

Psychoeducation: Implications for the Profession of Health Education

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Abstract

Mental illnesses contribute to substantial morbidity in the population. Education for prevention and control of mental illnesses is mandatory. Psychoeducation is the specialized education that comprises of educational endeavors directed toward the patients and their families with an aim to help prevent relapse of mental illnesses and restoration of health for mentally ill patients. Several studies have proven the value of psychoeducation in prevention and control of mental illnesses ranging from depression to schizophrenia. Psychoeducation helps the mentally ill by improving treatment adherence. Psychoeducation is a subset of health education. Psychoeducation imparted by medical professionals due to insufficient training, insufficient resources and insufficient time is at best modest. Therefore, health educators who have specialized training in health education are very well suited for psychoeducation. However, the amount of training currently being offered in many health education programs nationwide at the undergraduate and the graduate level is not sufficient to qualify the educator for dealing with mental illnesses. More course work in mental illnesses and their prevention needs to be in place. Also prospective studies need to be designed for testing the efficacy of health educators in psychoeducation. Finally incorporation of behavioral theories to psychoeducation by the profession of health education will make it more effective.

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Introduction

Mental illnesses affect a substantial proportion of the population. According to the Centers for Disease Control and Prevention (CDC, 1998), in the United States, an estimated 10% people had recent disability from a diagnosable mental illness and 24% had experienced a mental disorder during the preceding year. Another community-based survey found that 6.2 percent of respondents reported serious mental illness in the preceding year (Kessler et al., 2001). According to another study, approximately 4.3 million psychiatric-related emergency department visits occurred, yielding an annual rate of 21 visits per 1000 adults (Hazlett, McCarthy, Londner, & Onyike, 2004). For schizophrenia, the 12-month prevalence in the United States in 2002 was estimated at 5.1 per 1000 lives (Wu, Shi, Birnbaum, Hudson, & Kessler, 2006).

Owing to a variety of reasons including stigma, many mentally ill patients do not seek treatment. Among those who seek treatment, many do not comply with the treatment. Education for prevention and control of mental illnesses is mandatory. The importance of psychoeducation in the management of the mentally ill has been reinforced in recent times by multiple prospective clinical trials which have compared a medications only approach with techniques that blended psychoeducation with medications (Colom et al., 2003; Perry, Tarrier, Morriss, McCarthy, & Limb, 1999). The outcomes from most of these studies have validated the utilization of psychoeducation as an approach that improves the efficacy of pharmacological approaches. In most instances, the blended approach remains superior to a medications only approach. Bipolar illness and schizophrenia remain just two of the many mental health conditions where the combined approach has been found better.

As a result of these findings, the term “psychoeducation” is finding frequent mention in contemporary mental health literature, typically when referencing to techniques found useful in the management of the severely mentally ill. However, till date, due to a lack of unanimity on a standard definition of psychoeducation, the subject area has been riddled with a multitude of definitions. Some of the definitions are oversimplified while others over inclusive of techniques that should, strictly speaking, not fall within the purview of “psychoeducation”.

Psychoeducation: Controversies in Definition

In forming a consensus on the boundaries of “psychoeducation” and conceiving a working definition of the term, Goldman (1988) explores the different definitions and varying interpretations and ties them all together. Goldman (1988) defines psychoeducation as “Education or training of a person with a psychiatric disorder in subject areas that serve the goals of treatment and rehabilitation, for example, enhancing the person’s acceptance of his illness, promoting active cooperation with treatment and rehabilitation, and strengthening the coping skills that compensate for deficiencies caused by the disorder”

The two most important ways in which this definition differs from its preceding ones are as follows. First, this fairly expansive definition includes any education given to a patient with a psychiatric disorder if such education would enhance the patient’s ability to survive in the community. Second, this definition absolutely excludes any education given to the family as “psychoeducation” irrespective of what benefits or promises it may hold for the actual patient.

Despite the above developments, psychoeducation, as a formal term, has continued to be used as something that depicts educational approaches for both the mentally ill and their family members. Different researchers through the late 20th and the first decade of the 21st century have continued to use differing interpretations of the term due mainly to the fact that it remains, perhaps, the most well known umbrella term that somewhat effectively convey

to the audience any measures that are non-pharmacological and that benefit the mentally ill (Colom et al., 2003; Dixon, Adams, & Lucksted, 2000; Perry et al., 1999). Some researchers have gone on record to include any and all psychosocial interventions within the purview of psychoeducation.

