Evaluation of Psycho-educational Needs of Patients with Schizophrenia and Mood Disorders and their Relatives

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Abstract

This study was carried out at Assiut University Hospital, unit of psychiatry, on 150 patients *(75* schizophrenic patients and 75 mood disorder patients) and 300 patient relatives (2 relatives for each patient). **A** questionnaire containing 45 items pertaining to different areas of educational needs was applied to each patient and relative to determine specific educational needs and to compare the needs of different consumers. Schizophrenic patients were less interested than patients with affective disorder and both sets of relatives. The comparison, of the total 45 educational items surveyed, between different groups of patients and relatives, showed that mood disorders patients had statistically significant higher level of interest than schizophrenics and also their relatives more than relatives of schizophrenics. Analysis of variance revealed that the educational needs differed as a function of patient diagnosis. Multiple discriminate analysis showed differences between patient and relatives groups which support that consumers of mental health services are capable of specifying their own educational needs and educational programs should be tailored to meet these needs. The aim of the work was to determine specific psycho-educational needs of the patients (schizophrenics and mood disorders) in an Egyptian culture and to compare the educational needs of the patients of these two disorders and to help in the future in putting psycho-educational programs as psychiatric patients and their relatives benefit from learning about mental illness and how to cope with it (Mueser, et al., 1992).

Introduction

Surveys indicate that families have a strong desire for more information about the disorder as well as practical advice concerning how to cope with the patient (Spañoil et al., 1987). Just as family members benefit from learning about a relative's psychiatric illness, patients themselves need to be educated about the disorder, to enable them to ccomemore active partners in the management of their own illness (Swezey and Swezey, 1976). In the study by Hammond and Deans (1995) found that, knowledge about the illness will assist family member in developing their coping strategies. The community's attitudes towards the mentally ill will have a major influence on the acceptance of the mentally ill and their social integration. These attitudes may be at least partly determined by knowledge about mental illness (Wolff, et al., 1996).

Despite the widespread clinical practice of educating patients and relatives about psychiatric illness, relatively little is known about the specific educational needs of these peoples. The curriculum of most educational programs had been established by treatment providers, based on their own beliefs as to what information about the illness and its treatment patients and families need to know, rather than on objective data collected from the consumers themselves (Mueser, et al., 1992).

Materials and Methods

The subjects for the study comprised 150 psychiatric out patients (75 patients with schizophrenia and 75 patients with major affective disorder) diagnosed according to DSM-IV criteria and 300 relatives (2 relatives for each patient). All patients were symptomatically stable and were currently receiving out patient treatment at Assiut University Hospital, unit of psychiatry and may be admitted before that at any time. The relative to be included in the assessment (study) must have at least 4 hours contact with the patient daily.

The questionnaire used was obtained from Mueser K.T. as the authors (Mueser, et al., 1992) developed this questionnaire for that purpose. Dr. Aly A. El-Sayeh sent to obtain the questionnaire from the author who readily sent a copy which was translated into Arabic. The questionnaire contained 45 items pertaining to different areas of educational needs. The items generated could be classified into 6 general domains (1) basic facts about mental illness (13 items e.g. symptoms, medication, genetics), (2) coping with the patients symptoms (11 items e.g. negative symptoms, persistent hallucinations, delusions, anxiety, anger); (3) enhancing social functioning **(6** items e.g. improving social relationships, independent living skills); (4) community resources (6 items e.g. alternative living situations, patient and relative self help groups); *(5)* coping with stress and family problems (6 items e.g. stress management, family problem solving); and (6) miscellaneous (3 items, dealing with weight gain, coping with stigma and planning for when a parent dies).

Patients and relatives participating in the survey rated their interest, in learning more, about each educational topic on 5 point scale with 1 denoting not interested and 5 denoting very interested and the other degrees lie in between (2: slightly, 3: somewhat, 4: rather).

Statistical methods

Principal component factor analysis was performed using all 45 items from the total sample of the total sample 450 subjects.

Analysis of variance (ANOVA) was performed to evaluate whether interest level was related to diagnosis (schizophrenia v. mood disorder), respondent (patient v. relative) or the diagnosis x respondent interaction.

