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The participation of patients with schizophrenia in psychoeducation – the analyses from the patient's perspective

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Summary

Aim. The aim of this study was to find out what the patients opinion about psychoeducation in schizophrenia.
Method. We examined 169 patients suffering from schizophrenia. They answered once a questionnaire about demographic data, their opinion about participation in sessions, the motivation to psychoeducation and the themes of sessions.
Results. 84% of the patients declared that they like psychoeducation.The main reason for participation in psychoeducation was the willingness to get more information about the illness and prevent the relapses. Approximately 50% of the respondents considered level of their knowledge on the illness to be not satisfactory.
Conclusions. The patients want to get more information about the illness and obtain more knowledge how to cope with symptoms in order to improve the quality of their life. It is important for the therapists to create an emotional atmosphere which helps to understand each other. During the psychoeducation sessions the therapist should use more different means to get the patients involved in participation.

schizophrenia / psychoeducation

INTRODUCTION

Since the 1970's psychoeducation has been a well-established form of treatment and rehabilitation for persons suffering from schizophrenia and their families. It is being defined as use of methods, techniques and educational programmes in order to facilitate remission or reduce effects of the illness or disability [1]. Psychoeducational treatment does not include only delivering the knowledge. During the sessions therapeutic strategies that increase abilities and improve functioning of schizophrenia patients are being used. Psychoeducational sessions provide knowledge that is being related to individual course of illness and healing and in effect they engage patients on cognitive and emotional levels.

In the literature it is being underlined that the role of psychoeducation is not only to provide information, but it is also an interactive process which includes elements of psychotherapeutic strategies [2, 3]. Psychoeducation is an evidence based form of therapy [2, 3, 4]. Participation in this form of treatment is associated with shorter duration of hospitalisation, reduced number of relapses, improvement in state of health and psychosocial functioning of the patients, as well as their better cooperation and extensive knowledge about illness [5, 6, 7, 8, 9]. The most effective treatment includes both patients and their families, where psychoeduaction is carried out

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in a form of trialogue: patient–family–therapist [3, 4, 10, 11, 12]. Objective assessments of state of health, course of illness and cooperation indicate effectiveness of psychoeducation in the treatment of patients with schizophrenia. On the other hand, subjective assessments of the quality of life do not change with the increase in knowledge about schizophrenia [13, 14] whereas greater criticism regarding the illness – which is being gained during psychoeducational treatment- is associated with lower quality of life [15]. Thus, educational treatment can indirectly contribute to lower quality of life as it increases criticism towards illness. It is therefore important what are the opinions of the patients, how do they perceive benefits resulting from the participation in psychoeducational sessions and what do they think about organisation of these sessions and their own participation.

It is our assumption that not only the final effect of the psychoeducational treatment – which reveals itself in various time after the completion of the cycle of sessions – is of great importance. Direct gains resulting from the participation in this form of group therapeutic treatment are also crucial. This paper regards the perspective of participants of the sessions: their interest in the problems related to the illness and perceived benefits resulting from the participation in psychoeducational group. The patients have assessed subjective importance of the content of the sessions and suggested their own propositions of the sessions' topics. They have also indicated the elements that could improve sessions' outcome – related to therapist's attitudes and visual aids used.

Table 1. Characteristics of the patients participating in psychoeducational sessions

Characteristics of the patients	n	%
gender		
female	63	38.5
male	104	61.5
diagnosis (in groups)		
group of schizophrenia disorders	14	87.5
affective disorders	10	62.5
other	7	43.8
treatment centre		
inpatient ward	101	59.8
outpatient ward	50	29.6
other	14	8.3
	min–max	mean (SD)
age (years)	18–74	40.3 (13.0)
duration of illness (years)	1–50	10.5 (8.9)

MATERIAL AND METHOD

Opinions on psychoeducational sessions and therapist' attitudes were assessed by a questionnaire applied to the patients once. Demographic data was also gathered. The questionnaire included semi-open questions related to self-esteem, psychoeducation's subject, characteristics of the therapist and usefulness of visual aids applied as well as three open questions concerning the reason for participation in the sessions and their subject: "What is the most important reason why you like to participate in psychoeducation?", "Why do you consider the chosen subject to be of most importance to you?", "Which subjects of psychoeducation are missing?". The patients assessed the questions on ordinal scale. Due to the limited number of words of this publication, the questionnaire is not attached to this paper. The content of closed and semi-open questions (with the option to add the answer) is presented further in the text, in section "Results". Demographic data included gender, diagnosis, age, duration of illness and treatment centre where sessions were conducted.

