

# Survey on Psychoeducation: Current Status and Involvement of Healthcare Professionals

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**Abstract:** Objective: The general objective of our research is to take stock of the state of the art in psychiatry and to evaluate the participation of health care personnel in therapeutic education and their motivation in the educational follow-up of patients and their families. Material: This is a descriptive cross-sectional study carried out in May 2022 at the Department of Psychiatry at the "Saada" Regional Hospital in Marrakech, Morocco, on a sample of 60 health workers distributed as follows: 53 nurses, 6 doctors including 5 psychiatrists and a general practitioner and finally a clinical psychologist. Results: 94% of caregivers had notions about psychoeducation 70% reported having received training, 52% of which had benefited from it at the basic curriculum level. All participants in the survey stated the therapeutic effect of psychoeducation and 88% considered it a therapeutic act that must be performed by all health care staff. The high number of patients and the lack of trained staff were the main factors related to the inadequacy of psychoeducation according to our sample. Conclusion: The adoption by medical and paramedical personnel of an educational approach in their daily practice should be the rule. However the lack of training of caregivers remains an essential obstacle. staff motivation is an important element in therapeutic education, which must also involve the patient's family and friends.

**Keywords:** Psychoeducation, Mental Illness, Family, Patient, Caretaker

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## **1. Introduction**

Chronic diseases are the main source of physical disabilities, mental, social in the world [1]. In Morocco, nearly 350,000 Moroccans population with mental illness [2]. According to the WHO, mental illness, are ranked 3rd in terms of prevalence and are responsible for one 25% of disabilities [1] and 5 mental illnesses are among the top 10 diseases worrying for the 21st century: schizophrenia, bipolar disorders, addictions, depression and obsessive-compulsive disorder. [3] Patient education is intended to help patients and their families understand their disease and treatment, collaborate with caregivers, to live healthy lives and maintain a better quality of life.

In mental health, therapeutic education includes the term psychoeducation or psycho educational therapies, born in 1980 [4]. Psychoeducation is aimed at all patients with psychiatric disorders who can be integrated into a programme social rehabilitation. It is defined as a didactic and therapeutic intervention to inform patients and their families

about the various aspects of psychiatric disorder and promote abilities to do so. [5]. Studies have reported that psychoeducation may improve self-efficacy and social support, and reduce depression. However, some studies found no difference between groups in terms of self-efficacy, depression and anxiety [6].

Our study which started from the observation of the insufficiency of the practice in psychoeducation in all mental health facilities on the city of Marrakech with absence of premises.

Dedicated to it, aims to describe the state of the art, to evaluate the motivation of staff, to characterize the involvement of the caregivers in the notion of psychoeducation and to describe barriers that impede the implementation of psychoeducation sessions within a psychiatric department.

## **2. Material and Method**

1-Type of study:

This is a quantitative descriptive study carried out in May 2022 at the psychiatric ward at the Marrakech Regional Hospital in Morocco.

#### 2-Study population:

The population chosen for this work concerns the staff: doctors, paramedics.

Our sample included 53 mental health nurses, a psychologist Clinician and 6 doctors including 5 psychiatrists and a general practitioner (N= 60).

#### 3-Data collection and analysis:

Data collection was conducted by two medical specialists using a Questionnaire divided into three sections: the first section assesses the knowledge of the Personal on psychoeducation, the second assesses their perception on psychoeducation and the third reviews their practice. The data collection was done in the respect of anonymity and confidentiality of information. The data collected was entered and processed using computer equipment including: EPI Info, Word –EXCEL.

## 3. Results

We had 50 responses out of 60 questionnaires distributed to caregivers.

### 3.1. Staff Knowledge

#### 3.1.1. Proportion of Caregivers with Knowledge of Psychoeducation

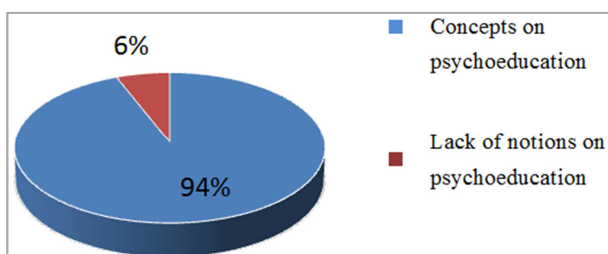


Figure 1. Proportion of caregivers with psychoeducation knowledge.

