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Models of Psychoeducation: an Indian Perspective

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ABSTRACT *Psychoeducation is an important element of psychiatric treatment. It has a significant role in promoting mental health, preventing mental illness, increasing mental health awareness, creating opportunities and improving the quality of life of the patient, caregivers and the community. There are many models explaining the process of psychoeducation. Applicability of different psychoeducational models depends upon the clinical judgement and feasibility. This review focuses on different models of psychoeducation, barriers of psychoeducation and finding a suitable model for Indian population.*

INTRODUCTION

Psychoeducation could be defined as a patient's empowering training targeted at promoting awareness and proactivity, providing tools to manage, cope and live with a chronic condition (i.e. adherence enhancement, early warning sign identification, lifestyle, crisis management, communication), and changing behaviors and attitudes related to the condition [1]. It replaces guilt by responsibility, helplessness by proactive care and denial by awareness[1].

Merely informing the patient and his/her family about the disorder and some general information about treatment / prevention/ crisis management is not psychoeducation [1]. It is education and training about a condition that causes stress to the person. Better understanding of condition leads to a feeling of control and results in reduced stress associated with the condition.

A person will feel more relaxed and in control of their condition if they have a greater level of understanding. An education about their condition is more likely to make people actively participate in their self-management and relapse prevention. This tends to brings about positive social and self-esteem changes which add to the individual's self efficacy and the accompanying benefits from other psychotherapies and medications.

Psychoeducation is highly effective in [2 - 4] preventing relapse, identification of early warning signs treatment adherence.

The psycho-educational model can be divided in many ways.

1. According to the target population for psychoeducation

a. Individual
b. Family
c. Group
d. Community

2. According to the focus of psycho-education

a. Compliance / Adherence focused
b. Illness focused
c. Treatment focused
d. Rehabilitation focused etc

Individual Psychoeducation

Individual psychoeducation can be more specific and focused and can cover information and content that is more relevant for an individual situation. If group situations are not comfortable then individual psychotherapy with the safety and confidentiality of one to one interaction with a therapist or doctor may be more suitable.

Group psychotherapy

Group psychotherapy is a form of therapy in which people share therapeutic experiences under the guidance of a therapist. Group therapy helps people learn to improve their interpersonal relationships.

The group therapy session is a collaborative effort.Usually a typical session lasts about 75-90 minutes; where members share their own problems, feelings, ideas and reactions. This exploration gives the information needed to understand and help one another. Members gain insight for themselves, their issues they gain encouragement from other participants and provide support and direction for others struggling with issues they have faced in the past.

Group therapy has shown to benefit in variety of illness both in medical and psychiatric disorders like, heart diseases, diabetes, epilepsy, schizophrenia [5], bipolar disorder[4], attention-deficit and/or hyperactivity disorder (ADHD).

Family psychoeducation

It is a therapeutic method of training families to take part collaboratively with the mental health professionals in the management plan of their family member with psychiatric disorder.The family psychoeducation training is intended for [6 – 9] mental health awareness, educate about coping skills, prevent relapse, ensure compliance, readjust the expectations, strengthen psycho-social support, improve social & occupational functioning, support the family.The immediate goal of family psychoeducation is the benefit of the patient and long term goal being benefit of patient & his / her family [6 – 9]Different models of family psychoeducation [6 – 9] are (a)Single family psychoeducation group,(b)Multiple family psychoeducation group, (c)mixed family psychoeducation group (includes family members as well as the patient). In studies, it was found that at least 10 family psychoeducation sessions are required to be effective in reducing the family burden and mixed group family psychoeducation is more effective than single family psychoeducation group [6 – 9].Family psychoeducation leads to [6 – 9] - decreased relapse rate, hospitalizationcost of treatment and caregiver burden.

Family psychoeducation is found to be effective in schizophrenia, bipolar affective disorder, obsessive compulsive disorder, eating disorder (anorexia nervosa) and borderline personality disorder [6 – 9].

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Community psychoeducation
In community psychoeducation, the information is imparted to a larger mass of population which may be non-homogeneous, irrespective of illness or illness related risk status. Media have a greater role in facilitating the psychoeducation process. Video conferencing, debate, tele-show may help in this process.

Individual psychoeducation has more impact than the other modalities as it is client- focused and more intensive. Other than the above modalities of psychoeducation, client centered psychoeducation focusing on different domains like – illness domain, treatment domain, rehabilitation domain or psychosocial support depending upon the need of the client are in clinical use.

Structure of Psychoeducation
A structure is usually required in order to make the program stays on track,although it can involve indirect "free-flowing" discussion. Each psychoeducation session have specific goals and content.The structure of psychoeducation is determined by whether the program involves the individual with the disorder or only involves the family or peers.

Topics discussed are the medical aspects of the condition by identifying and defining the diagnosis, the prognosis, the biology and psychology. The stigma attached to the diagnosis, what can be done to combat and manage the stigma. Understanding the nature of the illness this includes information on the disorder as well as the psychological aspects involved.

The main symptoms of the disorder as well as the identification of the disorder are discussed. Identifying the factors which trigger certain symptoms is also discussed to prevent these events from occurring and therefore improving symptomatic profile of the patient .Adherence to medication is important factor in maintaining and managing the condition. This includes information regarding the medication as to dosing, purpose, mechanism, benefits, side effects and how to manage. It also teaches ways to deal with any emergency conditions.

BARRIERS TO PSYCHOEDUCATION
Barriers to information
Psychoeducation programmes that are held at night may not be considered as convenient or accessible as onesheld during the day. Another barrier to carer participation in educational programmes is the restriction felt due to the responsibility of caring for their son or daughter.

Attitudes of health professionals
Doctors' andother health professionals' lack of empathy and understanding of carers' needs is the largest barriers to accessing information and support. Caregivers might experience frustration when they feel their intentions for the patient are being questioned

Processing information
The timing of the psychoeducation is important, which depends on the readiness and to absorb information. Admission is not always the ideal time to receive information. There is a time that they need information to cope, but this time varies for each person.

Stress and emotional needs
Care of a patient suffering from mental illness is always stressful and burdensome for the caregivers. The caregivers might neglect their emotional needs. These problems have to be dealt for proper psychoeducation.

Other than the above mentioned factors poor education, cultural myths and language variation can stand as a barrier in the process of psychoeducation.

PSYCHOEDUCATION: FOCUS IN INDIA
Psychoeducation in India is still in its infancy. Lack of manpower, funding, lack of expertise can all be taken as the reasons for this. Considering the chronic nature, impairment due to illness, no cure with medications and effectiveness of psychoeducation it should be provided to maximum number of patients.FrancescColom (2011) has suggested that an open-door policyteam effort and therapeutic relationship founded on trust, rather than authority might prove helpful in increasing the benefits of psychoeducation to the patients and caregivers [1].

In India, there is scarcity of mental health professionals. The existing mental health units are overburdened. Due to these major issues structured psychoeducation for patients or caregivers attending outpatient clinics seems impracticable in individual level. In this context the group psychoeducation seems more valid and practicable. India being a multilinguistic country, language stands as a major barrier to proper psychoeducation. There is a need to develop psychoeducation material in different languages keeping in view the cultural factors.

CONCLUSION
Psychoeducation is the basis for dealing and managing illness, it leads to more faith in the treatment and a higher sense of control over situation. Education and knowledge feeds into self-efficacy which is essential in treatment for any problem. Psychoeducation is not a monotherapy option. Although knowing about condition is important without the concurrent psychotherapy or medications condition will not improve. Psychoeducation is a simple and easy to use technique which leads to an add-on benefit to the patient in better management of illness.

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