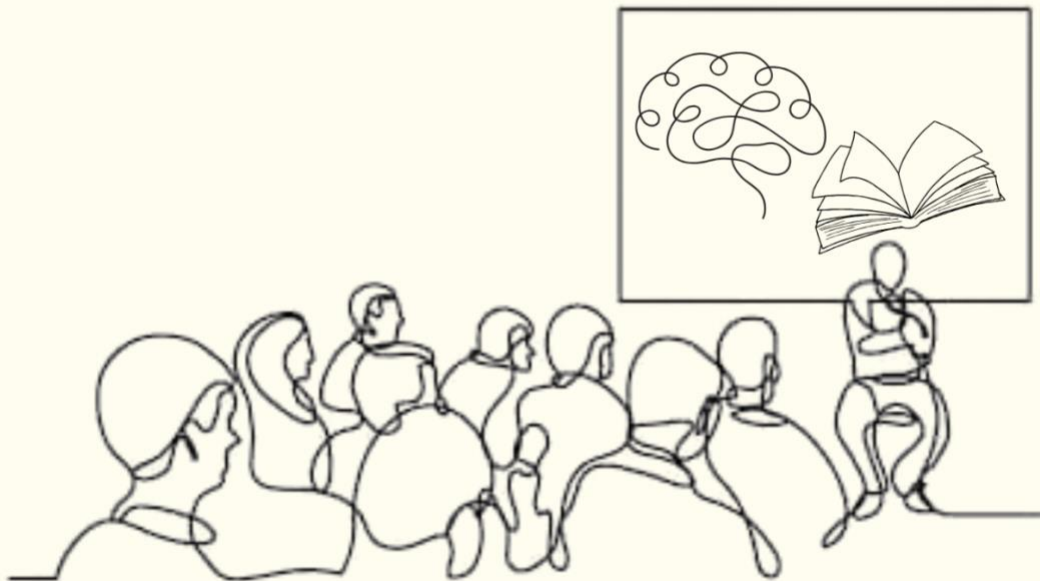

PSYCHOEDUCATION

Understanding Psychoeducation for Caregivers
of Patients with Mental Illness:
Importance, Types, & Limitations

A Compiled Psychoeducation Manual



Ellita Elsa Sunil



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Ellita Elsa Sunil
Supervised by Dr. Anil Vartak

Foreword

Estimates suggest that humans make anywhere between 122 to 35,000 decisions each day, depending on the source consulted. The precise number is less important than the fact that many of these decisions are influenced by people, technologies, businesses, and social systems. Even if a fraction of our choices are shaped this way, the implications are profound. Consider how shopping has evolved: once guided by personal lists, it is now steered by algorithms and advertisements. Often, we do not know what we need until we are told what we might want. This shift reveals how decision-making is no longer solely internal, but increasingly prompted by external cues.

When applied to health, and especially mental health, the complexity deepens. Here, decisions revolve not just around what one wants, but around identity, needs, and self-care. In such contexts, psychoeducation becomes invaluable. It is not just about offering information, but about helping individuals interpret that information in personally meaningful and empowering ways.

In India, the mental health landscape remains uneven. Regulatory clarity and ethical standardisation are limited, leaving the public with fragmented guidance on what psychological help involves. Though awareness has grown, especially since the pandemic, the rise of social media discourse and scattered advice has often left individuals overwhelmed. Psychoeducation offers a way forward. It not only makes knowledge available but helps people understand and apply it in everyday life. It turns confusion into insight and passive awareness into informed agency.

Community-level psychoeducation holds particular promise. Grassroots efforts, such as those led by Anganwadi workers, have long supported physical and nutritional wellbeing. However, these often stop short of addressing psychological concerns. Psychoeducation complements such initiatives by integrating mental and emotional health into broader developmental goals. When embedded into existing community programmes, even brief psychoeducational efforts can deepen collective understanding and support more holistic wellbeing.

Moreover, psychoeducation bridges the gap between clinical knowledge and real-world experience. While psychology in India continues to evolve, shaped by both Western frameworks and Indian perspectives, much of it remains confined to academic or clinical spaces. Diagnostic terms like depression or anxiety can feel distant or alien to many. Psychoeducation helps to translate these into everyday language and lived experience, shifting the focus from pathology to

emotional insight and practical coping. In doing so, it brings psychological concepts closer to those who may not have formal training, yet live with these challenges daily.

This manual arrives at an important moment. It brings together theoretical grounding and practical guidance in an accessible, culturally informed way. Whether for professionals, students, caregivers, or community workers, it offers tools to make psychoeducation relevant, inclusive, and impactful. With its clear structure and grounded examples, this manual succeeds not only in informing, but also in inviting broader engagement with mental health knowledge and practice.

A Sabu John

Counselling Psychologist and Counselling Educator

Assistant Professor, Christ University

Introduction

The Eklavya Foundation's Caregiver Training Program, conducted both in Pune and across other locations, has been a pioneering initiative aimed at supporting families and individuals caring for persons with mental illness. Over several rounds of successful implementation, the program has offered practical guidance, emotional support, and structured learning to caregivers, helping bridge the often-overlooked gap between clinical care and everyday caregiving.

To further support this work, Dr. Arun Rukadikar has developed a manual that serves as study material for participating caregivers, as well as a valuable resource for mental health professionals and facilitators seeking to initiate similar programs in their own cities. This manual reflects both clinical insight and field-based experience.

This manual, therefore, seeks to offer a clearer, more accessible understanding of psychoeducation, what it involves, how it can be adapted in various settings, and why it matters in the everyday lives of caregivers and individuals experiencing mental health challenges. It aims to bring together key concepts, common themes, and practical considerations drawn from both experience and evidence, while also acknowledging the limitations and challenges of implementing such programs in the Indian context. By doing so, the manual hopes to support those who are already engaged in this work, as well as those who are just beginning to explore how psychoeducation can be part of more inclusive, compassionate, and sustainable approaches to mental health care.

This manual, therefore, expands on the original material by addressing these gaps. It places the caregiver training program within the larger mental health ecosystem in India and outlines how Eklavya views this model as a scalable, affordable, and educative public health initiative. By equipping caregivers with knowledge and tools, this program not only strengthens families but also contributes to a more inclusive, informed, and sustainable mental health care framework.

Ellita Sunil
Intern with Ekalvya Foundation and
MSc. Counseling Psychology Student
at Christ University, Bangalore

Dr. Anil Vartak
President
Ekalvya Foundation for Mental Health
Pune

Foreword

Mental health is not merely a medical concern, it is a profoundly social, cultural, and human issue. In our communities, the silence and stigma surrounding mental illness often result in delayed help-seeking, unnecessary suffering, and the tragic loss of human potential. Yet, we possess powerful tools to bridge this gap. Among them, psychoeducation stands out as one of the most practical, scalable, and empowering strategies available.

This manual is built on a simple but transformative idea: knowledge is not just information — it is healing. When done well, psychoeducation can change lives. It equips individuals, families, and communities with the understanding they need to recognize mental health challenges, respond with empathy, and connect with care pathways. More importantly, it builds resilience and fosters hope. The approach outlined here goes beyond clinical care. It is community-centered, culturally rooted, and sustainably designed. By involving ASHA workers, teachers, peer supporters, caregivers, and local leaders, we aim to spark a grassroots movement that makes mental health everyone's business. Through the use of locally adapted materials, folk media, digital tools, and existing service platforms, psychoeducation can become not a one-time intervention, but a continuous, evolving process.

This manual offers a practical roadmap — not just for delivering information, but for building a self-sustaining mental health ecosystem. It provides clear guidance on training, delivery methods, impact measurement, and sustainability. From community meetings to tele-outreach, from shifting attitudes to improving service uptake, every step is rooted in evidence and guided by empathy.

Whether you are a frontline health worker, program manager, policymaker, or a passionate community member, this resource is crafted to support your work. Our collective goal is simple yet profound: to normalize conversations about mental health, reduce suffering, and ensure that care is available, accessible, and acceptable to all who need it.

Let us walk this journey together — towards awareness, inclusion, and healing.

Dr. Sachin Sunil Meena Ganorkar

Caregiver to his mother living with Schizophrenia.

MBBS (Mumbai University), MHA(TISS, Mumbai), PhD (Public Health), TISS, Mumbai.

