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PICTURES & PROSE

A psychoeducation tool for patients with first-episode psychosis

Psychoeducation and schizophrenia

Psychoeducation interventions have been developed to explain illness and treatment to people with schizophrenia, in order to enable them to cope more effectively with their illness. Psychoeducational interventions are administrated in group, individual, family or multifamily group formats and address the illness from a multidimensional viewpoint, including biological, psychological and social perspectives. Participants are usually provided with information, emotional support and management strategies. Most often the intervention includes didactic materials such as leaflets, flyers, presentation slides, posters, movies and so on. In terms of efficacy, psychoeducational interventions seem to reduce the risk of relapse rate, hospital readmission and length of stay and promote medication compliance (1). It has been pinpointed that the optimal time for starting psychoeducation is still unknown, but it is suggested that psychoeducation should be offered as early as possible in order to be more effective (2). However, few studies have validly assessed the best timing for psychoeducation. Feldman et al. (2) found that psychoeducation in patients with either long (>7 years) or short (<5 years) illness duration did not influence 5-year rate of readmission, while it did so in those whose illness duration ranged from 5 to 7 years. The authors hypothesised that in participants with longer duration of illness, psychoeducation may actually reinforce a more fatalistic view of the illness, while it may fail to have any impact on participants with shorter duration of illness due to illness denial. This suggests that insight may play a more central role in this issue; in our experience, psychoeducation in itself may actually promote insight in the early phase of psychosis, provided content is properly adapted. However, most psychoeducational interventions are designed for patients suffering from well-established schizophrenia and their content may be inappropriate for first-episode psychosis (FEP) patients. There is therefore a need for new tools to address this issue in this patient population.

Psychoeducation in FEP patients

To our knowledge, most published psychoeducational interventions for people with FEP include families (3,4) or focus on specific topics such as cannabis use (5). Psychoeducational interventions with FEP patients face several important challenges. First, FEP patients' viewpoint about their psychotic experience and their perception of the relevance is that the information they receive has been very little studied. The initial psychotic episode is often described as a confusing and frightening experience; it is accompanied by feelings of losing control and strangeness. Although the given information can be perceived as pertinent and meaningful if it is congruent with the experience of psychosis, it can also feel unacceptable or confusing if the words used are too specialised or technical, if clinicians do not base psychoeducation material on patients' experience or if provided information is too pessimistic or life-limiting. Patients may then reject such information in order to protect their self-esteem. Hence, psychoeducation interventions are likely to be accepted if the patients can integrate the given information in a way that allows them to cope better with their experience. Second, early intervention strategies are based on the postulate that the outcome in this phase of psychosis can be influenced by various interventions, which is more unlikely later in the evolution of the disorder. Although it may be premature to draw definitive conclusions about the actual impact of these new interventions and to integrate such results in psychoeducational programmes, elements on these new ways to approach treatment should nevertheless be presented to patients. For example, data from a large Early Psychosis Prevention and Intervention Centre study indicate that likelihood of symptom remission was significantly higher in patients who decreased or ceased substance use compared to those who continued to abuse substances. In addition, patients who reduced use appeared to have even better outcomes at 18 months than those who had never used substances (6). It is likely that such data may have an impact on patients if included in psychoeducational material, but it is often difficult to convey such information in an accessible way.

Third, patients who develop an FEP belong to a generation that has been the market target of numerous commercial firms during their adolescence. They are therefore used for good marketing techniques and will probably be more critical towards any new product, including psychoeducational tools. Additionally, this generation is used to channel-flick when a programme does not suit them. In this context, psychoeducational tools should provide concise and hard-hitting messages with attractive material. New interventions with patients suffering from well-established schizophrenia try to take care of these marketing aspects in making programmes attractive and entertaining (7,8). A psychoeducation programme for FEP

patients should also meet these different challenges.

A psychoeducation tool for patients with FEP

In this article, we present a four sessions' psychoeducational programme used in a hospital unit specialised in the acute treatment of FEP patients. The programme is currently composed of four modules: (a) psychotic symptoms, (b) cannabis and psychosis, (c) psychosis and medication and (d) psychosis and recovery. Each module includes a folder containing 9–11 cards. Each card contains a statement title illustrating a theme considered important for psychoeducation, a vignette related to this theme and is illustrated by a cartoon. Examples of cards are to be seen below:

Psychosis is not the end of the world

Suzanne just learned she has a psychotic disorder. She reminisces about 'One Flew over the Cuckoo's Nest' and thinks she will end up like a vegetable. She is terrified because not so long ago, just before she became sick, she had a lot of projects for her future.

