



The Efficacy of Psycho-Education in Treatment Compliance among the Schizophrenics

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ABSTRACT

The study examined the efficacy of psycho-education in treatment compliance among the schizophrenics using cross sectional survey, before and after design, and in-depth oral interview. A total number of 41 participants (male=25, female=16) with age range between 18-55 years, mean score of 35.12 and standard deviation of 11.29 were drawn from both neuropsychiatric hospital oda road Akure Ondo State and Ekiti State University Teaching Hospital (psychiatric unit) using health seeking behaviour scale developed by Okunade (1987) to explore health seeking behaviour pattern among the schizophrenics the mean score determined participants for intervention which is the psycho-education. The result revealed that psycho-education is a veritable tool in modifying health seeking behaviour pattern and treatment compliance among the schizophrenics.

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INTRODUCTION

Among the factors that are responsible for how mentally ill patients (schizophrenics) seek for help whenever they are ill include perceived stigma: anxiety about being diagnosed as schizophrenics, patients' belief system (religiosity).

As a result of this schizophrenics will seek and always seek alternative care providers as against western medical care, in these cause traditional healers find themselves being responsible for care of schizophrenics (Erinosho, 1982).

Several individuals are affected with one psychological or the other during a particular year amounting to over 70million worldwide (Kessler, Chiu, Demiler, & Walters, 2005). Schizophrenia affect people with lower socioeconomic and people with limited resources within the ethnic groups (Stangor, 2010), among the criteria for designating behaviour as either normal or abnormal include if a given behaviour is unusual or dysfunctional (American Psychiatric Association, 2000).

Diagnosing schizophrenia is often difficult considering that other psychological disorders like anxiety and mood disorders could occur alongside (Hunt, Slade, & Andrews, 2004) Because most psychological disorders are co morbid, concentrations are usually among small group of individuals (Kessler et al., 2005). Psychological disorders including schizophrenia have in common with other medical disorders; they are treated with drugs, like other medical problems, schizophrenia has both biological (nature) as well as environmental (nurture) influences. These causal influences are reflected in the bio-psycho-social model of illness (Engell, 1977).

Eugen Bleuler (1857-1939), was the first scholar to describe psychological disorder as split mind a Swiss psychiatrist, combining ideas from Kraeplin and Freud, Bleuler conceptualized Kraeplins' syndrome as a disorder whose primary feature was an alteration of the faulty of association.

Schizophrenia is a debilitating psychological disorder characterized by delusions, hallucinations, loss of contact with reality, inappropriate affect, and disorganized speech behaviour. Among the most chronic and worrisome psychological disorder schizophrenia is ranked first, this affects approximately 3 million people in the united states (National Institute of Mental Health, 2010).

Early developments of schizophrenia are usually experienced between the ages of 16-30 and may be difficult to experience above 45years or among children (Mueser & McGurk, 2004). It has been documented that in Nigeria five percent of our general population 18years and above are affected by major mental disorders (Adewuya, 2009). Corrigan (2007) in his study highlighted factors like stigma, shame, exclusion, inhumane treatment that affect sufferers of mental illness which eventually affect their health seeking behavior pattern, to him many did not even come out for treatment, equally he believes that mental health problems remain a hidden burden, resulting from isolation and unemployment. Also according to him, he believed the sufferers of this debilitating condition has this condition absolutely taken charge of their lives, feeling about one self, capacity for activity, social relationship, family with law and public life.

People suffering from schizophrenia could suffer from schizophreniform type, paranoid, catatonic, disorganized or residual (Rosenbush & Mazurek, 2010). However their management procedure is significantly related.

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As debilitating as this mental illness is (schizophrenia) there are so many factors responsible for the choice of treatment by its suffer, factors such as accessibility to health care facility, religiosity, stigma, health locus of control, perceived social support also socio-demographics factors like sex, marital status, religion, educational qualification, socio-economic status could influence choice of sufferers' treatment center. It's obvious that with the availabilities of mental hospitals, sufferers of schizophrenia still visit alternative mental health care practitioners (Lambo, 1969, Erinosh., 1979) even while in these alternative mental health

care centers with no obvious improvement some even deteriorate with their condition, yet they still find it very difficult presenting themselves in mental health care hospitals.

This has been linked with the aforementioned psychosocial factors. Health seeking behaviour pattern of the schizophrenics are significantly influenced by the factors listed earlier, research and clinical practice has shown that most of the schizophrenics patients in most mental health hospitals have once visited one alternative mental health care center or the other before considering mental health care hospital, while in the hospital they still contemplate (schizophrenics) with obvious improvement on their mental health whether to continue or not with treatment in mental health care hospital. The reasons are not farfetched from the factors listed earlier, hence they require psycho-education to remain and comply with hospital based treatment.

