

REVIEW PAPER**Family Psychoeducation for Schizophrenia: A Clinical Review***De Sousa A¹, Kurvey A², Sonavane S³*¹Desousa Foundation, Mumbai²Department of Psychology, LS Raheja College, Mumbai³Department of Psychiatry, Lokmanya Tilak Municipal Medical College and General Hospital, Mumbai**Abstract**

Family psychoeducation is an integral part of schizophrenia treatment programmes. Recent shifts to briefer hospitalization and an emphasis on community care have emphasized the significance of relative education in this phase of treatment. Psychoeducational family programs designed to increase medication compliance and effectiveness in coping with stressors have been successful in reducing the risk of relapse in the first year following hospital discharge. They are aimed to provide correct information about the illness, treatments available and long term course and prognosis of the disease. Over the last three decades various models and different types of family psychoeducation programmes have been implemented to empower relatives of patients with schizophrenia. In the present paper different models for family intervention are discussed and their strengths and weaknesses evaluated.

Keywords: Family, Psychoeducation, Schizophrenia

Introduction

Family members often play a vital role as caregivers in the lives of individuals with schizophrenia and other serious mental illnesses. It has been estimated across studies that 30-85% of adults with schizophrenia have a family member as a caregiver.¹ Recent trends point towards a community-based care for persons with schizophrenia where family members would assist with the care of these patients.² Over the past 2 decades, a body of evidence-based practices have emerged to meet family member's needs for education, guidance,

and support.³ A variety of interventions referred to as 'family psychoeducation' programs, have been developed and practiced all over the world in schizophrenia rehabilitation programmes.⁴ These programs are carried out along with an overall clinical treatment plan, and while the main focus is on improving the well-being and functioning of the patient, family members also experience significant benefits from such programs.⁵

The Use of the Term Psychoeducation

The term 'psychoeducation' was first

employed to describe a behavioural therapeutic concept consisting of four elements viz. briefing the patients about their illness, problem solving training, communication training, and self-assertiveness training, whereby relatives were also included.⁶

Psychoeducation often fulfilled less the function of an independent, self-contained therapeutic method and was viewed more as a combination of several therapeutic elements contained within a complex psychosocial intervention.⁷⁻⁸ Various studies have demonstrated clear superiority of psychoeducational family interventions when used in combination with standard treatments in schizophrenia compared to standard treatments being used alone.⁹⁻¹¹

There has been an evident decline in duration of stay in medical institutions of patients with schizophrenia since approximately 1990. The simultaneous necessity for an economic use of therapeutic resources exists and the demand for compact and yet efficient treatment methods exists.¹² Within this context, an independent understanding of psychoeducation began to unfold. The working group 'Psychoeducation of patients with schizophrenia' has formulated the following definition¹³ – *“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.”*

The roots of psychoeducation are to be found in behaviour therapy, although current conceptions also include elements of client centered therapy in various degrees.¹⁴

Within the framework of psychotherapy, family psychoeducation refers to the components of treatment where active communication of information regarding the illness and treatment methods along with a treatment of general aspects of the illness are prominent.¹⁵ Indications for family psychoeducational groups are wide ranging. There are only few mandatory contraindications, including relatives with massive formal thought disorders, manic elevated mood, schizophrenia or acute suicidality with generally reduced stress resilience.¹⁶

Family members can be integrated within the treatment as soon as they are capable of taking part in a group for a period of 60 min.¹⁷ Ideally, only relatives of patients suffering from schizophrenic psychoses should participate in the group, in order not to evoke unnecessary confusion in other caregivers through the schizophrenia-specific informational content.¹⁸ Group sittings last approximately 1 hour, take place once to twice a week, and consist of between 4 and 16 sessions. Group leaders are in most cases doctors or psychologists; co-leaders can be recruited from all relevant and complementary mental health faculties or even may be caregivers who have been trained to disseminate this information.¹⁹ The superordinate goal can be seen in the relatives acquiring basic competency in order that they may reach well-informed and self-competent decisions as to which of the modern therapeutic options viz. medications, electroconvulsive therapy, psychotherapeutic and/or psychosocial are recommendable and suitable in their own family member.²⁰