PG Diploma in Family Medicine & Diabetology(CMC, Vellore)

Consultant to Public Health Department, Government of Maharashtra

Voice from the Field

As we continue to navigate in the complexities of modern life, mental health awareness has become more important than ever.

This manual breaks down the stigmas and barriers providing a platform for open discussions and education by exploring the complexities of mental health. The author may empower the reader to take control of their mental well being and seek help when needed.

With my 35 years of journey throughout the country in military psychiatry and deaddiction saga, even today I understand that stigma in approaching mental health professional need much more motivation and awareness about mental well being.

I am sure, this manual is a powerful tool for creating positive change and promoting mental health awareness through psychoeducation.

Brig Ameetha M Peter

DPN Psychiatry

Principal Matron, CHSC, Pune

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Introduction to Psychoeducation

Definition

Psychoeducation may be defined as the education of a person with a psychiatric disorder regarding the symptoms, treatments, and prognosis of that illness. It is not simply 'providing information', but rather empowering training for patients targeted at promoting awareness, providing tools to manage, cope and live with a chronic psychiatric condition, and changing behaviours and attitudes related to the condition (Colom, 2011).

Psychoeducation programmes seek to provide families with the information they need about mental illness and the coping skills that will help them to deal with their loved one's psychiatric disorder (Srivastava & Panday, 2016). In a nutshell, Psychoeducation's goal is to offer education

and therapeutic strategies to improve the quality of life for the family while decreasing the possibility of relapse for the patient (Solomon, 1996).

Suzuki and Tanoue (2020) mention that the role of psychoeducation encompasses not only imparting knowledge and information regarding treatment/psychological support through media such as leaflets or information web sites or feedback to individuals based on test results, but it is also characterised by active cooperation such as intervention exercises with patients and their families.

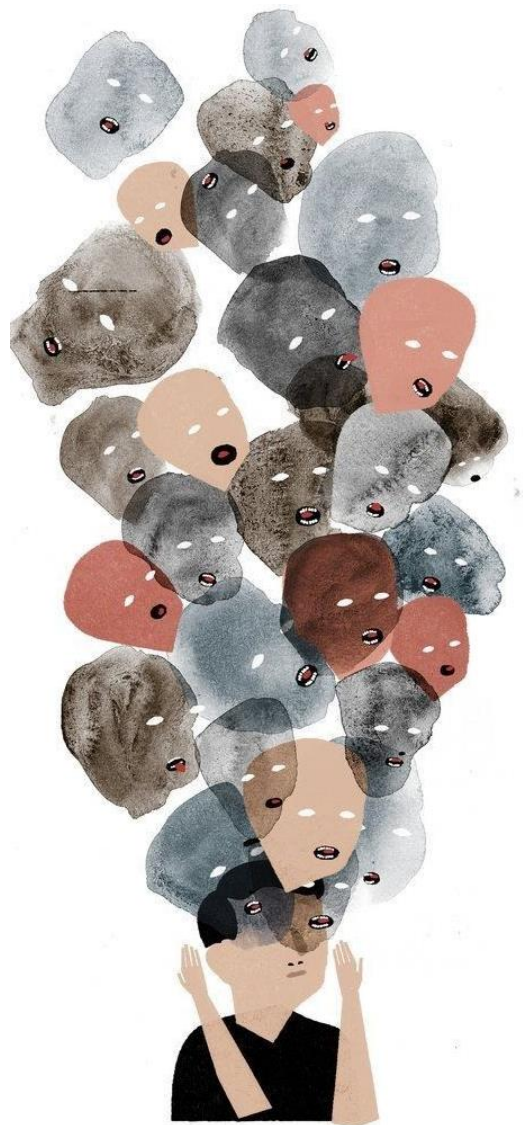
The information given here mainly deals with psychoeducation for caregiver rather than for patients directly. The information can be referenced for patients as well.

Essential components of a psychoeducation session (Sarkhel et al., 2020)

- Etiological factors
- Common signs and symptoms
- Awareness regarding the early signs of relapse/recurrence
- How to cope with the situation
- Various treatment options available
- When and how to seek treatment
- Need for adherence to treatment as per the guidance of treating team
- Long-term course and outcome
- Dos and don'ts for family members while dealing with the patient
- Clearing myths and misconceptions about the illness and dispelling stigma

Goals of Psychoeducation (Suzuki & Tanoue, 2020):

- Enhancement of adherence



- Improvement of illness management
- Stress control skills, like early recognition of episode recurrence and development of strategies for effective coping with symptoms
- Improvement of social and occupational functions
- Quality of life

What Research says about Psychoeducation

Research shows that psychoeducation appears to be effective in preventing any and manic/hypomanic relapse in bipolar disorder. Also, group psychoeducation seems to be effective in preventing relapse in bipolar disorder (Bond & Anderson, 2015).

Psychoeducation improves patients' medication compliance, mental health, and social functioning. It leads to better rehabilitation, reduced social disability, and enhanced understanding of schizophrenia. Additionally, it lowers anxiety and depression, and in the medium term, reduces



the risk of relapse. Overall, psychoeducation is a practical approach in mental health management (Zhao et al., 2015).

Research shows that how psychoeducational programs are presented can greatly influence participation; for example, Horrell et al. (2013) found that renaming workshops with non-diagnostic labels, such as "self-confidence workshops," significantly increased attendance, with 39% of self-referrers never having previously sought help for depression.

Psychoeducation has also proven effective for family caregivers, particularly for those supporting adults with schizophrenia, by reducing caregiver burden and improving knowledge and attitudes both immediately and up to one year post-intervention. However, ongoing sessions may be necessary for lasting benefits.

Worakul et al. demonstrated that even a one-day intensive session could achieve meaningful improvements. At the same time, Tessier et al. showed that a brief six-session multifamily program effectively reduced caregiver burden and depression and helped prevent patient relapse. However, accessibility issues, time constraints, stigma, and financial barriers can limit participation (Okafor & Monahan, 2023). Program developers are encouraged to address these barriers by ensuring high-quality, relevant information, emotional support, flexible delivery, and strong peer connections (Yu et al., 2023).

Additionally, early intervention in the disorder's course (Mesarič et al., 2023) and integrating mindfulness practices into psychoeducation (Zhang et al., 2023) can further enhance outcomes by reducing caregivers' expressed emotions, particularly over-involvement.

Models of Psychoeducation (Yadav & Kar, 2011)

<p><i>Information Model</i> The goal of this model is to equip families with an understanding of psychiatric disorders and their treatment. This strategy aims to enhance the families' knowledge of the condition and their role in the patient's management.</p>	<p><i>Skill Training Model</i> This model aims to cultivate specific behaviours consistently so family members can improve their ability to support sick relatives and handle the illness more efficiently.</p>
<p><i>Supportive Model</i> This model employs support groups to involve patients' families in expressing their emotions and experiences. The primary objective here is to strengthen and develop the emotional abilities of families to manage the challenges of caring for their sick loved ones.</p>	<p><i>Comprehensive Model</i> This is called a combination approach since it includes information, skills training, and a supportive model. During the first stage of this approach, participants receive lectures regarding the illness. They are required to join a multi-family support group. In the last stage, they must participate in individual sessions with a mental health professional.</p>

Outcomes of Psychoeducation

(Bhattacharjee et al., 2011)

1. Improved Knowledge and Awareness

- Increases understanding of mental illnesses (e.g., signs, symptoms, course, treatment options, and side effects)
- Dispels myths and misconceptions related to psychiatric conditions.
- Educates caregivers and patients on early signs of relapse.

2. Enhanced Treatment Compliance

- Promotes better adherence to prescribed medications and therapeutic regimens.
- Strengthens the cooperation between caregivers and mental health professionals.

3. Reduction in Relapse and Hospitalisation

- Associated with lower relapse rates in patients, especially when combined with other therapeutic approaches like family support and skills training.



4. Better Coping Skills and Problem Solving

- Empowers families with coping strategies and communication skills to handle mental health crises and daily caregiving challenges.
- Increases caregivers' ability to solve problems effectively within the family dynamic.

5. Improved Patient Functioning

- Psychoeducation for caregivers can enhance even the patients' social and occupational functioning and helps reintegrate them into their home and community.

