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How can psychoeducation help in the treatment of mental disorders?

Como a psicoeducação pode ajudar no tratamento de transtornos mentais?

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Abstract

Objective
The purpose of this study was to introduce psychoeducation as a strategy for building information on mental health, as well as to discuss its potential contribution to the decision of seeking treatment, treatment adherence, and decrease of mental disorder symptoms.

Method
For this purpose, a narrative review of the literature was performed.

Results
Results showed that psychoeducation contributes to the search for treatment by informing individuals that their suffering is the result of a treatable disorder rather than personal characteristics. Subsequently, it contributes to treatment adherence by communicating how it works and what results are expected. This contribution of psychoeducation to treatment adherence seems to reduce the symptoms of the disorder, i.e., the symptoms decrease because the individual is engaged in the treatment.

Conclusion
We conclude that psychoeducation acts as a "gateway" for seeking treatment and treatment adherence, consequently decreasing symptoms.

Keywords: Health Education; Literature review; Mental health.

Resumo

Objetivo
O objetivo deste estudo foi introduzir a psicoeducação como uma estratégia de oferta de informações sobre saúde mental e discutir sua possível contribuição para a decisão de buscar tratamento, adesão ao tratamento e na diminuição de sintomas de transtornos mentais.

Método
Foi realizada uma revisão narrativa da literatura.

Resultados
Verificou-se que a psicoeducação contribui para a busca de tratamento ao informar indivíduos

que seu sofrimento é resultado de um transtorno que pode ser tratado e não de características pessoais. Posteriormente, contribui para a adesão ao tratamento ao comunicar como o tratamento funciona e quais os resultados esperados. Essa contribuição da psicoeducação para a adesão ao tratamento que parece diminuir os sintomas do transtorno, ou seja, os sintomas diminuem porque o indivíduo se engajou no tratamento.

Conclusão

Conclui-se que a psicoeducação atua como "porta de entrada" para a busca e adesão ao tratamento e consequente diminuição dos sintomas.

Palavras-chave: *Educação em saúde; Revisão de literatura; Saúde mental.*

Mental Disorders (MD) are characterized by clinically significant changes in one's cognition, emotional regulation, or behavior, which interfere with social and professional activities (American Psychiatric Association [APA], 2013). The MD affect 25% of the population at some point in life and represent four of the ten leading causes of incapacity worldwide (Institute for Health Metrics and Evaluation, 2017). Health professionals usually consider the severity of symptoms, losses, and suffering caused by such disorders when referring individuals to treatment plans. This logic is also applied to individuals experiencing symptoms that do not satisfy all the criteria for a diagnosis of any MD but may need treatment and thus benefit from it (APA, 2013).

Regardless of a diagnosis, these individuals do not always receive the treatment they need (Gomes et al., 2014; Potijk et al., 2019). The reasons vary and may include the stigma of MD, the general population's lack of information on MD, as well as unavailability of adequate treatment options, lack of organization of mental health services, etc. (Bharadwaj et al., 2017; Cheng et al., 2018; Henderson et al., 2017; Lannin et al., 2016; Oliveira et al., 2014). Furthermore, some professionals do not pass on relevant information to their patients, believing they are unable to understand, assuming the information was already provided by another professional (Figueiredo et al., 2009), or even because of a lack of proper training in psychoeducation (Motlova et al., 2017). Lack of information may not only prevent individuals diagnosed with MD from seeking and/or maintaining treatment but also make people who are unaware of suffering from any MD take their symptoms as personal characteristics. They may live with impairments and suffering as if they could not be avoided or managed (Brady et al., 2016). Lack of necessary information may cause family members to blame patients for their symptoms, which is associated with higher levels of stress amongst these individuals (Anderson & Guthery, 2015) and stigma against people with MD (Simmons et al., 2017).

One way to provide information on mental health and disorders to the general population is psychoeducation. Therefore, the main objective of this study was to introduce psychoeducation to readers. More specifically, it was written to: (a) present the history of psychoeducation; (b) explain and give examples of how it can be used as a modality of psychosocial intervention or as a treatment component, such as in Cognitive-Behavioral Therapies (CBT); and (c) discuss its potential contribution regarding the decision to seek treatment, treatment adherence, and decrease of MD symptoms.