167 patients attending psychoeducational sessions as well as their therapists[1] were included in the study. 101 (59.8%) individuals were participating in the study while hospitalised in inpatient ward and 50 (29.6%) were the patients of outpatients wards. Characteristics of the study participants are presented in Tab. 1.

Study population included 63 females (37.3%) and 104 males (61.5%) aged 18–74 (mean age – 40.3). All participants were treated for schizophrenia spectrum disorders. Patients in 14 psychoeducational groups (85.5% of total number of groups) had only one diagnosis and in 10 groups (62.5% of groups) affective disorder was an accompanying diagnosis. Other diagnosis included personality disorders and substance use disorders. Mean duration of illness was al-

[1] Results of the study on psychoeducational therapists are described in article: Chądzyńska M, Meder J, Charzyńska K, Drożdżyńska A. Badanie sposobów prowadzenia zajęć psychoedukacyjnych dla osób chorych na schizofrenię – doniesienie wstępne (in press)

most 11 years, however study group was not homogenous in this respect (range of illness duration was 50 years, 82.8% was ill for less than 16 years).

RESULTS

Participants completed the questionnaire concerning their subjective opinions on both sessions and a therapist. They were asked for self- assessment with regard to attitudes toward the sessions, concentration and level on knowledge about psychoeducation. Results are shown in Tab. 2.

Table 2. Patients' self- assessment with regard to participation in the sessions and attitudes towards them.

Attitudes towards sessions	n	%
positive	142	84.0
negative	21	12.4
Self-assessment of level of concentration during sessions		
good	130	76.9
weak or very weak	35	20.7
Assessment of level of knowledge		
satisfactory	79	46.7
below satisfactory level	83	49.1

130 patients (76.9%) assessed their concentration during sessions as good and only 35 (20.7%) considered their level of attention to be poor. Almost half of the study population (83 patients) described its scope of knowledge about illness as being below satisfactory level. However, 79 patients (46.7%) assessed their knowledge with this regard as satisfactory. The definite majority (142 patients, 84%) considered its attitude towards sessions as positive and stated that it was nice to participate in psychoeducation.

Table 3. Reasons for participation in psychoeducational sessions

Reasons for participation in the sessions	n	%
knowledge gain	91	53.8
mood improvement	20	11.8
gains resulting from relationships with other patients	19	11.2
interesting activity, spending time	11	6.5
help in functioning and everyday life	8	4.8
general development	7	4.1
help in therapy	6	3.6
other	8	4.8

Gaining knowledge about the illness was the most common reason for participation in the sessions (91 patients, 53.8%). Knowledge regarded "course and reasons of illness, pharmacotherapy rules, learning about oneself, insight and coping with symptoms and generally with illness". 20 patients (11.8%) assessed that the sessions improve their mood. 11.2% (19 patients) indicated the gains resulting from interactions with other patients during the sessions. They regarded "possibility to talk about problems, experience exchange, support, sense of community and social contacts". As one of the patients put it "I know that I am not alone in my illness". Spending time is the reason for participation for 11 patients (6.5%). Help in functioning and everyday life (8 patients, 4.8%) regarded "coping with everyday life problems after discharge from the hospital and problems in both private and professional life, looking for one's place among people". 7 patients (4.1%) indicated personal development (widening of consciousness, widening of mental horizon, emotional development, better coping with oneself, mobilisation) as a gain resulting from psychoeducation. Sessions were helpful in therapy for 6 persons (3.6%). Following reasons were indicated by 21 patients who were not satisfied with participation in psychoeducation: sessions were tiring, irritating, boring, not interesting, causing anxiety of participation in them. Negative assessment of the sessions referred to their reception.