6. Increased Family Support and Engagement

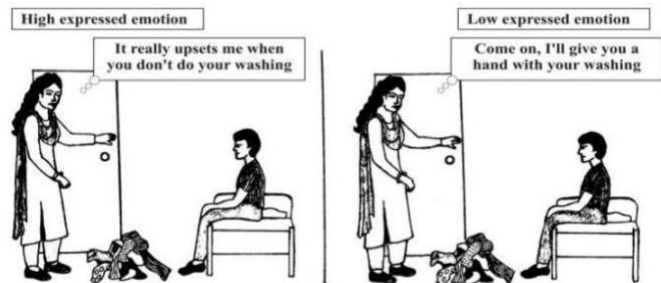
- Builds a stronger therapeutic alliance between families and treatment teams.
- Encourages families to become active participants in the rehabilitation process.

7. Effective Across Disorders

- It is beneficial for schizophrenia, bipolar disorder, and substance use disorders and other multiple disorders.
- Tailored psychoeducation (e.g., Family Focused Treatment for bipolar disorder) addresses disorder-specific challenges.

8. Decreased Family Burden and Expressed Emotion

- Reduces emotional distress and the critical/hostile attitudes of families toward the mentally ill.
- Leads to better emotional support within the family environment.



9. Preferred by Patients and Caregivers

- Participants often rated it as helpful and supportive.
- Peer-to-peer models particularly increase engagement and provide hope through shared experiences.

Importance of Psychoeducation/ Why do we need such content?

In the case of physical illnesses like diabetes, heart disease, or cancer, patients and families often receive clear, structured education: what the illness is, how it progresses, what treatments are available, what lifestyle changes are needed, and how to monitor symptoms or at least exposure is available in one or the other form.. Health systems provide this information through pamphlets, nurse educators, follow-up plans, and community support programs, even media and newspapers.

But when it comes to mental illnesses like schizophrenia, bipolar disorder, or severe depression, this level of structured, accessible education is often missing or inconsistent which becomes a barrier in coping with the illness and its consequences.

Mental Health Lacks the Structured Educational Support Found in Physical Health

- Mental health education is not standardized or universally included in school curricula, whereas physical health (e.g., hygiene, nutrition, and physical education) is a staple part of education across the world.
- Teachers receive limited training on mental health literacy, reducing their ability to identify, support, or refer students struggling with mental issues.
- Mental health is often underfunded and deprioritized in national healthcare systems. In education, this translates into limited integration into school health programs.
- While a diabetic patient might get a diet chart, glucose monitor, and scheduled nurse visits, a person diagnosed with schizophrenia may leave the clinic with only a prescription and confusion.
- Families of cancer patients often receive counselling and support group information—families of people with bipolar disorder often receive none.
- The result is that patients and caregivers are left in the dark about:
 - What does the diagnosis mean
 - What to expect during treatment
 - How to respond to relapses or crises

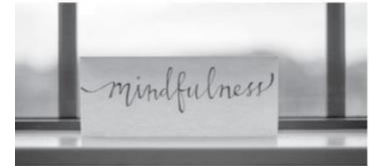
- How to support recovery without unintentionally causing harm

A comprehensive psychoeducation manual steps in where mental health systems still fall short. Unlike physical illnesses, mental disorders are still surrounded by myths and misconceptions: e.g., “It’s just laziness,” “They can snap out of it,” or “It’s caused by weak character.” A structured manual dispels these myths with science-backed information and helps patients and families replace fear with understanding.

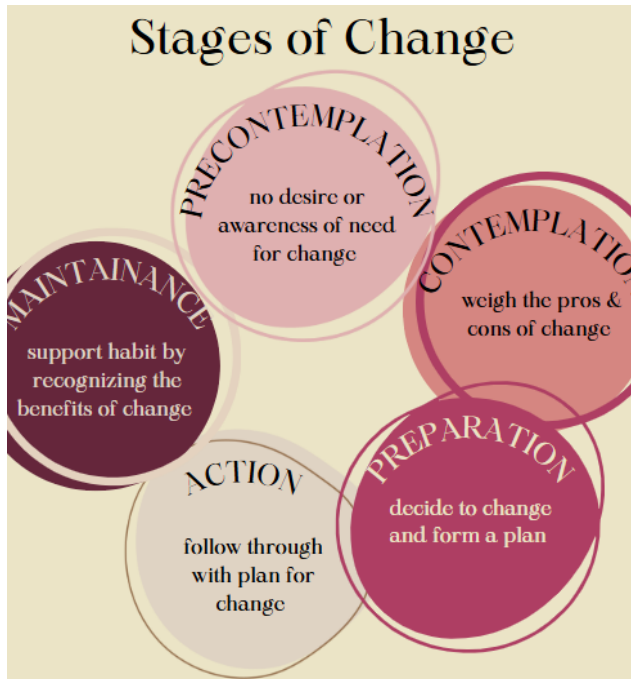
Common Topics that can be covered in Sessions

Psychoeducation can cover many areas depending on the audience (like clients, patients, families, or even communities). Research highlights several major topics that are especially helpful for psychoeducation, including:

- Understanding mental health conditions (depression, anxiety, bipolar disorder, schizophrenia, PTSD, etc.)
- Coping skills and emotional regulation (DBT skills, mindfulness, stress management)
- Cognitive-behavioural strategies (challenging negative thoughts, behaviour activation)
- Medication education (how medications work, side effects, adherence importance)
- Relapse prevention (recognising early warning signs, developing safety plans)
- Communication skills (assertiveness, conflict resolution, active listening)
- Self-care and wellness planning (sleep hygiene, nutrition, exercise)
- Trauma education (effects of trauma on the brain and body, grounding techniques)
- Grief and loss (normalising the grieving process, coping strategies)
- Family dynamics and support (how to support a loved one, boundaries)
- Resilience building (strengthening coping resources, post-traumatic growth)



- Mind-body connection (how stress affects the body, relaxation exercises)
- Topics of marriage, self sufficiency, attaining independence.
- Crisis management (what to do during a mental health crisis, safety resources)



- Substance use and addiction education (understanding cravings, stages of change)

Types of Psychoeducation

Brief Psychoeducation/ Single-session psychoeducation

Brief psychoeducation is a short period of psychoeducation, although what constitutes 'brief psychoeducation' can vary. One study conducted a 2-day psychoeducation program and, compared with the other (control) group, showed significant improvement in the level of recovery-oriented knowledge immediately after the workshops. However, the effect could not be sustained at follow-up (Mak et al., 2018). Another study, focusing on a one-day psychoeducation workshop for families, showed that the workshop was found to be an effective, low-intensity intervention that met short-term educational and emotional needs. It may also serve as a gateway to more intensive support services, particularly for families already seeking help (Pollio et al., 2006). Another study showed that while one session alone isn't sufficient for robust symptom reduction, it may serve as a valuable "stepping-stone" to care further (Ghafoori et al., 2016).

These studies show that even though most studies say 10 sessions are ideal for conducting psychoeducation sessions, even a one- or two-day workshop affects caregivers and patients. Hence, the definition of 'brief psychoeducation' is dynamic. It can vary depending on the needs of the intervention provider, the patient, the caregiver or other situational or structural factors. One-day psychoeducation sessions have been said to be a stepping stone rather than a complete intervention but due to the lack of resources in communities, one-day sessions bring significant changes.

According to the **predominant focus of psychoeducation**, it can be compliance/adherence focused, illness focused, treatment focused, and rehabilitation focused (Sarkhel et al., 2020).

According to who **provides** the intervention, psychoeducation can be done by psychiatrists, clinical psychologists, counselling psychologists, psychiatric nurses, occupational therapists, psychiatric social workers, dietitians, or lay people with experience or training.



Psychoeducation can be provided in a variety of **settings**, including hospitals (can be outpatient or inpatient), jails, the military, schools, businesses, career centres, mental health centres, and even over the Internet using chat rooms/ discussion groups or individual contact. Both

online and onsite interventions are effective at improving emotional health as they reduce the level of anxiety, depression, and sense of caregiver burden. (Karagiozi et al., 2021).

According to the **target population**, psychoeducation can be individual, family, group, or community-based.