Method

A narrative review of the literature was carried out. This type of study was chosen because it is considered appropriate for organizing, integrating, and evaluating scientific publications on a given subject (Collins & Fauser, 2005; Hohendorff, 2014; Yuan & Hunt, 2009). The search was performed on the Scientific Electronic Library Online Brazil and PsycINFO databases. The descriptors

psychoeducation or psychoeducational intervention were used in the abstract field. Articles whose title and abstract were relevant to the purpose of this study were retrieved for reading. Some references cited in these articles were also included in this review. Caution is recommended in interpreting the results presented here, as this method is subject to more biases than other types of literature review.

Results and Discussion

Psychoeducation

The development of psychoeducation began in clinical psychiatry in the 1970s and 1980s. Until then, scientific knowledge and clinical conduct were mental health professionals' exclusive domain, especially physicians. Patients and family members were usually considered incapable of understanding and taking part in the decisions regarding the treatment. At the same time, high levels of treatment non-adherence and relapses pointed to the need for alternative treatment options associated with pharmacotherapy, which required effective participation and adherence from patients and their families. Consequently, American and British specialized clinical research groups began to invest in treatment models that were educative and offered more support to patients and family members by providing information on MD and available treatment options. Thus, psychoeducation arose as an additional treatment to the use of medication, not as a technique to cure a specific illness. Its initial goal was to provide family members and psychotic patients with information on MD and, by doing so, allow them to live in their communities, avoiding new hospital admissions (Andrade, 1999).

Evidence of higher benefits from the use of psychoeducation combined with medication compared to the exclusive use of drugs resulted in the amplification of clinical strategies and research interest in this new modality (Andrade, 1999). Around the 1980s and 1990s, there was already discussion concerning the benefits that psychoeducation training might bring to psychologists, as psychology may positively impact several contexts, such as general hospitals, psychiatric hospitals, primary and secondary schools, universities, and companies (Watkins, 1985). In the 1990s, psychoeducation began to be carried out in groups with different MD such as Depressive Disorders, Bipolar Disorder (BD), Posttraumatic Stress Disorder, Obsessive-Compulsive Disorder (OCD), Attention Deficit/Hyperactivity Disorder (ADHD), drug addiction, and many others (Casañas et al., 2019; Joas et al., 2019; Lemes & Ondere Neto, 2017; Oliveira & Dias, 2018; Siegmund et al., 2016). Currently, psychoeducation is performed by different health professionals to communicate relevant information to patients and family members concerning the disorder (diagnosis, etiology, functioning), treatment, and prognostics, as well as answer questions and correct distorted beliefs regarding these issues (Motlova, 2017; Oliveira & Dias, 2018; Potijk et al., 2019).

Psychoeducation aims to empower patients, family members, and caretakers by providing information on disorders and developing abilities to face them (Brady et al., 2016; Kavak et al., 2019; Motlova, 2017). Increasing comprehension of one's condition and treatment options may contribute to patients' participation, as choosing the desired treatment based on reliable information may go along with higher treatment adherence and symptom decrease (DaWalt et al., 2017). The differentiation of a patient's authentic behaviors from those caused by the MD, understanding how the treatment works, and knowing what results to expect is highly important to family members and caretakers alike. In possession of such information, family members and caretakers can easily manage relationship struggles relating to the patient, present lower levels of stress, and stimulate

patients to follow the chosen treatment (Anderson & Guthery, 2015; Brady et al., 2016; Cordioli, 2014; Grenyer et al., 2019).

Psychoeducation must be didactic and use adequate language concerning the targeted audience, which may include patients, families, educators, and health professionals. Information can be transmitted in different formats: individually or in groups, in person or online, lectures, talks, manuals, films, videos, or bibliotherapy (Bai et al., 2015; Figueiredo et al., 2009; Lam et al., 2017; Siegmund et al., 2016). If psychoeducation assumes a group format, four to six sessions are structured and offered once a week. This is different from therapeutic groups, in which psychologists aim to treat MD in weekly sessions that vary from 12 to 20 meetings, and from self-help groups, whose meetings are not structured and where the contents are defined by the participants themselves (Neufeld et al., 2017).

Regardless of the format, information should also be available in writing, since learning and memory capabilities can be jeopardized in some diseases like anxiety, depression, psychosis, and ADHD (Sudak, 2012). Apart from the layout, professionals must listen to the patient's history and consider their sociocultural condition and values to develop good therapeutic alliances (Nakash, Nagar, & Kanat-Maymon, 2015). These individuals are looking for comprehension and information concerning diagnosis and treatment (Nakash, Nagar, & Levav, 2015).

