Psychoeducation: The way to Make Patients Manage their Illness and Fill their Future with Life

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I am happy and honoured to share some thoughts on psychoeducation and behavioural family therapy with the readers of Mental Health in Family Medicine Journal.

The focus of my research is linked till now to the psychoeducation of patients with severe mental illness and their families. The focus of my academic experience is linked to the training and supervision of mental health professionals in behavioural family therapy and psychoeducation.

It is well known that psychoeducation is a therapeutic approach whose origins can be found in the findings of the Expressed Emotion Theory (EE). That theory refers to caregivers’ attitudes towards a person with a mental disorder, considering negative factors - such as criticism, hostility and emotional over-involvement on the one hand and positive factors such as warmth and positive attitudes on the other - as important for patient recovery. If even one single person in a family scores high in the negative factors, the whole family is characterized as a "high EE family" [1]. Findings indicate that communication patterns in those families are usually characterized by more intense and negative verbal exchanges, oppositional or conflictual in nature. Significant is also that interaction patterns in high EE dyads are more likely to be rigid. Expressed Emotion is therefore a significant characteristic of the family milieu that has been found to predict symptom relapse in a wide range of mental disorders and especially schizophrenia [2,3]. It is measured by Camberwell Family Interview (CFI) [1] and by the shorter but reliable Five Minute Speech Sample (FMSS) which, based on the CFI, is designed to assess the respondent’s expressed emotional status toward a family member [4]. EE can be modified by psychoeducation [5].

Taking into account the need of the patients for an appropriate family environment when living in the community, as well as family members’ needs and rights to get information and training on how to cope with the illness of their beloved, psychoeducation was developed. Psychoeducation is an intervention that aims to increase patients’ emotional ability to cope with their disease and to improve their knowledge about disease and therapy while training and encouraging the family members to support the patient effectively [6-8]. When considering its evolution through time, psychoeducation could nowadays be defined as a training which empowers the patient, promotes awareness and proactivity, provides tools to manage, cope and live with a mental or physical chronic illness, while changing beliefs, attitudes and behaviors towards to the condition and its consequences [9].

However, the term “psychoeducation” can be misleading partially due to the name itself reinforcing the impression of education as also to lack of deepening in this psychological intervention. As Colom, [9] writes there is a “branding” problem of this therapy. Many health professionals claim to apply psychoeducation when applying just the general good practice of informing the patient about the disorder or giving them some basic guidelines on how to manage crises. Psychoeducation goes far beyond these general practices. Ian Falloon, one of the pioneers of psychoeducation formulated the ingredients in his intervention protocol known as "Behavioural Family Therapy". According to this, psychoeducation consists of three components: information about the illness, education in communication skills and problem-solving techniques and therapeutic support. It has to be noted that psychoeducation includes many therapeutic elements, coming from several psychotherapeutic approaches and mainly from behavioral family therapy, it often uses a consultative framework, and it shares characteristics with other types of individual or group therapies. The application of psychoeducation demands a trained therapist but not a long, complex or thorough special training. It is more important that the clinician applying is an expert on the disorder itself than on the technique. That is why psychoeducation is implemented not only on psychiatric conditions but on physical illnesses too. Of course, when working with families or groups of patients or families, then experience in group or in family work is a demand.

Direct scientific view, which has become in the last years available, demonstrates the positive impact of psychoeducation to the recovery of the illness and its efficacy especially when applied to patients with schizophrenia or bipolar disorder and their family members [10]. The results show that:

In schizophrenia, studies have shown markedly higher reductions in relapse and rehospitalization rates among patients who received psychoeducation, as compared to a control conditions. The effect was even more pronounced when their families received psychoeducation as well, with differences ranging from 20 to 50 percent over two years. In interventions with a higher duration, the reductions in relapse rates were even starker. In addition, the well-being of family members improved, patients’ participation in vocational rehabilitation increased, and the costs of care decreased [11].

The results of my research showed that the participation of relatives with schizophrenia in psychoeducational groups, based on the adapted Falloon's approach in the greek setting, advanced relatives' knowledge about the disease, increased their optimism for the future, established positive attitudes towards the mentally
ill, improved relatives' mental state and reduced family burden. It also led to improved communication and problem-solving strategies within the family, which was reflected in a reduction in hospitalization rates and patients' better compliance to the medication [12,13].

In bipolar depression, the application of psychoeducational interventions has led to fewer relapses, fewer hospitalizations of shorter duration and prolongation of symptom-free period [14]. In cases of bipolar disorder and anxiety disorders, only the combination of pharmacotherapy and psychosocial interventions such as psychoeducation seems to lead to an improvement in overall patient functioning and quality of life [15].

In depression, the application of psychoeducation to patients leads to improvement of the course of the disease, treatment enhancement and patients' better psychosocial functioning [16].

In several other chronic mental and physical diseases, the first attempts to apply psychoeducation have been recorded and the results are promising. More and more publications report the effectiveness of psychoeducational interventions in treating several chronic diseases, a few mentioned below. World Health Organization affirms that it should be provided in order to give information to the patients about treatment management, helping them to avoid complication and engaging patients in their own care path to achieve the best possible quality of life [17,18].

In patients suffering from dementia psychoeducation is found to improve stress management and social functioning of caregivers. In addition, it improves the knowledge of relatives about the disease, the management of patient's memory changes and the ability to make decisions [19].

There are encouraging findings in the literature with regard to patients with ADHD and Tourette's syndrome and their relatives. Interventions improve the knowledge about the disease and enhance positive attitudes and behaviors towards patients. In addition, interventions on parents of children with ADHD improve patient compliance in medication [20].