Therapeutic and Critical Factors in Psychoeducation

In accordance with the psychotherapeutic

nature of family psychoeducation, therapeutic alliance, causal and control attributions are also of utmost importance here.²¹ It is important that emotional, illness-related topics are deliberately discussed in family education sessions. Emotions with a positive overtone, such as pride in one's own role as a caregiver or the feeling of having used unique methods to manage the patient along with issues such as being out of one's depth or struggling with one's fate, are also addressed.²² Through the employment of techniques such as 'positivation' of prior experiences, normalization of relapses or systematic depathologization of the patient, participants are to be sent the signal that, given close cooperation, a viable solution can be found for all difficulties.²³

The primary goal of family psychoeducational interventions consists in finding a common denominator between the objective, textbook medical knowledge with regards to background information of the disorder and treatment measures, and the subjective viewpoint of the afflicted patient.²⁴ Carrying out this requires an extremely differentiated behavioral therapeutic approach, supported by a basic humanistic orientation.²⁵

Each session comprises a module which is highly structured, whose informational contents are to be interactively compiled and relatives are to gain access to information concerning appropriate mental health behavior.²⁶⁻²⁸ While individual opinions are appreciated and respected, great value is placed on clearly and comprehensibly presenting current scientifically founded expert knowledge in the form of direct information and advice giving.²⁹⁻³⁰ It is less about the absolute comprehensiveness of transmitted textbook knowledge which is important and more the construction of a

comprehensible concept of the illness and its treatment (causal and control attribution).³¹ In particular, the concrete elaboration of 'missing links' which enables lay persons to more fully understand why mental problems can be successfully treated by 'chemical' interventions, is of great significance for increasing functionality.³² In this capacity, psychoeducation can be seen to serve an 'interpreter' function, pursuing the aim of translating complicated 'technical jargon' into common and everyday language, which can be understood by relatives and helps them to become experts of their illness.³³ Relatives progress with the patient through each stage of treatment feeling encouraged and full of hope. The cautious introduction of the topic of handicaps caused by the illness, which are often severely protracted and unpredictable in terms of duration, also entails a great challenge for simultaneously working on feelings of guilt, anxiety and grief that the relatives may harbour.³⁴ Relatives are to increasingly gain access to positive thoughts and positive conceptualizations of themselves and their patient.³⁵

Psychoeducation is thus primarily a form of therapy conveying reassurance and hope, with the aim of optimally integrating empowerment of those whose close ones are affected, with professional therapeutic techniques in a working and therapeutic alliance.³⁶ The take-home-message of psychoeducational programs must be that schizophrenic psychoses are induced by biological factors in combination with psychosocial stress; therefore, they must be treated with both medication and psychotherapeutic interventions.³⁷

The Goals of Psychoeducation in Schizophrenia

The formulation of realistic and coherent

therapeutic goals in family psychoeducation is of particular importance for all involved i.e. relatives, and professional auxiliaries. Here, the greatest danger within psychoeducation is that despite the narrow time frame in which the intervention is to be carried out, goals are set which are too high and indeed unattainable.³⁸ The very strength of psychoeducation lies in the deliberate focus upon relatives attaining basic competence in the area of schizophrenic psychoses.³⁹ On the contrary, it is only when a basic understanding of the illness and its requisite therapeutic measures have been established that more continual and specific therapeutic elements can be employed.⁴⁰

Psychoeducation should ensure a comprehensive introduction into the realm of psychoses for relatives of patients with a first episode of schizophrenia and inform recurrent patients of the latest developments in terms of treatment options.⁴¹ The conscious limitation of sessions to an average of eight, together with a central focus upon facts, entails that these groups are also suitable for all types of relatives.⁴² In the case of more seriously impaired patients, these groups can be successful in motivating and convincing relatives of these patients to opt for involvement in long term rehabilitation and more differential therapy.⁴³ Relatives of chronic patients can, through recurrent integration in the family psychoeducation group concept, can be sent a sign of hope insofar that they have not been forsaken or abandoned to their fate despite multiple relapses in their patients.⁴⁴

