

Effects of Family Psychoeducation on Family Members of Patients Suffering from Schizophrenia at Psychiatric Emergency Wards

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ABSTRACT

Research Purpose

The purpose of this study, targeting family members of patients suffering from schizophrenia at psychiatric emergency inpatient wards (henceforth, psychiatric emergency wards), was to focus on the family members' perspective regarding the psychoeducation they received during the hospitalization of the patient and shed light on its effects.

Research Method

Semi-structured interviews were conducted with family members of patients with schizophrenia admitted to an emergency psychiatric ward regarding the effects of the psychoeducation both the patients and they received. The content of the interviews, recorded using a voice recorder, was transcribed verbatim, and then analyzed using the inductive qualitative method.

Results

The interviewed family members comprised seven families (two mothers, three fathers, and two sets of parents) ranging in age between their 50s and 70s. The average length of an interview was 38 minutes (ranging from 23 to 62 minutes.) In addition to four main categories, 15 sub-categories were selected from 71 analysis codes such as [Changes in awareness due to a better understanding of symptoms,] [Better understanding of the effects of and need for the medication,] [Utilizing dialogue to increase understanding of the condition of the illness,] [Improving the dialogue between the patient and his/her family,] and [Sharing steps to prevent recurrence.]

Conclusion

This study examined the family-patient psychoeducation based on four categories, namely, <Encouraging understanding toward the patient,> <Changes in approach brought on by a sense of security,> <Newly developed relationships among family members and the patient,> and <Improved quality of family life> as well as 15 sub-categories. The effects of this education were found to include an improvement in awareness of the illness and coping strategies, a gained sense of security, and a reduced sense of burden.

Key Words

psychiatric emergency ward, schizophrenia, family-patient psychoeducation

Introduction

Schizophrenia is a progressive illness whose symptoms include positive symptoms (hallucinations and delusions), negative symptoms (decreased motivation and activity level), and cognitive impairment (decreased memory and judgment). Patients suffering from schizophrenia appear to find it extremely difficult to gain insight into the illness and may experience repeated recurrences and hospitalization when they stop taking their medication (Okuma et al., 1970)[1]. In recent years, however, the psychiatric treatment of schizophrenia has combined the use of psychoeducation, namely cognitive behavioral therapy, along with medication. Psychoeducation here

includes psychosocial treatment whose aim is to increase the adherence to the medication and have the patient gain awareness towards his/her own illness (Gaebel.W, 1997)[2]. Psychoeducation can be conducted with the patient alone, with family members, or with both: however, the majority of the past studies have focused on the patient (Tsuge, 2008; Nakamura et al., 2008; Takasu et al., 2011; Shimizu et al., 2012)[3-6].

As Mushika (2003)[7] demonstrated, family members of a psychiatric patient admitted into care go through the stages of acceptance, namely, shock, denial, confusion, effort to problem-solve, and, finally, acceptance. Kato et al. (2009), meanwhile, suggested that families require information regarding the patient's condition, cause of

illness, treatment of illness, and patient care during hospitalization[8]. Furthermore, Fukui et al. (2004) showed that, when supporting family members of patients suffering from schizophrenia, it was most effective when that support included appropriate information, improved coping skills, and positively supported their experience[9]. It has also been illustrated that family psychoeducation in a psychiatric setting reduced the burden felt by the families and lowered the recurrence rate (Fukui et al., 2004; Fujita et al., 2006.) [9][10]. Iwasaki (1998) pointed out, however, that few of these families received appropriate support from psychiatric healthcare providers and, in reality, most of the families continued to provide care for their loved ones on their own while feeling that their knowledge and capacity were inadequate[11]. Amasa et al. (2005) also reported that families that succeed in connecting psychiatric patients with medical care were already suffering from a high level of fatigue and anxiety[12].

A psychoeducational program targeting both the patient and his/her family was implemented in 2011 as part of its family care procedure at the emergency psychiatric ward of a single-purpose psychiatric hospital we call B (henceforth B Ward), located in the Kansai region. Although nurses have given some positive feedback regarding the program, the effects of the program from the families' point of view are yet to be made clear.

Most of the past studies on family psychoeducation have focused on families of patients in long-term care (Inage et al, 2009; Kagawa et al., 2009; Sakanishi et al., 2010)[13-15]. As only a few studies have focused on the families of patients in an emergency ward or examined the effects of patient-family psychoeducation from the families' point of view, definite insight has not been obtained so far in this area. This research, therefore, aims to focus on the point of view of the family members of schizophrenia patients at psychiatric emergency wards regarding the patient-family psychoeducation and shed light on its effects.

