

Psychoeducation: A Strategy for Preventing Relapse in Patients with Schizophrenia

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Abstract

Psycho education in the context of schizophrenia is a technique that aims to improve the understanding of the disease for inpatients and their families, improving their behavior and attitude towards the disease, allowing them to recognize the early signs and warning symptoms that can lead to a relapse. Based on the needs found in one psychiatric and mental health community service in Lisbon it was built a program of psycho education sessions for people with schizophrenia which was held in 2014 during the second stage of the Masters Course in the Nursing Specialization of Mental Health and Psychiatry. The tools used: Sociodemographic Characterization Questionnaire, Knowledge Assessment Questionnaire, Medication Adherence Scale (MARS, 2011), some Outcome Indicators (adapted from NOC, 2008) and the Graffar Scale. The psycho educational program was held in 8 weeks, with a weekly thematic session lasting 60-90 minutes. The sample consisted of a group of 5 patients attending the community center. The evaluation of this program showed an increased level of knowledge about the disease and health resources as well as a positive displacement in terms of some Outcome Indicators such as Participation, Attention and greater Satisfaction with health services. These programs may result in greater health gains.

Keywords: Psychoeducation, Prevention, Relapse, Person with schizophrenia.

1. Introduction

This study reflects the planning, development and evaluation of a psychoeducational program for people with schizophrenia attending a community mental health center in the region of Lisbon, Portugal, and resulted from the journey made within the community stage of the Masters Course in the Nursing Specialization of Mental Health and Psychiatry in 2014. Schizophrenia is a chronic psychiatric disorder of unknown causes that affects the person and the family, and often leads to hospitalization. It is characterized by the lack of insight and risk of progressive worsening, due to lack of treatment. Non-adherence to medication has been regarded as one of the causes for relapse in schizophrenia. According to DSM-5 (2014), the spectrum of disorders in schizophrenia includes schizophrenia and other psychotic disorders, as well as schizotypal personality disorders. These are defined by abnormalities in one or more of the following five areas: delusions, hallucinations, thought, speech, motor behavior, including negative symptoms and catatonia. This study aimed to assess the needs of a group of people with schizophrenia as well as the development and evaluation of the psychoeducational program. The population of this study consisted of 5 patients attending a mental health and psychiatric community center with specific criteria, as other patients were integrated in individual rehabilitative programs. Mental disorders are responsible for more than 12% of the global burden caused by disease in general throughout the world, increasing this number to 23% in developed countries. Mental disorders include various neuropsychiatric disorders such as unipolar depression (11.8%), problems related to alcoholism (3.3%), schizophrenia (2.8%), bipolar disorder (2.4%) and dementia (1.6%) (Xavier et al, 2013:5).

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The magnitude of the impact of psychiatric disorders, including schizophrenia, only became more evident when the huge disabilities caused by these diseases were recognized. Schizophrenia is one of the five leading causes of disability and long-term psychosocial dependence, having a significant impact on family life. The person suffering from this disease "may have symptoms of distortion of reality that are expressed by delusions and hallucinations. It can also be manifested by reduced expression capabilities, a difficulty complement the activities of daily living and social withdrawal" (Favrod & Maire, 2014:1). The purpose of this intervention is to change behaviors through greater engagement, best therapeutic choices and proactive attitude towards the disease and the treatment. Nurses should have a profound knowledge of the patients, in order to adapt and diversify intervention strategies and techniques, evaluating the whole process and entering changes deemed necessary at any stage of the process. It is important to highlight the importance of the psychiatric rehabilitation, particularly social and community integration. The settings (either in a hospital's or in a community context) should promote a safe environment. They should become educational and training spaces, accompanied by emotional support, in order to develop socio-therapeutic and psychosocial interventions. Psychoeducation is part of psychosocial interventions and should be undertaken by specialized nurses in this area, through the therapeutic relationship. This relationship is paramount to develop the program's success. The therapeutic relationship in psychoeducation requires essentially a mutual alliance and a process of training in areas that facilitates the acquisition of skills and strategies for the treatment and rehabilitation of people with schizophrenia. The Nurse is in an excellent position to help patients and their families to increase their resilience and to improve their functioning.

A systematic review of the literature showed a variety of studies on psychoeducation and their effects on the recovery of schizophrenia. The programs are linked to psychiatric rehabilitation of people with severe mental illness. This must be worked in partnership with the patient, his/hers family and with the community in order to structure, maintain or enhance the capabilities of social integration, constituting themselves as support networks in their rehabilitation. The model of vulnerability to stress is one of the models often worked with the person and / or his/hers family, so that they can identify the factors of personal stress, the interrelationship between the various factors, relating them to individual vulnerabilities. Several randomized studies published in Cochrane conclude that psychoeducational interventions reduce significantly the rates of relapsing, reducing the number of days of hospitalization (Bauml et al., 2007; Xia et al., 2013). This program was preceded by an evaluation phase which allowed us to know the overall situation of the person and some factors related to the family, in order to adapt our intervention. In this context we ask ourselves how one can increase the health of the person with schizophrenia and his/her family, as well as their well-being. So, we took as a starting question: What is the effect of a psychoeducational program in the rehabilitative process of people with schizophrenia?