Psycho-education can be described as training rendered to individuals suffering from mental illness (usually schizophrenia) as well as their families basically to equip them in order to manage their condition. Psycho-education is implicated in the management of schizophrenia and other mental illness, this concept was first used by John E. Donley in a journal of abnormal psychology published in 1931 before it became popular some years after (Hogarty, et al 1991).

American Psychiatric Association (APA), German Society for Psychiatry, Psychopathology and Neurology (DGPN) explained that psycho-education is implicated in therapeutic program for both schizophrenics suffering from acute and post- acute phases. Pekkala and Merinder (2002) revealed that psycho-education if successfully carried will reduce relapse rate, promote compliance and give sufferers of schizophrenia better acceptance of their status.

The main target of psycho-education is empowering the patients to be able to tackle their condition optimally, by understanding the nature of their condition (insight) compliance with their medications and hospital appointments (Pekkala and Merinder, 2002). Linderman, Mueser and Wallace (1990) opined that the core of psycho-education is to ensure schizophrenics are independent and eventually have control over their condition to prevent relapse.

Parts of the major factors in psycho-education include: all participants must have common ailment, insightful and should be within the time frame as specified in the literature (Pen and Mueser, 2004). In order to successfully implement and achieve the aims and objectives of psycho-education family integration is paramount because in achieving stability and compliance, family roles are innumerable (Baumi, 2006).

The overall purpose of psycho-education is to modify health seeking behaviour pattern of the schizophrenics and reduce relapse significantly, ensure family members and the patients are better informed about the illness, take their medications regularly, comply with hospital appointments and understand basic first aids in case of relapse (Hogarty et al, 1991).

METHOD/ INSTRUMENTS

The study took place in both Neuro-psychiatric hospital oda raod Akure, Ondo State cited in the capital city of Ondo State with bed capacity of about 60, consisting about 3000 patients (in and out patients) yearly, 20% covering schizophrenic patients, has qualified mental health professionals and Ekiti State University Teaching Hospital (Psychiatric unit) Ado Ekiti, Ekiti State cited in the capital city, consisting of about 500 patients (in and out patients) yearly, 40% covering schizophrenics the unit has qualified

professionals in mental health care. A total number of 41 participants were used for the study, 25 males with 61% of the population and 16 females with 39% of the population, age range between 18-165 yrs. Each participants completed socio-demographic section and a fifteen –item self-administered health seeking behavioural scale with hospital compliance items, developed by Okunade (1987) with high reliability coefficient of .85 and validity coefficient of .80. This instrument has been used majorly among the Yorubas by the author.

PROCEDURE

After following the ethics of research, (letter of introduction, proposal, consent letter) the research took place in both hospitals (neuropsychiatric hospital oda road akure and Ekiti university teaching hospital (psychiatric unit)). The administration of the instruments were in two phases, the first phase was general screening to determine those who have visited alternative mental health care center as well as those who scored low on health seeking behaviour scale, interestingly all those who have visited alternative mental health eventually scored low on health seeking behaviour scale, they merited the intervention scale (Psycho-education). The screening mean score for this research was 35.12, indicating that those who scored below this mean score merited the intervention scale. Among the participants 21 scored below the mean score and these 21 participants were divided into both experimental (11) and control (10) participants the process was achieved by rolling paper yes experimental and No control The psycho-education sessions for the patients followed the literature based stages, each period lasted for 60 minutes, took place once to twice in a week and consisted of 16 sessions, the members of the group were mainly schizophrenic patients (Penn & Muesser 2004). The health seeking behavioural scale was re-administered after the intervention (psycho-education).

RESULTS

Table 1. Descriptive table showing accessibility to health care facilities and sources of health seeking among schizophrenic patients.

	n (%)	n (%)	N (%)
	Male n=25 (61)	Female n=16 (39)	Total N=41
Accessibility to health facilities			
No	2 (33)	4 (67)	6 (15)
Yes	23 (65)	12 (34)	35(85)
Sources of health-seeking			
Hospital	0 (0)	2 (100)	2 (5)
Traditional homes	3 (100)	0 (0)	3 (7)
Churches	8 (57)	6 (43)	14 (3)
Others	14 (64)	8 (36)	22(54)

From the table above (4.1.2) it revealed that 2 females with 33% of the population and 4 males with 67% among the population had no access to health care facilities, while 23 males with 65% of the population and 12 females with 34% among the population had access to health care facility. Also in the table only 2 males making 100% among the population consulted hospital, 3 males with 100% of the population had consulted traditional homes, 8 males with 57% of the population and 6 making 43% of the population consulted churches while 14 making 64% of the population and 8 making 36% of the population consulted other alternatives to health care facility before coming to the hospital.

