Psychoeducation for schizophrenia and other serious mental illnesses has grown in prevalence during the past 4 decades as more evidence accrues regarding its benefits for both patients and families. A variety of influences have come together to produce what we know today as psychoeducation. Further, once psychiatric patient education/psychoeducation became established in its own right, some of these influences have re-emerged in different forms to augment basic psychoeducation.

HEALTH EDUCATION
Psychoeducation is rooted in a variety of historical approaches and is closely related to newer theoretical approaches. During the past 2 decades, a flood of health-oriented messages have received mass exposure. These messages deal primarily with heart disease, diabetes, hypertension, cancer, prenatal care, nutrition, and exercise. A subspecialty within the field of psychology, “health psychology” has emerged to deal with the...
maintenance of healthful lifestyles and prevention of physical disease through psychological interventions.

Psychological health has been addressed through the advocacy of stress management, moderation in alcohol and drug use, and wellness. Serious mental illness has not been a common subject of health education; however, related health problems such as alcoholism and depression have been represented in these approaches. Many hospitals provide community education programs on general health issues and are gradually incorporating psychiatric illnesses into these presentations.

A growing number of psychoeducational programs now include mental health education interventions as data continue to show the association between medications for schizophrenia (particularly atypical antipsychotics), obesity, and metabolic disorders. Chronic disease self-management programs, such as Stanford University’s Living Well, or the Solutions for Wellness series developed by Lilly USA, have proven very valuable in addressing the overall health issues of patients with schizophrenia.

PATIENT EDUCATION IN MEDICAL DISEASE

Patient education has become a recognized necessity in medical care and is commonplace, particularly in the treatment of chronic diseases such as diabetes and heart disease. A description of one of the earliest applications of this method was recorded by McMichael in his 1968 account of the work of Matthew Baillie, MD, of the Royal College of Physicians in London in the late 1700s. He described Dr. Baillie thus:

In examining a patient, for the purpose of learning the symptoms of the complaint, the questions he put were so few as to give an impression of haste and carelessness; in conversing on the case with the physician whom he met in consultation, he was very short and clear; and it was not until the relations or friends of the patient were admitted, and he proceeded to communicate to them the result of the consultation, that he appeared to full advantage. He then gave a short practical lecture, not merely on the symptoms of the patient, but on the disease generally, in which all that was known on the subject was brought to bear on the individual case, and in doing this, his utterance was so deliberate, that it was easy to follow him. His explanations were so concise that they always excited attention, and never tired; and the simplicity of the language in which they were conveyed, where all technical terms were studiously avoided, rendered them perfectly intelligible.

Many hospitals, clinics, and physician offices offer diabetes education, employing a complex series of classes and individual instruction. For example, patients can often learn good dietary habits by manipulating plastic food models to construct meals with the proper amounts of nutrients and calories. Coronary disease is also rapidly becoming a widely taught illness, with numerous books, films, videotapes, computer applications, home monitoring systems, and other patient and family education programs being offered.

Patient education appears to improve patient understanding of illness; reduce delay in seeking treatment; and improve patient adherence to prescribed treatment regimens. Patient education has become recognized as a core component of nursing practice and as an expected part of their daily role.

Education plays a large role in the emerging field of chronic disease care coordination sometimes referred to as care transitions. Programs with a substantial educational component have emerged to support patients and families, and to increase skills among health care providers.

GROUP THERAPY AND OTHER APPROACHES

Group therapy is a multifaceted approach to psychoeducation, with a variety of theoretical orientations. Groups are offered based on transactional analysis, reality therapy, client-centered therapy, gestalt therapy, and many other theoretical approaches. This variegated collection got its start partly from Joseph Pratt, MD, of Worcester, MA. Dr. Pratt began conducting patient education classes for his tuberculosis patients in 1905. From this beginning, support groups developed to discuss the patients’ problems and fears.

Psychiatric or psychological individual and group therapy has always included a certain amount of teaching, even if not clearly identified and done on a systematic basis. In conducting psychotherapy with a patient who has a major psychiatric disorder, the therapist must usually do a great deal of explaining to the patient about the illness and about ways of coping. It is this effort on the part of therapists that has contributed to the development of patient education for psychiatric patients. Many therapists are conducting patient education without calling it that, and finding that the therapy itself is more efficient when the patient has this education.

Recent trends in psychotherapy with severely disturbed patients, especially those with schizophrenia, have been toward more structured approaches. Some of these patients may be withdrawn, dependent, and paranoid, have a low frustration tolerance, and show reduced thinking abilities. These cognitive deficits may make them unable to benefit from traditional dynamic therapy approaches because of their inability to process the level of ambiguity and symbolism.