2. Psychoeducation: A Strategy for the Prevention of Relapse in Schizophrenia

Psychoeducation in schizophrenia is a cognitive, behavioral and educational program, with interventions of emotional support (Prasko et al, 2011:387). It has been developed "to increase the knowledge, understanding and insight of people about their illness and maximize the effectiveness of their treatment"(Degmečić et al., 2007:111). With the increase of knowledge people should develop more effective coping mechanisms to deal with their illness, improving their quality of life. The psychoeducational approach translates better clinical and functional results to the person with mental illness and contributes to the alleviation of suffering of the family members. Psychoeducational programs should provide information about the symptoms, etiology, treatment and the course of the disease, aiming to improve the adherence to medication and insight of the person towards mental illness, stimulating people and family to commit actively and critically with the treatment (Pekkala & Marinder 2002; Cardoso 2008). This approach can be conducted in small groups of patients or families, reducing feelings of anxiety and intensifying feelings of confidence and self-esteem. Psychoeducational interventions are important in alleviating negative feelings (such as guilt, anger or remorse) allowing families to deal with their emotions and the burden caused by the disease (Maldonado et al., 2009:343). The caregiver's role is to help the person to find meaning in their illness allowing a constructively adaptation. This process will allow them to consider their vulnerability and develop their personal resources. Interventions with families aim to "increase the involvement of family members, in order to establish a cooperative relationship and a therapeutic alliance, broadening their knowledge and understanding of the disease (...) the increased insight can help changing attitudes towards the disease providing them with useful conflict resolution strategies "(Maldonado et al., 2009:344).

In this approach the family should be aware of their own perceptions and the roles they play in the process:

- Providing optimistic and realistic messages;
- Recognizing the suffering and isolation;
- Providing help in solving everyday problems;
- Providing the psychoeducational information at the time of its request;
- Systematically evaluating the problems perceived by the families and their avoidance strategies;
- Transmitting the contents with an understandable language, avoiding medical language;
- Including actively family members from the beginning and facilitate the access of multi-professional team and specialized supervision (Favrod & Maire, 2014).

The intervention process is the core of the clinical practice, where the patients are provided to make the necessary changes, in which the best results are focused on the person triad patient-family-therapist (Chadzynska & Chadzynska 2011:67).

The therapeutic relationship is an important component of the psychoeducation, characterized by a therapeutic alliance that requires:

- An egalitarian, open and participatory approach;
- An identification of areas or fields of mutual understanding;
- An agreement between the person with schizophrenia and their caregivers about the objectives to be achieved.

The amount of information that a person needs and in what this extent information is available, understood, remembered or used, will vary from person to person. The information is to be transmitted continuously and gradually. Several investigations show that the majority of the individuals with severe mental illness does not show up in community programs and that 70% of these people do not appear in their first post-admission consultation (Kopelowicz et al., 1998 mentioned by Duman 2010:658). Therefore, psychoeducation provides a cognitive and affective window of opportunity to help the patients to understand their disease and treatment. The systematic and structured activities based on teamwork, e.g. psychoeducation in groups, are important in the discharged preparation, motivating them for the compliance of their treatment (Rindner 2000 mentioned by Duman 2010:658). A systematic review of the literature shows that people who received psychoeducation increased their knowledge of the disease compared with people who did not. Structured programs that use the written and oral method are considered more effective (Mostacchi & Evans 2004 mentioned by Duman 2010:658).

The themes of the program obeyed the following principles: adoption of the model of vulnerability to stress in schizophrenia (complement to pharmacological treatment); strong therapeutic alliance with the patient and family; sessions preferably domiciliary; emphasis on family education about the disease; cognitive-behavioral orientation, focusing on practical issues of everyday life; communication training; problem-solving training; improving the family environment; maintaining realistic expectations and relapse prevention training (Fadden 1998, mentioned by Gonçalves Pereira et al., 2005:4). The programs sought to teach self-management of symptoms' strategies (identify early signs of relapse, strategies for dealing with persistent symptoms and deal with crisis), and on the other hand, to teach the proper use of medication (providing the information about the active principles, the knowledge of the correct dose and the drugs' side effects), with results on an overall increase of knowledge (Eckman et al., 1992; Smith et al, 1992; Hornung et al., 1998). A multicenter study conducted in 2006 in Munich showed that in a period of 2 years the application of a psychoeducational program was associated with a significant reduction in rehospitalization rates - 58% to 41% - as well as in the number of days of hospitalization - from 78 to 39 days (Bäumli; Froböse; Kraemer; Rentrop & Pitschel-Walz, 2006). Psycho-educational programs do not include the transmission of knowledge only. Therapeutic strategies are used during sessions to increase the person's ability to cope and to promote their functioning. The sessions provide knowledge about the course of the disease, its rehabilitation, working on cognitive and emotional levels (Chadzynska & Chadzynska 2011:67).

3. Methods

This is a descriptive study of mixed nature that followed the design methodology and had as inclusion criteria's:

- Patient with a diagnosis of schizophrenia according to DSM-IV criteria or ICD10;
- Person with schizophrenia at the age of adulthood (30-65years);
- Person with schizophrenia attending the community center that accepted to participate in the program.

Exclusion criteria's:

- Person with schizophrenia who is hospitalized at the beginning of the program implementation;
- Person with schizophrenia who presented disability in decision making.

Of the ten patients attending the community space, six attend the sessions. The rest of the patients were not integrated due to the implementation of individual rehabilitation projects ongoing. One of the patients quitted the program. The final group was composed of five elements, aged between 30 and 65. A survey about the needs of the patients with schizophrenia attending the community center was analyzed. The patients stressed the need of knowledge about: the course of schizophrenia, the available rehabilitation resources and other general information about mental illness including the obsessive compulsive disorder. A psychoeducational program with 8 sessions was created, lasting 60-90 minutes. The sessions were conducted in weekly groups and implemented on a large living room in the community therapeutic space.