Group Psychoeducation (Sarkhel et al., 2020)

This typically includes patients who share similar types of illnesses. Therefore, groups may be made up of individuals with conditions such as bipolar disorder, schizophrenia, substance abuse,



and so on. It is not ideal to create a group that consists of members with various kinds of illnesses. Groups generally contain 4 to 12 participants, with 8 being the ideal number. The number of sessions can range from 5 to 24, with the best number being guided by research and practical experience. The availability of resources, including time and staff, may often

result in adjustments to the session count, even though the key topics to be addressed for each disorder remain consistent. Typically, sessions last between 40 and 60 minutes and are predominantly conducted weekly. The ideal timing and frequency of these sessions facilitate a better understanding of the information that has been shared and discussed. Providing printed materials after each session that outline the main points in simple terms may be beneficial.

Family Psychoeducation (Sarkhel et al., 2020)

Family psychoeducation can be conducted within individual families or in groups that include multiple families with similar patient illnesses (multifamily groups). Family-oriented psychoeducation approaches can be highly beneficial in the Indian context, as most Indian patients live with their families, unlike their counterparts in the West. These family-based psychoeducation models have shown effectiveness in treating schizophrenia and bipolar disorder. Family psychoeducation is particularly crucial for managing severe mental illnesses during symptomatic

phases when patients often lack insight and may be hesitant to take their medications. It also plays a role in educating families about the early warning signs of relapse so they can recognise them and seek assistance as needed. The number and frequency of sessions can vary, but typically range from 6 to 12 weekly sessions. After a patient is discharged, follow-up sessions may be scheduled monthly.

The favourable results of studies indicate that for younger patients, it is essential to inform their parents or caregivers, even more than the patients themselves, to attain the intended outcome. (Sarkhel et al., 2020)

Community Psychoeducation

In community psychoeducation, information is communicated to a broad audience that may vary in characteristics, regardless of their health status or risk related to illness. The media play a significant role in supporting the psychoeducation process. Tools like video conferencing, debates, and tele-shows can assist this educational effort.

Status of Psychoeducation in India

India, as a developing country, faces a multitude of challenges in the mental health sector that span cultural, structural, and economic dimensions. One of the most significant barriers is the pervasive stigma surrounding mental illness, which often deters individuals and families from seeking help or engaging in mental health conversations. Mental health is still seen by many as a taboo subject, leading to denial, shame, and social exclusion of those affected.

Structurally, the delivery of mental health services in India is hindered by several factors, including limited access to care, especially in rural and remote areas, diverse linguistic and cultural contexts, low literacy rates, and stark socio-economic inequalities. These factors make the dissemination of psychoeducation particularly challenging. Additionally, the shortage of trained mental health professionals, the lack of integration of mental health into primary healthcare, and the insufficient infrastructure further limit the scope and reach of psychoeducational efforts.



Given these significant challenges, providing structured psychoeducation for or caregivers in outpatient clinics is unfeasible individually. In this regard, group psychoeducation seems more relevant and feasible. In India, a multilingual nation, language poses a significant obstacle to effective psychoeducation. It is necessary to create psychoeducational materials in various languages, considering cultural factors. (Yadav & Kar, 2011)

Despite these challenges, there have been notable strides in promoting psychoeducation nationwide. Several institutions and non-governmental initiatives are working to bridge the gap between mental health services and the communities needing them. For instance:

- NIMHANS (National Institute of Mental Health and Neurosciences) is pioneering mental health education, training, and outreach. It has developed modules for community-based interventions and offers programs to train caregivers and community health workers.
- The Banyan's Caregiver Interventions focus on empowering families and caregivers through structured psychoeducation, aiming to improve the home environment and reduce caregiver burden.
- VIMHANS (Vidya Sagar Institute of Mental Health and Neuro and Allied Sciences) runs various awareness and outreach initiatives to increase mental health literacy among different populations.
- SCARF (Schizophrenia Research Foundation) undertakes research-driven and community-based programs, integrating psychoeducation into rehabilitation and outreach services, especially for underserved groups.

Furthermore, the growing presence of digital mental health platforms and telepsychiatry services is slowly expanding the reach of psychoeducational resources, especially in underserved areas. However, to ensure widespread impact, there is a pressing need to localise psychoeducational content to cater to linguistic and cultural diversity and to develop sustainable, community-driven models that can be scaled across the country.

National Mental Health Policy

The National Mental Health Policy is a comprehensive framework launched in 2014 to improve mental health services and address the needs of individuals with mental illnesses. It emphasises a comprehensive, rights-based approach to mental health care, highlighting the importance of psychoeducation in addressing mental health challenges. It aims to promote mental health, prevent mental illness, enable recovery, and ensure socio-economic inclusion of those affected.

The policy puts forward some strategic directions and actions, effectively discussing comprehensive services for mental health problems that must be universally accessible.

Psychoeducation in India's Mental Health Policy

The NMHP recognises psychoeducation as a crucial component for:

- Reducing stigma: Increasing awareness and understanding of mental health issues among the public.
- Enhancing treatment adherence: Educating patients and families about mental illnesses and their management.
- They acknowledge the need to implement community-based programmes to support families and caregivers to foster recovery for persons with mental health problems and mental illness, and the family provides care and plays a critical role in promoting recovery.
- They also stress the formation of caregiver groups with professional inputs to facilitate a better and accurate understanding of the particular mental health problem their family member is living with



Overlap between other Modalities and Psychoeducation

In the Indian context, the study by Lamech et al. (2020) highlights that support groups for family caregivers of persons with dementia met critical information and emotional support needs. Caregivers particularly valued sessions led by specialists that provided practical knowledge about dementia care, while also benefiting from peer discussions that allowed emotional expression and mutual understanding. However, the findings also revealed that caregivers prioritised attending sessions where new knowledge was shared, suggesting that purely emotional support was insufficient without an educational component. This dual need demonstrates that effective caregiver interventions in collectivist and resource-limited settings like India should combine psychoeducation with peer support. Therefore, programs that integrate formal psychoeducation within a supportive group format are likely to maximise participation, meet the diverse needs of caregivers, and align better with cultural expectations of collective learning and support.

A primary distinction between psychoeducational and therapy groups is the incorporation of materials to convey crucial educational information to participants (Brown, 1998). Introducing these materials into the psychoeducational group creates a secure environment for clients to express their emotions and challenges and incorporates a strong educational aspect. Some examples of materials utilised in a psychoeducational group include informational sheets with statistics, videos, handouts, books, curriculum guides, and guest speakers. These resources allow clients to view statistics, read written examples, learn about others' recovery experiences, access study materials, and witness others sharing their journeys, including their struggles, successes, and



the consequences of their recovery. Such materials enhance participants' self-awareness regarding their decisions.

There is considerable overlap between psychoeducation and specific psychotherapies such as cognitive behavioural therapy (CBT), interpersonal and social rhythm therapy (IPSRT), and family-focused therapy (FFT) (Bond & Anderson, 2015). A research study examining group cognitive-behavioural therapy versus group psychoeducation in patients with acute schizophrenia found that there were no significant differences between the groups concerning re-admission rates, symptom severity, or medication

adherence. Nevertheless, on a descriptive basis, participants who underwent CBT generally had 21.8% fewer re-hospitalisations, spent 71 fewer days in the hospital, and demonstrated higher compliance ratings at the 24-month follow-up (Bechdolf et al., 2005).

In evidence-based PTSD treatments, psychoeducation usually kicks off the therapeutic process. It involves teaching clients about typical reactions to trauma and the challenges of adjusting afterwards, validating and normalising their experiences, and helping them recognise specific symptoms and coping strategies. It also brings to light any questions or misconceptions that might get in the way of their progress. The overarching aim is to boost their understanding of PTSD, foster more positive attitudes toward getting help, and reinforce the importance of engaging in treatment. This psychoeducational component will be built into the opening modules of Prolonged Exposure, EMDR, and trauma-focused cognitive-behavioural therapies (Ghafoori et al., 2016).

