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Psychoeducation: A Multifaceted Intervention

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The origins of psychoeducation can be traced back to the 1980s, when it was initially introduced as one of an array of therapeutic elements within the context of family treatment for schizophrenia. The term was coined by Anderson and colleagues to describe a therapeutic concept with behavioral orientation entailing the following four components: briefing the patient about his/her illness, problem-solving training, communication and self-assertiveness training, and involvement of family members in the treatment process [1]. Ian Falloon, one of the pioneers of family psychoeducation, formulated the intervention protocol known as “Family Behavioral Management” for individual families with a member suffering from schizophrenia spectrum disorders [2]. Since the 1980s, psychoeducation has expanded its focus and techniques, and many definitions have been put forward to capture this transformation. Nowadays the term denotes “any structured group or individual program that addresses an illness from a multidimensional viewpoint, including familial, social, biological and pharmacological perspectives, as well as providing service users and carers with information, support and management strategies” [3].

Converging evidence has corroborated the beneficial effects of psychoeducation in patients with schizophrenia and bipolar disorder [4–5]. While the literature is homogeneous for bipolar disorder, the same does not hold true for schizophrenia [6–7]. The inconclusive findings of a previous Cochrane review [8] resulted in a recent reevaluation of its effectiveness [5]. The findings of the review, including studies on both family and patient psychoeducation, suggest that psychoeducation reduces relapse and rehospitalization rates, promotes medication adherence, decreases the duration of hospital stays, improves global and social functioning, enhances patients’ quality of life, and increases their satisfaction with services. Therefore, it emerges as a clinically effective and cost-beneficial treatment for schizophrenia.
In line with the accumulated evidence in its favor, the American Psychiatric Association [9] and the German Society for Psychiatry, Psychotherapy and Neurology [10] have recommended psychoeducation as a standard treatment program for people with psychotic illness. Furthermore, a European Expert Panel on the Contemporary Treatment of Schizophrenia has maintained that the systematic provision of information constitutes a fundamental component of good practice in the care of patients with schizophrenia and their caregivers, both as a mode of treatment and for ethical reasons [11]. In spite of the benefits psychoeducational interventions confer, there has only been low uptake of this approach by mental health professionals and clinical settings worldwide [12–14]. Congruent with this, the present issue endeavors to synthesize evidence emanating from different applications of psychoeducation internationally, in order to add strength to the clinical value of psychoeducational interventions for severe mental illness.

The first paper, written by Cakir and Gümüş, addresses patient psychoeducation for bipolar disorder by comparing and contrasting two modes of delivery (individual vs. group) in terms of patient acceptance, motivation, and dropout rates. Participants were recruited from a mood disorders clinic in Turkey. The authors report a preference on the part of patients for individual psychoeducation sessions, on the grounds of feeling more secure and unique—feelings that can partly explain the lower, albeit nonsignificant, difference in dropout rates. This finding is important, as it is in contrast to the beneficial effects attributed to group processes, such as sharing information, exchanging experiences, and having mutual support. The ways that patient preferences shaped treatment outcome in the particular sample await investigation. However, the authors raise at this point the importance of striking a balance between empirical evidence, patient preferences, and organizational issues of a mental health setting.

The second paper, by Malm and colleagues, presents psychoeducational interventions with and without the patient, embedded in an assertive community-treatment service program in Sweden referred to as “Resource Group ACT.” In particular, the program employs psychoeducation, training, and consultative support for both service users and their caregivers (families and/or mental health professionals). The program’s promising results include improvement in social skills, better well-being, and amelioration of symptoms. Malm and colleagues show how psychoeducational principles, strategies, and techniques can be expanded and incorporated in an assertive community-treatment framework. They underline the importance of flexibility in combining psychoeducation with and without patient participation as a means of adding clinical effectiveness to assertive community treatment.

The remaining four papers assess the effectiveness of family psychoeducation in chronic and severe mental illness. Dr. Palli and colleagues investigated the family benefits conferred by a group psychoeducational intervention for relatives of patients suffering from schizophrenia in Greece. A secondary research aim pertained to identifying the subgroup of relatives that could benefit the most from the intervention. The results of the study showed a substantial increase in family cohesion, an enhancement of relatives’ well-being, and a reduction in the occurrence of relatives’ depressive symptoms. The largest improvements were observed for relatives caring for chronic patients; psychoeducation appears to have restored their feelings of hope after having witnessed multiple and recurrent relapses throughout the years. The study highlights that psychoeducation can constitute a valuable clinical asset even for relatives of chronic patients with schizophrenia.
Similar findings are reported by Kolostoumpis and colleagues, who investigated the effectiveness of relatives-group psychoeducation in bipolar disorder. Relatives were recruited from the Families’ Association for Mental Health and received seven psychoeducational sessions in line with the treatment protocol developed by the Barcelona Bipolar Disorders Program. The results of the study suggest that psychoeducation has a favorable influence in terms of relatives’ knowledge, burden levels, and psychological distress upon completion of the intervention and at the six-month follow-up. The study findings add strength to the effectiveness of the treatment protocol developed by the Barcelona Bipolar Disorders Program, even when implemented by research teams outside protocol development and working in another country.

Similarly, Schiffman and colleagues report promising results from the NAMI Family-to-Family educational program for relatives of individuals with mental illness. This peer-led family psychoeducational intervention results in considerable decreases in self-reported burden levels and distress, while it encourages positive attitudes toward relatives’ caregiving roles. Concomitantly, intervention was found to be more effective in relatives of young patients than in relatives of adult patients, underlining the potential of psychoeducation to confer benefits to different population subgroups and therefore to cover a diversity of needs.

From another angle, in the final paper of the issue, Tsiouri and colleagues investigated the influence of psychoeducation in tandem with the systemic properties of families, stressing the importance of family outcomes, such as family cohesion and functioning. Parents of patients with schizophrenia who attended group psychoeducation displayed marked improvements in all three family outcomes—cohesion, burden, and family functioning—as a result of the intervention. Congruent with this, the study underscores the importance of psychoeducation in transforming family atmosphere.

Converging evidence from the aforementioned articles highlights the multifaceted nature of psychoeducation and the wide array of applications it can have. The reports emanate from countries with different mental health systems, thereby corroborating the beneficial effects of psychoeducation in a diversity of outcomes (patients’ relatives or families) and in various mental health settings. There are multiple formats, such as group versus individual, patients versus relatives, peer-led versus professionally led, family with patient participation versus family without patient participation. These provide mental health staff with a variety of clinical tools to choose from and enable them to effortlessly incorporate psychoeducation in routine clinical practice. According to the studies in this issue, mental health professionals should be flexible in adopting a psychoeducation format, they should render the intervention appealing to their patients, and they should take into consideration the multiple benefits the intervention can confer on different population subgroups. Due to its multipronged nature, psychoeducation can be suited to any mental health setting irrespective of culture or the mental health care system, and therefore its low uptake by mental health professionals cannot be ascribed to the principles, application, and effectiveness of the treatment. On the contrary, as Colom [12] has recently noted, the low dissemination of psychoeducational interventions in clinical settings can be accounted for by the treatment paradigm shift that is often necessary prior to incorporating psychoeducation in routine clinical practice. Future research should further stress the effectiveness of these psychoeducation variants while identifying and targeting barriers to their clinical implementation. Psychoeducation can become a critical ingredient in successful community care for patients with severe and enduring mental illness and their relatives.
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