In as much as the primary purpose of this article is not to debate the validity or redundancy of the different definitions for “psychoeducation” but to make a link between psychoeducation and the profession of health education, we have tried to adhere to a more inclusive approach towards psychoeducation. Such an approach treats any educational endeavor (irrespective of whether it is directed to the patient or the family) designed to help a mentally ill patient gain some semblance of recovery as “psychoeducation”. However, the fact that controversy has been inherent in defining psychoeducation gives us reason to believe that it may be a time to revisit some aspects of it.

Psychoeducation: What Makes it so Important?

An evidence-based approach dictates that for most moderately to severely debilitating mental health conditions, a combined modality approach that blends drugs with therapy and/or education remains, by far, the best in terms of outcome and eventual prognosis. Multiple studies have proven the value of psychoeducation in psychopathologies ranging from depression to schizophrenia. Pekkala & Merinder (2002), in a meta analysis of all psycho educational interventions conducted on patients with schizophrenia, found that psychoeducation was a useful part of the treatment program. Colom and colleagues (2003, 2004) assert that in the treatment of bipolar patients, psychoeducation may have a role beyond the enhancement of patient compliance to drug treatment, and holds a special role for patients with co existing personality disorders.

Recent studies have proven the associations between multiple socio-environmental stressors and remission-relapse successions of mental illnesses. Levels of familial expressed emotion, parental warmth, disruptive life events that may

accelerate goal striving have all been found to predict acute exacerbations in bipolar depression. Other psychosocial variables like marital status, social support (and more importantly the lack of it), education, socioeconomic status and lack of accurate knowledge about one's condition all influence a patients' compliance to drug treatment (Miklowitz, Elizabeth, Jeffrey, Teresa, & Richard, 2003). Given that educational interventions can be designed around each of the above cited variables is in itself a prime reason that makes psychoeducation so important.

Ways in which adjunctive psychoeducation may help the mentally ill are by improving treatment adherence (which remains one of the most crucial factors that governs the outcome of a disease), helping in a greater stabilization of symptoms, preventing relapses and reducing inter-episode symptoms through enhancing patients stress management abilities and finally helping in the rehabilitation of patients to the maximum level of functioning possible (Miklowitz et al., 2003). Psychoeducation helps in improving the compliance to the long term drug treatment often prescribed in mental illnesses.

Psychoeducation: Contemporary Trends

Several factors govern the trends in the field of psychoeducation and decide who will be "authorized" to practice it. It is these very factors which would deter other professions from pursuing interests in the field.

If we analyze the current medical paradigm, we can find a fairly sharp split between the medical and the psychiatric domains as regards psychoeducation. Psychiatry has come closer and closer to traditional medicine in recent years, with the revelations that most psychiatric conditions are at least "partially" (and occasionally wholly) organic in nature. Despite these developments, psychoeducation (even basic information on psychiatric conditions that may not necessarily require an advanced degree in psychiatry) is sadly missing from most non-psychiatric physician-patient encounters. While a number of family physicians and internists will gladly and aggressively disseminate information

about possible ways one could protect against conditions drawing from other medical specialties, most professionals shy away from flirting with any condition that is viewed as being traditionally within the domain of "psychiatry". As an analogy, while a physician may be perfectly willing to discuss the prospects and prognosis of melanoma (which ideally is a dermatological condition) with a client even before he seeks a referral to a skin specialist, he may be more tempted to make an immediate referral to a psychiatrist if the same client seeks information about schizophrenia.

Unlike a lot of medical specialties, the field of mental health remains plagued with unique challenges. The diagnosis of a number of mental illnesses remains, at best, a subjective attempt. While it is fairly easy to educate a diabetic about his blood sugar levels and expect him to follow those levels closely; the same may not be expected of a manic depressive (bipolar) patient who may not have an objective end point to gauge the severity of his or her disease, only subjective sensations. Further, there are schools of philosophy, aptly called the anti-psychiatry movement, which openly challenge the very existence of several mental conditions. Dain (1989), in his reflections on anti psychiatry, maintains that hostility to psychiatry actually predates the establishment of psychiatry as a profession, and organized opposition to psychiatric practices appeared in the late nineteenth century and continued well into the 20th century. These challenges make the job of designing and implementing evidence-based practices for educating patients with psychiatric conditions a very difficult, if not impossible, endeavor.