Psychoeducation vs. Therapy

Feature	Psychoeducation	Therapy (Psychotherapy)
Primary Goal	Increase knowledge and understanding	Promote emotional healing and psychological change
Content Focus	Facts about illness, treatment options, and coping skills	Emotions, thoughts, behaviours, relationships, and deeper self-reflection
Format	Workshops, classes, group sessions	One-on-one or group sessions with a licensed therapist
Duration	Short-term (e.g., single day or a few sessions)	Usually medium- to long-term (weekly sessions over months or years)
Participants	Individuals with illness and/or family members	Individuals, couples, or groups seeking emotional or behavioural support
Facilitator	Often educators, clinicians, or support workers	Licensed mental health professionals (e.g., psychologists, counsellors)
Examples	Family education session on schizophrenia	Cognitive Behavioral Therapy for depression/ REBT/ DBT/Others
Approach Type	Educational and informative	Therapeutic and emotionally explorative
Level of Depth	Surface-level understanding and practical tools	Deep exploration of internal experiences and healing

Commonalities

Both psychoeducation and therapy are vital components of mental health care. They aim to support individuals living with mental illness and can often be used together to maximise benefit. Each fosters empowerment, self-awareness, and better coping skills, but they differ in depth and focus. Psychoeducation provides a solid foundation of understanding, especially helpful for those newly

diagnosed or their families, while therapy delves into emotional processing and personal growth. Ultimately, both contribute to improved mental health outcomes and can reinforce each other in a comprehensive care plan.

Psychoeducation vs. Self-Help

Feature	Psychoeducation	Self-Help
Primary Goal	Provide structured information and guidance about mental health	Empower individuals to manage their mental health independently
Content Focus	Education about diagnoses, treatments, and coping skills	Personal growth, emotional resilience, and habit change
Format	Delivered in group classes, workshops, or sessions	Books, apps, online forums, videos, journals
Facilitator	Trained professional or clinician	Self-guided; no formal facilitator
Audience	People with mental illness and/or their families	Anyone seeking improvement in mental or emotional well-being
Interaction	May involve group discussion, Q&A, or peer support	Primarily solo, but may include communities (e.g., online groups)
Structure	Usually follows a curriculum or specific modules	Flexible, customisable by the individual
Evidence Base	Often based on clinical research and best practices	Varies widely—from evidence-based to anecdotal
Examples	Family education on bipolar disorder; relapse prevention sessions	Reading <i>The Power of Now</i> , using a meditation app like Headspace

Advantages and Limitations of Psychoeducation

Advantages of Psychoeducation in the Indian Context

- Conducting psychoeducation for caregivers helps them better understand the condition, leading to more effective support and reduced stigma. It improves communication, reduces caregiver stress, and strengthens the treatment process. Informed caregivers are more likely to participate actively in recovery and relapse prevention.
- It also helps to avoid inappropriate behaviours and enhance self care in both caregivers and person with mental illness.
- Cultural Relevance in a Collectivist Society:
 - In India's collectivist culture, where family and community play a central role, psychoeducation serves as a valuable tool that empowers not only individuals but also their families and broader social networks.
 - By providing shared knowledge and skills, it encourages collective responsibility for mental health care and enhances collaborative support systems.
- Stigma Reduction Through Group Learning:
 - Group-based psychoeducational interventions create a safe and normalised space for discussing mental health, helping to dismantle taboos and dispel myths.
 - Open conversations within a group challenge deeply rooted societal stigma, making mental health discourse more acceptable.
- Alignment with Social Values:
 - The interactive nature of group sessions resonates with Indian values of interconnectedness and mutual support.
 - This cultural compatibility makes participants more receptive to the intervention, enhancing engagement and willingness to share personal experiences.
- Practical and Economic Efficiency:
 - Given the shortage of mental health professionals and infrastructure in India, psychoeducational groups offer a cost-effective solution to reach more people.
 - They require fewer resources than individual therapy, making them scalable and sustainable for long-term mental health promotion.

Evidence-Based Advantages of Psychoeducational Groups

- Cost-Effectiveness Over Traditional Therapy:
 - Geist et al. (2000) compared psychoeducational groups to family therapy and found both led to positive outcomes, but the psychoeducational approach was significantly less expensive, making it a more practical choice for widespread implementation.
- Impact of Brief Interventions:
 - McEvoy et al. (2019) demonstrated that even a short, two-session psychoeducational program resulted in measurable, lasting improvements, outperforming a control group in terms of patient outcomes.
 - Spettigue et al. (2015) found that a single, two-hour session conducted by a psychiatrist increased parents' understanding of eating disorders and enhanced their confidence in caregiving—showing that even minimal exposure to psychoeducation can lead to meaningful change.

Advantages for Patients

- Improved Understanding and Awareness:
 - Psychoeducation provides patients with clear, accessible information about their mental health conditions, including symptoms, treatment options, medication side effects, and early warning signs of relapse.
 - This knowledge reduces confusion and empowers individuals to take an active role in their recovery.
- Reduction in Fear and Stigma:
 - By clarifying the nature of mental illness, psychoeducation decreases internalised stigma and self-blame.
 - It fosters a sense of control, improving self-esteem and confidence in managing one's condition.
- Enhanced Social Functioning:

- Patients often experience better communication skills, stronger interpersonal relationships, and smoother reintegration into their social and community environments.
- Economic Empowerment:
 - As patients become more informed and functional, they are more likely to regain independence and return to work or education.
 - This reduces long-term dependency on institutional care and associated costs.
- Clinical Benefits:
 - Increased understanding leads to better treatment adherence, proactive self-monitoring, and a reduction in relapses.
 - It promotes self-help among the caregivers and patients.
 - These improvements support a more stable and sustainable recovery process.

Advantages for Family Caregivers

- Emotional Relief and Clarity:
 - Psychoeducation addresses caregivers' emotional challenges by reducing feelings of helplessness, anxiety, and confusion.
 - It provides them with a sense of direction and purpose in their caregiving role.
- Skill Development and Confidence Building:
 - Caregivers gain practical tools such as effective communication techniques, problem-solving skills, and emotional regulation strategies.
 - This enhances their confidence and competence in supporting their loved one.
- Social Support and Reduced Isolation:
 - Participation in group programs allows caregivers to connect with others facing similar challenges, fostering a sense of belonging and mutual understanding.
- Economic Resilience:
 - By equipping caregivers with tools to handle crises effectively, psychoeducation can prevent unnecessary hospitalisations and reduce time off work.
 - This contributes to greater financial stability for families managing long-term care.
- Clinical Collaboration:

- Educated caregivers are better equipped to support medication adherence and identify early signs of relapse.
- Their active involvement can significantly improve the continuity and effectiveness of care.

Advantages for Mental Health Professionals and Systems

- **Strengthened Therapeutic Alliance:**
 - Psychoeducation facilitates better collaboration between professionals, patients, and families by promoting transparency and shared understanding.
 - This improves trust and communication, which are critical for successful long-term treatment.
- **Improved Clinical Outcomes:**
 - When patients and caregivers are well-informed, they are more likely to adhere to treatment plans and follow up consistently.
 - This leads to reduced relapse rates and improved overall outcomes.
- **Efficient Use of Healthcare Resources:**
 - Psychoeducation can decrease the need for emergency care and hospital readmissions by promoting early intervention and ongoing self-management.
 - This optimises resource allocation in an already burdened mental health system.
- **Social Impact and Public Health Promotion:**
 - Widespread psychoeducational efforts contribute to greater mental health literacy in communities.
 - They support stigma reduction and align with broader goals of community-based, preventive mental healthcare.
- **Long-Term Economic Benefits:**
 - When integrated into standard treatment, psychoeducation leads to cost savings by reducing the frequency and duration of hospital stays.
 - It supports the shift toward more sustainable, community-oriented psychiatric rehabilitation models.

Advantages of organisations like Ekalvy Foundation for Mental Health

India reports 10.5% prevalence of mental health disorders in all age groups and an 84.5% treatment gap, which needs immediate attention (National Mental Health Survey, 2016). It has also been reported that there are only 0.3 psychiatrists per 100,000 people, 1.5 clinical psychologists, and two psychiatric social workers per 100,000 people, which is very insufficient for a country that is the world's most populous. It is reported that there are 90%, 97%, and 77% deficits of psychiatric social workers, clinical psychologists, and psychiatrists, respectively (Hans & Sharan, 2021). This is where community volunteers and organisations come in. The WHO developed the model of the Service Organisation Pyramid for an optimal mix of services to integrate mental health care into the primary healthcare system. This model is based on the principle that any single service setting cannot meet the mental health needs of the entire population. Support, supervision, collaboration, information-sharing and education across the different levels of care are the prime pillars in this system.