The instruments used:

- **Sociodemographic Questionnaire** (Socio-Demographic Data; Personal and Social History; Clinical Data / Evaluation of Mental State, Physical Examination, Family History, Use of Services and Person of Reference);
- **International Social Classification Graffar** (adapted from an original scale of 1956). A score on 5 criteria (1. Profession 2. Instruction Level 3. Sources of Household Incomes 4. Comfort Housing 5. Neighborhood aspects where it lies) was awarded after proceeding to the sum of the scores, allocating family in 1 of the 5 positions that they occupied in society (Class I - Upper Class, Class 2 - Upper Middle Class, Class III - Middle Class, Class IV - Low Middle Class and Class V - Low Class);
- **Knowledge Assessment Questionnaire** (This was made up of 17 multiple choice questions on disease characteristics, stress factors, treatment and rehabilitation, care for the physical health and substance use and its effects);
 - **Adherence Medication Scale (MARS)**, adapted from Vanelli et al, 2011, dichotomous scale consists of 10 items (internal consistency (Cronbach's $\alpha = 0.73$) and reliability (Pearson $r = 0.76$; $P < 0, 05$);
- **Some Evaluation Indicators** from Johnson et al., 2005, consisting of 4 individual indicators (Cognitive Ability, Knowledge about the Medication; Illness and Health Resources). 5 evaluation group items (behavior, participation, interaction, attention and satisfaction) assessed on a Likert scale of 5 points where 1 is the lowest score and 5 the highest.

The psychoeducational interventions were preceded by an evaluation phase which allowed us to know the overall situation of the person as well as some factors related to the family in order to adapt the content, form and rhythm. During the first stage of the internship in the hospital some incursions were made to the community center, to meet the group members, organizational dynamics, stress factors, research of the presence of positive and negative symptoms, among others.

The program of these sessions was designed as follows:

| SESSION | THEME | DESCRIPTION/ CONTENTS |
|-------------|--|--|
| Session No1 | A New Beginning | Presentation ... Who is whoThe implementation of the Program. 1 st evaluation. |
| Session No2 | Demystifying the disease | Situations where they felt they were stigmatized. How the experience was perceived... Thoughts... |
| Session No3 | Prevention is the Key | What was life like before and after contact with health institutions. Early warning signs. Factors associated with relapse. Strategies to avoid relapse. |
| Session No4 | A Rainy Day | Patients' vulnerabilities; Schizophrenia; Treatment forms; Drugs and ways of administration and consequences of its suspension. |
| Session No5 | Healthy Mind, Health Body | Healthy lifestyles; Weight Management; Movement importance. |
| Session No6 | The Fog | Psychoactive substances; tobacco and alcohol; Reasons for consumption; Motivation for change. |
| Session No7 | Storm at Sight | Stress: From Concept to Experience / The factors and their influence in everyday life. Biggest vulnerabilities. Role-play |
| Session No8 | One Day at a Time | What the program meant; What the patients liked and did not like; Suggestions for new sessions. Individual and group Interview. Strengthening of information. 2 nd Evaluation |
| Session No0 | Presentation of the results of the Program to the team | Sharing with the team the final results of the study. |

Chart No 1: Sessions of the Psychoeducational Program

The program began with the presentation of the nurse and patients in the session entitled: **A New Beginning**, whereit was:

- Given some general considerations on the psychoeducational program;
- Provided general information about the disease;
- Presented ways to improve adherence to treatment to rehabilitation;
- Promoted positive expectations regarding the treatment;
- Placed the focus on the patients, swapping experiences.

The first evaluation was made.

In session No 2 entitled **Demystifying the Disease**, patients were able to expose some situations that gave rise to stigma and prejudice. It was given information about: the meaning of the concept of healthy and sick, manifestations and course of schizophrenia and the importance of treatment adherence.

In session No 3, **Prevention is the Key**, patients were informed about: early warning signs of relapse and factors associated with it; types of strategies to prevent relapse and the importance of a support network.

The session No 4 entitled **A Rainy Day**, allowed to approach: the vulnerabilities of the disease; forms of treatment; drugs used to treat schizophrenia; consequences of interruption / discontinuation of medication.

In session No 5, **Healthy Mind and Healthy Body**, issues about healthy lifestyles, the importance of maintaining contact with the family doctor and some support structures were discussed.

In session No 6 entitle **The Fog**, were given information in a generic way about the main psychoactive substances and the role of cannabinoids in contributing to the development of schizophrenia.

In session No 7, **Storm at Sight**, patients were given awareness of: the concept of stress and usage of strategies to cope with it and some vulnerability factors. Patients were asked to enroll in a role-play, mediated by an auxiliary ego, in pursuit of a stressful situation. A discussion took place afterwards.

For the session No 8 entitled **One Day at a Time**, patients were asked to carry out an assessment of the content addressed and the feedback of the progression of the sessions.

4. Presentation and Discussion of the Results of the Psychoeducational Program

Of the five participants who integrated the group: all lived in family; age range between 30 and 65 years (mean = 40.4; median = 36; standard deviation = 9.6072); only one was divorced. Evolution of the disease >10 years. All patients were in the geodemographic area of the community. One of them was being submitted to a monthly shot. Three patients attended the middle school and two had the high school level. Regarding the results of the Graffar Scale, two participants were in the class IV (lower middle); two Class III (middle class) and one belonged to Class II (upper middle). In the first session the nurse and the patients presented themselves and it was given an explanation of the guidelines of the program and data collection. The remaining sessions were held weekly.