94% of caregivers had knowledge about psychoeducation.

#### 3.1.2. Proportion of Caregivers Trained in Psychoeducation

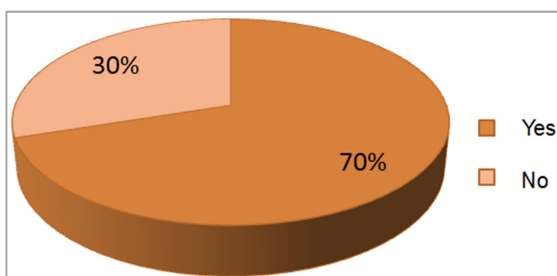


Figure 2. Proportion of caregivers trained in psychoeducation.

70% of our sample received training in psychoeducation.

#### 3.1.3. Psychoeducation Training Context

52% of staff reported training at basic level

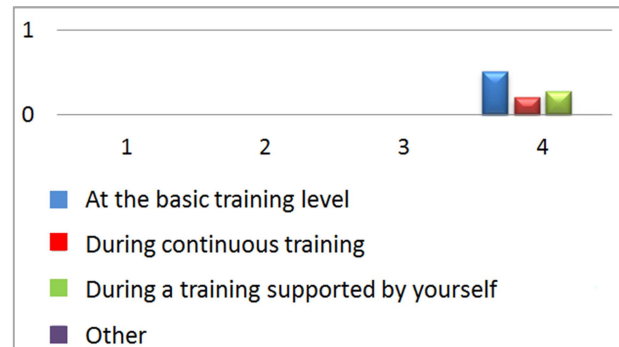


Figure 3. Psychoeducation training context.

#### 3.1.4. Knowledge Use in Psychoeducation

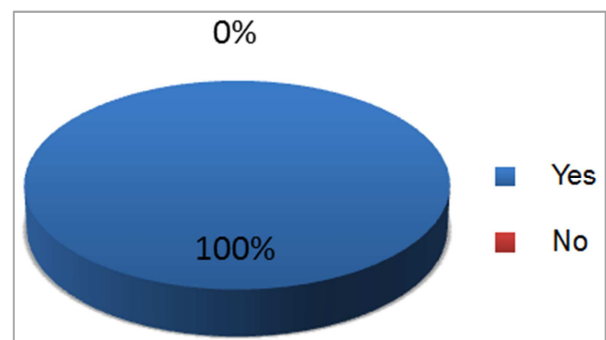


Figure 4. Knowledge Use in Psychoeducation.

All the staff surveyed felt that they had used their knowledge of psychoeducation in their practice.

### 3.2. Staff Perceptions of Psychoeducation

#### 3.2.1. Estimating the Therapeutic Effects of Psychoeducation in Practice

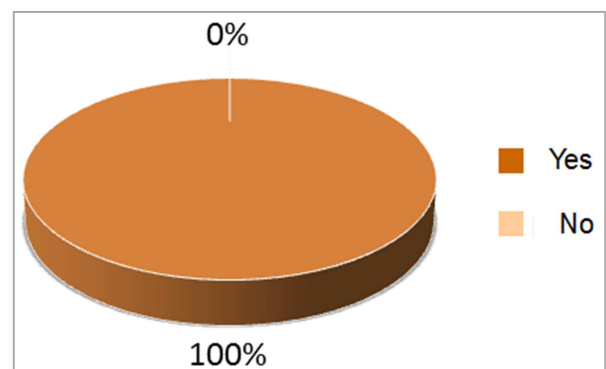


Figure 5. Estimating the therapeutic effects of psychoeducation in practice.

The therapeutic effect of psychoeducation was reported by all staff participating in the survey.

#### 3.2.2. Expected Effects of Psychoeducation as Perceived by Caregivers

According to the nursing staff surveyed the therapeutic alliance and adherence to care are the most expected effects of psychoeducation.

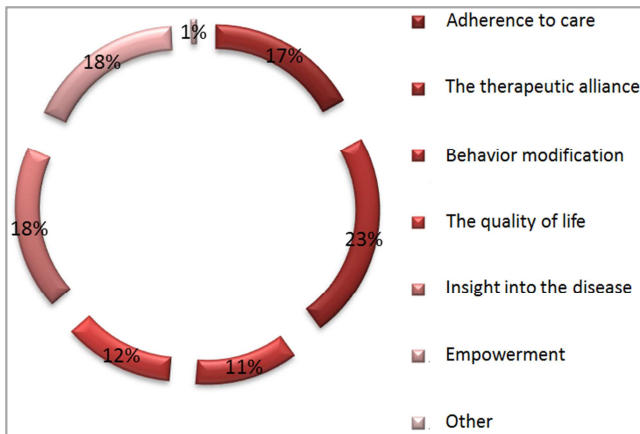


Figure 6. Expected effects of psychoeducation as perceived by caregivers.

