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EDITORIAL

Psychoeducation as an Opportunity for Patients, Psychiatrists, and Psychiatric Educators: Why Do We Ignore It?

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Providing information and educating patients about their illness and options for treatment is an essential part of medical practice. Little is known about medical students' and residents' training in these skills, however. It is well known that cooperation, effective communication, and a good relationship between the psychiatrist, the patient, and the patient's family improve the prognosis of severe mental illness. If the patient and family members are expected to become competent partners and to cooperate in long-term treatment, psychiatrists have to share information about the illness and its treatment with them. As providers of care, psychiatrists obviously have the knowledge and experience that patients and their families do not. The only way to bridge this natural knowledge gap is to share the information in a comprehensible and structured way, in what is known today as psychoeducation.

What Is Psychoeducation and Where Does It Help?

Psychoeducation is the provision of systematic, relevant, broad, and up-to-date information about an illness or condition, including its diagnosis and treatment. Psychoeducational programs provide both *disease-specific* information, e.g., early recognition and management of relapse symptoms or any potential genetic implications of the illness and *general information*, e.g., promotion of healthy lifestyle, problem-solving and communication skills training, identification of stressors in households, and education of family members and primary care takers in their amelioration. Furthermore, psychoeducation includes information on how to explain aspects of living with an illness to family members so that they can understand the effect of the illness and assist the patient and treatment providers in the treatment program.

There is evidence that psychoeducation improves the outcomes of mental illness and many other medical illnesses. Family interventions, including psychoeducation for schizophrenia, have proved to be one of the most consistently effective treatment modalities available, with relapse rate reduction at 50–60% over treatment as usual [1, 2]. Besides relapse severity reduction, psychoeducation leads to less frequent relapses, better treatment adherence, lower self-stigma, better quality of life, improvement of social competencies, active engagement in rehabilitation, and lower cost of care, either alone or as a part of complex treatment regimen [3–7]. Thus, family psychoeducation is recommended in several schizophrenia treatment guidelines [8–10], for example, as an evidence-based intervention.

There is similar evidence that psychoeducation and family interventions may reduce the recurrence of bipolar disorders and depression. Psychoeducation and cognitive behavioral therapy are associated with increased time to mood episode relapse or recurrence [11, 12]. Preliminary evidence shows that family psychoeducation for patients with depressive disorders improves patient functioning and the well-being of family caregivers [13]. Similarly, psychoeducation seems to reduce the burden of caregivers for dementia patients [14, 15].

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Studies indicate that providing educational information increases knowledge and positive attitudes and behaviors towards individuals with Tourette's syndrome and attention deficit/hyperactivity disorder [16].

Lessons learned from beneficial effects of psychoeducation on patients' stress and anxiety levels have led to the implementation of psychoeducation in the treatment regimens for patients with cardiovascular diseases, where psychosocial programs with psychoeducation and stress management help to reduce anxiety [17]. It has also been recommended that psychoeducation becomes a standard of care in pediatric oncology [18].

Lack of Psychoeducation Delivery

Despite these benefits and the fact that psychoeducation intervention is evidence-based, not all patients and their families have access to psychoeducation. In the USA, one estimate suggests that only around 10% of families of patients with mental illness have participated in family education [19]. In a survey among mental health professionals in German-speaking countries [20], psychoeducation for patients with schizophrenia was considered relevant and was offered in 86% of psychiatric hospitals. It is interesting that while 93% of professionals perceive the significance of psychoeducation for patients to be high, 59% perceive psychoeducation to be of only modest significance for families. In the Czech Republic, out of 550 mental health care departments (outpatient, inpatient, and community services) and 60 social services departments, only 46 departments provide some type of psychoeducation for schizophrenia—16 of those provide family psychoeducation for patients and relatives and 1 provides psychoeducation for relatives only [21]. In Japan, only approximately 30% of psychiatric care facilities have adopted psychoeducation [22].