Some patients with schizophrenia may have neurological impairments that make it impossible for them to...
DIDACTIC PROGRAMS AND SKILLS TRAINING

Many hospitals and treatment facilities have been conducting some type of didactic therapeutic programs, which concentrate primarily on the development of social skills and others needed to live successfully in a community setting. A major example of this approach is Liberman’s early development of programmed modules for community living skill training.9

These programs consist of patient workbooks, facilitator manuals, and various media on medication management, symptom management, leisure skills, and other areas pertinent to coping with serious mental illness in the community. The psychiatric rehabilitation approach10 also utilizes some didactic methods, but does not emphasize education about illnesses, working instead toward recovery of roles in living, learning, and working.

BEHAVIORAL MEDICINE

Behavioral medicine is the application of behavioral techniques in the treatment of physical illness.11 As a relatively young field, its influence in the area of psychiatric patient and family education has been rather limited. While these endeavors have been only loosely associated, the techniques of behavioral medicine are quite appropriate if one considers serious mental illness to be a physical condition.

Some of the techniques used in behavioral medicine can be applied when designing psychiatric patient education philosophies and methods. Typical applications of these behavioral medicine techniques are the use of cognitive re-structuring, relaxation, systematic desensitization, and biofeedback. These behavioral medicine techniques are, therefore, applicable to serious mental illnesses in the same way that they are applicable to medical illness, once one accepts the premise that schizophrenia, for example, is a medical disorder.

Most recent has been the emergence of cognitive-behavior therapy (CBT) for schizophrenia, which differs from psychoeducation in that it focuses more on symptoms rather than diagnosis, but has as one of its aims to help the patient accept and participate in treatment.12

PATIENT EDUCATION IN PSYCHIATRY

Psychoeducation for schizophrenia – sometimes known as psychiatric patient education – has gradually evolved since the mid-1970s. Some of the earliest efforts in this area took the form of medication classes or groups in inpatient psychiatric units, partial hospitalization programs, or community mental health centers. The nursing literature is a source of numerous articles describing this kind of program.13-16

A program targeted specifically for patients with drug-refractory unipolar depression used a CBT psychoeducational group as treatment for depressed patients who had not responded to antidepressant medications.17 Another program focused on depression and used the Coping with Depression Course for the treatment of patients with unipolar depression.18

Both of these programs de-emphasized the role of biological treatment and focused on treating depression using a CBT approach. The Community Interaction Program was established to integrate a psychoeducational approach into various aspects of community treatment, including teaching about medication, transitional employment, adult basic education, and other aspects of a comprehensive social rehabilitation program.19

Ascher-Svanum described a program of psychoeducational groups targeting inpatients with schizophrenia and has developed a manual for therapists’ use in conducting these groups.20,21 Laffal, Brown, Pearlman, and Burns established a classroom course for psychiatric inpatients at the Connecticut Valley Hospital. The course consisted of 16 sessions conducted over a 4-week period, which included patient workbooks and an instructor’s manual.22 McCrory has developed a Patient and Family Education Center (see following) patterned after
the original Patient Learning Center, but with additional courses in community resources and other “informed consumer” subjects at two South Carolina state hospitals.23

Although not solely a psychoeducation program, the Illness Management and Recovery program utilizes psychoeducation as a component.24 This program has been endorsed as an evidence-based psychiatric consumer recovery program by the Substance Abuse and Mental Health Services Administration (SAMHSA) of the US Department of Health and Human Services (DHHS); a toolkit is available from the SAMHSA website to enable full-fidelity implementation of the program.

This toolkit provides implementation information at the clinician, program director, administrator, and state mental health department levels, as well as videotapes, evaluation criteria (fidelity measures), and materials for distribution to participants.

PUBLIC PSYCHIATRIC SETTINGS

Before the 1970s, psychoeducation for patients with schizophrenia had not been offered in a structured format other than in small medication education groups and classes. In the mid-1970s, a program was initiated at Bryce Hospital in Tuscaloosa, AL, to teach a comprehensive array of topics related to patient management of schizophrenia and other serious mental illnesses. Osmond, Mullaly, and Bisbee developed the patient education program, initially called the Psychological Learning Center, later named the Patient Learning Center (PLC) at Bryce Hospital, Alabama’s largest state psychiatric hospital. The program initially consisted primarily of a “Responsible Patient” class in which patients with schizophrenia, bipolar disorder, or severe depression received information about their illnesses, medication and other treatment, and their role in illness management.25

This program was the first such educational effort to be systematically available at any inpatient or outpatient facility throughout the state mental health continuum of care in the country. In a 1979 paper and a 1984 manual,26,27 Bisbee described an expansion of the PLC to include a comprehensive program of subjects, description of psychiatric illnesses, medications, coping skills, nutrition and health, and other topics pertinent to patients with serious mental illness (See Table).

