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THE PRACTICE OF PSYCHO-EDUCATION FOR PEOPLE WITH MENTAL ILLNESS RECEIVING TREATMENT AT AMANUEL SPECIALIZED MENTAL HOSPITAL

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ADDIS ABABA UNIVERSITY

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Acronyms

DSM Diagnostic and Statistical Manual of Mental Disorders

MMAS Morisky Medication Adherence Scale

PI Principal Investigator

SPSS Statistical Package for the Social Sciences

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Declaration

I, the undersigned, declare that this thesis is my original work and has not been presented for a degree in any other university and that all sources of materials used for the thesis have been duly acknowledged.

Name: Addisalem Oldisha Kashasho

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Date of Submission: January 30, 2018

Abstract

***Background**: Psycho-education has been one of the core components of psychiatric treatment methods for some time. However, there is no information about the practice of psycho-education among clinicians at Amanuel Hospital.*

***Aim:** The purpose of this study was to assess the practice of psycho-education provided for people with mental illness receiving treatment at Amanuel Specialized Mental Hospital and to see its association with treatment adherence.*

***Method:** Quantitative approach was employed to conduct the study. The study was conducted on selected consecutive outpatients attending follow-up clinics at Amanuel Hospital. Records of 1128 patients were obtained from the outpatient clinic for sampling. Of these, 120 were selected from different types of disorders using simple random sampling technique. A questionnaire developed by the PI and MMAS were used to collect data from the respondents. Data analysis was conducted using SPSS version 20.*

***Results:** The majority of the participants (54.2) were men, 52.5% were single, and 60.0% Christians and 40.0% were Muslims. Over 80.0% were unemployed and 45.0% had attained high school level of education. 58.3% of the participants reported that they had not received any information about their illness. Among those who had received psycho-education, only 42% of them said patients receive information about precautions to take to prevent relapse. This study showed that there is a significant association between gender, age, educational level, marital status, employment status, residence, and psycho-education. These socio-demographic variables were also associated with medication adherence. The participants who reported to have received psycho-education were more likely to adhere to treatment compared to those who had not received it.*

***Conclusion:** The finding suggests that the practice of psycho-education provided for outpatients at Amanuel Hospital is very limited.*

***Keywords:** Practice, Psycho-education, Treatment, Mental illness, Amanuel Specialized Mental Hospital*

CHAPTER ONE

Introduction

1.1 Background

Psycho-education may be defined as the methods, techniques and educational programme to educate patients with a psychiatric disorder in the subject area that serves the goals of treatment and rehabilitation or reduces effects of the illness or disability (Guilford Press; 1983). The purpose of psycho-education for people with mental illness is many folds. Empirical evidence shows that psycho-education service has a significant influence on improving lives of patients, enhancing patients' knowledge and understanding of the illness and treatment, strengthening social and behavioral skill and positive emotions to enhance life adjustment, management of emotions and, self-awareness. It is also essential in changing unhealthy or harmful psychological and behavioral patterns and reducing relapse and strengthening the social participation of people with the severe mental illness. Hayes, Harvey, & Farahall, 2013.

Other positive outcomes have also been demonstrated for patients and family, suggesting that psycho-education provides multiple benefits. Such as decreasing symptomatology and improving social function for patients and improved well-being and decreased levels of medical illness among family members. (Dyck, 2002; Dyck et al., 2000; McFarlane et al., 1995; Montero et al., 2001). Because of these rationales, to offer psycho-education services for people with mental illness is critical.

The role of psycho-education is not only to provide information but, it is also vital during the sessions as part of the therapeutic strategies that increase abilities and improve the functioning of mentally ill patients. Psycho-educational sessions provide information and increase the knowledge that is being related to the individual course of illness and healing, and in effect, they engage

patients on cognitive and emotional levels. It is also an interactive process which includes elements of psychotherapeutic strategies (McGorry, 1995 & Czernikiewicz, 2006).

In the field of clinical practice, there are several multimodal psychotherapeutic interventions that have been developed for the patient with mental illness, such as family-focused therapy, interpersonal and social rhythm therapy, cognitive behavioral therapy and behavioral therapy. All these treatment approaches encompass and practice psycho-education. Most of the current researchers have also started to address the effects of psycho-education as a treatment for patients with mental disorder, and manual-based standardized psycho-education has been developed (Bartosz, G., Grzegorz, M., & Dominika D., 2007).

As an evidence-based form of the treatment modality, psycho-education has been mainly associated with reducing the rate of hospitalization and relapse of the illness, improving the state of health and psychosocial functioning of the patients, as well as their better cooperation and extensive knowledge about the illness (Lincoln, T., & Wilhelm, K., 2007). One of the most effective psychosocial approaches to people with mental illness is psycho-education. Psycho-education is a specialized education that consists of educational and psychosocial endeavors with an aim to create long-term behavior change in patients and their families. Planned psycho-educational programs assist patients and their families to cope with and adapt to the difficulties associated with the disease, enable them to develop their problem-solving skills and increase their quality of life (Tel, 1999; Yurtsever, 1999; Todd et al., 2002; Reid et al., 2005).

According to Colom and lam (2005), psycho-education covers a fundamental right of our patients; the right to be informed about his/her illness and treatment. It is a professionally delivered treatment modality that integrates and synergizes psychotherapeutic and educational interventions. Many forms of psychosocial intervention are based on traditional medical models designed to treat pathology, illness, liability, and dysfunction whereas psycho-education reflects a paradigm shift to a

more holistic and competency-based approach, stressing health, collaboration, coping, and empowerment (Dixon, 1999; Marsh, 1992). On the other hand, one of the problems with psycho-education is that of "branding" (joint with other therapies, including skilled ones): many health providers claim to use psycho-education when referring merely to informing their patients about the disorder or giving them some general indications on prevention and crisis management. Psycho-education goes far beyond these minimal standards of good medical practice. Even though in recent years, many psycho-educational interventions have been developed for patient's mental illness and their families in various fields around the world, structured psycho-education is rarely offered to patients and their families in non-psychiatric settings (Tel, 1999; Yurtsever, 1999).

In Ethiopia, mental health professionals are being thought to use psycho-education as one component of treatment for people with mental illness. However, the practice of psycho-education has not been carefully evaluated to the best of our knowledge. Therefore, this study aims to assess the practice of psycho-education that is being provided by mental health workers for people with mental illness.

1.2 Statement of the problem

Psycho-education practice has been introduced in the teaching of professionals who are engaged in caring for the mentally ill in Ethiopia. This practice is to be part of their day to day clinical activities in order to enhance awareness in patients about psychological, social, behavioral and emotional problems and to guide them about self-help strategies to understand and try to solve some aspects of their problems. However, the success of this service in Addis Ababa mental hospital has remained in doubt.

Antai-Otong's (1989) study result shows that the existence of the low level of providing psycho-education has contributed to several adverse outcomes such as, frequent relapse and getting readmitted due to poor compliance with treatment and poor understanding of the result of medication. It has also been stated that a high number of patients with substance abuse again

turned to use substance after treatment has been discontinued, reduced level of understanding about symptoms, cause, consequences, and illness. Many patients feel stigmatized by the disease and may deny its existence and stop their medication and other forms of treatment and that, in turn, leads them to clinical and functional deterioration.

This study specifically tried to assess the presence of the practice of psycho-education and to determine the extent of the practice by mental health workers to people with mental illness receiving treatment at Amanuel Mental Specialized Hospital in Addis Ababa. Therefore, this study attempted to find answers to the following basic research questions,

1. Is psycho-education being practiced as part of the routine patient care at Amanuel outpatient psychiatry clinics?
2. What is the content of the practice of psycho-education as a component of treatment provided to patients?
3. Is there any difference among those patients who received psycho-education compared to those who did not in terms of adherence to treatment and clinical outcomes?

1.3 Objective of the study

1.3.1 General objective of the study

The primary goal of this study was to: -

- Assess the practice of psycho-education provided for people with mental illness receiving treatment at Amanuel Specialized Mental Hospital and to see its association with treatment adherence.

1.3.2 Specific objectives of the study

The study specifically aimed to: -

- Examine the practice of psycho-education as part of the routine patient care at Amanuel outpatient clinics.
- Identify the pattern of the practice of psycho-education as a component of treatment provided to patients.
- Examine the difference among those patients who received psycho-education compared to those who did not in terms adherence to treatment.

1.4 Significance of the study

No study conducted on this particular issue in Ethiopia; therefore, this study is expected to be of significance. First and foremost, it will serve as a point of reference for institutions to orientate themselves in relation to the findings. It provides vital information which assists mental health planners to formulate a policy on how to strengthen the practice of psycho-education services in mental health hospitals. The findings of the present study also inform practitioners how to plan quality improvements and how to achieve a new level of emphasis in the training of mental health clinicians. Finally, it will also serve as a baseline reference for future researchers who interested in investigating the different aspects of psycho-education.

