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Explanatory model of illness of the patients with schizophrenia and the role of educational intervention

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ABSTRACT

This randomized controlled trial was conducted at Department of Psychiatry, Lady Reading Hospital, Peshawar from February to August 2015 to explore beliefs and concepts of patients with schizophrenia about their illness and to find out the effectiveness of structured educational intervention in changing the explanatory models of illness of the patients and in their symptoms reduction. One hundred and three patients were recruited in the trial who were randomly assigned to two groups i.e., Experimental ($n = 53$) and Control i.e., Treatment As Usual, TAU ($n = 50$). Intervention was applied to experimental group only, once a month for three months. Short Explanatory Model Interview (SEMI), Brief Psychiatric Rating Scale (BPRS), Positive And Negative Syndrome Scale (PANSS), Global Assessment of Functioning (GAF) and Compliance Rating Scale were applied on all patients at baseline and at 3 months follow up. Scores on PANSS (Total), BPRS and GAF showed improvement in the experimental group as compared to TAU group, at follow up, with the p values of 0.000, 0.002 and 0.000, respectively. On follow up, 44 (95.6%) patients of experimental group achieved complete compliance as compared to 17 (47.2%) patients of TAU group [$p = 0.000$]. On baseline analysis of SEMI, in the experimental group, only 3.8% ($n = 2$) knew about name of the illness, which increased to 54.3% ($n = 25$) on follow up, while in TAU group it improved to 5.6% ($n = 2$) as compared to 0% at baseline ($p = 0.000$). The result suggest that Structured educational intervention can be effective in modifying the beliefs of the patients regarding their illness.

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1. Introduction

Schizophrenia is a complex illness that does not follow scientific explanation for all the aspects of the illness from overt behavior to the intracellular changes (Carroll and Owen, 2009). Till date, the researchers have not been able to identify even a single factor which can commonly explain/define all patients with schizophrenia. In spite of the challenges, still, many researchers have put most of the pieces in proper place in this field but the puzzle is still unsolved (Walker et al., 2004).

It is important to know the health beliefs of the individuals suffering from psychiatric disorders. These beliefs are the main factors in health models and illness related behavior, and so they might affect clinical outcome, because these are directly related to patient's own viewpoint about his illness and treatment option (Williams and Healy, 2001). In the treatment process, the patient has now been considered an active partner because of the move towards patient centered care. For making the patient more active in the care process it is important to illustrate

patient's own perspective of the treatment plan. This demands the exploration of the patients' views about their illness and then addressing those views to strengthen therapeutic relationship and treatment effectiveness (McCabe and Priebe, 2004a). The pioneering explanatory approach developed by Klienman involved asking explanatory questions in a qualitative approach (Bhui and Bhugra, 2002). Beliefs about illness hold by the patients and their families effect their decisions about the consultation for the treatment and also perseverance of symptoms and the level of disability caused by illness. Illness perception models have theoretical structures to systemized the information about patients' beliefs and expectations and to explore their perceptions about the causes and consequences. These factors can strongly predict the outcomes related to health (Sumathipala et al., 2008).

For the last few decades, there is rising interest in how individuals think about their illnesses and how these explanations are different in culture (McCabe and Priebe, 2004b). Explanatory models greatly differ from culture to culture and even within the culture, and it is proved by evidence. However very less research has been done on how these model differ across divergent exploratory framework (Lynch and Medin, 2006).

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Evidence shows that patients with schizophrenia learn a lot through psychological interventions which help them to improve their quality of life. For the last 4 decades, psychoeducation is getting importance in the treatment of schizophrenia and other psychotic disorders. Number of psychoeducational approaches have developed in health psychology, specifically for patients with schizophrenia who are on antipsychotic medications and have problems of obesity and metabolic syndrome. Psychoeducational intervention designed for these problems help patients to adapt healthier lifestyle and dietary plans (Bisbee and Vickar, 2012). Furthermore, it is also a fact that these interventions are very helpful in reducing family burden, which is again associate in reduction of indirect costs due to loss of productivity of family members (Pingani et al., 2013). According to Cochrane analysis, psychoeducational interventions showed decrease rate of relapse, better compliance level, and improvement in psychopathology (Pekkala and Merinder, 2002; Magliano et al., 2006). Compliance is not that uncommon and the treating psychiatrist has to be mindful of it. Compliance counseling is important part of psychoeducation. Studies focused on educational formats have influenced improvements in general understanding of schizophrenia and its treatment (Turkington et al., 2006).