Psychoeducation directed toward MD usually presents countless benefits, such as increased knowledge regarding one's disorder, motivation to change, treatment participation, satisfaction and treatment adherence, relapse reduction, and fewer stigmas (Joas et al., 2019; Knapp, 2004; Nussey et al., 2013). Psychoeducation may also contribute to patients' feeling that they can be understood and help them manage despair, fear, stigma, and self-esteem issues (Colom et al., 2003; Ivezić et al., 2017), preventing the development of new psychopathologies (Vidal et al., 2013).

There are also specific benefits of psychoeducation for certain MD and forms of psychopathological functioning. For instance, psychoeducation for OCD can focus on correcting improper beliefs regarding fear and anxiety (Siegmund et al., 2016) and promoting a stronger therapeutic alliance and treatment commitment (Skarphedinsson & Weidle, 2018). Concerning BD cases, psychoeducation allows patients and family members to recognize the signs of maniac and hypomanic episodes, thus avoiding further hospitalizations (Chen et al., 2018; Colom et al., 2003; Joas et al., 2019). On the other hand, psychoeducation for ADHD may help patients control stimuli, plan activities, and increase their quality of life (Vidal et al., 2013).

Psychoeducation-only intervention

Psychoeducation as a psychoeducation-only intervention can be understood as a primary source of information for the non-clinical population. Non-clinical groups may benefit from psychoeducation as a process of psychological literacy (Siegmund et al., 2016). Educative materials, such as booklets, manuals, and videos (Sehnem et al., 2016) may be useful to reduce stigma around MD, as well as to promote mental health and early diagnosis (Cordeiro et al., 2010; Lam et al., 2017).

Stigma consists of rejection arising from judgment concerning an individual or group with a particular difficulty. Regarding mental health, stigma may seriously interfere with the life and well-being of diagnosed people (Simmons et al., 2017). Research shows that psychoeducation can decrease the stigma of MD (Grenyer et al., 2019; Griffiths et al., 2004) by improving the knowledge about it (Gustafson & Borglin, 2013). For instance, people who accessed a website about depression presented lower stigmatizing behaviors when compared to the control group that did not have access to this material (Griffiths et al., 2004).

Prevention of MD aims to avoid habits that may favor their incidence (Cordeiro et al., 2010). For example, people with genetic susceptibly (a family member with psychotic symptoms) who use cannabis may present a higher risk of developing psychosis (Di Forti et al., 2019). Hence, campaigns which offer the population this kind of information may be useful to prevent mental illness.

Early detection of MD aims to diagnose and treat a given disorder before it can cause serious effects on the individual. For instance, the early diagnosis and treatment of BD allow patients to identify maniac and hypomanic episodes and, therefore, avoid hospitalization (Joas et al., 2019; Menezes & Souza, 2012). Thus, materials informing the disorder's symptoms may enable the recognition of a mental illness and ways of managing it.

When psychoeducation is directed to family members, caretakers, and patients diagnosed with an MD, this isolated intervention may work as a source of information and support for other types of treatment. A study by Bai et al. (2015) exemplified how psychoeducation can be the first intervention for parents of children with ADHD, aiming to inform them about the disorder and treatment options so they can choose a treatment for their children. In this study, psychoeducation was developed in three distinct ways: lectures, a manual, and an online community. Lectures were held in two 40-minute meetings about the disorder (etiology, symptoms, and impairments), the efficacy rate of available treatments (pharmacological and non-pharmacological), and coping strategies related to the management of ADHD symptoms. The manual contained the same information presented in the aforementioned lectures. In addition, forms to help control doses of ADHD medication on their children and side effects were added. The online community held general health content and enabled communication with other parents and professionals responsible for the intervention to settle any questions regarding the disorder, treatment, or management (Bai et al., 2015).