Mean and standard deviation for the scores of each topic.

Multiple discriminate analysis.

Results

Table (1) showed the duration of the illness for the sample of patients studied.

Table (2) showed the comparison of the total mean of the 45 educational items screened between different groups of patients and relatives. It showed that mood disorders patients had more interest in educational topics in general than schizophrenics and also the relatives of mood disorder patients showed more interest than relatives of schizophrenics. Both were statistically significant ($P<0.001$). The relatives of schizophrenics had more interest than schizophrenics and also, relatives of mood disorder patients showed more interest than their patients. Both differences were statistically non-significant.

Table (3) Showed the educational topics ratings for all patients and their relatives. The relatives showed statistically significant more interest in some educational topics than the patients which include (a) symptoms of the illness (b) getting what you need from mental health system (c) psychiatric medications (d) how psychiatric diagnosis are made (e) dealing with weight gain.

Table (4) showed the comparison between schizophrenics and their relatives as regards the interest in educational topics. In general relatives had more interest, which showed statistical significance in some topics (a) symptoms of the illness (b) dealing with weight gain (c) what the illness is like for the person with it (d) psychiatric medication.

Table (5) showed the comparison between mood disorder patients and their relatives. The relatives showed more interest but it was non significant.

Table (6) showed the results of ANOVA to evaluate whether interest level was related to diagnosis (schizophrenia versus mood disorder), respondent (patients versus relatives) or the diagnosis respondent interaction. In this study the interest level was related to diagnosis factor which was statistically significant ($P<0.001$) which mean that patient with mood disorders were more interested than schizophrenics.

Table (7) showed the results of the multiple discriminate analysis (MDA) comparing different groups of studied subjects. In order to identify which specific educational needs most distinguished the different groups of subjects, multiple discriminate analyses, were conducted (Kleinbaum et al., 1988). This analysis identifies which educational needs were uniquely different for the groups of subjects, while controlling for the moderately high correlation between all the questions (Mueser et al., 1992). A total of **4** multiple discriminate analysis were performed comparing the following groups (1) relatives of mood disorders patients (MR) with their patients (MP). (2) patients with mood disorders (MP) with schizophrenic patients (SP) (3) relatives of schizophrenics (SR) and their patients (SP) **(4)** relatives of mood disorders (MR) with relatives of schizophrenics (SR). The variables, which were statistically significant for MDA comparing the patients with affective disorder with their relatives, were (a) How psychiatric diagnosis are made (b) getting what you need from mental health system. For MDA comparing schizophrenic patients and mood disorder patients. The patients with schizophrenia and those with affective disorder differed on several topics, those with affective disorders were more interested in (1) strategies for solving problems (2) setting limits on patients behaviour (3) coping with the stigma of mental illness **(4)**psychiatric medications (5) what the illness is like for the patient with it (6)Recent research on mental illness. MDA comparing schizophrenic with their relatives showed that schizophrenic relatives were more interested in (1) psychiatric medications (2) persistent delusions (3) symptoms of the illness (4) what the illness is like for the person with it (5) day treatment. The variables, which were statistically significant for MDA comparing the relatives of patients with mood disorders with relatives of schizophrenics were shown also in the table.

Table (8) showed the factor analysis for the whole sample the most significant items

was factor (1) which include 19 educational topics (1) How psychiatric diagnosis are made (2) symptoms of the illness (3) psychiatric medications (4) early warning signs of the illness (5) improving social relations (6) coping with depression and suicidal thoughts **(7)** anxiety and panic attacks (8) anger, violence, assaultive behavior (a) persistent delusions (10) sleeping problems (11) social isolation, avoidance (12) loss of pleasure (13) lack of interest and motivation (14) problems with concentration (15) alternative treatment approaches (16) getting what you need from mental health system (17) psychiatric hospitalizations (18) managing bureau (19) coping with stigma of mental illness.