I. Research Purpose

This research aims to demonstrate the effects of psychoeducation at a psychiatric emergency ward from the families' point of view and targets patients suffering from schizophrenia and their family members.

II. Significance of Research

Demonstrating the effects of the patient-family psychoeducation at a psychiatric emergency ward would significantly help in our effort to reduce the recurrence rate of the patients as well as the stress and anxiety of the family members. It is also expected that this research will contribute to improving the practical nursing capabilities in family care at psychiatric emergency wards.

III. Definitions of Terms Used

1. Patient-family psychoeducation

Psychoeducation refers to a program that provides appropriate and accurate information regarding the illness,

the effects and side effects of various medications, as well as how to cope with stress. It targets groups of schizophrenia patients and aims to increase the medication adherence and patients' awareness towards their own illness. To encourage patients to share their experience with the group, the program's approach is psychosocial with an added element of group dynamics. This research defines psychoeducation sessions that take place with both the patient and his/her family members present as "patient-family psychoeducation" (The patient attends four one-hour sessions of psychoeducation for one cycle, which is then followed by a session—approximately an hour in length—attended by both the patient and his/her family.)

2. Family

The family is defined as those who qualify for the patient-family psychoeducation, namely mothers, fathers, or both parents that reside with the schizophrenia patients.

IV. Research Method

1. Research method: Qualitative descriptive research
2. Research subjects: Seven families that participated in the patient-family psychoeducation while the patient was hospitalized for schizophrenia at the B Ward in the Kansai region.

1) Selection criterion: Family members living with a schizophrenia patient

2) Exclusion criteria: Families of patients who suffer from developmental or personality disabilities. Family members that appear to be mentally ill or developmentally delayed.

3. Research period: March to November 2013

4. Recruiting method:

Written consent to carry out the study was requested after the purpose of the study was thoroughly explained to the representatives of the facility as well as the managers of the ward. After consent was obtained, the representatives of the facility as well as the managers of the ward, including attending physicians and head nurses, were asked to select the research subjects. We then informed each subject, orally as well as in written form, about the protection of his/her privacy, the guarantee of anonymity, voluntary nature of his/her participation, and careful handling of transcribed verbatim records. Those who consented were then included in the study as subjects.

5. Data collection method:

1) General attributes:

General attributes included age, sex, and family structure.

2) Semi-structured interview method:

Interviews were conducted in a semi-structured fashion.

a. Interview description: After taking into account the existing references, the researchers formulated four questions for the interview as an interview guide. After the consent of the interviewee was obtained, the interview was recorded using a voice recorder, or notes were taken. A verbatim written transcript was then produced.

Approximately 30 minutes per session.

Table 1 Attributes of Research Subjects

	A	B	C	D	E	F	G
Age	60s	60s	60s	60s	70s	50/60s	60s
Relationship	Mother	Father	Father	Mother	Parents	Parents (Mother50s, Father60s)	Father

Interview guide

- Have there been any changes in the way you feel or the way you deal with the patient after going through the patient-family psychoeducation.
- What did you think was useful about participating in the patient-family psychoeducation (regarding the illness, progression and treatment of illness, medication, and recurrence prevention.)
- What did you think was useful about participating in the patient-family psychoeducation with regard to the positive impact on the way your family relates to the patient?
- Have there been any changes in your own daily life after going through the patient-family psychoeducation?

b. Interview time:

6. Method of data analysis

The data obtained through semi-structured interviews were transcribed verbatim. In order to understand the perspective of the family with regard to the effects of the patient-family psychoeducation at a psychiatric emergency ward, statements related to the effects of the program were subsequently extracted, summarized, and codified. According to the similarities within each individually named code, sub-categories were created. The research followed the methodology of the inductive qualitative method. Researchers repeatedly performed member checks among them and were supervised by a senior researcher with extensive experience in qualitative research in order to ensure the validity as well as the reliability of the results.