The program initially opened in a vacated facility in the admissions unit on the campus of historic Bryce Hospital to serve patients admitted to the hospital primarily involuntarily through probate court commitment.

The facility was renovated to serve as classrooms, offices, and social gathering space, complete with all of the trappings of an educational facility — bulletin boards, chalkboards, student desks, and any educational materials available on schizophrenia, bipolar disorder, and severe depression. Patients were referred by their treatment teams for all or specified parts of a 3-week program.

The daily schedule included four classes interspersed with ample nutrition breaks and socialization time. Staff included mental health technicians (2-year-degree personnel), nurses, and master’s level psychology staff, and was directed by a doctoral level psychology staff member. Pre-and post-knowledge was assessed through five-question surveys on each topic. Patients completing the program received a certificate of completion in a weekly graduation ceremony. In addition to knowledge gain measures, the program was evaluated by patient satisfaction instruments and measures of changes in attitude toward mental illness.

Documentation of the program was later expanded in a comprehensive manual,28,29 which includes literature review, introductory material program structure, teaching topics, adult learning techniques, media, and other topics pertaining to establishment of a comprehensive psychoeducation program for patients with schizophrenia.

Included are a 15-topic curriculum for patient education (focusing on education about serious mental illnesses, medications, nutrition and health, illness monitoring and relapse prevention, skills for daily coping with symptoms, and specific lessons about schizophrenia, bipolar disorder, and depression).

The manual also includes: a 12-topic curriculum for families addressing the etiology and treatment of mental illness;
management skills (eg, relapse prevention); rights and responsibilities; and general coping skills. Specific handouts and slides are included for each topic, and permission is given to copy these materials for use with patient and family education sessions.

The psychoeducation program continued until the early 2000s, when it was gradually reduced in scope due to decreasing lengths of stay of hospital patients and decreasing funding levels for state hospital programming. After several years of program operation and expansion into the South Carolina state hospital system, Kay McCrary, EdD, concluded that psychoeducation for serious mental illness was a specialty intervention that required both educational skills and fairly extensive knowledge of the related content in biological and psychosocial arenas, and she proposed development of a program to train practitioners to deliver this intervention.

Dr. McCrary and Bisbee subsequently developed a training program consisting of a certification based on successful completion of 4 days of intensive training, passing a content examination, and observed practice teaching of a selected content topic. Program faculty consisted of pharmacists, psychiatrists, nurses, psychologists, social workers, and front-line psychoeducation instructors. This program was conducted for approximately 15 years in South Carolina and Alabama.

The training program ultimately ended due to state funding limitations; however, in that the program trained both hospital staff and community mental health professionals, hundreds of workers now carry their knowledge of serious mental illness and of psychoeducation interventions into community settings where forms of the program still exist today.

PRIVATE SECTOR PSYCHIATRY

Believing it to be important to have a structured psychoeducational program in the hospital’s psychiatric service, Vickar and colleagues developed Schizophrenia Treatment and Education Programs (STEPS) in a private psychiatric setting at Christian Hospital Northwest in St. Louis. The program was based in part on experience with the Patient Learning Center (PLC) and the Nova Program in Alabama, and in part on work by Abram Hoffer, MD, and Moke Williams, MD, in Fort Lauderdale, FL.

This program and the PLC were the subjects of a symposium at the Institute on Psychiatric Services (then known as Hospital and Community Psychiatry) and has continued to evolve with additional components and materials.

Carol North, MD, evaluated the program through a grant from Barnes-Jewish Hospital Innovations and determined that the study showed both the cost effectiveness and the clinical value of the structured program. The program still exists and — in addition to the structured psychoeducational program — offers aftercare meetings and social events for participants and other persons in the community.

CONCLUSION

Research on psychoeducation for patients with schizophrenia and their families has shown the intervention results in numerous benefits. Participants in psychoeducation not only increase their knowledge, families also experience lower perception of family burden and higher quality of life, patients learn better how to cope with symptoms and to develop behaviors such as relapse prevention skills that help them move toward recovery. The medical system also benefits in that educated patients tend to have decreased chances of relapse, make better treatment decisions and decrease their use of emergency department and other high-intensity psychiatric services.

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