Group Work in Psychiatric/Mental Health Nursing: The Case for Psychoeducation as a Means to Therapeutic Ends

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21.1 Introduction

Over the past two decades, there has been an increase in the provision of psychoeducation in mental health care, coupled with, for some at least, a shift towards promoting pluralistic approaches and challenging the view that there is a single explanatory system for understanding mental health problems. These approaches have evolved from increased recognition of the complexity of mental health problems, acknowledgement of the myriad of interconnecting contributory factors to mental distress and acceptance of the limitations of biomedical illness models. The authors propose that psychiatric/mental health (P/MH) nurses can contribute to this paradigm shift, congruent with their core functions of therapeutic engagement and person-centred care, through the provision of psychoeducation.

This chapter discusses psychoeducational group work and its relevance and application to contemporary psychiatric/mental health (P/MH) nursing practice. Psychoeducation addresses a range of complex human needs, targeting specific mental health concerns, populations and marginalised communities. These interventions have demonstrated significant psychotherapeutic and psychosocial benefits for service users and carers. There is a significant body of theoretical models and evidence-informed practices within mental health care that the P/MH nurse can draw on to deliver psychoeducational interventions that are complex, flexible and responsive. Much of this literature problematises hierarchical relationships and dispels notions of the P/MH nurse as an expert providing information and imparting

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advice. P/MH nurses are in a prime position to deliver psychoeducation at multiple levels of service provision, given their easy access to service users and carers.

21.2 Psychoeducation and Groups

Psychoeducation is the fusion and integration of psychological theory and teaching methods resulting in combined psychotherapeutic and educational interventions (Lukens and McFarlane 2004; Reyes 2010). It is designed to engage, inform and educate (Lucksted et al. 2012). Psychoeducation involves provision of information that is clear, accurate, accessible, up-to-date and jargon free and may include components of skills training. Contemporary psychoeducation emphasises the context in which information or skills are offered, privileging a holistic- and strengths-based approach, emphasising health, collaboration, coping, empowerment (Lukens and McFarlane 2004), choice, peer learning and self-responsibility (Thomas and Pender 2008). Shared decision-making is cultivated, combining expertise from personal and professional perspectives. Reyes (2010) views psychoeducation as a cyclical process that helps empower individuals to deal with situations in optimal ways. Enhancing an individual's knowledge broadens their perspective and awareness, which in turn influences their behaviour and emotions leading to greater self-efficacy and self-control (Reyes 2010).

While psychoeducation can be individually tailored, groups have many advantages. They are cost-effective typically having one or two leaders working with up to 15 group members. The power of the group is utilised to foster change and support, as members challenge each other (which they often experience as more effective than leader input), mirror each other, practise reflective listening, help each other reframe key issues, witness the progress of others and receive feedback on their own progress (Substance Abuse and Mental Health Services Administration (SAMHSA) 1999). These processes enhance self-advocacy and counter a sense of defeat (SAMHSA 1999).

21.3 Evidence Base for Psychoeducational Groups

A significant and growing body of evidence indicates that psychoeducational groups can and often do have positive outcomes. Psychoeducational groups for people with mental health problems have demonstrated improved quality of life and reductions in distress and symptoms (Lukens and McFarlane 2004). They have the potential to eliminate the need for more intensive treatments or to reduce waiting times for other interventions when delivered to people presenting for the first time with acute mental distress (Chien et al. 2012). Psychoeducational groups for carers have been found to increase their self-efficacy (Solomon et al. 1996), social connectedness and capacity to cope and decrease burden and psychological stress (Pharoah et al. 2010), while enhancing recovery and reducing relapse rates of relatives (Dixon et al. 2001).

In a systematic review of general and mental health systems, Lukens and McFarlane (2004) reported that psychoeducational groups that are underpinned by

an ethos of recovery are associated with psychosocial and psychotherapeutic benefits and service users and carers who are more informed demonstrate better outcomes. They concluded that these interventions are among the most effective of the evidence-based approaches and extend the potential to improve community-based care provision by teaching people with health concerns and their carers how to anticipate and manage periods of crisis and life challenges.