Table **(1):** Duration of illness for the studied patients

Duration of illness	All patients (N = **150)**		Chronic Schizophrenic patients (N = **75)**		M.D. patients (N = **75)**		**P**
	No.	**%**	**No.**	**%**	**No.**	**%**	
- ↓ 2 years	58	38.7	28	37.3	30	40.0	
2- ↓ 4 years	51	34.0	26	34.7	25	33.3	
4- ↓ 6 years	23	15.3	11	14.7	12	16.0	N.S.
6- ↓ 8 years	18	12.0	10	13.3	8	10.7	
Mean ± SD	3.14 ± 2.74		3.08 ± 2.95		3.20 ± 2.54		

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Groups	No.	Mean±SD	**(a)** x (b)	(c) x (d)	**(a)** x (C)	(b) x (d)
(a) Chronic Schizophrenic Patients	75	3.36f1.25	<0.001	<0.001	N.S.	N.S.
(b) M.D. Patients.	75	3.84±1.28				
(c) Chronic Schizophrenic Relatives	150	3.51f1.23				
(d) M.D. Relatives	150	3.97±1.17				

M.D. = Mood disorder.

Table (3): Educational topics ratings for all patients and their relatives.

Educational Topics	Patients (N = 150)			Relatives (N = 300)			P
	Order	Mean	SD	Order	Mean	SD	
Improving grooming and hygiene.	1	4.01	1.4	1	4.12	1.33	NS
Improving social relationships.	2	3.97	1.47	11	3.89	1.47	NS
Improving communication with relatives.	3	3.89	1.56	6	3.95	1.43	NS
Strategies for solving problems.	4	3.89	1.51	4	4.01	1.38	NS
Enhancing leisure and recreation activities.	5	3.87	1.46	10	3.91	1.4	NS
Ways of managing stress more effectively.	6	3.86	1.52	3	4.02	1.4	NS
Patients self-help organizations.	7	3.85	1.49	20	3.82	1.46	NS
Improving independent living skills.	8	3.81	1.52	7	3.94	1.41	NS
Relatives support and advocacy organizations.	9	3.81	1.51	29	3.75	1.47	NS
What happens when parent dies.	10	3.8	1.54	19	3.83	1.52	NS
Managing “burnout”.	11	3.79	1.5	16	3.84	1.46	NS
Involuntary commitment to hospital.	12	3.77	1.56	28	3.75	1.56	NS
Sleeping problems.	13	3.76	1.54	27	3.76	1.46	NS
Coping with stigma of mental illness.	14	3.74	1.58	5	3.98	1.42	NS
Alternative treatment approaches.	15	3.73	1.53	18	3.83	1.49	NS
Symptoms of the illness.	16	3.71	1.57	2	4.02	1.4	0.05
Stress and the illness.	17	3.69	1.58	8	3.93	1.43	NS
Social isolation, avoidance/withdrawal.	18	3.69	1.6	17	3.83	1.47	NS
Coping with dep. & suicidal thoug.	19	3.66	1.57	13	3.85	1.48	NS
Loss of pleasure.	20	3.64	1.56	15	3.84	1.44	NS
Side effects of medications.	21	3.61	1.58	21	3.81	1.46	NS
Problems with concentration.	22	3.61	1.6	25	3.77	1.49	NS
Getting what you need from mental health system	23	3.6	1.62	9	3.92	1.39	0.05
Setting limits on the patient’s.	24	3.59	1.62	22	3.8	1.46	NS
Alternative living situations.	25	3.59	1.58	26	3.76	1.44	NS
Persistent hallucinations.	26	3.59	1.61	33	3.7	1.55	NS
Early warning signs of the illness & relapse.	27	3.58	1.59	12	3.87	1.44	NS
							NS