There is dearth of research on explanatory model of illness of psychosis in our settings and the inadequate and inaccurate knowledge about schizophrenia in general population is well documented (John, 1992.). It has been revealed that gaps between patients and mental health professionals understanding may affect help-seeking behavior, adherence to medication and provision of effective psychosocial therapy. Dissonance between cultural and scientific explanations further deteriorates the much needed therapeutic relationship and long-term care of schizophrenia. To improve patient outcome, health professionals need to look at wider picture of illness rather than scientific model of disease and develop good communication skills to gain patients' trust. Therefore, we investigated the explanatory models of illness in patients suffering from Schizophrenia in our setting to find out the role of educational intervention, which is expected to be beneficial not only for the patients, caregivers and mental health professionals but also for overall care of psychiatric patients.

2. Methods

2.1. Trial design

This was a randomized controlled trial, conducted to explore the effectiveness of Structured Educational Intervention. The study consisted of two groups, i.e. the control group and the experimental group. Structured Educational Intervention was applied on the experimental group only, and, the control group received treatment as usual (TAU) only. The trial was approved by the Research Ethics Committee of Lady Reading Hospital Peshawar, Pakistan and was conducted in compliance with the Declaration of Helsinki.

2.1.1. Instruments

Semi structured-interview was conducted at first on all the patients in order to get basic sociodemographic information and to satisfy the diagnosis according to ICD-10 criteria.

The first scale we used was Short Explanatory Model Interview version 3.0 (Mirza et al., 2006) which elicited the patients' concepts, causes, treatment choice and severity of the illness, responses of the patients were recorded in a written verbatim form. SEMI has been designed in a simple way that it can be easily used in day to day clinical practice and research. The language used in the scale is non-technical and can be easily translated. It does not require any special training for the interviewer from any background. Qualitative analysis methods are suitable for the analysis of the data taken from this tool.

Positive and Negative syndrome scale (Kay et al., 1987) was applied to measure the severity of the symptoms. It is a 30 item rating scale, designed to assess individuals with schizophrenia and other psychotic

disorders and is widely used in research settings. Items are divided into 7 positive items, 7 negative and the remaining 16 constitute general psychopathology scale. Each item is scored from 1 to 7 and total scores are obtained by the sum of ratings of each component of the scale. Therefore, possible ranges of score are 7–49 for the positive and negative scales, and 16–112 for the general psychopathology.

Global assessment of Functioning was administered to rate the functioning of the patients. GAF is representation of clinical interpretation through numerical approach to the person's overall functioning level. Impaired functioning in psychological, social, occupational and academics are taken under consideration. The scale ranges from 0 (inadequate information) to 100 superior functioning or having no impairment at all.

Brief Psychiatric Rating Scale (Leucht et al., 2005) was also applied on all the patients in order to rate the psychotic behavior of the patients. It is one of the most widely used instrument for assessing psychopathology in patient suffering from schizophrenia. BPRS includes 5 sub scales, i.e., Thought disorder, Withdrawal, Anxiety/Depression, Hostility and Activity, which is symbolically denoted as (TD), (W), (AD), (H), and (A) respectively.

Compliance Rating Scale (Herz et al., 2000) was administered to check the patient's adherence to treatment. It has three measures. None, partial and complete compliance. However, for the sake of analysis, none and partial were combinedly considered as non-compliance.

All these scales were administered on all the patients on baseline and on 3 months follow up.

2.1.2. Setting

This randomized controlled trial was conducted at the inpatient care of the department of Psychiatry, Lady Reading Hospital, Peshawar from February to August 2015. This department has the capacity of 36 beds for in-patients, both male and female. It is one of the very few purpose built departments of Psychiatry in Pakistan, catering for patients of almost all sub specialties of Psychiatry.

2.1.3. Procedure

All the patients who visited psychiatric OPD and diagnosed by the consultant psychiatrist as schizophrenia were referred to the researcher after prescribing medications. Outline of the research was given to all the patients and after getting their willingness for the participation in the research, written Informed consent was taken from the patients and attendants. Patients who fulfilled the inclusion criteria were randomly assigned to each treatment group using computer generated randomization method. After complete assessment, the patients who were included in the experimental group were administered Structured Educational Intervention 19, which was repeated once in a month.

2.1.4. Participants

Patients who fulfilled the ICD-10 diagnostic criteria for schizophrenia were included in the study with their relatives. Patients with any other psychiatric co morbidity, for example Learning Disability or with any severe physical problem were excluded. Patients who were not able to respond or communicate were also excluded.

A total of 121 participants were referred (Fig. 1) and 103 were randomized; 53 were randomized to the intervention arm and 50 were randomized to the control (Treatment As Usual, TAU) arm.

2.1.5. Sample size

Based on the prevalence reported in a previous study and using WHO sample size calculation software, a total of 103 patients were included in the study.

2.1.6. Randomization

After completion of the assessment, participants were randomized to two groups i.e., TAU and experimental by using computer generated randomization method. The allocation list was kept in a remote secure

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