1.5 Delimitation of the study

The study was delimited in terms of geographical location, methodology and time. The study focused on assessing the practice of psycho-education provided to people with mental illness at Amanuel Specialized Mental Hospital. This study could have examined differences at national or regional levels or between members of different religions or ethnic groups; however, this study was limited only to Amanuel Specialized Mental Hospital. Therefore, the results of this study

cannot necessarily be generalized to other mental health hospitals in Ethiopia. This area was selected because of its proximity to the researcher and thus for organizational convenience. Therefore, the findings of this study can only be interpreted as being typical of Amanuel Specialized Mental Hospital. Methodologically the study employed quantitative research methods. The main data collection tool for research was the use of questionnaires. Furthermore, the study used a simple random sampling technique.

1.6 Operational definition

Practice: - the actual implementation of a plan, the methodological and theoretical activities used to provide services to people with mental illness.

Psycho-education: - is defined as the systematic, structured teaching by professional bodies, of information relating to symptoms, etiology, treatment, related difficulties and coping skills (Glick, Burti, Okonogi, & Sacks, 1994).

Treatment: - refers to the process of applying therapies to assist people with mental illness.

Mental illness: - the state of suffering from symptoms which are diagnosed as being of a psychological nature.

CHAPTER TWO

Literature review

2.1. Define psycho-education

Psycho-education is a professionally provided treatment modality that integrates psychotherapeutic and educational interventions (Lukens & McFarlane, 2004). Such education can take the form of information about diagnoses and treatments (Psycho information) or teaching clients about psychological skills to decrease symptoms and get better functioning (mad skills). Psycho-education is used to help take away an individual's confusion, anxiety, and other obstacles or problems surrounding a psychiatric diagnosis, which may hinder progress in treatment. Psycho-education is often confused with psychotherapy (Friedberg & McClure, 2002). However, the main difference between the two is that psycho-education deals with the acquisition of information or skills whereas psychotherapy involves the actual application of information skills to a person's specific life situations inside and outside of therapy (Friedberg & McClure, 2004). The theoretical mechanism of change in psycho-education is based on the centuries‟ old assumption, "Knowledge is power" (Bacon, 1597) and the Chinese proverb of "Give a man a fish, you feed him for a day, but teach a man to fish, and you feed him for a lifetime."

2.2. The Importance of Psycho-education

Psycho-education has several advantageous in treatments of mental illness; various studies have been conducted on diverse aspects of the treatment of mental disease. Surveys employed in comparing intervention groups with control groups showed a higher level of well-being scores in the former, it was found that the difference in the mean post-education subjective well-being scores was significant. (Songul, D. & Gul, U., 2016). Again pre-test, post-test and follow up test I-II scores were compared, between the tests a control group used Bonferonni experiments, to demonstrate the efficacy of the experimental procedure, while a statistically significant difference

was found between the test group and control group in the mean scores of post-test. The mean post-test scores of subjective well-being scale of the test group were higher than the mean post-test scores of the subjective well-being scale of the control group. Consequently, the result indicates the efficacy of the education program in increasing the subjective well-being scores of the parents. (Songul, D. & Gul, U., (2016).

A statistically significant difference favoring the test group was found between the pre-test scores and the post-tests and follow up test scores in the sub-dimensions of self-compassion including self-kindness, self-judgment, awareness of common humanity, isolation, mindfulness and over-identification counts of the parents taking part in the control and test groups of the study. This result indicates the advantageous effect of psycho-education. (Songul, D. & Gul, U., 2016).

2.3. Effects of psycho-education practices in the treatment of mental illness

When applying psycho-education methods in the clinic for patients with psychological illnesses it is significant that the programs should allow the measurement of symptom reduction, improving mental functioning and patient's satisfaction with the intervention. Franaz F., Hossein, & Mina's (2015) study show that most of the families in the experimental group, and the control group had a negative attitude toward mental illness before the intervention. But, in comparison with the control group, most of the families in the experimental group had a positive attitude toward mental illness after the intervention. According to Lukens and McFarlane's (2004) study conducted on psycho-education the interventions for children, and adults showed that "Psycho-education is among the most effective of the evidence-based practices that have emerged in both clinical trials and community settings." In fact, psycho-education is such a powerful foundation for recovery and resilience the President's New Freedom Commission on Mental Health (2003) recognizes its value for consumers in three of its six goals. Furthermore, psycho-education has the potential to give consumers cognitive and emotional "power" over their conditions (empowerment); accurate

information to correct previous misinformation and prevent future errors; and the ability to distinguish, access, and utilize effective and cost-effective mental health and educational services.

The effects of group psycho-education in compliance with scheduled clinical appointments in a Neuro-psychiatric hospital showed that 72% of the treatment group had been admitted to the hospital for the first time, and 28% had 2 or more episodes of relapse of their illness. This result indicated that giving psycho-education for admitted patients could have positive effects by reducing the relapse rate of symptom's illness. For instance, Psychotic disorders rather than depressive disorders were more prominent in both the treatment (72 %) and control groups (65.2%), which accounted for 28% in the treatment group and 34.8% in the control group. We found that the rate of compliance with appointments after discharge from hospital was statistically significantly better for the treatment group than that observed in the control group. For both, we found no significant statistical difference in compliance with clinic appointments between the psychotic and depressive patients. (Aqara, A. & Onibi O., 2007).

The Study conducted on the Effects of a mindfulness-based psycho-education programme for Chinese patients with Schizophrenia: 2-year follow-up result showed that the mindfulness-based psycho-education for approach schizophrenia appears to be promising for the treatment of this condition. A 6-month programme involving intervention among 11 patients, when compared with conventional psycho-education or usual care, resulted in better patient outcomes (severity of psychiatric symptoms, level of psychosocial functioning, awareness of and insight into illness and need for treatment and duration of readmissions to the hospital) after a 2-year follow-up. With a paucity of clinical trials reported, these findings suggest that mindfulness-based psycho-education can be useful not only among patients with recurrent depression but also among people with schizophrenia and probably other psychotic disorders. (Wai, T. & David, R., 2014).

Some of the studies conducted in various parts of the world have proved that psycho-education is useful in multiple ways, while other studies have provided conflicting results. It has been discovered that psycho-education either provided to individual clients, to a group of clients or clients and their families have increased clients knowledge on their illness and the medication, improved medication compliance, reduced relapse rates and rehospitalization and also enhanced clients' attitudes towards the prescribed medication hence enhancing adherence to treatment. There is considerable evidence that psycho-education accelerates the change process (Dinkmeyer, 1991; Watkins, 1985).

The acquisitions of purposeful information about r illness have positive effects on the expression of emotions (Ozkan et al.2013). Studies conducted on the impact of psycho-education and telepsychiatric follow up given to the caregivers of schizophrenic patients on their family burden, indicate depression, and less expression of emotion; demonstrating that the mean scores of expressed emotion of the caregivers in the experimental group were higher than those of the control group before the psycho-education, problems were found to have significantly decreased after the education and telephone follow-up phone calls. Furthermore, disease management, which began with psycho-education and was supported by telephone follow-up, including being informed about the correct use of the drugs and awareness may have positively affected the expressed emotions of the caregivers. Psycho-education also has an excellent effect on knowledge, attitude, and burden of caregivers of clients with bipolar affective disorder.

Therefore, the results of the study showed that psycho-education had a highly significant effect on knowledge, attitude towards bipolar affective disorder and burden perceived by caregivers of clients with bipolar affective disorder. Assessment of burden showed that the psycho-education was significantly effective in the domains of physical and mental health, external support,

caregiver's routines and taking responsibility for caregiving. The study results also found that there was a definite correlation between knowledge and attitude. A negative correlation was found between mentality and burden and between education and responsibility. This implies that as knowledge improves, attitude improves and burden reduces and as attitude improves burden of care reduces (Jisme Mathew et al., 2015).

A study conducted by Whiteside (1983) on admitted patients to determine whether structured educational programmes with written reinforcements would statistically bring about an increase in patients' knowledge, discovered that the patients in the education programme improved in their understanding of their illness and medication. From this study, therefore, the deduction can be made that in preparation for discharge, information and reinforcement is essential and that a patient who has insight is more likely to comply. Similar results were reported in an exploratory study by Soareset al. (1997) in Australia on effects of a psycho-education package on outpatients with the bipolar affective disorder. The study showed that clients who participated in the psycho-education group showed significant improvement in knowledge about illness, attitudes towards prescribed drugs, and self-esteem. The utilization of psychiatric inpatient services decreased for three patients whereas the other seven did not use the service at all.

Another study was conducted to determine the effects of psycho-education on functioning levels among patients with bipolar disorder. To the best of our knowledge, this study was most effectives in showing the effects of combined pharmacological education plus psycho-education programs in multiple functioning areas among subjects with bipolar disorder. At the end of the study, the study outcomes show that "psycho-education increases the functioning levels of patients with bipolar disorder" and the psycho-education provided to patients with bipolar disorder was proven to have beneficial effects on their functioning levels. Ebru, K. T., & Haluk, A., S. (2014). Therefore, the

results of research indicate that psycho-education has manifold benefits for the treatments of mental health; through providing information and teaching patients about their illness and increasing the knowledge of patients, in this way it plays a great role.