21.4 Theoretical and Practical Issues in Psychoeducational Groups

While psychoeducational groups have been shown to be effective, group leaders need appropriate knowledge and expertise (Brown 2011) to successfully implement these interventions, thereby maximising their benefits and minimising the risk of harm (Lukens and McFarlane 2004; SAMHSA 1999). Selected group work literature and frameworks for best practice are outlined below to assist the P/MH nurse to deliver safe and effective psychoeducational groups.

21.4.1 Therapeutic Factors

Therapeutic or curative factors promote engagement and result in positive outcomes in group work. Eleven such factors have been outlined by Yalom (1970) and Yalom and Leszcz (2005). *Universality* refers to the realisation that one is not alone in their pain or suffering, which brings a sense of relief and belongingness, encourages personal disclosure, builds trust and fosters identification with others and compassion for self and others. *Installation of hope* involves witnessing others overcoming adversity, which can mobilise hope in the intervention and for oneself, and fosters self-advocacy. *Imparting of information* pertains to gaining knowledge and understanding of ones' life situation and oneself and is seen as enhancing progress and self-control. *Altruism* describes the opportunity to be helpful and of benefit to others, typically through sharing or giving advice, increases a sense of usefulness and personal value, fosters positive self-reflection and encourages role versatility between being helped and helping. *The corrective recapitulation of the primary family group* occurs when unresolved response patterns associated with negative experiences in primary relationships are replicated, explored, challenged and resolved within the group. *The development of socialisation techniques* highlights how enhancement of social skills is made possible in the group, explicitly through experiential learning such as skills training and interpersonal feedback or implicitly through development and enforcement of ground rules and modelling. *Imitative behaviour* describes how an adaptive skill used by one group member is imitated by others. *Interpersonal learning* refers to how individual members learn about intimacy and relationships through the supportive group environment, where honest feedback can be given and received. *Cohesiveness* pertains to a sense of belonging and acceptance that being part of a group fosters, generating experiences of being valued and allowing group members to take risks and experiment with change.

Catharsis describes the expression and sharing of emotions that occurs within the group. *The existential factor*, how groups develop to begin to accept rather than avoid their own limitations and the realities of life, is often provoked by significant events in the group, such as a member leaving or the imminent ending of the group. Awareness of these therapeutic factors can enhance opportunities for their development within the group providing the P/MH nurse with framework to use the power of the group to good effect, for example, carefully handling emotional expression so that the emotion is processed in a way that makes sense to the member, or developing imitative behaviours through practical skills teaching and experimentation.

21.4.2 Group Approaches

Theoretical literature often distinguishes between *directive* and *process* groups. Directive groups offer structured goals and leader-directed interventions to assist members to change through sequential activities that facilitate learning, self-discovery and growth (SAMHSA 1999). The leader has a central role in terms of organising and implementing activities and managing participation. Process groups emphasise the importance of the "group-as-a-whole" (Bion 1961); thus relationships within the group are attended to as a means of helping members understand themselves and build relationships that support their learning and recovery. The leader, while not assuming a central role, facilitates the group to become the agent of change. Although there is debate regarding the importance of incorporating a process approach in psychoeducational groups, both approaches can be successfully combined. Achieving and maintaining balance between group relationships and content enhance emotional safety and stimulation, which facilitates achievement of the group's objectives (Champe and Rubel 2012). Attending to process within groups fosters a sense of belonging, cohesion and motivation, factors associated with better outcomes. Combining directive and process approaches can promote the development of the therapeutic factors associated with positive outcomes. The P/MH nurse can use more structured inputs to enhance learning by helping group members to identify and build upon the skills, resources and personal strengths they have utilised to survive and that they continue to use to cope with life challenges and distress. They can support members to share and reflect upon their life experiences and use group relationships to facilitate members to process this material, gain new perspectives and strengthen their resilience.