Further, unlike a number of fields where the role of education is handed over the specialists employed specifically for that purpose, psychoeducation is, at best, shared between psychiatrists, therapists and other allied mental health workers. In an outpatient setting, the education role is taken over mostly by the psychiatrists and the therapists while in an inpatient setting, it is variedly divided between all mental health professionals. As long as a patient is being followed as an outpatient, he

remains in regular contact with his psychiatrist and therapist and receives whatever psychoeducation is deemed necessary from them. Under more trying conditions when such a patient develops acute exacerbations and may have to be admitted, the “Psychoeducator” role is embraced by nurses and other allied workers. However, the current trend of de-institutionalization of the mentally ill ensures that only the sickest and floridly psychotic patient would gain entrance to a psychiatric facility. It is a matter of conjecture then as to how receptive these patients can really be to the education they may be receiving inside of the facilities at a point when their powers of deductive reasoning are at a record low. In such a closed loop system it is hard for a health educator to step in even if it were proven that such a course would benefit the patients.

Moreover, a 2005 study was done in Germany to assess the current status of relapse prevention in schizophrenia reveals some shocking findings (Hamann, Mischo, Langer, Leucht, & Kissling, 2005). Hamann and colleagues found that psychiatrists routinely communicated treatment plans and offered psychoeducation to only about one third of their patients, even though psychoeducation has been shown to increase medication compliance. Hogarty (2003) discusses the possible reasons why few families of the severely mentally ill have ever been offered family psychoeducation within North America, despite a quarter century of duplications. The rare families that are engaged receive mostly an occasional lecture or 'bibliotherapy', but education about evidence-based family approaches are mostly lacking. Multiple policy and organizational impediments, which may include staff burdens, cost, cynicism, philosophical differences, and lack of leadership, may be responsible (Dixon et al., 1999; Hogarty, 2003). Such findings raise serious questions about how deficient the current delivery of evidence-based mental health services (especially as regards psychoeducation) might be, and what we could do to improve them.

Finally, there are vital issues about the accessibility to health education/promotion services by those with mental illnesses. The

mentally ill may find it hard to seek education about their condition outside of the medical domain due mainly to the fact that their accessibility to these efforts is further compromised as a result of their disease.

Psychoeducation: A Subset of Health Education

Whether psychoeducation should be included as a subset of health education or not, is a question best answered by pitting the defining elements of health education against those of psychoeducation. Green, Kreuter, Partridge, and Deeds (1980) have defined health education as, “Any combination of learning experiences designed to facilitate voluntary adaptations of behavior conducive to health”

Reasons why psychoeducation qualifies for each element of this definition and more are not far fetched. The key elements in this standard definition are learning experiences, voluntary adaptations and behavior conducive to health. Each of these three elements can be found within psychoeducation.

Irrespective of how we go about defining psychoeducation (i.e., whether or not we chose to include the education being given to the family as psychoeducation), there is a definitive learning experience involved. By educating a bipolar manic depressive patient about the warning signals for a possible manic exacerbation, we are in essence, helping him or her internalize a learning process. The education of the family members of a severely depressed individual about the importance of a 24-hour watch on that person is not hard to picture as a learning experience more or less indelibly imprinted on the minds of those people for future references.

As previously mentioned, increased patient compliance to a pharmacological regimen is just one of the many benefits of psychoeducation. In that it leads to a fairly stable change in the behaviors pertaining to medication compliance, psychoeducation can be visualized as a voluntary adaptation, voluntary because no aspect of it is forced and adaptation because it

better helps the individual in dealing with his illness.

Finally, by enlightening the patients and their families about the different aspects (warning signs, symptoms, medication adherence, resources available) of the patients' illness and how they interact to have a bearing on the disease itself, we can direct both the patient and the family into behaviors conducive to the mental health of that particular individual. It is fairly easy to compare and contrast the education imparted to diabetics about the premonitory signs of a low blood sugar (dizziness, rapid heart beat, etc.) with that provided to a manic depressive individual about the warning signs for a possible manic attack (speedy thoughts, disturbances in sleep rhythm and so on).

Why We Need Health Educators to “Psychoeducate”?

Despite multiple commonalities between the fields of health education and psychoeducation, there have been few attempts by practitioners in general to design studies or attempt any convergence of these two fields. Some of the reasons why this may be are fairly intuitive while others lie deeper. Perhaps one of the more important reasons is the fact that rights to any and all psychoeducation are strongly held by medical practitioners despite the fact that due either to lack of sufficient resources or sufficient time, such attempts may at best be modest (Hamann et al., 2005). The recent “Deinstitutionalization” movement in psychiatry has virtually ensured that a patient will only spend his most incapacitated period as a psychiatric inpatient, further reducing the time available for the educational process. Leslie and Rosenheck (1999), in their analysis of psychiatric inpatient service patterns for a group of 3.9 million privately insured individuals, found that substantial cost reductions for mental health services, over a period of two years, were primarily a result of reductions in inpatient and outpatient treatment days. Declines in inpatient service use were not accompanied by increases in outpatient service use, even for severely ill patients requiring hospitalization.