Session No 2: Demystifying the Disease

In this session we asked the patients to describe, with their own words, their experience on stigma in mental illness that they had faced up front. Patients stressed the limited availability of the general population and the need to raise awareness about this disease and treatment in order to be seen as any other illness. As to how the disease has affected them, they mentioned a limited impact due to taking the medication, which is reflected in the improvement of symptoms, allowing a greater acceptance of the disease and improving the relationship level. Adherence to medication is a contribution to the prevention of relapse. Estimates predict that 75% of the patients with schizophrenia will become non-adherent to medication after two years of hospital discharge (Weiden & Zygmunt 1997 mentioned by Cañas et al., 2013:98). Problems with adherence to medication are particularly common during the early stages of schizophrenia, with reports of about 59% of patients becoming partially adherent or non-adherent in the 12 months following the first psychotic episode (Coldham et al., 2002 mentioned by Cañas et al., 2013:98). The treatment time to achieve remission increases continuously by each psychotic episode. Individuals vary considerably its pattern of symptoms as the disease progresses. While most people will recover from the acute phase of the disease, only 14 out of 20 % will recover. Many will improve, but will have several setbacks related to stress, adversity, social isolation and poor treatment adherence (Wiersma et al., 2000). With regard to the concept of schizophrenia, patients have indicated that it was a mental disease manifested by: hearing voices, rigidity on the limbs and tremor. One patient claimed that the disease was related to poor mental health, while another said it was the result of a depression (with specific attitudes and specific symptoms that should be monitored). People with schizophrenia have a fragmentation between thoughts, feelings as well as individual and social reality (Neeb 2000:229). According to the DSM-IV (1996:280) the "essential features of schizophrenia are a set of characteristic signs and symptoms (both positive and negative) that were present during a major part of the time during a period of one month (or a shorter period in case of successful treatment), some signs of the disorder persisting for at least six months".

Session No 3: Prevention is the Key

Patients in this session mentioned that before the intervention and support of health structures, they were: more isolated, angry, with persecutory delusions, without pleasure to the daily activities, with obsessive behaviors and social phobia and that after the intervention of the structures a relational improvement and also organization of thoughts were possible. Psychiatric rehabilitation promotes recovery, full integration into the community and improvement of the quality of life of the people, who had been diagnosed with a mental health problem (Marques & Queiroz 2012: 15). The emphasis is placed on positive rehabilitation capacities of the sick person, in order to try to obtain "greater autonomy (...) such perspective requires a multidisciplinary intervention continued support, so that, of all the action resulting in a integrative function, aimed at providing the patient with a larger family, social and professional integration"(Navalhas & Jubilot 1996:173). Psychiatric rehabilitation brought to the area of mental health the sole basis of values for rehabilitation, which emphasizes the involvement, the choice, the strengths of the patient, the potential for growth, shared decision-making and accountability for results, by service providers (Marques & Queirós 2012:18).

Session No 4: A Rainy Day

In this session the patients discussed some issues related to the disease (weaknesses / vulnerabilities of the person); the various forms of treatment; drugs and forms of administration as well as the consequences of the suspension of medication. The patients were asked if they knew the causes that led them to stop taking their medication, either in the past or present.

Two participants reported that sometimes they did not take the medication because they thought they were not sick; one related the discontinuation of the medication with the fact of being bored taking it every day and two patients mentioned that they had a hard time remembering to take it. One of the key criteria for referral for a psychoeducational program is the lack of insight and non-adherence to medication. The non-persistent recognition of the disease can disrupt not only the relationship of the affected person with those they love and with the mental health professionals, but also the patient's recovery, preventing him/her to lead a satisfying and productive life. So "interventions that aim to improve directly the insight or the realization of negative consequences of poor insight (non-adherence, social isolation, indifference to people who are dear to them and health system) should be developed" (Cardoso 2008:349). The term adherence refers to an active participation of the patient in the treatment plan and not a passive, uncritical of therapeutic instructions posture. A schizotypal personality risk of 14.5% was reported in first-degree relatives of people with schizophrenia (Baron et al 1983 mentioned by Dalery and d'Amato et al. 2001:49). More recent studies confirm the high frequency of schizotypal personalities in relatives of people with schizophrenia (Onstad et al., 1991; Kendler et al., 1993 mentioned by Dalery and d'Amato et al., 2001:49). The risk of a paranoid personality is also higher in first-degree relatives of a person with schizophrenia, in which case reaches 7.3% against 2.7% in relatives of control subjects (Baron et al., 1985 mentioned by Dalery and d'Amato et al., 2001:49).

Some studies show a family connection only between schizoaffective disorder and schizophrenia; others only with mood disorders or simultaneously with schizophrenia and mood disorders. It is documented an increased risk of major depression in first-degree relatives of people with a family history of schizophrenia (Gershon et al., 1988; Baron & Gruen 1991; Maier & Propping 1991; Maier et al., 1993 mentioned by Dalery & Amato et al., 2001: 51). Studies show that schizophrenia has a heterogeneous route. Therefore, people are distributed in relation to the degree of disease: low, moderate or severe. After an initial psychotic episode, over 20% of people have a good prognosis with only one or two psychotic episodes during the recovery period. More than a third have a poor outcome and continued negative psychotic symptoms. Between these two extremes lie the majority of people, reportedly having several relapses episodes. Research indicates that people with schizophrenia have a deficient knowledge regarding their medication and disease and on dealing with their symptoms (Clarey, Duty & Schweizer, 1992; Luderer & Blocker, 1993 mentioned by Landsverk & Kane, 1998: 421). The pharmacological treatment in schizophrenia is composed of antipsychotic drugs called neuroleptics. Conventional antipsychotics are antagonists of dopamine and its effect results in the reduction of positive symptoms (delusions, hallucinations, disorganized thinking). Sometimes arise extra pyramidal effects, which have the basic symptoms of movement disorders (tremor, rigidity, bradykinesia, dystonia and akathisia) (Giacon & Galera 2006). Prolonged use of typical antipsychotic contributes to a disorder called chronic and irreversible tardive dyskinesia. These extra pyramidal side effects are one of the main factors contributing to non-adherence to drug treatment. Atypical antipsychotics inhibit dopamine and serotonin receptors, improving the positive symptoms and assisting in treating negative symptoms without significant extra pyramidal side effects (Giacon & Galera 2006).

