

# Patient Education In Psychiatric Illness

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Patient education has a long tradition in medicine, and has become a recognized necessity in patient care in recent years. The literature abounds with program reports about patient education in diabetes (Pridham, 1971; Trayser, 1973), hypertension (Mitchell, 1977; McKenney, Slining, Henderson, Devins, and Barr, 1973), coronary disease (Soflin, Young, and Clayton, 1977), spinal cord injury (Henderson, 1971), burns (Williams, 1971), and kidney disease (O'Neill, 1971), as well as many other illnesses. It has been clearly established that patient education improves patient understanding of illness (Gillum, 1974), reduces delay in seeking treatment when needed (Newman and Fuenning, 1977), reduces hospitalization resulting from lack of early illness detection and treatment (Knowles, 1977), and improves patient compliance with prescribed treatment regimens (Mazullo and Lasagna, 1972; Blackwell, 1973). Additional effects of improved patient understanding are benefits to health care personnel, including lowered cost of treatment and fewer broken appointments and malpractice suits (Newman and Fuenning, 1977).

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Given the obvious benefits of patient education with a variety of illnesses, it is

surprising that this necessary activity has received little attention in psychiatry, at least as indicated by the lack of literature describing patient education in psychiatric illness. The reasons for this apparent neglect are unclear; however, one might speculate that they are related to the following issues:

1. Psychiatry has been in recent years involved in a "model muddle," which has been clearly and fully described by Osmond and Siegler in *Models of Madness, Models of Medicine* (1977). Psychiatric illness has been thought of as a search for enlightenment, the result of family conflict, or the natural consequence of a "sick" society. Mental illnesses thus have not consistently been thought of as medical illnesses, requiring medical treatment, and about which patients needed to be educated. There is however, a large body of knowledge regarding the physical basis of mental illness, and indeed the field of Orthomolecular psychiatry is based upon the assumption that the chemicals which go into the body affect the mental condition. Psychiatric conditions are clearly medical in nature, and require medical treatment. Patients need to be educated about these illnesses.

2. Psychiatric illnesses often bring about confusion, disorientation, perceptual distortions, thought disorders, and resulting loss of judgment, and patients suffering from

these illnesses have been considered unable to understand teaching and to take responsibility for their actions. The benefits of education thus have not been considered to outweigh the costs. Recent technological developments in understanding illness, such as the Experiential World Inventory (El-Meligi and Osmond, 1970) have given access to the patient's perceptual world, however, and have led to a common language and therefore to increased understanding between patient and therapist. There is growing evidence that patients can indeed understand teaching about their illnesses, and that they desire this information.

3. Mental illness has for many years carried with it a stigma and an aura of embarrassment and fear, and perhaps it has been thought that informing a patient of the presence of a mental illness would be frightening at the worst and embarrassing at the least. While mental illness is indeed a serious matter, most patients prefer to know what illness they do have (Siegler, Cheek, and Osmond, 1968), and it seems clear that the fear of not knowing is much worse than that of the reality. Further, by not disclosing the information to the patient, mental health workers reinforce the attitude that the illness is something to fear and of which to be ashamed. An open and informative approach to dealing with mental illness, however, leads to a healthy acceptance and a responsible attitude toward learning to cope with the illness.

4. Perhaps as an offshoot of the confusion in models, patients with mental illnesses may have been considered to be "acting crazy" to reach some ulterior end such as avoiding responsibility, and so might use the information given to them to do a better job of "acting crazy" and thus thwarting treatment efforts. There is likely to be a small percent of patients who might use the information given to them in an irresponsible way, which might be termed "malingering". The great majority of patients, however, are simply relieved and more hopeful and more motivated toward getting well when they are given accurate and straightforward information about illness. It seems cruel in the least to withhold information from all patients out of fear that some may use it to disadvantage, and indeed

treatment efforts which rely on ignorance of the patient are likely to have questionable effectiveness. 5. Patients have often been considered irresponsible if they called themselves ill. Considering oneself to be mentally ill was thought of as synonymous with passivity or irresponsibility, and accepting illness was thought of as shirking one's obligation for personal growth or behavioral change. It is now known that placing psychiatric patients in the sick role, with its accompanying rights and duties, assures responsibility rather than encourages irresponsibility as a result of accepting sickness.

