disorders General Principles of Psychoeducation

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INTRODUCTION

In the last few decades, psychoeducation has come up as a useful and effective mode of psychotherapy for persons with mental illness. It has been found to be fruitful in both clinical and community settings.

Psychoeducation has its roots in the "Mental Hygiene Movement" of the early 20th century and "Deinstitutionalization Movement" of the 1950s and 1960s. Subsequently, studies on the role of "Expressed Emotions" in schizophrenia provided further impetus to the growth of psychoeducation.

Psychoeducation combines the elements of cognitive-behavior therapy, group therapy, and education. The basic aim is to provide the patient and families knowledge about various facets of the illness and its treatment so that they can work together with mental health professionals for a better overall outcome.

WHAT IS PSYCHOEDUCATION?

Anderson *et al*. used the term for the first time in 1980 for the family treatment of patients with schizophrenia. They mentioned four essential elements of psychoeducation [Table 1]. They suggested that the relatives of the patients were also to be included in the sessions.

Barker, in the Social Work Dictionary, defined psychoeducation as the "process of teaching clients with mental illness and their family members about the nature of the illness, including its etiology, progression, consequences, prognosis, treatment, and alternatives."

GOALS OF PSYCHOEDUCATION

- To ensure basic knowledge and competence of patients and their relatives about the illness
- To provide insight into the illness
- To promote relapse prevention
- Engaging in crisis management and suicide prevention.

BASIC COMPONENTS OF PSYCHOEDUCATION

Psychoeducation usually includes certain basic components of information, which are to be imparted to patients and their family members regarding a particular mental disorder. The modules may be modified to suit the needs of the patients, family members, clinicians, or vary according to a particular disorder. Thus, the number and timing of the sessions may vary along with alterations in the overall content. However, it is desirable to cover the essential components, as shown in Table 2.

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VARIOUS TYPES OF PSYCHOEDUCATION

According to the target population, psychoeducation can be individual, family, group, or community based.

According to the predominant focus of psychoeducation, it can be compliance/adherence focused, illness focused, treatment focused, and rehabilitation focused.

Active psychoeducation involves the active involvement of the therapist with the patient/family during the process, leading to interaction and clarification. In passive psychoeducation, materials are provided to patients/family members in the form of pamphlets, audio/video material that they are supposed to read and assimilate on their own. In a busy clinic with limited available time, a clinician may take resort to passive psychoeducation by distributing leaflets or educative materials about the illness written in a simple language, which the patient and guardians can easily understand and assimilate.

GROUP PSYCHOEDUCATION

This usually comprises patients having similar kinds of illness. Thus, groups may consist of patients with bipolar disorder, schizophrenia, substance abuse, etc. It is not desirable to form a group with members having different kinds of illness. Groups usually have 4–12 members, with the optimum number being 8. The number of sessions usually varies from 5 to 24, with the optimum number of sessions being determined by research and practice. Often, the availability of resources in terms of available time and workforce may lead to modifications in the number of sessions, though the broad areas to be covered for each disorder remain the same. The sessions usually last 40–60 min and are mostly held at weekly intervals. The optimal time and frequency of sessions help in the better assimilation of the information, which has been shared and discussed. It may be useful to hand over printed material after each session, which highlights in simple language the salient features of the topics discussed in that particular session.

Table 1: Essential elements of psychoeducation

1. Briefing the patients about their illness
2. Problem-solving training
3. Communication training
4. Self-assertiveness training

Table 2: Essential components of psychoeducation sessions

Etiological factors
Common signs and symptoms
Awareness regarding the early signs of relapse/recurrence
How to cope with the situation
Various treatment options available
When and how to seek treatment
Need for adherence to treatment as per the guidance of treating team
Long-term course and outcome
Dos and don'ts for family members while dealing with the patient
Clearing myths and misconceptions about the illness and dispelling stigma

FAMILY PSYCHOEDUCATION

Family psychoeducation can be carried in the setting of single families or in a group with more than one family having similar kinds of illness in their patients (multifamily groups). Family-based psychoeducation models can be quite useful in the Indian context as most of the Indian patients stay with their families unlike their Western counterparts. Family-based psychoeducation models have been found to be effective in schizophrenia and bipolar disorder. Family psychoeducation becomes especially important in dealing with severe mental illnesses when in symptomatic phases, patients lack insight and may be reluctant to take medicines. It is also helpful to make them aware of early signs of relapse so that they can identify and seek help accordingly. The number and frequency of sessions are variable, though the average number is between 6 and 12 sessions held at weekly intervals. Follow-up sessions may be conducted at monthly intervals following the discharge of the patient.

