Original Research Paper

Volume -10 | Issue - 4 | April - 2020 | PRINT ISSN No. 2249 - 555X | DOI : 10.36106/ijar

Psychology

MODELS OF PSYCHOEDUCATION IN MENTAL HEALTH – AN OVERVIEW

Ms. Rashi Juneja*	Clinical Psychologist, Mind Ease Psychological Services & Wellness Centre, Delhi, India *Corresponding Author
Ms. Anuja Kapoor	Clinical Psychologist, Mind Ease Psychological Services & Wellness Centre, Delhi, India
Mr. Aman Choudhary	Assistant Professor, G.D. Goenka University, Haryana, India

ABSTRACT Psychoeducation is the heart of psychotherapy and plays a significant role in awareness, treatment of mental health disorders and improving the quality of life of the patient, caregivers and the community. The current article focuses on the importance of psychoeducation and the various models of psychoeducation used in treatment of psychiatric disorders.

KEYWORDS : Models of psychoeducation, mental health, psychoeducation, psychiatric disorders.

INTRODUCTION

Education vs. Psychoeducation

Education includes knowledge and awareness with reference to a particular topic and is a Nomothetic approach. Psychoeducation includes providing knowledge and awareness keeping patient the center of discussion in order to facilitate the changes that are required. It is an Ideographic approach. [20]

Psychoeducation is an important component of any psychotherapy programme. It is education about a certain condition or situation that causes psychological stress. This is not necessarily to be psychotherapy as it does not exclusively deal with psychological or mental illness' but rather any condition. Example: Breast Cancer – not a mental illness but the patient might feel anxious, disheartened, scared about their condition. So it becomes important to address their psychological issues. Psychoeducational training involves dealing with individuals with Schizophrenia, Clinical Depression, Anxiety Disorders, Psychotic Illnesses, Eating disorders and Personality disorders, as well as patient training courses in context of the treatment of physical illness. [21,12]

Psychoeducation includes cognitive, behavioral and supportive theraputic elements. It is usually carried out by a psychologist or someone who is trained in who is an expert in the specific condition the individual is experiencing and who has experience in psychotherapies such as nurses, social workers, occupational therapists, psychologists and physicians. Psychoeducation came into the field of psychiatry strongly after the appearance of **"Expressed Emotion"** and **"Family Burden Concept"** in connection to severe and chronic psychiatric disorder like schizophrenia. That is after the **"Mental Hygiene Movement"** of early 20th Century and **"Deinstitutionalization Movement (1950-60)". [2,10,22]**

The concept of psychoeducation was given by ***Johm. E. Donley*** in "Psychotherapy and Re-education" in *Journal of Abnormal Psychology*, published in 1911. The popularization of Psychoeducation is attributed to American researcher **C.M. Anderson in 1980** regarding the treatment of schizophrenia. There are number of definitions given to describe psychoeducation as following: [5]

"*The term psychoeducation comprises systemic, didactic psychotherapeutic interventions, which are adequate for informing patients and their relatives about the illness and its treatment, facilitating both an understanding and personally responsible handling of the illness and supporting those afflicted in coping with the disorder"* **(Anderson, 1980)**. [5]

"The education of a person with psychiatric disorder in subject areas that serves the goal of treatment and rehabilitation" ***(American Psychiatric Association)***. [1]

"Systematic, structured, didactic information on the illness and its treatment, and includes integrating emotional aspects in order to enable patients – as well as family members – to cope with the illness" **(Bäuml et al, 2006)** [2]

"Process of teaching clients with mental illness and their family members about the nature of the illness, including its aetiology, progression, consequences, prognosis, treatment and alternatives" **(Baker, 2003).** [3]

Psychoeducation is an educative method aimed to provide important information and training to families having individuals with psychiatric illness to work together with mental health professionals as part of an overall clinical treatment plan. This can significantly improve the level of understanding of people about mental disorders, ensuring active participation of both patients and their caregivers.