Considering the advantages of patient education which have been observed in the treatment of other illnesses, it seems essential practice to educate psychiatric patients about their illnesses with the goals of achieving the same benefits which have accrued to patients with illnesses such as diabetes and heart disease. Fortunately, these benefits are now being demonstrated, and education of psychiatric patients about illness has begun (Osmond, Mullaly, and Bisbee, 1978). The remainder of the present paper will describe a patient education program in existence at Bryce Hospital, Alabama's largest state hospital for the mentally ill, and will discuss methodological issues for the benefit of others who wish to establish similar programs. The program, called the Psychological Learning Center, combines the medical approach to mental illness with patient education techniques derived from teaching in other illnesses such as diabetes, and the curriculum centers on a "responsible patient" concept.

### **History of the Program**

The Psychological Learning Center was born out of the inspiration of Dr. Humphry Osmond, who has believed for many years that mental patients ought to be taught about their illnesses. Dr. Osmond provided the guidance through which the program has evolved from its small beginning in the

summer of 1977. It began with one class entitled the Responsible Patient Class, which taught the physical basis of mental illness and the rights and duties of patients. Gradually, over the past months, more classes have been added which elaborate on the basic theme of the responsible patient, giving patients the information they needed to understand their illnesses and to become responsible participants in their own treatment programs. Each class has been developed and refined by a professional in the field of the class content, before being taken over by the mental health technology instructors. For example, the Responsible Patient Class was developed by Dr., Robert Mullaly and Dr. Humphrey Osmond. The class on medication was developed by the hospital pharmacist, who taught and refined the content of the class until it was suitable for the patients to whom it was being taught, and then he trained a mental health technologist to teach the class. Each class has been developed in this manner to assure the greatest accuracy and most up to date information possible. Continual refinements have been made in the class content and program procedures, including a refined screening process to assess learning readiness and an evaluation process which allows for continuing improvement of teaching methods.

The program now consists of nine classes which can be completed in three weeks. Subjects include: Responsible Patient, Nutrition and Health, Learning to Live Effectively, Medication, Principles of Mental Illness, Family Dynamics, Coping Skills, Community Resources, and Communication Skills. Three sessions per day are attended, interspersed with exercise sessions, nutrition breaks, and recreation periods, and the final session of each day is spent in an additional discussion group designed to repeat and reinforce the learning of the day. Patients come to the program by referral from their treatment teams, with the approval of their psychiatrists. Each patient is referred to the center and is assigned an advisor whose function it is to assure learning readiness, reinforce learning, and evaluate progress.

Individual instruction is done by the advisor if

the patient is unable to learn in the classroom. The majority of patients served are those with schizophrenia or affective disorders and who are early in hospitalization. The program, however, once established with these admissions patients, has spread to numerous other settings and populations, including adolescents, chronic patients, a community hospital psychiatric unit, and a community mental health center.

### **Methodological Concerns**

In the development of any new program, certain methods will evolve, molded out of a combination of the particular environmental circumstances, the resources available, and the characteristics of the people who establish the program. While the methods which have evolved during the development of the Psychological Learning Center remain to be tested objectively, certain of these methods seem to work well, at least in this particular program, and also appear to make sense in regard to the needs and characteristics of mentally ill patients and the people who work with them. It must be kept in mind that establishing such a program is not to be taken lightly, and that definite concerns need to be attended to in order to assure that the program meets its goals and serves the patients for whom it is established.

### **Models**

It would seem imperative that a model be chosen which will determine many of the program characteristics and all of the content. While other models may be suitable to other circumstances, the medical model of mental illness is that upon which the Psychological Learning Center is founded. This model offers several advantages: (1) It is consistent with the surroundings in which the patients find themselves. They are in hospital, treated by doctors and nurses and other medically oriented staff, and are receiving medication and other medical

treatment. The only logical conclusion to reach from one's placement in such circumstances is that of illness, and teaching the patient otherwise would serve only to create confusion and a "model muddle."

(2) The model is consistent with the latest technical and scientific information about the causes and treatments of mental illness.

(3) The medical explanation of mental illness is reassuring to the patient, who can take comfort in the knowledge that he or she is ill rather than "crazy," "bad," "possessed," or "socially unacceptable," and that the illness is well known and has a treatment.