### 3.2.3. Qualification of the Practice of Psychoeducation by Staff at the Saada Hospital Level

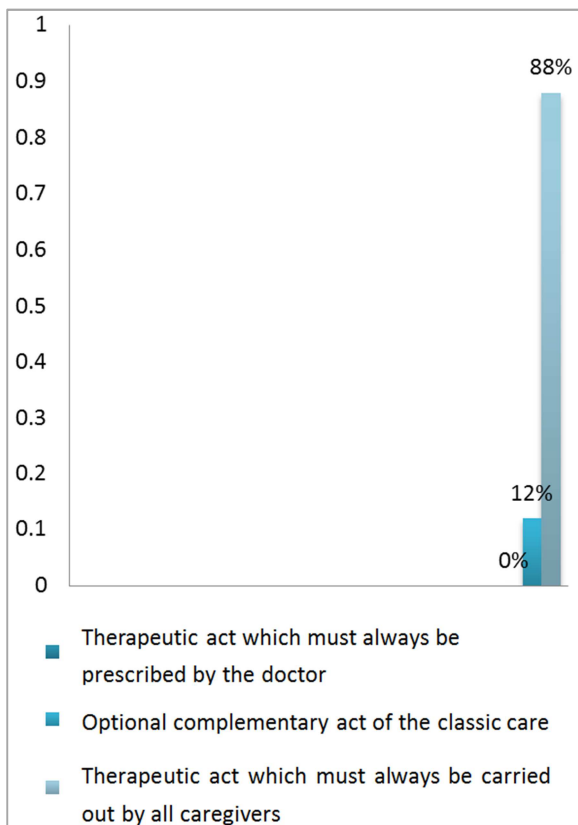


Figure 7. Qualification of the practice of psychoeducation by staff at the level.

88% of participants considered psychoeducation as a therapeutic act that must be performed by all health care personnel.

### 3.2.4. Possibility of Negative Repercussions in the Absence of Psychoeducation on the Patient's Therapeutic Project

72% of staff who participated responded that the absence of psychoeducation can negatively influence the patient's therapeutic plan.

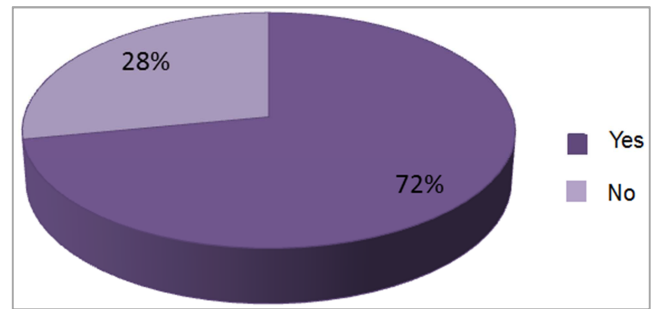


Figure 8. Possibility of negative repercussions in the absence of psychoeducation on the patient's therapeutic project.

### 3.2.5. Parameters Related to Patients and Their Families That May Come into Play During Psychoeducation

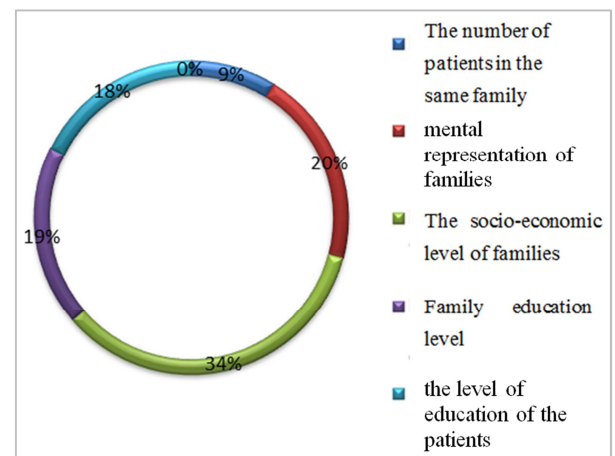


Figure 9. Parameters related to patients and their families that may come into play during psychoeducation.

