Review

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Psychoeducation in Mental Disorders: A Brief Review

Ruhsal Hastalıklarda Psikoeğitim: Kısa Bir Gözden Geçirme

Sinem Sönmez[1], Hülya Arslantaş[2]

[1]Kapadokya University, Nevşehir
[2]Aydın Adnan Menderes University, Aydın

ABSTRACT

Psychoeducation, an evidence-based practice, is an educational and psychotherapeutic method applied to patients, families, and groups. It aims to enhance the coping skills of individuals, whether patients or healthy individuals, and their families, while reducing the rates of relapse and repeated hospitalizations. Psychoeducation is defined as a structured, systematic, and psychotherapeutic intervention that combines theoretical and practical approaches to understanding and managing illness. Its primary objectives include equipping patients and their families with fundamental knowledge and skills related to the illness, fostering insight, supporting relapse prevention, and mitigating suicide risk through crisis management. Psychoeducation primarily involves knowledge dissemination and skill development. Programs can vary in the number, frequency, and content of sessions, depending on the specific clinical condition. The effectiveness of psychotherapy in schizophrenia, bipolar disorder, depression, anxiety disorders, substance dependence, and personality disorders has been proven in numerous randomized controlled trials and meta-analyses in the relevant literature. Despite having limited effects when used alone, when combined with pharmacotherapy and other psychosocial interventions, it significantly improves treatment adherence, reduces hospital admission duration and frequency, enhances social functioning, and decreases caregiver burden and stigma. This review examines the definition, types, areas of application, and effectiveness of psychoeducation, with a particular focus on its implementation across various psychiatric disorders, drawing on evidence from the existing literature

Keywords: Psychoeducation, mental disorders, family psychoeducation, treatment compliance

ÖZ

Kanıta dayalı uygulamalar arasında yer alan psikoeğitim, hasta, aile ve gruba yönelik uygulanabilen hasta/sağlıklı birey ve ailesinin baş etme becerilerini geliştirme yöntemlerine odaklanan, hastaneye tekrarlı yatışları ve nüksleri azaltan bir eğitim yöntemdir. Sistematik, psikoterapötik müdahaleler olarak tanımlanmaktadır. Psikoeğitim, psikoterapötik ve eğitsel müdahaleler ile hastalığın anlaşılması ve beraberinde hastalıkla baş etmede teorik ve pratik yaklaşım sunmaktadır. Psikoeğitimin amacı; hasta ve hasta yakınlarının hastalık hakkında temel bilgi ve yeterliliklerini sağlamak, hastalığa ilişkin içgörü kazandırmak, nüksün önlenmesini teşvik etmek ve kriz yönetimi ile intiharı önlemektir. Psikoeğitimde bilgi aktarma ve beceri geliştirme ön plana çıkmaktadır. Psikoeğitim farklı hastalık gruplarına göre değişen oturum sayısı, sıklık ve içeriklerle uygulanabilir. Literatürde psikoeğitimin şizofreni, bipolar bozukluk, depresyon, anksiyete bozuklukları, madde bağımlılığı ve kişilik bozukluklarında etkinliği çok sayıda randomize kontrollü çalışma ve meta-analizlerle kanıtlanmıştır. Tek başına uygulandığında sınırlı etkisi olmakla birlikte, farmakoterapi ve diğer psikososyal müdahalelere eklendiğinde tedavi uyumunu belirgin artırdığı, hastaneye yatış süresini ve sayısını azalttığı, sosyal işlevselliği yükselttiği, bakım veren yükünü ve damgalanmayı düşürdüğü gösterilmiştir. Bu derlemede, psikoeğitimin tanımı, psikoeğitim türleri, kullanım alanları ve etkinliği, çeşitli psikiyatrik bozukluklarda psikoeğitim kullanımı literatür doğrultusunda gözden geçirilmiştir.