Table (3) continued

Anxiety and panic attacks.	29	3.57	1.61	31	3.74	1.52	NS
Genetics and vulnerability to illness.	30	3.56	1.64	35	3.66	1.56	NS
What the illness is like for the person with it.	31	3.54	1.58	23	3.78	1.52	NS
Psychiatric hospitalization.	32	3.53	1.61	32	3.71	1.53	NS
Persistent delusions.	33	3.51	1.62	36	3.66	1.56	NS
Persistent medications.	34	3.47	1.62	14	3.84	1.51	0.05
Applying for financial assistance.	35	3.45	1.7	37	3.66	1.59	NS
How common the illness is and what tends to happen when a person has it.	36	3.43	1.67	34	3.69	1.54	NS
Recent research on mental illness.	37	3.4	1.65	40	3.48	1.62	NS
Anger, violence, assaultive behavior.	38	3.37	1.67	39	3.53	1.6	NS
How psychiatric diagnoses are made.	39	3.33	1.71	30	3.74	1.51	0.01
Day treatment.	40	3.33	1.66	38	3.62	1.54	NS
Vocational rehabilitation.	41	3.31	1.76	41	3.44	1.7	NS
Dealing with weight gain.	42	3.23	1.7	45	2.78	1.66	0.01
Planning/coping with holidays.	43	3.15	1.73	44	3.16	1.67	NS
Biological theories.	44	3.13	1.68	42	3.29	1.66	NS
Drug/alcohol abuse.	45	3.12	1.77	43	3.25	1.75	NS
Total mean	--	**3.60**	**1.28**	---	**3.74**	**1.22**	**NS**

Table (4): Educational topics ratings for chronic schizophrenic patients and their relatives.

Educational Topics	**Chronic Schizophrenic Patients (N= 75)**			**Chronic Schizophrenic Relatives (N = 150)**			**P**
	Order	**Mean**	**SD**	**Order**	**Mean**	**SD**	
Improving grooming and hygiene.	1	3.88	1.4	1	3.98	1.37	NS
Improving communication with reiatives.	2	3.84	1.6	8	3.72	1.52	NS
Improving social relationships.	3	3.84	1.52	15	3.65	1.53	NS
Ways of managing stress more effectively.	4	3.75	1.53	4	3.78	1.51	NS
Relatives support and advocacy organizations.	5	3.67	1.55	20	3.6	1.49	NS
Strategies for solving problems.	6	3.63	1.6	5	3.74	1.47	NS
Enhancing leisure and recreation activities.	7	3.63	1.53	10	3.68	1.42	NS

Table (4) continued

Patients self-help organizations.	8	3.63	1.52	21	3.6		
Involuntary commitment to hospital.	9	3.61	1.59	34	3.43	1.64	NS
What happens when parent dies.	10	3.57	1.62	13	3.66	1.48	NS
Improving independent living skills.	11	3.53	1.57	9	3.72	1.41	NS
Managing "burnout".	12	3.53	1.55	19	3.61	1.5	NS
Sleeping problems.	13	3.52	1.58	25	3.55	1.46	NS
Social isolation, avoidance/withdrawal.	14	3.51	1.63	11	3.68	1.48	NS
Alternative treatment approaches.	15	3.48	1.58	23	3.57	1.57	NS
Stress and the illness.	16	3.44	1.63	3	3.78	1.48	NS
Coping with stigma of mental illness.	17	3.44	1.65	7	3.73	1.49	NS
Symptoms of the illness	18	3.43	1.65	2	3.87	1.48	0.05
Loss of pleasure.	19	3.43	1.57	17	3.63	1.45	NS
Getting what you need from mental health system	20	3.43	1.61	6	3.74	1.46	NS
Lack of interest and motivation.	21	3.4	1.64	22	3.59	1.48	NS
Problems with concentration.	22	3.4	1.62	28	3.51	1.53	NS
Coping with depression and suicidal thoughts.	23	3.36	1.61	16	3.63	1.52	NS
Early warning signs of the illness and relapse.	24	3.33	1.63	14	3.65	1.5	NS
Side effects of medications.	25	3.29	1.64	24	3.55	1.53	NS
Alternative living situations.	26	3.29	1.65	27			
Applying for financial assistance.	27	3.27	1.64	29	3.51	1.49	NS
Psychiatric hospitalization.	28	3.27	1.61	35	3.41	1.59	NS
Genetics and vulnerability to illness.	29	3.25	1.67	38	3.29	1.63	NS
Persistent hallucinations.	30	3.25	1.7	31	3.49	1.6	NS
Anxiety and panic attacks.	31	3.24	1.66	26	3.53	1.56	NS
Vocational rehabilitation.	32	3.21	1.73	39	3.23	1.7	NS
Setting limits on the patient's behavior.	33	3.2	1.69	32	3.47	1.5	NS
Dealing with weight gain.	34	3.2	1.69	45	2.74	1.61	0.05
How common the illness is and what tends to happen when a person has it.	35	3.16	1.68	33	3.43	1.62	NS
Planning/coping with holidays.	36	3.15	1.68	42	3.02	1.64	NS
What the illness is like for the person with it.	37	3.13	1.66	18	3.61	1.55	0.05
Recent research on mental illness.	38	3.12	1.66	41	3.19	1.68	NS
Psychiatric medications.	39	3.08	1.63	12	3.67	1.54	0.01
Persistent delusions.	40	3.08	1.71	36	13.38	1.58	NS