The majority of staff felt that psychoeducation is influenced by factors mainly related to the family

### 3.2.6. Factors Related to Inadequate Psychoeducation in Hospitals

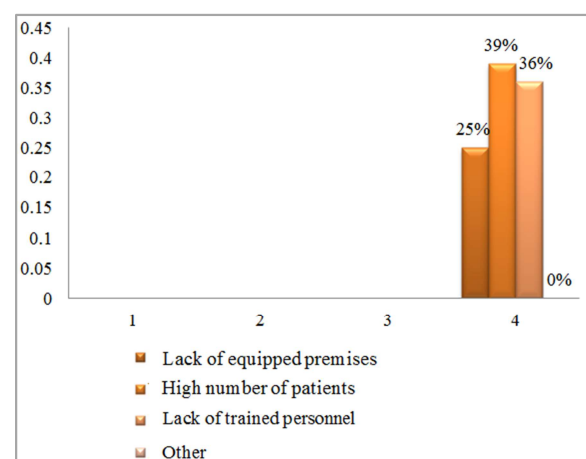


Figure 10. Factors related to inadequate psychoeducation in hospitals.

The high number of patients and the lack of trained staff were the main factors associated with the absence of psychoeducation in our sample.

### 3.3. Practice of Psychoeducation

#### 3.3.1. Conduct of Psychoeducation Practices

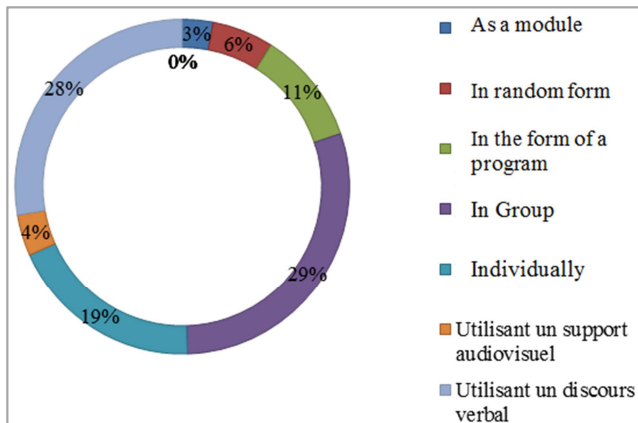


Figure 11. Psychoeducation practices.

29% of staff proceeded in groups and 28% acknowledged using verbal speech for their practice.

#### 3.3.2. The Types of Pathologies That Have Benefited from Psychoeducation

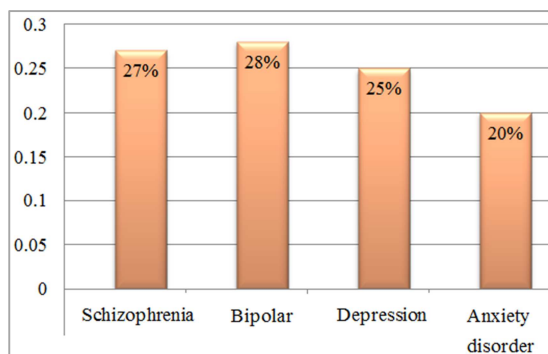


Figure 12. Types of pathologies that have benefited from psychoeducation.

In the majority of cases, the staff surveyed provided psychoeducation for psychotic patients.

#### 3.3.3. Existence of a Valid Psychoeducation Programme in Morocco

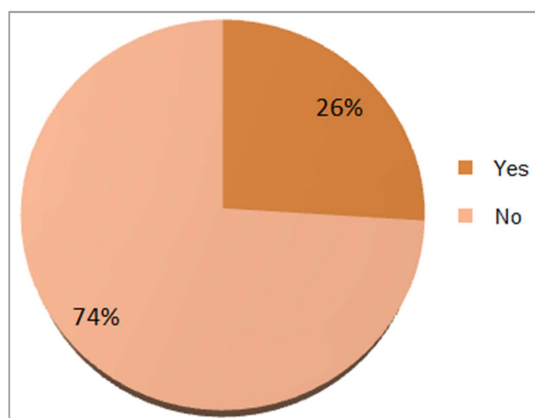


Figure 13. Existence of a valid psychoeducation programme in Morocco.

74% of staff who participated said there was no valid program in psychoeducation in Morocco.