21.4.3 Group Models

While contemporary psychoeducational groups are underpinned by a recovery ethos, many different therapeutic models and methods can be drawn upon depending on the nature and purpose of the group. The model of the intervention serves to guide the group leader, hold group members and sustain a clear focus. The model incorporates key philosophical concepts (e.g. recovery) and theoretical approaches (e.g. systems, cognitive-behavioural, humanistic/person-centred, psychodynamic,

integrative) underpinning the group, its structure, purpose, content and methods (e.g. experiential learning exercises, didactic teaching). Each of these elements requires consideration and clarification (Thomas and Pender 2008).

The fit between the model and the group leader's values (Brown 2011; Thomas and Pender 2008) and group member's needs (Bohart and Greaves Wade 2013) are important considerations. A clearly defined and explicit model and congruence between this and group leader disposition assist with selection and preparation for the group, guide practical decisions such as the group format (open, closed) and setting (community, clinic, hospital), help anticipate issues that might impact on member access and engagement, facilitate member informed consent, foster a good working alliance between leaders and group members and ensure the approach is clearly understood and adhered to. P/MH nurses have a long tradition of working from models that, at their core, promote person-centred care, interpersonal therapeutic relationships and effective communication (Barker 2001; Pepleau 1991), which form a strong foundation for effective psychoeducational groups.

21.4.4 Group Dynamics

Group dynamics (Lewin 1947) describes the positive and negative forces operating within groups. These forces give rise to the structure, norms, roles and goals that characterise a group and the nature of interpersonal interactions as members negotiate participation and communication patterns (Champe and Rubel 2012). Members take up different roles at various times in groups with constructive or destructive effects. Benne and Sheats (1948) identified three main types of roles: task roles concerned with completing the group's goals, building/maintenance roles concerned with building interpersonal relationships and self-centred roles which disrupt the group and prevent it from reaching its goals. It is important to recognise these roles as they emerge, by noting how members attend to group tasks, how they communicate and how decisions are made. The P/MH nurse can encourage the group to reflect on these issues and address emotions evoked in this process to enhance opportunities for constructive emotional and relational experiences and for new understandings to emerge.

21.4.5 Group Development

The nature and dynamics of a group evolve over its lifetime, and a number of models describe how groups develop (Tuckman 1965; Tuckman and Jensen 1977; Yalom 1970). For example, Tuckman (1965) describes five stages of group development. *Forming* is concerned with orientation to the group, group members and facilitators, and is characterised by testing behaviours and a strong dependence on group leaders, other members and familiar patterns of structure. *Storming* involves a phase of resistance to the task demands and group influence and is characterised by interpersonal conflict and polarisation. *Norming* refers to when resistance has been overcome as in-group cohesiveness develops, new standards evolve, new roles are adopted and

personal opinions are more freely expressed. *Performing* refers to the phase wherein issues have been resolved, roles become flexible and functional and group energy is channelled into the task, and *adjourning*, the termination phase of the group, recognises the importance of group separation for members who have been involved in a range of activities and interpersonal exchanges together.

Recognising the developmental stage of the group helps the P/MH nurse to pace the introduction of new and more challenging materials and activities and to be aware of interpersonal challenges that are likely to arise at particular points in the group. The leader's role also changes as the group develops. Typically in the beginning phases, the leader is more active and directive, and as the group develops, their role becomes more consultative (Brown 2011). Awareness and knowledge of group development models assist the P/MH nurse to adjust their leadership style to match evolving group needs and developmental stages.