Types of Psychoeducation Interventions in Schizophrenia

Behavioral Family Management

Researchers have developed a family-based approach that involves illness education, as

well as structured training in problem-solving and effective communication in the family. In behavioural family management, the active phase of intervention typically lasts 1–2 years, and sessions are conducted within the home to increase accessibility, treatment adherence, and generalization of skills.⁴⁵ In a study using this model, 36 patients and their families were assigned to behavioral family management (BFM) or a supportive individual therapy condition. After 9 months, 6% of BFM patients had relapsed, compared with 44% who were treated individually.⁴⁶ The BFM group also showed lower relapse rates and lower hospitalization days in a two year follow up.⁴⁶ In a number of research studies, BFM has been found to impact important patient outcomes (reduced relapse rates, improved symptoms), as well as improve family member knowledge and well-being.⁴⁷⁻⁴⁸

Family Psychoeducation

The family psychoeducation model emphasizes connecting with the family, providing illness education, and ongoing support and crisis intervention in the rehabilitation process.⁴⁹ In a two year study involving 106 patients family psychoeducation was proven to reduce relapse rates when combined with standard treatments. The patients whose families received psychoeducation had lower expressed emotion scores and did better at a society level and employment level at the end of two years.⁵⁰ Thus family psychoeducation is effective in reducing patient relapse and enhancing the outcomes of vocational rehabilitation for patients with schizophrenia.⁵¹

Relatives Groups

This is a model of family intervention involving individual family sessions and a

separate group for patients' relatives. It was developed in the UK but has been used all over the world.⁵² Like other models, there is a strong focus on providing education and helping the patient and family members develop skills to cope with the disorder. A unique component of this model is biweekly relatives' groups (which do not include patients), focusing on support and problem-solving for the family.⁵³

Psychoeducational Multi-Family Groups

The psychoeducational multi-family group model was designed to integrate components of each of the approaches discussed above. As in other models, there is an initial emphasis on joining with the family and providing education.⁵⁴ At the core of the model is the multi-family group that the patient and family members attend, with group sessions primarily focused on enhancing problem-solving and coping skills. The group is also designed to provide a valuable support network for the patients and family members.⁵⁵ Controlled research studies have indicated that the program significantly reduces relapse rates and improves the functioning of patients with schizophrenia.⁵⁶⁻⁵⁷ In an outpatient patient group where this model was used, 63 outpatients with schizophrenia were randomized to receive either standard care or multiple-family group psychoeducation at a large community mental health center. Among the 42 patients who completed 1 year of the study, the multiple-family group treatment was found to significantly reduce levels of negative symptoms, compared with standard care.⁵⁸ This study is in contrast to most psychoeducational studies that are based on inpatient relative groups. In a novel combination of approaches, the above model was integrated with assertive community treatment (ACT), to create a model called Family-Aided Assertive Community

Treatment (FACT).⁵⁹ and studies done demonstrated that this combination has significant benefits for improving the clinical and psychosocial functioning of patients with schizophrenia.

Specific Educational Programs

Alongside these models of family psychoeducation, a number of specific family education programs have been developed. There are noteworthy differences between these family education programs and models of family psychoeducation discussed above. First, family education programs do not involve intervention with the patient and do not focus on patient outcomes as the primary goal. Instead, education programs typically focus on helping family members find support and information to cope with their relative's illness. Secondly, these programs are briefer and provide less-intensive services to family members. Third, the research evidence on family education programs is limited, and, in contrast to family psychoeducation, studies have not indicated that family education programs influence patient outcomes (though they may provide important benefits to family members).⁶⁰⁻⁶¹

Professional Family Education and Consultation

Certain authors have developed and evaluated individual and group education programs for family members. In their study both intervention programs significantly improved family members' self-efficacy in coping with issues related to their ill relative.⁶² There is also an educational intervention, the Support and Family Education program, for family members of patients in the Veterans Administration treatment system. This program consists of a series of monthly workshops that family

members can attend, focusing on a variety of challenges faced by family members.⁶³ Some researchers have proposed a family consultation model in which individual families meet periodically with a professional involved in the patient's treatment (most often the psychiatrist or primary clinician). This flexible model may be particularly well suited for families who would have difficulty participating in a longer intervention, for families who are coping relatively well, or, alternatively, in times of crisis.⁶⁴