2.4. Psycho-education and medication adherence

In the clinical setting, psycho-education is considered as one component of treatment in improving a client's medication adherence. Providing psycho-education to patients with mental illness offers them a great opportunity to in order their lives with low-stress levels, increased knowledge of illness and reduced negative attitudes, minimizing relapse rates and readmission to hospitals, speeding-up recovery of patients and improving adherence to medication. (Cheng et al. 2005). According to Crane, Kirby & Kooperman (1996), many clients with psychiatric disorders are hospitalized because of an exacerbation of their mental illness, stabilized with medication and then discharged home. At home, a large number fail to take their medication correctly, if at all. Relapse often occurs, and rehospitalization follows. Apart from relapse and rehospitalization non-adherence also leads to a lot of other problems, for instance, homelessness, episodes of violence, incarceration in jail or prison, and victimization of the clients. Underlying factors for accidental non-adherence include complex medication regimens that clients do not understand, inability to pay for medication, forgetfulness, and failure to follow instructions due to the severity of the illness, lack of insight and lack of understanding of the disease.

According to Lehne, Moore, Crosby & Hamilton (1994), 70% of non-adherent cases are intentional. It as the opinion of these authors that the clients believe that the drug is not needed as prescribed; this is the primary reason for deliberate non-adherence. Additionally unpleasant side effects, as well as patients' denial of the presence or severity of the illness, contribute to medication non-adherence (Crane et al, 1996). Non-compliance with prescribed medical regimes is not only a problem among people on psychotropic medication, but it is also a problem for other medical

conditions for which medication must be taken for extended periods, including hypertension, diabetes, epilepsy, asthma, and tuberculosis (Scort & Pope, 2002).

Client education is an initial step and the favored way to promote adherence among mentally ill individuals (Falvo, 1995). According to this author, patient education can be a crucial component in enabling patients to follow the recommendations of health professionals accurately. Such teaching can be done in groups or individually. The use of group education has an added advantage in enhancing the learning process, as peers can share similar feelings, experiences, and questions. Lassiter in Stanhope and J. Lancaster (1992) noted that groups bring about changes to improve the well-being of individuals. He stated that certain individual improvements in health would be difficult if not impossible to achieve without the support and encouragement of a group. Groups can influence thoughts, choices, behavior, and values.

Many individuals meet their social needs through association with others. Mueser et al., (2004) also contend that when patients with psychiatric disorders are given information or taught skills either by peers or health professionals they are helped to take good care of themselves. Peers can convey the lessons they have learned from personal experience when teaching others how to manage their symptoms, whereas health professional cannot. Education interventions have shown to be effective in promoting adherence among patients with chronic mental illness. Clients cannot follow treatment recommendations if they do not understand or accept them. When the client understands the symptoms and the severity of the disease, and if they have clear, explicit instructions, the client is more likely to assume increased responsibility for self-care which can increase the likelihood of compliance with the medication regime (Crane et al. 1996). Psycho-education interventions, which are aimed at medication compliance, can result in less time spent in

hospitals; improve functioning in the community, promote greater family stability, and more satisfying and independent lives.

Psycho-education about medication involves providing information about the name of medication, possible of outcomes and the side effects of medication, adherence to medication and teaching strategies for managing side effects so that clients can make informed choices about taking medication. In some studies, this intervention has been effective in promoting adherence to medication for clients suffering from bipolar disorder (Crane et al. 1996). A review of available literature on psycho-education for clients with the bipolar affective disorder by Gonzalez et al. (2004) discovered that some studies demonstrated that psycho-education enhances adherence to treatment, but only one study found that it improved outcomes in the bipolar affective disorder. In this study psycho-education significantly enhanced medication adherence among clients with bipolar affective disorder and in the long run, it improved quality of life for clients who were followed up for four years (Kelly, Scott & Mamon, 1991).

Kusumakar, et al. (1997) in a review article, showed that psycho-education offered to families and couples might be useful in improving patients' partners' knowledge about the illness, medication and social support strategies during research of 6 to 18 months. Similarly, favorable results were reported by Miklowitz, et al. (2003) in a randomized trial of family-focused psycho-education for bipolar affective disorder in Colorado, USA. After 11 months the study revealed significant effects favoring couples that received combined treatment (psycho-education and medication). Psycho-education provided to spouses was associated with improved medication adherence.

While psycho-education has been known to improve clients' knowledge about the illness, improve their skills for self-medication and to improve adherence to treatment in some studies, in others knowledge gain did not impact on behavior change in clients' adherence to medication. Mueser et

al. (2004) reviewed four randomized controlled studies where all but one provided at least eight sessions of psycho-education. In these studies, the follow-up period ranged from ten days to two years, and the results indicated that three of the controlled studies found that psycho-education improved people's knowledge of mental illness, one did not. In two studies, improved knowledge had no effects on taking medication as prescribed but one study reported adherence to treatment. In summary, the research on broad-based psycho-education indicates that psycho-education increases participants' knowledge about mental illness but does not affect the other outcomes studied, for instance, little evidence indicated that it improved taking medication as prescribed or changed other areas of functioning.

Nevertheless, the authors indicate that psycho-education remains essential because access to information about mental illness is crucial to people's ability to make informed decisions about their treatment, and that psycho-education is the foundation for more comprehensive programmes. Education intervention delivered at frequent intervals is used as part of a treatment programme for people with mental illness. Literature shows that structured education sessions involving both written and verbal methods followed by discussions were demonstrated to be effective in improving clients' knowledge about their illness, but they had no significant effect on relapse rates and clients' insight into their illness. In a literature search by Griffiths, et al. (2004) where 21 studies were included, knowledge was assessed in 15 studies, and compliance was evaluated in 13 studies, relapse was assessed in 5 studies and insight was assessed in 6 studies. Those patients who were provided with multiple education sessions demonstrated a significant increase in their level of knowledge compared to those who were not. Although the clients showed an increase in learning about the illness and medication the study also identified that there were no differences in the incidence of relapse and insight among those who were provided with education.

Though this was the case, this review provides evidence that multiple education sessions are better than single education sessions in improving knowledge relating to illness and medication. According to Sajatovic, Davies & Hrouda (2004) adherence to treatment for the bipolar affective disorder may be enhanced by interventions that directly address issues of appropriately taking medication to manage illness rather than general information. It is also recommended that for optimum outcomes, promotion of clients' adherence to treatment needs to be integrated into the medication management of the bipolar affective disorder.

2.5. Psycho-education, prevention of relapse and readmission

Patients with severe mental illness, like bipolar affective disorder, have been found to suffer declines that in most cases lead to readmission. The risk of relapse after a bipolar episode remains high throughout the client's lifetime. Moreover, the risk of chronic disorder rises with every decline the client has. Therefore relapse prevention is a primary focus in the treatment of the bipolar affective disorder. The results of Chadwick, Birchwood & Trower's (1996) study shows that symptoms of acute relapse in psychotic disorders are universally distressing, disempowering and potentially traumatic experiences. Relapse can quicken a transition to multiple episodes and chronic resistance stages. Burden and stress for families' are most likely to be worsened with the advent of each regression, and the financial cost to the community of the treatment of relapsed patients comprises a significant portion of the health budget (Kissling, 1992; Weiden & Olfson, 1995). Patient education has been distinguished as an essential prevention intervention to help break the cycle of multiple relapses and psychiatric readmission (revolving door syndrome). Basic education about mental illness facilitates the clients' ability to regain control over their lives, and it also establishes more collaborative and less hierarchical relationships with health professionals (Corrigan, Lieberman & Engle, 1990). Although relapses and rehospitalization can be viewed as important learning opportunities for clients and health professionals, Miller (1990) states that

prolonged periods of relapses and rehospitalization can erode a persons' sense of wellbeing, and avoiding the disruption associated with relapse is a typical recovery goal for the client as well as the health professionals.

Psycho-education has been demonstrated to improve clients' adherence to treatment and incidences of relapse are reduced in clients who adhere to their medication. A study conducted by Colom et al. (2003) (b) in Spain, on psycho-education efficacy in bipolar disorders over a period of 4 years, indicated that 92% of the control group had recurrences, as compared to 60% of the psycho-education group. The researchers concluded that psycho-education induces efficacy in preventing relapse in bipolar clients who were adherent to drug treatment. The action of psycho-education seems to go beyond compliance improvement and may support a tripartite model, composed of lifestyle regularity and health habits, early detection of prodromal symptoms followed by prompt drug intervention and finally treatment compliance.

Some of the studies conducted explicitly on interventions may indicate a reduction in the number of reappearances of bipolar clients. There has been a lack of organized, well designed, blind, control studies indicating the efficacy of group psycho-education avoiding recurrence in clients with bipolar affective disorder. A study on the efficacy of group psycho-education: the prophylaxis of recurrences in bipolar clients whose disease was in remission by Colom et al (2003) (a) in Barcelona, Spain, involving 20 weeks of treatment and 2 years of follow up, indicated that group psycho-education significantly reduced the number of relapsed patients, and it cut incidence of relapse or recurrence. The number and length of per patient treatment sessions were also lower in patients who received psycho-education, but the number of patients who needed hospitalization was practically equal in both groups. Therefore psycho-education may not be sufficient to help

some patients avoid admission but may facilitate early detection of an episode and thereby decrease the severity of the event.