21.4.6 Group Boundaries

Boundaries refer to "the physical, temporal, emotional, cognitive and /or relational limits that define entities as separate from one another" (Ashforth et al. 2000, p. 474). Healthy boundaries (neither overly fluid/porous nor rigid) allow members to value and express their own views and experiences without compromising those of others and to be aware of their own needs while respecting those of others. Setting boundaries involves establishing ground rules for the acceptable behaviours and attitudes of group members. Ground rules need to be established early in the life of the group as they build security and order in the group and create a sense of relational safety. A collaborative approach actively involves group members and leaders in the development and ongoing review of rules that they consider important for the smooth and efficient running of the group, thereby promoting joint ownership and responsibility. The extent to which rules are defined and how well they are reinforced and adhered to by the leader will determine the ongoing stability and progress of the group.

The role and responsibilities of a leader may differ from their roles and responsibilities in other clinical activities. Thus, there may be a role boundary transition for the P/MH nurse, and it can be helpful to explicitly acknowledge this transition in the group to avoid the confusion caused by role blurring and to maintain security and clarity of focus. This might require a psychological and physical shift, for example, a change in self-presentation (e.g. clothing) and environment.

21.4.7 Group Leaders

The term leader is used to denote the interlinked roles of teaching and facilitation. Brown (2011) highlights that this is a complex role, with varied and multiple responsibilities, and therefore emphasises the need for the effective leader to have a sound knowledge base and to be mentally and physically prepared for the group. She

outlines the range of competencies required by leaders to successfully manage their responsibilities, based on the acronym KASST. *Knowledge* means specialised and accurate information about the topic or focus of the group, understanding of group dynamics, stages of development and therapeutic factors. *Art* refers to the capacity to utilise self-awareness, personal development and inner experience to provide sensitive leadership and ensure that personal issues do not impact negatively on the group. *Science* incorporates administrative and executive abilities necessary for the optimal functioning of the group, such as securing resources, planning, organising, directing and developing group materials. *Skills* refer to good communication and interpersonal capabilities and include teaching, facilitating, modelling, conflict management and resolution, and anxiety management. *Techniques* are the means and methods that aid the generation of new ideas, facilitate problem solving, encourage participation and promote and reinforce group learning, including didactic teaching, use of media and experiential exercises (ice-breakers, role play, skills practice).

When planning groups it is wise for leaders to anticipate some challenging behaviours. These may occur, for example, during the storming phase when boundaries are being tested or later when group members know each other better and realise that their beliefs or value systems are being challenged by others giving rise to conflict. Before intervening it is helpful for the leader to consider why the behaviour is perceived as difficult, as this helps them to clarify the purpose and focus of their response. It is beneficial for the leader to demonstrate empathy and understanding by acknowledging the validity of the member's emotional upset, exploring the cause of the challenging behaviour and distinguishing between the emotional experience and the behavioural response. The P/MH nurse has several models for de-escalation to draw on to defuse intense situations (Bowers 2014; Price and Baker 2012) and allow opportunities for modelling and reinforcing prosocial behaviours. When comparing more successful groups with less successful groups, McKenzie et al. (1987), p. 55, found that "the former's leaders were characterized as more caring, charismatic, skillful, and less inhibiting". Group leaders, who can convey genuine belief, who demonstrate interest in and concern for group members and who use their own creativity and take the risk of being authentic and open, can positively influence the group process and outcomes. The reflective capacity of the P/MH nurse can be utilised to develop these skills and enhance therapeutic use of self. This can be facilitated by good mentoring and supervision, which can also aid the leader to reflect on the group dynamic and identify and process personal issues as they arise to prevent negative impact on group functioning, thereby stimulating personal and professional awareness, growth and development.

21.4.8 Group Evaluation

It is helpful to include evaluation structures to ensure the leader and members are on track and the group is progressing towards its objectives. Adherence scales can be designed, if not readily available, that help monitor compliance with the core content and processes of the intervention, and these can be particularly beneficial when

delivering an unfamiliar intervention. Reviews can be conducted in-group and between groups helping to consolidate member learning (Thomas and Pender 2008). Outcome data can be gathered prior to, during and following the group intervention, targeting specific objectives, such as well-being, coping skills or progress towards personal goals. Free and accessible outcome measures that track group (Duncan and Miller 2007) and individual member (Miller et al. 2003) progress can highlight problem areas allowing the group leader to intervene early to facilitate constructive engagement and goal achievement. Systematic evaluation helps the P/MH nurse to gather practice-based evidence and monitor the ongoing impact of their psychoeducational group interventions.