Session No 5: Healthy Mind, Healthy Body

In this session we discussed some issues related to healthy lifestyles: the importance of exercise and consumption of healthy foods; problems related to the weight increase related to alcohol, tobacco and other harmful substances. Patients were asked to write a typical menu of their meals. We found out that: three patients did proper meals (two of them had the support of a dietitian); One would only eat breakfast correctly. All patients made long fasting periods. Statistically, people diagnosed with schizophrenia tend to die earlier (men <20 years and women <15 years from the average life expectancy) than the general population (Wahlbeck et al., 2011 in NICE Guidelines 2013:20). People with schizophrenia are two to three times more likely to develop diabetes compared to the general population. A study in a London hospital indicates that 39 (6.1%) of the 606 people hospitalized had diabetes or impaired glucose tolerance (Taylor et al., 2005 in NICE Guidelines 2013: 21). The prevalence of obesity has increased dramatically in the population in general in the last 30 years and it has climbed rapidly in people with schizophrenia (Homel et al., 2002 in NICE Guidelines 2013:22). Environmental changes appear to cause this increase in both populations; however in schizophrenia could coexist specific genetic susceptibilities in which it's synergistic or additive action may increase the weight in the future (NICE Guidelines 2013:22). However, the most important factor of overweight is the use of antipsychotics, since they are obesogenic medications.

The increase in weight leads to insulin resistance and other adverse effects such as dyslipidemia, diabetes and hypertension (NICE Guidelines 2013: 22). The first psychotic episode often begins when a person is in adolescence and the impact of antipsychotics may coincide with a critical development phase. Not only premature weight gain can lead to metabolic disorders and cardiovascular diseases, but also lead to restrictions of physical exercise leading to low self-esteem (Vancampfort et al., 2011 in NICE Guidelines 2013: 23). About 70% of people with schizophrenia are smokers. Studies show a strong correlation between smoking and cardiovascular diseases (Brown et al., 2010 NICE Guidelines 2013: 23).

Session No 6: The Fog

In this session, patients were asked about their knowledge on the most common and consumed psychoactive substances. Regarding the consumption of psychoactive substances, patients said that they were linked to: management of everyday problems; social pressure or even a detachment of social responsibilities. Several lines of evidence suggest that cannabinoids may produce a range of psychotic symptoms in a transient unchanged consciousness (Sewell et al., 2010). Exposure to cannabis is associated with "a negative impact on the course and expression of schizophrenia" (Sewell et al., 2010). The inhaled cannabis consumption can exacerbate the symptoms of schizophrenia and its continued use predicts the presence of more psychotic symptoms and worsens the prognosis of people who already have schizophrenia (Sewell et al., 2010). The onset of cannabis consumption may precede, succeed or be simultaneous with the onset of schizophrenia (Sewell et al., 2010). In 69% of a sample of Swedish patients with schizophrenia (n = 112), cannabis abuse preceded the onset of psychotic symptoms in at least one year (Allebeck et al., 1993 mentioned by Sewell et al., 2010). Hambrecht and Hafner (2000), mentioned by Sewell et al., (2010) studied patients with first-episode schizophrenia, and found that in 37.9% of the subjects, the drug abuse was subsequent to the first schizophrenia signal and in 34.6% of patients, the first sign of schizophrenia and drug abuse began in the same month.

Session No 7: Storm at Sight

In this session the patients were asked to debate about the meanings of stress and strategies to cope with it. They relate stress to: unrest; conflict between family members and third parties; tiredness; uncontrolled anxiety; life of excess; concerns and accumulated nervous tensions due to social demand. The model of vulnerability to stress was approached. Participants were interested and satisfied highlighting difficulties in the following areas: public speaking; getting ready in the morning to go to the center; managing medication, especially when it is necessary to buy more. Lazarus & Folkman (1984) define stress as a relationship between the person and the environment that is understood by the person as something that overwhelms or exceeds their resources and threatens their well-being. A precipitating event is a stimulus resulting from internal or external environment and the individual who is knowledgeable in a particular way. The Express Emotion (EE) is the largest psychosocial stressor and is in direct association with disease recurrence (Amaresha & Venkatasubramanian 2012:12). Research on EE show that people with mental illness living with family members who have negative attitudes, are more likely to relapse. The family experiences are important in the person's stability with severe mental illness. The Expressed Emotion (EE) is a measure of observation of family involvement in the lives of people with schizophrenia. Families of people with schizophrenia that express high levels of criticism, hostility or too involvement, have more frequent relapses than people with schizophrenia from families that tend to be less expressive of negative emotions (Pharoah et al., 2010 mentioned by Kritzinger et al., 2011:141). It was not possible to work with families due to uncontrollable factors.

Session No 8: One Day at a Time

In the overall impact of the sessions, patients expressed the pleasure and satisfaction which was also shown by the outcome indicators. The highlights were the guidelines on physical health and the genesis of schizophrenia. In the end, it was made a separate interview to answer questions and reinforce the information transmitted on this program.