(4) Unlike other models, the medical model does not exclude the use of treatment techniques based on other models, such as the behavioral and social models, nor does it exclude the necessity for workers other than the physician. Behavioral programs are essential to stress management in illness; family therapy can greatly aid the management of an illness in the home. The medical approach indeed relies upon the technologies which are the expertise of nonmedical workers, such as measurement, education, counseling, psychotherapy, family therapy, and recreation therapy, all of which augment chemical intervention and enhance its effectiveness.

### **Classroom Structure**

While there are many possible configurations of teachers, learners, and space, the one which has achieved the best results in the Learning Center is the traditional schoolroom arrangement, complete with chalkboards, easels, visual aids, student desks arranged in rows, classroom rules, and the lecture method, in which the teacher presents specific material in structured fashion and students are asked to raise their hands to comment or ask questions. This method was chosen over its more commonly used rival, the "group therapy" configuration, for several reasons, all of which relate to the goal of maximizing learning: (1) Patients are familiar with the concept of "going to school" and understand the behavior which is expected in the classroom. This structure is

comforting to a mentally ill patient whose world is "going to bits" because of perceptual disturbances, and who does not, therefore, need the added ambiguity of trying to figure out what to do in a group therapy setting. The structure sets the patient up in the role of student or learner, and increases readiness to receive information.

(2) The purpose of group therapy, in which the chairs are placed in a circle and patients must interact with one another, is to maximize interpersonal interaction, and this setting, therefore, is detrimental to attention to content presentation. The classroom, on the other hand, is arranged so that the only interaction called for is that between student and teacher, a situation designed to increase attention to the material being learned. Thus, patients can concentrate on the subject matter rather than on uncomfortable and distracting social interactions.

(3) Many patients are frightened of group therapy and do not want "therapy" when they are hospitalized for treatment of an illness, whereas they do not object to the idea of going to classes, and welcome the information given to them through educational programs. Group therapy often has a negative connotation to the patient, either because the prospect of a "group" of people is frightening or because of the prospect of undesired "therapy." The concept of "class" is much less threatening and is positive because of the prospect of learning.

### **Readiness to Learn**

In the initial phases of the program development, the goal was to teach as many patients as possible about illness and their participation in treatment. It became apparent, however, that some patients were unable to learn or unwilling to learn, for various reasons. In some cases, the patient was too confused or was experiencing perceptual distortions to the extent that it required all of his or her energy to maintain composure, leaving no energy to concentrate on learning. In other cases, patients were no longer psychotic, but had not

stabilized on psychotropic medications to the extent that side effects were no longer interfering with learning. Still other patients were unwilling to attend classes because they misunderstood the concepts of mental illness and the need for education. It became necessary, therefore, to develop a procedure to maximize learning readiness through screening and orientation. This process has several important features:

1. Assessment of mental condition must be done to assure ability to concentrate and to follow classroom rules to the extent that the patient will not interfere with the learning of others.
2. Patients must be oriented regarding the purpose of the educational program so that they will understand that information will be provided upon which they can make informed, responsible choices in regard to treatment participation. This feature is the beginning step in inducting the patient into the sick role.
3. A certain amount of willingness to attend classes must be obtained from the patient to assure a mental set conducive to learning without disrupting the learning of others. Patients who are forced to attend classes can be very disruptive to the entire program, and the likelihood that they will learn is minimal. Encouragement, however, is very helpful, even if the patient is asked simply to try the program for a day before deciding to refuse it. It is important to assure the patient that information will be given which will be vital to his/her understanding and getting well.

### **Staff Understanding and Acceptance**

It is desirable that all staff who work with a patient who is receiving instruction are aware of what the patient is learning, and accepting of what is being taught. If staff are operating under various models, for example, they can create confusion in the patient by answering questions inconsistently. This state of affairs is not too unlikely, given the "model muddles" to which staff are likely to have been subjected over the years. For this reason, it is imperative that sufficient preparation be made during development of the program to get as much agreement among the relevant staff as possible.

This preparation may take the form of staff education, group consensus meetings, and gaining administrative acceptance of the program concept and methods. Lack of agreement can be handled within the program, however, by the use of an educational approach incorporating the realities of theoretical differences and ways for the patient to handle these differences. The most practical way to gain staff understanding is through the use of staff education, using methods similar to those used with patients.