Psychoeducational interventions are effective in eating disorders, and in particular in "healing processes" such as self-awareness, delineation, feelings, self-mobilization, self-regulation and self-improvement. Immediately they lead to greater readiness to seek treatment [21].

In the rare cases of Munchausen by Proxy Syndrome, it has been found to be very effective in conjunction with behavioral exposure techniques [22].

In Tic disorders, it has been found that treatment should always start with personalized psychoeducation strategies to ensure the best progression of the disorder [23].

With regard to diabetes, integrated psychoeducational interventions in both Type I and Type II patients enhance the maintenance of medication and have been associated with a fall in glycosylated hemoglobin. In addition, the application of psychoeducational interventions to caregivers enhances the results [24,25].

As survival in various forms of cancer has increased, the need for documented efficacy interventions in the recovery of cancer sufferers has grown up. Results of psychoeducation to patients diagnosed with breast cancer, prostate cancer, thyroid cancer, etc. have shown that it improves the patients' emotional well-being within 6 months post-intervention, the quality of life, overall quality of life, reduces levels of depression and anxiety, and improves symptoms associated with the illness such as fatigue, pain, sexual dysfunction and eventually return to work [26-28]. In addition, the application of psychoeducational interventions to children diagnosed with cancer and their families furthers knowledge of the disease and the ability to control the symptoms [29].

In HIV patients, it has been found that psychoeducation should be delivered during the initial assessment, so as to reduce negative beliefs about antiretroviral therapy [30].

Furthermore, it has been reported that applying psychoeducation to patients with Functional Non-Epileptic Attacks led to a reduction in episodes and nearly 40% of those who completed the treatment were not infected by another episode until the end of the treatment. Significant improvements have also been documented in terms of the degree of psychological distress, beliefs about disease and patients' understanding of the condition [31].

The latest publications refer to the implementation of psychoeducation to patients with chronic pain conditions. Evidence indicates that it contributes to gaining control and finding an appropriate level of activity [32]. Investigating the efficacy of psychoeducation in several chronic pain disorders, it has been shown that the intervention, combined with relaxation techniques, significantly reduces frequency of headache attacks (45.9%) and disability degree (44.2%) caused by headache. There is also a sensible reduction in medication use [8,33]. The application of psychoeducation to patients with chronic obstructive pulmonary disease was found too to increase the ability of the patient to self-manage the disease [34].

Single attempts are found in chronic neurological patients suffering from Multiple Sclerosis (MS) or Chronic Kidney and their caregivers. The development of the psychoeducational support group series based on a biopsychosocial model and wellness approach was designed to improve Quality of Life among individuals with MS. A comprehensive, whole-person approach to MS care has been recommended. The results showed that psychoeducation was effective in improving self-reported depression, anxiety, perceived stress, and pain. The findings also suggest that participants in the treatment group experienced an increase in positive affect [35]. Predialysis psychoeducational interventions increase patient knowledge about chronic kidney disease (CKD) and its treatment and extend time to dialysis therapy without compromising physical well-being in the short run. An interesting research exploring the long term (20 years) effects of psychoeducation on survival rates indicated that median survival was 2.25 years longer after patients with CKD received predialysis psychoeducational interventions [36].

**Future questions**

There are several aspects which need to be more precisely researched. To my opinion, the following three constitute major future challenges.
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The exact amount of psychoeducational sessions is a question causing a lingering debate among different clinicians and researchers. That question is related to the content of the sessions, which seems to differ in various clinical settings and allows simple educational interventions to be misnamed psychoeducation and bring confusion to the empirical findings. Psychoeducation should be implied entire, in its three dimensions, in order to keep both the clinical and educational components and to lead to amelioration of the illness and avoidance or at least delay of relapses. According to the international literature and the reviews published, only when it is fully implicated are such results guaranteed [37].

The second major issue is the dissemination of psychoeducation. The publication of the theory of Expressed Emotion lies in the 1980s and the first attempts of psychoeducation in patients with schizophrenia can be traced in that decade. Today at least 2222 articles measuring the efficacy of psychoeducation in clinical trials can be found in search machines. But still the intervention is not integrated to the routine clinical practice, neither in my country, nor elsewhere. This could be definitely due to the lack of trained therapists[38]. As J. Leff, another pioneer of psychoeducation, once declared, the person who would manage to create a drug that could reduce the relapse rate to schizophrenia by 30% in two years would become the richest man in the world, but if developing a family therapy and did the same, he would not be wealthier [39]. Perhaps the most significant difficulty is the integration of psychosocial interventions, psychoeducation and psychosocial rehabilitation in the mentality and practice of mental health specialists. Attitudinal, knowledge-based, practical, and systemic obstacles have to be overcome. An open-door policy of the health services encouraging a proactive attitude of the patient to handle the disorder and answering with flexibility and speed, a multidisciplinary team effort serving a holistic approach of the needs of the patient will create the right clinical environment for psychoeducational interventions in all illnesses.

The third interesting issue is the challenge of applying psychoeducation at more types of chronic diseases. Chronic and severe diseases are mainly characterized by dependence and gradual loss of the capabilities and abilities of the patient and the need to involve the relatives as carers. A wide array of applications can be palpated in very different health and mental health settings. They support the thesis that psychoeducation fits very well on the clinical models of the illnesses and may be very useful to ameliorate the burden of the pain, to avoid medication overuse by the patient and to improve quality of life of the patient and his family. More studies concerning the functioning of the families, their communication and emotional climate and diverse special parameters are needed [40].

I hope these thoughts will contribute to the dissemination of the idea of psychoeducation and to the spread of this simple though effective therapeutic tool to mental health professionals, chronic patients and their families.

REFERENCES


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18. Reed K. Therapeutic Patient Education: Royal Prince Alfred Hospital, Sydney, Australia. 2010.


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