Studies have also revealed that psycho-education given to the clients for a short time has also proved to be useful in medication management and has significantly reduced relapse rates. In a review of studies by Kusumakar et al. (1997) a six-hour psycho-education intervention designed from a cognitive therapy perspective improved lithium compliance and clinical outcomes in a random controlled trial. In this study, patients giving this response had a lithium non-compliance of 21% and significantly fewer hospital admissions than the control group, which received treatment as usual and had a lithium noncompliance level of 57%. Family psycho-education has equally shown similar results with individual and group psycho-education for clients with the bipolar affective disorders. A study by Tompson, Rea & Miklowitz (2003) conducted in Los Angeles, USA, on family-focused treatment versus individual treatment for bipolar disorder indicated that family psycho-education decreases relapse and readmission to hospital in people with bipolar disorders after an episode of mania. These results may not be generalizable to people with a depressive episode or those with weak medication compliance or less supportive families.

Miklowitz, et al. (2003) in their study of family Psycho-education and pharmacotherapy in the management of outpatients with bipolar disorder revealed that clients undergoing family focused psycho-education combined with pharmacotherapy had fewer relapses and showed a reduction in mood disorder symptoms and better medication adherence than clients experiencing only crisis management. Therefore, it can be deduced, from this study that psycho-education with pharmacotherapy enhances clients' ability to manage early relapse symptoms and also enhances drug compliance.

Studies have been carried out in South Africa on the effects of psycho-education in combination with other psychosocial rehabilitation technologies, such as skills and vocational training programmes. A survey conducted by Uys (1994) on the results of two treatment strategies (psycho-education and living skills training) and organizational strategies in the rehabilitation of long-term psychiatric outpatients in Pietermaritzburg, found that there were no indications that psycho-education groups improved functional status, reduced the symptoms or reduced periods of hospitalization for the clients. In this study, it was however discovered that two clients used the information from psycho-education to monitor their symptoms and to report signs of pending relapse to the staff of the clinic. The declines were averted in both cases. However, the study had a problematic design, since the initial group could not be maintained hence the findings could not be generalized.

CHAPTER THREE

Methodology

3.1. The study setting

The study was conducted at Amanuel Specialized Mental Hospital. The hospital was established in 1930, to serve as a general hospital for the local Ethiopian population during the short Italian occupation. The design of the hospital was not initially intended to serve the needs of mental patients, and it was only after 1956 E.C that the hospital was designated as a center for treatment of mental cases. After 1997 E.C, the hospital was recognized as a specialized mental hospital. This hospital is one of the very few specialized mental hospitals and the only one of its kind situated in the Addis Ketema sub city area of Addis Ababa, the capital city of Ethiopia. The hospital has a 300 beds capacity. Of these, 277 are for inpatients and 23 are emergency beds. There is no separate forensic inpatients unit in the country. Twelve out of 300 beds in the hospital are used for forensic purposes. The average length of stay in the hospital is less than one year. It is estimated that about 25 million Ethiopians suffer some form mental disorder, while less than 10 per cent receive any form of treatment, and less than 1 per cent receive specialist care. Of these, around 115,000 outpatients had treatments in the hospital each year. The hospital focuses on providing services intended to improve the mental health of its clients. Almost all patients receive one or more psychosocial interventions (Alem et al. (2009). Psychiatrists are an extremely scarce resource in the hospital; in population of over 101 million, there are only 63 psychiatrists, yielding a ratio of 0.65 psychiatrists to 1 million people. Mental health professionals working in the hospital include psychiatrists, other medical doctors (not specialized in psychiatry), nurses, social workers, and health assistants but no occupational therapists nor psychologists as reported by (Alem et al. (2009).

3.2. Research Design

To investigate this study descriptive survey research design was employed because the researchers can select a representative sample of subjects and generalize the findings to a large population and can gather a large amount of information's in a relatively short period of time. In doing so quantitative approaches was used

3.3. Population of the study

The target group of this study was composed entirely of patients diagnosed with mental illness, who came for treatment and follow up at the outpatient unit of Amanuel Specialized Mental Hospital, during the period of research.

3.3.1. Inclusion criteria

The criteria included all patients diagnosed with mental disorders, who were 18 to 65 years and who were stable enough to receive treatment and follow up at the outpatient unit of the Amanuel Specialized Mental Hospital, during the period of research.

3.3.2. Exclusion criteria

Those participants unwilling to participate in the study were excluded. Patients below 18 and above 65 years of age were not included. Acute patients who were unstable, cognitively impaired patients, those unable to communicate with others were also excluded. Moreover, patients who were not able to speak the Amharic language and who came to Amanuel Hospital for a first visit were not part of this study.

3.4. Sample size

Sample size was determined with the aim of estimating the proportion of out-patients that receive recommended psycho-education in Amanuel Specialized Mental Hospital. To this effect, it was assumed that 10% of outpatients currently receive recommended a level of psycho-education with

95% confidence and 5% margin of error. This resulted in a minimum number of 139 patients which need to be interviewed and the content of psycho-education they receive be evaluated.

3.5. Recruitment of study participants

List of outpatients who had followed up appointment in the hospital from September 13 to 26/2017 was the sampling frame. During this time a total of 658 outpatients had follow-ups. Inclusion criteria set for the study was that the patients should be age over 18 and below 65 years, had no cognitive impairment, and speak Amharic, provide informed consent to participate in the study, all patients diagnosed with mental disorders, who were stable enough to receive treatment and follow up at the outpatient unit of the Amanuel Specialized Mental Hospital, during the period of research. Therefore, this criterion has reduced the total eligible to 139. From these, since 19 of them were not fully participated to complete their interview process during the data collection period, the researcher was obligated to reject the data obtained from these participants. Patients not able to give informed consent participation due to the lack of decision-making capacity and dementia were excluded from the study (Roberts et al. 2002). All patients during the data collection process were evaluated if they fulfilled the study criteria. For reasons of patient confidentiality, psychiatric nurses evaluated whether or not patients fulfilled inclusion criteria. If they did, they were recruited into the study. Only 120 of the sampled participants completed their interview process properly, and the data obtained from these participants were analyzed.

3.6. Data Collection Tools

Data collection was done using questionnaires. Questionnaires were developed by the researcher in combination with techniques for evaluating treatment adherence. The developed questionnaires were translated into Amharic and back translated into English to check consistency of the translation and other relevant questions were included to these questionnaires to capture more

information of interest. The questionnaire had three parts. The first part was aimed at collecting Socio-demographic characteristics and some clinical data of the participants. The second part was questions to measure knowledge about their illness. The final part is an 8-item Morisky Medication Adherence Scale (MMAS). This was used to ascertain the association with psycho-education, and was widely used in different parts of the world for a variety of medical and psychiatric conditions. In Ethiopia, there are a few studies which used (MMAS-8) to determine the level of adherence among patients with mental illness and show the visibility and acceptability of this scale. The study conducted by the Getahun Hibdy, 2015 in Amanuel Specialized Mental Hospital, on the prevalence of drug non-adherence and associated factors among patients with bipolar disorder at outpatient unit showed the visibility and acceptability of Morisky Medication Adherence Scale. Therefore, to I employed in this study. It is valid and reliable with Cronbach's Alpha 83%; and its sensitivity and specificity is 93% and 53% respectively (Morisky et al. (2008). Morisky medication adherence scale (MMAS-8) consists of eight items that assess the medication-taking behavior with a scoring scheme of "Yes"=0 and "No"=1 for the first seven items and a 5-point Likert response for the last item. Responses of ''never,'' ''once in a while,'' ''sometimes,'' ''usually,'' and ''all the time'' were scored 1, 0.75, 0.50, 0.25, and 0, respectively. Whereas the score for the item was ''1'' for ''never'' and ''0'' for other responses. The total scores ranged from 0 to 8. Scores of 8, 6-8, and < 6 indicate high, medium, and low adherence, respectively. Patients with scores of 8 and 6-8 were considered adherent, and a score < 6 was regarded as non-adherent in our study. The items were summed up to give a range of scores from low adherence to high adherence, though they were dichotomized in this study by considering scores greater than or equal to 4 as non-adherence.

Pre-test of the questionnaires

3.6.1. Visibility and Acceptability

The purpose of the pilot study was to assess the relevance of the instruments designed to collect data for the study. The aim was also to find out ambiguities, omissions, and misunderstanding of items. In cases involving misunderstanding or ambiguities modifications were made thereby improving face validity. Wording and similar items were also modified. Thereby, with the help of the Adviser, appropriate study instruments were constructed. The pilot study was conducted on 30 outpatients. Of these 15 of them were men and 15 were women in order to have equal proportions. Finally, the data were analyzed with an SPSS-20 version. The reliability of the study instruments was also enhanced using the spss-20 version; the reliability of the instruments was .767. Therefore, the questionnaires were considered acceptable.

3.7. Data collection procedure

The researcher provided general information about objects and the overall issues concerning the research and was granted permission to begin the research. The researcher was informed about consent with a written note, first in English and then it was translated into the local language Amharic, and both oral and written proofs of consent were used when collecting data. The developed questionnaires were translated from English to Amharic, a time was determined and the questionnaires were organized and distributed to the data collectors, before being eventually collected. After this whole processes had been completed all the data was arranged, entered into Spss version 20, analyzed, interpreted and summarized.