Table (4) continued

How psychiatric diagnoses are made.	41	3.07	1.73	30	3.5	1.52	NS
Anger, violence, assaultive behavior.	42	3.01	1.69	40	3.22	1.63	NS
Day treatment.	43	2.95	1.66	37	3.3	1.57	NS
Drug/alcohol abuse.	44	2.91	1.79	44	2.91	1.73	NS
Biological theories.	45	2.89	1.62	43	2.97	1.66	NS
Total mean	--	3.36	1.25	---	3.51	1.23	NS

Table (5): Educational topic ratings for M.D. patients and their relatives.

Educational Topic	Patients (N = 150)			Relatives (N = 300)			P
	Order	Mean	SD	Order	Mean	SD	
Strategies for solving problems.	1	4.16	1.37	1	4.28	1.23	NS
Improving grooming and hygiene.	2	4.13	1.39	3	4.26	1.28	NS
Enhancing leisure and recreation activities.	3	1.12	1.36	9	4.14	1.34	NS
Improving social relationships.	4	4.09	1.41	10	4.13	1.36	NS
Improving independent living skills.	5	4.08	1.43	7	4.15	1.37	NS
Patients self-help organizations.	6	4.08	1.44	20	4.05	1.42	NS
Managing "burnout".	7	4.05	1.41	18	4.06	1.38	NS
Coping with stigma of mental illness.	8	4.04	1.46	4	4.23	1.3	NS
What happens when parent dies.	9	4.03	1.43	26	3.99	1.48	NS
Symptoms of the illness.	10	4	1.44	5	4.17	1.31	NS
Sleeping problems.	11	4	1.48	30	3.96	1.42	NS
Ways of managing stress more effectively.	12	3.97	1.51	2	4.27	1.25	NS
Setting limits on the patient's behavior.	13	3.97	1.46	8	4.14	1.33	NS
Alternative treatment approaches.	14	3.97	1.44	13	4.09	1.35	NS
Coping with depression and suicidal thoughts.	15	3.96	1.48	16	4.07	1.41	NS
What the illness is like for the person.	16	3.95	1.39	32	3.95	1.49	NS
Persistent delusions.	17	3.95	1.39	35	3.93	1.5	NS
Relatives support and advocacy organizations.	18	3.95	1.47	37	3.91	1.44	NS
Stress and the illness.	19	3.93	1.49	15	4.08	1.36	NS
Improving communication with relatives.	20	3.93	1.52	6	4.17	1.3	NS
Persistent hallucinations.	21	3.93	1.46	36	3.91	1.47	NS