Organisations like Ekalvy Foundation for Mental Health come in cases like this. They



believe that most persons with mental illness and their family members are without any support, without periodic meetings or consultations with psychiatrists/ treatment providers. These support groups provide practical information and skills from people with similar issues. These meetings offer opportunities for time-to-time interaction and learning from other group members. This platform provides the opportunity for sharing, ventilation, learning skills,

cultivating hope, imbibing a positive attitude, etc. This provides individuals with mental illness with community support as well as primary care that they might not always have access to. Such interventions are accessible, structurally, as they can be done in local languages and multiple settings, catering to the needs of the community while being economically accessible.

Mental health needs do not end with a single session. Information alone, while important, is not always enough. People benefit most when learning is followed by connection, reflection, and

continued support. Ekalavya recognizes this. While it offers focused 1-day programs that provide valuable knowledge and tools to individuals, families, and communities, its approach does not stop there. What makes Ekalavya's model more meaningful is the space it creates after the program, through support groups that meet regularly, allowing participants to continue learning, sharing, and growing together.

Why It Matters

- Psychoeducation is a starting point. Support groups keep the conversation going.
- One-time programs can raise awareness, but regular meetings build trust, reduce isolation, and allow for long-term engagement.
- Many people struggle to access mental health care consistently. These groups offer a free or low-cost bridge, a place to check in, ask questions, and stay connected.

Evidence from Indian initiatives, such as the support group evaluated by the Schizophrenia Research Foundation (SCARF) in Chennai, further emphasises this need. Their caregiver support group for families of persons with disorders showed that combining psychoeducation with peer-led emotional support can meet multiple caregiver needs, including information, coping skills, and emotional resilience. Members reported that regular meetings allowed them to share experiences, ventilate emotions, and learn practical caregiving skills, fostering a sense of hope and empowerment in managing long-term mental health conditions.

Limitations of Psychoeducation

There are no identified or studied dangers of psychoeducation when presented correctly; however, improper delivery can result in various problems, such as:

- Not a replacement for therapy: While psychoeducation is beneficial, it cannot substitute the need for individualised therapy or professional care if necessary.
- Varying Effectiveness: The effect of psychoeducation may vary depending on your level of engagement and the quality of the information provided.
- Not a personalised approach: General information may not address your unique situation or requirements, potentially omitting crucial details. Overreliance on educational resources can sometimes hinder your pursuit of tailored help when needed.

- Risk of Misuse: Inaccurate or insufficient information can result in self-diagnosis or ineffective self-treatment if not derived from or discussed with a professional. With reliable professionals.
- For many new patients, attending a 1-day psychoeducation program can feel overwhelming due to the amount of new information shared in a short time. However, access to well-chosen reading materials or bibliotherapy resources can help participants revisit key concepts at their own pace, reinforcing learning and reducing the sense of overload.



Caring for Yourself through Psychoeducation

Psychoeducation is not just about sharing knowledge, it's about supporting people to live more informed, meaningful, and manageable lives with mental health challenges. Psychoeducation plays a vital role in empowering individuals by helping them understand their mental health conditions, available coping strategies, and the broader context of recovery. When people gain accurate, relatable, and culturally relevant information, they begin to make sense of their experiences, often reducing fear, confusion, and stigma.

This understanding fosters a sense of ownership and agency, encouraging individuals to take active steps in their own well-being. Rather than feeling dependent or passive, they begin to identify what they can do for themselves, from recognizing early warning signs to setting small goals or communicating their needs to others.

As people grow more confident and informed, self-help naturally follows. They start applying strategies learned during psychoeducation sessions, such as journaling, relaxation techniques, or behavior tracking, to manage their emotions and daily routines. Similarly, self-care practices become more intentional, as people recognize the importance of rest, boundaries, and meaningful activities in sustaining mental wellness.

In this way, psychoeducation is not only about transferring knowledge, it is about building the foundation for long-term resilience and self-directed recovery. When caregivers, individuals, and communities understand mental health better, they are more equipped to support one another and themselves with compassion and clarity.

The Schizophrenia Research Foundation Intervention Schedule (Shankar & Menon, 1993)

The study by Shankar and Menon (1993) presents a culturally grounded framework for family-based interventions in schizophrenia care, developed by the Schizophrenia Research Foundation (SCARF) in India. Recognising the critical role families play in the Indian context—due to both cultural norms and the scarcity of mental health resources—the authors designed an eight-module intervention schedule addressing core areas such as symptom and medication management, relapse prevention, social challenges (e.g., marriage, employment), and caregiver support. Interventions are delivered in a flexible, needs-based format, with three levels of involvement ranging from passive information sharing to active family–client collaboration and self-help initiatives. The approach emphasises cultural sensitivity, avoids pathologising family dynamics, and seeks to optimise the existing strengths of families while reducing caregiver burden. Case illustrations demonstrate how the model adapts to diverse socioeconomic and educational backgrounds. This framework represents an important step toward scalable, community-based psychiatric rehabilitation in low-resource settings.



The fundamental conceptual frameworks are detailed below: (as given by Shankar & Menon, 1993)

- The onus of care for people with serious mental illness must continue to rest with the family.
- There is no attempt to blame families either for the causation of the disease or for relapse. There is a concerted effort to acknowledge the meaningful role that families have to play.
- Interventive inputs are offered to strengthen the positive role that the family plays in the care of their ill relative.
- Interventive inputs attempt to be sensitive to families' needs wherever feasible. This is particularly crucial in fiscal assistance and employment, where prevailing socioeconomic realities will likely determine the quantity and quality of inputs to be offered.
- Packages of intervention may not be appropriate given the wide disparities in education, expectations of families, and, more importantly, the disabilities of the client.

- In-depth interventions cannot be offered to all families, given the paucity of manpower and the unwillingness of families to participate in interventions that could disrupt their daily schedule.
- The family intervention effort is to be integrated with the total rehabilitation objective for the client and is not to be viewed in isolation from this goal.
- Planning the intervention systematically is as crucial as the actual implementation process because it should incorporate the three-dimensional perspective of the client, the family and the professional.

The Intervention Framework

SCARF developed an 8-module family intervention schedule tailored for urban, community-based, non-residential settings. It includes:

1. Aetiology, symptom identification & management
2. Relapse identification & prevention
3. Medication management
4. Managing specific behavioural problems (e.g., violence, suicide risk)
5. Marriage, pregnancy & childbirth concerns
6. Family support services (child education support, leisure, self-help groups)
7. Employment assistance (vocational guidance, job placements, cooperatives)
8. Realistic goal setting

Planning and Implementation

- A three-stage process:
 1. Identify a key family participant.
 2. Prioritise needs based on family input.
 3. Choose an appropriate intervention level:
 - Level 1: Basic info & support (passive involvement)
 - Level 2: Active family–client interaction support (moderate involvement)
 - Level 3: Promote self-help and family-led initiatives (high involvement)

Sample Session Plan (1-Day Program)

Loosely following the comprehensive model of psychoeducation:

The session plan can be flexible depending on the person with mental illness, the caregiver, their needs, etc. Hence, it does not follow a rigid structure, but this is a sample structure made using research evidence.

Audio-visual materials like PPTS and video clips help keep individuals engaged.



Screening of Participants

A screening can assess the fit of the participants to be in the program, which can be done through interviews (written/verbal) or referrals from professionals.

Beginning Stage

- Warm-up to the group/Rapport building (10-15 mins)
 - The facilitator could conduct a small/simple activity to set the mood for the day.
 - It can be movement-based, written, art-based, or vocal, depending on the population type and the group's purpose. (Jacobs, E., Schimmel, C. J., Masson, B., & Harvill, R. (2021). *Group counseling: Strategies and Skills*. has extensively talked about conducting groups, which can be referred to.)
- The purpose of the group and the flow of the day can be explained to the participants.