7. Ethical considerations

Table 2 Category Table

Category	Sub-category
Encouraging the family's understanding toward the patient	Changes in awareness prompted by a better understanding of symptoms
	Better understanding of the effects of medications and the necessity for them
	Sharing signs of recurrence
	More information on social resources and hope
Changes in approach brought on by a sense of security	Utilizing dialogue to better understand the symptoms
	Gaining a sense of security and serenity through understanding toward the patient
	Awareness toward the importance of dialogue
	Changes in approach based on individuality
Newly developed relationships among family members and the patient	Improved conversations between the patient and family
	Sharing information on a regular basis about the illness
	Sharing steps to prevent recurrence
	Re-examining the future prospects
Improved quality of family life	More freedom in the family's daily life
	Reduced sense of burden and more stable family life due to a patient gaining more awareness about the illness
	Sense of satisfaction from feeling the positive effects of the patient-family psychoeducation

- 1) Consent was obtained from the president of the hospital, head nurses, and attending physicians, as well as from the head nurse of the psychiatric emergency ward after providing oral and written explanation of the research.
- 2) An explanation was provided to study subjects regarding the purpose of the research and its method. Subjects were also assured that participation was voluntary and that they had the right to refuse to participate or suspend their participation with no repercussions (financial or otherwise) whatsoever. The method of publication, anonymity of the subjects, and privacy protection were also explained to the subjects.
- 3) To ensure that interviews did not place any burden on the family, the interview date and time as well as the location were determined after consulting the subjects. (The interview schedule accommodated the subjects' schedule as much as possible.)
- 4) It was ensured that the subjects were able to consult the interview guide prior to the actual interview.
- 5) Interviews were conducted in a quiet location where the subjects could not be overheard.
- 6) If a subject preferred not to be recorded, his/her wish was respected. It was also ensured that the subject understood that his/her preference would have no repercussions (financial or otherwise.) It was further explained that note taking during the interview would be necessary and consent was obtained for this.
- 7) To prevent individual events and characteristics from being used to identify the subjects, anonymity was ensured through data processing. It was also ensured that the subjects understood that the results of the research, as well as the data, would not be used for any purpose other than this research.
- 8) The data recorded using a voice recorder was only handled and heard by researchers of this study. All data (recorded data, written records, notes, etc.) are to be destroyed when the research is completed.
- 9) It was ensured that the study subjects understood that they would not incur any expenses by participating in this study.
- 10) This research was conducted after obtaining an approval from the hospital Executive Committee acting as the Ethics Committee for the participating facility.

V. Results

The subjects comprised seven family members of schizophrenia patients (two mothers, three fathers, and two sets of parents) in their 50s to 70s. The average interview lasted 38 minutes (23 to 62 minutes.) Seventy-one codes were extracted, which subsequently were divided into four categories and 15 sub-categories. (Table 2)

VI. Observations

In this research, categories are shown with < >, sub-categories with [], and comments by study subjects with “ ”. Furthermore, anything added to the statements for the sake of clarity is shown with ().

1. <Encouraging understanding toward the patient>

“Now, (psychiatric) symptoms are not as confusing.” From the conversation after the psychoeducation took place, it was revealed that family members can deal with the patients' symptoms and changes in his/her condition with more confidence. By gaining accurate knowledge about the illness, including the risk factors for the onset of the illness, family members can free themselves from inaccurate perceptions and the feeling of guilt associated with them. As a result, we believe that [Changes in awareness prompted by a better understanding of the symptoms] can occur. Furthermore, aside from understanding the effects and side effects of medications during psychoeducation, family members were also able to share signs of recurrence with the patients. The results regarding [Sharing the signs of recurrence] in this research match those of Shimizu et al. (2012)[6], which examined the effects of psychoeducation on schizophrenia patients hospitalized at a psychiatric emergency ward. Both studies demonstrated that such programs help people notice the signs of recurrence. This research also conducted interviews where both the patient and his/her family were present. We also believe that this particular setting further reinforced the [Sharing signs of recurrence].

“I really appreciated how we are taught how to care for him/her at home.” “I don't know where to turn to and what steps to take to consult others.” “I worry about him/her after we are both gone. The support we get from the case workers/support workers is indispensable.” Family members typically feel stressed and anxious about the future while also feeling burdened. These statements express the heartfelt wishes of the families to gain [More information on social resources and hope.] Similarly, they also demonstrate the vulnerability of the current system as well as its failure to provide adequate information on social resources. “I would have liked to have been provided with (the knowledge about the illness) earlier.” “(Regarding the frequent requests for visits by the patient.) It was hard to come see him/her every day when we didn't have time.” These statements, as pointed out by Sakanishi et al. (2010)[15], illustrate the need for implementing the support for the family including family psychoeducation at an early part of the acute phase. The statements also confirm anew the importance of an early intervention for <Encouraging understanding toward the patient> by offering a comprehensive nursing care—not limited to providing information on the patient's condition and progress of treatment—of which the aim is to reduce the burden placed on the family and the anxiety they feel by providing individualized care and information during the visit.