Table 2.Overall mean scores and standard deviations of schizophrenic patients on health seeking behaviour pattern.

Variable	N=41	M (SD)	95% CI
Health Seeking Behaviour		35.12 (11.29)	[31.56, 38.69]

Table 3.Paired sample t-test showing pretest and posttest differences on health seeking behaviour pattern for the experimental group.

Variable	Pretest		Posttest		t ₍₁₀₎	P	95% CI	Cohen's d
	M	SD	M	SD				
Health Seeking Behaviour	26.36	5.39	40.36	1.69	-8.62	<.0001	[-17.68, -10.38]	-3.63

A paired sample t-test (table 3) showed that the difference between pretest scores on health seeking behaviour (n = 11, M = 2.36, SD = 5.39) and posttest scores on health seeking behaviour (n = 11, M = 40.36, SD = 1.69) of the experimental group were statistically significant, $t(10) = -8.62$, $p = .<0001$, 95% CI (-17.68, -10.38), $d = -3.63$. This means that the posttest scores on health seeking behaviour were significantly higher than pretest scores on health seeking behaviour after psycho-education interventions with a large effect size as shown by the Cohen's d value of -3.63. Cohen's d value of .20 represents small effect size, .50, moderate effect size and .80 and above, large effect size (Cohen, 1977).

Table 4.Paired sample t-test showing pretest and posttest difference on health seeking behaviour pattern for the control group.

Variable	Pretest		Posttest		t ₍₉₎	P	95% CI	Cohen's d
	M	SD	M	SD				
Health Seeking Behaviour	24.30	4.93	25.50	3.54	-1.2	.25	[-3.38, .98]	-.29

A paired sample t-test (table 4) showed that the difference between pretest scores on health seeking behaviour (n = 10, M = 24.30, SD = 4.93) and posttest scores on health seeking behaviour (n = 10, M = 25.50, SD = 3.54) of the control group were not statistically significant, $t(9) = .25$, $p = .29$, 95% CI (-3.38, .98), $d = -.29$. This means that both pretest and posttest scores on health seeking behaviour for the control group were not significantly different from each other.

DISCUSSION

The improvement and treatment compliance (hospital based) manifested after re-administering the health seeking behavioural scale among the participants can as well be linked with the justice the researcher did to psycho-education among the sampled participants (experimental group) enough sessions were dedicated to educate the patients on the nature of the antipsychotic medications and their side effects used among the schizophrenic patients, in clinical practice medications' side effect contribute to patients' poor compliance to orthodox treatment, they were educated that there are newer drugs known as atypical antipsychotics that have bearable side effects, it was so surprising that one of them indicated he is on olanzepine and he is experiencing relieved side effects, also the need for clinic compliance was stressed that in the hospital there are great mental health care professionals dedicated specifically for their care these include psychiatrists, clinical psychologists, psychiatric

nurses, social workers, occupational therapists, pharmacists, medical laboratory scientists, medical record officers, many of the participants got to know these professionals and their job descriptions during the psycho-education sessions. Many confirmed they have been seeing these professionals within the hospital but could not recognize them by their professions, the leader of the group who doubles as the researcher and the clinical psychologist further educated them that these set of professionals are only available in the psychiatric hospitals, that government has subsidized the patients' consultation fees to the professionals by paying their salaries hence their compliance should not be compromised. The modified behaviour exhibited by the participants through the health seeking scale administered on them after psycho-education can also be attributed to the results of researchers like Kuipers and colleagues (2014), Pekkala and colleagues (2002), Knurf (2001), Baumi (2004, 2006), Liberman and colleagues (1990) they demonstrated in their various works the efficacy of psycho-educational interventions in modified health seeking behaviour pattern and treatment compliance as seen in this study. In the study part of what the researcher put into consideration among the experimental group during psycho-education is the fact that psycho-education groups carry the claim of bringing group dynamics effect to bare in the case of acute and post acute schizophrenic patients (Baumi, 2006).

CONCLUSION

Psycho-education is a veritable tool in the management of treatment compliance among the mentally, proper understanding about their illness (schizophrenics) will make them comply and remain in treatment; this can only be achieved by trained clinical psychologist and implemented in treatment center (hospital). Several researches have demonstrated the efficacy of psycho-education in treatment compliance among the schizophrenics and this has reduced rehospitalization from 58% to 41%, and days spent by schizophrenic patients in the hospital from 78 to 39 days (Baumi, 2003). This is equally achievable if qualified professionals implement it in treatment centers.