Patients assessed level of difficulty of the topics on a scale: 1– easy, 2 – moderately difficult, 3- very difficult. Tab. 4 – *next page*, presents level of difficulty of topics discussed according to the patients.

According to the patients the topics differed with regard to level of difficulty (Friedman test $p<0.001$). The most difficult topics included: coping with symptoms, asking for help, causes of illness and noticing the first signs of health state worsening. On the other hand, contact with a doctor, pharmacotherapy and avoiding alcohol and narcotics were least difficult, but also least important topics – they were reported as being most important by 7.1%, 8.9% and 6.5% respectively. Coping with illness's symptoms was mentioned as most important topic as it was useful for "understanding the causes of the

Table 4. Level of difficulty of topics discussed according to the patients

Topics of psychoeducational sessions			
	mean difficulty	importance of the topic	
		n	%
coping with symptoms	2.01	34	20.1
asking for help	2.0	7	4.1
causes of illness	1.94	30	17.8
noticing first signs of illness	1.94	26	15.4
worsening of health state			
course of illness	1.85	24	14.2
contact with doctor	1.6	12	7.1
pharmacotherapy	1.4	15	8.9
avoiding alcohol and narcotics	1.4	11	6.5

illness, gaining the knowledge which helps to counteract the illness, daily functioning and for getting rid of helplessness against symptoms". The second most important topic was causes of the illness (30 patients, 17.8%). Asking for help appeared to be the least important topic for the respondents (it was mentioned as most important by 7 patients, 4.1%). Patients also indicated missing topics that they would find interesting. They referred to following areas: knowledge about illness ("types of mental disorders", "differentiating reality from illness, effects of the illness, realizing the symptoms and coping with them"); pharmacotherapy ("activity of medication, chemical composition of medicines"); legal regulations; functioning in society ("preparation to continuing professional career, how to function in society"); specific social skills ("communication, assertiveness"); functioning in family ("how to adjust to living with illness in family, what influence family may have").

Patients assessed importance of therapist qualities on a scale where 1 meant moderate importance and 3 – very important. Results are presented in Tab. 5.

Differences in patients' assessments of therapist qualities were statistically significant (Friedman test $p<0.001$). The most important characteristic was "capable of listening and talking" followed by: trustworthy, effective, communicating in a clear and straightforward way, patient, having extensive knowledge. According to the patients the least important quality was therapist's sense of humor followed by being convincing, intelligent, in control of the group, smart and warm.

Patients and therapists were asked about usefulness of different visual aids. Schemes facilitating illness comprehension, photos, brochures, charts with most important information concerning the illness, video materials and boards were considered by both patients and therapists to be most helpful. Patients also found scripts including most important information about the illness to be very useful. Task books and tests verifying patients' knowledge were considered to be relatively least helpful. According to the patients, they would definitely like to use video materials (103 persons, 60.9% of the respondents), schemes and pictures (76 persons, 45%) as well as internet (68 persons, 40.2%) during the sessions.

Table 5. Importance of therapist characteristics with regard to conducting psychoeducational sessions

Therapist characteristics	mean importance assessment
able to listen and to talk	2.8
trustworthy	2.7
effective	2.7
communicating in a clear and straightforward way	2.7
patient	2.7
having extensive knowledge	2.7
open to patients' input	2.6
kind	2.6
easily gets in touch with new people	2.6
competent	2.6
engaged in his/ her work	2.6
likes patients	2.5
with practical experience in the field	2.5
matter-of-fact	2.5
persuasive	2.4
intelligent	2.4
in control over a group	2.4
wise	2.4
warm	2.4
with sense of humour	2.2