Table (5) continued

Involuntary commitment to hospital.	22	3.93	1.53	17	4.07	1.41	NS
Side effects of medications.	23	3.92	1.46	14	4.08	1.34	NS
Anxiety and panic attacks.	24	3.91	1.49	34	3.95	1.46	NS
Alternative living situations.	25	3.89	1.46		4.02	1.39	NS
Genetics and vulnerability to illness.	26	3.87	1.56		4.02	1.39	NS
Social isolation, avoidance / withdrawal.	27	3.87	1.56	29	3.97		
Psychiatric medications.	28	3.85	1.54	24	4.01	1.45	NS
Loss of pleasure.	29	3.85	1.52	19	4.05	1.39	NS
Early warning signs of the illness and relapse.	30	3.83	1.53				
Problems with concentration.	31	3.83	1.55	23	4.02	1.41	NS
Psychiatric hospitalization.	32	3.8	1.57	25	4.01	1.42	NS
Getting what you need from mental health system	33	3.77	1.62	11	4.11	1.3	NS
Lack of interest and motivation.	34	3.76	1.63	28	3.98	1.37	NS
Day treatment.	35	3.72	1.57	33	3.95	1.44	NS
Anger, violence, assaultive behavior.	36	3.72	1.58	38	3.84	1.52	NS
How common the illness is and what tends to happen when a person has it.	37	3.69	1.62	31	3.95	1.42	NS
Recent research on mental illness.	38	3.68	1.61	40	3.77	1.52	NS
Applying for financial assistance.	39	3.63	1.75	39	3.82	1.57	NS
How psychiatric diagnoses are made.	40	3.6	1.65	27	3.98	1.45	NS
Vocational rehabilitation.	41	3.4	1.79	41	3.65	1.67	NS
Biological theories.	42	3.36	1.71	42	3.62	1.59	NS
Drug/alcohol abuse.	43	3.33	1.74	43	3.59	1.7	NS
Dealing with weight gain.	44	3.27	1.72	45	2.81	1.72	NS
Planning/coping with holiday	45	3.15	1.79	44	3.31	1.7	NS
Total mean	--	**3.84**	**1.28**	---	**3.97**	**1.17**	**NS**

Table (6): Results of ANOVA test

Source of variation	Sum of squares	Degree of freedom	Mean square	F	Sig.
Respondent factor	1.911	1	1.911	1.283	N.S.
Diagnosis factor	24.334	1	24.334	16.347	<0.001
Interaction: (Pt/Relative) (Schizophrenic/ MD).	0.014	1	0.014	0.009	N.S.

group discrim-inated	Variables entered at P<0.05	direction of effect	Partial r2	F	P
MWMP	how psychiatric diagnosis are made	MWMP	0.23	6.39	P<0.01
MR/MP	getting what you need from mental health system	MWMP	0.22	4.91	P<0.001
MP/SP	strategies for solving problems	MPISP	0.26	7.24	P<0.001
MPISP	setting limits on the patient's behaviour	MPISP	0.35	5.98	P<0.001
MP/SP	coping with stigma of mental illness	MPISP	0.28	5.19	P<0.001
MPISP	psychiatric medications	MPISP	0.35	4.87	P<0.001
MP/SP	what the illness is like for the patient with it	MPISP	0.38	4.11	P<0.001
MP/SP	recent research on mental illness	MP/SP	0.25	3.69	P<0.001
SR/SP	psychiatric medications	SR/SP	0.29	6.97	P<0.01
SR/SP	persistent delusions	SR/SP	0.22	11.71	P<0.001
SR/SP	symptoms of the illness	SR/SP	0.22	7.25	P<0.001
SR/SP	what the illness is like for the person with it	SR/SP	0.24	5.34	P<0.001
SR/SP	day treatment	SR/SP	0.17	5.03	P<0.001
MR/SR	genetic and vulnerability to illness	MR/SR	0.42	17.2	P<0.001
MWSR	setting limits on the patients behaviour	MWSR	0.42	10.3	P<0.001
MWSR	involuntary commitment to hospital	MWSR	0.37	6.9	P<0.001
MWSR	biological theories	MWSR	0.36	6.38	P<0.001
MWSR	how common the illness is and what tends to happen when a person has it.	MWSR	0.38	5.96	P<0.001
MWSR	psychiatric hospitalization	MWSR	0.35	5.91	P<0.001
MR/SR	sleeping problems	MWSR	0.25	5.35	P<0.001
MR/SR	vocational rehabilitation	MWSR	0.22	5.12	P<0.001
MWSR	strategies for solving problems	MWSR	0.35	4.89	P<0.001
MWSR	anger, violence, assaultive behavior	MWSR	0.35	4.74	P<0.001
MR/SR	early warning signs of the illness and relapse	MWSR	0.28	4.39	P<0.001

MR = relative of patient with mood disorder.
MP = mood disorder patient.
SP = schizophrenic patient.
SR = relative of schizophrenic patient.

