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Psychoeducation

This week's reading focused on the topic of family psychoeducation. The major themes discussed included the eight major tenets of family psychoeducation, the psychoeducation workbook, and single/multi family approaches. Family psychoeducation is about family members being the caretaker for members who have a mental illness or chronic medical condition. Challenges that families face is usually the disruption the illness causes rather than the illness itself. Psychoeducational therapy aims to give families the tools to provide effective care for members with special needs while not compromising the welfare of the family. Keys to this therapeutic approach is information and emotional support. The major tenets of psychosocial education views family as partners with professionals that need the appropriate tools and support to deal with family circumstances. Overall, family relationships can either be a risk or protective factor (or both) with disease management. Family can be helpful in preventing relapse, and culture within a family can determine the experience and response by family members.

The psychoeducational workbook is a tool for families and caregivers to support members with mental illness. This approach provides knowledge about mental illness that provide problem solving skills, communication skills, coping skills, and developing social supports. This teaches families how to apply information about mental illness in their lives, with aims to achieve learning outcomes and quality of life. There is a single and multiple family approach in psychoeducation. The single approach starts with single psychoeducation family

therapy, which starts with partnership with the consumer, family and practitioner and is known as the “joining phase.” The single family psychoeducation phase then establishes the alliance with family members and the consumer, and educates on dealing with the illness and creating a path toward recovery. Multifamily therapy joins multiple families in one treatment in a multifamily group format. In this therapy, this model will focus on preventing relapse for a year, before moving on to the second phase in year two to move beyond stability into social and vocational rehabilitation. Finally, the third phase goes into molding the group into a social network to support consumer needs.

Overall, what I found most interesting about the material this week on psychoeducational family therapy was the tenants aspects. Personally seeing how illness can impact a family, the tenant of family relationships serving as a risk or protective factor is something that resonated with me. Chronic illness can negatively impact or drain a family if the proper supports, systems and expectations are not in place to support the consumer and ensure the family can adequately act as a support. What I have learned from the tenants is that in a sense you have to respect and understand them, otherwise the family or the consumer will suffer. For example, if families don’t help in identifying potential relapse, the consumer could fall into the relapse which could have negative outcomes. In my practice, I believe a key for incorporating family therapy would be to see if family could be seen as a strength for a client when evaluating them. Family therapy makes sense in the context if the consumer has chronic physical or mental illness, and if they can truly support/assist in the process for the consumer. In practice family therapy should be considered when putting into context the clients ecosystem and identifying relationships within the family system and using this to the clients benefit. By identifying family as a strength in practice, family therapy can enhance client/family wellbeing in addition to other treatment options.