The application of psychoeducation-only intervention does not mean that its exclusive use is sufficient for an MD treatment. For example, a systematic search showed that single-session psychoeducation and guided psychoeducation appear to be less effective in reducing Posttraumatic Stress Disorder symptoms than psychological interventions such as trauma-focused cognitive behavior therapy (Morina et al., 2021). Another systematic review demonstrated that psychoeducation is useful for patients diagnosed with schizophrenia to gain knowledge about their illnesses and reduce the burden of stigma, yet the results ranged from a positive effect to no effect when it comes to psychiatric symptoms (Alhadidi et al., 2020). At the same time, studies that compare the efficacy of a psychoeducation-only intervention to other treatments found that both were associated with the improvement of main disorder symptoms (Menezes & Souza, 2012; Vidal et al., 2013) and highlighted that participants of the psychoeducation-only intervention were also receiving assistance by other care services (medication, psychotherapy) outside the study. Hence, conclusions regarding the isolated influence of psychoeducation on symptom reduction were not possible. Nevertheless, examples of a psychoeducation-only intervention program are worth describing.

A study by Vidal et al. (2013) compared the efficacy of a psychoeducation-only intervention against a Group Cognitive-Behavior Therapy (GCBT) intervention for adults with ADHD. The authors justified that the psychoeducational interventions targeting BD and schizophrenia had been proven effective for better social functioning, treatment adherence, and relapse reduction and that these results were common for CBT. Thus, they decided to compare GCBT to psychoeducation in ADHD. Both interventions counted eleven sessions. The psychoeducational program was conducted by psychologists who transmitted information regarding ADHD to help

patients have a better understanding of related problems. The addressed content was symptom recognition, disorder understanding (myths and reality), ADHD causes, a cognitive model for ADHD, impairments caused by symptoms, and pharmacological and psychological treatment options. The information focused on problems associated with ADHD and not on solving such difficulties. In the GCBT program, psychologists directed the content to solve patients' difficulties with revision and repetition of learned abilities. There was only one psychoeducation session. Further sessions focused on developing abilities to deal with symptoms such as distraction delaying, planning skills, procrastination management, problem-solving, thoughts identification, and cognitive restructuring. Both interventions were associated with the improvement of main disorder symptoms (inattention, hyperactivity, and impulsivity) and the individual's self-esteem. Moreover, symptoms of depression and anxiety decreased amongst participants of both modalities (Vidal et al., 2013). However, participants of both interventions (psychoeducation and GCBT) were medicated for ADHD, which prevents conclusions regarding the isolated influence of psychoeducation on symptom reduction.

Other psychoeducation-only group interventions directed at other MD apparently present the same functioning. A psychoeducational intervention was described by Menezes and Souza (2012) as directed to family members and patients with BD as a part of Prevention of Relapses Program for BD. Lectures were given by health professionals (nurses, psychiatrists, psychologists, nutritionists) on topics suggested by participants, followed by testimonies of a disorder-bearing volunteer to promote experience exchange. Nonetheless, that was not the only form of support used by participants who also benefited from medication, psychotherapy, and self-help groups (Menezes & Souza, 2012).

In this context, psychoeducation-only interventions may suffice on their own if applied to non-clinical groups aiming at acquiring psychological literacy. They can also be a gateway concerning the identification of possible diagnoses and seeking additional treatment, as well as a source of complementary information and emotional support for other kinds of treatment. The exclusive use of psychoeducation appears to be insufficient for treating MD, and there are no reports evaluating its isolated influence on symptoms (Siegmund et al., 2016).

Few studies have explored the efficacy of different psychoeducation formats. It is unclear whether different modalities may generate different results. A meta-analysis conducted by Lincoln et al. (2007) evaluated the efficacy of psychoeducation for psychotic patients. They compared psychoeducational interventions that included family members with interventions destined only for patients regarding knowledge, pharmacological treatment adherence, patient's psychosocial functioning, symptom reduction, and relapses. The interventions that included family members were more effective than the ones designed for patients alone regarding symptom reduction and relapse prevention from seven to twelve months. Hence, the authors suggest integrating family members into psychoeducation interventions for psychotic patients (Lincoln et al., 2007). In addition, a literature review by Rummel-Kluge and Kissling (2008) on psychoeducation for schizophrenia reported that stable patients seem to benefit more from psychoeducation than symptomatic patients do. Still, any type of psychoeducation should consider the patient's needs (Alhadidi et al., 2020). The results of these studies define some aspects concerning the definition of psychoeducational interventions for psychotic patients. The validity of such information for patients with other disorders and consideration of possible differences between individual and group formats, number of participants, in person, online, or printed is not mentioned, which indicates the need for further research.