21.4.9 Group Members

Yalom (1995) reported that members who were prepared for the group were less anxious, participated more, had less dropout and better attendance rates, demonstrated improved communication skills and expressed emotion more than those who were not adequately prepared. Members need to be ready and motivated; this means being willing to acknowledge and address problematic issues and being prepared to engage in change. The concept of "readiness to change" has been emphasised as an important factor influencing engagement, completion and positive outcomes of treatment (Prochaska and Diclemente 1982; Prochaska et al. 1994). Models of change suggest that people move through five non-linear stages before change is firmly established, with a sixth stage marking the end of the change process. *Precontemplation* refers to resistance to change and denial of a problem, although others may clearly see a difficulty. *Contemplation* describes the phase when the person acknowledges that they have a problem and begins to think about possible solutions, although they may not be ready to take action. *Preparation* is when the person is planning to make change but because they have not resolved their ambivalence they require a clear plan for action. *Action*, when the person overtly modifies their behaviour and their surroundings, requires commitment, time and energy. *Maintenance* describes when the person consolidates the gains made and works to prevent setbacks. *Termination* describes the absence of former problems or when they are no longer viewed as a temptation or threat. Collaboratively assessing a group member's readiness to change helps set appropriate goals. Setting unattainable goals can result in failure; choosing goals that have already been mastered can delay progress, while matching goals to stage of change can maximise the ability to change.

Up to 90% of people seeking treatment for mental distress were exposed to abuse and/or neglect in childhood, and a substantial proportion have experienced trauma (Fruech et al. 2005; Muskett 2014). Many people who have experienced traumatic life events and mental distress lose their sense of purpose and meaning in life, resulting in "existential frustration" (Frankl 2004, p. 106). Consequently, they often feel different, isolated, alone and empty and question their own value and the value

of life (Gordon et al. 2014a; Gordon 2016). The group can assist a member who feels lost and alone to reconnect with the self, others and life through sharing their desperation, fears and lost hopes and by identifying with and witnessing their shared human experiences. These processes enhance new understandings about the self and life circumstances, and combat shame, stigma and isolation (Gordon et al. 2014b, 2015). A P/MH nurse who is sensitive to forms of abuse and oppression, including subtle forms of prejudice and discrimination, can help ensure that member's past experiences are acknowledged and resolved within the group and not replicated or left unresolved.

21.5 Contemporary Practice: Examples of Psychoeducational Groups

The authors describe two clinical examples of innovative, well-defined and empirically supported psychoeducational groups from their own practice and research. The first example is a hearing voices group for adults on an acute in-patient unit. The second is a community-based carer group for family and friends of those with mental health problems. Some direct quotations from member-participants are provided to illustrate key aspects of their experiences.

21.5.1 Hearing Voices Group

Hearing voices (HV) groups are based on the work of Romme and colleagues who proposed that HV and other unusual (not typically experienced by others) sensory phenomena are part of a continuum of human diversity and are meaningful in the context of the person's life. This approach highlights the interrelationships between subjective experiences and environmental context, challenging models that view HV as symptoms of mental illness. This view is based on research demonstrating significant causal associations between HV and trauma and/or emotional neglect (Read et al. 2005; Romme and Escher 1989, 1993) and observations that the characteristics of an individual's voices often contain references to their traumas (Romme et al. 2009). The HV approach advocates support, social inclusion, empowerment and justice for voice hearers. HV groups are underpinned by an ethos of *self-help*, whereby expertise by experience is harnessed, *respect* for diverse views and beliefs and *empathy*, fostering a desire to listen to and understand one's own and others' experiences.