Anahtar sözcükler: Psikoeğitim, ruhsal bozukluklar, aile psikoeğitimi, tedavi uyumu

Address for Correspondence: Sinem Sönmez, Kapadokya University, School of Health Sciences, Department of Nursing, Nevşehir, Türkiye
e-mail: snmz.sinem@hotmail.com
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Introduction

As with other non-pharmacological interventions in mental healthcare, the integration of psychoeducation, despite its proven effectiveness, into routine clinical practice has been a long and challenging process (Higgins et al. 2020). In recent years, psychoeducation has emerged as a valuable and effective psychotherapeutic approach for individuals with mental disorders, demonstrating benefits in both clinical and community settings. The origins of psychoeducation can be traced back to the Mental Hygiene Movement of the early 20th century and the Deinstitutionalization Movement of the 1950s and 1960s. Subsequent research on the role of emotional expression in schizophrenia further accelerated its development. Psychoeducation integrates elements of cognitive-behavioral therapy, group therapy, and structured educational strategies. Its primary aim is to provide patients and their families with information about various aspects of the illness and its treatment, thereby facilitating collaboration with mental health professionals to achieve better outcomes. Over time, psychoeducation has been recognized in the literature as an effective adjunctive psychotherapeutic tool for individuals with a range of psychiatric disorders and their families. Its efficacy in enhancing patient adjustment and preventing relapse has been well-documented, particularly in schizophrenia and bipolar disorder. While additional studies have explored its impact in other psychiatric conditions, further research is needed to confirm its effectiveness across broader populations. Psychoeducation remains a simple, accessible, and cost-effective intervention that empowers patients and their families by increasing their understanding of mental illness, ultimately improving their ability to cope with and manage the condition more effectively (Bulut et al. 2016, Sarkhel et al. 2020).

Psychoeducation, as an evidence-based practice, is now widely implemented across various settings as a key component of psychosocial interventions targeting patients, healthy individuals, and their families. It emphasizes strategies aimed at enhancing coping skills and seeks to empower individuals and families in managing illness more effectively. The literature includes several studies evaluating psychoeducational interventions, both as standalone methods and in combination with other treatment approaches, across prevention, treatment, and rehabilitation contexts. These studies consistently demonstrate the positive impact of psychoeducation on both care processes and patient outcomes (Şengün et al. 2011, Bulut et al. 2016).

As an evidence-based intervention, psychoeducation seeks to inform individuals about self-management approaches to the care and treatment of their own or their family members' mental health conditions. In doing so, it aims to enhance communication, problem-solving, and coping skills (Şengün et al. 2011, Tsiourive et al. 2015, Zhao et al. 2015, Bulut et al. 2016, Brady et al. 2017, Petrakis and Laxton 2017). This review examines current studies in the literature and aims to contribute by exploring the definition of psychoeducation, its historical development, key dimensions, core components, types, models, target populations, and applications in various mental disorders. It also includes an overview of global and national (Türkiye-based) research on the subject. In this context, the review seeks to support the sustainability of psychoeducation in psychiatric practice in Türkiye by highlighting recent advancements in its application for mental health care.

Definition of Psychoeducation

Psychoeducation forms the foundation of psychosocial rehabilitation and aims to facilitate changes in both knowledge and behavior. It focuses on equipping individuals with the skills needed to manage their problems effectively. Core components include education about the illness, recognition of stressors and potential relapse, lifestyle modifications, symptom management, problem-solving strategies, enhanced insight, and understanding the effects and side effects of medications. Systematic, team-based, and structured activities, such as psychoeducational group interventions, play a crucial role in sustaining outpatient treatment and maintaining motivation following hospital discharge (Duman et al. 2006, Dikeç and Kutlu 2023).

Psychoeducation is defined as a systematic, psychotherapeutic intervention designed to inform patients and their families about the illness and to strengthen their coping abilities. Its fundamental components include illness education, problem-solving training, communication skills training, and self-esteem enhancement (Sarkhel et al. 2020).