### **Individualization of Teaching**

The classroom method offers the advantages of familiarity and structure, as well as cost efficiency, due to the fact that much of the material which often forms the basis for individual therapy can be given in the classroom setting to a group of patients, rather than having to be repeated by the therapist to each patient individually. However, each patient's circumstances are different, and some individualization must take place to allow for differences in learning rates and to enable the patient to apply the classroom material to his or her own situation. In the Learning Center, the advisor serves the function of providing individual instruction to patients who do not learn at the same rate as most of the other patients in the class. Additionally, counseling and psychotherapy are provided, in which patients build on classroom learning to work out their individual methods of illness management. General information is provided in classes, and individual counseling tailors the information to the particular patient and family for application. This process often involves the specialized application of the Experiential World Inventory (Bisbee, Mullaly, and Kuechenmeister, 1979) for individual treatment monitoring and stress management. Such individualization provides for reinforcement of the concepts learned and for specific methods for applying these concepts. Psychotherapy is useful in overcoming patient and family barriers to effective use of the information provided in class and in individual counseling.

### Teaching of Rights and Duties

Bryce Hospital is in perhaps a unique situation, having gotten a federal court order to provide adequate treatment in the form of Judge Frank Johnson's (Wyatt v. Stickney, 1972) ruling that it is the patient's right to receive adequate treatment for mental illness. This eventuality has created at Bryce a great emphasis on the rights of patients and on protecting these rights, and indeed contributed to the atmosphere in which a program like the Learning Center could develop. This emphasis on rights, however, has led to neglect of the rights of staff and of families and to the near exclusion of duties of patients. It is imperative that both rights and duties of patients be taught in balance so that rights are protected, but that the patient does not become a tyrant. Patients must learn duties of the responsible patient role. Neglecting the teaching of duties and responsibilities creates in the patient a dependency and a lack of ability to be responsible upon discharge or upon removal of the doctor's watchful eye. This eventuality is one factor which has led to the discredit of the medical model of illness, in that duties of patients have been neglected in favor of rights. In order for patients to be responsible, monitoring their own illnesses and participating in their own treatment, it is necessary that they be taught duties as well as rights. It is very important that patients understand their role in learning about illness, cooperating with those who are treating them, following prescribed treatment, and trying to get well as quickly as possible.

### Patient Choice

Related to the topic of patient rights and duties is that of the patient's choice whether to believe in the information taught, to accept the model given, and to comply with the advice of the instructors. In keeping with the concept of responsibility, it is necessary that these matters be left to the choice of the patient. While those who teach would prefer that patients believe in what is taught and follow the advice given, this

decision ultimately belongs to the patient. Thus the goal of patient education is to teach the latest and most accurate information possible, in the clearest possible manner to effect maximum understanding of illness and treatment in the patient. Behavior change is desirable, and every effort should be made in teaching to achieve behavior change, but it is not the measure by which the program should be evaluated. If this were the case coercive methods would fare better in comparison to education for insuring behavior change. The assumption behind patient education is that if the information can be provided in-such a way that the patient will have a full understanding of illness and of his or her role in its treatment, then the patient will make the choices which will insure the best treatment effects and lead to faster recovery and fewer relapses.

### Reinforcement of Learning

Learning theory has shown that learning takes place more rapidly and endures longer when it occurs under certain identifiable circumstances. These learning principles are applicable to patient education as well as to other forms of learning (Swezey and Swezey, 1976). It is important, especially with psychiatric patients whose attention span and concentration are not at their best, to utilize these principles to their fullest. Thus, it is necessary to use practice, constant feedback, repetition, and presentation of material in several ways, and to allow for flexibility in educational methodology to compensate for the differing needs of patients. An example of this concept is that in the Learning Center, the material is presented both in lectures and through posters and other visual aids, thus maximizing the learning by the use of more than one sensory mode. Discussion groups are also held each afternoon in which the main points covered during the day are repeated, and patients are asked to give the information back in their own words. Individual instruction is also used to reinforce the classroom learning.