Psychoeducation as a treatment component

Psychoeducation may be used as one of the strategies composing a psychological and/or pharmacological treatment. Studies generally show that as an element of an individual or group psychological treatment, psychoeducation refers to a cognitive-behavioral approach (Hirvikoski et al., 2015; Safren, 2008; Skarphedinsson & Weidle, 2018; Vidal et al., 2013).

The process of educating patients about their disorder or functioning is one of the basic principles of cognitive therapy (Knapp, 2004). It is included in cognitive-behavioral protocols for depression, BD, anxiety disorders, drug addiction, eating disorders, ADHD, psychotic disorders, and personality disorders (Chen et al., 2018; Joas et al., 2019; Knapp, 2004; Safren, 2008; Skarphedinsson & Weidle, 2018). In these cases, specific information regarding the disorder is offered as well as its characteristics, origin, prognostic, and indicated treatment. Offering scientific information in adapted adequate language on the problem helps patients differentiate symptoms from personal characteristics. These explanations may relieve patients and diminish self-criticism. Moreover, information regarding a cognitive model and clients' functioning is communicated. The explanation for the relationship among thoughts, emotions, and behavior (cognitive model) helps patients in emotional regulation since they can identify triggers for mood alternations (patient functioning) and develop cognitive and behavioral strategies to respond to them differently (Knapp, 2004).

Psychoeducation is also used when medication is prescribed. The reason why a drug was prescribed, its risks and benefits, side effects, and treatment length is explained to the patient. The patient's previous knowledge regarding the disorder, treatment, and medication must be identified by the professional so that the amount of information provided is regulated and possible distortions are corrected. Furthermore, it is recommended that professionals remain aware of the questions and values of both patient and family members and answer their questions with patience and clarity. After all, the individual's decision to take the prescribed medication and the comprehension of the reasons behind such prescription may improve the adherence to treatment and its result (Cordioli, 2014; Joas et al., 2019; Sarkhel et al., 2020; Sudak, 2012).

Cognitive-behavioral protocols for ADHD in adults by Safren (2008) and OCD patients by Cordioli (2014) can serve as examples of how psychoeducation may be included as a strategy for psychological and/or pharmacological treatment. In the first case, the initial session's focus is on ADHD psychoeducation and treatment. Amongst information regarding adult ADHD, it should be emphasized that it is a neurobiological disorder with a valid diagnosis, not related to laziness or low levels of intelligence (Safren, 2008). Concerning treatment, the author suggests that the therapist should explain the role of cognitive and behavioral components in adult CBT for ADHD. This explanation should be related to how thoughts can generate negative feelings that may interfere with task achievement (the cognitive component) or even how avoidance of homework assignments or the non-adoption of an organization system (behavioral components) may increase disorder symptoms. Similarly, it is necessary to explain the role of drugs and how they may potentialize other forms of treatment (Safren, 2008).

Regarding OCD's CBT, psychoeducation is used throughout the psychotherapeutic process (Cordioli, 2014). One of the therapist's main goals during the first sessions is to help the patient make decisions concerning treatment options. During this period, the therapist provides information on the disorder in a clear and accessible language, such as factors that contribute to its development, kinds of patient behavior that are linked to the maintenance of symptoms, available treatments (and their advantages and disadvantages), and the cases in which medication can be

helpful. Reading informative material such as booklets, books, and specialized website pages that can help patients decide is recommended. After the patient's option to initiate cognitive-behavioral treatment, psychoeducation addresses other topics, such as treatment principles, technical rationality, and expected results (Cordioli, 2014).

From these examples (Cordioli, 2014; Safren, 2008), it is possible to observe that psychoeducation topics are usually maintained. Psychoeducation as a CBT strategy addresses disorder etiology, the relation between patient symptoms and diagnosis, how the disorder is sustained, treatment options (advantages, disadvantages, and expected results), cognitive model, patient functioning, and treatment consistency. Psychoeducation's specificities regarding these topics depending on the patient's MD.

How can psychoeducation help in treatment-seeking?

Psychoeducation-only intervention may work as a gateway to addiction treatment. This is possible because it is a reliable source of information that allows patients to identify better and name some of the difficulties they experience. Additionally, it allows them to recognize other people facing the same difficulties and the different treatment options with distinct advantages and limitations.