3.8. Data analysis

The collected data was organized, coded and entered onto data sheets created in a Statistical Package for Social Science (SPSS) version 20. Descriptive statistics (frequencies, tables, percentages, mean, and standard deviation) was used to describe socio-demographic variables,

knowledge about illness and medication adherence. A Chi-Square test was used to measure the association between socio-demographic characteristics and psycho-education plus medication adherence (outcome variables). A logistic regression model was also used to assess predictors of the medication adherence. Medication adherence was considered in the logistic regression as a dependent variable, whereas socio-demographic characteristics and psycho-education concerning illness were included in the model as independent variables.

3.9. Ethical Considerations

While conducting the study, the researcher adhered to different moral principles of research. The researcher first submitted the study proposal to the Amanuel Specialized Mental Hospital ethical committee; asking permission from the Hospital ethical committee to conduct the study. After the committee accepted the study proposal, ethical clearance was obtained from the Amanuel Specialized Mental Hospital ethical committee to conduct the study. During the period of data collection, informed consent was obtained from participants, and they were informed that participation was on a voluntary basis and that they had full rights to withdraw at any time of need during the data collection process. Moreover, the researcher made efforts to protect and to respect the privacy, secrecy, and wellbeing of persons concerned as far as the conditions allowed. The data that was collected for this study did not contain identifying information, thus ensuring the confidentiality of the participants. The data collected was only used for the current research project.

CHAPTER FOUR

Results

Out of the 120 participants, the majority (54.2 %) were men. The age range was 18 to 65 years with a mean age of 32.55 years and standard deviation of ±.966 years. Almost half of the participants (40%) were in the age category of 28-37. Among participants, 52.5% were single, 60.0% were Christians, 45% had attended high school education, and 82.5% of them were unemployed. Most of the participants (65.85%) came from outside Addis Ababa city and 64.2% of them were from urban areas (Table 1).

Table 1 Socio-demographic characteristics of participants

Characteristics		N	%
Gender (n=120)	Male	65	54.2
	Female	55	45.8
Age (n=120)	18-27	37	30.8
	28-37	48	40.0
	38-47	27	22.5
	48-57	8	6.7
Marital status (n=120)	Single	63	52.5
	Married	43	35.8
	Divorced	14	11.7
Religion (n=120)	Christians	72	60.0
	Muslim	48	40.0
Level of Education (n=120)	No formal education	20	16.7
	Primary school	21	17.5
	High school	54	45.0
	College and above	25	20.8
Employment status (n=120)	Employed	21	17.5
	Unemployed	99	82.5
Region (n=120)	Addis Ababa	41	34.2
	Outside Addis Ababa	79	65.8
Residence (n=120)	Rural	43	35.8
	Urban	77	64.2

Note: n=120

Concerning the clinical characteristics of participants, as shown in Table 2, at least a third of participants 35.0% were diagnosed with major depressive disorders. Regarding help-sought at

onset, 66.7% of the patients got support from family, 23.3% from modern health services and 10% of them got help from traditional healers. Availability of support, especially from family members, is associated with a high level of functioning and better illness management. The result also indicated that the majority of the participants were non-adherent 59.2%, and did not receive psycho-education 58.3%.

Table 2 Clinical characteristics and help-sought at onset of the problem by the participants

Characteristics		N	%
Diagnosis (n=120)	Schizophrenia	30	25
	Posttraumatic Stress Disorder	6	5
	Somatic Disorder	4	3.3
	Major Depressive Disorder	42	35
	Bipolar Disorder	21	17.5
	Substance Abuse	14	11.7
	Epilepsy	3	2.5
Help-sought at onset (n=120)	Family	80	66.7
	Traditional healers	12	10
	Modern health service	28	23.3
Medication adherence (n=120)	Adherent	49	40.8
	Non-adherent	71	59.2
Psycho-education about illness	Psycho-education received	50	41.7
	Psycho-education is not received	70	58.3

Note: n=120

As indicated in Table 3, 58.3% of the participants did not receive psycho-education about illness, while 41.7% of them received psycho-education. With regard to the clarity of information they received, 52% of them said it was somewhat clear, while 36% of them said that it was very clear. In relation to precautions to take medication, 42% of patients they had received information about precautions. Regarding diagnosis, 40% of the participants said they were informed of their diagnosis and of those who were informed, most of them 83.3% could recall their diagnosis.

Table 3 Information given to participants by their therapists about their illness

Items		N	%
Psycho-education about illness(n=120)	No	70	58.3
	yes	50	41.7
Clarity of information(n=50)			
	Very clear	18	36
	Somewhat clear	26	52
	Not clear	6	12
Course of illness (n=50)		18	36
Early signs of relapse (n=50)		8	16
Precaution to take/Advice(n=50)		21	42
Diagnosis informed(=120)	No	72	60
	yes	48	40
Diagnosis recall(n=48)			
	forgot	8	16.6
	recalled	40	83.3

Regarding psycho-education about medication (Table 4), 53.3% of the patients did not receive psycho-education about medication, while 46.7% of them received psycho-education about medication. Out of those who received psycho-education, about 41.1% of them knew the names of medication they were taking in the period of research. The duration of taking medication was also assessed and 51.7% of patients started taking their medication four years ago, and 16.7% of them were well-informed concerning the duration of taking medication. The results also indicated that the medication prescribed for most patients 76.7% eventually changed, and of these 46% of patients received information about why their medication was changed.

Table 4 Information provided about medication

Items		N	%
Information about medication(n=120)	No	64	53.3
	yes	56	46.7
Information about the name of the Drug(n=56)			
	Forget	33	58.92
	Name	23	41.07
Duration on treatment(n=120)	five months ago	58	48.3
	4 years and above	62	51.7
Expected duration to take medication(n=120)	No	100	83.3
	yes	20	16.7
Change of medication(n=120)	No	28	23.3
	yes	92	76.7
Reason for the medication switch (n=92)	No	49	54
	yes	43	46

Regarding knowledge about the course of treatment and relapse (Table 5), 61.7% of participants received psycho-education about the importance of adherence to treatment, and of this number 94.5% of them had a positive outcome from the medication. The results also indicated that about two thirds 61.7% of the participants had side-effects from the medication. Regarding relapse, while 59.2% of the participants received explanations about possible causes of relapse, 40.8 % of them did not receive. The results also showed that 57.5% of the participants had psycho-education about possible consequences of relapse; and from this number most of them 95.65% experienced a relapse and half of them 50% relapsed more than three times.

Table 5 Knowledge about course of treatment and relapse

Items	**yes**	**50**	**41.7**
Positive effects of adherence to treatment(n=120)	No	46	38.3
	yes	74	61.7
Possible outcome of medication(n=74)	No	4	5.4
	yes	70	94.5
Side effects (n=120)	No	43	35.8
	yes	74	61.7
Information about possible cause of relapse(n=120)	No	49	40.8
	yes	71	59.2
Information about consequences of relapse(n=120)	No	51	42.5
	yes	69	57.5
Had relapse(n=69)	No	3	4.34
	yes	66	95.65
Number of relapses (n=66)	1time	16	24.2
	2times	17	25.7
	3 times and above	33	50

The result of psycho-education about illness and socio-demographic characteristics associated with medication adherence are presented in table 6. Significant associations ($P<0.05$) were observed between psycho-education about the illness, gender, age, educational level, marital status, employment status, residence and medication adherence. Based on row percentages, women 38.20% had the lowest percentage of adherence compared to men 43.10%. The highest level of adherence was observed in the age group 28-37(41.66%) when compared with the age groups 18-27 (35.13%) and 38-47(37.03%). With regard to marital status, about 62.79% of married participants adhered to medication, as compared to 39.7% among unmarried and 35.70% among the divorced. As regards patients who attended high school the rate were 42.60% of adherence to medication and 40% among the college and above educated as compared with 35%-38% among those who only had non-formal and primary education. A lower level of adherence to medication was also observed among participants that came from rural areas 32.55%, as compared to those

coming from urban areas 40.30%. The participants who reported having received psycho-education 48% were more likely to adhere to treatment, as compared to those who had not received psycho-education.

The result also indicated no significant association between religion or region and medication adherence. Nearly 38.9% of Christian patients were medication adherents as compared with 43.8% of Muslims. Almost 41.50% of participants from Addis Ababa had high percentages as compared to those from outside Addis Ababa 40.5%.