MODELS OF PSYCHOEDUCATION

Information model

The focus is on providing families knowledge about psychiatric illness and their management.

Skill training model

The skill training model focusses on developing certain skills so that the family members can manage the illness more effectively.

Supportive model

The supportive model mainly involves taking help of support groups for engaging the family members of the patients in sharing their feelings.

Comprehensive model

The comprehensive model uses a combination of the previous three models.

HOW EFFECTIVE IS PSYCHOEDUCATION

Zhao *et al*. in a systematic review of 20 studies concluded that psychoeducation appears to reduce relapse and promote adherence in severe mental illnesses such as schizophrenia. Most studies have evaluated family psychoeducation for schizophrenia or schizoaffective disorder only. However, the results of several controlled studies support the benefits of psychoeducational family

interventions for other psychiatric disorders, including bipolar disorder, major depression, obsessive-compulsive disorder, substance abuse, and borderline personality disorder.

PSYCHOEDUCATION IN VARIOUS PSYCHIATRIC DISORDERS

Psychoeducation for schizophrenia

Initial discussions should start by encouraging the patients to come out with their understanding of the disorder. Once this area has been clarified, a common denominator between layman's knowledge of illness and scientific textbook knowledge of illness is gradually developed. The basic message should be that schizophrenia is caused by biological factors in combination with psychological stress. Hence, both medications and psychosocial interventions are essential for management. Apart from the essential components mentioned before, other information specific to the illness which needs to be shared includes

- Meaning of the term "Schizophrenia"
- Positive and negative symptoms
- Neurobiological origin of symptoms
- Stress-vulnerability-coping model
- Various medicines and their side effects
- Psychosocial measures
- Psychotherapeutic interventions and suicide prevention
- Early warning signs and relapse prevention
- Long-term course and outcome, including remission and recovery.

PSYCHOEDUCATION FOR BIPOLAR DISORDER

The working group on psychoeducation in bipolar disorder defines psychoeducation as information-based behavioral training aimed at adjusting lifestyle to cope with bipolar disorder. The components include increasing the awareness of illness, treatment adherence, early detection of relapse, and avoidance of potential triggers such as illegal drugs and sleep deprivation.

Illness awareness

Most of the patients of bipolar disorder have poor insight into their condition. If the patient does not gain insight into his condition, he would be unlikely to take interest in the subsequent sessions of psychoeducation. Emphasizing the medical model of the illness helps in reducing stigma related to the illness. It is also taught that the illness has a biological origin, though triggering factors may be either biological or psychological.

The issues addressed cover the following areas:

1. Introduction
2. What is Bipolar Disorder?
3. Etiologies and triggering factors
4. Symptoms of mania and hypomania
5. Symptoms of depression and mixed episode
6. Course and outcome of bipolar disorder.

Treatment adherence

Almost half of the patients with bipolar disorder discontinue treatment abruptly and without supervision sometime in their lives. Almost all patients of bipolar disorder think of discontinuing medications at some point of time during the course of illness. This occurs quite commonly during the euthymic phase or in those with comorbid substance abuse or personality disorder. The areas that need to be covered while targeting better treatment adherence are as follows:

1. Mood stabilizers
2. Antimanic agents
3. Antidepressants
4. Serum levels of lithium, carbamazepine, and valproate
5. Pregnancy and genetic counseling
6. Psychopharmacology versus alternative therapies
7. Risks associated with treatment withdrawal.

A detailed discussion about the side effects of the commonly used medications and the ways of handling them is essential for getting rid of several myths among the patients in relation to medications. Fears of becoming "dependent for life" on these medications or "losing sharpness of mind" are some of the well-publicized misconceptions regarding psychotropics which force patients to discontinue medicines abruptly. Such myths must be gradually dispelled by careful discussion.

Avoiding substance misuse

More than half of bipolar disorder patients have comorbid substance abuse. Alcohol is the most frequently misused drug among bipolar patients. This is associated with more depressive episodes, greater problems with adherence, and poor recovery. Sometimes, substance use can trigger a full-blown affective episode. Psychoeducation must involve knowledge about alcohol and other drugs and their harmful effects on patients with bipolar disorder.