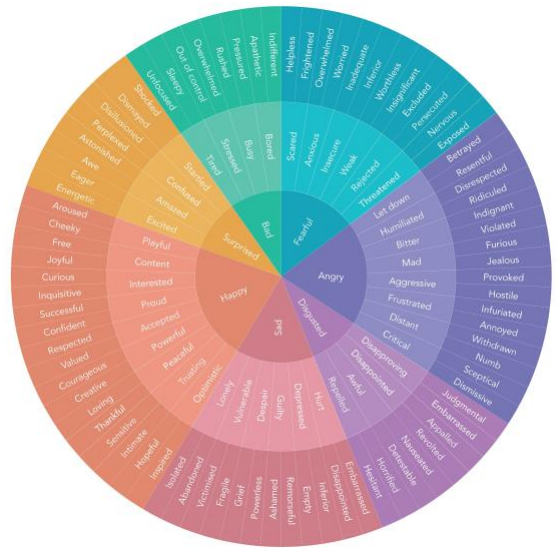
Working Stage

- First Session:
 - The first session can start here with 'Understanding the Disorder', explanation of the disorder, the aetiology, factors (precipitating, predisposing and perpetuating) associated with the course and the outcome of various mental disorders, signs and symptoms of mental disorders, etc.
 - The specific mental disorder would be targeted that the individuals have in common. If it's a mix of people with various disorders, topics of coping skills and emotional regulation, cognitive-behavioural strategies, medication education, relapse prevention, communication skills (assertiveness, conflict resolution, active listening), self-care and wellness planning, etc., would be more appropriate.

- Break
- Second Session:
 - In the second session, an activity can be done to energise the participants and keep them in the here and now.
 - This can be followed by a video/clip screening related to the day's topic and a group discussion.
 - The visual material would help keep the participants engaged and evoke insights within them.
 - Here, a group discussion can be done so that it does not feel like an academic lecture and gives the participants the power to discuss their opinions.
 - The facilitator can evoke discussions by bringing in topics and linking people's words.
 - This can end in summarising the discussion and pointing out important points that the participants bought, giving them a feeling of universality and commonality, which becomes of grave importance.
- Lunch Break
- Third Session
 - The third session can again go back to being a 'lecture-oriented' part where the facilitator explains aspects of how to act as a responsible person, how to cope with the situation, and when and whom to seek treatment, dos and don'ts to family members while handling a patient at home, dispelling off stigma, prejudices, misconceptions and negative attitudes to mental illness and patients, etc.
- Break
- Fourth Session
 - This session can specifically focus on the caregivers where they receive empathetic engagement, coping strategies, learn problem-solving skills, enhancement of their like-minded social network, clinical aid, and allied resources during an emergency, etc.

Closing Stage

- For the closing face, a summarisation of what was discussed can be done, which would help everyone be on the same page.
- Resources can be shared with the participants that they might require during emergencies.
- Resources regarding pamphlets and study material related to the day's discussion or related topics relevant to the individuals can be shared.
- A short check-in on how everybody is doing would be a good end to the psychoeducation session, a feeling wheel can be used.



Community Roll-out Guidelines

How to Launch a Community Psychoeducation Program: A simple structure you can use:

Step	What to Do
Step 1: Build a small core team	1–2 mental health professionals + volunteers
Step 2: Identify the target group	Families? Patients? Schools? Rural women?
Step 3: Find a space	Community centre, local NGOs, school, panchayat hall, even online
Step 4: Prepare simple material	PPTS, handouts, videos in the local language
Step 5: Promote	Word of mouth, posters, WhatsApp groups
Step 6: Conduct a session	Icebreakers → Main Content → Activities → Feedback
Step 7: Collect feedback	Short form: What worked? What didn't?

Recommended Materials

International research papers/ manuals on psychoeducation

- Family Psychoeducation Toolkit – Substance Abuse and Mental Health Services Administration (SAMHSA, USA)
- CBT-Based Psychoeducation Workbooks – Centre for Clinical Interventions (Australia)
- NAVIGATE Program – Coordinated Specialty Care for First-Episode Psychosis (USA)
- Coping with Voices – Hearing Voices Network (UK & International)
- “Managing Mental Health” – MIND (UK)
- World Health Organization (WHO) – Mental Health Gap Action Programme (mhGAP)
- Pekkala & Merinder (2002), Psychoeducation for schizophrenia. *Cochrane Database Syst Rev.* 2002;(2):CD002831.
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Research papers on psychos education in India

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Other recommended materials

- Sarkhel, S., Singh, O., & Arora, M. (2020). Clinical Practice Guidelines for Psychoeducation in Psychiatric Disorders General Principles of Psychoeducation. *Indian Journal of Psychiatry*, 62(8), 319. https://doi.org/10.4103/psychiatry.indianjpsychiatry_780_19
- SAMHSA has many valuable psychoeducational materials available for download, or hard copies can be ordered. Many are available free of charge at <http://store.samhsa.gov/home>
- NIMH has many other valuable psychoeducational materials on schizophrenia available at <http://www.nimh.nih.gov/health/topics/schizophrenia/index.shtml>.



- NAMI Family-to-Family Education Program is a free, 12-week course for family caregivers of individuals with severe mental illnesses.
 - Jacobs, E., Schimmel, C. J., Masson, B., & Harvill, R. (2021). *Group counseling: Strategies and Skills*, has guidelines for conducting groups in general and specific requirements of different kinds of populations.
 - The UK National Health Service Cheshire and Merseyside Rehabilitation Network has produced helpful psychoeducation videos. It can

be used to educate clients on issues of fatigue, memory, anxiety, and even the consequences of an injury.

Audio-Visual Material

- Dr. Badamath’s video on Psychoeducation: <https://youtu.be/E6uyZavKVLU>
- SAMHSA’s Family Psychoeducation Evidence-Based Practices: https://youtu.be/68oBIF_5Aqs

- Department of Mental Health Education NIMHANS, YouTube Channel
- Podcasts serve as a valuable resource for psychoeducation since clients can listen at their convenience and share them with friends and family interested in understanding a new diagnosis and the right approach to care.
- The Anxiety Podcast by Tim JP Collins and the Trauma Therapist Podcast are helpful podcasts.
- TED-Ed has videos on various psychological phenomena that can be used: <https://www.youtube.com/@TEDEd>.
- Psychiatry.org for more information that can be referred to.
- <https://www.therapistaid.com/tools/education> has various tools like videos, worksheets, and interactives that can be used.
- <https://www.psychologytools.com/professional/techniques/psychoeducation> again, has multiple resources that can be referred to clients.



Psychoeducation Insights from Patients and Caregivers

Extracted from Ekalavya Vartapatra – April to June, July to Sept and Oct to Dec 2024 (Marathi)

“In Marathi there is a saying that blind man asks for one eye but god grants him two. At that moment what will be his state of mind, th is what I am experiencing now on 29 May, two months after attending Ekalavya's one day session for caregivers held on 23 March 2024.”

- caregiver J

“The reason behind all of this was my participation in Eklavya's programme and the bond I developed with Eklavya. I truly hope that both my subhankar and I continue to grow and change for the better. Living together, we've gained the confidence to embrace change within ourselves more easily. We've received support from many people, but the most important thing has been being with person with mental disorder and feeling a sense of empathy.



Being part of self-help groups has awakened a deep realization in us—we are not alone.”

- caregiver Sister

“Your Eklavya group has done a great deal of meaningful social work—thank you! I had the opportunity to personally interact with Prof. Dr. Anil Vartak, and under his guidance, certain concepts became easier to understand. I also read literature by Dr. Abraham Lo, as well as a booklet by Prof. Dr. Anil Vartak. Regular online meetings helped keep our ideas consistent and focused. Writing in a diary brought clarity to my thoughts. Today, I am self-reliant—thanks to self-help groups, the support of my family, expert guidance, and the strength of community.”

- Sanyogita

“The training programme gave me the confidence to express myself. I’ve decided to attend self-help group meetings regularly. I understand that this journey will take time—person with mental disorder and I won’t be ready overnight—but we will keep trying. The information and experiences I gained at the programme changed my perspective toward people living with mental illness. I found support, and more importantly, I found hope. Many heartfelt thanks to the Eklavya Foundation. I am especially grateful to Dr. Rukdikar sir—because of you, a ray of light has entered our lives!”