2. <Changes in approach brought on by a sense of security>

Iwasaki (1998) reported that few of these families receive appropriate support from psychiatric healthcare providers and, in reality, most of the families continued

to provide care for their loved ones on their own while feeling that their knowledge and capacity were inadequate[10]. This research also revealed that families of patients who had been repeatedly hospitalized “(regarding the treatment for schizophrenia) were never given any explanation.” One also reported that he/she “read up on (information about schizophrenia) on my own.” Although these families did gain knowledge through their struggle and found practical ways to cope, it was clear that they also felt they lacked knowledge and worried about how to cope. The research also illustrated that their approach changed from “time and work were required to cope with the characteristics of the illness” and “we felt confused by the changes in his/her personality at the onset of the illness” before the psychoeducation to “the way we deal with him/her (the patient) has changed since we learned to understand his/her feelings and symptoms” and “we feel less burdened” afterward. These statements demonstrated that a sense of security and serenity had been engendered when it came to dealing with the patients. In other words, psychoeducation enhanced the families’ approach toward the patients, which had been inadequate. It may be that the category [Changes in approach based on individuality] is a testament to the opportunity the program provided. Furthermore, Motlova, L. (2000)[16] stated that one of the reasons schizophrenia patients feel negatively about the anti-psychotic medications was their side effects, while Gaebel, W. (1997)[2] added that the phenomenon was a complex one, influenced by the dynamics between the patient and his/her family members. Given the background and current situation, it is hoped that psychoeducation will continue to be offered as a means to support both the patients and their families. As illustrated by “(When pointing out the symptoms to the patient,) I tell him/her to take it easy if he/she is not feeling great,” families acquired the [awareness toward the importance of dialogue] and engaged in conversation while [utilizing dialogue to better understand the symptoms]. In other words, they realized that “communication is very important for understanding the symptoms and preventing the recurrence.” These families previously coped with the patients’ symptoms and difficult situations and were being pushed to their limits; however, acquiring the accurate information has allowed them to [Gain a sense of security through understanding toward the patient]. We believe that this also allowed the families to cope with the characteristics of the illness at onset and with personality changes through dialogue with the patients. The category <Changes in approach brought on by a sense of security> and the aforementioned <Encouraging an understanding toward the patient> played a significant role as part of the effects of patient-family psychoeducation.

3. <Newly developed relationships among family members and the patient>

Changes before and after psychoeducation are demonstrated by statements such as “I was walking on eggshells around him/her before” and “Our relationship changed to a place where we can talk really frankly

(about the illness or give words of thanks).” We can imagine that, prior to psychoeducation, family members were hesitant to engage the patients in conversation, not knowing how to approach them. [Improved conversations between the patient and family] allowed the families to remove the barrier between them and “mutual discussions about how to deal with certain symptoms now became possible.” The improvement also allowed them to [Share information on a daily basis about the illness] and [Share steps to prevent recurrence] in their regular daily conversations. Fujita et al. (2005) reported that, as families often tended to lose opportunities to express their feelings, nurses and healthcare workers would need to support both parties to create opportunities where they could freely express their wishes and feelings rather than attempting to speak for each of them[17]. Based on the results of this research, it can be surmised that the patient-family psychoeducation helped create a setting where the patients and their families could resolve issues as well as express their feelings. Furthermore, although families do feel anxiety toward the future, they also seemed to be [Re-examining the future prospect] that takes the patients’ wishes into account by exploring the life the patients’ wish to lead and improving how they interact with them. This has demonstrated that the patient-family psychoeducation generates a multi-dimensional set of effects by not only educating people about the illness but also improving the relationship between the patient and his/her family.

4. <Improved quality of family life>

As illustrated by the heartfelt statement “His/Her (the patient) stability is the family’s stability,” families felt the real effect of [Reduced sense of burden and more stable family life due to a patient gaining more awareness about the illness]. Furthermore, as the patients’ daily routines became more of a pattern, the family life also stabilized, which gave the families [More freedom in the family’s daily life] including an opportunity to “concentrate on work,” “get some rest,” and “leave him/her at home for a while.” Suzuki et al. (2004) reported that the families that have less knowledge regarding the name of the illness, medication adherence, role of the family, and rehabilitation, tended to experience a higher level of difficulty and argued that this level of difficulty can be reduced by educating the families about the above-mentioned topics[18]. Psychoeducation has also been shown to have an effect on reducing the level of difficulty experienced by these families due to newly developed relationships between the patients’ and their families. This result, similarly, can be said to reflect the daily difficulties of these families due to their confusion about the illness and symptoms as well as the burden the illness places on them. It can therefore be suggested that improving the quality of family life had an effect on both the patients and their families. In terms of the [Sense of satisfaction from feeling the positive effects of the patient-family psychoeducation,] one expressed that pointing out the symptoms prompted a negative reaction from the patient and created daily conflicts between the patient

and the family saying, "He/She would get mad at me when I did." The same family also found that it was

lies. Its data collection, however, is based on one participating facility and may be difficult to generalize. In