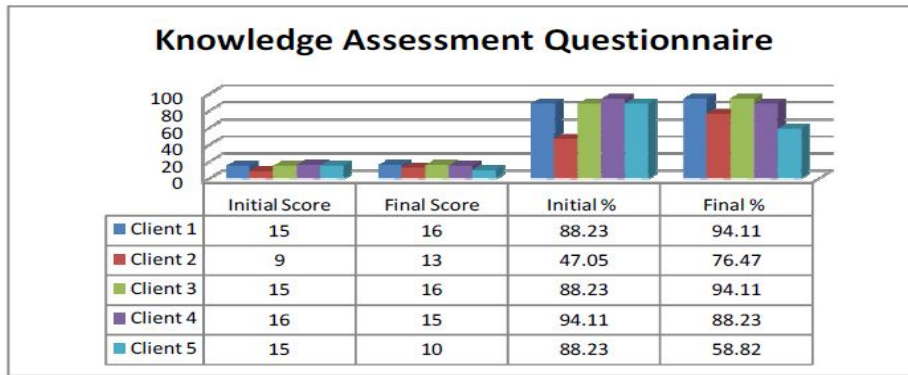


Chart No 2. Knowledge Assessment Questionnaire

Of the 5 patients in evaluation, 3 increased their levels of knowledge of the disease, 1 maintained its score of knowledge and 1 decreased his score of knowledge. We can infer from the knowledge of their clinical condition that the last patient showed more spontaneous delusional activity and lower attention span and concentration.

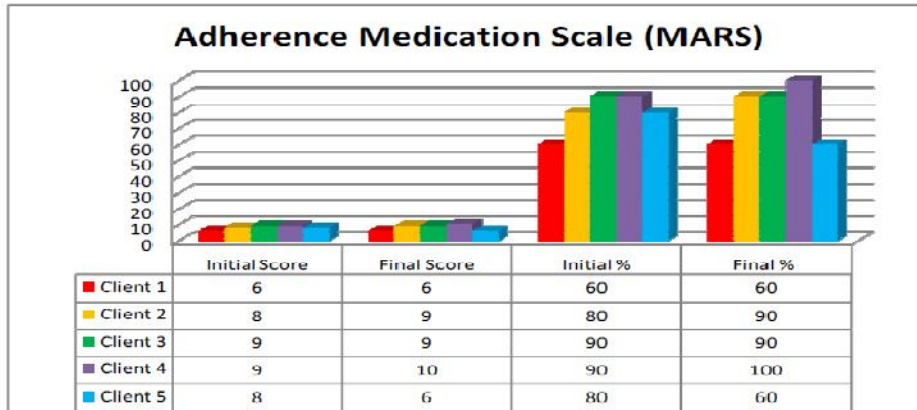


Chart No 3. Adherence Medication Scale (MARS) Adapted Vanelli et al., 2011

Of the 5 patients in evaluation, 2 increased their score of knowledge, 2 maintained, while 1 patient decreased its score. The last patient showed more spontaneous delusional activity and lower attention span and concentration.

After using the Evaluation Indicators (adapted from Johnson et al, 2005):

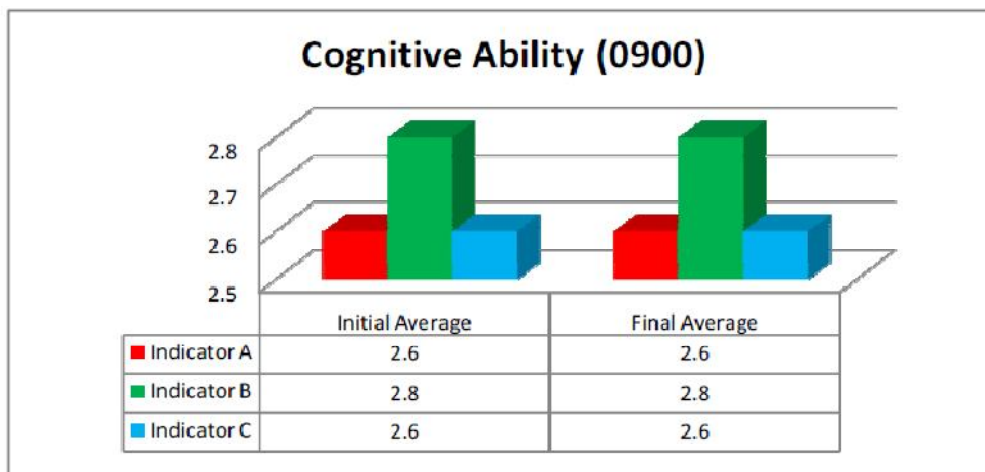


Chart No 4. Cognitive Ability

In terms of Cognitive Ability (0900), the selected indicators showed no oscillation.

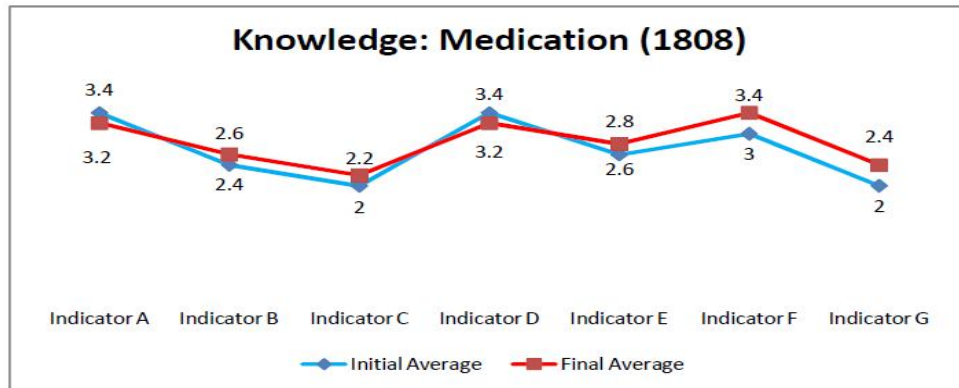


Chart No 5. Knowledge: Medication

Regarding the knowledge about medication, there was a positive displacement of all indicators, except for: Lists the proper names of the products (180802); Description of the correct name of the drug and Description of the proper administration of the drug. (180810).