DISCUSSION

Participants' positive attitude towards psychoeducational sessions is an important finding of this study. This is not obvious as during the sessions patients have to confront the illness, its symptoms as well as limitations and changes in everyday life that follows. Positive attitude might arise from expectations that are connected with participation in the meeting and which concerns gaining knowledge about the illness. It is worth considering what changes knowledge about the illness may cause in patients' life. Study participants indicated increase in awareness and insight in illness and healing processes, gaining information on treatment options as well as practical guidelines how to cope with life with schizophrenia. Furthermore professionals underlined patients' better compliance with treatment [8]. About 50% of the respondents reported limited knowledge about the illness. Such subjective assessment motivates to participate in the sessions. It is interesting what the motivation of the rest of the participants was. Second reason for participation in psychoeducation was temporary gains, e.g. mood improvement, spending time and therapeutic gains such as possibility to establish relationships with other patients. This allows exchanging experiences, receiving support and counteracting loneliness. In the literature it is being stressed that participation in psychoeducational process brings the patients emotional relief and helps to accept and cope with schizophrenia [8]. It is especially important after the first episode that the patients understand, create meaning of illness and inscribe illness experience into the picture of themselves, at the same time protecting their own image against negative assessment [2]. Development of coping style leads to increase in control over illness's consequences in different life spheres. Goals of psychoeducation are being reached through raising variety of topics. The participants have assessed their subjective level of importance and difficulty. Following topics related to understanding, recognizing and coping with illness were reported as most important: course and causes of illness, early symptoms recognition and coping with symptoms. Suggested additional topics also referred to different skills facilitating coping with illness. This shows what patients' expectations towards psychoeducation are. Its most important aim is to provide the participants with ways of coping with illness: monitoring, reacting to worsening health state, counteracting the symptoms in order to be able to fully participate in everyday life. This is the primary goal of psychoeducation as reported by both patients and therapists [1, 16]. The participants highly assessed the level of their own concentration during the sessions; however the therapists reported concentration disturbances as a problem demanding adjusting the course of the meeting to participants' abilities [16].

The participants assessed importance of therapists' qualities. Communicativeness, patience, trustworthiness, knowledge and ability to share it seem to be of most significance. They provide a patient with a feeling that he is being listened to and enable to build trust. Instead of enforcing his own model of schizophrenia, a therapist is expected to deliver information. He follows the patients referring to their subjective sensation of schizophrenia and suggests different understandings in order to allow them to give new meanings to their experiences. It happens in the process of meanings negotiation which occurs between the therapist and sessions' participants and requires patients' cognitive and emotional engagement. Psychoeducation is not only a process of education as it requires use of therapeutic techniques and the leader's tasks involve both education and therapy [2, 3, 16]. Nevertheless the therapists' qualities appreciated by the respondents were related both to their educational skills and ability to establish positive contact.

Practical issues related to psychoeducational sessions were also researched in the current study. Both patients and therapists agreed that aids involving different senses (e.g. photos, boards, schemes, video materials) were useful. The patients would be particularly interested in using the forms which can be seen, heard and touched. This shows that form of the sessions as well as engagement of all senses may also be used to arise the interest of the participants. Additionally, the way of conducting the sessions may include different components: discussion group, behavioural- cognitive training, therapeutic techniques [3, 6, 17]. Forms of the sessions are important on many levels. Firstly, attractive, interesting sessions increase patients' motivation for participation. Secondly, various, multimodal techniques improve learning and memorizing process. Thirdly, group process engages the participants emotionally, inclines to reflection and referring the presented knowledge to own experiences.

CONCLUSIONS

Patients with schizophrenia have positive attitude toward psychoeducational sessions that are offered at both inpatient and outpatient wards. Increase in knowledge on illness was the most important gain resulting from the participation in the sessions. Significant effects of the sessions included also receiving support through possibility to talk as well as exchanging experiences with others. Mood improvement was a temporary gain resulting from the sessions.

Approximately 50% of the respondents considered level of their knowledge on the illness to be not satisfactory. The major motivation for the participation in psychoeducation was gaining the knowledge which aim is to increase self- awareness in the illness and to create the ways of coping.

The most important subjects rose during psychoeducational meetings included course and causes of the illness, identification of relapse symptoms and coping with symptoms.

Desirable qualities of the therapists included extensive knowledge as well as ability to talk and listen in a way which creates atmosphere of trust and understanding.

Use of visual aids, such as video materials, internet, scripts, boards and schemes, is of great importance as they influence learning process as well as motivation for participation in the sessions.