### **Holistic Approach**

It is necessary to consider the individual as a whole in any therapeutic endeavor, and patient education is no exception to this necessity. In the Learning Center, patients are taught about their illnesses from a medical standpoint of symptoms, diagnosis, and treatment; but in addition, they are instructed regarding healthful habits such as nutrition, exercise, proper sleep and rest, and stress management, all of which contribute to the wholesomeness of the body and to maintaining it in the best possible physical condition. They are warned about the hazards of "junk foods" containing sugar, caffeine, and food additives, and are given suggestions for wholesome eating habits. Discussions are held about the responsible use of alcohol and other drugs and the consequences of lack of exercise, and of inadequate rest and sleep. Stress management techniques are emphasized, with the goal of decreasing illness relapse by maintenance of a low-stress daily routine. The purpose of this approach is to help the patient realize that the effects of illness can be greatly reduced by proper attention to healthful habits and stress management.

### **Evaluation**

Once the goals have been set for a program, it is necessary to evaluate the program to determine if the goals are being met. Evaluation in the Psychological Learning Center takes the form of pre- and post-testing to determine the amount of material which has been learned by the patient. Each week, each patient is given a fifteen-item pre-test assessing the main points to be taught in that week's classes. The same test is given at the last session of the week and pre- and post-test scores are compared, to determine gain in knowledge. While it is true that the knowledge of the patient is being assessed, it is additionally the case that the teaching methods are being evaluated. Since the test measures knowledge of the most important points taught in the program, then teaching methods must be used which will assure that those points are

learned by the majority of the patients. Thus, testing can be used to show where modifications are needed in teaching methods to increase the gain of knowledge. Additional, less objective, methods of evaluation are also relied upon, such as reports from patients, as well as from community workers to whom the patients return after they are discharged.

### **Certification**

It is vital that the extremely important nature of learning about one's illness be made very clear to the patients. One of the ways in which they can be given this understanding is by providing the proper "trappings" of an important endeavor. Examples of these "trappings" include a serious (although friendly and kind) attitude of the staff toward the learning, a serious approach toward testing and attention toward making the test scores important, and certification of completion of classes. In the Learning Center, pre- and post-test scores are posted on a bulletin board and patients are encouraged to find out and compare their scores before and after attending classes. At the end of their course of study, the patients are given certificates attesting to their completion of a course of study entitled "Patient Responsibility in Mental Illness." All these methods attest to the importance of the learning to treatment.

### **Conclusions**

There are many advantages to teaching mentally ill patients about their illnesses, and these benefits are being realized in the Psychological Learning Center. They can be summarized as follows:

- (1) It is the right of a patient to know about his or her illness. This benefit seems obvious, but it is still not recognized widely, especially in the case of psychiatric patients.
- (2) Educating the patient improves compliance with prescribed treatment. If the patient understands that his or her illness is medical in nature rather than being an example of "bad" or "crazy" behavior or of demonic possession, or the fault of his or

her family, then the patient is more likely to see the need for and to participate in medical treatment.

(3) The patient can be placed in the proper role if he or she understands the illness. The patient who is mentally ill can be placed in, take advantage of the rights of, and fulfill the duties of the sick role without the fear and confusion of being placed in another role.

(4) The locus of control is placed with the patient, rather than with the doctor and other treatment workers. The patient who truly understands the nature and treatment of his or her illness can be responsible and make informed choices about treatment participation.

Patient education for mentally ill patients is a new venture and it has only begun to be carried out on a large scale. It remains to be pioneered and tested out in many settings, but its benefits are clear to those who work in this important endeavor. Many anecdotes are available in which patients have attested to their gratefulness that the care has been taken to give them this vitally needed information. Comments such as, "This is the first thing anyone has told me that made any sense," or "They told me it was a search for meaning and I knew I could find meaning without being so sick," are not uncommon among patients who have attended the classes. Mental health center workers who see the patients after discharge have remarked that they have seen a definite change in the patients who are coming to them for followup appointments, in that they are more knowledgeable and more motivated to get medication and stay on it. Patients' rights advocates have expressed agreement and praise for the program, saying that it is in line with the legal aspects of mental health care. Patients affectionately refer to "going to school" here at the hospital and speak knowledgeably about perceptual distortions, schizophrenia, mood swings, and delusions. The Friday afternoon awards ceremony has become a vital part of the program, and there is always applause for those who have completed their course of

study.

The Psychological Learning Center has shown, both through objective testing procedures, and through less objective anecdotal evidence that patient education is beneficial to psychiatric inpatients. A few inroads have been made with outpatients in private settings and more recently with aftercare patients in community mental health centers. Programs of this nature do take time and care to develop, but their benefits in the form of better patient treatment through development of responsible patients are worth the effort.

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