The HV psychoeducational group for adults aimed to provide information about the HV approach, share effective coping strategies, highlight stories of recovery, heighten awareness of a local community peer support group and signpost relevant, credible and accessible resources. The group sought to engage with members as partners in the provision of care, which has been shown to be an effective way of preparing individuals to avail of other recovery-oriented community resources and supports (Lukens and McFarlane 2004).

The psychoeducational intervention comprised three brief groups, as it was designed for individuals who typically experienced acute levels of distress and had brief admissions. The groups were structured: the beginning focussed on a brief introduction to the purpose of the group and agreement on the ground rules; the middle of the group focussed on a specific theme, following the structure of the Maastricht Interview (Escher et al. 2000), where the leaders provided relevant written and oral information and ensured time was made available for open dialogue among group members; groups concluded with information about various coping strategies.

The leaders made explicit their positions about confidentiality and clinical note writing, as group members were wary of talking openly about their HV experiences because such information was frequently used to gauge their mental state. Thus, a critical group rule was that information shared within the group was confidential to the group and limitations to confidentiality were addressed and agreed. "I felt comfortable and safe to express myself" (member). This can require a shift in position for P/MH nurses on acute units who may transfer detailed information to other colleagues, a practice inconsistent with the rules and ethos of the group and the HV approach.

In the first group, with the theme "the experience of hearing voices", leaders introduced members to the HV approach, facilitated exploration of the impact of HV on their lives, discussed various ways of understanding HV and provided information about common life situations associated with the onset and progression of HV. Basic distraction-based coping strategies were introduced.

In the second group, the theme "engaging and triggers" involved exploring each person's history of HV, noting changes in their HV experience, identifying associated changes in life circumstances and discussing the meanings of each person's HV experiences. Leaders provided information about recovery in HV and the recovery journeys of experts by experience. Advanced coping strategies were offered, such as voice dialoguing and mapping, which involve drawing a picture of each voice in terms of its message, tone, origins and triggers, so that the individual begins to know their voices and the functions they may serve in their life.

In the third group, the theme, "understanding the experience", focused on the individual's relationship with his/her voices. Information was provided about the three stages of recovery in HV (startling, organisation, stabilisation) (Romme and Escher 1989, 1993), the importance of developing personal and social value and the association between regaining personal power and reductions in distress and improvements in quality of life. Further advanced coping strategies were introduced to support these ideas, behavioural experiments designed to support the regaining of control in ones' life, such as balancing time alone and with others, reorganising daily routines and trying new ways of engaging with the voices, and cognitive strategies to reconstruct ones' relationship with the voices through acceptance and reorganising attention to them. The leaders also provided information on accessing post-discharge community resources and credible sources of information.

Evaluation of these groups indicated members had high levels of satisfaction with the groups, and they found it helpful and liberating to explore their HV

experiences. "What I liked best was understanding each other, being able to share…" (member). Members reported increased hope having identified with other experts by experience and having witnessed their stories of recovery, increased awareness of coping strategies and increased interest in their relationship with their voices. Many had ideas about the origins and meaning of their HV experiences but had not previously felt supported to openly discuss such matters. Some group members expressed the desire for more of this kind of intervention. "I would like to learn more about the sources of my voices" (member).

The P/MH nurse can introduce voice hearers to these contemporary ways of understanding and managing their voices and can provide information on community-based peer groups.

21.5.2 Carer Group

Carers play a key role in the recovery and support of relatives struggling with mental health issues (Watkins 2007). Their role is complex and can be stressful, compromising their well-being and ability to provide support for their relative (Higgins et al. 2011; Maurin and Boyd 1990). Despite their key role, carers are frequently excluded from the treatment of their relative due to a variety of issues, such as being viewed as part of the problem (Higgins et al. 2011) or concerns about confidentiality (Kenny et al. 2015). "I don't want to know what secrets my [son] tells his psychiatrist but I do want to know how to care for him…we need to know how to care for them and how to care for ourselves..." (Carer). Despite the known burden associated with caring, support for carers is inadequate, unsuitable or not visible (Higgins et al. 2011; Kenny 2011), and there is growing evidence that carer psychoeducation is effective but persistently underutilised (Lucksted et al. 2012).