Table (8): Factor analysis

	Factor name	Eigne value	% of variance
Factor 1 includes			
1	How psychiatric diagnoses are made.		
2	Symptoms of the illness.		
3	Psychiatric medications.		
4	Early warning signs of the illness		
5	Anxiety and panic attacks		
6	Anger, violence, assaultive behaviour	29.87	66.4%
7	Persistent delusions.		
8	Sleeping problems.		
9	Social isolation, avoidance, withdrawal.		
10	Loss of pleasure.		
11	Lack of interest and motivation.		
12	Problems with concentration.		
13	Alternative treatment approaches.		
14	Getting what you need from mental health system		
15	Psychiatric hospitalization.		
16	Managing burn out.		
17	Coping with stigma of mental illness.		
	Factor 2		
1	Stress and the illness.		
2	Ways of management of stress more effectively.		
3	Improving communication with relatives.		
4	Strategies for solving problems.	1.22	2.7%
5	Improving social relationships.		
6	Applying for financial assistance.		
7	Patient self help organizations.		
	Factor 3		
1	Dealing with weight gain.		
2	Planning and coping with holidays.	1.16	2.6%

N.B.: Eigenvalues below 1 are nonsignificant. Finally factor 1 is considered significant as it has large values.

Discussion

'The 2 year effect of a family psycho-education management approach on delaying schizophrenic relapse is both clear and consistent with a growing number of reports (Hogarty et al., 1991; Tarrier et al., 1989; Falloon, et al., 1985; Leff, et al., 1985). Hogarty et al. (1991) reported that among schizophrenic patients exposed to the disorder relevant approaches of family psycho-education/management and social skill training relapse was reduced at 1 year from the nearly 40% observed among medication controls to approximately 20% in each of the experimental treatment conditions alone (Psycho-education or social skill training).

In general, all groups of respondents were most interested in learning basic information about the illness. The topic that was of greatest interest to all respondents was learning how to improve grooming and hygiene, as this topic may reflect improving appearance and is important in facilitating acceptance by others and in decreasing the liability of patients to get medical disorders especially in such cultures where endemic diseases are common. While the least common, has the last order 'order 45' was drug and alcohol abuse, the decreased interest in this psycho-educational topic was due to decreased alcohol and drug abuse in this culture especially alcohol and one of the causes of non compliance seen in patients, in this locality, is fear of addiction which makes the patient stop psychiatric medications. Mueser et al. (1992) found both patients and relatives were relatively uninterested in the educational topic drug and alcohol abuse. This is surprising in light of the prevalence of substance abuse in schizophrenia and affective disorder (Christie et al., 1988; Mueser et al., 1990) and suggests that when substance abuse is prominent, the clinician may need to galvanize the family and patient to address the abuse as an important focus of treatment. The low interest level could also reflect the substance abuse was a current problem for only a minority of the patients surveyed (Mueser et al., 1992), which may be true in this culture.

On comparing the total mean of the **45** educational topics between different groups of patients and relatives, the schizophrenic patients were the least interested and this also was proved on using other tests. This finding is consistent with the finding of Mueser et al. (1992). This could reflect anhedonia a core symptom of schizophrenia (Meehl, 1975); some interest is present, impaired hedonic capacity may attenuate schizophrenics response curiosity about their illness and strategies for managing common problems (Mueserd, et al., 1992). Cognitive impairments including deficits in information processing (Nuechterlein and Dawson, 1984) could contribute.