By combining theoretical knowledge with practical strategies, psychoeducation offers an integrated psychotherapeutic and educational approach to understanding and managing mental illness (Ong and Caron 2008). The primary goals of psychoeducation are to provide patients and their families with essential knowledge and skills related to the illness, to foster insight, to promote relapse prevention, and to reduce the risk of suicide through effective crisis management (Sarkhel et al. 2020). As an evidence-based practice, it has been shown to benefit both patients and their families (McFarlane et al. 2003, Lukens and McFarlane 2004). It focuses on enhancing coping mechanisms in the face of the challenges and limitations associated with mental illness, ultimately aiming to empower individuals in the effective management of their condition (Rummel et al. 2006, Griffiths and Smith 2010).

In psychoeducation, knowledge transfer and skill development are paramount. The overarching goals include providing individuals with comprehensive information about their condition, facilitating the free expression of emotions, teaching effective coping strategies, improving family and interpersonal relationships, reducing excessive emotional expression, and enhancing social functioning (Swaminath 2009, Reichhart et al. 2010, Tambağ and Öz 2014, Brown 2018).

Historical Development Process of Psychoeducation

The integration of psychoeducation's proven effectiveness into routine mental health care has been a long and challenging process, similar to other non-pharmacological interventions (Higgins 2020). Therapeutic services and care-oriented education for individuals with physical and psychological problems were first provided in the late 18th and early 19th centuries by pioneers such as Johann Heinrich Pestalozzi (1746–1827) and Dr. Samuel Gridley Howe (1801–1876) (Üstün 2016).

However, before the early 20th-century Mental Hygiene Movement and the community care policies that emerged in the 1950s and 1960s, there was no structured or organized form of psychoeducation. The practice of psychoeducation gained momentum in psychiatry with the recognition of concepts such as emotional expression and family burden concerning chronic and severe psychiatric disorders like schizophrenia. The concept of psychoeducation was first formally defined by John E. Donley in his 1911 article, "Psychotherapy and Reeducation," published in The Journal of Abnormal Psychology (Üstün 2016).

The popularization and development of the term psychoeducation in its current sense are credited to the American researcher C.M. Anderson, who in 1980 described it as a complementary and effective treatment method for schizophrenia (Nolan and Petrakis 2019, Niksalehi et al. 2019).

The Dimensions of Psychoeducation

Psychoeducation comprises four key dimensions: diagnosis and preparation, identifying needs and establishing goals, implementation, and assessment (Swaminath 2009, Şengün et al. 2011). During the diagnosis, preparation, and goal-setting phases, the purpose, content, duration, number of sessions, and requirements related to the implementation environment are determined for the individual or patient receiving psychoeducation. Based on these needs, the practitioner employs interactive methods such as lecturing, role-playing, and discussions to facilitate knowledge transfer and skill development (Stuart 2014, Brown 2018, Boz and Akgün 2020). The implementation and evaluation phase involves both process and outcome assessments. Process evaluations monitor the progression of the training and the extent to which identified needs are being addressed. Outcome assessments measure the degree to which the set goals have been achieved. These evaluations can be conducted by the psychoeducation practitioner using standardized measurement tools or completed in writing by the patient or individual (Stuart 2014, Boz and Akgün 2020).

Basic Components of Psychoeducation

Psychoeducation generally includes essential information components that should be communicated to patients and their family members regarding a specific mental disorder. The modules can be customized to meet the needs of patients, family members, and clinicians or tailored to particular disorders. Consequently, the number and timing of sessions may vary according to the overall content (Sarkhel et al. 2020).

Key components of psychoeducation sessions:

1. Etiological factors.
2. Common signs and symptoms.
3. Recurrence/awareness of early signs of relapse.
4. Coping strategies for managing the condition?
5. Available various treatment options.
6. When and how to seek treatment?
7. The importance of treatment adherence as guided by the healthcare team.
8. Long-term course and outcomes.
9. Things to do and not to do for family members when providing care for the patient.
10. Addressing myths and misunderstandings about the disease and reducing stigma (Sarkhel et al. 2020)

Types of Psychoeducation

Depending on the target audience, psychoeducation can be delivered in individual, group, community, or family-based formats. Its focus may vary, encompassing adaptation, illness, treatment, or rehabilitation, and it can be implemented through either active or passive approaches. Active psychoeducation involves direct interaction between the professional and the patient or family, with the professional explaining relevant topics. In contrast, passive psychoeducation allows individuals to learn independently through resources such as booklets and audiovisual materials (Sarkhel et al. 2020).