Structure of Psychoeducation

Each psychoeducation session has defined goals and focus. The structure of psychoeducation is deter- mined by whether the program involves only the disturbed individual, only the family or peers. Discussion includes all the medical aspects of the condition by explaining the diagnosis, prognosis and the holistic management.

Objectives of Psychoeducation [17]

- Providing knowledge about various facets of illness signs, symptoms, course, outcome and prognosis and making patients and their relatives confident in attaining the basic competence
- Dispelling myths, misconceptions and unawareness
- Helping people have knowledge regarding do's and don'ts' while rendering care to ill people
- How to interact or behave and communicate with ill people
- Treatment options, side effects of medication and other somatic treatments,
- Helping people to track early signs of relapses of illness and deepening the patient's role as an expert
- To increase the likelihood of mentally ill peoples to rehabilitate back to their home communities, with particular regard for their social and occupational functioning

Elements of Psychoeducation [21]

- Briefing patients about their illness,
- Problem solving training
- Communication training
- Self- assertiveness training.

Models of Psychoeducation

Schizophrenia Patient Outcomes Research Team (PORT) – 1995

Schizophrenia Patient Outcomes Research Team (PORT) developed treatment recommendations for the care of persons with schizophrenia. Recommendations covered both psychosocial and psychopharmacologic treatments. PORT gave three recommendations on family psychosocial interventions: [10,11]

a) Patients who have been having **intensive interaction** with their

families and living in same household with family members should be given a family psychosocial intervention which should continue for at least nine months and should incorporate:
I. Education about the illness,
ii. Family support,
iii. Crisis intervention,
iv. Problem solving skills training.

b) Family interventions should not be restricted to patients whose families have been found to have high levels of 'expressed emotion'.
c) Family therapies based upon the premise that family dysfunction has some aetiological role in schizophrenia should not be used. PORT do not prescribe one specific formula of family intervention. Rather talks about inclusion of those above-said components in any kind family of family intervention.

Information model
The emphasis of this model is to provide families the knowledge about psychiatric illness and its management. The aim of this approach is to improve the families' awareness about the illness and contribution to the management of the patient.

The skill training model
This model is directed at systematically developing specific behaviors so that family members can enhance their capability to assist the ill relatives and manage the illness more effectively. This model is recommended for Individuals with schizophrenia and dementia that have deficits in skills that are needed for everyday activities, to improve social interactions and independent living.[9]

Comprehensive model
It is also called combination approach because it consists of information, skill training and supportive model. In the initial phase of this approach members are given lectures about the illness. They are to take part in multi-family support group. In the final phase they have to participate particularly as a member of individual sessions with a mental health professional.

The Multiple Family Group Therapy Model (The MGFT Model, 2002)
This model was developed by **William McFarlane (2002)** with the aims of engaging families in the rehabilitation and after care programmes of severe psychiatric illness like schizophrenia. Model acknowledges the essentially chronic nature of the disease and seeks to engage families in the rehabilitation process by creating a long-term working partnership with them and providing them with the information needed to understand schizophrenia. Model seeks to assist the patient and family in accommodating the disease while developing social support systems for the reduction of confusing, anxiety, and exhaustion in the patient's family, while they learn adaptive strategies. [12,13]

The Behavioral Family Management Model (1998)
Model of family intervention gives maximum importance to family and views family as the most effective and efficient resource for community rehabilitation of severely ill mental patients. Healthy functioning of the mentally ill individual can be achieved through **teaching positive coping skills** that may help the vulnerable family member from the negative effects of environmental stresses. Family members can be provided knowledge that can be helpful in planning rehabilitation and aftercare of patient. The family therapy also attempts to enhance coping skills of family members through increasing the efficiency of family problem solving. [10,15,16]