On comparing the mean of the score of various educational topics between all patients and relatives, the following topics were statistically significant (a) symptoms of the illness, this topic reflect the relatives interest in knowing the symptoms of the illness to improve their ability to detect the illness and improve their insight and orientation (b) getting what you need from mental health system, which will be discussed latter (c) psychiatric medications as this will improve compliance of the patients as their relatives will be convinced about the role of medications in converting the abnormal biological changes and also in

acute treatment, maintenance and prophylactic treatment of these disorders, their benefits and their side effects and how to deal with this side effects (d) how psychiatric diagnoses are made, as most relatives do not know the nosology of psychiatric disorders and that there are standardized criteria for each disorder (e) dealing with weight gain as antipsychotics, antimanic, and antidepressants cause weight gain, so weight gain is an important problem for the relatives who do not know its mechanism, which enhanced their interest. On comparing the mean of the scores of the interest of relatives of patients with mood disorders and their patients, both showed equal interest, which is in agreement with Mueser, et al. (1992). The MDA (multiple discriminate analysis) showed that relatives of mood disorder patients were more interested than their patients in (1) how psychiatric diagnosis are made as this topic is important for them to be confident in the mode of diagnosing psychiatric patients and that the manner of diagnosis is not a haphazard one as this may indicate a perfect diagnosis and so perfect treatment methods. This also may reflect the ignorance of the peoples about the official classification systems and the criteria of diagnosis (nosology of psychiatric disorders). (2) getting what you need from mental health system. The interest in this topic echoes the dissatisfaction of many consumers with the standard treatment they receive and with the poor coordination of treatment services in many areas (Walsh, 1985). This interest may be going in the same direction of the results of a questionnaire survey conducted in the states by Holden and Lewine (1982), they found only 9% had confidence in mental health professionals, 26% felt they were unhelpful and 33% felt frustration with the way they had been treated. In all, 75% of relatives felt the explanation of diagnosis or illness was inadequate. While a variety of interpretations can be offered to account for the other differences between patients and relatives, between different groups of patients and between relatives of different patient groups, the results support the utility of assessing patients and relatives own perceptions of their needs to be able to design real educational programmes, which may be different on the patient level and also according to cultures.

Conclusion and Recommendations

The results of the study showed that consumers of mental health services are capable of specifying their own educational needs and educational programs should be tailored to meet these needs. Tailoring educational materials to the expressed needs of family members and patients appears vital, especially in terms of practical advice for coping with problems. This survey of psychiatric patients and relatives educational needs emphasizes the importance of assessing the specific needs of different diagnostic groups, as well as the value of distinguishing between the needs of patients and family members. Patients and family members are capable of identifying their educational needs and these perceptions need to be accommodated in order for providers to overcome the dissatisfaction of mental health consumers with current treatments. If we are to promote the growing dialogue between patients, families, and mental health professionals (Tarrier and Barrow clough, 1990). We would be advised to design educational programmes which are based on objective data collected from specific

subject groups and which, therefore, match the interests of the mental health consumers (Mueser et al., 1992).

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تقييم للاحتياجات التعليمية النفسية
لمرضى الفصام والاضطراب الوجداني وأقربائهم

أجريت الدراسة في مستشفى أسيوط الجامعي وحدة الطب النفسي على ٧٥ مريضـــا بالفصـــام و ٧٥ مريضا بالاضطراب الوجداني و ٣٠٠ من أقارب المرض (اثنان لكل مريض) طبق عليـــهم اســـتفتاء يحتوى على ٤٥ سؤالا تتعلق بجوانب مختلفة للنواحي التعليمية التي يحتاجها هؤلاء المرضى وذلـــك لتحديد احتياجاتهم الخاصة بهم فعلا وكذلك لمقارنة الاحتياجات التعليمية لمختلف المرضى.

وأظهرت الدراسة أن مرضى الفصام أقل شغفا بالحاجات التعليمية من مرضى الاضطراب الوجدانـــي (الهوس – نوبة الاكتئاب العظمى) وأوضحت التحاليل الإحصائية أن الاحتياجات التعليميـــة تختلـــف حسب تشخيص المريض وأن المرضى وأقاربهم قادرين على تحديد احتياجاتهم التعليمية وعلـــى هـــذا فيجب أن تقوم البرامج التعليمية الطب نفسية الموجهة للمريض على أسس دراسية لاحتياجات المرضى الفعلية حتى تكون أكثر فائدة لأنها تلبى الحاجة الفعلية.