Individual Psychoeducation

Individual psychoeducation is more specific and tailored, prioritizing personalized training and scheduling sessions according to the patient's needs. It has been reported that patients express themselves more freely in individual settings and tend to have lower dropout or withdrawal rates. However, despite these advantages, individual psychoeducation can be more time-consuming and costly, which may be considered a limitation. Typically, individual psychoeducation is conducted over 7 to 12 sessions (Swaminath 2009, Gümüş et al. 2016, Duran 2024).

Group Psychoeducation

Group psychoeducation typically involves patients with similar diagnoses, such as bipolar disorder, schizophrenia, or substance use disorders. Groups comprising individuals with different illnesses are generally not combined. Group sizes usually range from 4 to 12 participants, with the number of sessions varying between 5 and 24. The optimal number of sessions is determined through research and clinical practice; however, practical considerations such as time constraints and staff availability may influence session frequency, even when the content remains consistent for each disorder. Sessions typically last 40 to 60 minutes and are often conducted once or twice weekly. The timing and frequency of sessions are

optimized to promote better understanding and assimilation of the material presented (Sarkhel et al. 2020).

Group psychoeducation offers several advantages, including the ability to reach multiple patients simultaneously, reduced costs, and the promotion of peer interaction (Gümüş et al. 2016). The setting should remain consistent, with session dates and times posted in the service area. During sessions, participants should be encouraged to interact, with each meeting beginning with a review of the previous session and concluding with a summary. Accurate feedback from group members should be acknowledged, while inappropriate feedback can be managed through gentle, corrective interventions (Duran 2024).

Family Psychoeducation

Family-based psychoeducation can be delivered either to individual families or in multifamily groups comprising families experiencing similar illnesses. This approach has proven effective in managing conditions such as schizophrenia and bipolar disorder. Family psychoeducation is particularly valuable during symptomatic periods when patients may lack insight or refuse medication. It also aids in recognizing early signs of relapse, facilitating timely diagnosis and intervention. The number and frequency of sessions vary, typically ranging from 6 to 12 weekly meetings, with follow-up sessions conducted monthly after patient discharge (Bulut et al. 2016, Sarkhel et al. 2020). Family psychoeducation equips caregivers with current information on disease etiology, treatment options, and medication effects and side effects. It also teaches symptom management, crisis intervention, prodromal symptom recognition, communication skills, and problem-solving techniques. Additionally, it provides a forum for families to ask questions, reduces hospital stays and readmissions, and has been shown to improve medication adherence (Duran 2024).

Psychoeducation Models

1. Information Model: This model aims to educate families about psychiatric illnesses and their management to increase family awareness and to support effective illness management.
2. Skills Training Model: This model focuses on systematically developing specific behaviors necessary for family members to cope with the illness. The goal is to strengthen families' coping skills.
3. Supportive Model: Support groups are established to provide families of patients with a space to share their feelings and experiences. The primary goal of this model is to assist and empower families in coping with the challenges and burdens associated with the illness.
4. Comprehensive/Broad Model: Also known as the combined model approach, this method integrates knowledge transfer, skill development, and supportive elements. A comprehensive program typically includes the following components:
    a. The educational element provides information about the illness and the mental health system.
    b. The skills element includes conflict resolution, problem-solving, assertiveness, communication, and stress management.
    c. The emotional element aims to foster catharsis, sharing, and resource mobilization.
    d. The family process element focuses on enhancing the family's coping strategies.
    e. The social element emphasizes increasing the utilization of informal and formal support resources (Üstün 2016, Sarkhel et al. 2020).

Target Groups of Psychoeducation

In psychoeducation, the target groups include newly diagnosed patients and their families, patients at risk

of readmission, and families living with the patient (Gümüş and Buzlu 2018).

Patients Receiving a Diagnosis and Their Families

Newly diagnosed patients and their families often experience complex emotions. Psychoeducation for this group aims to support their adaptation to the illness (Gümüş and Buzlu 2018).