#### 3.3.4. The Effectiveness of Individual Non-Formal Practices in Psychoeducation

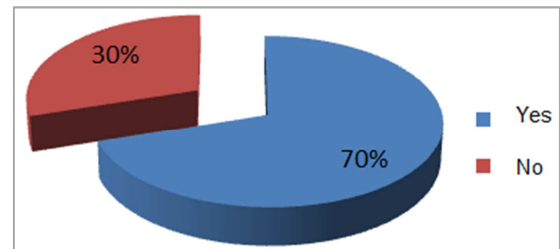


Figure 14. Effectiveness of individual non-formal practices in psychoeducation.

70% of cases recognized the effectiveness of individual non-formal practices in psychoeducation.

#### 3.3.5. Psychoeducation of Patients' Families

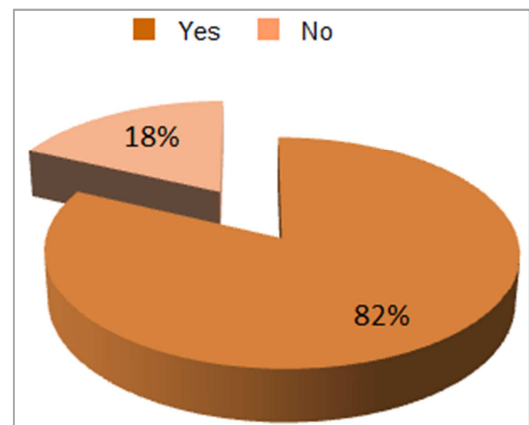


Figure 15. Psychoeducation of patients' families.

82% of staff reported psycho-educational contact with patients' families.

#### 3.3.6. Motivation of Caregivers to Participate in Psychoeducation Training

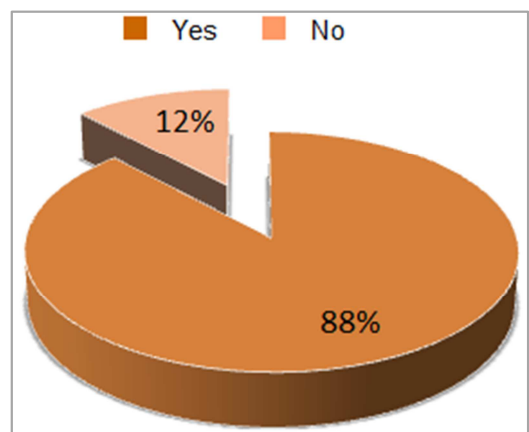
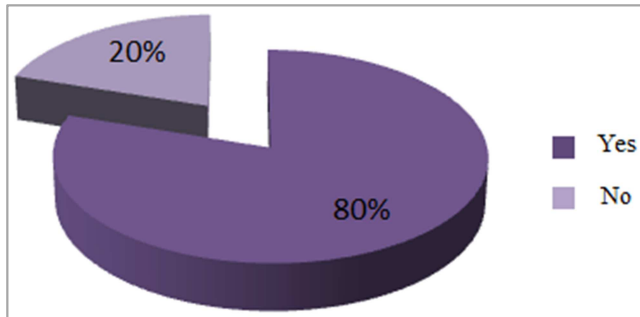


Figure 16. Motivation of caregivers to participate in psychoeducation training.

88% of staff reported being motivated to participate in psychoeducation training.

### 3.3.7. Involvement of the Hospital Administration in Raising Awareness of Psychoeducation



**Figure 17.** Involvement of the hospital administration in raising awareness of psychoeducation.

80% of staff replied that their administration is not involved in the psychoeducation project for patients.

## 4. Discussion

Psychoeducation is defined as a process of training a person with a psychiatric disorder in the areas of treatment and rehabilitation, to promote acceptance of the illness and active cooperation in treatment [4]. According to the quality criteria of the "Haute autorité en santé", it must be carried out by professionals trained in the patient's therapeutic approach and in teaching techniques [4].