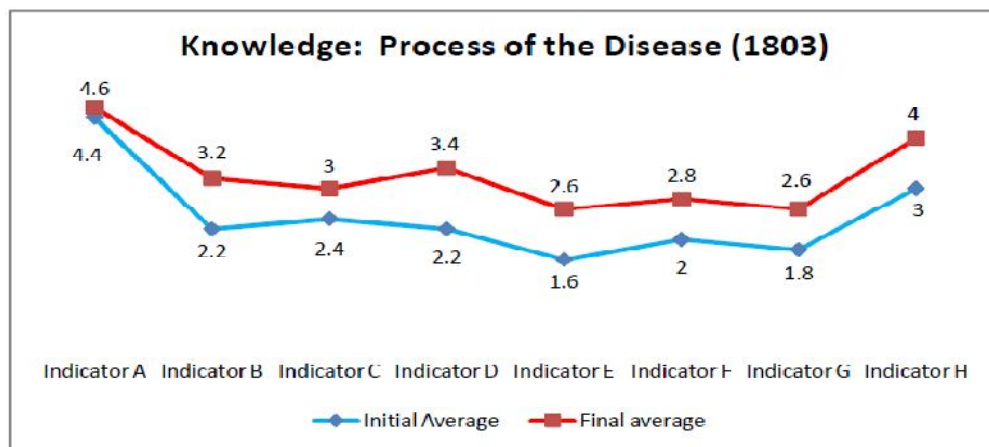


Chart No 6. Knowledge: Process of the Disease

Regarding the knowledge about the process of the disease, all indicators varied in a very positive way, and the indicator with the highest oscillation was: Description of the signs and symptoms of the disease (180306).

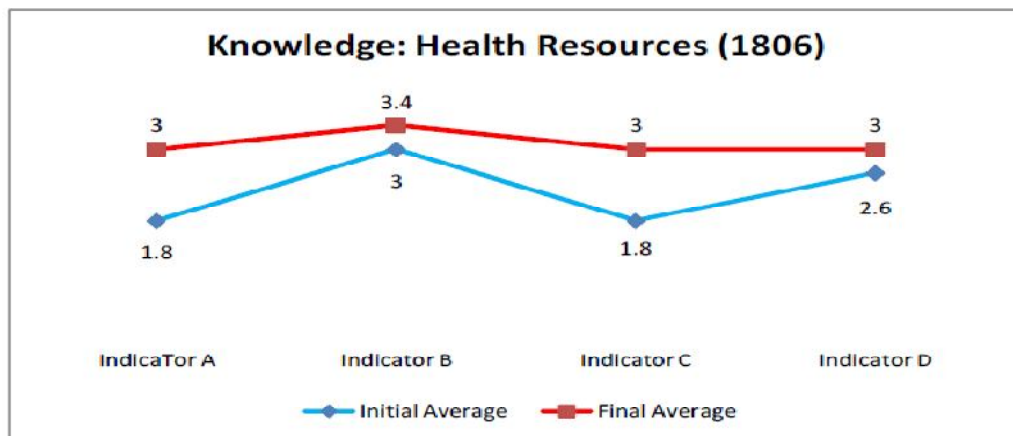


Chart No 7. Knowledge: Health Resources

On the knowledge about health resources, all indicators have moved very positively, and the indicators that varied were: Description of the features that enhance health (180601) and Description of the available community resources (180607).

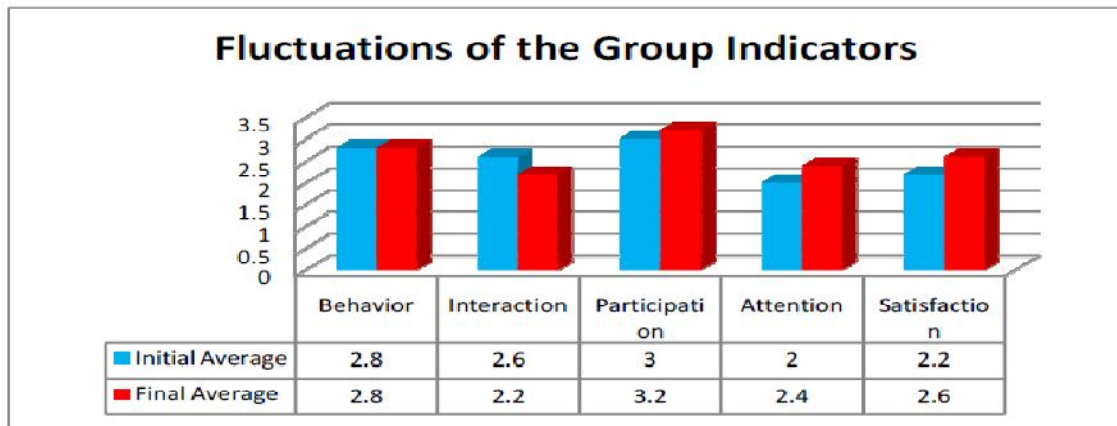


Chart No 8. Group Indicators

For the evaluation of the group intervention, the 5 patients:

- Do not showed changes in "Behavior";
- Presented a change in "Interaction" (slight fluctuation);
- Presented an increased level of "Satisfaction", "Participation" and "Attention".