Patients at Risk of Repeated Admissions

Individuals with psychiatric illnesses who experience frequent hospitalizations are at high risk of readmission. The families of these patients often face significant stress, burnout, and sometimes serious conflict. In some cases, hospital readmission may be used as a coping strategy. Therefore, psychoeducation for this group focuses on teaching families skills to manage stressful situations and to control patients' negative behaviors. Psychoeducational interventions may be applied across diagnostic groups or tailored to specific diagnoses (Gümüş and Buzlu 2018).

Families Living with the Patient

Mental illness profoundly affects family members' lives, especially caregivers, disrupting family balance and causing tension (Gümüş and Buzlu 2018). Additionally, the stigma associated with mental illness negatively impacts not only patients but also their families. Many families experience discomfort due to stigma and may attempt to conceal the illness from others. Psychoeducation for this group aims to reduce stigma, encourage active family participation in treatment and care, and thereby improve patient adjustment to treatment, reduce relapse rates, and decrease hospitalizations (Çinçinoğlu 2024).

Psychoeducation in Various Psychiatric Disorders

Psychoeducation for Other Disorders Accompanying Schizophrenia and Psychosis

First, patients should be encouraged to express their understanding of the disorder. Once these perspectives are clarified, a common ground can be established between everyday knowledge of the illness and scientific textbook knowledge. The key message is that schizophrenia arises from the combined influence of psychological stress and biological factors. Therefore, effective disease management requires both pharmacotherapy and psychosocial interventions.

In addition to the core components mentioned previously, the following disease-specific information should be communicated:

1. The meaning of the term "schizophrenia".
2. Positive and negative symptoms.
3. Neurobiological origin of symptoms.
4. The stress-sensitivity-coping model.
5. Various medications and their side effects.
6. Psychosocial interventions.
7. Psychotherapeutic interventions and suicide prevention.
8. Early warning signs and relapse prevention.
9. Long-term course and outcome, including remission and recovery (Zhao et al. 2015, Sarkhel et al.

Psychoeducation for Bipolar and Related Disorders

The group working on psychoeducation for bipolar disorder defines it as knowledge-based behavioral

training focused on lifestyle modifications to better manage the illness. Key components include increasing awareness of the disorder, promoting treatment adherence, facilitating early detection of relapse, and avoiding potential triggers such as illicit drug use and sleep deprivation (Gümüş and Buzlu 2018, Buizza et al. 2019, Sarkhel et al. 2020). It has been emphasized that psychoeducation should complement medication and other treatment modalities (Hedayati 2022).

Awareness of the illness: Many patients with bipolar disorder have limited knowledge about their condition. Without sufficient insight, patients are less likely to engage fully in psychoeducation sessions. Emphasizing the medical model of bipolar disorder helps reduce associated stigma. Psychoeducation topics should include the definition of bipolar disorder, its etiologies and triggers, symptoms of mania and hypomania, symptoms of depression and mixed episodes, as well as the typical course and outcome of the disorder (Gümüş et al. 2016, Sarkhel et al. 2020). Nearly half of patients with bipolar disorder discontinue treatment abruptly and without supervision at some point in their lives, and most consider stopping medication during their illness. A thorough discussion of the side effects of commonly used medications and strategies to manage them is crucial for dispelling myths about pharmacotherapy (Çakır and Özerdem 2010, Sarkhel et al. 2020). Co-occurring substance abuse is common, with over half of patients affected; alcohol is the most prevalent substance. Substance abuse is linked to increased depressive episodes, adjustment difficulties, and poorer recovery outcomes. Therefore, psychoeducation should address the harmful effects of alcohol and other drugs in this population (Çakır and Özerdem 2010, Sarkhel et al. 2020). It is also important to provide patients and their families with a contingency plan for managing relapse. Psychoeducation highlights the significance of maintaining a regular lifestyle, including consistent sleep patterns and structured daily activities. The necessity of regular physical exercise is also emphasized. Additionally, patients are taught stress management techniques and simple problem-solving skills applicable in daily life (Sarkhel et al. 2020).