DETECTING EARLY WARNING SIGNS

Detecting early warning signs is a very important step for preventing a full-blown episode. It is very important to emphasize that a hypomanic episode needs to be identified and acted upon very quickly as it may quickly escalate to a manic state. It also needs to be addressed that many patients enjoy the initial mood elevation of the hypomanic episode and hence have a tendency not to report the symptoms to family members or psychiatrists. It is also important to give the patient and family members an emergency plan of what is to be done in case of a relapse.

Regularity of lifestyle

Regular habits, including proper sleep habits and structuring of activities, are emphasized. The necessity of 7–9 h of night-time sleep is emphasized with avoidance of daytime naps is taught. The role of sleep deprivation in triggering manic episodes is also highlighted. The patients are also taught the necessity of regular physical exercise. Stress management techniques are also taught followed by simple problem-solving skills which may be of use in a day-to-day life.

PSYCHOEDUCATION FOR ANXIETY AND DEPRESSIVE DISORDERS

Psychoeducation has become an important step in the management of anxiety and depressive disorders. After the diagnosis of anxiety and depressive disorder and performing necessary assessments, the mental health professionals should provide detailed information to the patient regarding the symptoms, causes, various treatment options, side effects of medications, need for adherence, and overall course and outcome of the disorder. Apart from medications, the role of nonpharmacological measures such as activity scheduling and regular physical exercise is emphasized. Passive psychoeducation is very popular in patients with anxiety disorders. This involves passing on to the patients' various resources such as books, pamphlets, or videos which explain clearly various aspects of anxiety disorders. Unlike active psychoeducation, here the therapist does not interact actively with the patient while imparting education about the illness.

PSYCHOEDUCATION FOR SUBSTANCE USE DISORDER

Group psychoeducation is one of the cornerstones of psychosocial management of patients with substance use disorder. Such groups educate patients about substance misuse and its consequences. Such groups usually deal with individuals in precontemplation and contemplation phase of change and help in increasing their motivation to abstain. Typical group psychoeducation for substance abuse must highlight certain points which are as follows:.

Medical complications

Detailed discussion of physical and psychological complications is carried out. Many times, patients have wrong conceptions about physical illness, for example, they think that they are alright as long as they do not have obvious physical symptoms. Such misconceptions are cleared.

Family issues

Various aspects of family problems in patients with alcohol dependence are discussed. This includes family conflicts and the role of family in maintaining substance-related behavior. How the family can help in promoting relapse prevention is also discussed.

Social and professional aspects

This includes the role of peer group in initiating and maintaining substance dependence. The role of friends in promoting relapse prevention and avoiding critical comments is also discussed.

Treatment process and recovery

The different phases of treatment from detoxification to relapse prevention are discussed. The role of various drugs and their side effects is discussed.

Craving and relapse

In this session, the role of craving in causing relapse is discussed. This also includes the role of various triggering factors and how to avoid them. The methods of controlling craving are also discussed.

Utilizing free time

The importance of finding alternate sources of pleasure is discussed along with the need to "decondition" the concept of substance with "good times" and "enjoyment."

Adaptation to a new life

The patient is taught to adopt and gradually accept the new role of a "substance-free individual."

PSYCHOEDUCATION FOR PERSONALITY DISORDERS

The primary objective of the psychoeducation program is to make the patients aware of personality disorders in general, and the particular personality disorder with which he has been diagnosed. Initially, a baseline idea regarding the patient's knowledge about his own diagnosis is obtained and what according to him would help him. The concepts of personality and personality disorder are discussed. How personality disorders can cause problems to affected individuals is highlighted. The particular personality disorder which affects the individual is discussed in detail. The patient is also encouraged to point out those features that are present in him from a written checklist consisting of various maladaptive personality traits. As psychoeducation progresses, the attempt is gradually made to make the patient aware of his maladaptive traits. Once the patient develops some insight, detailed psychoeducation of the biological and psychological factors, leading to his current maladaptive traits is carried out. However, in cases with severe personality disorders, one has to gradually work through the areas where the patient takes recourse to denial.

PSYCHOEDUCATION FOR DUAL DIAGNOSIS

Dual diagnosis refers to patients having a psychiatric disorder along with comorbid substance abuse or dependence. About one-third of patients with serious mental illness has a comorbid substance use disorder. The dominant models

of care for these groups of patients include parallel and sequential models. In the parallel model, separate specialists treat the comorbid disorders separately. In the sequential model, the primary condition is treated first followed by the comorbid condition. The group psychoeducation model for patients with dual diagnosis relies on an integrated holistic approach where the same team deals with the treatment of both the conditions. The main advantage of the integrated approach is that both the conditions can be given due attention in the same sitting by the same team.