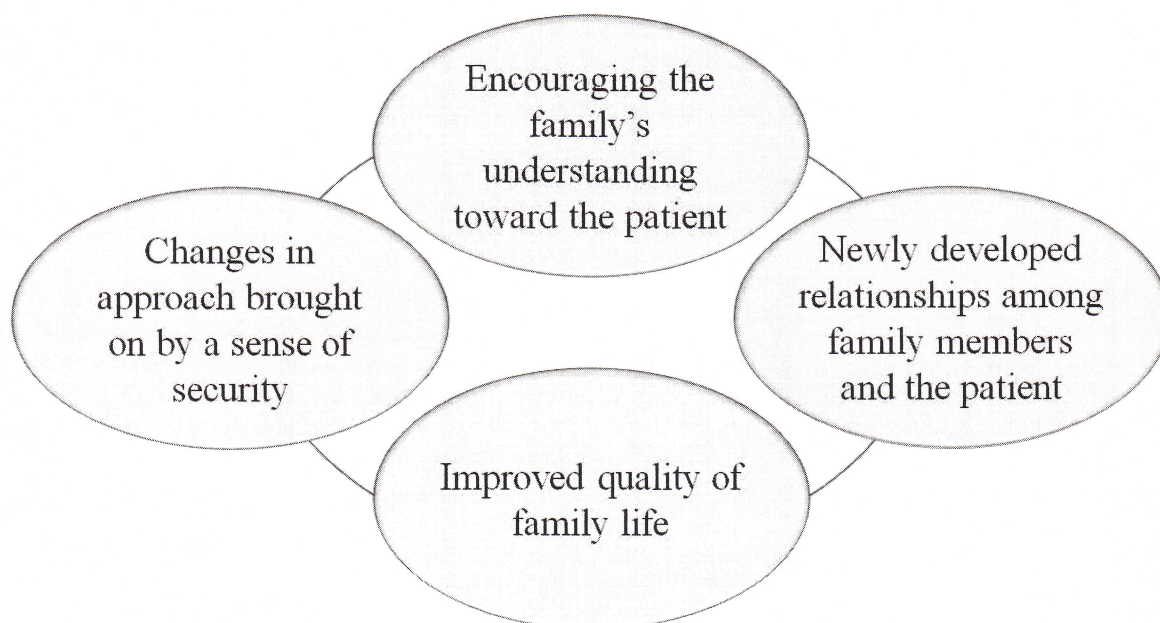


Figure 1 Effects of Family Psychoeducation on Family Members of Patients Suffering from Schizophrenia at Psychiatric Emergency Wards

"best to have a doctor tell him/her (through psychoeducation)." As Uchino et al. (2005)[19] suggested that "providing psychoeducation early during the psychiatric acute stage is expected to be an essential foundation for the families to understand the treatment and for the healthcare professionals to maintain a relationship based on trust with them," this research was also presumed to produce similar results regarding the patient-family psychoeducation.

VII. Conclusion

This research has selected, based on the statements by the subjects during the patient-family psychoeducation, four categories: <Encouraging the family's understanding toward the patient,> <Changes in approach brought on by a sense of security,> <Newly developed relationships among family members and the patient,> and <Improved quality of family life> as well as 15 sub-categories. We have learned that, from studying these categories, the patient-family psychoeducation has been effective in improving their knowledge, coping methods, giving them a sense of security, and reducing the sense of burden felt by the family. Graphic Chart: Effects of Family Psychoeducation: Family Members of Patients Suffering from Schizophrenia at Psychiatric Emergency Wards

Limitations of This Research and Future Considerations

This research, whose subjects were family members who went through patient-family psychoeducation, demonstrated that patient-family psychoeducation could be useful in supporting both the patients and their fami-

lies. Its data collection, however, is based on one participating facility and may be difficult to generalize. In the future, a systematic examination with a wider range of attributes and a broader data collection field would be necessary to produce a generalized view of the effects of the patient-family psychoeducation.

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