Research Needs in Family Psychoeducation for Schizophrenia

Over the past 25 years over 35 randomized clinical trials have indicated that family psychoeducation is a highly effective evidence based treatment intervention, particularly in reducing relapse rates for patients with schizophrenia.⁶⁵ It should be noted that definitions of 'relapse' in research vary from study to study moving from symptom worsening to hospitalization. Relapse rates have averaged to 10-15% when psychoeducation has been added to standard treatment models compared to an average of 30-50% for those receiving individual therapy and medication or medication alone.⁶⁶ Research indicates that such programs provide support and help family members feel more knowledgeable and better able to cope with their relatives' illness.⁶⁷

While there is compelling evidence in support of implementing family psychoeducation, there are a number of important topics for further study to gain a more comprehensive base of knowledge for treatment recommendations.⁶⁸

First, more knowledge is needed regarding the influence of cultural factors in the implementation of programs. Research has

generally supported the cross-cultural effectiveness of family psychoeducation across various nations. Further work is needed to more comprehensively understand the role of cultural factors in working with families via psychoeducation.⁶⁹

Second, while there is clear evidence that family psychoeducation improves other aspects of recovery beyond relapse rates, a more complete understanding of this topic is needed.⁷⁰ Additionally, studies have documented improvements in family member well-being and decreased feelings of subjective burden among family members. More research is needed to examine how family interventions impact the lives of patients and families in other important areas of functioning beyond relapse and symptomatic improvement. Such studies will help make family psychoeducation more relevant to the concerns of patients and their families.⁷¹

Third, research is needed to identify which interventions are most likely to be effective for particular families. Patients in families with low levels of expressed emotion and unusually favorable medication response have fared relatively better in single-family formats than in multi-family groups. More research is needed to gain a more comprehensive understanding of which patients and families are most likely to benefit from which particular models of intervention.⁷²

Fourth, research is needed to identify the necessary ingredients for effective intervention, beyond the general principles offered by the World Schizophrenia Fellowship⁷³ and PORT treatment guidelines.⁷⁴

Family Psychoeducational Interventions in Clinical Practice

Despite strong research support, the implementation of family psychoeducational interventions in clinical practice has been very limited. This is due to a number of factors, including practitioner restraints (eg, time, expertise, training), systems-level issues (eg, lack of administrative support for programs, reimbursement/funding issues), and barriers related to patients and families (eg, time, reservations about participation).⁷⁵ Family interventions are a vital service and efforts must be made to make these programs more available and accessible.

An optimal clinical program would provide access to family psychoeducation for all serious mental illnesses patients in treatment and their families.⁷⁶

In clinical practice, the implementation of family interventions may vary depending on setting and available resources. In the treatment of patients with serious mental illness, the degree of involvement of and role of family members and significant others should be routinely assessed.⁷⁷ Psychoeducational interventions are likely to have equivalent effects when conducted with other significant support figures, regardless of the degree of biological relation while the term 'family' is used in a broader connotation.⁷⁸

Once the support network of the patient is clearly understood, clinicians can then assess the preferences of the patient and family regarding intervention and support programs. In many geographical areas, formal resources to involve the family in treatment are limited or non-existent, highlighting the need for increased dissemination of research-based practices.⁷⁹

Conclusions

Family psychoeducation is a well-established, efficacious psychosocial treatment for schizophrenia. A large body of controlled studies indicates that patient relapse rates are generally cut in half with the use of family psychoeducation interventions. Programs have also been shown to impact other important clinical outcomes, such as levels of positive and negative symptoms, as well as psychosocial outcomes, such as employment rates and social functioning. Thus family psychoeducation represents a vital component of comprehensive and evidence-based care for persons with schizophrenia and is applicable in both short and long term treatment and rehabilitation settings.

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