The psychoeducational group for carers was embedded within an action research project, which was initiated by a group of carers, clinicians and researchers who sought to increase carer involvement in the planning and delivery of services. The project comprised a focus group with carers designed to explore their experiences of being a carer and being involved with mental health services and two psychoeducational groups. Analysis of the focus group revealed that caring and being involved with services were experienced as "nightmarish and challenging". This theme refers to the psychological, emotional and physical struggles that carers experienced in supporting a relative with mental health problems and engaging with mental health services that were difficult to access and were sometimes hostile (Kenny et al. 2015). "It has been a nightmare because I was thrown totally into a situation I knew nothing about. I found it very difficult to get information" (Carer). The outcomes of the focus group were presented to the clinical teams providing treatment to these carers' relatives, and their responses were recorded.

In the first psychoeducational group, the leaders presented the themes extrapolated by the researchers, along with the responses of the clinical teams. Leaders provided information about the complex and varied role of being a carer, the burden of caring, the need for support, the often neglected role of self-care and some of the

dilemmas the teams encountered when dealing with carers. This facilitated carers to reflect upon their experiences from different perspectives and begin to process and make sense of their emotional experiences in a context where they felt heard and safe. The leaders explored carers' perceptions about how clinical teams could respond differently to them, revealing a desire for more information, collaboration and involvement. The group concluded with discussion about the final group and carers identified self-care as their primary need.

In the final group, leaders provided information about local community-based resources, including a local carer support group, common mental health concerns and the clinical teams' plans to promote involvement of carers. Group leaders facilitated experiential exercises designed to support self-care, including mindfulness, guided imagery and relaxation, and led a discussion about prioritising, planning and implementing ongoing self-care activities. "It hasn't been recognised that this has impacted on the families so greatly. It's not just the person [with mental health issues] it's the whole family and the needs of the family" (Carer).

Evaluation indicated that members felt acknowledged and empowered by being able to voice their concerns and needs and by connecting with others who had similar experiences (Kenny et al. 2015). "To be able to talk about what you were experiencing and were heard and understood, the feeling that at last someone cared was good" (Carer).

The P/MH nurse can promote the establishment of psychoeducational groups for carers by facilitating carers to come together, helping them find suitable meeting venues, leading the groups until the members feel ready to take on this role, attending established groups as guest speakers to impart knowledge and teach skills and encouraging their colleagues to involve and support carers. These interventions validate the important role they have as carers, help educate them about the burden of caring and support them to acknowledge and promote self-care. The provision of information early in their involvement with mental health services also helps encourage open dialogue between carers and clinicians and helps to identify and address their emotional and practical needs (Walker and Dewar 2001).

21.6 Conclusions: Psychoedu-Caution

Contrary to a common misperception that psychoeducation is a simplistic form of intervention, the authors have argued that a skilled and knowledgeable group leader can deliver psychoeducational group interventions that result in positive psychotherapeutic and psychosocial outcomes and are cost-effective. Through the promotion of interventions that reflect the diverse, complex and yet to be known aspects of human experiences that intersect with well-being and mental health, the P/MH has opportunities to help reduce stigma, discrimination and social isolation and promote health, resiliency and self-agency among service users, carers and communities. By delivering psychoeducational groups based on emancipatory, recovery-oriented and ecological approaches, the P/MH nurse can contribute to the re-construction of new realities in mental health and mental health nursing. While the clinical examples described demonstrate the versatility and benefits of psychoeducational groups that

can be incorporated into contemporary P/MH nursing, caution is advised when considering psychoeducational group interventions. Such interventions also have the potential to reproduce restrictive and oppressive practices and reinforce outdated hierarchical structures and processes when delivered, knowingly or unknowingly, in a poorly informed manner.

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