Table 6 Bivariate association between medication adherence and socio-demographic characteristics

Variables		Adherent	Not-adherent	chi-square	P- value
Gender	Male	28(43.1%)	37(56.9%)		
	Female	21(38.2%)	34(61.8%)	0.295	0.024
	18-27	13(35.13%)	24(64.86%)		
Age	28-37	20(41.66%)	28(58.33%)		
	38-47	10(37.03%)	17(62.96%)	2.754	0.039
Marital status	Married	27(62.79%)	16(37.20%)		
	Single	25(39.70%)	38(60.30%)	0.386	0.001
	Divorced	5(35.70%)	9(64.30%)		
Religion	Christians	28(38.89%)	44(61.1%)	0.282	0.596
	Muslim	21(43.8%)	27(56.2%)		
Level of Education	Nonformal	7(35.00%)	13(65%)		
	primary school	8(38.09%)	13(61.90%)	0.394	0.017
	High school	23(42.60%)	31(57.40%)		
	college and above	10(40.00%)	15 (60%)		
Employment status	Employed	9(42.90%)	12(57.10%)	0.043	0.035
	Unemployed	40(40.40%)	59(59.60%)		
Region	Addis Ababa	17(41.5%)	24(58.5%)	0.10	0.919
	Outside Addis Ababa	32(40.5%)	47(59.5%)		
Residence	Rural	14(32.55%)	29(67.44%)	0.029	0.014
	Urban	31(40.30%)	46(59.70%)		
Psychoeducation about illness	psycho-education is not received	24(48%)	26(52%)	1.657	0.0198
	psychoeducation not received	32(45.7%)	38(54.3%)		

Note: The value within refers to row percentage n=120

Gender, age, marital status, religion, educational level, employment status, region, help-sought at onset, residence, diagnosis, and psycho-education about illness were entered into a multivariable regression model to determine factors independently predicting medication adherence. After adjustment, Gender, education level and psycho-education about illness independently predicted a higher level of adherence (Table 7). Therefore, gender (i.e. being male) predicted a level of medication adherence of (OR=1.826, 95% CI=1.83, 2.07). High school educational level, (OR=1.966, 95% CI=2.28, 3.33), and psycho-education concerning illness (OR=1.612, 95% CI= 3.189, 18.098), thus this also predicted the level of adherence. Gender, educational level and psycho-education about illness were associated significantly with medication adherence and independently with increased medication adherence among participants. In this analysis, age, marital status, religion, region, employment status, help-sought, residence, and diagnosis were not associated with predicted medication adherence.

Table 7 Socio-demographic correlates of treatment adherence

Variables	Crude OR (95% CI)	P-value	Adjusted OR (95% CI)	P-value
Gender(male)	**1.816(1.16,1.698)**	**0.021**	**1.826(1.83, 2.07)**	**0.017**
Age	----------	0.437	----------	0.589
18-27	1.467(0.316,6.797)	0.624	1.422(0.246,8.223)	0.694
28-37	2(0.442,9.056)	0.368	1.846(0.325,10.503)	0.489
38-48	0.929(0.192,4.5)	0.927	0.797(0.131,4.867)	0.806
Marital status	----------	0.825	----------	0.956
Single	0.702(0.201,2.444)	0.578	1.261(0.278, 5.723)	0.764
Married	0.844(0.253,2.815)	0.783	1.195(1.268,5.324)	0.815
Religion	1.222(0.582,2.565)	0.596	1.611(0.621,4.175)	0.327
Educational Level	----------	0.942	----------	0.886
Nonformal	1.238(0.366,4.187)	0.731	1.643(0.348,7.762	0.531
Primary school (1-6)	0.889(0.274,2.886)	0.845	1.022(0.235,4.436)	0.977
High school (7-12)	**1.899(1.21,2.35)**	**0.028**	**1.966(2.28,3.33)**	**0.034**
Employment status(employed)	0.904(0.349,2.344)	0.835	1.120(2.343,3.659)	0.851
Region (Addis Ababa)	0.961(0.447,2.069)	0.919	0.851(0.258,2.804)	0.791
Help sought at onset	----------	0.182	----------	0.162
Family	1.078(0.446,2.608)	0.867	0.88(0.307,2.522)	0.811
Traditional healers	0.324(0.078,1.338)	0.119	0.207(0.038,1.134)	0.070
Residence(urban)	0.936(0.439,1.997)	0.864	0.93(0.299,2.89)	0.090
Diagnosis	----------	0.209	----------	0.339
Schizophrenia	2.286(0.187,27.994)	0.518	1.568(0.093,26.53)	0.755
PTSD	1(0.053, 18.915)	1	0.809(0.025,26.043)	0.905
Somatic disorder	6(0.221, 162.531)	0.287	1.231(0.07,21.692)	0.675
MDD	2.2(0.185, 26.157)	0.532	2.185(0.056,84.82)	0.887
Bipolar disorder	8.5(0.609, 118.637)	0.112	6.655(0.337,131.42)	0.213
Substance abuse	5(0.348,71.9)	0.237	3.067(0.151,62.327)	0.466
Psycho-education about illness	**1.455(1.289,1.296)**	**0.045**	**1.612 (3.189,18.098)**	**0.008**

Note: medication adherence (dependent) and participant characteristics (independent) with n=120

CHAPTER FIVE

Discussion

There is no single study that investigated the practice of psycho-education in Ethiopia in general and in Amanuel Specialized Mental Hospital in particular. Consequently, this is the first report on the practice of psycho-education in an outpatient psychiatric clinic in Ethiopia.

Brown et al (2007) suggested that providing adequate and vital information about an illness and medication to patients at the baseline is important to improve their adherence to medication and knowledge about illness. An earlier study by Chadzynska and Charzynska on the perspectives of patients with mental disorder who participated in psycho-educational sessions showed that although a majority (142 patients, 84%) held positive attitudes towards the intervention, almost half of them (83 patients) were not satisfied with the knowledge about the illness provided by the programme. In general, patients felt an increase in knowledge about the illness was the most important gain from the psycho-education. Thus, psycho-education is important and effective; having access to such educational information seemed to be important to patients with mental illness in clinical settings. However, in practice, the prevalence of psycho-education concerning illness and medication is low in the clinical setting for the treatment of patients with mental illness at outpatient's department. Indeed, some patients received insufficient information due to the low provision of services in the clinical settings.

The finding of this study indicates that 58.3% of participants reported not receiving psycho-education about an illness. The results of the study conducted by Takai and Aghukwa, in a Nigerian Tertiary Hospital in 2015, were similar to the current study. Assessment of the patients and their relation to basic knowledge of their illness showed that only 27.4% of the respondents were ever told the name of the illness they were suffering from, and 59.2% of them did not know what kind of illness they were suffering from. Another similar finding suggested that most of the

respondents had no basic knowledge about their illness, about (79 patients, 46.7%) were not satisfied with their enhanced knowledge about their illness from the psycho-education. Prost et al. (2013). It is a common belief that greater knowledge empowers people to make better skill in coping themselves. To provide information for people with mental illness, a broad-based psycho-education program is very crucial. Generally, the contents of explanation were an early sign of relapse, and precaution to take medication, diagnosis informed, and course of illness. The findings of this study showed that the content of explanations the patients received was highly focused on precautions to take medication. Thus, to received psycho-education most of seem to have no clear understanding regarding their illness. In a review of the outcomes of four randomized controlled trials of broad-based psycho-education programs, Mueser et al (2002) reports that limited content of explanations showed poorer improvement in a clinical setting; they do not enhance knowledge about an illness. This finding is consistent with this finding of psycho-education programs: without broad contents of explanations the patient knowledge does not improve and does not automatically lead to a change in behavior (Whitehead & Russell 2004).

The findings of the current study indicate that most of the outpatients with mental illness who use the Amanuel Hospital mental health services are not empowered enough to deal optimally with the illness. The patients report not being given adequate information. There seems to be an association between lack of knowledge about illness, and adherence to medication, and thus more relapses in an outpatient unit of Amanuel Specialized Mental Hospital. In general, the findings suggest that the practice of psycho-education provided for outpatients at Amanuel Specialized Mental Hospital is very limited. A similar study conducted by Takai and Aghukwa, 2015, in a Nigerian tertiary Hospital, suggested that the patients did not receive enough psycho-educational interventions during routine clinical visitations. Another similar finding was reached in Japan with regard to the low-level practice of psycho-education at mental hospitals. The study conducted on the evaluation

of psycho-education practice showed that only 30% performed well in a psychiatric institution (Funkui, 2011). This might be because of certain factors such as poor environmental conditions, lack of knowledge and skill about psycho-education among psychiatric nurses and lack of resources such as skilled manpower, and infrastructure at the psychiatric hospital.

The literature identified several factors that contribute to a lack of adherence to medication such as the impact of socio-demographic characteristics and lack of delivery of psycho-education. Addressing these factors is a significant step towards the successful control and management of mental illness. The finding of this study indicated that there is a significant association between medication adherence and the variables of gender, age, educational level, marital status, employment status, and residence. The result of this study was similar to the study was conducted in Mekelle in northern Ethiopia concentrating on the factor of adherence to medication among patients with schizophrenia, this showed that the important association of socio-demographic factors with antipsychotic medication adherence among patients with schizophrenia. The following variables were significantly related to adherence to the bivariate analysis: age, marital status, educational status, residence, and employment status, (Eticha et al., 2015).

The finding of the current study revealed that the participants who reported having received psycho-education were more likely to adhere to treatment compared to those who did not receive it. This study was similar to the study conducted in South Africa by Sorayas et al. (2008) which demonstrated 65% patients of those participating in the psycho-educational program adhered to medication at four months. Shuhei et al. (2015) found that outpatients who received explanations had an understanding score that was significantly higher than those who received no explanations. Similar results were also reported in an exploratory study by Soares et al (1997) in Australia on the effects of a psycho-education package on outpatients with bipolar disorder. The study showed that

patients who received psycho-education showed significant improvement in knowledge about illness, adherence to medication, and displayed higher self-esteem than those who did not. Therefore, psycho-education could be associated with the significantly higher prediction of adherence to medication.