The individual or group psychoeducation programs for dual diagnosis patients must highlight the following points:

- Stages of motivation and how to overcome the barriers to change
- Various aspects of substance misuse and its effects on mood and behavior
- How substance abuse adversely affects mental health and negatively alters the course and outcome of mental disorders
- Techniques of relapse prevention and skills training
- Ways to cope with emotional problems and symptoms of mental illness
- Skills training and lifestyle change.

CONCLUSION

Over the years, psychoeducation has emerged as an effective adjunctive psychotherapeutic tool for patients and their families with various types of psychiatric disorders. Its efficacy in promoting adherence and preventing relapse has been well established by trials in schizophrenia and bipolar disorder. Studies are also being carried out in other psychiatric disorders to firmly establish its efficacy. It remains a simple and cost-effective treatment modality, which goes a long way in empowering the patients and their family members with the knowledge of their illness, which helps them cope better with the condition and manage it more effectively. Although studies on psychoeducation are relatively scarce in India, the overwhelming family support available to most of the psychiatric patients makes this treatment modality an ideal tool for implementation in our settings.

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REFERENCES

1. Anderson CM, Hogarty GE, Reiss DJ. Family treatment of adult schizophrenic patients: A psycho-educational approach. Schizophr Bull 1980;6:490-505.
2. Bäuml J, Froböse T, Kraemer S, Rentrop M, Pitschel-Walz G. Psychoeducation: A basic psychotherapeutic intervention for patients with schizophrenia and their families. Schizophr Bull 2006;32 Suppl 1:S1-9.
3. Barker RL. The Social Work Dictionary. Washington DC: NASW Press; 2003.
4. Kulhara P, Chakrabarti S, Avasthi A, Sharma A, Sharma S. Psychoeducational intervention for caregivers of Indian patients with schizophrenia: A randomised-controlled trial. Acta Psychiatr Scand 2009;119:472-83.
5. Goldstein MJ, Miklowitz DJ. The effectiveness of psychoeducational family therapy in the treatment of schizophrenic disorders. J Marital Fam Ther 1995;21:361-76.
6. Colom F, Vieta E, Martinez-Aran A, Reinares M, Goikolea JM, Benabarre A, *et al*. A randomized trial on the efficacy of group psychoeducation in the prophylaxis of recurrences in bipolar patients whose disease is in remission. Arch Gen Psychiatry 2003;60:402-7.
7. Colom F, Vieta E. Psychoeducation Manual for Bipolar Disorder. Cambridge, UK: Cambridge University Press; 2006.
8. Miklowitz DJ, George EL, Richards JA, Simoneau TL, Suddath RL. A randomized study of family-focused psychoeducation and pharmacotherapy in the outpatient management of bipolar disorder. Arch Gen Psychiatry 2003;60:904-12.
9. Lewinsohn P. The coping with depression course: Review and future directions. Canadian J Behav Sci 1989;21:470-93.
10. Gunaydin N, Barlas GU. Effectiveness of a group and brochure psychoeducation intervention to improve depression level and treatment continuity among adults with depression in Turkey: A controlled study. Biomed Res 2017;4:1493-9.
11. Donker T, Griffiths KM, Cuijpers P, Christensen H. Psychoeducation for depression, anxiety and psychological distress: A meta-analysis. BMC Med 2009;7:79.
12. Chandiramani K, Tripathi BM. Psycho-educational group therapy for alcohol and drug dependence recovery. Indian J Psychiatry 1993;35:169-72.
13. Substance Abuse and Mental Health Administration. Substance Abuse Treatment: Group Therapy Inservice Training. HHS Publication No. (SMA) SMA-11-4664. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2012.
14. D'Silva K, Duggan C. The development of a psychoeducational programme forpersonality disordered patients. Psychiatri Bull 2002;26:268-71.
15. Chilton J, Crone D, Tyson PJ. Clinical outcomes from a 10-week follow-up psychoeducational program for dual diagnosis. J Dual Diagn 2018;14:102-10.
16. Zhao S, Sampson S, Xia J, Jayaram MB. Psychoeducation (brief) for people with serious mental illness. Cochrane Database Syst Rev 2015;9:CD010823.