What are some possible barriers to the provision of psychoeducation? Certainly, lack of adequate reimbursement for such services is a serious obstacle. Moreover, we speculate that the biggest hurdle in implementation and use of psychoeducation is possibly the lack of knowledge and skills in delivering it due to a lack of training opportunities. While information about medication in the treatment and management of serious mental illness is taught in all undergraduate and psychiatry residency programs worldwide, perhaps information on delivery skills and training on how to conduct psychoeducational interventions are not so consistently taught. If a patient had diabetes or heart disease, it would be expected that the nature, course, and treatment of the illness would be explained. Is there a difference in psychiatry? It should be noted that it is a core competency in psychopharmacology to provide detailed information about the indications, use, risks, and benefits of medications to all patients. Yet the diagnosis, prognosis, and impact of the underlying disorder may not be so formally discussed. Although time may serve as a barrier in some settings, psychoeducation is a critical first element in the provision of a comprehensive treatment plan and should not be neglected. Also, psychoeducation is likely to save time in the long term by reducing relapses and improving patient and family engagement in care.

What Should Psychoeducation Provide?

In order to provide psychoeducation, clinicians should be able to teach patients and their families or primary caretakers about early warning signs and management of recurrence. Based on our experience with patients suffering from schizophrenia, these topics can, at times, provoke anxiety, which may lead to temporary worsening of illness in patients with incomplete or fragile remission. Dealing with the frustration of relatives is another important skill of family psychoeducation. The clinician providing psychoeducation must be ready to deal with emotions and anger and must be able to keep boundaries and set limits to preserve a constructive and therapeutic atmosphere (e.g., in a group, if group psychoeducation is provided). Time should be set aside for this purpose, and an effort should be made to ensure that the material can be recalled and understood. We believe that lack of these skills is an obstacle to providing good family psychoeducation. We also believe that part of the skill set in psychoeducation is providing ample time for questions about the illness and its treatment. Further, it must be determined if, after psychoeducation, the patients and family really understand what was discussed about the illness. Asking patients and their families to recount what they heard provides a window into appreciating their accurate appraisal and understanding of the disorder.

Psychoeducators should be able to encourage communication; should listen, talk, and explain; should be trustworthy; should communicate in a clear straightforward way; should respond to the patient's verbal and nonverbal cues; should establish goals for communication in patients; and should be able to teach in an empathic and comprehensible manner [21–24]. Psychoeducation educators should therefore be experienced clinicians who are able to present their knowledge in a comprehensible way and should also be skilled moderators to ensure interactivity.

What Are the Active Ingredients of Psychoeducation?

First, psychoeducation should take account of the whole person and build on strengths and resilience [25]. Second, psychoeducation crucially involves the ability to deal with emotional aspects, as the patient—often at a very young

age—suffers from a severe illness that interferes with overall life plans, goals, and dreams. To accept this reality and adapt to the illness, a patient must not only receive proper information but also receive emotional support and guidance. In the case of youth who sustain a psychiatric disorder, the clinician needs to communicate in a manner consistent with the developmental level of the child or adolescent. And, of course, the parents or caregivers need detailed information, including information about how to reduce stress in the household, as they are the most important treatment resource that should not be ignored [7, 8]. Third, psychoeducation must include behavioral interventions, notably promotion of healthy activities in daily living such as good sleep habits, nutrition, exercise, and support from friends. Fourth, psychoeducation ensures that patients and family members have access to reliable online resources and/or handouts, since they may want additional information or may forget the material heard in the clinician's office. Further, many online sites provide poor, biased information about psychiatric disorders, and patients may seek additional information through online searches. Clinicians should be prepared to guide patients and families to trusted online resources for additional information.