In our study, 94% of the staff had some knowledge of psychoeducation, 70% of whom had received training that corresponded to the initial basic curriculum, with a reduced hourly volume, which remained very inadequate in 52% of cases. All the staff questioned said that they had used their knowledge of psychoeducation in practice, but 12% were not motivated to take part in training. This can be explained in part by the lack of awareness and interest in psychoeducation on the part of the administration, as reported by 20% of the staff, and in another proportion by the lack of premises and the high number of patients, reported by 25% and 39% of the population respectively. In fact, psychoeducation is not simply a transmission of information, but also a pedagogical method adapted to the disorders, with therapeutic objectives that psychological aspects, a modification of attitudes and behaviors [5]. Neville and al [7] showed in a study of more than 2,000 health professionals that training led to an improvement in indicators of structure, procedure, patient satisfaction and a reduction in the use of emergency care. Several studies show that psychoeducation is an effective way to improve the therapeutic alliance, compliance and reduce relapse [8]. These results correlate with those of our work since, according to the nursing staff surveyed, the therapeutic alliance and adherence to care were the most expected effects of psychoeducation. These data also corroborate the initiative of all the staff to practice psychoeducation according to the notions they possess in the

global management of patients. These initiatives have the disadvantage of not being integrated into a well-defined program and source of standardized training. Thus the problem of training has been raised by the "National institut for prévention and education for health" in France, which found that only 55% of the initial training structures offer specific teaching [9]. Psychoeducation is considered an important aspect of psychological treatment and is recommended in the treatment of schizophrenia (American Psychiatric Association, 2021). For patients with schizophrenia, psychoeducation was first described as summarizing clear information to patients and/or families about the phenomenology, onset, course, treatment and outcome of schizophrenia. Family involvement is seen as an important component of psychoeducation, in order to involve and educate family members so that they can better support their loved one with mental illness [10]. The patients who benefited from an educational contact were mostly suffering from schizophrenia or bipolar disorder, which is understandable given that these pathologies come first in the department with rehospitalizations. In this context and especially because of the lack of psychiatric beds in Morocco, psychoeducation can play an important role in reducing decrease in hospitalizations. Beauchamp and al conducted a longitudinal study and observed a clinical improvement and a significant decrease in the number of the group of patients who attended the information sessions (12% versus 31% in the control group) [11]. Since therapeutic education has become widespread in psychiatry, several individual and family programs have been developed for schizophrenia, which essentially aim to place the subject schizophrenia in the position of actor of his illness [12]. For schizophrenia, numerous studies have shown the increase in the objective and subjective burden borne by the family [13, 14]. The use of work stoppages or hospitalizations is more frequent with a higher depressive symptomatology in family members of schizophrenic patients [15, 16]. Family-based interventions are very important in reducing the burden of chronic mental illness on the family, coping with it, reducing caregiver distress and contributing to levels of resilience. The main aim of working with families is to help family members acquire the knowledge and skills they need to support their recovery [17]. When parents learn that their children have special needs, some of them experience significant stress, depression, emotional exhaustion, interpersonal problems and economic problems. In addition, some spouses may drift apart, become distant and, as a result, derive less marital satisfaction [18]. There is compelling evidence that psychoeducational interventions with families reduce patients' relapse rates, as well as the length of hospitalizations, and facilitate medication compliance [8, 19, 20]. In a recent review of the literature on this subject, the Cochrane collaboration shows that the effectiveness of working with the family of a schizophrenic subject is well established by a series of international studies [21]. In spite of all these results, the number of families benefiting from such a program would be at best 10%, but most often



between 0 and 2% [22].

There are two reasons for this. The first is the frequent lack of knowledge about the value of these, The second is that families are rarely considered as partners [23]. In our survey, the majority of staff showed interest in psychoeducation with families, and considered the family as a partner in the care of the patient. Thus, 82% of the staff who had practiced psychoeducation said that they had done so for families [24, 25]. The reason for this important figure in our context is that any contact that comes close to psychoeducation, even if unstructured, was considered a reliable practice, as noted by 70% of the respondents, unlike other studies that were based on valid and well-codified programs in this area.

## 5. Conclusion

Psychoeducation continues and intensifies the paradigmatic shift of recent years that has seen the years, which has seen the relationship between caregiver and patient evolve from a model of prescription to a model of education and autonomy. This mode of intervention has changed the relationship between caregivers, patients and their families to make them partners in the treatment and to increase their treatment and to increase their power to act. However, only the effectiveness of structured programs has been demonstrated. In our context, and despite the small number of people involved in the survey, several obstacles were raised, notably the lack of training, the lack of premises, the high number of patients and the lack of financial support.

Other more positive aspects are the motivation of the staff to engage in training, the awareness of the interest of working with families as partners, and the presence of family associations which are increasingly demanding that psychoeducation programs be included in patients' therapeutic project.

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