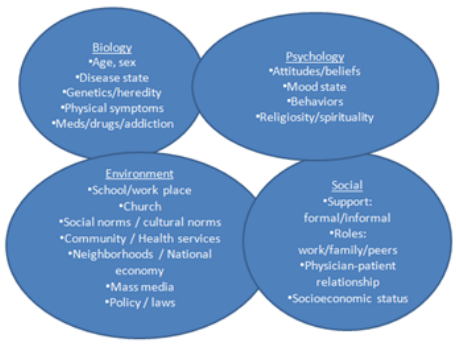
Family Focused Treatment (FFT, 1995)
This model was developed by David J. Miklowitz and MJ Goldstein (1995), primarily developed for the treatment of bipolar patients. Model has three modules: [14,8]
a) First module, included seven or more sessions. During these sessions patients and relatives are to be told about the symptoms, nature, causes, and treatment of bipolar disorder. Clinicians would educate the targeted people about the biological and genetic underpinnings of bipolar from a vulnerability–stress diathesis perspective. Participants are to be educated to know the prodromal signs of illness and relapsing episodes.
b) The second module aims to help patients and caregivers to learn communication skills for dealing with intra-familial stress and techniques like role-playing/behavior-rehearsal format are generally used to teach these people about communication related skills.
c) Third module, participants are given a framework for defining problems and how to develop as well as implement effective solutions to those problems.
d) This approach also aims to instill problem-solving and coping skills of the caregivers of these patients.

The **Six** Objectives of FFT:
i. Assist the patient and relatives in Integrating the experiences associated with mood episodes in bipolar disorder
ii. Accepting the notion of a vulnerability to future episodes
iii. Accepting a dependency on mood-stabilizing medication for symptom control
iv. Distinguishing between the patient's personality and his/her bipolar disorder
v. Recognizing and learning to cope with stressful life events that trigger recurrences of bipolar disorder
vi. Re-establishing functional relationships after a mood episode

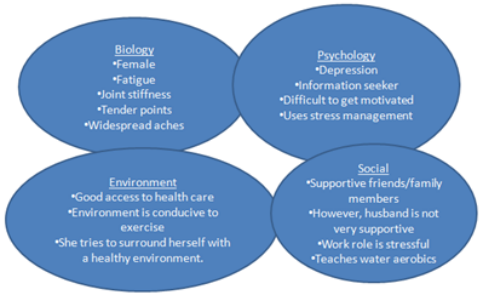
Peer-to-Peer Psychoeducation (2005)
This approach was successfully established by **Rummel *et al (2005)*** in clinical settings. In Peer-to-peer psychoeducation programme mentally ill persons are given the access to mix with the people who had the same problem earlier but they recovered from that problem. These people can motivate the patients up to considerable extent and provide them a new ray of hope. [18]

Medical Model
The medical model of mental illness treats mental disorders in the same way as a broken arm, i.e. there is thought to be a physical cause. This model has been adopted by psychiatrists rather than psychologists. Medical model consider symptoms to be outward signs of the inner physical disorder and believe that if symptoms are grouped together and classified into a 'syndrome' the true cause can eventually be discovered and appropriate physical treatment administered. The model believes psychopathology to have an organic or physical cause. The focus is on genetics, neurotransmitters, neurophysiology and neuroanatomy. The approach argues that mental disorders are related to the physical structure and functioning of the brain. [7,14]

Biopsychosocial Model
The biopsychosocial model states that health and illness are determined by a dynamic interaction between biological, psychological, and social factors. The psychological component seeks to find a psychological foundation for a particular symptom or symptoms (e.g., impulsivity, irritability, overwhelming sadness, etc.). Social and cultural factors are conceptualized as a particular set of stressful events that may differently impact the mental health of people from different social environments and histories. [5,6,18]



Biopsychosocial Model



Example: Fibromyalgia

Benefits of Psychoeducation

- Individual feels more relaxed and in control of their situation
- Individuals who are educated about their condition are more likely to actively participate in their self-management and relapse prevention
- Brings positive social and self esteem changes which adds positively to individual's self efficacy
- Helps in reducing social stigma, promote awareness, prevent emergencies and reduce relapses
- Reduce hospitalizations
- Increase adherence to medication, satisfaction with mental health services and improved quality of life.

CONCLUSION

Psychoeducation is the basis for managing psychiatric and psychological illness. It helps the patient and the family to understand the illness in depth and makes them competent and confident in dealing with it. Psychoeducation is a simple and easy to use technique which leads to an additional benefits to the patient, family and peers in better management of illness.