Research has repeatedly demonstrated that for a large number of mental illnesses, psychotherapy (which often includes psychoeducation) with medications produces the best outcomes (Colom et al., 2003; Dixon et al., 2000; Perry et al., 1999). However, recent evidence also maintains that severely ill patients may be unlikely to receive such evidence-based services (Lehman & Steinwachs, 1998). Even standard pharmacological conventions rooted in research are usually not followed, and as few as 10% of patients receive more complex interventions, such as supported employment or family psychoeducation. The multiple policy and organizational level factors responsible for such an abysmal state of affairs have already been mentioned above (Dixon et al., 1999; Hogarty, 2003). The problem of poor access to evidence-based practices for persons with severe mental illness has been cited by multiple reviewers of the literature (Drake et al., 2001) and was noted in the mental health report of the US Surgeon General (United States Surgeon General, 2000).

Cultures which traditionally shy away from mental health, mental health practitioners and discussions about psychopathology in general may be more receptive to psychoeducation by health educators. The South Asian population in the United States offers a perfect example of one such cultural group. In their exploration of the mental health issues of the South Asian population in United States, Lin & Cheung (1999) maintain that this population has a documented historical record of low inpatient psychiatric admission, further augmented by a more recent establishment of an equally low utilization of outpatient mental health services. It has been shown that these low rates of utilization of mental health services are not correlated with low rates of psychopathologies.

The earlier notion of a “model minority”, which maintained that a low rate of utilization of mental health services stemmed from a low rate of psychopathology, has been discarded. Instead, recent research suggests that cultural barriers may prevent help seeking by the mentally ill patients of this group early on in the disease process. Patients may wait for a substantial length of time and seek help only when all

alternate options have been exhausted and the mental illness has deteriorated significantly (Lin, Inui, Kleinman, & Womack, 1982). For precisely this last argument, psychiatrically ill populations may be more receptive to education given in non-medical and less threatening settings. Since the simplest way of defining psychosis is to imagine it as a process whereby the individual loses touch with his reality, it is not hard to imagine why such an individual may not be receptive to any "education" while in the midst of an acute psychotic attack.

Health educators intercept populations at a preventive level. Such an approach could better serve the mentally ill or even candidates with a subliminal mental pathology who have not been formally diagnosed. As an example, by spreading awareness about the leading signs of mania and depression, much could be done about the rising adolescent suicide rates. Also, preventive psychoeducation could possibly better serve the communities since so many of mental health needs remain unmet. A recent Centers for Disease Control and Prevention report (CDC, 2007) revealed that after falling over 28% during the period 1990 - 2003, suicide rates in America for males and females aged 10-24 climbed 8%. This is the largest single one-year rise in 15 years. Apparently, despite our best intentions, the current model, while perfect in theory, has failed to be translated into practice. Translation of theory into practice is a task well-suited for a health educator.

Recommendations for the Field of Health Education

Having established some cause for why psychoeducation is but a subset of health education and that consequently, health educators need to assertively treat it as one of their own areas of expertise, we need to talk about the possible steps that might help us, as a profession, achieve this goal. What is needed is an appreciation of the fact that mental health conditions are quite different from most other health education initiatives, even the ones which directly deal with diseases. The amount of tact and care needed while broaching existing or

potential issues related to mental health is essentially not required elsewhere.

The amount of training currently being offered in many health education programs nationwide at the undergraduate and the graduate level is not sufficient to qualify the educator for dealing with mental illnesses. More course work in mental illnesses and their prevention needs to be in place. Emphasis needs to be given to a practical approach on ways by which psychoeducation could be blended with routine health education.

On a more advanced note, it would also be in the interest of the field if well-designed prospective studies could be initiated which would help gather data about the efficacy of psychoeducation by health educators in non-medical settings. A need also lies for studies that would compare the efficacy of psychoeducation as delivered by health educators in non-clinical settings (with or without other more traditional topics) and that delivered by conventional practitioners in clinical settings. These proposed studies would help in multiple ways. First, they will help establish the feasibility of psychoeducation by credentialed health educators. Second, by benchmarking the efforts of health educators against their counterparts in other domains, they will help create higher levels of motivation amongst the educators. Third, by incorporating behavioral theories which are very much integral to health education in psychoeducational programs, a better outcome can be assured. Finally, prospective studies would help establish evidence-based guidelines for educators in this field and help standardize any approach to the subject.

Once psychoeducation by health educators becomes an accepted norm, a concerted attempt to truly blend the knowledge from the two fields could be made. Combining behavioral change theories with existing psychoeducational models to ensure enduring behavioral change in an individual would perhaps be a worthy ultimate goal.

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