Psychoeducational interventions are generally perceived as a safe place in which it is possible to obtain reliable information from health professionals. Even after the Psychiatric Reform, prejudice against MD patients continues (Candido et al., 2012). People who suspect being affected by MD may often feel embarrassed and not seek further information (Lam et al., 2017; Lannin et al., 2016). Receiving information directly from health professionals through lectures, videos, or booklets contributes to individuals feeling more comfortable in asking them questions about the disorder and its treatment. Moreover, they get to expose their experiences regarding the condition more easily and are less afraid of suffering prejudice for having a mental illness (Menezes & Souza, 2012).

Some people do not feel comfortable taking part in interventions in person because of the stigma such participation may cause (Lannin et al., 2016). In such cases, seeking information online is an advantage for those who do not wish to reveal their identities or prefer to investigate the topic on their own before investing in an appointment with a health professional. Generally, websites specialized in mental health are preferred to check information obtained in medical appointments, investigate medication side effects, and identify the best ways to deal with a given disorder (Conell et al., 2016). Thus, reliable website recommendations may be useful as a psychoeducation strategy for both non-clinical populations and patients, given that the search for information online contributes to lessening stigma and increasing the search for treatment (Bauer et al., 2016; Conell et al., 2016; Lam et al., 2017; Simmons et al., 2017).

Several people suffer the consequences of MD for years without knowing that they may be symptoms or impairments of these diseases (Menezes & Souza, 2012). The lack of information concerning the symptoms, etiology, and consequences of a given MD may interfere with the bearer's self-image, self-criticism, and the opinion of other significant people (Knapp, 2004; Lannin et al., 2016). For instance, an individual who has no will to accomplish their activities, cries constantly, has trouble concentrating, and feels sleepier than usual may think they are weak and incapable when they may be experiencing symptoms of depression (Knapp, 2004). Consequently, being able to differentiate personal characteristics from the characteristics of an MD can contribute to the acknowledgment that one has a treatable MD and the impairments can be managed or even reduced (Figueiredo et al., 2009; Joas et al., 2019). For instance, psycho-educated bipolar

patients can develop self-knowledge to the point of monitoring their affective, cognitive, and behavioral states and predicting when it is time to resort to hospital admission. Moreover, when psychoeducation is done in groups, shared experiences of the disorder may help other participants (patients, family members, and other significant people) to identify symptoms and impairments caused by it, as well as possible ways of managing and treatment available. Knowledge about the disorder and coping strategies contribute to patients' empowerment. By acquiring information, patients can make decisions regarding their health, such as continuing as they are or looking for professional help (Menezes & Souza, 2012; Joas et al., 2019).

How can psychoeducation help in treatment adherence?

Psychiatric patients frequently consider medical appointments to be merely for drug prescriptions and insufficient as a source of information (Menezes & Souza, 2012). Questions regarding prognostics, treatment goals, and expectations in the short and long term may demotivate patients and negatively affect treatment engagement. Psychoeducation as a parallel intervention or part of health appointments may help fill this blank (Alhadidi et al., 2020; Peet & Harvey, 1991).

The patient and family members' comprehension of the prescribed treatment seems to be one of the factors promoting adherence to the treatment. A study with bipolar patients using lithium revealed that the group of patients who received psychoeducation (attended a lecture and received its transcription) presented higher medication adherence compared to the group that only received medication (Peet & Harvey, 1991). Other examples refer to ADHD patients who may feel more motivated to take medication as they understand how it can increase gains from other treatment forms (Safren, 2008). Likewise, OCD patients may feel more motivated to accomplish exposure and response prevention if they understand how habituation works and that abstaining from executing rituals leads to symptom disappearance (Cordioli, 2014).

Knowledge transmitted during psychoeducational interventions allows one to increase awareness concerning his or her MD and become an active participant in the search for and adherence to treatment as a way to improve their quality of life (Hirvikoski et al., 2015; Menezes & Souza, 2012; Sarkhel et al., 2020). Bipolar patients who took part in psychoeducation groups reported more knowledge regarding the disorder, solace in knowing they are not the only ones who are affected by it, and relief in finding more severe cases. Exchanging experiences through testimonials and informal conversations in such groups reinforce the need for treatment search and maintenance since it enables patients to resume personal and professional activities despite the disorder and take over the management of their lives instead of being at the mercy of BD (Menezes & Souza, 2012).

How can psychoeducation improve the symptomatology of mental disorders?