CHAPTER SIX

Conclusions and Recommendations

6.1. Conclusions

The following conclusions were deduced from the results of the research:

- The findings of this study indicate that the practice of psycho-education in the Amanuel Specialized Mental Hospital at outpatient psychiatric clinics was considered as a routine component of patient care. But the manner of providing this service was insufficient. The majority of the patients did not receive enough psycho-education about illness, medication, course of treatment, risk of relapse, and symptom management techniques.
- Of those who reported to have received psycho-education most of seem to have no clear understanding regarding their illness.
- Another finding of the study demonstrated that there was a significant association between socio-demographic factors such as, gender, age, educational level, marital status, employment status, residence, and medication adherence. Finally, the participants who reported receiving psycho-education were more likely to adhere to treatment as compared with those who did not receive any.
- In general, the findings indicated that the practice of psycho-education provided to outpatients at Amanuel Specialized Mental Hospital was very limited.

6.2. Recommendations

Based on the findings of this study, the researchers formulated the following recommendations.

- As a routine component of patient care, psycho-education practiced at Amanuel Specialized Mental Hospital was very limited, especially with regard to outpatient psychiatric clinics. Thus, providing adequate psycho-education about illness, medication, course of treatment, risk of relapse, and symptom management is very important as it is a major way of providing knowledge and skills which assist the clients to manage their illness cope with problematic symptoms and adherence to medication.
- The findings showed that the content of explanation provided for people with mental illness at the outpatient department of Amanuel Specialized Mental Hospital focus on precautions to take medication. Therefore, policymakers and mental health planners at all levels need to broaden the content of psycho-education and use patient centered activities to engage patients in the information.
- Effective psycho-education has a positive value in enhancing patient's adherence at outpatient psychiatry clinics. The study showed participants who reported having received psycho-education were more likely to adhere to treatment compared to those who did not receive any. Therefore, Mental health professionals such as, psychiatrists, psychiatric nurses, and clinical psychologists need to give much attention to providing information to their clients and helping them manage their medication more effectively.
- A number of studies reported that the prevalence of Psycho-education given to patients with mental illness at outpatient psychiatric clinics was sufficient. However, this study does not at all indicate adequate practice of psycho-education among Amanuel Specialized Mental Hospital Psychiatric clinic outpatients. Psycho-education plays a great role in improving medical services and make the treatment of clients more efficient, improving the

quality of life of the patients'. Thus, Ministers of health, Hospital management, mental health planners, and professionals have to take this issue seriously, in order to ensure the improvement of their services.

- Therefore, emphasis should be given to psycho-education as an important component of service provision in the Hospital.

1.7 Limitation of the study

Any study has its own limitations; this particular study has the following limitations: It was conducted in a specific mental health institution, Amanuel Specialized Mental Hospital. Thus, it may not be typical of mental health hospitals in Ethiopia in general. The sample sizes of the study were relatively small and consequently it is difficult to make generalizations about all outpatients. Another methodological problem was that the study used a simple random sampling technique, there was insufficient time to gather information about the specific population, and lack of economic resources prevented identifying potential biases which might occur, when the sample size was not large enough to adequately represent the full population.

Also, the time-consuming process of collecting data from the respondents was difficult to complete within the limited time scheme, which the researcher had to follow while conducting this study. Thus, due to the brevity of the course, there was insufficient time for detailed research work. All these considerations could easily have discouraged the researcher from achieving the study objectives. Moreover, according to the knowledge of the researcher in Ethiopia, not a single study has been conducted on this issue. Consequently, the researcher faced a lack of material for a literature review, and it was difficult to refer to the work done by other researchers.

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Appendix -1

ADDIS ABABA UNIVERSITY

SCHOOL OF MEDICINE

DEPARTMENT OF PSYCHIATRY

Dear potential participant you are being asked to be participating in this study to provide very crucial information for the success of this study. Therefore, I would like to express my thanks and appreciation for agreeing to be interviewed.

Part one = Socio demographic data

1. Gender : Male ☐ Female ☐
2. Age_____
3. Marital status: Single ☐ Married ☐ Widowed ☐ Divorced ☐
4. Religion : Orthodox ☐ Catholic ☐ Muslim ☐ Protestant ☐ other ☐
5. Educational status: educated ☐ Not educated ☐
6. Level of educational, grade completed _____
7. Employment status : Employed ☐ Not employed ☐
8. Address, Region: _____
9. Where did you get help from when you first got ill?

 9.1. Family ☐

 9.2. Traditional healers ☐

 9.3. Modern health service ☐

10. Residence: rural ☐ Urban ☐
11. Diagnosis: _____

Part two: Knowledge about the illness

1. Have you ever received any explanation about your illness from your therapist?

   Yes ☐ No ☐

2. If your answer is**" yes"** how much clear was the explanation to you?

   - Very clear ☐
   - Somewhat clear ☐
   - Not clear ☐

3. What was the content of the explanation you received? _____

4. Were you told the name of the illness you are receiving treatment for?

   Yes ☐ No ☐

5. If the answer to the above question is yes, what is it called?

   Name_____ Forgot _____

6. Did your therapist tell you about possible causes of your illness?

   Yes ☐ No ☐

7. If **yes**, what did you understand about the cause? _____

8. Has your clinician told you what medication you are going to take?

   Yes ☐ No ☐

9. Do you know what medication you are taking? Yes ☐ No ☐

10. Can you tell me the name of the medicine? _____

11. Have you had side effects from the medicine? Yes ☐ No ☐

12. When it was first prescribed for you? _____

13. Have you been told how long you will take the medications? Yes ☐ No ☐

14. Has your medicine been changed? Yes ☐ No ☐

15. Were you informed why it was changed? Yes ☐ No ☐

16. Do you think the medication you are taking is helping you? Yes ☐ No ☐

17. Have you been told the importance of adherence to treatment? Yes ☐ No ☐

18. Have you been told about possible relapse? Yes ☐ No ☐

19. If **"yes"** what are those effects? _____

20. Have you been told about consequences of relapse? Yes ☐ No ☐

21. Have you had any relapse? Yes ☐ No ☐

22. If yes to question **No 21**, how many relapses did you have so far? _____

Part three: - Medication Adherence

You indicated that you are taking medication for yourself, Individuals have identified several issue regarding their medication taking behavior and we are interested in your experience. There is no right or wrong answer. Please answer each questions based on personal experience with your medication. Therefore, make in the provided space if yes (0) /No (1).

Dichotomous version of Morisky 8 item self-report scale.

	Questions	**No=0**	**Yes=1**
1	Do you sometimes forget to take your medicine?		
2	People sometimes miss taking their medicines for reasons other than forgetting. Thinking over the past 2 weeks, were there any days when you did not take your medicine?		
3	Have you ever cut back or stopped taking your medicine without telling your doctor because you felt worse when you took it?		
4	When you travel or leave home, do you sometimes forget to bring along your medicine?		
5	Did you take all your medicines yesterday?		
6	When you feel like your symptoms are under control, do you sometimes stop taking your medicine?		
7	Taking medicine every day is a real inconvenience for some people. Do you ever feel hassled about sticking to your treatment plan?		
8	How often do you have difficulty remembering to take all your medicine? A. Never/rarely ☐ B. Once in a while ☐ C. Sometimes ☐ D. Usually ☐ E. All the time ☐		

Appendix -2

አዲስ አበባ ዩኒቨርስቲ
የህክምና ትምህርት ቤት
የሳይካትሪ ትምህርት ክፍል

የክሊኒካል ሳይኮሎጂ ድህረ ምረቃ መርሃ ግብር

ውድ ተሳታፊዎች የዚህ ጥናት አካል ሆነው ለቃለ ምልልስ ፍቃደኛ ስለሆኑ ከወድው ምሰጋናየን አቀርለሁ።።

ክፍል አንድ፡ ግላዊ መረጃዎች

መመሪያ:- ከዚህ በታች የቀረቡት ጥያቄዎች ግለሰብዓዊ የሆኑ መረጃዎችን የሚሹ ናቸው።። ስለሆነም እርስዎ እያንዳንዱ ጥያቄዎች በሚነበብልዎት ጊዜ በጥሞና በማዳመጥ ትክክለኛውን ምላሽ እንዲሰጡ በትህትና እጠይቃለው።።

1. ፆታ ወንድ ☐ ሴት ☐
2. ዕድሜ .....
3. የጋብቻ ሁኔታ ..... ያገባ ☐ ያላገባ ☐ የፍታ ☐
4. ሃይማኖት ኦርቶዶክስ ☐ ካቶሊክ ☐ ሙስሊም ☐ ፕሮቴስንታንት ☐ ሌላ ከሌ ☐
5. የትምህርት ደረጃ .....
6. የስራ ሁኔታ የተቀጠረ ☐ ያልተቀጠረ ☐ የግል ድርጅት ☐
7. አድራሻ፣ ክልል .....
8. መጀመሪያ ስታመሙ እርዳታ ያገኘት ከየት ነበር ?
   8.1 ከቤተሰብ ☐
   8.2 ከባህላዊ አካሚዎች ☐
   8.3 ከዘመናዊ የህክምና ማዕከል ☐
9. የመኖሪያ ቦታ ገጠር ☐ ከተማ ☐
10. የህመሙ ዓይነት.....