Psychoeducation for Anxiety Disorders

Psychoeducation plays a vital role in the treatment of anxiety disorders. Following diagnosis and necessary assessments, mental health professionals should provide patients with comprehensive information about symptoms, causes, treatment options, medication side effects, the adjustment process, and the overall course of the disorder. Additionally, the importance of non-pharmacological approaches, such as regular physical exercise and activity planning, should be emphasized. Passive psychoeducation is commonly employed for patients with anxiety disorders. This approach delivers information through resources such as books, brochures, or videos and does not require active interaction between the patient and therapist (Rodrigues et al. 2018, Sarkhel et al. 2020, Hedayati et al. 2022).

Psychoeducation for Depressive Disorders

Psychoeducation is a crucial component in the treatment of depressive disorders. Following diagnosis and necessary assessments, mental health professionals should provide patients with comprehensive information about symptoms, causes, treatment options, medication side effects, the adjustment process, and the overall course of the illness. Furthermore, the importance of non-pharmacological interventions, such as regular physical exercise and structured activity planning, should be emphasized (Rodrigues et al. 2018, Sarkhel et al. 2020, Hedayati et al. 2022).

Psychoeducation for Substance-Related and Addictive Disorders

Group psychoeducation is a cornerstone of the psychosocial management of patients with substance use disorders. These groups provide education about substance abuse and its consequences, typically engaging individuals before and during the transition phase to enhance their motivation for abstinence (Sayed 2020, Kargin and Hiçdurmaz 2020, Lopes 2021). Typical group psychoeducation for substance use disorders should address the following key areas:

1. Medical Complications: Physical and psychological problems are discussed in detail, and patients' misconceptions about their health, even in the absence of physical symptoms, are corrected.

2. Family Problems: Family conflicts and the role of family in the addiction process are explored, emphasizing the importance of family and friends in relapse prevention.
3. Treatment Process and Recovery: The stages of treatment, from detoxification to relapse prevention, are reviewed, including the roles and side effects of medications.
4. Cravings and Relapse: The impact of cravings on relapse and strategies to avoid triggers is highlighted, alongside techniques for managing cravings.
5. Leisure: The importance of identifying alternative sources of pleasure and restructuring the concept of "pleasure" previously associated with addiction is discussed.
6. Adapting to a New Life: Patients are supported in embracing and accepting their new identity as "substance-free individuals" (Sarkhel et al. 2020).

Psychoeducation for Personality Disorders

The primary goal of psychoeducation for personality disorders is to increase patients' awareness of personality disorders in general, as well as the specific disorder with which they have been diagnosed. At the outset, patients are provided with an understanding of their diagnosis and guidance on how to respond effectively. The concepts of personality and personality disorders are explained, with emphasis on the challenges these disorders may present. Patients are given a written checklist to help identify maladaptive personality traits, encouraging greater self-awareness. As insight develops, the biological and psychological factors contributing to these traits are discussed in detail. However, for individuals with severe personality disorders, a careful and gradual approach may be necessary to address issues that patients initially deny (Sarkhel et al. 2020).

Several Research on Psychoeducation

Buizza et al. (2019) conducted a four-year follow-up study to evaluate the long-term effectiveness of psychoeducation for individuals with bipolar disorder within mental health services. During the treatment phase, all participants received standard care, while the experimental group received an additional 21 weeks of psychoeducation. The results revealed significant differences between the groups over the four-year follow-up period, with the psychoeducation group experiencing fewer hospitalizations than the control group.

Sayed et al. (2020) investigated the effects of a psychoeducation program on depression in substance-dependent patients. Their findings indicated that, while most participants in the experimental group initially exhibited severe depression, their symptoms significantly decreased following the program. In contrast, the control group, which did not receive psychoeducation, showed no such improvement. The authors concluded that psychoeducation should be an integral part of treatment strategies for both substance-dependent individuals and their families.