RECOMMENDATIONS

Government should provide rehabilitation centers all over the country for the vagrants psychotic/lunatics littering our major streets in some towns, because the few that had social support were sampled in this study but many are still out there without treatment. While much money is pumped into the maintenance of such centers by the governments, philanthropists (Red-Cross Society, Club Associations,) should be encouraged to donate in kinds and cash (building and money) generally to psychiatric homes.

Government should consider integrating in their policy making mental health care affordable and accessible if not totally free to mentally ill patients, government should understand that management of this illness is a life time and many could be victims due to bad government policies that lead to psychosocial stress (unemployment, underemployment, late marriage, etc) when this is achieved many psychological and social factors hindering them from attending hospital for treatment will be significantly reduced.

REFERENCES

Adewuya, A.O., & Makanjuola, R.O.A. (2009). Social distance towards people with mental illness amongst Nigerian University Students. *Social Psychiatry*, 40, 865-875.
American Psychiatric Association. (2000). *Diagnostic and*

Statistical Manual of Mental Disorders (DSM) (4th Ed-rev.). Washington, DC: Author.
Baumi, J., & Pitschel-Walz, G. (2003). *Psychoedukation bei Schizophrenen Erkrankungen*. Stuttgart, Germany: Schattauer.
Baumi, J. (2006). Psycho-education: A basic psychotherapeutic intervention for patients with schizophrenia and their families. *Schizophrenia Bulletin* 32, 1-9.
Buchanan, R.W. & Carpenter, W.T. (2005). *Concept of schizophrenia*. In B.J. Sadock V.A Sadock (Eds). Kaplan & Sadock's comprehensive textbook of psychiatry. Philadelphia, PA . Lippinch. Williams.
Butcher, J., Mineka, S & Hooley, J. (2007). *Abnormal Psychology* (13th ed) Susan Hartman (ed). Boston: Pearson Education, Inc.
Corrigan, P.W. (2007). How stigma interferes with mental health care. *American Psychologist* 59, 614-625.
Erinosho, O.A. (1983). Mental health planning in Africa: Some issues. *African Journal of Psychiatry*, 5, 43-47.
Engel, G.L. (1977). The clinical application of the biopsychosocial model. *American Journal of Psychiatry*. 136: 5
Hunt, C., Slade, T., & Andrews, G. (2004). Generalized Anxiety Disorder and Major Depressive Disorder Comorbidity in the Natural Survey of Mental Health and Wellbeing. *The official Journal of Anxiety related disorders, (ADAA)*. 20:1.2331.
Kessler, R.C., Berglund, P., Demler, O, Jin, R., & Walters, E.E. (2005). Prevalence, Severity and Comorbidity of 12-month DSM-IV disorders in National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62(6), 617-627.
Knuf, A., & Seibert, U. (2001). *Selbsterziehung fördern*. Bonn, Germany: Psychiatric. Verlag. *Journal of Experimental Psychology*, 130 (4) 779-798.
Kuipers, E., Yesufu-Udechukwu, A., Taylor, C., Kendall, T. (2014). Management of Psychosis and Schizophrenia in Adults: Summary of Updated NICE Guidance. *British Medical Journal*, 348.pg.1173.
Lambo, T.A., (1969). *Psychiatric disorder among Yorubas*. Cornell University press. Ithca, New York, pp 226-252.
Liberman, R.P., Mueser, K.T., & Wallace C.J. (1990). Training skills in the psychiatric disabled: learning coping and competence. In: Straube, E, Hahlweg, K, eds. *Schizophrenia. Concepts, Vulnerability and Models*. Berlin, Germany: Springer -Verlag: 193-216.
Lindemyer, J.P., & Khan, A. (2006). *Psychological disorder*. In J.A. Liebman, T.S Stroup, & D.O. Perkins (Eds), *Textbook of schizophrenia* (pp.187-222). Washington, DC: American Psychiatric Publishing.
Penn D.L., & Mueser K.T., (2004). Research update on the psychosocial treatment of schizophrenia. *American Journal of Psychiatry*. 53: 607-617.
Pekkala, E., & Merrinder, L. (2002). Psycho-education for schizophrenia. *Cochrane Review Cohchrane Data Base System Revision (serial online) No.CD002831:1-41*.
Maher, B.A. (2001). Delusions. In P.B. Sutker & H.E. Adams (Eds), *Comprehensive Handbook of psychological disorder* (3rd ed pp.309-370). New York, NY: Kluwer Academic /Plenum.
Mueser, K.T., & McGurck, S.R. (2004). *Schizophrenia*. *Lancet*, 363 (9426), 2063-2072.
National Institute of Mental Health (NIMH) (2010). Hereditary and mental disorders (Biogenic influence): *Report of the National Institute of Mental Health's Hereditary Work group*.
Stangor, C. (2010). *Introduction to psychology*. Irvington, NY: Flat World Knowledge