- A caregiver

“Hope emerged from the training programme organized by Eklavya. It gave us the belief that both we and person with mental disorder could come out of this situation. The programme also provided a platform for both caregiver and person with mental disorder through self-help groups, which felt very supportive. Dr. Rukdikar shared valuable information about the illness. I had many questions, and I received clear answers. caregiver learned how to take care of himself and how to support and care for person with mental disorder. We also received practical guidance on treatment methods. One of the most important realizations from the programme was the need to track person with mental disorder's behavioral changes, administer medication on time, maintain full trust in the doctor, and monitor progress—because all of these are essential for person with mental disorder’s improvement.”

- A caregiver

“The caregiver training programme was incredibly helpful in deepening our understanding. What matters even more is that the person with mental disorder now speaks openly with Vartak Sir and Smita tai about his concerns, and he feels truly supported by them. He accepts their guidance with trust. That’s why we feel that the Eklavya organization has become an integral part of our lives.”

- A caregiver

“The programme held on June 29th gave us many hopeful answers. Both caregiver and person with mental disorder found a platform where they could express themselves freely. The fear that we were alone in this crisis has disappeared. Be assured, there are many people standing with you.”

- Nilima

FAQs with an Expert

To bring in an expert perspective, we posed a few frequently asked questions to Dr. Arun Rukadikar. Here's what he had to say.

1. Is it appropriate to conduct psychoeducation sessions for individuals with different diagnoses together (e.g., substance use disorders, intellectual disabilities, mood disorders)?

→ Yes. The professionals interviewed stated that combining patients with different diagnoses like schizophrenia, mood disorders, and substance use disorders was not only feasible but reflective of real-world clinical complexity. In fact, they found that many individuals with substance use disorders had underlying psychiatric conditions, and addressing them together helped in holistic understanding. However, exceptions were made for individuals with intellectual disabilities and autism due to difficulties in comprehension. In those cases, such participants were sometimes included for others to learn how such disorders manifest rather than for direct educational benefit.

2. What challenges arise when delivering psychoeducation in a group that includes individuals with varying levels of insight, literacy, or cognitive ability?

→ Initially, participants with lower literacy or cognitive ability may struggle to grasp concepts. However, the professionals emphasized that psychoeducation delivered over several weeks (e.g., 6-8 weeks with 30-40 sessions) allowed insights to deepen. Caregivers often understood information earlier and supported patients' learning. Some uneducated participants were found to comprehend and answer questions effectively, showing that formal education was not a prerequisite for benefiting from psychoeducation.

3. Could mixed-group psychoeducation work better if caregivers (rather than patients) are the primary participants?

→ Yes. In practice, Monday sessions were exclusively held for caregivers, allowing more open and detailed discussions without the patients present. This separation helped family members discuss issues more freely and understand how to support the patient better. Caregivers were also able to reinforce lessons with patients later on.

4. Does psychoeducation have universal elements that benefit individuals across different psychiatric conditions?

→ Yes. Interviewees consistently identified themes like improving mental health literacy, understanding relapse prevention, and quality of life as universally applicable. They emphasized environmental factors, especially family environment, and reducing high expressed emotions as key elements that benefited all patients, regardless of diagnosis.

5. Are themes like stigma, medication adherence, and family involvement relevant regardless of diagnosis?

→ Absolutely. These themes were described as foundational. Stigma was compared to medical illnesses like appendicitis to normalize mental illness. Medication adherence and family involvement were emphasized as universally critical, and relapse prevention was discussed in every group. Professionals insisted these themes be integrated into every psychoeducation session.

6. Is a tiered psychoeducation model (e.g., shared introductory session, followed by condition-specific modules) a feasible structure?

→ Yes. The idea of tiered psychoeducation was appreciated. The professional explained that initial sessions could be shared among all diagnoses, followed by condition-specific groups. Insight develops progressively, and this model helps participants understand common issues first before delving into disorder-specific knowledge. This method was also considered practical in settings with frequent comorbidities.

7. In low-resource or rural settings, do you think combining psychoeducation groups makes sense from a feasibility standpoint?

→ Yes. Group psychoeducation was deemed more cost-effective and sustainable than individual therapy in rural or resource-poor settings. The psychiatrist mentioned charging as little as Rs.10-100 per session to keep it accessible. Given the shortage of professionals in India, such combined sessions were strongly advocated.

8. Can psychoeducation be conducted for people at different stages of their illness together?

→ Yes. There was no differentiation in group settings based on illness stage, whether acute psychosis or chronic schizophrenia. However, individual and family sessions were tailored accordingly. Professionals believed that shared learning among patients helped normalize experiences and was not detrimental.

9. What are your views on combining sessions for caregivers and patients?

→ Combined sessions were generally encouraged. Early resistance or emotional reactions were expected, but over time, both caregivers and patients benefited from shared discussions. Professionals ensured neutrality to avoid perceptions of bias. Separate sessions were also used when needed to address sensitive issues.

10. Do you think it could have any deteriorating effects?

→ Rarely. One concern was the development of 'insight-related depression' where patients become temporarily depressed after gaining insight into their condition. However, this was usually short-lived and manageable through continued group or individual therapy. On balance, the benefits outweighed the risks. Even Dr. Suresh Badamath video on psychoeducation clearly says that there are no documented risks of psychoeducation session.

11. Do you think such sessions can be fully conducted by lay volunteers?

→ Yes. The professionals were strong proponents of training lay volunteers to deliver psychoeducation. One long-serving lay counselor worked over 20 years effectively. They emphasized that traits like empathy and dedication were more important than formal qualifications, and that the mental health professional workforce alone is insufficient to meet demand.

12. Would that be an acceptable plan to professionals?

→ Some professionals may not prioritize psychoeducation due to lack of financial incentive, but interviewees argued that acceptance by professionals should not be a barrier. They advocated for community-led and peer-led efforts regardless of professional endorsement.

13. Do you think ongoing psychoeducation sessions (such as 8-10 sessions) are better or single-day programs are better, especially in the Indian context?

→ Ongoing sessions were preferred for deeper understanding and habit formation. Single-day programs were useful for initiation or awareness-building. The professionals strongly supported support groups and self-help networks for sustained impact.

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Acknowledgement

This manual is the result of many conversations, shared experiences, and collective efforts.

I would like to express my sincere gratitude to the caregivers, individuals, and families who participated in the Ekalavya Foundation's training programs and generously shared their insights and reflections in the Newsletter.

I am deeply thankful to Dr. Anil Vartak Sir, whose guidance, encouragement, and thoughtful insights supported the development of this manual at every stage. His clarity of thought, grounded perspective, and deep commitment to community mental health shaped not only the content of this work, but also its spirit and intention. Whether through detailed feedback, reflective conversations, or simply by holding space to think through complex questions, Dr. Vartak's presence has been a steady and meaningful influence throughout this process.

To my colleagues, mentors, and collaborators at Ekalavya Foundation who contributed to the design and facilitation of these sessions over time. Their inputs, both practical and thoughtful, have informed this manual in important ways. Their continued commitment to accessible, community-rooted mental health support.

I also thank Dr. Arun Rukadikar who was more than willing to contribute to the manual and provide us with his very valuable insights after working for more than 50 years in the field. His thoughts not only helped kickstart this manual but also gave us answers to many unanswered questions.

To Sabu Sir, who so willingly and generously wrote one of the forewords for this manual. Beyond this kind gesture, I remain deeply grateful to him as a teacher whose classes and guidance played a formative role in shaping my understanding. Much of the thinking and content within this manual draws inspiration from the foundations he helped lay during my time as his student.

I am also truly grateful to Ms. Rutuja Dixit, who supported the creation of this manual in countless ways. Her involvement went far beyond technical or logistical help, she offered steady encouragement, thoughtful input, and consistent support at every stage of the process.

Lastly, I remain grateful to the many unnamed individuals who contribute every day to making mental health care more compassionate and inclusive, often quietly, but always meaningfully.

Understanding | Supporting | Empowering

Psychoeducation is more than just sharing information. It can offer space for understanding, support, and practical ways to cope and grow.

This manual brings together key ideas and approaches for planning and conducting psychoeducational sessions with individuals, families, and communities. It includes concepts drawn from research, clinical work, and lived experience, with the aim of offering a useful resource to students, caregivers, mental health professionals, and community workers.

Inside, you'll find essential topics, sample plans, and reflections from people who have participated in psychoeducational programs. Whether you are beginning to explore this area or looking to build on what you already do, this manual is meant to support everyday practice in simple, thoughtful, and realistic ways.



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