The term 'psychotic' is a word that is often been misconstrued from its original meaning by the media. They use it in every way to designate fear, erratic behaviour, dangerousness or phenomena that are beyond belief. Terms stemming from psychiatry have often become part of everyday vocabulary while losing their medical meaning.

Its true that in the past, the treatment of psychotic disorders included medication that knocked the patients out or gave them a rigid demeanour, along with electroshock therapy or confinement. Nowadays, the medications have become much more specific and are prescribed in small dosage. From a neurological standpoint, they have very few to no side effects. Electroshock therapy is very seldom used and once the acute episode is under control, the treatment is ambulatory.

The reduction of risk factors, the monitoring of a preventive medication treatment and the acquisition of competences in disorder management allow to reduce the risk of a relapse and to actively work towards resuming life projects. About 85% of the patients will not experience psychotic symptoms after 6 months of treatment. One third of the patients fully recover. We also know that the chances of recovery increase if the patients and their therapeutic team manage to develop a cooperative relationship.

Its my soul that's hurting, not my molecules!!

Martin is not feeling well, he hears scary voices, he is sad and he has been suffering for several weeks. Yet, when the doctor suggests medication, he refuses and says:

'. . . I'm not feeling well, I'm sad, but it's not a chemical thing, it's feelings. It's my soul that's hurting, not my molecules!'

For quite a while, psychiatrists had a hard time agreeing:

1 Some were saying that psychosis was a psychological problem based on life's incidents, going through hardships and that the way to solve the problem was through psychotherapy.
2 Others were saying that psychosis is a brain disease, a matter of biology and that medication was the best way to deal with it.

We now know that its actually a little bit of both. The disease often manifests itself in the context of trying events in life, but biology also plays a part. The overwhelming majority of caregivers agree on the fact that the two kinds of treatments must be combined: medication and psychotherapy.

When dealing with psychosis, the recovery of a person's balance relies on several pillars: the patient's resources, the support of caregivers, friends and relatives, communication, psychotherapy and medication. Once that balance has been re-established, and the patients' resources are solid again, the other pillars can then be gradually removed; the person gets out of the hospital, they do not need as much help from caregivers and medication can be gradually decreased, if not terminated.

A good spliff is relaxing

The effects of cannabis vary not only from one person to the next, depending on the quantity used, but also on the context of this use. Consumers look for the relaxing or stimulating effects of Tetrahydrocannabinol (THC). But they do not always obtain these effects. Dependence to the product decreases these effects and increases the negative consequences. Think of the effects of your very first joints. How many do you need now to have the same reaction?

Cannabis makes psychosis worse by increasing strange voices and ideas. It seriously decreases the ability to focus on people suffering from this disorder and it reduces their motivation. These adverse effects increase social exclusion, which causes significant stress to the user.

Its not fair!

Marc was a successful senior in high school who planned on going to college. A few weeks before his final exams he gradually started having a hard time concentrating and felt a little threatened by his classmates. The symptoms got worse. He was hospitalised and could not take his finals. Marc felt sad, belittled and that what was happening to him was unfair. He thought, 'Why me'?

He was right, it was totally unfair, but thanks to the work they did at the hospital and the medication treatment, he recovered from this episode. Thanks to the therapy he continued to follow after being hospitalised; Marc learned to better cope with stress and to accept the vulnerability that comes with psychosis. In the end, he managed to graduate from high school.

Psychosis can have a negative effect on self-esteem. Therapy can help a person rebuild themselves and find the means to regain control over their life. The psychotic episode turned into an opportunity to develop better knowledge of self and to strengthen the aspects that were exposed as being fragile.

How the programme is led

The intervention is directed to patients who have recovered well enough from the acute episode to attend a group meeting. The sessions are held once a week for 45 min in a comfortable meeting room. The intervention is led by a psychiatrist and a nurse. Every session focuses on one of the four themes: psychosis, medication, cannabis and recovery. To begin the meeting, the goal of the session is briefly presented; new participants are welcomed and introduced to the group. Then the participants receive the folder containing the various cards and have a few minutes to go through the cards to choose one or two of them. Alternately, each participant reads the chosen cards. Then the leaders will ask the participants why they have chosen these specific cards in order to launch the discussion; they facilitate the discussion, make short summaries and reformulations and provide additional information on the basis of questions that may occur. They may also ask other participants to explain how they have solved a problem or a question raised.

Clinical experience indicates that this psychoeducational programme meets the need of the participants and a study to assess its efficacy in naturalistic hospital conditions as well as in an outpatient setting is planned. New cards are in development, notably a folder on trauma and psychosis which is identified as a major problem with FEP patients (9) as well as one on affective symptoms associated with bipolar disorders (10).

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