ክፍል ሁለት፤ ስለ ህመሙ ያለዎት መረዳት

መመሪያ:- **ከዚህ በታች የተዘረዘሩት ዓረፍተ ነገሮች ስለ ህመሙ ያለዎትን እውቅት የሚገልጹ ጥያቄዎች ናቸው። ስለሆነም እርስዎ እያንዳንዱ ጥያቄዎች በሚነበብልዎት ጊዜ በጥሞና በማዳመጥ ትክክለኛውን ምላሽ እንዲሰጡ በትህትና እጠይቃለው።**

1. **ከዚህ በፊት ሐኪሞዎ ስለህመሞዎ ገለፃ አድርጎልዎታል?**

   አዎ ☐ **አላደረገልኝም** ☐

2. ***መልስዎ "አዎ" ከሆነ ገለፃው ምን ያህል ግልጽ ሆኖልዎታል?***

   - **በጣም ግልጽ** ☐
   - **በተወሰነ መልኩ ግልጽ** ☐
   - **ግልጽ አልነበረም** ☐

3. **የተደርጎልዎት ገለፃው ይዘቱ ምን ነበር?----------**

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4. **ህክምና የተደረገልዎት የህመሙ ስም ተነግሮዎት ነበር?**

   አዎ ☐ **አልተነገረኝም** ☐

5. **በጥያቄ ተራ ቁጥር "4" መሰረት መልስዎ "አዎ" ከሆነ የበሽታው ስም ምን ይባላል?**

   ስም …….. ረስቸዋለሁ …….

6. **ሐኪሞዎት ለህመሞዎት መንስኤ ሊሆኑ የሚችሉ ምክንያቶች ነግሮዎታል?**

   አዎ ☐ **አልነገረኝም** ☐

7. ***መልስዎ "አዎ" ከሆነ ስለ መንስኤው ምን ተረዱ?----------***

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8. **ሐኪሞዎት ለህመሞዎ ስወስዱ የነበረውን መድሐኒት ነግሮዎታል?**

   አዎ ☐ **አልነገረኝም** ☐

9. **እየወሰዱ ያሉት መድሐኒት ምን እንደሆነ ያውቃለህ?**

   አዎ ☐ **አላውቅም** ☐

10. **የመድሐኒቱን ስም ልነግሩኝ ይችላሉ?……**

11. መድሐኒቱ የጎንዮሽ ጉዳት አላስከትሎቦትም?

አዎ ☐ አላስከተለብኝም ☐

12. ለመጀመሪያ ጊዜ የታዘዘሎዎት መቼ ነው? .....

13. ሐኪሞት ስወስዱ የነበረውን መድሐኒት ለምን ያህል ጊዜ እንደሆነ ነግሮዎታል? አዎ ☐ አልተነገረኝም ☐

14. ስወስዱ የነበረውን መድሐኒት ተቀይሯሎታል?

አዎ ☐ አልተቀየረም ☐

15. መድሐኒቱ ሲቀየር የምቀየርበት ምክንያት ተነግሮዎት ነበር?

አዎ ☐ አልተነገረኝም ☐

16. እየወሰድክ ያለህው መድሐኒት እየጠቀሞዎት ያለ ይመስልዎታል?

አዎ ☐ አይመስለኝም ☐

17. ሐኪሞት ህክምናውን በደንብ የመከታተል ጠቀሜታውን ነግሮዎታል?

አዎ ☐ አልተነገረኝም ☐

18. ሐኪሞት ህመሞት ሊያገረሽ እንደምችል ነግሮት ነበር?

አዎ ☐ አልተነገረኝም ☐

19. መልስዎ "**አዎ**" በማገርሸቱ ምክንያት የሚመጣው ችግር ተገልያልዎታል?

አዎ ☐ አልተገለጸልኝም ☐

20. ህመሞት አገርሽቶቦት ያውቃል?

አዎ ☐ አያውቅም ☐

21. መልስዎ ለተራ ቁጥር "21" "**አዎ**" ከሆነ እስካሁን ስንት ጊዜ አገርሽቶቦት ያውቃል ? ----------

ክፍል 3፡መድኃኒትንበታዘዘውመሰረትበአግባቡስለመውሰድ

ተ.ቁ	ጥያቄዎች	አዎ	አይደለም
1	አንዳንድ ጊዜ መድኃኒትዎን ረስተው ሳይወሰዱ ቀርተው ያውቃሉ?		
2	ሰዎች አንዳንድ ጊዜ ከመርሳት ውጪ ባሉት የተለያዩ ምክንያቶች መድኃኒታቸውን ሳይወስዱ ይቀራሉ፡፡ ባለፉት ሁለት ሳምንታት፣ መድኃኒትዎን ሳይወስዱ የቀሩበት ቀናቶች ነበሩ’?		
3	ሐኪምዎን ሳይነግሩ፣ መድኃኒትዎን እየወሰዱ ህመምዎ ሲባባስ፣ መድኃኒትዎን አቋርጠው ያውቃሉ?		
4	በጉዞ ምክንያት ወይም ከቤትዎ አርቀው ሲጓዙ፣ አንዳንድ ጊዜ መድኃኒትዎን (ወደ ጉዞው) ረስተውት ሳይወስዱት ያውቃሉ?		
5	በትላንትናው ዕለት ሁሉንም መድኃኒትዎን ወስደውታል?		
6	ህመምዎ ሲሻልዎት (የህመምዎ ስሜቶች ሲጠፉ) አንዳንድ ጊዜ መድኃኒትዎን አቋርጠው ያውቃሉ?		
7	በየቀኑ መድኃኒት መውሰድ፣ ለአንድአንድ ሰዎች ምቾት አይሰጣቸውም፡፡ እርስዎ በየቀኑ፣ እንድሁም አንድም ሰዓት ሳያሳልፉ መድኃኒትዎን መውሰድዎ፣ የመሰላቸት ስሜት ተሰምቶት ያውቃል?		
8	መድኃኒትዎን አስታውሰው ለመውሰድ ምን ያክል ይቸገራሉ? ◯ጭራሽ አይቸግረኝም ◯ከዕለታት አንድ ጊዜ ይቸግረኛል ◯አንዳንድ ጊዜ ይቸግረኛል ◯አብዛኛው ጊዜ ይቸግረኛል ◯ሁልጊዜ ይቸግረኛል		

ውድ ተሳታፊ

ስሜ አዲስአለም ኦልድሻ የአዲስ አበባ ዩኒቨርስቲ የጤና ሳይንስ ኮሌጅ የሳይካትሪ ትምህርት ክፍል የክልኒካል ሳይኮሎጅ ሁለተኛ ዲግሪ ሁለተኛ አመት ተማሪ ስሆን በአሁኑ ስዓት የመመረቂያ ጥናቴን በመስራት ላይ እገኛለሁ፡፡ ስለዚህ ይህ ጥናት የሚካሄደው የመመረቂያ መስፈርትን ለማሟላት ሲሆን ከዚህ አልፎም ለውይይትና ለህትመት ይቀርባል፡፡ የዚህ ጥናት ዋና አላማው በአማኑኤል ስፔሻላይዝድ የዓዕምሮ ሕክምና ሆስፒታል ለሚገኙት ህመምተኞች የሚሰጠውን የስነ-ልቦና ትምህርት አስጣጥ ለመዳሰስ ነው፡፡

ስለሆነም የዚህ ጥናት መጠየቅ ጥቅሙ ለጥናቱ የሚረዱ መረጃዎችን መሰብሰብ ነው፡፡ የዚህ ጥናት መሳካትም ሆነ አስተማማኝነቱና ትክክለኛነቱ የሚወስነው እርስዎ ለእያንዳንዱ ጥያቄ የሚሰጡት እውነተኛ ምላሽ ላይ የተመሰረተ ሲሆን ከዚህ በታች የተቀመጡትን መመሪያዎችና ጥያቄዎችን በሚነበብልዎት ጊዜ በጥሞና በማዳመጥ ትክክለኛውን ምላሽ እንዲሰጡ በትህትና እየጠየኩኝ የርስዎ ተሳትፎ በዚህ ጥናት ውስጥ ትልቅ ቦታ አለው፡፡ ለተሳትፎዎ ምንም አይነት ክፍያ የለውም፡፡ ስለዚህ የርስዎ ተሳትፎ በፍቃደኝነት ላይ የተመሰረተ ሲሆን በማሀል ማቋረጥ ከፈለጉ ማቋረጥ ይችላሉ::

ስለሆነም እርስዎ በመሳተፍም ሆነ ባለመሳተፍም ምንም አይነት ተጽኖ የለውም ስለዚህ እምቢም ወይም እሺ የማለት መብትዎ ሙሉ በሙሉ የተጠበቀ ነው፡፡ ለመጠየቁ ቃለ ምልልስ የሚወስደው ጊዜ 30 ደቂቃ ሲሆን እያንዳንዱ ጥያቄ የሚስጢር ቁጥር እንደሚሰጠውና እርስዎ የሚሰጡት ምላሽ ሚስጢራዊነቱ የተጠበቀና ለጥናቱ አገልግሎት ብቻ የሚውል መሆኑን አረጋግጣለሁ ፡፡

ከላይ በተገለጸለዎት መሰረት ሁሉንም ነገር ከተረዱ መስማማትዎን ለመግለጽ ከዚህ በታች በፊርማዎ ያረጋግጡ፡፡

የጠያቂው ፊርማ ..... የተጠያቂው ፊርማ.....

ቀን ..... ቀን .....