Training in Psychoeducation: Why, What, and How

Psychoeducation should be part of the management of all mental disorders and should be offered in individual or group format. Basic curricula should be well defined and manualized, covering four major areas: (a) information about the illness, (b) recognition and management of early warning signs, (c) lifestyle management, including how to ameliorate stress in families and household groups, and (d) importance of involvement of relatives and primary care providers. The curriculum should emphasize that information delivery should respect neurocognitive or other impairments and should include, whenever applicable, graphic models or visualizations. The curriculum should also stress the importance of interactivity and active involvement of all participants, regardless of the format of psychoeducation. In psychoeducation, family members and caregivers should participate whenever possible and should be provided with discrete disease-specific modules, covering high expressed emotions recognition and adaptive communication skills training.

Unfortunately, psychoeducation as an intervention is not consistently included in medical training curricula nor required as a skill among core competencies. The closest requirement in the U.S. ACGME Requirements for Psychiatry [26] seems to be part of Interpersonal and Communication Skills competence: "Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals." The Practice Based Learning and Improvement competence also requires that residents develop skills and habits to be able to "participate in the education of patients, families, students, residents and other professionals" [26]. Similarly, with reference to the Psychiatry Milestones (a joint initiative of the ACGME and the ABPN), the Milestone for Information Sharing and Record Keeping (ICS2) calls for residents to use "active listening, 'teach back,' and other strategies to ensure patient and family understanding" [27]. In addition, as part of System-Based Practice competence, residents should "assist patients in dealing with system complexities and disparities in mental health care resources" [26]. Overall, neither the ACGME requirements nor the Milestones appear to explicitly mention the term psychoeducation. Psychoeducation has also been mentioned among the family skills for general psychiatry residents: "Following the assessment interview, the resident should be able to: integrate the impact of current relational functioning and the case formulation; present the case formulation and, when appropriate, psychoeducation, to the family within a framework that is respectful, culturally acceptable, and comprehensible" [28]. However, specific information on how to do so is missing, as residents are vaguely recommended that they "can inform and support families about services" such as Family-to-Family Education Program [28].

Psychoeducation has proved to be highly relevant for many diagnoses both in psychiatry and in other medical speciailties. Many clinicians who have had the chance to provide psychoeducation or who have met with patients that participated in psychoeducational programs already call for its widespread implementation [29]. Psychoeducation is not just a one-way delivery of information from clinicians to patients and their families; as an interactive process, it allows clinicians to receive valuable insights into problems connected with mental illness, and these insights may be different from what is learned from usual doctor-patient contact. Therefore, we advocate for the consistent provision of training in psychoeducation and recommend that it be included in psychiatric residency curricula as a required set of skills.

A comprehensive curriculum for residency training should cover: (1) how to "translate "medical information to a form presentable to laypeople; (2) how to prepare a diagnosis-specific, patient-centered curriculum; (3) group dynamics and communication skills for group formats; (4) family psychodynamics in serious mental illnesses; (5) methods for teaching early warning signs and for teaching problem-solving and communication and social skills; (6) clinical coaching as a method for modification of behavior; and (7) motivational interviewing for sustaining effects of achieved changes, eliciting questions from patients and families, and verifying that they understand what was communicated. Psychiatric educators with experiences in providing psychoeducation should

be ready to implement such a curriculum. Psychiatry residents should similarly be encouraged to regularly review and discuss psychoeducation during supervision. As psychoeducation is not unique to psychiatry, medical students should also become familiar with its practice and should receive basic information about it.

Individuals living with mental illnesses and related conditions have the right to receive relevant and complex information about their health and optimal therapeutic approaches, along with guidance to help support their capacity to cope with their illness. Therefore, psychiatric educators, leaders, and clinicians should pay attention to methods that help achieve this mandate, with psychoeducation clearly being a method of choice. Psychoeducation, we suggest, should become a valued part of the training of residents in all areas of psychiatry and in other specialties.

Compliance with Ethical Standards

Disclosure On behalf of all authors, the corresponding author states that there is no conflict of interest.

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