REFERENCES

1. McFarlane WR. Family therapy in schizophrenia. New York, London: The Guilford Press; 1983.
2. McGorry PD. Psychoeducation in first-episode psychosis: A therapeutic process. Psychiatry. 1995; 58(4): 313–328.
3. Czernikiewicz A. Psychoedukacja w schizofrenii. In: Meder J, Sawicka M, editors. Psychoterapia w schizofrenii. Kraków: Biblioteka Psychiatrii Polskiej; 2006. p. 101–126.
4. Kasperek B, Michałowska J, Sala P, Spiridonow K. Modele oddziaływań edukacyjnych dla rodzin osób chorych na schizofrenię. In: Meder J, editor. Rehabilitacja przewlekle chorych psychicznie. Kraków: Biblioteka Psychiatrii Polskiej; 2000. p. 63–88.
5. Lincoln TM, Wilhelm K. Effectiveness of psychoeducation for relapse, symptoms, knowledge, adherence and functioning in psychotic disorders: A meta-analysis. Schizophrenia Research 2007; 96(1-3): 232–245.
6. Bechdolf A, Koln D, Knost B, Pukrop R, Klosterkotter J. A randomized comparison of group cognitive-behavioural therapy and group psychoeducation in acute patients with schizophrenia: outcome at 24 months. Journal Acta Psychiatrica Scandinavica. 2005; 112(3): 173–179.
7. Merinder LB, Viuff AG, Laugesen HD, Clemmensen K, Misfelt S, Espensen B. Patient and relative education in community psychiatry: a randomized controlled trial regarding its effectiveness. Soc Psych Psych Epid. 1999: 34(6): 287–295.
8. Pitschel-Walz G, Bauml J, Bender W, Engel RR, Wagner M, Kissling W. Psychoeducation and compliance in the treatment of schizophrenia: results of the Munich Psychosis Information Project Study. J Clin Psychiat. 2006; 67: 443–452.
9. Magliano L, Fiorillo A, Malangone C, De Rosa C, Maj M. Patient Functioning and Family Burden in a Controlled, Real-World Trial of Family Psychoeducation for Schizophrenia. Psychiat Serv. 2006; 57(12): 1784–1791.
10. deBarbaro B, editor. Schizofrenia w rodzinie. Kraków: Wydawnictwo Uniwersytetu Jagiellońskiego; 1999.
11. McFarlane WR, Dixon L, Lukens E, Luchsted A. Family psychoeducation and schizophrenia: a review of the literature. J Marital Fam Ther. 2003; 29(2): 223–245.
12. Motlova L, Dragomirecka E, Spaniel F, Goppoldova E, Zalesky R, Selepova P, Figlova Z, Hoschl C. Relapse prevention in schizophrenia: does group family psychoeducation matter? One-year prospective follow-up study. International Journal of Psychiatry in Clinical Practise. 2006; 10(1): 38–44.
13. Kasperek B, Spiridonow K, Chądzyńska M, Meder J. Jakość życia chorych na schizofrenię a umiejętność rozwiązywania problemów związanych z chorobą – porównanie grup pacjentów uczestniczących w treningu behawioralnym i psychoedukacji. Psychiat Pol. 2002; 36(5): 717–730.
14. CortenP, Mercier Mercier, Pelc I. Subjective quality of life: clinical model for assessment of rehabilitation treatment in psychiatry. Psychiatr Epidemiol. 1994; 29: 178–183.
15. Chądzyńska M, Kasperek B, Spiridonow K. Zmienne kliniczne i demograficzne a jakość życia osób przewlekle chorych na schizofrenię. Wiadomości Psychiatryczne. 2001; 4(4): 275–281.
16. Chądzyńska M, Meder J, Charzyńska K, Drożdżyńska A. Badanie sposobów prowadzenia zajęć psychoedukacyjnych dla osób chorych na schizofrenię – doniesienie wstępne – w druku.
17. Staring ABP, Mulder CL, Van der Gaag M, Selten J-P, Loonen AJM, Hengeveld MW. Understanding and improving treatment adherence in patients with psychotic disorders: a review and a proposed intervention. Current Psychiatry Reviews. 2006; 2(4): 487–494.