REFERENCES

1. Association, A. P. (2003). Psychoeducational programs help families cope with mental illness. Retrieved from https://www.apa.org/monitor/apr03/mental
2. Bäuml, J., Froböse, T., Kraemer, S., Rentrop, M., & Pitschel-Walz, G. (2006, October). Psychoeducation: a basic psychotherapeutic intervention for patients with schizophrenia and their families.
3. Baker, D., Hunter, E., Lawrence, E., et al (2003) Depersonalisation disorder: clinical features of 204 cases. British Journal of Psychiatry, 182, 428–433
4. Bhattacharjee, D., Rai, A. K., Singh, N. K., Kumar, P., Munda, S. K., & Das, B., (2011, April). Psychoeducation: A Measure to Strengthen Psychiatric Treatment. DELHI PSYCHIATRY JOURNAL, 14, 33-39.
5. Donley, J. E. (1911). Psychotherapy and re-education. The Journal of Abnormal Psychology, 6(1), 1-10. http://dx.doi.org/10.1037/h0071950
6. Engel GL: The clinical application of the biopsychosocial model. Am J Psychiatry 1980;137:535-544.
7. Engel GL: The need for a new medical model: a challenge for biomedicine. Science 1977;196:129-136.
8. Falloon IRH, Boyd JL, McGill CW, Williamson M, et al. Family management in the prevention of morbidity of schizophrenia. Arch Gen Psychiatry 1985; 42 : 887–896.
9. Hogarty, G. E., Anderson, C. M., Reiss, D. J., Kornblith, S. J., Greenwald, D. P., Ulrich, R. F., & Carter, M. (1991, April). Family psychoeducation, social skills training, and maintenance chemotherapy in the aftercare treatment of schizophrenia. II. Two-year effects of a controlled study on relapse and adjustment. Environmental-Personal Indicators in the Course of Schizophrenia (EPICS) Research Group.
10. Joanne Nicholson, Elaine M. Sweeney, and Jeffrey L. Geller. "Focus on women: Mothers with mental illness: II. Family relationships and the context of parenting." Psychiatirc Services 49 (1998): 643–49
11. Lukens, E. P., & William R. McFarlane, W. R. (2004). Psychoeducation as Evidence-Based Practice: Considerations for Practice, Research, and Policy. Brief Treatment and Crisis Intervention, 4, 205–225. doi: 10.1093/brief-treatment/mhh019
12. McFarlane WR, Lukens E, Link B, et al: Multiple-family groups and psychoeducation in the treatment of schizophrenia. Arch Gen Psychiatry 1995; 52 : 679-687.
13. McFarlane, W.R. (2002). Multifamily groups in the treatment of severe psychiatric disorders. New York: Guilford Press.
14. Mcleod, S. (1970, January 1). The Medical Model.
15. Miklowitz DJ, Goldstein MJ. Behavioral family treatment for patients with bipolar affective disorder. Behav Modif 1990; 14 : 457–489.
16. Morris, C. D., Miklowitz, D. J., & Waxmonsky, J. A. (2007, January 13). Family-Focused Treatment for Bipolar Disorder in Adults and Youth.
17. Psychoeducation: Definition, Goals and Methods. (2016, June).
18. Rummel CB, Hansen W, Helbig A. et al Peerto-peer psychoeducation in schizophrenia: a new approach. J Clin Psychiatry 2005; 66 : 1580-1585.
19. Schotte, Christiaan & Bossche, Bart & Doncker, Dirk & Claes, Stephan & Cosyns, Paul. (2006). Bio-psychosocial model as a guide for psychoeducation and treatment of depression. Depression and anxiety. 23. 312-24. 10.1002/da.20177.
20. Simon, C. (n.d.). Previous Chapter Chapter 8: Psychoeducation: A Contemporary Approach Next Chapter.
21. Srivastava, Prashant & Panday, Rishi. (2017). Psychoeducation an Effective Tool as Treatment Modality in Mental Health. The International Journal of Indian Psychology. 4. 123-130.