Psychoeducation is not an isolated and miraculous solution to the complexity of the hitches that concern MD. However, it can contribute to disorder awareness, reduction in mental health stigma, higher treatment adherence, and symptom reduction. Psychoeducation helps BD patients detect prodromal symptoms, which contributes to earlier intervention and, therefore, avoidance of maniac and hypomanic episodes (Colom et al., 2003; Joas et al., 2019; Menezes & Souza, 2012). Active treatment involvement and accountability for illness management are fundamental for BD's successful treatment (Chen et al., 2018; Colom et al., 2003). On the other hand, individuals suffering from ADHD benefit from psychoeducation through learning and usage of skills directed

at avoiding losses from symptoms, which do not always diminish through medication. Stimuli control, for instance, helps patients resume their attention on the tasks they perform. Alternatively, planning strategies, for instance dividing complex tasks into smaller parts and using shorter periods to execute them, are useful attempts to maintain one's productivity (Safren, 2008). The way psychoeducation supports symptom improvement is similar in OCD cases. The better patients understand the treatment, the more they will follow instructions of exposure with response prevention, leading to symptom reduction (Cordioli, 2014).

These examples show the importance of both patients and family members clearly understanding that the difficulties presented are symptoms of an MD and that the losses caused by it may be reduced through treatment. On the other hand, treatment engagement can bring difficulties or side effects. For instance, facing the fears related to anxiety disorders may cause discomfort to the patient, or using a specific drug may trigger side effects until one's body adapts (Cordioli, 2014; Safren, 2008). Understanding a treatment process helps patients persist in it (during adherence and maintenance). Better informed patients tend to not stop doing what has to be done regarding their treatment as they understand its dynamics, with its limitations and potentialities (Cordioli, 2014; Chen et al., 2018; Joas et al., 2019; Figueiredo et al., 2009; Safren, 2008).

Conclusion

For many years, psychoeducation has been a part of mental illness treatments. More than offering information on MD and patient treatment, psychoeducation can be used as a way of psychological literacy. In other words, identification, and damage and suffering control may be reached through the transmission of relevant information about MD to the general population.

The literature presents several studies (mainly quantitative) that describe psychoeducational interventions and their benefits. Still, understanding the way psychoeducation creates such benefits is still insufficiently explored (qualitative studies). Psychoeducation may assume different formats, but which are the factors that make it more effective? Are there any differences between individual and group psychoeducational interventions? What should be its recommended length (how many appointments and for how long)? Is psychoeducation facilitated by healthcare professionals superior to those ministered by peers? In which cases are bibliotherapy, video therapy, or online websites recommended? Does the effectiveness of each format depend on the clinical condition shown by individuals? The answer to these questions, combined with participants' perceptions, may help provide more effective interventions.

This study intended to gather information from both quantitative and qualitative research to answer the question of how psychoeducational interventions, in their different modalities and applied to varied MD, can contribute to seeking treatment, adherence, and symptom decline. We propose, based on the literature, that psychoeducation contributes to treatment seeking by informing individuals that their suffering may be part of a disorder that can be treated, and it is not due to personal or stigmatizing characteristics. Moreover, it contributes to treatment adherence by explaining how it works and showing the expected results (what research shows and what other people with the same disorder report). This particular psychoeducation contribution to treatment adherence seems to reduce symptoms, i.e., symptoms decrease once the patient engages in treatment because he or she knew how it worked and what to expect from it. Thus, psychoeducation possibly acts as a gateway to search for treatment, adherence, and symptom reduction.

We presented different possible ways through which psychoeducation can be carried out, such as professional explanations during appointments, lectures, manuals, movies, videos, and

bibliotherapy. Furthermore, psychoeducation can be performed in person or online to reach a larger number of people. In face of its flexibility regarding modalities and benefits, we encourage mental health professionals to adopt such a strategy, associated with listening to the patient's history as well as taking his or her values and sociocultural conditions into account when transmitting MD information. Otherwise, professionals risk performing psychoeducation mechanically, i.e., informing for the sake of informing, without verifying if the targeted audience is able to understand the information and use it.

As a narrative review of the literature, this study has some limitations that must be considered when interpreting the results. Even though criteria were applied to search and select papers, this review did not intend to be exhaustive regarding databases, MD, and psychoeducation interventions. Additionally, the bias of selection and interpretation of information with the interference of authors' subjective perception makes this study non-reproducible.

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Contributors

C.T. OLIVEIRA was responsible for the conception of this study, study design, analysis, and discussion of its results. A.C.G. DIAS was responsible for the conception of this study, its revision, and the approval of its final version.