The psycho educational program was implemented in an open group. One of the sessions was a role-play and it was assisted by a pedagogical advisor (with previous authorization and presentation). The presence of the pedagogical advisor could have contributed to an oscillation in the evaluation of this program, making it not so interactive. Limitations to the study: the existence of an open group; the sample was very small and we have not been able to establish a control group; existence of difficulties in some responses; reduced internship time which did not allowed a follow-up after six months of the program. In terms of overall assessment there was a positive movement in relation to seized contents. The key ingredient in the interaction with the group was the relationship established. As in the early relationships in which the child tries to "conquer" the attention and love of parents, doing everything to please them, there is also here a connection. Winnicott (1962) mentioned by Carvalho (2011) reported that the child's development was guided by the inherent need of learning, growing and to adapting to the environment. The healthy development of a child depends on the "good enough" mother's presence ("good enough mother"). This is characterized by providing support to a child's self, and therefore meeting his needs. In this context, the relationship metaphor mother / baby could be transposed to the nurse and to the group. The patients were in different stages of their disease, knowledge and relationship. The results and the relationship established with the group allowed them to express their true self and reveal their real difficulties. The fact that it is a space for themselves to use and think, allowed them to feel safe, establishing a therapeutic alliance in a contained space which allowed a progressive revelation. So we can say that the therapeutic alliance can be defined as a positive and stable relationship between therapist and patient (Gomes et al., 2008:110). Nurses should have the ability to listen to what the patients have to say: their needs, their difficulties, their preferences, respecting the rhythm, personal characteristics, and as well as the experiential reality in which they are at the moment. The psychoeducational program revealed positive movements in terms of knowledge. During this period, the balance was positive. Several cognitive and emotional aspects were worked as the patients were being *maternaged* and nourished and while establishing a therapeutic relationship.

5. Conclusions and Future Considerations

Psychoeducation can be seen as "a group of approaches based on two pillars: helping patients and their families to learn what they need to know about mental illness and to master new ways of dealing with it and the problems of daily life, reducing family stress, providing social support and encouragement, allowing a focus on the future rather than a morbid dwelling on the past"(Gonçalves Pereira et al., 2005:2).

The psychoeducational interventions led to a new understanding of people with schizophrenia and their disease, which associated with new forms of participation and communication, had a positive effect on the knowledge of the disease, improving symptoms, decreased pain and increased satisfaction and the stabilization of the disease. The evidence of data resulting from the application of nursing interventions in participating people, emphasize the positive results that strengthen the relevance of the implementation of intervention programs, designed to promote the overall functioning of the person and compliance and better adaptation to the disease. The various sessions of the program allowed us to work the knowledge about the disease and some coping strategies. It was found that sometimes patients had difficulty to understand some of the content. Given the complexity and the little familiarization of patients with some concepts about mental illness, we realize more and more the importance of creating supporting networks and close monitoring. Professionals should offer a secure place, allowing patients to reflect on their experiences. Schizophrenia is a serious mental health problem that leads to change in perceptions, thoughts, feelings and behaviors depending on the particular circumstances of each person. The difficulties may include changes in memory and attention, social isolation, maladaptive behaviors, communication and affection, unusual perceptive experiences, which may be accompanied by specific ideas, self-care deficit and reduced interest in the activities of daily living. During this period, people with psychosis often feel that their world has changed, but their interpretation of this change is not shared by others. Change can affect a person's ability to study, to remain employed or in a relationship. The prodromal period is followed by an acute phase, marked by positive symptoms (hallucinations, delirium, disturbed behavior and changes of thought and speech).

Continuity of care is a vital component of environmental support for patients with schizophrenia and deserves the attention of all the health care professionals and families. The greater the continuity, the lower the risk of relapse. Since not all psychiatric services have psychoeducational programs available, it is important to share knowledge among peers and a cohesive integration of psychoeducation in the treatment team. Given the experience in mental health and psychiatry, we believe that the implementation of this psychoeducational program tried somehow to respond to psychotherapeutic and psychoeducational interventions. These programs have several components that include improving adherence to antipsychotic medication and ensure that patients and / or family member's can detect the early warning signs. In this program it was not possible to include families, due to the stage of temporal contingencies. We think that this approach is fundamental and should be put to use in future programs, especially in families with high expressed emotion. According to the review of several psychoeducational studies, we believe that to improve adherence to medication there are several treatment modalities (individual, group of patients or families), also allowing a therapeutic orientation, with a cognitive approach, emphasizing patient attitudes, strengthening behaviors and social support. Several studies have shown that patients and families that were informed about the disease developed a positive attitude and a therapeutic alliance, less likely to have prodromal symptoms of relapse and to be hospitalized within two years of follow- up (Smerud 2008 mentioned by Cañas et al., 2013:99). The key elements in the effectiveness of family interventions are education for the disease, crisis intervention, emotional support and coping and training in disease symptoms and problem solving (NICE 2013 mentioned by Cañas et al., 2013:102).

In terms of future considerations, we highlight the importance of establishing community teams, implementing a case manager program in full time in order to closely help monitoring and promoting adherence to treatment, ensuring continuity of care, becoming partner with family and reducing family burden. These programs have therapeutic and economic advantages. It is important that the sick person could be treated at home next to their families. This may translate into greater gains in health. More research and implementation of this type of work on mental health nursing and psychiatry is necessary, given the quality standards of care for these patients and the support for their families.

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