However, Zygmunt et al. (2002), in a systematic review of randomized controlled trials, concluded that psychoeducation alone was not effective. Similarly, reviews by McDonald et al. (2002) and Dolder et al. (2003) emphasized that psychoeducation was more effective when combined with other interventions. Supporting this, Kurtz and Mueser (2008) conducted a meta-analysis demonstrating that "social skills training" significantly improved functional outcomes. In a Cochrane systematic review of interventions for schizophrenia, psychosis, and bipolar disorder, studies focusing on psychoeducation for schizophrenia patients found increased treatment adherence, reduced hospital readmissions, and improved overall well-being. However, no significant improvements were observed in patients' insight, treatment attitudes, or satisfaction with psychiatric services (Jung XT and Newton 2009).

In a study conducted in Türkiye, Duman et al. (2006) evaluated the effectiveness of psychoeducational group therapy for hospitalized patients. The findings revealed significant differences between pre- and post-program scores across four domains: disease management, medication knowledge, awareness of precursor symptoms, and emergency planning. Similarly, Yıldırım et al. (2012), in a study carried out in

Erzincan, reported that social skills training provided to outpatients with schizophrenia led to significant improvements in symptom levels, functional abilities, insight, and the ability to cope with stigma.

Kargın and Hiçdurmaz (2020) investigated the effects of a 10-session psychoeducation program on relapse rates, social functioning, perceived well-being, and coping strategies among individuals with substance use disorder (SUD). Their results indicated that the relapse rate was higher in the control group than in the intervention group. The program also contributed positively to participants' social functioning, perceived well-being, and stress management.

Çinçinoğlu (2024) examined the impact of acceptance and commitment therapy (ACT)-based psychoeducation on stigma among relatives of individuals with schizophrenia. The eight-week intervention resulted in a significant reduction in stigma levels among the relatives who received the ACT-based psychoeducation. In another study, Aşık and Ünsal (2020) evaluated the effects of a psychoeducation program focused on emotion recognition and expression in individuals with schizophrenia. The 10-week program was found to improve participants' ability to recognize facial emotions and enhance their social functioning. Bulut et al. (2016) explored the effect of schizophrenia on caregivers' perceived burden. Following an eight-session psychoeducation program administered to family members, the researchers concluded that psychoeducation was effective in alleviating the perceived caregiving burden.

Conclusion

Psychoeducation forms the cornerstone of psychosocial rehabilitation and aims to facilitate changes in both knowledge and behavior. It focuses on equipping individuals with the necessary tools to manage their difficulties more effectively. Core components of psychoeducation include providing information about the illness, recognizing stressors and early signs of relapse, lifestyle adjustment, symptom management, developing problem-solving skills, enhancing insight, and understanding the effects and side effects of medications. The primary goal is to empower patients and their families with foundational knowledge and competencies regarding the illness, foster insight, support relapse prevention, and reduce suicide risk through effective crisis management.

Psychoeducation emphasizes both knowledge dissemination and skill development. It typically follows a structured process that includes diagnosis and preparation, identification of needs and goal setting, implementation, and evaluation. Psychoeducation programs usually cover essential information about a specific mental disorder, tailored to patients and their families. Modules can be adapted according to the needs of patients, family members, clinicians, or the specific mental disorder in question. Based on the intended audience, psychoeducation may be delivered individually, in groups, or at a community or family level.

Depending on its focus, psychoeducation may center on adaptation, illness management, treatment, or rehabilitation, and it can be delivered through active or passive means. Active psychoeducation involves interactive communication between the healthcare professional and the patient or family, while passive psychoeducation enables individuals to acquire information independently through materials such as booklets, brochures, and audio-visual resources.

There are several models of psychoeducation, including the Knowledge Model, Skills Training Model, Supportive Model, and Comprehensive Model. Target populations for psychoeducation include newly diagnosed patients and their families, individuals at high risk for relapse, and families living with the patient. Psychoeducation has been effectively implemented across a wide range of psychiatric conditions. The number, frequency, and content of sessions may vary depending on the specific diagnosis. When conducted regularly and systematically, psychoeducation provides significant benefits for both patients and their families. In this regard, it is recommended that nurses adopt psychoeducation as an independent and evidence-based practice, actively implementing, discussing, and promoting its use in clinical settings.

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